COMMONWEALTH of VIRGINIA

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COMMISSIONER

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July 20, 2023

To: Governor Glenn A. Youngkin

The Honorable Janet D. Howell
Co-Chair, Senate Finance & Appropriations Committee

The Honorable George L. Barker
Co-Chair, Senate Finance & Appropriations Committee

The Honorable Barry D. Knight
Chair, House Appropriations Committee

Fr: Nelson Smith
Commissioner, Department of Behavioral Health & Developmental Services

Item 312.C.4 of the 2022 Appropriations Act requires the Department of Behavioral Health and Developmental Services to conduct a review of the Discharge Assistance Program's (DAP) current rate structure and to make recommendations on the allocation and use of DAP funding through the development of a tiered rate structure for individuals living in congregate care. The language states:

> *In addition to the amounts in C.1. above, $400,000 the first year is provided for the costs of a contract to study and implement rates for services provided with Discharge Assistance Planning funds. No fewer than ninety days prior to implementing any rate structure recommended by the study, the Department of Behavioral Health and Developmental Services shall report the results of the rate study and the projected impact of any changes in rates to the Governor and the Chairmen of the House Appropriations and Senate Finance and Appropriations Committee. This report shall be due no later than June 30, 2023.*

In accordance with this item, please find the enclosed report for Item 322.Z.2. Staff are available should you wish to discuss this report.

CC: The Honorable John Littel, Secretary, Health & Human Resources

Report on Discharge Assistance Program (DAP), Development and Implementation of a Tiered Rate Structure

(Item 312.C.4)

July 2023

DBHDS Vision: A Life of Possibilities for All Virginians

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1.0 Background and Purpose

Item 312.C.4 of the 2022 Appropriations Act requires the Department of Behavioral Health and Developmental Services to conduct a review of the Discharge Assistance Program's (DAP) current rate structure and to make recommendations on the allocation and use of DAP funding through the development of a tiered rate structure for individuals living in congregate care. The language states:

> *In addition to the amounts in C.1. above, $400,000 the first year is provided for the costs of a contract to study and implement rates for services provided with Discharge Assistance Planning funds. No fewer than ninety days prior to implementing any rate structure recommended by the study, the Department of Behavioral Health and Developmental Services shall report the results of the rate study and the projected impact of any changes in rates to the Governor and the Chairmen of the House Appropriations and Senate Finance and Appropriations Committee. This report shall be due no later than June 30, 2023.*

Virginia Department of Behavioral Health and Developmental Services (DBHDS) engaged BerryDunn to conduct a review of the Discharge Assistance Program's (DAP) current rate structure and to make recommendations on the allocation and use of DAP funding through the development of a tiered rate structure for individuals living in congregate care. The purpose of this document is to report the results of the rate study conducted by BerryDunn and provide recommendations to assist the DAP in developing a more comprehensive, sustainable, and transparent structure. DBHDS has a requirement to report the results of this study and the projected impact of any changes in rates to the Governor and the Chairmen of the House Appropriations and Senate Finance and Appropriations Committee, no fewer than 90 days prior to implementing any rate structure recommended by the study. This report shall be due no later than June 30, 2023.

The DAP was initiated by the DBHDS in 1998 to support DBHDS' commitment to person-centered and recovery-based care and vision. The DAP has four purposes:

1. To serve individuals already discharged from state hospitals who are presently receiving services through the DAP and transition them into non-DAP funded services and supports;
2. To serve adults in state hospitals who have been determined to be clinically ready for discharge and for whom additional funding for services and supports is required to support their placement in the community through the development, funding, implementation, and utilization review of discharge assistance funds,
3. To fund start-up and/or support ongoing costs for community-based services and supports that enable individuals in state hospitals to be discharged to those services; and
4. To serve individuals transitioning from DBHDS funded transitional placements (i.e., Alternative Living Facilities and Supervised Living settings) to different levels of care.

The DAP offers an approach for responding to barriers to discharge from state hospitals once an individual has been determined to be clinically ready for discharge. Community Service Boards

(CSBs) and the Behavioral Health Authority, through the regions, use the DAP to provide community services and supports that enable individuals to transition from state hospitals to communities where they can recover in the least restrictive and most integrated settings possible.

The DAP is supported with a pool of state mental health funds allocated to each DBHDS region to implement community capacity, individualized services, and supports. Approximately 84% of funding is used for congregate residential living, including mental health group homes, assisted living and nursing homes. Under the current program, these services do not have standardized rates, or a system of rates based on individual needs. With the development of a standardized rate structure, DBHDS sets expectations for continual review and assessment of patient needs to help decrease the amount of DAP and free funds for assistance with additional hospital discharges.

2.0 Executive Summary

DBHDS engaged BerryDunn to review the discharge assistance program (DAP) for the purpose of developing a tiered rate structure to better support individuals utilizing DAP funds in congregate care settings; to increase program management efficiency; and to free funds for assistance with timely discharge of individuals from state hospitals into community environments. At the conclusion of the engagement, BerryDunn is to present a fiscal impact report with recommendations for more efficient utilization of funds.

The following focus areas were identified by DBHDS:

Rate Setting Model Review. To identify recommendations for the DAP rate-setting model, DBHDS and BerryDunn reviewed current DAP policy documents, regional rate models, provider agreements, and budgetary restrictions. Additional information was gathered from stakeholder group meetings, interviews with key program staff and DAP utilization reports for SFY 2021 – 2023. DBHDS and BerryDunn developed a set of recommendations for a tiered rate structure that is based on expectations for individualized patient care, with differentials to account for type of facility, provider's licensure, regional cost of care, periodic cost-of-living adjustments, as well as calculations for 1:1 services, and a rate component based on quality of care, consistent with the nation-wide effort to promote value-based purchasing and cost-containment.

Assessment Tool Review. Based on a review of the existing processes and assessment tools used in determining level of care and provider reimbursement rate for individuals leaving state hospitals, recommendations are included for use of specific assessment tools to help promote consistency and objectivity of assessments.

Training and Staffing Review. Current staffing levels and trainings required by state licensing rules to evaluate organizational capacity were researched and used to develop recommendations for various levels of care in the rate.

Subsections 2.1 – 2.3 of the report summarize the recommendations identified in each of the review areas. The potential economic impact of the recommended changes is described in subsection 2.4, consistent with the scope of work requested for this engagement. Sections 3.0 – 6.0 address the methodology and approach used to complete the review and develop findings. The appendices contain additional information supporting this work.

