



COMMONWEALTH of VIRGINIA
Department of Medical Assistance Services

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MEMORANDUM

TO: The Honorable Terence R. McAuliffe
Governor of Virginia

The Honorable Charles J. Colgan
Co-Chairman, Senate Finance Committee

The Honorable Walter A. Stosch
Co-Chairman, Senate Finance Committee

The Honorable S. Chris Jones
Chairman, House Appropriations Committee

FROM: Cynthia B. Jones *CBS/EN*
Director, Virginia Department of Medical Assistance Services

SUBJECT: Report on the Medicaid Intellectual and Developmental Disability
Waivers Redesign

The 2015 Appropriation Act, Item 301 MMMM(2) requires:

The Department of Medical Assistance Services, in collaboration with the Department of Behavioral Health and Developmental Services, shall report on plans to redesign the Medicaid comprehensive Intellectual and Developmental Disability waivers prior to the submission of a request to the Centers for Medicare and Medicaid Services to amend the waivers. In developing the report, the departments shall include plans for the list of services to be included in each waiver; service limitations, provider qualifications, and proposed licensing regulatory changes; and proposed changes to the rate structure for services and the cost to implement such changes. In addition, the Department of Medical Assistance Services, in collaboration with the Department of Behavioral Health and Developmental Services, shall report on how the individuals currently served in the existing waivers and those expected to transition to the community will be served in the redesigned waivers based on their expected level of need for services. The departments shall complete their work and submit the report to the Governor and the Chairmen of the House Appropriations and Senate Finance Committees by November 1, 2015.

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

CBJ/

Enclosure

pc: The Honorable William A. Hazel, Jr., MD, Secretary of Health and Human Resources



My Life, My Community: Medicaid Intellectual and Developmental Disability Waiver Redesign

Report to the Governor and General Assembly

Submitted by: The Department of Medical Assistance Services and

The Department of Behavioral Health and Developmental Services

November 2015

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EXECUTIVE SUMMARY

The Department of Medical Assistance Services (DMAS) and Department of Behavioral Health Developmental Services (DBHDS) have worked diligently for two years, engaging the expertise of consultants as well as stakeholders across the Commonwealth, to redesign Virginia's Home and Community Based Services waivers (HCBS) for individuals with intellectual and other developmental disabilities. The redesign combines the target population of individuals with both intellectual disability and other developmental disabilities and offers services that promote community integration and engagement.

The agencies intend to amend the three existing waivers into three distinct waivers that will support all individuals who are eligible and have a developmental disability. Once the elements of waiver redesign detailed in this report are implemented, the Commonwealth's Medicaid HCBS waiver system will:

- Better support individuals with intellectual and/or other developmental disabilities to live integrated and engaged lives in their community,
- Standardize and simplify access to services,
- Offer services that promote community integration and engagement,
- Improve the capacity and quality of providers by increasing their compensation as they increase their expertise,
- Align with current research to achieve better outcomes for individuals supported in smaller community settings, and
- Meet the Commonwealth's obligations under the community integration mandate of the ADA, the Supreme Court's *Olmstead* Decision, and the 2012 DOJ Settlement Agreement requirements to create a community system of care.

Significant input throughout the redesign process has been collected from individuals, families, providers, advocates and stakeholders as well as national experts. Extensive data has been collected to design a waiver system that more closely links needs with costs. For individuals with developmental disabilities and their families, the system will be simplified with a single point of entry through the CSBs and include an array of meaningful service options.

Virginia will better serve individuals and families due to improved provider reimbursement rates, choice and flexibility, improved understanding of needs, preferences, and service utilization. The new system will allow the Commonwealth to decrease the waiver waiting list by getting the right services at the right time to the right people.

I. BACKGROUND

Report Mandate

301 MMMM:

“The Department of Medical Assistance Services, in collaboration with the Department of Behavioral Health and Developmental Services, shall report on plans to redesign the Medicaid comprehensive Intellectual and Developmental Disability waivers prior to the submission of a request to the Centers for Medicare and Medicaid Services to amend the waivers. In developing the report, the departments shall include plans for the list of services to be included in each waiver; service limitations, provider qualifications, and proposed licensing regulatory changes; and proposed changes to the rate structure for services and the cost to implement such changes. In addition, the Department of Medical Assistance Services, in collaboration with the Department of Behavioral Health and Developmental Services, shall report on how the individuals currently served in the existing waivers and those expected to transition to the community will be served in the redesigned waivers based on their expected level of need for services. The departments shall complete their work and submit the report to the Governor and the Chairmen of the House Appropriations and Senate Finance Committees by November 1, 2015.”

Community Integration Mandate of the ADA/Olmstead/DOJ/CMS final regulations

The legal mandate shifting the delivery of home and community based services (HCBS) from traditional congregate settings to integrated person-centered settings is well established in public policy and public funding of services. The Americans with Disabilities Act (ADA), with further clarification through the Olmstead decision, affirmed that people with disabilities have the same rights as all citizens¹. In Olmstead, the Supreme Court ruled that public services and supports must be furnished in the most integrated settings appropriate to each person’s needs in order to prevent their exclusion from the rights of citizenship.²

In 2009, the U.S. Department of Justice (DOJ) Civil Rights Division launched an aggressive effort to enforce *Olmstead*. The division was involved in more than 40 matters in 25 states. Through a series of system-wide settlement agreements, DOJ has expanded the understanding of *Olmstead* obligations. Complying with *Olmstead* no longer means simply transitioning people out of institutions – it has come to mean helping them engage in community life. The DOJ Civil

¹ Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and *Olmstead v. L.C.* retrieved from http://www.ada.gov/olmstead/q&a_olmstead.htm

² Ibid

Rights Division has been holding states increasingly accountable for ensuring their services fully comply with the community integration mandate of the ADA and the tenets of *Olmstead*.

On January 26, 2012, the Commonwealth of Virginia and the US Department of Justice (DOJ) signed a settlement agreement as a result of a DOJ investigation of services provided to individuals with intellectual disabilities in Virginia’s training centers, as well as services for individuals with intellectual and other developmental disabilities (I/DD) in the community. Supports and services for individuals in the target population defined in the Settlement Agreement are almost exclusively funded by the state’s Medicaid HCBS waivers. Meeting the requirements of the Settlement Agreement’s 122 provisions requires changes to multiple policies and practices.

In January of 2014, in support of the ADA and *Olmstead*, the Centers for Medicare and Medicaid Services (CMS) issued the HCBS Final Rule. The rule established in federal regulation requirements for all 1915(c) waivers, authorized under 1915(c) of the Social Security Act, to enhance the quality of HCBS and provide additional protections to individuals that receive services under these Medicaid authorities. The home and community-based setting provisions of this regulation establish a more outcome-oriented definition of HCBS settings.

The regulatory intention is for Medicaid HCBS to provide alternatives to services provided in institutions and maximize the opportunities for individuals receiving waiver services to have access to the benefits of community living, including services in the most integrated setting.³ Federal Medicaid regulations give states flexibility in designing their service systems, allowing them to “waive” certain requirements to provide community alternatives to institutionalization. If a state submits an application for a new waiver, it must fully comport with the new CMS HCBS setting provisions upon implementation. States were required to submit to CMS a Statewide Transition Plan detailing how the state would ensure all of its HCBS waivers fully comply with the new setting provisions by March 2019.

II. Introduction

The Virginia Department of Medical Assistance Services (DMAS) is the state agency with administrative authority for Virginia’s waivers and is the agency that submits waiver applications to CMS for approval. The Virginia Department of Behavioral Health and Developmental Services (DBHDS) maintains operational authority for the three HCBS waivers being redesigned: the Intellectual Disability (ID) Waiver; Individual and Family Developmental Disability (DD) Supports Waiver; and Day Support (DS) Waiver.

³ Key Provisions of the Final Rule *1915(c) Home and Community-Based Waivers* retrieved from www.cms.gov

Virginia's existing waivers have not been significantly updated in recent years. Recognizing the changes taking place at the federal policy level, and to ensure Virginia's system of services and supports fully embrace community inclusion and full access, DBHDS and DMAS jointly undertook an effort to redesign three of the Commonwealth's waivers. The redesign of the waivers is important to:

- Comply with elements of the Settlement Agreement requiring an expansion of integrated residential, day services and employment options for persons with I/DD;
- Provide community-based services for individuals with intense medical and behavioral support needs;
- Expand opportunities that promote smaller, more integrated independent living options with needed supports; and,
- Incentivize providers to adapt their services and business model in support of the values and expectations of the community integration mandate consistent with federal court decisions, the DOJ Settlement Agreement, CMS regulations and Virginia's proposed changes.

Currently, Virginia's ID, DD and DS Waivers separately distinguish eligibility between those with intellectual disability and the rest of the population of individuals with developmental disabilities. However, developmental disability is an umbrella term which includes individuals with intellectual disability. Advocates and stakeholders support incorporating the eligibility of individuals with DD, including ID, in the eligibility criteria for all waivers.

The Human Services Research Institute (HSRI) is under contract with DBHDS to: (a) evaluate the state's current service delivery system for I/DD; (b) make recommendations to move the system to a more person-focused/needs-based system of supports; and (c) review the existing rates paid to service providers and the current method of allocating resources to support individuals receiving services. Its work involved assessing the support needs of individuals receiving HCBS; helping the Commonwealth restructure the current HCBS waivers, including associated rate reimbursement schedules; and projecting the types and amounts of services individuals will use in relation to their support needs.

