REPORT OF THE
DEPARTMENTS OF MEDICAL ASSISTANCE SERVICES
AND MENTAL HEALTH, MENTAL RETARDATION AND
SUBSTANCE ABUSE SERVICES

A REPORT ON THE MENTAL RETARDATION WAIVER

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

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TO: The Honorable James S. Gilmore, III

And

The General Assembly of Virginia

The report contained herein is provided pursuant to the 1998 Appropriations Act at House Bill Item 341. The purpose of this report was to study the current Medicaid waiver for mental retardation services; examine ways to maximum service efficiencies and greater cost containment; and review the array of services under the waiver.

The Report is based on research conducted by CHPS Consulting. However, the Departments of Medical Assistance Services and Mental Health, Mental Retardation and Substance Abuse are responsible for the report, including the findings and conclusions.

Respectfully submitted,

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A Report on the Mental Retardation Waiver

April 1999

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1. INTRODUCTION

1. INTRODUCTION

1.1 BACKGROUND OF STUDY

CHPS Consulting (CHPS) has prepared this report on the Medicaid funded Waiver program for mental retardation services for the Commonwealth of Virginia's Department of Medical Assistance Services (DMAS) and Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS).

Virginia funds community support services for individuals with mental retardation through its Medicaid Home and Community Based (HCB) Waiver, which was granted to DMAS by the Health Care Financing Administration (HCFA) under section 1915(c) of the Social Security Act. The Waiver provides funding for individuals in the community who would otherwise require the level of care provided in an intermediate care facility for the mentally retarded (ICF/MR). To qualify for the MR Waiver, individuals must:

- be financially eligible for Medicaid services;
- have a diagnosis of mental retardation or a related condition or be developmentally at risk if under age six, and
- need services provided at the ICF/MR level of care.

1.2 PURPOSE OF STUDY

This study was mandated by the Virginia General Assembly in the 1998 Appropriations Act at House Bill Item 341, which states,

> The Department of Mental Health, Mental Retardation and Substance Abuse Services and the Department of Medical Assistance Services, in cooperation with community mental retardation service providers, shall study the current Medicaid waiver for mental retardation services and possible changes that will lead to maximum service efficiencies and greater cost containment. Emphasis shall be placed on developing waiver services focused on individualized supports, that would complement and maximize personal resources and natural supports while ensuring that the least intrusive or restrictive services are provided to eligible individuals. A report shall be provided to the Governor and the Chairmen of the House Appropriates and Senate Finance Committees by December 1, 1998.

As indicated in the language from House Bill Item 341, the purpose of this study was to review the current Waiver for the mental retardation (MR) population and identify and explore potential changes. There were three specific objectives for this review of the Waiver:

- to examine ways to maximize MR service efficiencies,

- to identify opportunities for greater cost containment in serving the MR population, and
- to review the array of services covered under the Waiver.

1.3 OVERVIEW OF THE REPORT

This report is presented in four chapters and ten appendices. The following chapter discusses the methodology that was used to conduct the study and presents the data sources that were consulted. Chapter Three describes the current Waiver for MR services, including administration of the Waiver, service array and delivery, and financial management issues. Chapter Four presents study findings and recommendations regarding Waiver administration, service array and delivery, financial management, and other issues.

The appendices include an overview of MR/DD service delivery in the United States and a discussion of MR/DD services in Virginia and the United States. MR Waivers in other states are discussed including states with innovative Waivers and states in the same geographic area as Virginia. Draft recommendations, as developed by the Waiver Advisory Committee, for the Waiver renewal are presented. A list of the interviews conducted by the project team is provided, followed by the interview guides and consumer interview summaries. A review of recent case law regarding MR services is presented. Copies of the documents distributed to the Project Advisory Group and the minutes of weekly telephone conferences are included. One appendix provides a short glossary of terms used in the report.

2. STUDY METHODOLOGY

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2.1 INTRODUCTION

The study methodology is described in this chapter. Project activities included the conduct of interviews about the MR Waiver with almost 80 individuals, participation and coordination with other current projects related to the provision of MR services in the Commonwealth, the conduct of surveys of MR Waiver programs in other states, a review of current literature and program materials, and a review of the most recent case law.

A project advisory committee provided guidance to the project team in the conduct of the project activities. The advisory committee included the project officers from DMAS and DMHMRSAS and representatives from private providers and Community Service Boards. Conference calls were held on a weekly basis with the project advisory committee between June 22 and August 17, 1998. Materials prepared for these meetings and minutes of the meetings are presented in Appendix I.

Each of the project activities is discussed in the sections that follow. The final section presents a bibliography of resources that were consulted for this study.

2.2 CONDUCT OF INTERVIEWS

Interviews were conducted with individuals in seven major groups in order to get a general understanding of how the MR Waiver is administered in Virginia as well as to represent the viewpoints of the spectrum of individuals that work within or are impacted by the MR service system. These groups included:

- DMAS staff who have responsibilities for different aspects of the MR Waiver,
- DMHRSAS staff who have responsibilities for different aspects of the Waiver,
- other Commonwealth staff that are impacted by the MR service system,
- CSBs who have service delivery and/or administrative responsibilities for the Waiver,
- private providers who deliver services covered by the MR Waiver,
- advocacy groups for the MR population, and
- consumers of MR services and their family members.

Individuals were selected for interviews so that a diversity of perspectives within these groups could be heard. The project officers at DMAS and DMHRSAS selected the appropriate individuals on the state level to interview. The Project Advisory Committee assisted in the selection of CSBs, private providers, and consumers and family members for interviews. The CSBs selected included local agencies that:

- primarily contract for services,
- provide most of the services for their MR population,

- both provide services and contract with other providers,
- have converted all of their state match,
- have not converted all of their state match,
- are located in a rural area, and
- are located in an urban area.

In addition, one CSB was randomly selected. At each CSB, the Executive Director, the MR Director, a case manager, and a staff member from the finance department were interviewed. The private providers interviewed included both for-profit and not-for-profit agencies that were of varying size and composition. Consumers and family members with different circumstances were chosen for interviews representing people who present varying levels of need for supports, those who receive different services under the Waiver, are on the waiting list for MR services, no longer receive Waiver services, live in different geographic areas of the state, and/or are currently institutionalized. A total of 78 interviews were conducted. Appendix H lists these interviews.

Overall, the project team used the interviews to gain an understanding of the Waiver program service delivery, the supply and demand of Waiver program services, the current array of services, the level of payments for Waiver services, rate setting methodologies, and administrative policies and procedures. Also, input regarding ways to improve the MR Waiver in Virginia was solicited from each person interviewed. Most interviews were conducted in person, with a few being conducted via telephone. The interview with private providers was conducted in a group setting. Appendix G presents the instruments that were used to guide the discussion for the interviews. These instruments were tailored as appropriate for each individual that was interviewed based on their expertise and specific relationship to the Waiver. Interviewees from DMAS, DMHMRSAS, CSBs and private providers were faxed interview instruments prior to the interviews.

2.3 PARTICIPATION AND COORDINATION WITH RELATED PROJECTS

In addition to this legislative study of the MR Waiver, a number of other projects are being conducted concurrently regarding the Waiver in Virginia. While this is not meant to be a comprehensive discussion of all DMHMRSAS and DMAS initiatives regarding the Waiver, this section briefly describes several efforts that CHPS and its consultants either participated in or were enabled to consider in developing recommendations regarding the Waiver. It should be noted that many projects are ongoing, and these efforts continue to look for ways to improve the MR service system in Virginia beyond this current study.

DMHRSAS organized a Waiver Advisory Committee (WAC) made up of representatives from several state agencies, CSBs, private providers, consumers and families. The WAC has been working to develop recommendations for changes to be included in the Waiver renewal application. The draft recommendations from the WAC are included in Appendix A of this report and final recommendations will be forwarded to DMAS for application development in November 1998.

Three subgroups of the WAC were established to review the entire Waiver process and develop consensus-based recommendations for refining the Waiver. The three subgroups were charged with researching improvements for administrative processes, the MR service array, and the financial structure of the Waiver. CHPS attended two sub-group meetings, including one in which consultants from the National Association of State Directors of Developmental Disabilities presented their recommendations for improving Waiver financial management, case management services, service array, and payment for services. CHPS also heard the draft recommendations from the three subgroups regarding improvements for administrative processes, the MR service array, and the financial structure of the Waiver.