2.1 Rate Setting Model Review Recommendations

Based on the analysis, the following recommendations were made to help optimize DAP rate structure and support more efficient utilization of funds through standardization of rates by facility type and location. **Section 3.0 Rate Setting Review – Methodology & Results** provides detail supporting the conclusions.

1. Utilize the Auxiliary Grant (AG) rate and services as baseline for residential rate structure and service provision. The AG program is an income supplement for individuals receiving Supplemental Social Security income (SSI) and certain aged, blind, or disabled individuals residing in a licensed supportive housing program. The AG rate, determined by the Virginia General Assembly, is adjusted periodically, and funded by 80% state and 20% local funds.
2. Implement a tiered DAP rate and services structure to help:
   - 2.1. Align values and payments for housing and medical services provided
   - 2.2. Free up acute care beds and utilize state funds for hospital care for patients requiring acute care services, rather than those waiting for placement in post-acute care settings
   - 2.3. Help improve transparency and standardize expectations for participating providers, including range of support services provided, staff training and administrative reporting requirements, to promote quality of care and stability of housing for the individuals
   - 2.4. Reduce the administrative burden and decrease costs of administering DAP.
3. Adjust DAP funding and reimbursement principles to include mechanisms for:
   - 3.1. An annual rate review and update for cost-of-living adjustment (COLA);
   - 3.2. A rate adjustment for Northern Virginia, reflecting higher cost of labor in the region.
   - 3.3. A mechanism for annual quality of care adjustment for provider payments, consistent with national efforts to promote value-based purchasing in healthcare settings.

2.2 Assessment Tool Review Recommendations

DBHDS and BerryDunn reviewed the assessment forms and supplements currently used by CSBs, regions, hospitals, and providers. There is no one standard assessment instrument meeting DAP information needs under the current program. To support the proposed tiered rate structure, it is recommended to:

1. Utilize existing the standard Virginia Uniform Assessment Instrument (UAI), supplemented by DAP Behavior Assessment.
2. Develop a training curriculum and provide periodic training on proper completion of the assessment forms used for the DAP rate calculation, to help ensure objectivity and consistency of information collected and used for patient-specific rate setting.

Please refer to **Section 4.0 Assessment Tool Review – Methodology & Results** for additional information supporting these recommendations.

2.3 Training and Staffing Review Recommendations

The Commonwealth of Virginia has comprehensive training requirements, including facility-specific emergency procedures, resident rights, and supportive care, for licensed assisted living and nursing facilities. For providers accepting funding, it is recommended the DAP require:

1. Unlicensed facilities to provide training related to patient care needs and patient rights.
2. Licensed facilities to provide additional patient need-specific training if not already included in licensing requirements.

Please refer to **Section 5.0 Training and Staffing Review – Methodology & Results** for more detail on the recommendations and a summary of the regulatory requirements by provider licensing level.

2.4 Potential Economic Impact Analysis

The scope of this engagement requires BerryDunn to develop fiscal impact report to be presented to General Assembly regarding the implementation of the proposed rate structure. For the detailed analysis of the potential economic impact, please refer to **Section 6.0 - Potential Economic Impact Analysis.**

Estimated Benefits and Costs. While incorporating cost-containment strategies, the proposed tiered rate structure was planned to be budget-neutral for care cost expenditures and achieving savings through a reduction of administrative burden of managing DAP and promoting timely state hospital discharges to free up acute care beds. The proposed rate structure may improve quality of patient care through clarified expectations and consistent standards for staff training.

Economic Impact. No adverse impact is anticipated on congregate housing organizations, some of which may be classified as small businesses.

Northern Virginia adjustment related to higher cost of labor for the region is included in the proposed DAP rate structure. There are no other factors affecting any particular locality more than others or additional costs for local governments.

The proposed rate structure modifications are not expected to affect total employment or value of private property or real estate development costs.

3.0 Rate-Setting Review – Methodology & Results

3.1 Need for Discharge Assistance Program (DAP)

The Department of Behavioral Health and Developmental Services initiated the Discharge Assistance Program (DAP) in 1998 to support the Department's commitment to person-centered and recovery-based care. The DAP is supported with a pool of state mental health funds allocated to each DBHDS region. The DAP provides a solution by addressing barriers to discharge from state hospitals and enable individuals to transition from state hospitals to communities where they can recover in the least restrictive and most integrated settings possible.

DAP funds are used for individuals at the state hospital whose needs cannot be met through the typical array of services. These individuals have complex conditions or specialized needs that create barriers to discharge, which include a forensic legal status, absence of guardians or authorized representatives; lack of affordable housing with sufficient and reliable services and supports that are necessary to enable independent living, and challenging behaviors or conditions, including complex psychiatric symptoms or hard-to-manage behaviors, and complex medical and/or chronic health conditions.

Table 1 summarizes FY 2021-2022 Extraordinary Barriers to Discharge List (EBL) and estimated state hospital costs associated with the wait list for community placement of the individuals no longer requiring acute care setting services.

Table 1A: Extraordinary Barriers to Discharge List – Select Statistics

	April 2020 - March 2021		April 2021 - March 2022	
Barrier	**Individuals**	**Avg. Days on EBL**	**Individuals**	**Avg. Days on EBL**
No willing provider	58	158	41	188
No guardian	20	171	18	81
NGRI process	47	347	52	410
Other factors	61	126	30	164
Pending discharges	34	204	39	121
Totals	**220**	**201**	**180**	**225**

Source: DBHDS EBL, March 2020-March 2022

Table 1B: Estimated Cost of EBL, 2021-2022

	April 2020 - March 2021	April 2021 - March 2022
Est. Total EBL Days	44,317	40,555
Est. Total Hospital Cost - EBL	$50,576,776	$46,283,394

Source: HCRIS As Filed Medicare Cost Reports, FY 2022. Average per diem cost for six of ten state hospitals, routine care, Worksheet D-1, Line 38

Per available FY2022 Medicare state hospital cost reports, an average per-patient day routine care cost was $1,165, and DBHDS estimate showed $1,141 per diem. The variance is related to per-diem costs of the hospitals not required to file Medicare cost reports. To achieve state expenditure reduction, DAP ongoing monthly support expense should be kept below $34,000. DBHDS estimates current average per patient per month DAP expenditures, net of patient pay contributions, at $5,110, or about 15% of cost of care in hospital setting.

BerryDunn reviewed cost and utilization data to better understand the DAP's current rate structure, and to identify budgetary restrictions and opportunities.

The Discharge Assistance Program is funded by General Assembly from the General Fund. In FY22, $36,670,271 in DAP funds were allocated directly to the five major CSB regions and two sub-regions for use for individual discharge plans (see **Appendix A** for the listing of the DBHDS regions, CSBs and participating state mental health hospitals). Through this funding, 1,337 individuals were served. This number includes a combination of individuals already discharged from state facilities in previous years, as well as 520 new discharges in FY22. These newly discharged patients were served in the community at the cost of $6,248,946.