Stakeholders and advocates asked that the redesign of the waiver system take into consideration streamlining application and administrative processes, improving care coordination and service quality, increasing choice and options for community integration and engagement and improving oversight. Virginia's proposed Statewide Transition Plan addresses stakeholders' suggestions and will bring the state into full compliance with the setting provisions by the March 2019 deadline.

Waiver redesign initially centered on creating one new comprehensive waiver. However, if the Commonwealth were to continue developing one new waiver, implementation could not take place until after the March 2019 deadline for compliance with CMS HCBS settings provisions. For this reason, waiver redesign moved toward amending three existing waivers.

III. The Commonwealth's Proposed New Waiver System

The Departments of Medical Assistance Services and Behavioral Health and Development Services have been working over the past 24 months to update and modernize Virginia's Medicaid HCBS waivers for I/DD by July 1, 2016. The design of the new system, including the development of new services, was accomplished with significant stakeholder involvement. The new services will provide opportunities for greater community integration and engagement, and optimize individual lifestyle preferences and choices.

Currently, the ID Waiver is comprehensive with a wide array of services including 24 hour residential supports. The DS Waiver provides minimal supports and is limited to individuals on the ID Waiver urgent or non-urgent waitlist. Generally, this supports waiver excludes the provision of services in licensed residential settings. The DD Waiver also serves as a supports waiver, albeit with a more robust array of services than the DS Waiver, but there is no congregate residential supports component.

Amending Current Waivers

These three existing HCBS I/DD waivers are being redesigned to:

- (1) Better support individuals with intellectual and/or other developmental disabilities to live integrated and engaged lives in their community,
- (2) Standardize and simplify access to services,
- (3) Offer services that promote community integration and engagement, and
- (4) Meet the Commonwealth's obligations under the community integration mandate of the ADA; the Supreme Court's *Olmstead* decision; the DOJ Settlement Agreement; and the settings requirements of the CMS HCBS final regulations.

Proposed changes to the current waivers are described below.



These amendments propose a new and unified waiver system with an array of services for each waiver. Tables 1.0 and 1.1 provide an overview of the waivers described above, including a side-by-side comparison of the services available in the current waivers as well as the new services being proposed. Appendix D gives more detailed explanations of all services to be included in the amended waivers.

Table 1.0: Redesigned I/DD Waiver Services Array

Current Services	ID	Community Living	DD	Family & Individual	DS	Building Independence
Assistive Technology	✓	✓	✓	✓		✓
Case Management (Medicaid state plan benefit)	✓	✓	✓	✓		✓
Companion Services	✓	✓	✓	✓		
Group Home Residential	✓	✓				
C-D Companion Services	✓	✓	✓	✓		
C-D Personal Assistance Services	✓	✓	✓	✓		
C-D Respite	✓	✓	✓	✓		
Community-Based Crisis Supports *	✓	✓	✓	✓		✓
Center-Based Crisis Support*	✓	✓	✓	✓		✓
Crisis Support Services*		✓		✓		✓
Group Day Support Services	✓	✓	✓	✓	✓	✓
Environmental Modifications	✓	✓	✓	✓		✓
Family/caregiver Training	✓	✓	✓	✓		
In-home Support Services	✓	✓	✓	✓		
Personal Assistance Services - Agency Directed	✓	✓	✓	✓		
Personal Emergency Response System (PERS)/Medication Monitoring	✓	✓	✓	✓		✓
Prevocational Services	✓		✓		✓	

*previous service revised/modified as new service model

Table 1.0: Redesigned I/DD Waiver Services Array

Current Services	ID	Community Living	DD	Family & Individual	DS	Building Independence
Respite Services - Agency	✓	✓	✓	✓		
C-D Services Facilitation	✓	✓	✓	✓		
Skilled Nursing Services	✓	✓	✓(RN)	✓		
Individual Supported Employment Services	✓	✓	✓	✓	✓	✓
Group Supported Employment	✓	✓	✓		✓	✓
Therapeutic Consultation	✓	✓	✓	✓		
Transition Services	✓	✓	✓	✓		✓

*previous service revised/modified as new service model

Table 1.1: New I/DD Waiver Services Array

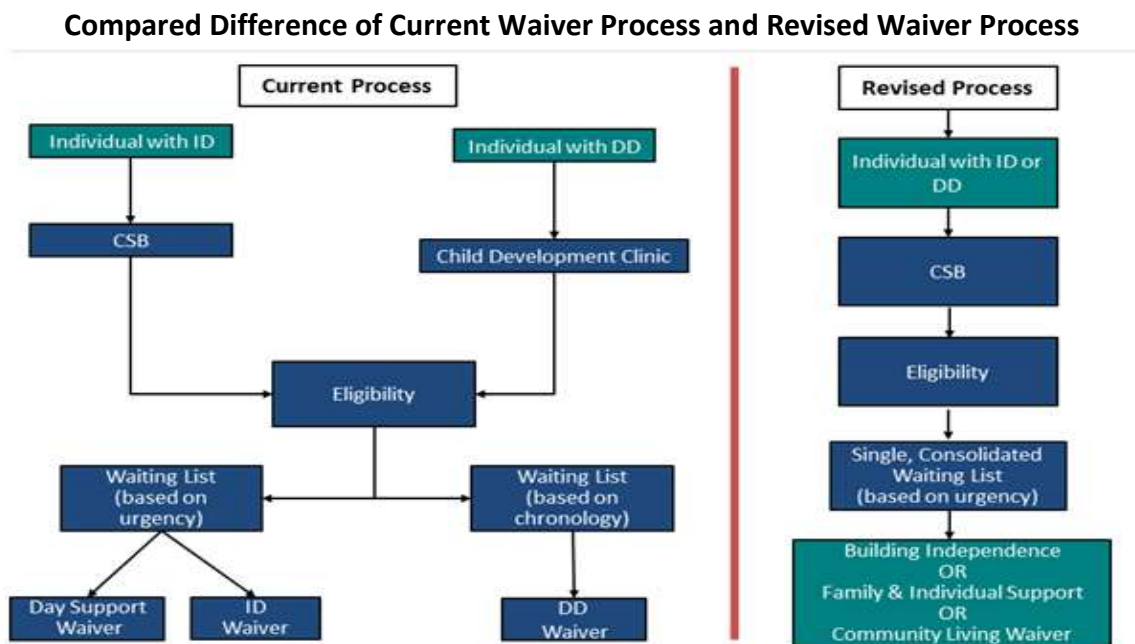
New Services	ID	Community Living	DD	Family & Individual	DS	Building Independence
Supported Living Residential		✓		✓		
Shared Living		✓		✓		✓
Independent Living						✓
Sponsored Residential		✓				
Elec Based Home Support		✓		✓		✓
Non-Medical Transportation		✓		✓		✓
Benefits Planning		✓		✓		✓
Community Guide (Peer mentoring)		✓		✓		✓
Community Coaching		✓		✓		✓
Community Engagement		✓		✓		✓
Workplace Assistance Services		✓		✓		
Private Duty Nursing Services		✓		✓		

Implementation – Phase One

It is recommended that the new waiver system be implemented in two phases. It is anticipated that Phase One will be implemented beginning July 2016 and will include the redesigned waivers and new services as described above, non-diagnosis specific eligibility, assessment of needs and implementation of supports levels, and a single statewide waitlist.

Eligibility

One of the most significant elements of the amended waivers is that all three waivers will serve individuals with a diagnosis of ID or DD. For example, in the current system an individual with a diagnosis of autism, but no specific diagnosis noting an intellectual disability, would only be eligible to receive services under the DD Waiver. In the new plan, the three waivers will be open to all eligible individuals, creating a unified system for individuals to access waiver services. All individuals seeking I/DD waiver services will have diagnostic and functional eligibility confirmed by their local CSB and, as appropriate, have their names placed on a single, statewide waiting list. The graphic below illustrates the difference between the current system and the proposed system.



Assessment of Needs

The new waivers are designed to support individuals based on their needs, choices and preferences. Supports needs are determined using the Supports Intensity Scale® (SIS®) and the Virginia Supplemental Questions. The SIS® is a nationally recognized, standardized, norm-based assessment tool.⁴ The SIS® is multi-dimensional and comprehensively evaluates the pattern and intensity of needed supports in the following domains:



The redesigned waiver system is built upon using the SIS® to determine supports needs. Another component of the process is the completion of a tool called the “Supplemental Questions,” which is unique to Virginia. These questions are designed to identify individuals with unique needs that fall outside of the SIS® standardized instrument. These combined tools are used to determine an individual SIS® score, which can then be used to correlate an individual’s supports needs to one of seven levels. The seven levels were recommended by a study of Virginia’s waiver utilization and assessment data.⁵ The design of the seven supports level system has been validated through a review of a random sample of individuals’ records by DBHDS and Community Services Board (CSB) staff. Table 2.0 provides a brief description of the seven supports levels and corresponding range for scores for parts A, B and E of the SIS®, as well as medical and behavioral supports.