DMHMRSAS is participating in the National Core Indicators Project, which is co-sponsored by the National Association of State Directors of Developmental Disabilities Services and the Human Services Research Institute. The anticipated outcome of this project will be statewide implementation of a new standard system for measuring and evaluating performance measures for MR service delivery, which is scheduled for implementation in 2001. CHPS also was made aware of work on a protocol on consumer choice issues, a joint effort of private providers, case managers, DMHMRSAS staff, and CSB MR Directors.

CHPS' consultant, Marilyn Hill, is also participating in the Comprehensive Community and Facilities Master Plan Project for the Delivery of Mental Health, Mental Retardation, and Substance Abuse Services, which is a study of Virginia's state hospitals and ICF/MR facilities. This plan will project the numbers of people who will need state facility services and those who could be served in the community, recommend the type of facility of service and number of beds that will be needed for each region of the state, and recommend future options for each state facility.

In a separate project for DMAS, CHPS is working with an accounting firm on a cost audit of a sample of CSBs and private providers in the state. The accounting firm is reviewing 1997 cost data from the CSBs and private providers. CHPS is assisting in analyzing findings, examining payment rates and methodologies, developing recommendations, and writing a report. This project will not be completed until late spring 1999.

2.4 SURVEY OF OTHER STATES

Telephone interviews were conducted with staff from other states to gather information on their MR waiver programs and to solicit any lessons learned regarding MR service delivery and waiver administration. Two groups of states were purposefully selected for interviews: (1) states that are considered to have innovative or "model" elements in their MR waivers; and (2) states that are within the same geographic region as Virginia. The states in the same geographic region as Virginia were surveyed principally to gain a better understanding of their payment rates and methodologies. The Project Advisory Committee and project officers helped to select the states within both groups. Model state programs included Michigan, Colorado, Utah, Wyoming, Rhode Island, and Wisconsin. Regional state programs included Kentucky, Maryland, North Carolina, Tennessee, and Pennsylvania.

Interview guides for model and regional state programs are presented in Appendix G. All states interviewed were asked to provide CHPS with a copy of their Waiver application, regulations, and information on services covered under the Waiver, numbers of consumers served, and the administrative structure of the program. All states were also asked how they would change their waiver if given the opportunity. Model states were asked to describe their programs, and discuss both benefits and disadvantages. States within Virginia's region were asked to provide their rate schedule and rate methodology for the waiver. Appendix E presents an overview of the model and regional state MR Waiver programs.

2.5 LITERATURE REVIEW

A literature review was conducted to examine pertinent documentation regarding Virginia's MR Waiver as well as to review current research on MR service delivery. The resources that were consulted included a number of documents that CHPS requested from DMHMRSAS and DMAS, as well as reports and journal articles identified through a literature search. The documents provided by DMHRMSAS and DMAS included reports, manuals, regulations, and journal articles. CHPS used the literature review to gain an understanding of the history and current status of MR service delivery in Virginia and to identify other relevant research that may be useful for recommendations on the Waiver. A bibliography from the literature review is provided at the end of this chapter.

2.6 CASE LAW REVIEW

CHPS also conducted a review of recent federal and state case law related to MR service delivery and funding issues. The case law review was conducted to identify current litigation or legal precedents that may be important to consider when making changes to Virginia's MR Waiver program and the provision of MR services. The case law review is presented in Appendix D.

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3. CURRENT WAIVER PROGRAM AND ADMINISTRATION

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3.1 INTRODUCTION

This chapter describes Virginia's current Home and Community Based (HCB) Waiver for MR services and how it is administered. Prior to discussing Virginia's Waiver it is useful to review the background regarding the Federal government's creation of HCB Waivers. The Health Care Financing Administration (HCFA) allows states to be flexible through their Medicaid HCB Waivers in creating and implementing alternatives to institutionalizing Medicaid-eligible individuals. The philosophy behind the creation of HCB Waivers is that many people can be cared for in their homes and communities at an over-all cost that is no higher than the cost of institutional care, which also allows them to be more independent and close to family and friends. Waiver services may also be provided to individuals who would otherwise qualify for Medicaid only if institutionalized. States may provide HCB Waivers to people with physical disabilities, mental illnesses, developmental disabilities, or to people with other specific illnesses or conditions.

In effect, Section 1915 (c) of the Social Security Act gives a state considerable latitude in deciding who will be eligible to receive HCB services, what kinds of services and supports they will be offered, the maximum number of individuals who will receive such services, how much the state will spend on their behalf, and whether services and supports will be limited geographically. The discretion afforded has motivated states to expand their HCB waiver programs.

However, there are various provisions of federal law and administrative policy that govern the way a state must structure and operate its Medicaid program that are not waived. Those provisions include the following:

- Entitlement – Although the state can target specific populations and cap utilization and expenditures for the eligible individuals, the waiver must be administered on an even basis for all eligible individuals. Thus, within the terms and conditions the state has spelled out, the program could be considered to be an entitlement for eligible persons.
- Comparability – The HCB waiver permits a state to define more narrowly which Medicaid recipients will be eligible for the program. However, it does not allow a state to treat such individuals differently once they become participants in the program. The services that a state offers must be uniformly available in all parts of the state unless a waiver of statewideness is approved.
- Freedom of Choice – Recipients must be provided freedom of choice of Waiver services or institutional services. If they choose Waiver services, they must also be afforded the opportunity to choose among eligible providers of Waiver services.
- Contracting – The provisions governing state Medicaid-vendor provider agreements are in force for services furnished under an HCB waiver.
- Payments – Medicaid policies generally require fee-for-service payment methods, which means that payment is made for rendering a discrete unit of service. Federal

policy also requires that there be a direct and verifiable trail of documentation from the actual delivery of the specific service to the vendor claim for the service to the state Medicaid agency payment to the vendor.

According to federal regulations, there are seven services that may be provided through HCB Waivers including: case management, homemaker services, home health aid services, personal care services, adult day health, habilitation, and respite care. Additional services may be provided if approved by HCFA, which have included for many states transportation, residential services, in-home support services, meal services, special communication services, and home modifications. States are given the flexibility to design their Waivers as they see fit for their populations and to provide the best array of Waiver services to meet consumers' needs. HCFA also allows Waiver services to be limited to specific geographic subdivisions should states so choose. The MR Waiver is the predominant way in which community-based services are provided to persons with mental retardation.

HCFA has some specific requirements for HCB Waivers. It is required that there be a specific plan of care for each consumer. This plan must list the services and supports to be provided to each consumer, the provider of these services, and how often they will be provided. Consumers must also be allowed to choose to participate in the Waiver, to choose the services that they will receive, and to choose from among appropriate service providers. The state must also define how it will insure the quality of services for consumers. Appendix C provides additional information on MR Waiver Services in the U.S. and in Virginia.

The following section provides a general overview of Virginia's MR Waiver. The organization and administration of the Waiver is then detailed, including a discussion of the different roles of DMAS, DMHRSAS, CSBs and private providers in Waiver administration. The array of services covered under Virginia's MR Waiver and the delivery of these services is described. The chapter concludes with a discussion on financial management of the Waiver.

3.2 OVERVIEW OF VIRGINIA'S MR WAIVER

Since 1991, Virginia has been providing Medicaid funded MR Waiver services for consumers in the community. In 1995, it was estimated that there were between 46,318 and 79,402 Virginians with a diagnosis of mental retardation.[1] As of April 1998, approximately 2,300 individuals were receiving services in their communities through the MR Waiver.[2] In its *Comprehensive State Plan: 1998-2004*, DMHMRSAS states that the waiting list for community-based day support services is 1,974 consumers, and the waiting list for community based residential services totals to 2,897. It is expected that an additional 2,172 consumers will need residential services within five to ten years. In 1997, DMHMRSAS anticipated that 499 of the more than 2,000 residents in ICF/MR facilities would be ready for community placement by July 1998.[3]

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[1] Comprehensive State Plan 1998-2004, DMHMRSAS, December 11, 1997.
[2] DMAS Draft Audit Report, April 1998, Report Number 144.
[3] Comprehensive State Plan 1998-2004, op cit.