Individuals may have multiple Individualized Discharge Assistance Program Plans (IDAPPs), including one-time, ongoing, or a combination of both, depending on circumstances and needs. The 1,337 individuals that were served during FY22 used 1,549 IDAPPs. The average statewide cost of an ongoing plan was $38,909 annually (this amount does not account for patient pay contributions). The average statewide cost of a one-time plan was $7,028.

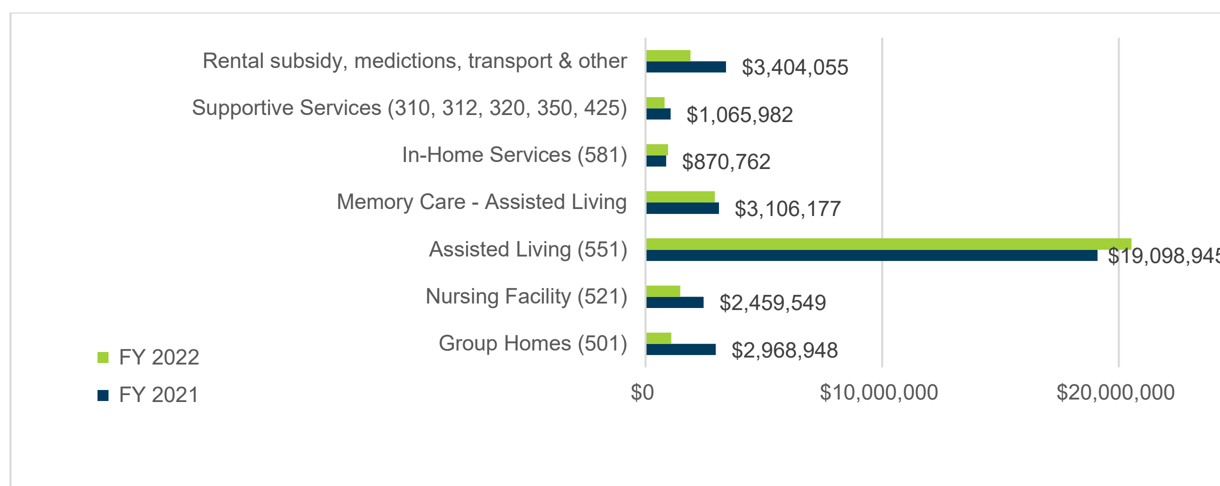
Table 2: Number of Individuals Served and Expenditures FY21-22

cFiscal Year	Number of Persons Served	Number of Individualized DAP Plans	Amount Encumbered	Amount Spent
FY21	1,386	1,573	$44,878,529	$32,577,870
FY22	1,337	1,549	$36,670,271	$29,548,203

- Over 90.9% of that funding was spent to support individuals in supervised living situations which included assisted living facilities, nursing homes, mental health group homes, developmental disability supervised living options, traumatic brain injury placements, and memory care placements, for which no other funding was available.
- 2.7% of funding was spent on services including case management, mental health skill building, psychosocial rehabilitation, and supported employment.
- 6.4% of funding was spent on services including rental subsidy, transportation, personal and other needs, and medications.

Table 3 summarizes DAP spending based on specific service-type categories, FY 2021-2022.

Table 3: DAP Expenditures FY21-22 by Service Type



3.2 Stakeholder Feedback

BerryDunn engaged with a representative stakeholder workgroup identified by DBHDS, which included representation from Regions, CSBs, participating hospitals and participating provider organizations. A list of stakeholders participating in meetings is available in **Appendix B**. The group discussed the need for reforms to DAP allocation and recommended services to meet the needs of the DAP population to increase the sustainability of the program.

For a complete list of barriers to timely patient discharge from state hospitals, please refer to **Appendix C**. The workgroup determined that the top challenges encountered in identifying services for recently discharged patients include inconsistent availability of affordable supervised living options, lack of services for individuals with dementia and traumatic brain injury, need for ongoing provider staff training and support from CSB with case management, and administrative burden on parties who manage DAP. To address these issues, BerryDunn used feedback from the workgroup to develop the following recommended updates and investments in the DAP program to promote more effective utilization of funds, as well as to continue to provide effective services for special populations.

- Develop DAP rate components addressing:
  - location of services (region) to reflect cost of living and to simplify patient transfer agreements between CSBs or regions;
  - type of provider and their licensure status;
  - resolution of common barriers to hospital discharges, such as:
    - patient characteristics, including, but not limited to, a presence of a neurologic condition or diagnosis, co-morbidities requiring additional staff support;
    - lack of legal decision-making capacity;
    - one-time high-cost accommodation needs (such as special equipment or community notification requirements for sex offenders, etc.);

        - social history of the patient, including criminal convictions, Not Guilty by Reason Of Insanity (NGRI), or not competent to stand the trial.
- Evaluate a mechanism for encouraging provider participation in DAP to promote timely hospital discharges and a reduction of the Extraordinary Barriers to Discharge List (EBL);
- Evaluate a mechanism for periodic DAP rate review and cost-of-living adjustments;
- Evaluate a mechanism for cost containment;
- Review staff training requirements as they relate to DAP and include a rate component for necessary staff training;
- Recommend a standardized patient assessment tool for the information that needs to be collected from an acute care setting, allowing for clear identification of patient needs, appropriate care settings, one-time and ongoing support requirements.

3.3 Tiered Rate Structure

DBHDS engaged BerryDunn to conduct a review of the DAP's rate structure and make recommendations to the rate structure, including the development of a tiered rate structure for individuals living in congregate care utilizing DAP funds. BerryDunn reviewed current regional DAP rate models as well as the DAP pilot program for tiered rate structure in Region 3b. A videoconference was held with a stakeholder workgroup in Region 3b to discuss the DAP pilot program for tiered funding, including observed benefits of the tiered structure implementation, implementation challenges, impact on provider relations, and key takeaways.

As DBHDS requested, BerryDunn utilized the auxiliary grant (AG) rate and services as a baseline for the new rate structure. The BerryDunn team reviewed the current AG program description, covered services, and authorized AG CY2022 and CY2023 rates to determine a baseline for the residential rate structure and service provision.

BerryDunn developed a tiered rate structure based on knowledge of the industry in various care settings, research that included a review of Virginia licensing and reimbursement rules for assisted living providers and nursing facilities, and state budget information. In addition, the BerryDunn team utilized historical cost information and feedback from the tiered rate pilot program shared by Region 3b. See **Appendix D** for the proposed DAP rate tiers.