⁴ J. Ivey, J. LaVelle, J. Thompson, A. Tribble, J. Loon, S. Wrigley. Relating Supports Intensity Scale Information to Individual Service Plans. *AAIDD White Paper* (June 2008)

⁵ HSRI. [Redesigning Supports and Services for Virginians with I/DD. A Validation Study.](#) (June 2015)

Table 2.0: Seven Supports Levels and their Derivation

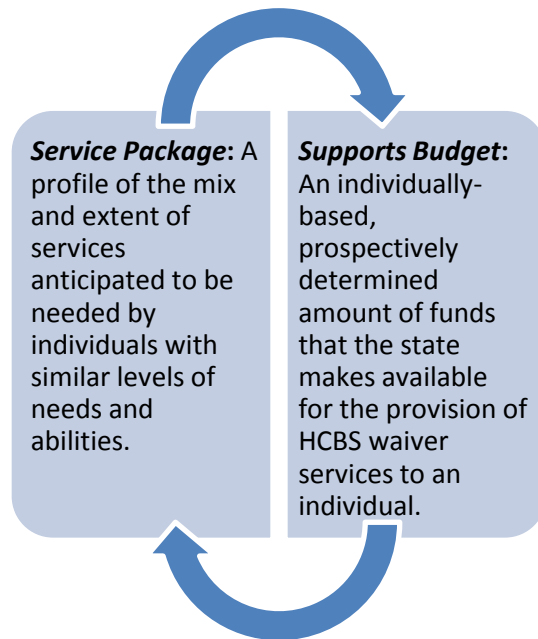
Levels Brief Description		Scales ABE	Medical Support	Behavioral Support
1	Least Support Needs	0 to 22	0 to 6	0 to 6
2	Modest or Moderate Support Needs	23 to 30	0 to 6	0 to 6
3	Least/Moderate Support Needs with Some Behavioral Support Needs	0 to 30	0 to 6	7 to 10
4	Moderate to High Support Needs	31 to 36	0 to 6	0 to 10
5	High to Maximum Support Needs	37 to 52	0 to 6	0 to 10
6	Extraordinary Medical Support Needs	Any	7 to 32 verified extraordinary medical risk	
7	Extraordinary Behavioral Support Needs	Any	Any	11 to 26 verified danger to others or extreme self injury risk

This model has been employed in a number of other states, leading to more equitable distribution of funding for core waiver services. Currently in Virginia, funding and payment for services are broadly related to individual supports needs, and different amounts of funding are associated with people who have similar supports needs. An individual’s level of need for resources and supports is often not correlated to waiver expenditures. Implementing the SIS[®] assessment process and assignment of a supports level is a critical step to more equitable resource distribution in the first phase of waiver redesign. Over time, the Commonwealth anticipates the waiver redesign will bring a higher degree of correlation, aligning individuals’ supports level with the cost of their services. This will enable the Commonwealth to better predict costs and serve more individuals.

The SIS[®] does not provide the same type of information that a person-centered planning process offers, such as information regarding the settings the person enjoys most, activities the person wishes to participate in, and life experiences the person desires. Therefore, the SIS[®] will be used in conjunction with person-centered planning for individualized service plan (ISP) development.

Implementation - Phase Two

Implementation of Phase Two of waiver redesign is expected to begin in July 2018. Phase Two may include the introduction of service packages and supports budgets, defined as follows:



Each supports level will align with specific *service package* options based on where the individual lives and spends his/her day. In particular, a service package will outline the type and amount of services an individual may utilize, consistent with the data collected during Phase One. When service package information is combined with known costs per unit of service, a “supports budget” can be calculated. After an individual is assigned to one of seven levels, potential service packages will be reviewed based on this assignment and other elements, including type of services and age group. Supplemental services, such as crisis services, companion services, and environmental modifications, may be provided in addition to the individual’s base support budget.

During the implementation of Phase One (July 2016 – June 2018), neither the discussion of service packages nor supports budgets will be part of the person-centered planning process with individuals/family members. Rather, current assumptions of anticipated service utilization (i.e., types and amounts of services) within each supports level will be studied and compared to actual service utilization. The data and analysis from 2016-2018 will enable DBHDS and DMAS

to further validate the design of service packages against supports levels, make any needed adjustments to the service packages and determine future courses of action. Person-centered principles and practices will continue to be the foundation for an individual's service plan.

When fully implemented, service packages will allow individuals to “mix and match” a menu of services to suit their needs/desired outcomes, up to the total supports budget amount for that service package. This permits flexibility and customization of supports according to individuals' needs and lifestyle choices, while maintaining fiscal controls and budget predictability. Service packages are an integral part of modernizing the structure and framework of the system. The integration of service packages and supports budgets into service planning will move the system from a post-utilization management model to a predictive utilization management model.

DBHDS and DMAS recognize that, in spite of sound research, public input and best efforts, some individuals may have an assigned supports level that does not align with a service package that meets their essential needs. Therefore, prior to Phase Two implementation, a process for individuals and families to request modifications/exceptions to their service package and supports budget will be developed.

Service Limitations

Each waiver service has certain parameters or limitations associated with it, such as maximum number of hours/units in a given period. Some of the current service limitations will continue in the redesigned waivers and within approved new services.

Residentially-Based Services

- ✓ Individuals in the Community Living Waiver will be able to choose one of the residential services.
- ✓ Group home and sponsored residential services will be reimbursed on a daily basis based upon a full year of funding. Providers may bill for 344 days during the 365 day year, allowing for individuals to be absent for 21 days.
- ✓ Individuals receiving 24/7 type services may **not** receive In-home Support Services, Shared Living, Personal Assistance, Respite and Personal Emergency Response System (PERS)

- ✓ Environmental Modifications are also not approved when individuals reside in Group Home, Supported Living and Sponsored Residential settings.

Day Services

- ✓ Individuals and their individual support team will determine the combination of supported employment and other day services to meet their needs.
- ✓ Policy decisions will be made regarding the maximum number of hours per day an individual may receive each service similar to the current waivers.
- ✓ Workplace Assistance Services may only be accessed as a follow-up to Individual Supported Employment.
- ✓ None of the day services are mutually exclusive.

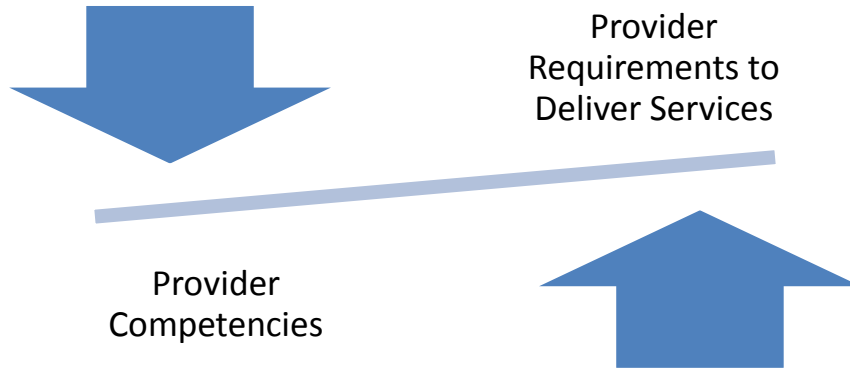
Supplemental Supports and Services

The proposed changes are designed to either fill a long-standing gap in service (e.g., adult dental, non-medical transportation, benefits planning), rectify a current service issue/deficit in the waivers (e.g., private duty nursing will enable skilled nursing to be used more appropriately), or be used in lieu of paid staff to reduce overall costs and promote independence (e.g., electronic-based home supports).

- ✓ As in the current waivers, some services may not be available to all individuals (e.g., those living in a residential situation with a paid caregiver are not eligible for respite; children are not eligible for companion services).
- ✓ Many of the existing services will continue to have annual caps (e.g., environmental modifications, assistive technology, and transition services) or annual unit limits (e.g., respite services).
- ✓ Adult dental is proposed to have an annual dollar cap.
- ✓ Benefits planning is proposed to be reimbursed at the Department of Aging and Rehabilitative Services rate.
- ✓ Electronic-based home supports may not be authorized for individuals who are receiving group home or sponsored residential services.

Additional service limitations may be developed during the regulatory process.

Provider Qualifications



Provider Requirements to Deliver Services. Each waiver service requires that the providers of that service possess certain licenses or certifications to obtain Medicaid approval to deliver and bill for those services. For the existing waiver services, the provider qualifications criteria are already established and will remain. For new services that are similar to existing services, a comparable license will be required. New services that are currently licensed by another entity will require verification of that license by the provider (e.g., providers of adult dental must be dentists licensed through the Virginia Board of Dentistry and be enrolled with Medicaid’s dental contractor). DBHDS and DMAS will look to national standards to determine the appropriate requirements for new services that do not have existing state requirements.

Provider Competencies. Providers of current services must have certain types of training or certifications per their license (e.g., CPR, first aid, medication administration). Some services also require staff to complete DBHDS-developed training regarding best practices in supporting individuals with disabilities.

DBHDS is developing a voluntary, competency-based rating system for providers of certain services to assess themselves against established criteria of best practices. This provider rating system includes designations that demonstrate expertise with certain specialty areas of service provision, such as supporting those with Autism Spectrum Disorder intense medical and behavioral needs. The intent is to provide a means for providers to benchmark their own progress in supporting individuals with more intense or unique needs, encourage providers to develop an internal process of ongoing quality improvement, and enable individuals and families to locate providers who can meet unique support needs.

Proposed Licensing Regulatory Changes

To comply with the settings provisions of the CMS HCBS regulation and certain DOJ Settlement Agreement requirements, DBHDS has drafted new licensing regulations. DBHDS will likely make further modifications, some of which will incorporate changes needed to support the licensing of new services created by waiver redesign. Individual, family, provider and stakeholder input will be sought in the development of permanent licensing regulatory changes.