DMAS and DMHMRSAS have different roles and responsibilities in regard to the MR Waiver, which are delineated in an interagency agreement. DMAS is responsible for all the regular responsibilities as the Single State Agency. This includes submitting appropriate waivers and waiver renewals to HCFA, as well as paying claims for waiver services. DMHMRSAS administers the Waiver program and oversees the Community Service Boards (CSBs), which are local government agencies responsible for delivering mental health, mental retardation, and substance abuse services in their communities.

State statute requires every jurisdiction to join a CSB. There are 40 CSBs serving every city and county in Virginia, 135 localities in all. Under the Waiver, CSBs are responsible for determining the necessity and/or the appropriateness of Waiver services for qualified individuals. Services that are covered under the Wavier include:

- residential support services;
- day support services;
- supported employment services;
- personal assistance services
- respite care services;
- environmental modification services;
- nursing services;
- assistive technology;
- therapeutic consultation services; and
- crisis stabilization services.

Each person covered by the MR wavier is assigned a case manager employed by his or her local CSB.[4] Case managers coordinate completion of comprehensive assessments, develop comprehensive service plans (CSPs), assess eligibility for Waiver services, request authorization for services, and coordinate Waiver services. Services may then be provided by the CSB or by private providers. Service providers are responsible for developing and implementing individual service plans (ISPs) to describe the specific services to be provided to each person.

3.3 ORGANIZATION AND ADMINISTRATION OF MR WAIVER

In this section, the specific responsibilities of DMAS, DMHMRSAS, CSBs and private providers regarding the MR Waiver are described.

[4] CSBs are also permitted to provide case management services through private providers by special arrangement or contract.

3.3.1 Department of Medical Assistance Services

HCFA specifies that a single state agency must administer or supervise the administration of the State Plan for the Medicaid program. In Virginia, DMAS is the agency that has this authority. DMAS is responsible for the entire Medicaid Program as well as the state's Medicaid HCB Waivers. DMAS has a formal interagency agreement with DMHRSAS to administer the HCB Waiver for MR services, while assuming overall responsibility to HCFA for its management.

DMAS has specific responsibilities regarding the MR Waiver that are delineated in its Interagency Agreement with DMHRSAS. These responsibilities include:

- submitting the MR Waiver and Waiver renewal requests to HCFA;
- developing and maintaining the State Plan for Medical Assistance;
- consulting with DMHRSAS on changes to the State Plan for Medical Assistance or the MR Waiver;
- monitoring and overseeing DMHMRSAS quality assurance activities;
- providing payment to DMHMRSAS for administrative services that are specifically related to the Waiver;
- providing any requested training and technical assistance to DMHMRSAS staff;
- maintaining agreements with providers of MR Waiver services;
- processing claims for MR services; and
- providing DMHMRSAS with tapes of all claims paid under the Waiver on a monthly basis.

The Virginia General Assembly appropriates certain funds (the federal Medicaid share and the state general funds match for the federal Medicaid share) to DMAS to provide for MR Waiver services, in addition to other funds appropriated to DMHMRSAS for MR services. DMAS uses the funds to pay claims for MR services. DMAS later reconciles with DMHMRSAS regarding matching funds and reimbursements for services rendered.

3.3.2 Department of Mental Health, Mental Retardation, and Substance Abuse Services

In the Code of Virginia, the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) is designated as the state authority for alcoholism, drug abuse, mental health, and mental retardation services. DMHMRSAS is charged with ensuring that these services are appropriately available to the populations that need them in Virginia. As stated in its *Comprehensive State Plan: 1998-2004*, the role of DMHMRSAS is to provide leadership, direction, and accountability throughout its service system. Specific DMHRSAS functions include:

- interpreting and implementing policy,
- strategic planning,
- licensure,
- human rights,
- providing technical assistance,

- providing oversight and monitoring on an operational level,
- funding
- performance contracting
- risk management and quality assurance
- research and evaluation, and
- staff development and training.

DMHMRSAS assumes the primary duties for administrating the MR Waiver. In its interagency agreement with DMAS, the specific responsibilities of DMHMRSAS for the MR Waiver are defined, which include:

- certifying providers of MR Waiver services and case management services;
- conducting quality assurance reviews of MR Services in consultation with DMAS;
- providing non-federal matching funds to DMAS for MR Waiver services (except for funds included in DMAS' budget);
- ensuring that reimbursements for MR services are appropriate, both on an individualized consumer and aggregate level; and
- collecting and managing documentation and an audit trail to support DMHMRSAS' administrative expenses for the MR Waiver.

DMHMRSAS works closely with CSBs in managing how public funds are spent for MR services. DMHMRSAS approves and controls Waiver slot utilization, transfers projected CSB matching funds to DMAS, and monitors collections on projected plans. DMHMRSAS also reconciles with each CSB to cover match for services rendered.

Staff from the DMHMRSAS Office of Mental Retardation conduct annual, on-site utilization reviews of each CSB regarding MR Waiver and case management services. Utilization reviews (UR) include reviewing consumer and provider records; auditing billings; observing consumers who are receiving services; and interviewing CSB staff, supervisors, and consumers. The UR approach focuses on whether the services provided addressed consumers' needs and desires. Compliance with regulations regarding assessments and documentation is also assessed.

3.3.3 Community Services Boards

Community Service Boards (CSBs) are the local government entities that are charged with delivering mental health, mental retardation, and substance abuse services in the community. Forty CSBs provide some level of services in the 135 cities and counties of Virginia. In FY 1996, 19,169 individuals received MR services from CSBs.

The code of Virginia describes the requirements and responsibilities for CSBs, which include:

- serving as the single point of responsibility and authority for assessing consumer needs;
- accessing a comprehensive array of services and supports; and
- managing state-controlled funds for community-based services.

CSBs may provide services directly to consumers or contract with private providers. In addition to providing services, CSBs advocate for consumers; serve as educators, planners and organizers in the community; advise local government entities, and serve as gatekeepers for accessing needed services and supports.

Virginia's 40 CSBs vary in composition, organizational structure, service provision, size of service area, relationship with local government entities; and budget size. Some CSBs serve populations in urban areas, and others are more rurally located. In its *Comprehensive State Plan: 1998-2004*, DMHRSAS classifies nine of its CSBs as small boards, with total budgets of less than $5 million; 21 of its CSBs as medium boards, with total budgets between $5 million and $11 million; and 10 CSBs as large boards, with budgets over $11 million. CSBs with a population density of less than 130 people per square mile are considered rural CSBs, and those with 130 or more per square mile are classified as urban boards. More than 7,700 direct and contract agency staff work in the CSB system.

CSBs are the single point of entry for individuals who need Waiver services, and CSBs are required to assign a case manager to each MR Waiver consumer. CSBs confirm and document individuals' eligibility for the Waiver based on diagnosis, level of functioning, and Medicaid eligibility. For those who are not already receiving Medicaid, CSBs assist in applying to local Departments of Social Services to determine financial eligibility for the Waiver. Once a CSB determines the level of services to be provided based on need and determines whether or not there are funds available to use for the required match, the CSB requests a Waiver slot from DMHMRSAS. If a slot is available and once it has been approved, the case manager coordinates assessments, the service provider develops a Plan of Care, and the case manager submits a Service Authorization request (SAR) to DMHMRSAS to authorize the Plan. CSBs must certify the knowledge, skills, and abilities of all case managers to the DMHMRSAS.

3.3.4 Private Providers

MR Waiver services and SPO targeted case management services may be provided by CSBs or the more than 200 private providers of Waiver services. It is not required that CSBs hold contracts with private providers to provide services, although CSBs are responsible by regulation for monitoring quarterly reports of Waiver consumers. Case managers must also inform consumers of their possible choice of providers. There are both for-profit and not for profit private providers in Virginia, and each provider may choose the amount and array of Waiver covered services to offer. A private provider must be enrolled with DMAS as a Medicaid provider prior to billing for services, must sign a participation agreement, and must meet DMHMRSAS licensure and certification requirements. Once approved, private providers notify relevant CSBs of their approved provider status so that they may be considered for service delivery.

3.4 SERVICE ARRAY AND DELIVERY

This section describes the array of services covered under the MR Waiver and service delivery. Also discussed are targeted case management services, the providers of MR services, and consumer choice with the Waiver.

3.4.1 Waiver Service Array

Services currently covered by the MR Waiver include residential support services, supported employment, personal assistance services, respite care, day support, assistive technology, environmental modifications, nursing services, therapeutic consultation and crisis stabilization. Each of these services is described in the paragraphs that follow.