The proposed rate structure reflects key considerations and requests, as per the RFP# 720-4961-3312 and stakeholder input:

- Aligns values and payments for housing and medical services provided with the goal of expediting state hospital discharges to free up acute care beds and minimize state funds used for hospital care;
- Utilizes Auxiliary Grant rate and services as baseline for residential rate structure and service provision;
- Aims to resolve barriers to hospital discharge, as per the EBL and feedback received from the stakeholder group;

- Sets up expectations for care to be provided through a standardized assessment mechanism with a goal of minimizing subjectivity and promoting better and more consistent care outcomes;
- Aims to contain costs by setting expenditure caps based on facility type or care setting;
- Promotes transparency and standardization of expectations for participating providers, including services provided and staff training required, to emphasize quality of care and stability of housing for the individuals;
- Simplifies budgeting and information gathering for patient transfer between different regions;
- Aims to reduce administrative burden and decrease cost of administering DAP;
- Provides a mechanism for:
    - an annual rate review and adjustment of DAP funding for cost-of-living adjustment (COLA) and promotes quality care and increased lengths of stay with the same provider/care setting;
    - a rate adjustment for Northern Virginia, reflecting higher cost of labor in the region, at the rate established by the General Assembly;
    - an annual quality of care adjustment for provider payments, consistent with national efforts to promote value-based purchasing in healthcare settings;
    - reimbursement of necessary staff training costs beyond the training required by provider licensure.

3.4 Patient Pay Policy

It is recommended to keep the patient pay amount consistent with AG personal needs allowance or BLS Consumer Price Index for the related category of cost.

3.5 Implementation Approach

The Region 3b workgroup identified several benefits of the tiered rate program, including increased transparency, consistency, and predictability with participating providers. The program also benefited from receiving improved documentation from providers, access to a wider network of participating providers, and improved care quality for patients by emphasizing program requirements and expectations. BerryDunn reviewed workgroup feedback and identified several key challenges and takeaways. To address these issues, BerryDunn developed the following recommended updates and investments to assist the DAP program's transition to a tiered rate structure.

- Implement a change management approach and processes to reduce grievances during the transition and to facilitate a gradual move from higher paying DAP plans.
- Develop and provide necessary training to individuals completing recommended patient assessment tool, Virginia Uniform Assessment Instrument (UAI), and the supplemental behavioral assessment form, as they serve as the basis for the tiered rate structure.

- Identify and document a process for review and approval of the extraordinary circumstances payment request portion of the rate, as necessary.
- Identify required patient reassessment timelines and due dates (such as a periodic, annual reassessment and/or a significant change in patient condition assessment).
- Implement a quality assurance process to help ensure adherence to the new rate structure and avoidance of exceptions.
- Provide education and guidance to inform providers of the transition plan and assist them throughout the transition process.
- Host regular periodic meetings with providers to address any questions related to DAP policies, reporting, administrative compliance, regional processes, quality of care, or documentation expectations.
- Include hospital discharge planners, CSB representatives and other identified stakeholders in provider meetings.
- Identify timelines for the annual rate review and rate calculation sheet update for AG portion and an inflation adjustment, if any.
- Identify and document a process for the recommended quality payment component calculation, budgeting, and distribution to participating providers.

4.0 Assessment Tool Review – Methodology & Results

A review was conducted of the assessment forms and supplements currently used by CSBs, regions, hospitals, and providers to assess patient care and support needs and appropriate level of community placement. There is not one standard assessment instrument meeting DAP information needs under the current program. To support the proposed tiered rate structure, which is largely based on patient characteristics and needs, it is recommended to:

- Utilize the existing standard Virginia Uniform Assessment Instrument (UAI), supplemented by DAP Behavior Assessment.
- Develop a training curriculum and provide periodic training on proper completion of the assessment forms used for the DAP rate calculation, to help ensure objectivity and consistency of information collected and used for patient-specific rate setting.

Please refer to **Appendix E** for instructions on utilizing UAI for purposes of completion of the DAP tiers rate calculation sheet.

5.0 Training and Staffing Review – Methodology & Results

BerryDunn examined current required staff qualifications and training practices within the context of the DAP program's specific needs and priorities. To accomplish this, the team reviewed state licensing rules for nursing and assisted living facilities, and AG and DAP requirements.

Commonwealth of Virginia has comprehensive training requirements, including facility-specific emergency procedures, resident rights, and supportive care, for licensed assisted living and nursing facilities. It is recommended that DAP require unlicensed facilities to provide training related to patient care needs and patient rights, and licensed facilities to provide additional patient need-specific training if not already included in licensing requirements, to accept DAP funding. Unlicensed providers are currently utilized for DAP, but are encouraged to pursue licensure as a mental health group home. Placements with more than three residents must be licensed as an assisted living facility (ALF), therefore, no license is necessary it there are less than three residents.

The proposed rate structure addresses provider staff training needs beyond state required licensure. The proposed rate structure for licensed providers assumes that participating organizations are in compliance with the respective licensing rules as per:

Service Location	Applicable Licensing Regulation	Rule sections
Unlicensed Assisted Living	N/A	N/A
Assisted Living (facilities serving 4+ adults)	State Board of Social Services - STANDARDS FOR LICENSED ASSISTED LIVING FACILITIES 22VAC40-73 10/21	22VAC40-73-120 - Staff orientation and initial training; 22VAC40-73-210. Direct care staff training; 22VAC40-73-260. First aid and CPR certification; 22VAC40-73-270. Direct care staff training when aggressive or restrained residents are in care.
Nursing Facility	Administrative Code, Title 12. Health - Agency 5. Department of Health - Chapter 371. Regulations for the Licensure of Nursing Facilities - Part III. Resident Services	12VAC5-371-260. Staff development and in-service training

Recommendations:

- Schedule periodic provider training (virtual or in person) focused on:
  - De-escalating behaviors;
  - DAP administrative rules, resources and methods of communication;

- Partner with the Department of Aging and Rehabilitative Services (DARS) and the Department of Medicaid Assisted Services (DMAS) to develop recorded presentations that could be available to providers on-demand, addressing needs of individuals with dementia and traumatic brain injury;
- Recommend that Regions or CSB hold regular in-person patient care management trainings to support participating providers.

6.0 Potential Economic Impact Analysis

The scope of this engagement requires BerryDunn to develop fiscal impact report to be presented to General Assembly regarding the implementation of the proposed rate structure.