IV. RATE METHODOLOGY

Another hallmark of waiver redesign is the development of proposed reimbursement rates based on a methodology developed and implemented by nationally-recognized consultant Burns & Associates, Inc. This rate-setting methodology, required by CMS, builds rates to cover all the components of costs for providers to meet the service requirements (e.g., wages, benefits, travel, training, documentation, program support and administration). This methodology allows the Commonwealth to adjust the assumptions for each service based on current data.

To establish rate methodologies for services, a statewide rate study of I/DD waiver providers and services was conducted. The study used Bureau of Labor Statistics data and reviewed market costs, service definitions, and provider requirements. The subsequent rate calculations were disseminated for public comment in late 2014, and adjustments were made. The final proposed rates were published on April 23, 2015.

Relationship between “Levels” and “Tiers”

Various “congregate” residential services (e.g., group home and sponsored residential), as well as other services (e.g., group day, community engagement, and group supported employment) will require a tiered reimbursement schedule based on the expected number of hours of direct supervision and support that an individual may need. The reimbursement tiers are tied to individuals’ supports levels, so that service providers are reimbursed at a higher amount for supporting individuals with greater needs. The rate structure also reflects higher reimbursement for more integrated and/or smaller settings.

The first two tiers are directly tied to the first two supports levels, while tiers 3 and 4 are associated with multiple supports levels. Figure 2.0 illustrates the relationship between levels

and tiers and the projected percentage of individuals in the current waiver population who are expected to fall into each level based on the HSRI SIS® study.

Figure 2.0: Reimbursement Tiers and Corresponding Supports Needs Levels

Tiers	Levels		# of Individuals	%
①	①	Mild Support Needs	840	7.3%
②	②	Moderate Support Needs	4,360	37.9%
③	③	Mild/Moderate Support Needs with Some Behavioral Support Needs	276	2.4%
	④	Moderate to High Support Needs	4,452	38.7%
④	⑤	High to Maximum Support Needs	610	5.3%
	⑥	Intense Medical Support Needs	794	6.9%
	⑦	Intense Behavioral Support Needs	173	1.5%

Proposed Changes to Rate Structure and Cost Implications

Table 3.0 on the following page illustrates the major changes to the rate structures for the most commonly used existing I/DD Waiver services. The proposed rates are designed to encourage the national best practice of smaller community-based models over larger, self-contained models.

Table 3.0: Waiver Rate Structure Change

Service	Waivers	Current Rate Structure Per Individual (7/1/15)	Proposed Rate Structure Per Individual
In-Home Residential	<ul style="list-style-type: none"> • Community Living • Family and Individual Supports 	\$20.73/hour \$23.83/hour (NOVA)	<p>Supporting one person: \$25.61/hour \$29.84/hour (NOVA)</p> <p>Supporting two people: \$14.09/hour \$16.41/hour (NOVA)</p> <p>Supporting three people: \$10.24/hour \$11.94/ hour (NOVA)</p>
Group Home Residential	Community Living	\$15.40/hour \$17.71/hour (NOVA)	<p>Homes with 4 or fewer beds: Tier 1: \$201.76/237.62 (NOVA) Tier 2: \$240.00/283.29 (NOVA) Tier 3: \$264.26/312.26 (NOVA) Tier 4: \$315.36/373.27 (NOVA) Daily rate decreases incrementally as size of home increases down to:</p> <p>Homes with 12 beds: Tier 1: \$148.12/174.09 (NOVA) Tier 2: \$150.98/177.50 (NOVA) Tier 3: \$173.82/204.76 (NOVA) Tier 4: \$224.91/265.76 (NOVA)</p>
Supported Living	<ul style="list-style-type: none"> • Family and Individual Supports • Community Living 	\$15.40/hour \$17.71/hour (NOVA)	<p>Tier 1: \$136.76 / \$160.03 (NOVA) Tier 2: \$177.12 / \$208.22 (NOVA) Tier 3: \$205.98 / \$242.67 (NOVA) Tier 4: \$259.25 / \$306.26 (NOVA)</p>

Table 3.0: Waiver Rate Structure Change

Service	Waivers	Current Rate Structure Per Individual (7/1/15)	Proposed Rate Structure Per Individual
Sponsored Residential	<ul style="list-style-type: none"> Community Living 	\$15.40/hour \$17.71/hour (NOVA)	Daily Rate: Tier 1: \$131.98/\$137.80 (NOVA) Tier 2: \$180.98/\$186.79 (NOVA) Tier 3: \$232.60/\$239.15 (NOVA) Tier 4: \$301.19/\$307.75 (NOVA)
Day Services (inclusive of Group Day, Community Engagement, Community Guide)	<ul style="list-style-type: none"> Community Living Family and Individual Supports Building Independence 	<i>Regular Intensity:</i> \$26.71/block \$30.72/block (NOVA) <i>High Intensity:</i> \$38.02/block \$43.73/block (NOVA)	Group Day Support Tier 1: \$8.60/ hour \$10.01/ hour (NOVA) Tier 2: \$11.25/ hour \$13.12/ hour (NOVA) Tier 3: \$13.31/ hour \$15.55/ hour (NOVA) Tier 4: \$17.34/ hour \$20.29/ hour (NOVA) Community Engagement Tier 1: \$14.29/ hour \$16.19/ hour (NOVA) Tier 2: \$16.01/ hour \$18.21/ hour (NOVA) Tier 3: \$18.38/ hour \$21.01/ hour (NOVA) Tier 4: \$22.61/ hour \$25.98/ hour (NOVA) Community Guide (a 1:1 service) \$29.24/ hour \$33.53/ hour (NOVA)
Group Supported Employment	<ul style="list-style-type: none"> Community Living Family and Individual Supports 	\$35.48/block \$40.81/block (NOVA)	Group of 2: \$19.25/ hour \$20.99/ hour (NOVA) Group of 3 – 4: \$13.52/ hour \$14.70/ hour (NOVA) Group of 5 – 8: \$11.21/ hour \$12.18/ hour (NOVA)

New rates are proposed for existing services and new services. Future costs were projected using Fiscal Year 2014 claims data and the number of individuals receiving services for a full year. When fully annualized, existing services are projected to cost \$19.2 million in general fund (GF) dollars under the proposed new rates. Because there is no utilization data available for new services, it is necessary to project both utilization and cost. DBHDS and DMAS have projected a cost of \$5.1 million GF for adding new services, excluding adult dental, to

meet the mandate to increase community integration. This would be offset by \$3.7 million GF that was appropriated for “exceptional rates” (a 25% higher rate for services provided to individuals with complex medical or behavioral needs in the community) prior to the rate adjustments that are now proposed. Combined, the total cost of proposed rate changes and new services is \$20.6 million GF (including the offset) when fully annualized. If the proposed changes are authorized, the phased- in costs in the 2016-18 biennium are \$10.5 million for FY 2017 and \$20.3 million for FY 2018.

Table 4.0 summarizes the average change in cost of the majority of the existing services under the proposed rate model.

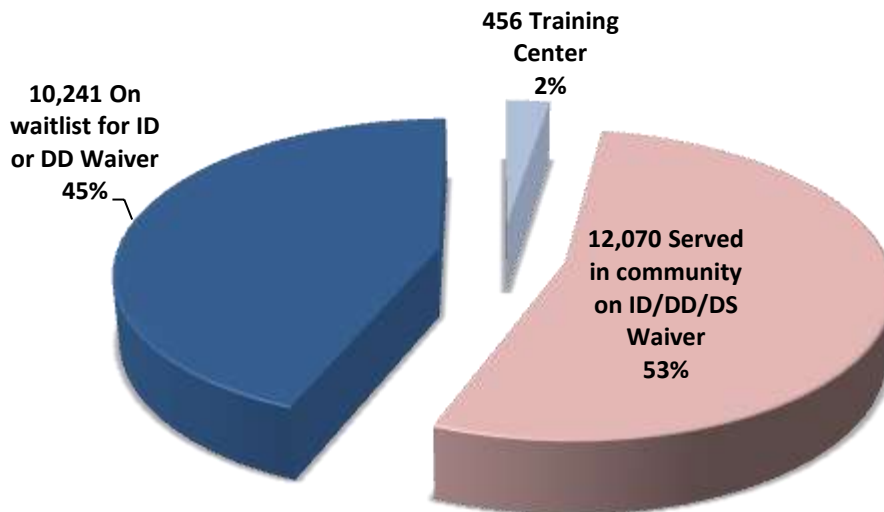
Table 4.0: Average Change to Cost of Existing Services

Changes to Current Services – General Fund (\$ in millions)	% Change	\$ Change
Group Home	+2.8	\$4.0
Sponsored Residential	-0.4	-\$0.2
Supported Living	-1.1	-\$0.1
In-Home Residential	+23.7	\$6.2
All Other Congregate	+2.7	\$.9
Day Support	+9.1	\$4.1
Pre-Vocational Services	+5.9	\$0.3
Group Supported Employment	-3.7	-\$0.2
Skilled Nursing	+40.0	\$3.5
Therapeutic Consultation	+43.8	\$0.2
DD Case Management	+38.4	\$.4
Total		\$19.2

Current Cost of the ID and DD Waiver Programs

Currently, there are over 11,000 individuals served on I/DD waivers at a total cost approaching \$900 million, while thousands remain on the waiting list (see Figure 3.0). Approximately 3,500 individuals on the waiting lists for I/DD waivers are currently being served in the Elderly or Disabled with Consumer Direction (EDCD) Waiver. CMS permits an individual to be on a waiting list for a waiver and receive services under another waiver if they are eligible for both. The EDCD Waiver does not provide the full range of services an individual with I/DD may need; therefore, they remain on the I/DD waiting list.