Residential Support Services consist of training and support provided in a consumer's home (In-Home Residential Support) or a licensed Adult Care Residence or group home (Congregate Residential Support). These services are aimed at enabling consumers to acquire, improve or maintain the health status and functional skills necessary to live in the community. Room and board is not covered. In-Home Residential Support Services are generally provided with a 1:1 staff to consumer ratio in a private residence, where a consumer has general supervision from a parent or caregiver. Congregate Residential Support Services are provided in licensed residential programs operated by public or private agencies. Multiple staff typically provide both the primary care and the Residential Support services to the consumers that they serve. Specific activities that are included in Residential Support Services are as follows:

- training in skills related to activities of daily living such as toileting, hygiene, and household chores, and assisting with these skills when necessary;
- training in how to use community resources such as transportation, social and recreational activities, etc., and assisting with these activities when necessary;
- training in adaptive behavior;
- monitoring and assisting with health and medical needs;
- assisting with transportation; and
- providing supervision to ensure health and safety.

Personal Assistance Services may be provided to MR Waiver consumers who do not receive Residential Support Services. These services are provided to consumers for whom training and skills development are not primary objectives or are received through other means. These services may be provided in residential or non-residential settings, with the goal of enabling consumers to maintain their health status and functional skills for living in the community. Activities that are included in Personal Assistance Services include:

- direct assistance with personal care and hygiene activities;
- monitoring health status and providing for medication and other medical needs;
- assistance in housekeeping, meal preparation and in eating;
- supervision to ensure consumer's safety;
- assistance and supervision with recreational activities; and

- providing needed supervision when consumer attends appointments or meetings.

Respite Care provides temporary care to Waiver consumers that would normally be provided by another caregiver. Respite Care is meant to substitute for this care in instances where caregivers need temporary relief or need to take an emergency absence. Services may be provided in a consumer's home or residence, or in an alternative community respite setting. Activities to be provided under Respite Care are the same as those offered for Personal Assistance Services, and payment for Respite Care is the also the same as for Personal Assistance. Respite Care services are not covered for consumers who reside in Adult Care Residences or for Foster Care residents.

Nursing services are provided under the MR Waiver for consumers with serious health care needs that require physician-ordered skilled nursing services that cannot be accessed under the State Plan for Medicaid. These services are provided in a consumer's home or in a community setting by licensed nursing personnel. Activities included in Nursing Services are:

- monitoring consumers' medical status;
- administering medications and medical treatments; and
- providing training to caregivers to perform these activities.

Environmental Modifications may be provided for a consumer's residence, work site, or vehicle in situations of direct medical or remedial benefit to the consumer. Consumers who receive environmental modifications must also receive at least one other MR Waiver-covered service. These modifications may include physical adaptations to the residence to ensure health and safety or to enable the consumer to live in the community with greater independence. Also included are modifications to a work site for those who receive Supported Employment Services. Modifications to a family vehicle to allow for safe travel are included as well. Examples of Environmental Modifications include installation of ramps and grab-bars and modifications to bathroom facilities in a consumer's residence.

Assistive Technology provides for adaptive devices, appliances, and/or controls, which enable consumers to be more independent in the areas of personal care, activities of daily living, and communication. This may also include medical equipment that is necessary for life support, other durable or non-durable medical equipment, and personal emergency response systems. As with Environmental Modifications, consumers who receive Assistive Technology must also receive at least one other MR Waiver-covered service.

Day Support Services are provided to consumers primarily in non-residential settings to enable them to acquire, improve, and maintain maximum functional abilities. Day Support settings allow for peer interaction and community and social integration. These services may be provided in the community or in a center-based program. Transportation for the consumer between activity sites, supervision to ensure health and safety, and assistance with personal care needs is included. Training may be provided to consumers in:

- self, social and environmental awareness skills;
- sensory stimulation and gross and fine motor skills;

- communication and personal care;
- use of community resources and community safety;
- learning skills and problem solving; and
- adapting behavior to social and community settings.

Opportunities may also be provided for consumers to use skills in community settings. For consumers who have previously been institutionalized, Day Support may also cover training to prepare the consumer for paid employment.

Supported Employment is paid employment for consumers for whom competitive employment at or above the minimum wage is unlikely and who needs intensive ongoing support to perform in a work setting. Supported employment is provided in a variety of community work sites where non-disabled persons are also employed. Consumers may receive training in specific skills related to the job, assistance and supervision, and transportation to and from the work site. Services may be provided on an individual basis in which a job coach provides intermittent support or as continuous support provided to a work crew.

Therapeutic Consultation services are provided by members of psychology, therapeutic recreation, speech therapy, occupational therapy or physical therapy disciplines to assist in the implementation of an individual service plan. Services may be provided to assist family members, caregivers, and providers in supporting the consumer. Therapeutic Consultation does not provide for direct therapy for consumers.

Crisis Stabilization is a time limited intervention for consumers with serious psychiatric or behavioral problems that jeopardize their current community living situation. These services are aimed at averting emergency admissions to hospitals or other institutions. In order to qualify, consumers must either experience a marked reduction in psychiatric, adaptive or behavioral functioning; experience an extreme increase in emotional distress; need continuous assistance to maintain stability; or cause harm to himself or others.

3.4.2 Waiver Service Delivery

This section discusses the delivery of the Waiver services described above in terms of the Waiver slots, waiting list for specific services, and total claims paid for each type of service.

As of June 22, 1998, there were 3,140 active Waiver slots for individuals receiving services in their communities through the MR Waiver. There are currently 5,386 approved MR Waiver slots.

DMHRSAS reports that the following numbers of consumers were on the waiting list for MR services as of March 31, 1997:

- Day Support Services: 973
- Supported Employment: 1,001
- Residential Support: 2,897

It is expected that an additional 2,172 consumers will need residential services within five to ten years. In 1997, DMHMRSAS anticipated that 499 of the more than 2,000 residents in ICF/MR facilities would be ready for community placement by July 1998.[5]

DMAS receives all claims for Waiver services and makes payment for the services. The total claims paid for each type of Waiver service for 1997 is found on Table 3-1 below. There are three Waiver services for which total claims paid were not available – Personal Care, Respite Care, and Private Duty Nursing. The unduplicated count of consumers served in 1998 was as follows: Personal Care, 107 consumers; Respite Care, 153 consumers; and Private Duty Nursing, 12 consumers.

TABLE 3-1
TOTAL PAYMENTS FOR WAIVER SERVICES FOR 1997

SERVICE	CLAIMS PAID
Case Management	$10,977,299
Res. Support, Congregate 5 or >	$24,996,047
Res. Support, Congregate 4 or <	$36,853,007
Residential Support, In-Home	$ 4,001,342
Day Support, Reg Center	$ 3,589,189
Day Support, High Center	$ 9,925,020
Day Support, Reg Non-Center	$ 346,745
Day Support, High Non-Center	$ 5,369,607
Therapeutic Consult	$ 111,262
Supportive Emp – Individual	$ 61,936
Supportive Emp – Enclave	$ 910,792
Assistive Technology, Off the shelf	$ 23,821
TOTAL	$ 97,166,067

From this table of total claims paid, expenditures made for different types of Residential Support were $65,850,396; expenditures made for different types of Day Support were $19,230,561; expenditures for Therapeutic Consults were $111,262; expenditures for Supportive Employment were $972,728; and expenditures for Assistive Technology were $23,821. This list, together with the unduplicated count of individuals served for Personal Care, Respite Care and Private Duty Nursing services, illustrates that most of the expenditures under the Waiver were made for Residential Support Services and Day Support Services. There were no claims paid for Crisis Stabilization services.

[5] Comprehensive State Plan 1998-2004, op cit.

3.4.3 Targeted Case Management Services

Case management services must be provided to all consumers who are referred to CSBs for MR Waiver services. Case management includes assessment of consumers in addition to coordination and monitoring of service delivery. Case managers ensure the development, coordination, implementation, and monitoring of each consumer's individual service plan, and they link consumers with appropriate community resources and supports. Case managers also coordinate the provision of services by providers and monitor quality of care. While all MR Waiver consumers are required to receive case management services, these services are funded by Medicaid State Plan Option (SPO) funds instead of by the MR Waiver.