Background: Currently there is no standardized approach to reimbursement rate setting for congregate living facilities accepting patients discharged from state hospitals with no other source of funding. Rates are negotiated with providers for each person discharged. While effective, this approach lacks efficiency as it requires excessive program staff time for development and administration on multiple provider-specific contracts and does not promote cost-containment strategies. The diverse reimbursement arrangements make it difficult to budget expenditures. Lack of periodic reimbursement reviews places some providers in a disadvantaged position, discouraging acceptance of patients from the state hospitals and contributing to longer than required hospital stays, resulting in higher cost and lack of acute bed availability.

Estimated Benefits and Costs. While incorporating cost-containment strategies, the proposed tiered rate structure was planned to be budget-neutral for care cost expenditures and achieving savings through a reduction of administrative burden of managing DAP and promoting timely state hospital discharges to free up acute care beds. The proposed rate structure may improve quality of patient care through clarified expectations and consistent standards for staff training.

Businesses and Other Entities Affected. The proposed DAP rate structure will affect payments to licensed and unlicensed providers participating in the program. It is expected the existing DAP agreements will be aligned with the new structure by the end of FY24, through the scheduled reassessments process. Since the proposed rate structure is not retroactive and is a clarification of currently existing agreements, no adverse impact on congregate housing organizations is anticipated. As assessments are completed, noting the patient rate, agreements/contracts will have to be updated to include training.

Small Businesses Affected. Some of the unlicensed congregate housing providers may be classified as small businesses. The proposed rate structure is not expected to adversely affect small businesses.

Localities Affected. The proposed modifications to DAP rate setting structure include Northern Virginia region adjustment to include reimbursement related to higher cost of labor (wages and benefits) for the region. The model is using a 15% region cost differential approved by the General Assembly for the Auxiliary Grant. There are no other factors affecting any particular locality more than others or additional costs for local governments.

Projected Impact on Employment. The proposed rate structure modifications are not expected to affect total employment.

Effects on the Use and Value of Private Property. The proposed rate structure modifications are not expected to affect value of private property or real estate development costs.

Appendix A

DBHDS Regions, Community Service Boards (CSB) and

Mental Health Hospitals supported by DAP

Primary DBHDS Regions		State Hospitals
DBHDS Region 1 (9 CSBs)	Alleghany Highlands CSB	Western State Hospital (WSH), Catawba
	Harrisonburg-Rockingham CSB	
	Horizon Behavioral Health	
	Northwestern Community Services	
	Rappahannock Area CSB	
	Rappahannock-Rapidan Area CSB	
	Region Ten CSB	
	Rockbridge Area Community Services	
	Valley CSB	
DBHDS Region 2 (Northern) – 5 CSBs	Alexandria CSB	Northern Virginia Mental Health Institute (NVMHI), Piedmont Geriatric Hospital (PGH)
	Arlington County CSB	
	Fairfax-Falls Church CSB	
	Loudoun County Department of Mental Health, Substance Abuse and Developmental Services	
	Prince William County CSB	
DBHDS Region 3 – 10 CSBs	Blue Ridge Behavioral Healthcare[1] (3a)	Catawba
	Cumberland Mountain CSB (3c)	Southwestern Virginia Mental Health Institute (SWVMHI)
	Danville-Pittsylvania Community Services[2] (3b)	Southern Virginia Mental Health Institute (SVMHI), PGH
	Dickenson County Behavioral Health Services (3c)	SWVMHI
	Highlands Community Services (3c)	SWVMHI
	Mount Rogers CSB (3c)	SWVMHI

[1] Part of sub-region 3.a in Region 3
[2] Part of sub-region 3.b in Region 3

Primary DBHDS Regions		State Hospitals
	New River Valley Community Services (3c)	SWVMHI, Catawba
	Piedmont Community Services (3b)	SVMHI, Catawba
	Planning District One Behavioral Health Services (3c)	SWVMHI
	Southside CSB (3b)	SVMHI, PGH
	New River Valley Community Services (3b)	
DBHDS Region 4 – 7 CSBs	Chesterfield CSB	Central State Hospital (CSH), PGH
	Crossroads CSB	
	District 19 CSB	
	Goochland-Powhatan Community Services	
	Hanover County CSB	
	Henrico Area MH and Developmental Services	
	Richmond Behavioral Health Authority	
DBHDS Region 5 – 9 CSBs	Chesapeake Integrated Behavioral Healthcare	Eastern State Hospital (ESH)
	Colonial Behavioral Health	
	Eastern Shore CSB	
	Hampton-Newport News CSB	
	Middle Peninsula-Northern Neck CSB	
	Norfolk CSB	
	Portsmouth Department of Behavioral Healthcare Services	
	Virginia Beach CSB	
	Western Tidewater CSB	

Appendix B

List of organizations and individuals invited to participate in stakeholder group meetings

December 12 and 19, 2022

Invitations to the stakeholder group meetings were distributed by DBHDS to the following group with a request to forward invitations to community providers and others in their organizations that should be included in the discussion.

Organization	Position	Name
DBHDS	DBHDS Commissioner	Nelson Smith
DBHDS Regions	Region 1 Regional Managers	Kristin Chesser, Trinita Turner
	Region 2 Regional Managers	Jean Post, Eleanor Barber
	Region 3a Regional Manager	Cathy Shenal
	Region 3b Regional Manager	Richard Harris
	Region 3c Regional Manager	Frankie Fuller
	Region 4 Regional Managers	Amy Erb, Kim Claros
	Region 5 Regional Manager	Carmen Kheziah
	DBHDS Community Transition Specialists	Berandette Persina, Susan Anson, Heather Tickle and Jamie Elzie and Katie Powers
Department of Social Services	DSS Licensing Specialist	Sharon Debover
Department of Aging and Rehabilitative Services	DARS/ AG manager	Tishauwn Harris
Virginia Association of CSB Executive Directors		Jennifer Faison
	40 CSB Executive Directors	