Figure 3.0: Number of Individuals Waiting for Waiver Services Effective 10/23/15



The table on the following page illustrates the total number of individuals in each of the three current I/DD waivers as of the end of FY 2015, and the number of individuals that will occupy slots and associated costs once all FY 2016 funded slots are filled .

Table 5.0: Total Number of Individuals by Slot Designation

Waiver	Total FY 15 Occupied Slots	Total with FY 16 Approved Slots	Amended Waivers	FY 17 Settlement Slots	FY 18 Settlement Slots
Day Support Waiver	288	300	Independence Waiver	0	0
Developmental Disabilities Waiver	1,013	1,053	Family & Individual Supports Waiver	25	25
Intellectual Disability Waiver	10,307	10,717	Community Living Waiver	390*	415*

*Includes planned slots for facility downsizing

The current mix of individuals served in I/DD Waivers as of the start of FY16 is shown below. The estimated average cost per waiver slot is based on calendar year 2014 figures (the most recent figures available). During FY15, the total expenditures for the I/DD Waivers reached \$886 million annually.

Table 6.0: Costs Associated with Current ID/DD Waivers Calendar Year 2014

Waiver	# Served	Est. Average Cost per Individual
ID	10,717	\$68,206
DD	1,053	\$30,809
Day Support	300	\$13,000
Total	12,070	

Once the amended waivers are fully implemented, it is likely that the distribution of individuals on each of the waivers will change, with an increase in those receiving the Family & Individual Supports Waiver. Per the DOJ Settlement Agreement, the Commonwealth must add 855 new ID and DD Waiver slots during the 2016-18 biennium at a cost to the general fund of \$44 million; these slots include waivers for individuals transitioning from training centers to the community.

V. TRANSITIONING FROM THE EXISTING I/DD WAIVERS TO THE REDESIGNED I/DD WAIVERS

The Commonwealth is doing many things to ensure a smooth and efficient transition to the redesigned waivers including:

- Providing extensive training of case managers/support coordinators;
- Developing provider capacity;
- Working to help CSBs assume an expanded role with eligibility determination as the single point of entry;
- Increasing access to integrated housing through various housing initiatives; and
- Strengthening oversight and quality assurance systems.

It is expected that individuals within each of the three existing I/DD waivers will transition directly to the corresponding amended waiver without a lapse in services. In addition, waiver service definitions are being updated, with a greater focus on achieving optimal outcomes for each enrolled individual.

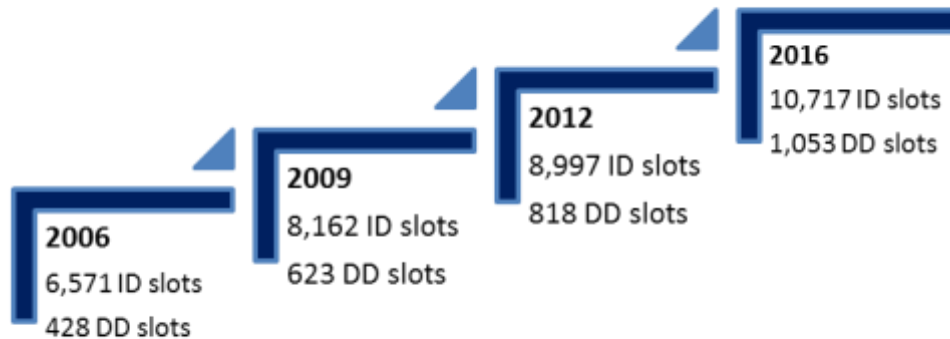
Following the submission of this report, DBHDS and DMAS will draft the three waiver amendments for submission to CMS. The submissions will include a caveat that implementation of planned changes are dependent on increased funding and approval by the 2016 General Assembly. The current process for amending waivers involves a 30-day public comment period prior to the submission of changes.

The redesigned waivers, once fully implemented and funded, provide the Commonwealth with a systematic means of providing services for those individuals with more intense medical and/or behavioral challenges. This approach enables Virginia to complete the transition of individuals towards more integrated settings and away from training centers and other institutional settings.

I/DD Waiver Waiting Lists

Although Virginia's waiting list for waiver services continues to grow, over the last ten years there has been a 63% increase in slots made available for the ID Waiver program and a 143% increase in the DD Waiver program (See Figure 4.0). Providing these additional waiver slots through the Medicaid program costs \$504.9 million.

Figure 4.0: Ten year Allocation History of ID and DD Waiver Slots



As of October 9, 2015, the waitlist for the ID Waiver was 8,143, with 4,966 individuals on the urgent needs list. In contrast to the needs-based ID Waiver waiting list, the DD Waiver waiting list is maintained in chronological order, so that individuals are offered slots on a first come, first served basis. The chronological waitlist for the DD Waiver is 2,109; 40 slots were awarded in FY16. Approximately 70 percent of the individuals on the waiting list are under age 25. Consistent with CMS guidance, the Commonwealth will need to have the capacity to address emergencies; this will be accomplished by maintaining a reserve pool of slots for each waiver each fiscal year.

As previously mentioned, there are approximately 3,500 children and adults on the waiting list for ID and DD Waiver services who are currently receiving services through the EDCD Waiver. These individuals, accounting for more than one-third of the waiting list, have full access to Medicaid benefits, including acute and primary care services. These individuals are waiting for DD or ID Waiver services to more effectively meet their needs.

An important aspect of waiver redesign will be the transition to a single statewide waitlist for all three waivers. This wait list will be based on need and individuals will be grouped into one of three “priority needs” categories. DBHDS has in place five regional SIS® specialists who are working directly with each CSB and assisting with each regional waitlist. These staff will also support waiver slot assignment committees within each region, comprised of community members recommended by CSBs. As required by CMS, the redesigned waivers

separate the entity that determines eligibility for the waiver (CSB support coordinators/case managers) from the entity which allocates slots (DBHDS-supported regionally based committees).

Conclusion

With the input of multiple stakeholders, DMAS and DBHDS has proposed the redesign of the intellectual and developmental disability waivers to better address the needs, choices and preferences of individuals and assist their families. These efforts reviewed all aspects of the programs including provider reimbursement rates, services and definitions, choice and flexibility, access to services, eligibility, assessment, and service utilization. Recommendations in this report incorporate improvements in these very important areas of the system. The new system will provide an opportunity for the Commonwealth to decrease the waiver waiting list by providing the right services at the right time to the right people. Finally, the redesigned waivers will also meet federal requirements by supporting individuals in smaller, more integrated community settings.

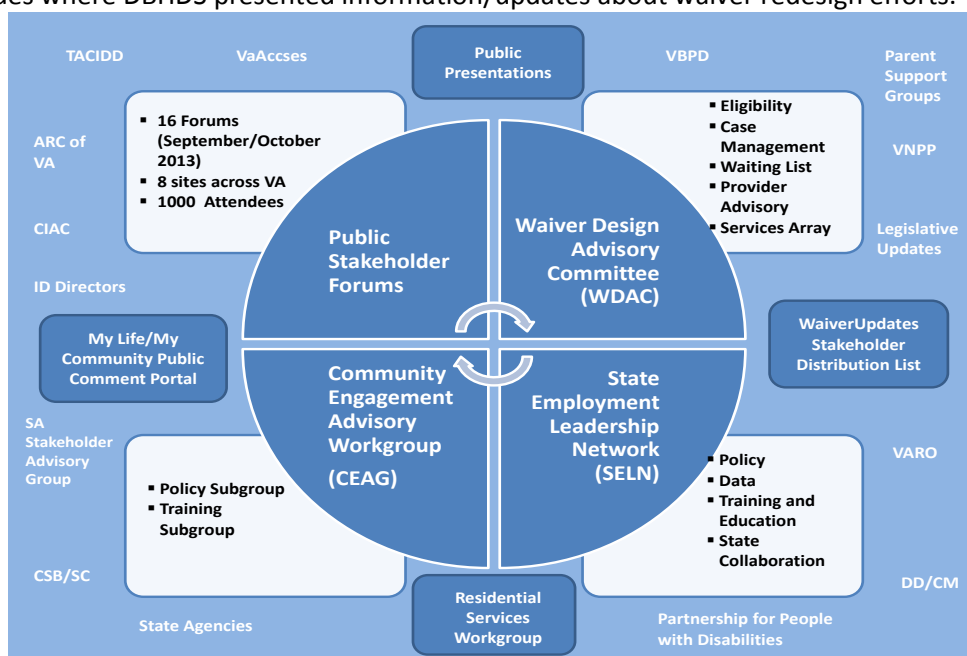
Appendix A

Expert Consultation and Stakeholder Involvement

To redesign the I/DD waiver, DBHDS contracted with national experts to provide consultation and gather data to inform state policy makers of the best possible options for waiver redesign. The Human Services Research Institute (HSRI) and its affiliates undertook a statewide “town hall” style effort in the fall of 2013 to gather stakeholder input regarding the challenges associated with the current waivers, as well as best ways to improve waivers for individuals with I/DD in the future. In addition to personal interviews with key state stakeholders, the 16 public forums gathered information from approximately 1,100 people, including individuals with disabilities, family members, service providers and the general public. The information gleaned through this process, as well as HSRI’s review of waiver and other related regulations and policies, informed recommendations made in December 2013.