Every MR Waiver consumer is assigned a case manager, who is employed or contracted by a CSB. The case manager first determines an individual's needs for Waiver services after completing a comprehensive assessment of the consumer's eligibility for the Waiver, level of need, and available support. Case managers are responsible for gathering data and documenting relevant information about consumers' service needs. They must explore alternative settings for service provisions and communicate these potential choices to consumers and their family members. Consumer Service Plans (CSP) must be developed by case managers in collaboration with other service providers. These plans must be based on current assessment data, and they must state the type and frequency of services to be rendered, the type of service provider, and a description of the services and supports that are needed. There must be formal assurances that the consumer has made a choice for Waiver services and the consumer has been given a choice of potential providers. Case managers complete and submit Service Authorization Requests (SAR) to the Office of Mental Retardation (OMR) at DMHMRSAS to preauthorize service provision. OMR reviews SARs prior to authorizing services for up to twelve months. SARs are required to permit both billing and reimbursement.

Case managers must review CSPs at least every three months to assess whether goals and objectives are being met and whether modifications are needed. They also must complete comprehensive reassessments of consumers annually. Case managers submit CSPs to DMHMRSAS, who reviews the plans at least every year and who must authorize any service changes.

Case managers must be qualified mental retardation professionals, who possess a combination of MR work experience and relevant education, and this must be formally certified to DMHMRSAS by the CSBs. Case managers must have basic knowledge, skills, and abilities to perform case management services. They must be knowledgeable about the etiology of MR; treatment modalities, assessments, and interventions; consumers' rights; community resources and supports; and types of MR programs and services. They must be able to effectively complete CSPs and other required documentation; communicate and negotiate with consumers and providers; evaluate and report on individuals' functioning; and identify and document consumers' needs.

3.4.4 Service Providers

MR Waiver services as well as targeted case management may be provided by CSBs or private providers. Both for-profit and not-for-profit providers may deliver Waiver services. Across Virginia, MR service providers vary in size, geographic coverage, and services provided. DMAS must certify all MR Waiver service providers according to the basic standards and requirements for providers of MR Waiver services, as stated in the State Plan for Medical Assistance. Providers must be able to serve those who are Medicaid eligible and need Waiver services, as well as maintain individual case records as required. Providers must also have the administrative and financial management capacity to meet state and federal requirements. Other requirements for providers include:

- meeting state licensing requirements (DMHMRSAS and VDH);
- accepting referrals only when staff are available to initiate services;
- assuring consumers' freedom of choice and right to refuse care and treatment;
- notifying DMAS of any changes in information previously provided;
- providing services without regards to race, color, religion, national origin, or handicap;
- providing services to MR Waiver consumers that are of the same quality and mode of delivery as provided to the general public;
- charging DMAS for services amounts that do not exceed charges to the general public;
- accepting Medicaid payment from the first day of a consumer's eligibility and accepting payment amounts that are established by DMAS;
- using designated billing forms for submission of charges;
- maintaining and retaining documentation of services provided to MR Waiver consumers, and providing state and federal personnel access to records and facilities;
- holding consumers' Medicaid information confidential; and
- adhering to their provider contract and DMAS' provider service manual.

Providers develop Individual Service Plans (ISP) for the consumers that they serve, which are incorporated into the CSPs that are prepared by case managers. ISPs specify the particular tasks that the provider will complete for each consumer, and they outline measurable objectives and activities for meeting a consumer's goals. ISPs document consumer and staff responsibilities for meeting these goals and objectives and set target dates for accomplishment. Providers must notify case managers whenever ISPs should be modified, such as when consumers need changes to the type or amount of services.

3.4.5 Consumer Choice

Federal law mandates that MR Waiver consumers have the right to select from among all qualified providers of their respective services. DMAS and DMHMRSAS, in compliance with this law, also require that consumers be provided a choice of providers. DMHMRSAS states:

> A consumer (or parent/guardian when appropriate) must be informed of all available Waiver providers in the community and must have the option to choose

> from among those agencies which can appropriately meet the needs of the consumer. Choice must be offered when Waiver services are initiated and when there are changes in services. The choice must be documented in writing by having the consumer (or parent/guardian when appropriate) sign a list of available providers and designate the chosen provider.[6]

DMHRSAS allows CSBs to annotate their provider lists to assist consumers and families in identifying and choosing appropriate providers to deliver the services that they need. DMAS additionally requires that case managers consider the preferences of consumers or their authorized representatives in developing plans of care.

3.5 FINANCIAL MANAGEMENT

This section describes the budgeting process for the MR Waiver, rates for Waiver services, and the methodology used to set rates.

3.5.1 Budgeting

The Virginia General Assembly appropriates funds to both DMAS and DMHMRSAS for MR Waiver services. DMAS is appropriated federal financial participation (FFP) funds and state General Funds to provide for MR Waiver and State Plan Option targeted case management services. DMHRSAS is appropriated State General Funds for MR services. These funds are then allocated to CSBs for MR services on a combination of historical, targeted, and formula funding.

As of FY 1999, the General Assembly has appropriated a total of $43 million for MR Waiver services and $10.5 million for State Plan Option services. These appropriations have grown gradually over the last eight years. DMHMRSAS has been appropriated $31 million in MR State General Funds. CSBs and other groups lobby the State General Assembly to appropriate funding for MR services. The current federal matching for Virginia is 51.57 percent federal to 48.43 percent state funds.

Match funding for MR Waiver services must be identified and accessed through CSBs, and it must be available on an on-going basis for as long as consumers are eligible for the Waiver and need services. CSBs decide how much of State General Funds they will budget and use for Waiver matching funds. On an individual consumer basis, CSBs must identify matching funds when requesting Waiver slots and transfer their portions of their State General Funds to DMAS to be used as Waiver match.

Matching funds from the CSBs may come from three sources: (1) conversion of ICF/MR funds when MR consumers leave institutional or community ICF/MR settings to receive community services (thereby closing ICF/MR beds and converting funds match from ICF to HCB), (2) new funds designated by the General Assembly for Waiver match and formula-driven, and (3) CSBs

[6] Mental Retardation Community Medicaid Services Operations Manual, June 1997.

matching funds based on the historic allocation. CSBs must manage their match resources for individual consumers so that expenditures do not exceed available matching funds. DMHMRSAS tracks matching funds by individual, by CSB, and by source of funds, and provides reports to CSBs. DMHMRSAS then projects revenues three to four times per year and adjusts CSBs' General Funds as necessary. DMHRSAS reports that the average percentage of conversion of CSB State General Funds as match for MR services is approximately 60 percent across the state, ranging from 10 to 100 percent.[7]

CSBs receive funding to provide all of their community services at a 90:10 ratio of state to local matching funds. The ten percent or more local match may be from local government appropriations, charitable contributions, and specific types of donations. Match ratios vary significantly among CSBs.

3.5.2 Claims Payment and Reimbursement

CSBs and private providers bill DMAS for MR Waiver and State Plan Option services. DMAS processes claims and pays providers and CSBs the rates listed in Table 3-2. Also listed in Table 3-2 are the limits that DMAS sets for service coverage. In FY 1997, DMHRSAS reports that there were $67,429,885 in MR Waiver collections for private providers and CSBs.

DMHMRSAS and DMAS reconcile the amount of matching funds used for reimbursements to CSBs and private providers. DMHMRSAS then reconciles with each CSB to cover match for services rendered to Waiver consumers by the CSB and private providers.

3.5.3 Rate Setting

Payment rates for MR Waiver services were set by DMAS in 1991 when the Waiver was first implemented. Rates were not established based on cost, and subsequently rates for many services have not changed significantly. Since the initiation of Virginia's Waiver, some community services have been added to the Waiver that were previously covered under State Plan Option services due to a HCFA requirement that all community services for Waiver consumers be covered under the Waiver (with the exception of targeted case management services). At the time of change from SPO to Waiver services, a few of the rates were examined and updated. Since the rates have not been consistently derived or updated there is concern that they are not set at an appropriate level. To examine the costs underlying the provision of MR Waiver and SPO services, a cost study was initiated in 1997 by the CSBs. The study methodology used self-reporting of CSBs on a standard survey form. There was wide variance reported for costs of different services and ultimately, the study results were set until a cost audit could be conducted by an independent CPA firm. The cost audit study of a sample of CSBs and private providers, conducted under a DMAS contract, will begin during the fall of 1998 and be completed by late spring 1999. Findings from this study will be available for evaluating current rates and establishing new ones.