Appendix C

Stakeholder Feedback - Barriers to Timely Patient Discharge from State Hospitals

Category	Description of the Barriers
Behavioral management competency	Past behaviors and past history
	People are scared of these types of individuals. Mixed population of different people, hard to find qualified staff to deal with harder-to-deal-with behaviors
Complexity of needs	Complexity of clinical needs (ex. co-morbidities)
	Not enough places in Virginia that can accommodate people with TBI, sex offenders, etc.
	Providers who have the choice of who they are going to pick will pick people that don't have as many challenges. The system needs more specialized facilities that are willing to take our clients and there is a need for clear requirements that can't be overlooked.
Criminal background	Nobody wants felons, criminal backgrounds sex offenders, etc. due to increased risks. It only becomes enticing through private pay.
	Discharged patients with criminal backgrounds might have certain parameters of location such cannot be placed next to schools, etc.
Facility type	Assisted living facilities were never designed to serve severe mentally ill. They are historically mismatched, and they are not designed to house certain individuals. The system doesn't want to pay more for a difficult individual if they aren't getting more supervision or care, but just more to "cope" with them.
	States do not have the proper facilities to care for a large range of behaviors and mental illnesses
Legal decision maker	Facilities are hesitant to take dementia patients that don't have a legal guardian. This is a concern because dementia is progressive, and programs want to be guaranteed that they will get paid and having someone responsible for patients' care
Licensure	Licensed vs. unlicensed facility
Medications, behaviors	Assisted living facilities denying people with certain medications since the facilities can only take a limited number of people with behavioral medications
Progressive client needs	Facilities want some type of reassurance that they're not going to get stuck with someone who is decompensating. The facilities are already anticipating that things are going to go downhill.
Regional COLA	Rate is so high due to costs of living

Category	Description of the Barriers
Relationship building	When administration changes, it causes challenges with relationships already established prior to the change.
Staff education	Finding a facility that has the staffing expertise to work with our clients and issues with staff turnover
	Training fees since staffing doesn’t have trained employees that can handle our discharged individuals with a high variety of different behaviors. Facilities are losing staffing because they aren’t trained to handle our individuals.
Staff experience	Experience with the agencies outside the facility, people don’t have direct hands-on experience with clients, lack of funds, don’t understand how to work with residents. Doctors aren’t easy to get in contact with.
	Limited ability to get in contact with resources, lack of training for staff, limited options for training, staff doesn’t know what they are doing. There is a need for more information on the front end and a lack of questions being asked.

Appendix D

Proposed DAP Rate Structure

PROPOSED DAP REIMBURSEMENT TIERED RATE STRUCTURE

Area of concern	Category	Reason for inclusion	Qualifying Information Source	Assessed Status/Need	Estimated Average Additional Monthly Care Hours	Base FY2023 Amount - all regions except Northern Virginia	Base FY2023 Amount, Northern Virginia	Periodic COLA Adjustment Recommendation	Subject to Cap
Provider	Location/Cost of labor	To reflect higher cost of living & vendor contracts for support services	Facility Location/CSB/Region	Region	N/A	$ 1,682.00	$ 1,934.00	Yes*	Yes - Up to total facility monthly care reimbursement cap, based on facility type (AL, Memory Care, NF)
			VIRGINIA UNIFORM ASSESSMENT INSTRUMENT (UAI)	Room and Board, Support Services					

*Auxiliary Grant (AG) Program Note: The current monthly AG rate may be adjusted periodically by a cost of living (COLA) increase by Social Security Administration effective January 1st of each year and should remain the same throughout the year unless providers receive notification of a rate change. There is a 15% differential per month for localities in Planning District 8, which includes the counties of Arlington, Fairfax, Loudoun, and Prince William and the cities of Alexandria, Fairfax City, Falls Church, Manassas City and Manassas Park. These rates are subject to change.

Area of concern	Category	Reason for inclusion	Qualifying Information Source	Assessed Status/Need	Estimated Average Additional Monthly Care Hours	Base FY2023 Amount - all regions except Northern Virginia	Base FY2023 Amount, Northern Virginia	Periodic COLA Adjustment Recommendation	Subject to Cap
			Total Section 1 - Auxiliary Grant			$ 1,682.00	$ 1,934.00		
			PATIENT CARE NEEDS - FUNCTIONAL AND MEDICAL						
Client/Patient	Clinical (physical health) complexity	Increased staff time required for monitoring or assistance	UAI Section 2 - Functional Status	ADLs and Ambulation - "Physical assistance" needed	20	$ 528	$ 607	Yes	Yes
			UAI Section 2 - Continence	Continence - "Not self care/needs help"	20	$ 528	$ 607	Yes	Yes
			UAI Section 2 - Functional Status	Eating and ambulation - "Performed by others"	45	$ 1,188	$ 1,366	Yes	Yes
			UAI Section 2 - Functional Status	Bathing, dressing, toileting, and transfers - "Performed by others"	45	$ 1,188	$ 1,366	Yes	Yes
			UAI Section 3 - Physical Health Assessment: Diagnoses & Medication Profile - Up to 3 Major, Active Diagnoses	Cancer (03)	20	$ 528	$ 607	Yes	Yes
				Dementia (08,09), Developmental Disabilities (10-17)	15	$ 396	$ 455	Yes	Yes
				Diabetes (19) or renal failure (40)	15	$ 396	$ 455	Yes	Yes
				Immune System Disorders / HIV (22)	15	$ 396	$ 455	Yes	Yes
				Psychiatric Disorders (30-35)	15	$ 396	$ 455	Yes	Yes
	Needs related to TBI			Neurological Problems Brain Trauma/Injury (26-29)	N/A	$ 1,521	$ 1,521	No - See Note**	Yes
	Sensory functions		UAI Section 3 Sensory Functions	Vision, Hearing, Speech - Complete loss - any function	30	$ 792	$ 911	Yes	Yes

Note** Traumatic brain injury care (TBI) reimbursement differential limited to $50 per patient day, VA Administrative Code, Title 12. Health - Agency 30. Department of Medical Assistance Services - Chapter 90. Methods and Standards for Establishing Payment Rates for Long-Term Care

Area of concern	Category	Reason for inclusion	Qualifying Information Source	Assessed Status/Need	Estimated Average Additional Monthly Care Hours	Base FY2023 Amount - all regions except Northern Virginia	Base FY2023 Amount, Northern Virginia	Periodic COLA Adjustment Recommendation	Subject to Cap
			Total Section 2 - Functional status						
			PATIENT CARE NEEDS - BEHAVIORAL						
Client/Patient	Mental health, Behavioral health	Increased staff time required for monitoring or assistance	UAI Section 3 - Behavior pattern	Behavior pattern - Abusive / Aggressive / Disruptive – Less than weekly:					
			DAP Behavioral Assessment Form	Behavioral score 1 - 6	10	$ 264	$ 304	Yes	Yes
			DAP Behavioral Assessment Form	Behavioral score 7+	15	$ 396	$ 455	Yes	Yes
			UAI Section 3 - Behavior pattern	Abusive / Aggressive / Disruptive – Weekly or more:					
			DAP Behavioral Assessment Form	Behavioral score 1 - 2	20	$ 528	$ 607	Yes	Yes
			DAP Behavioral Assessment Form	Behavioral score 3 - 4	40	$ 1,056	$ 1,214	Yes	Yes
			DAP Behavioral Assessment Form	Behavioral score 5 - 6	60	$ 1,585	$ 1,822	Yes	Yes
			DAP Behavioral Assessment Form	Behavioral score 7+	80	$ 2,113	$ 2,430	Yes	Yes
			DAP Behavioral Assessment Form	Behaviors requiring 1x1 care	180	$ 4,754	$ 5,466	Yes	Yes
			Total Section 3 - Behaviors						
Program Administration	Program reimbursement transparency and fairness	Cost containment	Total Patient Care Needs (sum of Sections 1-3)						
			Patient Care Needs Cap	Assisted Living		$ 6,500.00	$ 7,475.00	Yes	N/A
				Memory Care		$ 7,500.00	$ 8,625.00	Yes	N/A
				Nursing Facility		$ 8,500.00	$ 9,775.00	Yes	N/A
			Total authorized patient care rate (Lower of Sections 1-3 or cap)						
Program Administration	Other barriers to community-based care	Complexity of needs not addressed above	Extraordinary circumstances payment request - please provide description					N/A	N/A
			Total authorized patient care, monthly payment						