In 2014, DBHDS convened a number of committees to respond to and expand upon HSRI’s recommendations on various elements of waiver redesign. These committees were populated by individuals with disabilities, family members, CSB staff, private providers, members of advocacy organizations and other state agencies. They dealt with topics such as case management, waiting list management, waiver eligibility, services array, and input to HSRI’s subcontractor, Burns and Associates, regarding the implementation and findings of a statewide rate study.

In addition, all committee recommendations were vetted through an overarching committee of expert stakeholders: the Waiver Design Advisory Committee. The groups’ recommendations are woven throughout this document. The following graphic illustrates the sources of input into waiver redesign (in the dark blue and white center elements of the graphic), as well as a number of venues where DBHDS presented information/updates about waiver redesign efforts.

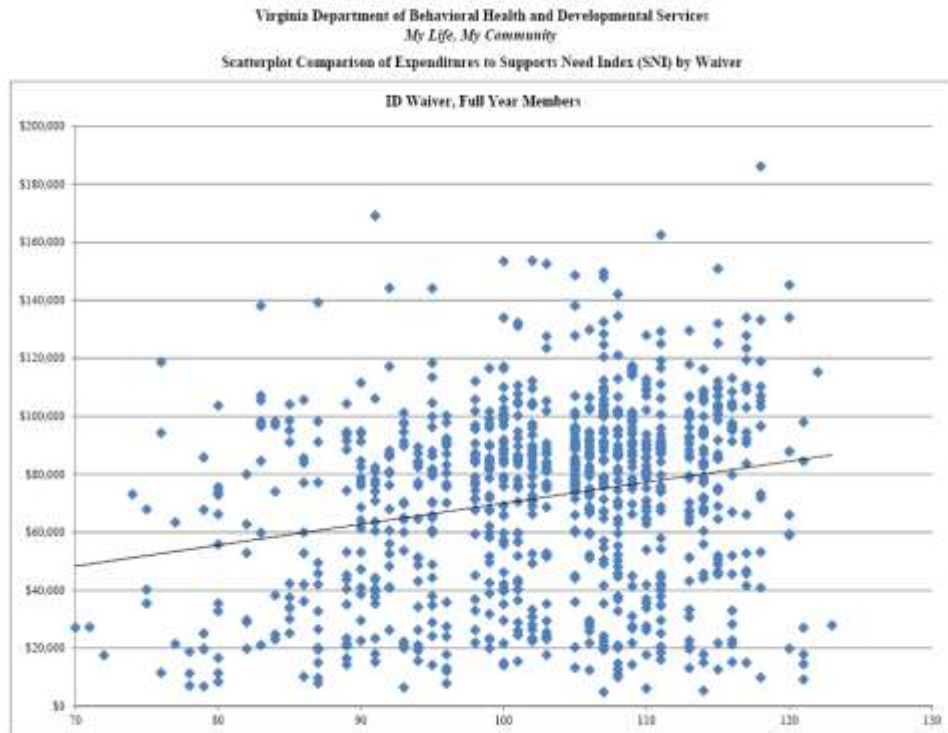


APPENDIX B

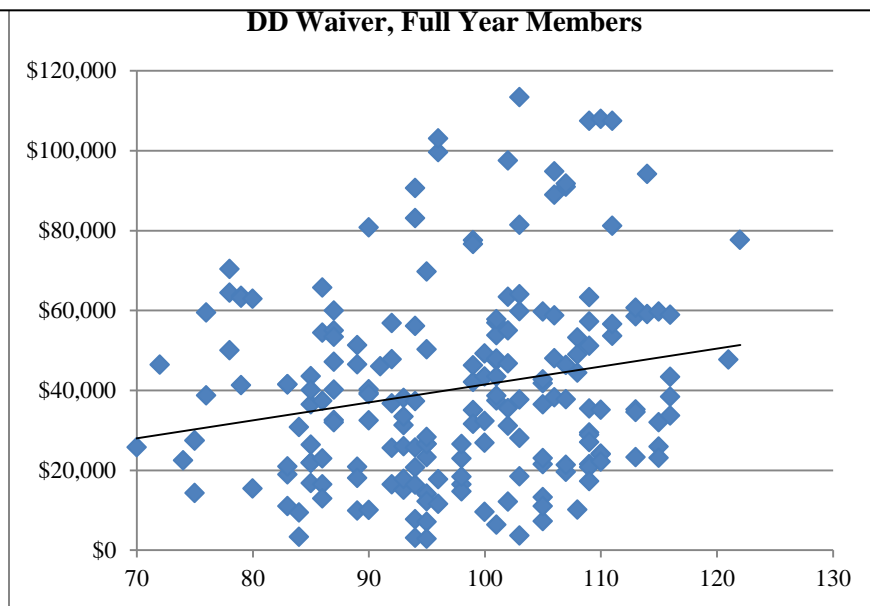
Scatterplot Charts of Current Systems and Alignment of Supports

The “scatter plot” charts in Appendix B are samples of the current system and alignment of supports required for individuals and expenditures for those supports in the three existing waivers. An individual’s level of need is depicted on the horizontal axis by the SIS® Supports Need Index score. The waiver expenditures related to those individuals is depicted on the vertical axis.

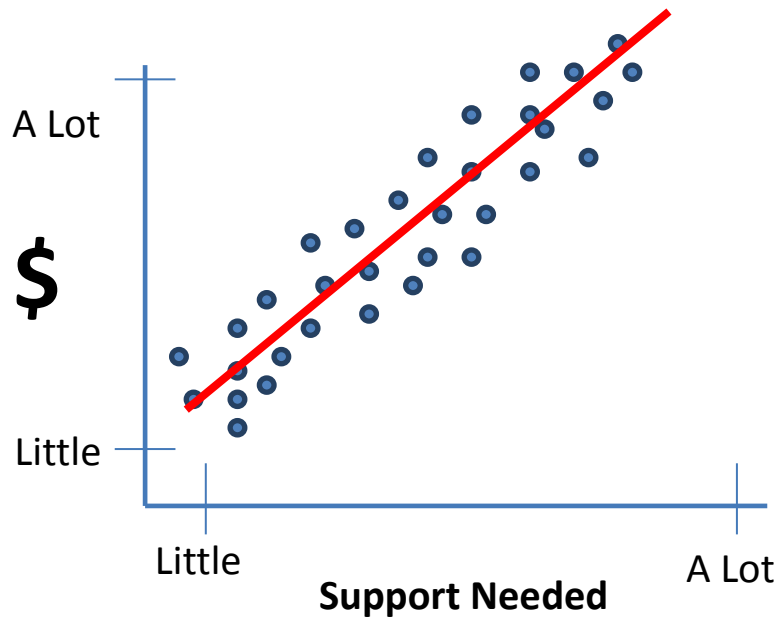
Scatter Plot Depicting Current ID Waiver Service Distribution:



Scatter Plot Depicting Current DD Waiver Service Distribution:



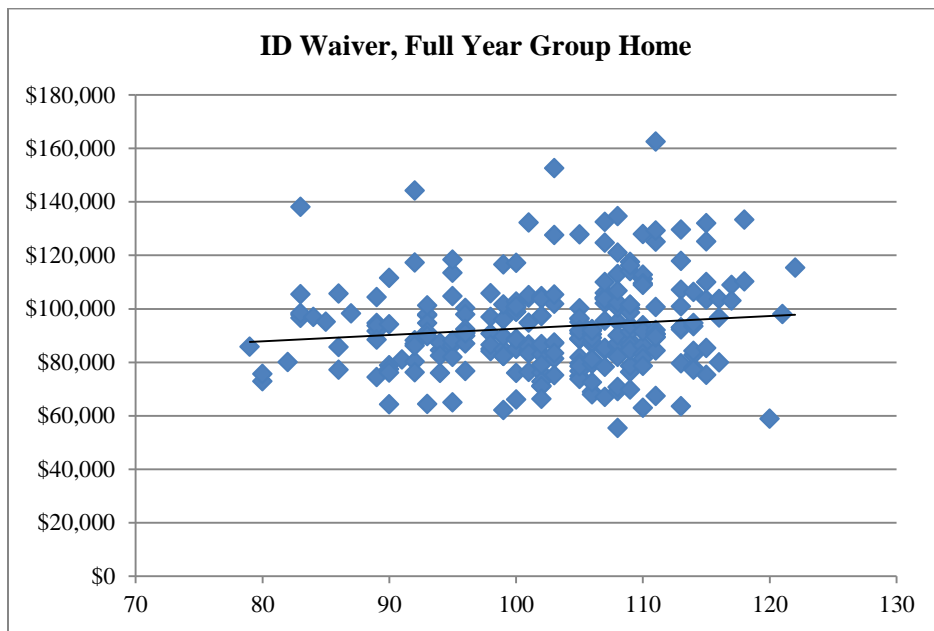
Project Degree of Correlation between Needs and Funding:

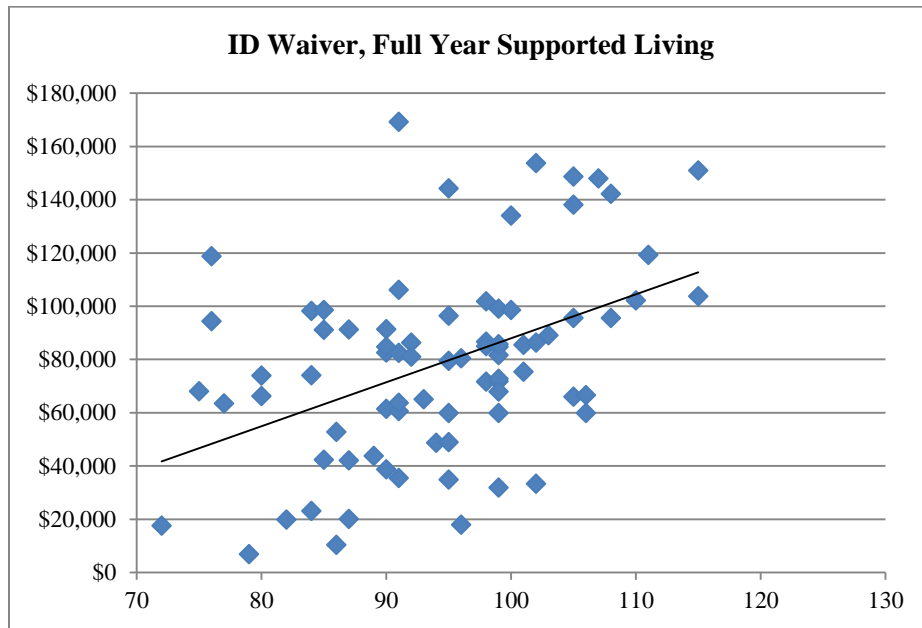
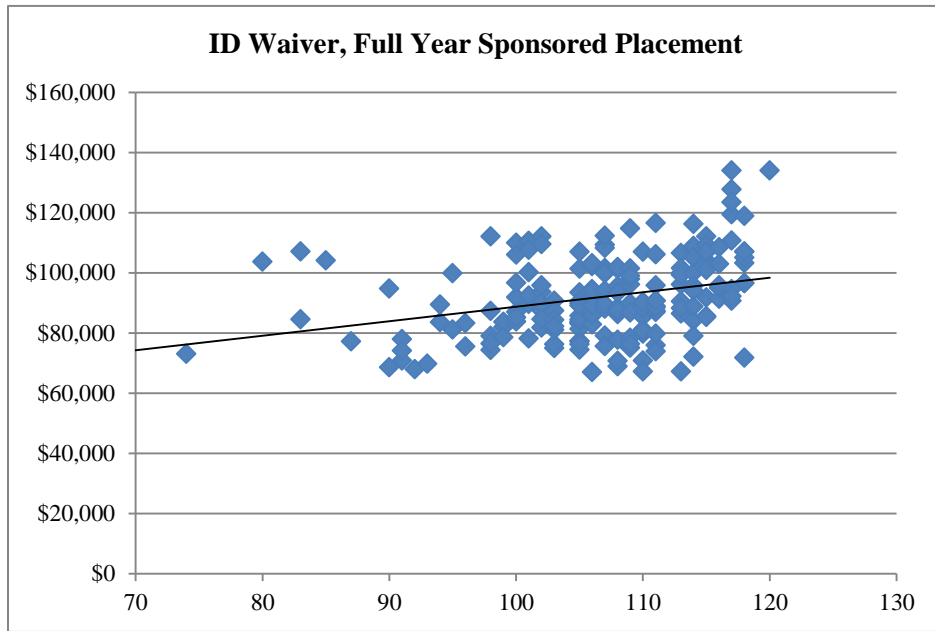


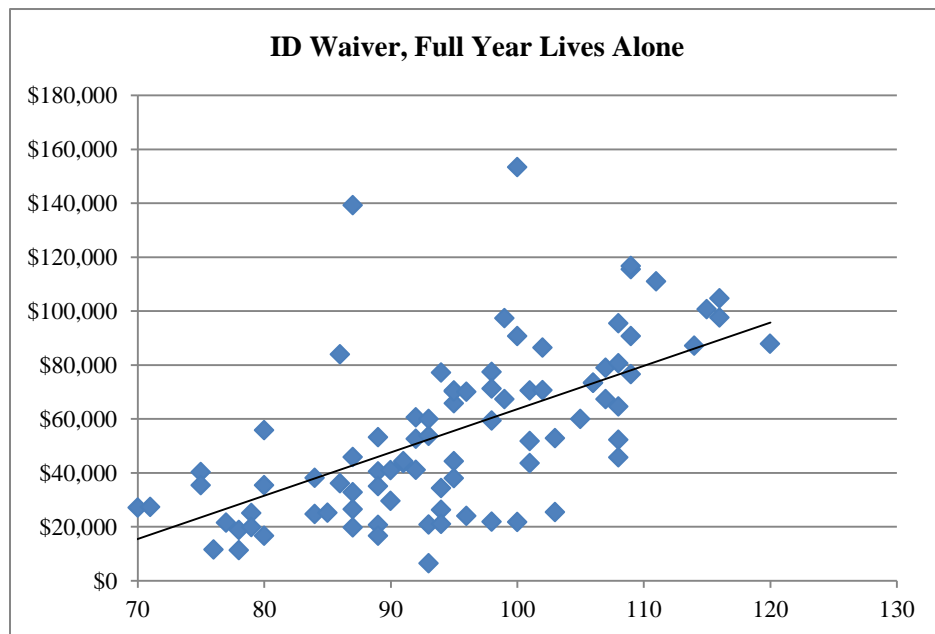
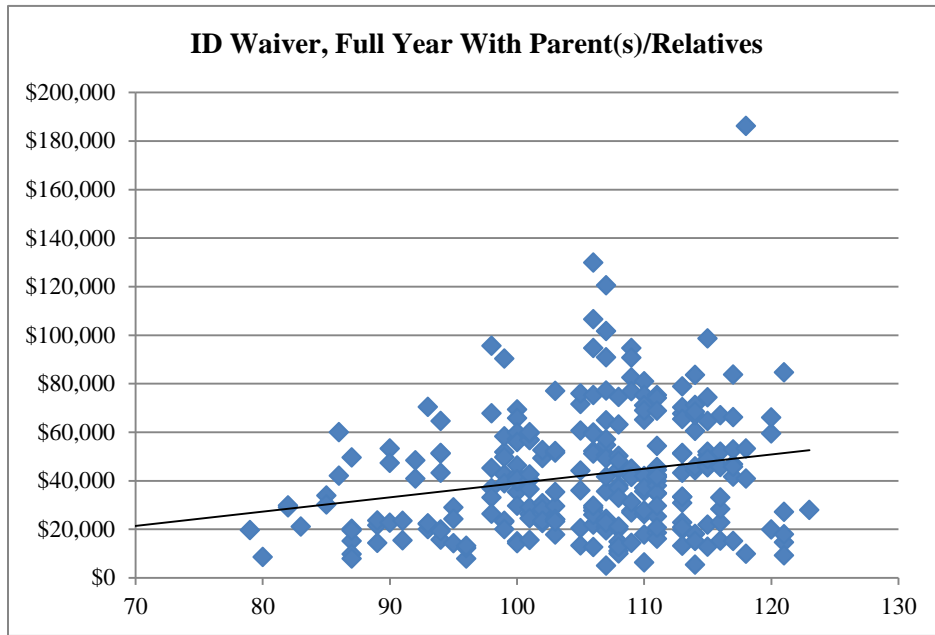
APPENDIX C

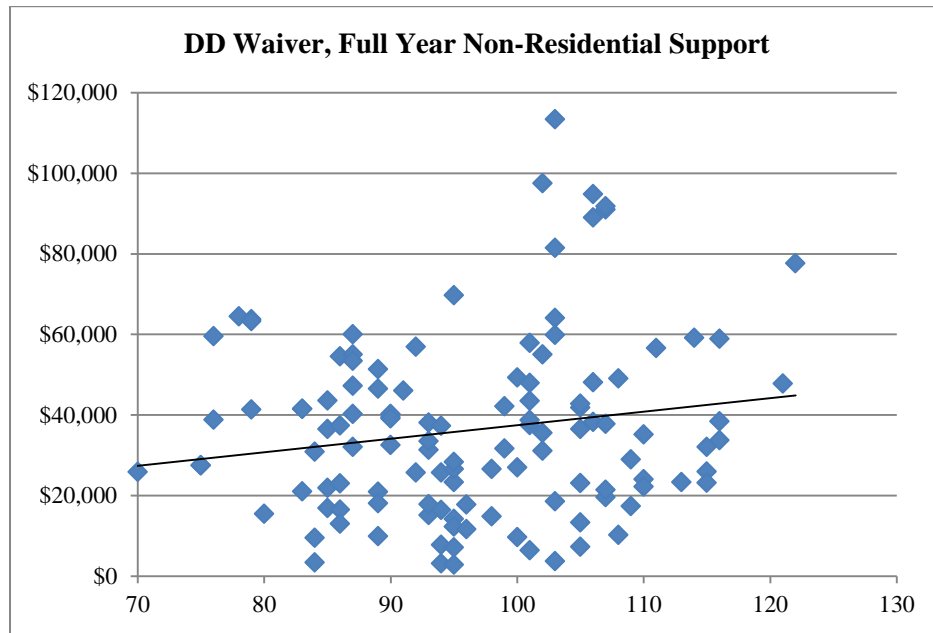
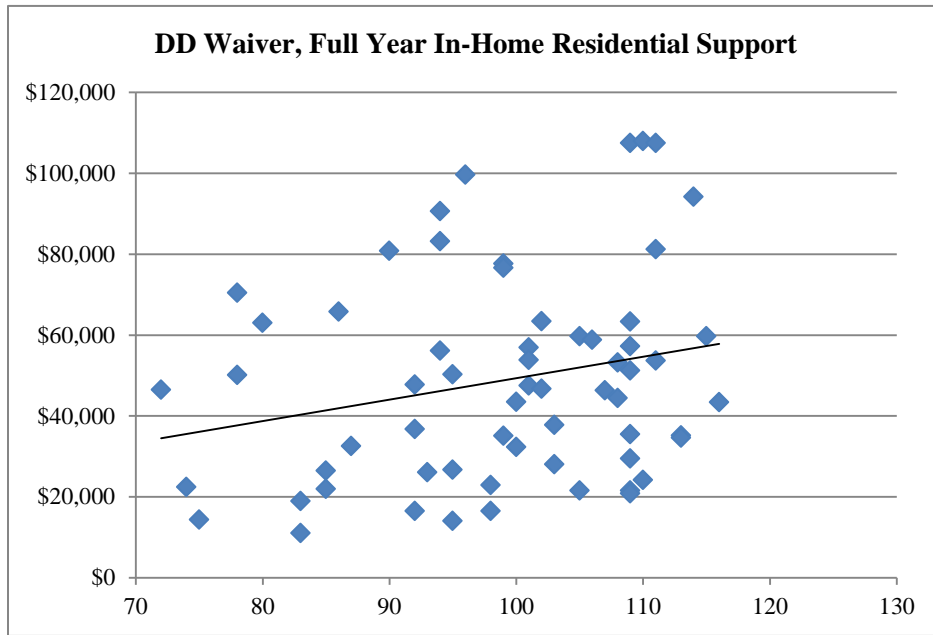
Scatterplot Comparisons of Expenditures to Supports Needs Index (SNI) by Residential Status