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[7] Current Waiver Funding/Administrative Process of Virginia. Handout from DMHMRSAS Waiver Advisory Committee Meeting, July 6, 1998.

TABLE 3-2
PAYMENT RATES AND SERVICE LIMITS FOR MR SERVICES

Service	Rate per Unit	Unit	Service Limit
Residential Support: Congregate	$12.50/hour	Hour	30 days per month when billing is based on average daily hours
Residential Support: In-Home	$18.00/hour	Hour	
Supported Employment/ Individual	$16.00/hour	Hour	
Supported Employment/ Enclave	$32.50/unit	1 unit = 1 - 3.99 hours; 2 units = 4 - 6.99 hours; 3 units = 7 or more hours	
Day Support/ Regular Intensity	$23.99/unit	1 unit = 1 - 3.99 hours; 2 units = 4 - 6.99 hours; 3 units = 7 or more hours	780 units per year
Day Support/ High Intensity	$34.15/unit	1 unit = 1 - 3.99 hours; 2 units = 4 - 6.99 hours; 3 units = 7 or more hours	780 units per year
Therapeutic Consultation	$50.00/hour	Hour	
Environmental Modifications	Individually Contracted		$5,000 per year
Assistive Technology	Individually Contracted		$5,000 per year
Nursing Services, RN	$24.70/hour or $30.00/hour*	Hour	No limit
Nursing Service, LPN	$21.45/hour or $26.00/hour*	Hour	No limit
Personal Assistance	$9.50/hour or $11.50/hour*	Hour	5 hours per day for personal care; 8 hours per day for general supervision
Respite Care	$9.50/hour or $11.50/hour*	Hour	720 hours or 30 days per year
SPO Case Management	$175.40/month	Month	
Crisis Stabilization, Clinical/Behavioral Intervention	$81.00/hour or $89.00/hour*	Hour	15 day period; 60 days per year
Crisis Supervision	$22.00/hour or $24.00/hour*		

* Rate in HSA II

4. FINDINGS AND RECOMMENDATIONS

4. FINDINGS AND RECOMMENDATIONS

4.1 INTRODUCTION

This Chapter presents a discussion of the project team's findings and recommendations. There were three very impressive findings that should be noted. Without exception, everyone interviewed believed the MR Waiver had afforded the State an opportunity to expand services for consumers in need of MR services. Second, everyone interviewed believed that the MR Waiver had provided a means to move consumers out of institutions and to provide services for them in the community. Third, those interviewed seemed to be very dedicated to making MR services better for the consumers.

The MR Waiver program currently is conducting, or the subject of, several studies and has taken initial steps in making changes to many of the aspects of the program. These initial steps are very positive and do address some of the issues that are discussed in the findings of this report. The findings and recommendations that are presented in this Chapter are focused on issues within the MR program that perhaps could be changed to produce more efficient and effective results.

4.2 ADMINISTRATION

4.2.1 Service Authorization

Finding: The current waiver procedures require that DMHMRSAS field-office staff review plans of care and prior authorize waiver services for 100% of the waiver recipients. The field office staff also conduct waiver utilization reviews and provide other technical assistance including a limited amount of training to the CSBs. Most of the staff activity is directed to prior authorization, however. The 100% prior authorization was believed necessary during the early years of the waiver until both the state agencies and the CSBs gained some experience with the program. Now, that experience has long since occurred. Additionally, the waiver has grown large enough that the prior authorization requirements have become excessively burdensome and probably unnecessary for 100% of the cases.

Recommendation: DMAS and DMHMRSAS could develop an alternate method of providing service authorization which does not require 100% prior service authorization. Possible solutions are:

- Central office prior authorization could be required only above a certain level of requested services.
- DMHMRSAS field-office staff could monitor the CSBs' waiver management by redirecting their focus to additional utilization review and quality monitoring activities.
- Increase emphasis on accurate information management including reliable data collection and reporting to assist in necessary state-agency (DMAS and DMHMRSAS) monitoring of the waiver.

4.2.2 State Agency Roles and Responsibilities

Finding: The MR waiver is actually administered by both DMAS and DMHMRSAS. The responsibilities are spelled out in a very global way in a formal agreement between DMHMRSAS and DMAS. Because of the general way in which the responsibilities of both agencies are described, the agreement has limited utility for waiver management and administration. It would be advisable for the agreement to be reviewed, updated and strengthened, especially to provide DMAS as the Single State Agency with the assurances needed from DMHMRSAS as the primary administering agency.

Recommendation: The Director of DMAS and the Commissioner of DMHMRSAS should direct that an interagency work group be formed, with specifically established objectives to improve levels of understanding between the two agencies, and to streamline procedures for service authorization and quality monitoring. As part of its mission, the work group should also review the interagency agreement between the two agencies, updating it as necessary to reflect revised responsibilities of the two agencies.

Finding: There are also few apparent formal mechanisms outlining expectations for coordination between DMHMRSAS and other state agencies. For example, agencies such as Vocational Rehabilitation, and the public school system through Special Education often serve the same persons, including waiver recipients. Improved coordination at the state and local level could lead to better services for waiver recipients, and could result in possible efficiencies by making better use of limited resources of the various parties.

Recommendation: DMHMRSAS should take the lead in developing cooperative agreements with agencies at the state level who have primary responsibilities to provide supports to children and adults with disabilities, providing the blueprint for additional cooperative agreements and improvements in service coordination at the local service-delivery level. Consideration should be given to including requirements for the development of such interagency agreements in the performance-based contracts between DMHMRSAS and the CSBs.

Finding: Given the fact that staff at both Departments has been reduced and the Waiver enrollment with its accompanying responsibilities has increased, neither DMAS nor DMHMRSAS appear to have sufficient staff to manage the MR Waiver.

Recommendation: Remedies for the limited staffing of the MR Waiver should be discussed by each Department and jointly.

4.2.3 Coordination of Institutional and HCB Services

Finding: Historically the state Training Centers have been the predominate means of providing services to the MR/DD population in the state. Under the Medicaid program, the State must assure that ICFs/MR are available and that eligible consumers have a choice of ICF/MR services or community services. There have been improvements in the communities' capacity to respond

to the needs at the local level through the CSB system, however, there are times that consumers would have preferred community services, if the appropriate community services had been available. Recently, admissions to ICFs/MR have been held to a minimum due to required central office prior approval. Nonetheless, admission to the Training Center still provides a safety valve to CSBs whereby they avoid the cost of serving persons (some of whom may have some significant needs) but who can and should be served in their communities closer to families and friends. Additionally, institutional services on average are the most costly. Consequently the entire system continues to have a disproportionate amount of its resources devoted to costly institutional services. Until Virginia can reduce its reliance on institutional settings, the community system will continue to be shortchanged.

Recommendation: Systems of incentives to provide additional community services, coupled with disincentives for admissions to Training Centers, should be instituted. One possibility would be to have CSBs share in the institutional cost of care. This could occur through fiscal consequences in the CSB performance contracts whereby CSBs would pay for all or part of the cost of care beyond a targeted number of days, including both current residents and new admissions. This would both encourage placement of persons ready to leave Training Centers, and discourage new admissions. Another possibility would be to provide additional waiver match dollars for CSBs who reduce days of care in the Training Center.

Finding: Currently Training Centers often provide Medicaid match dollars to CSBs for persons who are being placed from the Center into community settings/services funded by the waiver. However, it is up to the CSB and the Center to negotiate the amount of match to be paid. Due to the fixed costs which remain for the facility, there is not a dollar-for-dollar trade off from the facility to the community, and the amount to be transferred is often not adequate to meet the cost of the Individual Plan of Service for the waiver recipient. Thus, there is little or no central coordination of the funding implications for the various agencies, and no uniformity of expectation about how much money should be moved to the community system.

Recommendation: There should be a more uniform method of determining the amount of match money to be made available to the CSB when a person leaves a Training Center and is enrolled on the waiver. DMHMRSAS should take the lead in establishing the system.

4.2.4 Waiting Lists

Finding: At the present time, CSBs keep waiting lists of persons who are waiting for admission to the MR Waiver, as well as those who are waiting for admission to a Training Center. However, there is questionable consistency about the methods by which such data are defined, collected and reported. Additionally, it is unclear whether information is derived from a comprehensive community-needs assessment for everyone requesting admission to the waiver, rather than just a maintenance of waiting lists of people who request services. Therefore, there is no assurance that this list is an accurate measure of the need for MR services.