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PROPOSED DAP REIMBURSEMENT TIERED RATE STRUCTURE (CONTINUED)

			PATIENT CARE NEEDS - SOCIAL HISTORY						
Client/Patient	Address stigma, client management within the facility	Increase complexity of patient management and required reporting protocols	Hospital Discharge Notes / H&P or Documented Social Work Note	NGRI/pending trial/incompetent to stand the trial - Non-violent offence	N/A	$ 500	$ 500	No	Yes
				NGRI/pending trial/incompetent to stand the trial - Violent offence	N/A	$ 1,000	$ 1,000	No	Yes
				Registered Sex Offender - Non-violent	N/A	$ 750	$ 750	No	Yes
				Registered Sex Offender - Violent	N/A	$ 1,000	$ 1,000	No	Yes
				Arson	N/A	$ 1,000	$ 1,000	No	Yes
				Other significant social history impeding hospital discharge (such as no legal decision maker currently in place, other)	N/A	$ 1,000	$ 1,000	No	Yes
			Total Social History Section						
			Social History Section Cap			$ 3,000.00	$ 3,000.00		
			Total authorized social history one-time add-on payment (Lower of the cap or section total)						
			FACILITY INFORMATION SECTION						
Provider	Facility incentives to promote quality of care through adherence to regulations and staff education	Additional administrative time	Licensure status - additional cost of compliance with licensing requirements	Facility is a licensed provider	N/A	$ 500	$ 500	No	Yes
			Training needs - to relieve the burden of provider staff training and education for a successful client integration into the community	Special behavioral or medical management needs training beyond that required by applicable facility licensing regulations	N/A	$ 500	$ 575	Yes	Yes
			Total facility section						
			Facility Section Cap			$ 1,000.00	$ 1,075.00		
			Total authorized social history on-time add-on payment (Lower of the cap or section total)						
			Total authorized one-time add-on payment						
			DAP QUALITY INCENTIVE SECTION - TBD						
Program management	Quality outcomes	State-level incentive to promote quality of care and decrease hospital days waiting placement in community	State reporting file	TBD - quality outcomes measures (such as low hospital readmissions, client/family satisfaction, number of DAP clients. Recommendation: distribute quality incentive payment to all DAP participating providers. Facilities with no reported abuse or neglect qualify for an annual incentive, up to a cap (such as $5,000), based on number of DAP-covered patient days (calculated as: ((Facility DAP days / total state DAP days) x state quality fund pool)					

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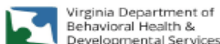
Proposed DAP Rate Calculation Worksheet – Tiered Structure



VA DBHDS DISCHARGE ASSISTANCE PROGRAM
DAP RATE CALCULATION FORM - CALENDAR YEAR 2023

Patient	
CSB	
Region	
Request/Assessment Date	

Qualifying Information Source	Assessed Status/Need	Select from the drop down lists	Line total	Section Total
Facility Location/CSB/Region	Region			
VIRGINIA UNIFORM ASSESSMENT INSTRUMENT (UAI)	Room and Board, Support Services		Information needed	
Total Section 1 - Auxiliary Grant				Information needed
Potential placement facility type				
PATIENT CARE NEEDS - FUNCTIONAL AND MEDICAL				
UAI Section 2 - Functional Status	ADLs and Ambulation		Information needed	
UAI Section 2 - Continence	Continence		Information needed	
UAI Section 2 - Functional Status	Eating and ambulation		Information needed	
UAI Section 2 - Functional Status	Bathing, dressing, toileting, and transfers		Information needed	
UAI Section 3 - Physical Health Assessment: Diagnoses & Medication Profile	3 Major, Active Diagnoses - #1		Information needed	
	3 Major, Active Diagnoses - #2		Information needed	
	3 Major, Active Diagnoses - #3		Information needed	
UAI Section 3 Sensory Functions	Vision, Hearing, Speech		Information needed	
Total Section 2 - Functional status				$ -
UAI Section 3 - Behavior pattern	Behavior pattern			
DAP Behavioral Assessment Form	Description of behaviors		Information needed	
Total Section 3 - Behaviors				Information needed
Total Patient Care Needs (sum of Sections 1-3)				Information needed
Patient Care Needs Cap				Information needed
Total authorized patient care rate (Lower of Sections 1-3 or cap)				$ -
Extraordinary circumstances payment request - please provide description				
Total authorized patient care, monthly payment				$ -
PATIENT CARE - SOCIAL HISTORY				
Hospital Discharge Notes / H&P or Documented Social Work Note	NGRI/pending trial/incompetent to stand the trial		Information needed	
	Registered Sex Offender		Information needed	
	Arson		Information needed	
	Other significant social history impeding hospital discharge		Information needed	
Total Social History Section				$ -
Social History Section Cap				$ 3,000
Total authorized social history one-time add-on payment (Lower of the cap or section total)				$ -
FACILITY INFORMATION SECTION				
Licensure status			Information needed	
Training needs			Information needed	
Total facility section				$ -
Facility Section Cap				$ 1,000
Total authorized social history on-time add-on payment (Lower of the cap or section total)				$ -
Total authorized one-time add-on payment				$ -
Person completing request				
Person reviewing/authorizing				

Appendix E

Instructions for Utilizing UAI for Purposes of Completion of the DAP Rate Calculation Sheet