Scatter plot charts are useful to illustrate the relationship between supports needs and supports received as measured by expenditures. The following graphs (broken out by waiver and type of residential situation) illustrate that Virginia currently does not have a system that fully matches support needs to service costs. Rather, some individuals with low needs (as determined by the Supports Need Index score on the horizontal bar) have very high dollar plans of care (as determined by the dollar amounts on the vertical bar). Similarly, some individuals with high needs have low dollar plans of care.









Appendix D Service Descriptions

Residential Services <i>Individual/family home or congregate, community-based services available to help individuals develop skills necessary to live more independently as an alternative to institutional residential placement and as a means of increasing integrated, community living.</i>	
<i>Shared Living Residential Service</i>	A residential arrangement available to adult individuals in which the cost of room and board for a person/roommate without a disability incurred by the individual with a disability is reimbursed to the individual with a disability. The roommate, in exchange for the room and board, provides limited companionship supports.
<i>Supported Living Residential Service</i>	A licensed or DBHDS authorized provider-owned residence, typically in an apartment complex, which provides up to 24 hours of supports including medical and behavioral, to help individuals develop and maintain self-help, socialization and adaptive skills in a home and community based setting.
<i>Independent Living Residential Support Services</i>	Intermittently delivered supports provided in the individual's home offering skill building, assistance and supports necessary to help an individual acquire and maintain the skills to live independently and successfully in his or her own home, absent primary caregiver supports.
Integrated Day and Community Access Services <i>Activities which help to facilitate the meaningful interaction, integration, autonomy, and personal preferences of individuals with disabilities within their respective communities.</i>	
<i>Community Engagement</i>	Service delivered at a ratio of no more than 1:3 designed to support and foster the ability of the individual to acquire, retain, or improve skills necessary to build positive social behavior, employability, interpersonal competence, greater independence and personal choice necessary to access typical activities and functions of community life, using the community as the natural learning environment.
<i>Community Coaching</i>	Service delivered at a 1:1 ratio for individuals who need one-to-one support in order to build a specific skill to address barriers preventing participation in activities of Community Engagement.
<i>Community Guide and Peer Support Services</i>	Direct assistance to individuals by a trained Community Navigator or peer support mentor in brokering community resources and assistance necessary for connecting to and developing supportive community relationships that promote integration, self-determination and successful implementation of the individual's person centered plan.
Employment Services <i>Preparatory and necessary on the job training and supports to help the individual obtain and maintain competitive employment. Employment and Integrated Day/Community Access Services are designed to work together to help an individual achieve a meaningful day/life in the community.</i>	
<i>Workplace Assistance Services</i>	Services and supports provided to someone who has completed (or nearly completed) individual job development

	and job placement training but requires more than typical follow-along services to maintain stabilization in their employment.
<i>Benefits Planning</i>	A set of services to assist individuals on social security benefits (SSI, SSDI, SSI/SSDI) to better understand the how those benefits might be affected if they are working. Benefits Planning Services enable waiver beneficiaries to make informed choices about work, and support working beneficiaries to make a successful transition to financial independence.
Medical/Behavioral Maintenance Services	
<i>Medical/clinical care and/or behavioral maintenance and support services in a home or community-based setting serving as an alternative to institutional care.</i>	
<i>Private Duty Nursing Services</i>	Individual 1:1 and continuous care (in contrast to part-time or intermittent care) for individuals with a serious medical condition and or complex health care need, that has been certified by a physician as medically necessary to enable the individual to remain at home, rather than in a hospital or nursing facility. Care is provided by a registered nurse (RN) or a licensed practical nurse under the direct supervision of an RN.
<i>Crisis Support Services</i>	Intensive supports provided by appropriately trained staff in the areas of crisis prevention, intervention, and stabilization to an individual who may experience a behavioral crisis.
<i>Center Based Crisis Supports</i>	The Crisis Therapeutic Home provides Long Term Crisis Prevention and Stabilization in a residential setting through utilization of assessments, close monitoring, and a therapeutic milieu provided through planned and emergency admissions.
<i>Community Based Crisis Supports</i>	Ongoing community or home-based based crisis support services to individuals with a history of multiple psychiatric hospitalizations, frequent medication changes, multiple setting changes, and enhanced staffing required due to mental health or behavioral concerns, to prevent loss of a home or work arrangement.
General Support Services	
<i>Services and supports to increase the independence, self-determination, safety and welfare of individuals while reducing reliance on paid staff supports.</i>	
<i>Non-Medical Transportation Service</i>	Service providing reimbursement for transport to work and/or other community activities or events specified by the individual's plan for supports when no other means of transportation support is available.
<i>Electronic-Based Home Supports</i>	Goods and services that allow individuals with intellectual and developmental disabilities to access technology that can be used in the individual's home to support greater independence and self-determination and supplant the need for paid staff support in the residence.

Appendix E

My Life, My Community: IDD Service Delivery System Assessment, Service Planning and Service Delivery Process

	July 2016- June 2017	July 2017 - July 2018	After July 2018
System	Moving from Post Utilization Management To Predictive Utilization Management, Person-Centered		
Individual	<ul style="list-style-type: none"> • Continues to be assessed for needs using the Supports Intensity Scale and other factors • Assessment results in a level of care (Assessment Levels 1-7) assignment that is reflective of their support needs 		
Case Manager	<ul style="list-style-type: none"> • Works with the individual and significant others using a person-centered process to develop an individual support plan (ISP); informs individuals of new services/opportunities for an integrated life; uses the “calendar of activities” for individual flexibility. • CSBs/Behavioral Health Agencies receive ongoing dashboards regarding integrated day services and employment. 		
	<ul style="list-style-type: none"> • Service packages/Supports budgets will not be part of the process of developing the calendar of activities and supports for two fiscal years to gain experience with system changes, review relevant data and ensure sufficient training 	<ul style="list-style-type: none"> • Continues to work with individuals and their families whose ISPs are outliers within the Assessment Levels and encourage use of services that are more appropriate for the individual within the Assessment Level 	<ul style="list-style-type: none"> • Individuals’ ISPs are reflective of packages/budgets that are appropriate for that Assessment Level • Greater correlation of level of need with the intensity and type of community services utilized • Process for exceptions will be developed based on data collected
Providers	<ul style="list-style-type: none"> • Providers will refine service models and adjust to the targeted population they serve based on an individual’s Assessment Level and 		

	July 2016- June 2017	July 2017 - July 2018	After July 2018
	service needs		
	<ul style="list-style-type: none"> New services added to the system/rates adjusted for some services and tied to Assessment Levels (1-7) 	<ul style="list-style-type: none"> Begin receiving “dashboard data” that reflects individual service utilization 	
DBHDS	<ul style="list-style-type: none"> Continue to use prior authorization (PA) and data analysis to monitor system; utilize the calendar to facilitate review; ask for further justification or information as needed prior to PA approval. 		
	<ul style="list-style-type: none"> Conduct comprehensive data analysis on Assessment Levels, service authorization and utilization patterns to model service package algorithms. Conduct a targeted review of individuals whose services packages seem to be outliers or service utilization that does not match the Assessment Level Determine whether the service package process should remain part of the authorization process and behind the scenes and/or part of case management duties (e.g. assessment, care planning) 	<ul style="list-style-type: none"> Implement service package algorithms which will be validated reflecting rate adjustments and new service implementation Continue to monitor system progress towards inclusive community services 	
		<ul style="list-style-type: none"> Pilot with 5 to 8 CSBs for case managers to authorize services with post-review monitoring to determine training, oversight and rules needed. 	