Recommendation: DMHMRSAS should take the lead in establishing expectations for how CSBs will conduct the community needs assessment processes. There should be a concerted effort to

clarify how information on persons waiting for services is defined, collected and reported. Also, an individual needs assessment should be completed on each individual requesting admission to the Waiver. This will render the information much more useful for purposes of planning and working with the General Assembly on matters related to funding needs.

4.2.5 Role of CSBs

Finding: The CSBs are designated in the Virginia Code as the local service entity for MR services. However, there is no apparent common approach to how that mission is carried out, nor uniformity of what is available to consumers from one CSB service area to another. In 1998, House Bill 428 significantly tightened the CSB responsibilities. It also assured that review would continue to determine other clarifications needed. In the past there has not been uniformity in determination of the recipients who have priority for services, and for the range of services each CSB is required to provide. CSBs can elect to only manage services delivered by the CSB, or manage services through contracts with local providers, or they can elect to both manage services and provide services themselves. Many do a combination. In the areas where the CSB is both manager and provider, it appears that consumers may be steered to CSB programs, with the result of limiting their choice of providers. Federal Medicaid law guarantees recipients the right to select from among all qualified providers of a particular service. Additionally, in areas where CSBs are providers, there is reluctance by private provider organizations to establish services/sites for fear that they will not see sufficient volume of referrals to be able to sustain the operation. This also has the effect of limiting provider choice for consumers, and may negatively affect the overall system by inhibiting competition.

Recommendation: Additional legislative action may be needed to clarify the role of CSBs. In the meantime, CSB performance contracts should be strengthened to specify additional requirements for CSBs who provide services in addition to their management responsibilities. Issues of consumer choice should receive special attention.

Recommendation: Consideration should be given to moving toward CSBs serving as gatekeepers, with services being provided by private providers. This would eliminate some of the conflicts of interest that are present in the system today.

Finding: There are currently 40 CSBs covering the 135 cities and counties in Virginia. Many types of inefficiencies can result from this high number of administering agencies. The most obvious is the duplication of administrative functions and costs. It also results in a small demand for some services in some CSB areas, and can cause proportionately more financial risk for high cost cases in less populous and/or lower funded areas.

Recommendation: The number of CSBs should be reduced, probably through consolidation of existing CSBs.

4.2.6 Performance Contracts with CSBs

Finding: DMHMRSAS has recently instituted performance-based contracts with CSBs. This is a

very positive step and should assist in correcting some of the inequities and inconsistencies in the system. It should also result in improved services to consumers. However, the initial performance contracts are fairly minimal in their expectations, and do not carry consequences for poor performance.

Recommendation: DMHMRSAS should continue to develop performance-based contracts with CSBs, and should move more rapidly to strengthen the requirements of the contracts and the consequences if CSBs do not perform as expected.

4.2.7 Role of Private Providers

Finding: Many of the services provided through the CSB system are done through referral to private providers. These private agencies contract directly with DMAS for their Medicaid provider agency status. They also submit bills directly to, and are paid by DMAS for the services they provide. The amount of services which they can bill to Medicaid is governed by the prior-authorized Plan of Service for the consumers.

In some cases the private agencies may develop formal contracts with the CSBs, but often they do not. Their relationship with the CSB is governed only by letters of cooperation between (the directors of) the two agencies. However, it is the CSB appropriation which provides the state match for the Medicaid payments to the private agencies. And although there are local match funds for other CSB services, the CSBs are not required to put up local match dollars for Medicaid services. However, even though this arrangement is not an unfettered fee-for-service, the private providers are still "spending" CSB state-match dollars, yet there is no contractual arrangement stating service planning, quality, reporting, monitoring or any other expectations for the two parties.

Recommendation: CSBs should develop formal contracts with private provider agencies. In addition to matters of funding, the contracts should address other aspects including service planning, quality improvement systems, reporting requirements, and monitoring methods, as well as other areas of mutual concern.

4.3 SERVICE ARRAY

4.3.1 Flexibility of Service Array

Finding: The services and supports available under the MR waiver comprise most of the services which are provided to persons with mental retardation through Virginia's CSB system. The only other non-waiver service provided to any extent is Case Management which is a Medicaid State Plan optional service. The currently defined waiver service and support array is relatively comprehensive and reasonably flexible. Improvements in some definitions would be beneficial because more individualized, flexible supports could then be provided. It would also be helpful to include a few additional coverages that are not now available under this waiver. Additionally, the state should assure that consumers have better access to the services and supports that are

already approved but currently infrequently used.

This waiver is due for renewal in 1999, and discussions are now underway concerning desired modifications to be requested during the renewal process. Planned changes include amendments to some current definitions in order to increase flexibility, as well as the addition of a few missing services that would benefit consumers. A copy of the draft Waiver Advisory Committee Recommendations is included in Appendix A to this report.

Recommendation: As part of the 1999 renewal, revisions and additions to the array of services and supports should be requested. The state should proceed with its plans to do so, according to the discussions currently underway.

Finding: There is also a noticeably uneven pattern of utilization for available waiver services across CSBs. In many areas of the state, only structured day program services and more intensive levels of residential (group-home) services are used with any frequency. Other defined services and supports are much less utilized, even though they would undoubtedly benefit consumers and families. This finding is substantiated by data from the DMAS claims processing system for claims and is presented in Section 3.4 of this study.

Recommendation: DMHMRSAS should review patterns of utilization of specific waiver services and supports. Discussions and/or specific performance expectations should be initiated with CSBs which do not utilize available services/supports on behalf of consumers who could benefit from same.

Finding: Even if DMAS contracts with private providers, they may not have clients because CSBs can direct individuals away from the private providers. Also, there is no assurance that all Waiver services will be able to be provided by private providers or that they will deem it cost-effective to offer the services in a given area. As noted above, private sector providers are reluctant to establish services for fear that they will not see sufficient volume to sustain the operation.

Recommendation: CSBs should make available in each locality, any of the Waiver services that are needed by the clients, either through their own operation or through private providers. DMHMRSAS has planned educational programs in early 1999 to educate CSB staff regarding Waiver services and supports.

4.3.2 Person-Centered Planning

Finding: Virginia, like most other states, expresses the intent to utilize a much more person-centered approach to planning services and supports. However, the Commonwealth is not very far along in its implementation of this direction. Discussions about how consumers' needs are assessed, how individual plans are developed, and the roles which consumers play in the process reveal a limited understanding of person-centered concepts, especially among CSB staff and private provider staff.

Recommendation: DMHMRSAS should assist the Virginia Association of Community Services Boards and network of private providers to organize training for CSB staff in person-centered planning concepts and methods.

4.4 SERVICE DELIVERY

4.4.1 Case Management Services

Finding: Even though technically not a waiver service, case management is provided to most MR waiver recipients. Additionally, it is often the only Medicaid service provided to many CSB non-waiver service recipients. Analysis of the CSB case management experience reveals several issues.

First, case managers are apparently spending considerable amounts of time providing actual support services to recipients, especially non-waiver recipients. Typically, case manager responsibilities are intended to be focused on assessment and periodic reassessment, service and support planning, linking and coordination of necessary services, and monitoring of service delivery, and perhaps some advocacy for consumers. However, case managers would only do a limited amount of direct assistance to consumers. Some CSB case managers report that their duties include time being spent in activities to assist consumers because there are few other staff or services available to do so. This can also limit the amount of time which case managers can devote to their "true case management" functions. It can also make it very difficult to establish equitable case loads for case managers, because they are actually functioning as a combination case manager/clinician/support staff. Confusion of roles and staff burn-out rates can be expected to be high.

Recommendation: Case manager roles and case-loads should be re-examined. Other types of staff including consumer support staff or case manager- assistants should be employed to relieve case managers of the portion of their tasks that do not require trained case managers. Standards for case-loads should be established by DMHMRSAS.

4.4.2 Control of Waiver Slots

Finding: Waiver slots are currently distributed by DMHMRSAS to CSBs on a request-basis. This method is not particularly problematic, except that it is the CSB's decision whether on not to participate in the waiver. This results in very uneven availability of waiver slots/services across the state. Recently DMHMRSAS used a limited amount of new match funds which became available as incentive to those CSBs which chose to participate in the waiver and were more aggressive about conversion of their funds for waiver Medicaid match purposes. This type of incentive should encourage better and more uniform participation, but it is uncertain how much opportunity there will be to make this type of arrangement, because new match money is not regularly available.