Potential placement facility type		Memory Care		
PATIENT CARE NEEDS - FUNCTIONAL AND MEDICAL				
UAI Section 2 - Functional Status	ADLs and Ambulation	Ambulation - physical assistance needed	$	607
UAI Section 2 - Continence	Continence	Continence - not self care/needs help	$	607
UAI Section 2 - Functional Status	Eating and ambulation	Eating/Ambulation - no assistance needed, supervision only or minimal assistance	$	-
UAI Section 2 - Functional Status	Bathing, dressing, toileting, and transfers	Bathing, dressing, transfers - no assistance needed, supervision only or minimal assistance	$	-

2 FUNCTIONAL STATUS *(Check only one block for each level of functioning.)*

ADLS	Needs Help?		MH Only 10 Mechanical Help	HH Only 2 D Human Help		MH & HH 3 D		Performed by Others 40 D			Is Not Performed 50 D
	No 00	Yes		Supervision 1	Physical Assistance 2	Supervision 1	Physical Assistance 2				
Bathing		✓			✓						
Dressing	✓										
Toileting	✓										
Transferring	✓										
								Spoon Fed 1	Syringe/Tube Fed 2	Fed by IV 3	
Eating/Feeding	✓										

Continence	Needs Help?		Incontinent Less than Weekly 1	Ext. Device/ Indwelling/ Ostomy Self Care 2	Incontinent D Weekly or More 3	External Device D Not Self Care 4	Indwelling D Catheter Not Self Care 5	Ostomy D Not Self Care 6
	No 00	Yes						
Bowel	✓							
Bladder		✓			✓			

Ambulation	Needs Help?		MH Only 10 Mechanical Help	HH Only 2 D Human Help		MH & HH 3 D		Performed by Others 40 D	Is Not Performed 50 D
	No 00	Yes		Supervision 1	Physical Assistance 2	Supervision 1	Physical Assistance 2		
Walking		✓		✓					
Wheeling	✓								
Stairclimbing	✓								
								Confined Moves About	Confined Does Not Move About
Mobility	✓								

UAI Section	Item	Selection		Amount
UAI Section 3 - Physical Health Assessment: Diagnoses & Medication Profile	3 Major, Active Diagnoses - #1	Dementia (08,09), Developmental Disabilities (10-17)	$	455
	3 Major, Active Diagnoses - #2	Not applicable - no health conditions	$	-
	3 Major, Active Diagnoses - #3	Not applicable - no health conditions	$	-

3 PHYSICAL HEALTH ASSESSMENT

Professional Visits/Medical Admissions

Doctor's Name(s) *(List all)*	Phone	Date of Last Visit	Reason for Last Visit

Admission: In the past 12 months have you been admitted to a . . . for medical or rehabilitation reasons?

No 0	Yes 1		Name of Place	Admit Date	Length of Stay/Reason
		Hospital			
		Nursing Facility			
		Adult Care Residence			

Do you have any advance directives such as… (Who has it…Where is it…)?

No 0 Yes 1 *Location*

____ ____ __________

____ ____ Durable Power of Attorney for Health Care, __________

Other, __________

Diagnoses & Medication Profile

Do you have any current medical problems, or a known or suspected diagnosis of mental retardation or related conditions, such as … (Refer to the list of diagnoses)?

Current Diagnoses	Date of Onset
Dementia, non-Alzheimer's (9)	2021

Enter Codes for 3 Major, Active Diagnoses: ____ **None**00 9 **DX1** ____ **DX2** ____ **DX3**

Diagnoses:
Alcoholism/Substance Abuse (01)
Blood-Related Problems (02)
Cancer (03)
Cardiovascular Problems
- Circulation (04)
- Heart Trouble (05)
- High Blood Pressure (06)
- Other Cardiovascular Problems (07)

Dementia
- Alzheimer's (08)
- Non-Alzheimer's (09)

Developmental Disabilities
- Mental Retardation (10)
- Related Conditions
  - Autism (11)
  - Cerebral Palsy (12)
  - Epilepsy (13)

Instructions for Utilizing UAI for Purposes of Completion of the DAP Rate Calculation Sheet (Continued)

UAI Section 3 Sensory Functions	Vision, Hearing, Speech	Sensory functions - No Impairment	$ -

Sensory Functions

How is your vision, hearing, and speech?

	No Impairment $_0$	**Impairment** *Record Date of Onset/Type of Impairment*		**Complete Loss** $_3$	**Date of Last Exam**
		Compensation $_1$	No Compensation $_2$		
Vision	✓				
Hearing	✓				
Speech	✓				

Instructions for Utilizing UAI for Purposes of Completion of the DAP Rate Calculation Sheet (Continued)

UAI Section 3 - Behavior pattern	Behavior pattern	Behavior pattern - Abusive / Aggressive / Disruptive – Less than weekly	

Behavior Pattern

Does the client ever wander without purpose (trespass, get lost, go into traffic, etc…) or become agitated and abusive?

- Appropriate 0
- Wandering/Passive – Less than weekly 1
- Wandering/Passive – Weekly or more 2
- ✓ Abusive/Aggressive/Disruptive – Less than weekly 3
- Abusive/Aggressive/Disruptive – Weekly or more 4
- Comatose 5

Type of inappropriate behavior: taking possessions of others, hoarding Source of Information:

DAP Behavioral Assessment	Description of behaviors	Disruptive – Less than weekly - Behavioral supplement score 1-6	$ 304

Virginia Department of Behavioral Health & Developmental Services

DAP Behavior Assessment

Date of Assessment	
Name and Role of Assessor	

Totals	
No support needed	0
Some Support Needed	2
Extensive Support Needed	0

Instructions: For the last 30 days consider each description then please choose the appropriate box for level of care needed. Once completed use the totals to complete the behavioral section of the DAP calculation worksheet. Definitions for level of care are as follows:

No Support Needed: No support needed because the behavior is not an issue or no support is needed to manage the behavior.

Some Support Needed: Some support is needed to address the behavior. Please who support must be cognizant continuously of the condition to assure the individuals health and safety. For example: Checking in and observing, monitoring and providing occasional assistance; minimal/physical hands on contribution; support is episodic and or requires minimal support

Extensive Support Needed: Extensive support is needed to address the behavior. For example: Significant physical/hands on contribution or support is intense and requires daily significant support time (more than 1 hour a day)

Behavior	Level of Support Required	Comments
Prevention of assaults or injuries to others		
Prevention of property destruction (eg fire setting, breaking furniture)		
Prevention of stealing	Some Support Needed	aggressive towards others when confronted
Prevention of self-injury		
Prevention of Pica		
Prevention of suicide attempts		
Prevention of sexual aggression		
Prevention of non- aggressive but inappropriate behavior	Some Support Needed	Hoarding