Recommendation: DMHMRSAS should include performance expectations in the CSB contracts

which obligate them to participate in the waiver. Incentives should be used where possible, for the purpose of increasing participation. Areas of the state where the waiver is currently not well utilized should be targeted. Penalties for non-participation should also be considered. Incentive options might include allocating waiver slots and additional match dollars on a one-for-one basis. Example: DMHMRSAS provide funds for one new waiver consumer for each new consumer for which the CSB provides match funds. This could be done via arrangements where DMHMRSAS provides match for placement of a person out of a Training Center when the CSB picks up match for a person from their waiting list. Several other variations are also possible.

4.4.3 Access to Waiver Services

Finding: The CSBs decide which waiver services they will provide, even though they should be providing all covered Waiver services. Additionally, it appears to be common that it is the CSB and/or the private provider organizations that determine which services will be provided to an individual consumer. A planning process which includes the consumer does occur, but much of the decision about the type of service to be provided is, for all practical purposes, pre-determined by the agencies. The result is that the waiver is often used to assure a level of income for providers, rather than a method to provide and pay for individual supports for consumers. The CSBs report that consumers are given as much choice as is possible in their choice of services and Waiver providers. However, the private providers report that there is often no "real" choice because consumers are steered to CSB-provided services and/or the CSB services are the only ones available because there is insufficient volume of referrals in some areas to make it feasible for private providers to participate. The overall result is that there is actually limited choice for consumers.

Recommendations: A person-centered planning process should be used within the standard assessment process for developing plans of care. The consumer and family should play an integral role in this process, along with professionals and clinicians.

Finding: CSBs reported that at times there were problems with consumers moving, or being provided services, in other local jurisdictions. The problems were related to funding and to the understanding of consumer and guardian location of permanent residence.

Recommendation: The project team did not get a clear understanding of the extent of these types of problems. However, there seems to be confusion that should be addressed through training and clarification of procedures, definitions, and rules. Clear transfer guidelines need to be established and required within the performance contracts.

Finding: Due to the Comprehensive Services Act (CSA) funding for children, one would not expect to see as many children on the MR Waiver as adults. However, there are very few children served under the MR Waiver. The Medicaid Elderly and Disabled Waiver currently serves 158 children, many of whom have developmental disabilities or mental retardation. The MR Waiver was designed to provide services and supports to two groups of eligibles: (1) persons coming from a nursing facility to the waiver, who would otherwise require placement in an ICF/MR facility; and (2) persons coming from an ICF/MR or the community who would

otherwise require placement in an ICF/MR facility. The Elderly and Disabled Waiver was designed to provide services and supports to two groups of eligibles: (1) persons who meet the nursing facility level of care criteria; and (2) persons who are determined to be at risk of nursing facility placement and for whom community-based care services under the waiver are the critical services that enable the individual to remain at home rather than being placed in a nursing facility. A person should not be placed on the E&D Waiver unless the person is in one of the two groups. It appears that because of waiting lists, some CSBs may be prioritizing services under the MR Waiver and making them available to adults, while children have been placed on the E&D Waiver if they are in need of services that are not covered by CSA funding. This is not allowed under the MR Waiver; there is no age limit in the Waiver and, therefore, all eligible children should be served.

Recommendation: The State should examine the needs of children with MR for additional services that are not provided under CSA funding. Those children should be provided services under the most appropriate waiver.

4.4.4 Services Provided

Finding: There were informal reports that sometimes MR Waiver consumers had plans of care that included services for programming and training in areas that were excessive when the consumer would have preferred more personal, flexible supports.

Recommendation: One of the reasons for the development and support of the HCB Waivers by HCFA was to provide states with the opportunity to provide less rigid supports or services in the community. Since a state may reimburse a provider only for the service that it has decided to cover, one way to achieve more flexibility is to cover a wider variety of services and supports. In lieu of coverage of a wider variety of services and supports, the state could use wrap-around service definitions and/or payment methods that would be more accommodating. DMHMRSAS currently is discussing the possibility of using a standardized assessment instrument to determine each consumer's service level. Rates could then be assigned to each service level and used for a budgeting tool. In the future, individual case payment rates could be developed.

4.4.5 Consumer Choice

Finding: The CSBs report that consumers are given as much choice as is possible in their choice of services and waiver providers. However, the private providers report that there is often no "real" choice because consumers are steered to CSB-provided services and/or the CSB services are the only ones available because there is insufficient volume of referrals in some areas to make it feasible for private providers to participate. The overall result is that there is actually limited choice for consumers.

Recommendation: Quality mechanisms to be developed by DMHMRSAS should include methods to monitor the choice which consumers have in their services and providers. Feedback loops for consumers directly to DMHMRSAS are advisable. Where necessary, CSB performance indicators should include items related to the choice afforded to consumers.

Finding: Generally, a referral is made to a provider (private or CSB) when a waiver recipient is seen to be in need of a residential service or a day service. Based on an approved level of service, the provider bills Medicaid directly, and the Medicaid payment provides the funding for that "slot." There is little incentive to make more individualized services or supports available to the consumer, because the provider would lose the revenue associated with that slot. In some areas, CSBs appear to utilize existing services and resources rather than providing the more individualized services or supports that the individual and their family might prefer.

Recommendation: Mechanisms should be studied by which consumers would have an individual waiver "budget" (probably a designated funding level or a specified service level) within which to select the services, supports and providers they choose. Care should be taken to assure services are not provided at a higher cost than is necessary. For example, the consumer may chose a higher cost service than is needed and, while he may still be within his "budget," he may not need the level of services requested. One way to address this issue is to assure the individual meets the criteria for each service.

4.4.6 Coordination of Service Providers with Other State and Local Agencies

Finding: There are apparently few established methods of coordination between service providers and other state and local agencies. Private provider organizations often see themselves as autonomous entities, and not obligated to coordinate what they do with CSBs or other agencies. This is also essentially true of CSBs as providers, as well. The result is a fragmentation which does not facilitate overall quality assurance processes or monitoring, and which complicates comprehensive planning for individuals. It can also lead to CSBs and other agencies duplicating services in lieu of services which may be the responsibility of another agency, or overlooking other generic supports which may be available for people living in that community.

Recommendation: DMHMRSAS performance contracts with CSBs, and CSB contracts with private providers should contain requirements for the various agencies to coordinate services on behalf of individuals, and to participate in quality monitoring mechanisms. These requirements should also be contained in DMAS policy governing waiver services.

Finding: The problem of coordination of service providers with other state and local agencies was referred to in many of the interviews with CSBs, private providers and consumers, especially with respect to "aging out" and transition from school to work. While some of the CSB case managers reported good cooperation and coordination, others reported very poor planning. There was mention of MR consumers in need of services appearing after they turned 22, without any earlier notification to the CSB, and also mention of MR consumers abruptly leaving the school system and CSA funding who immediately needed MR services.

Recommendation: In addition to the performance contracts as a vehicle to gain better coordination of services and monitoring mechanisms, there could be formal agreements among the local-level agencies. These agreements should stipulate more coordination and monitoring.

4.4.7 Quality Improvement and Monitoring

Finding: There is currently little evidence of a systemic approach to quality improvement for the waiver. Most state agency efforts are directed to service authorization and utilization management activities. Furthermore, it does not appear that the CSBs are required to have formal quality mechanisms, although that would be advisable for all parts of their service systems including the waiver. It is also unclear whether or not waiver recipients are adequately informed about how to use formal appeal mechanisms. It does not appear that recipient appeals occur often, so it is difficult to tell whether recipients are not aware of the methods to use, or whether they are over-all very satisfied with the waiver.

Recommendation: The existing waiver should be reviewed to determine if adequate monitoring methods are currently identified, and/or if revisions are needed. DMAS and DMHMRSAS should work together to identify further quality mechanisms which would help alleviate DMAS' concerns about the operation of the waiver. There should be a contractual requirement for the CSBs to have adequate internal quality mechanisms. This could also be included as a Medicaid policy requirement for the waiver. Additionally, the CSB quality mechanisms should include methods to monitor the quality of services delivered to CSB-area recipients by private providers.

DMHMRSAS should also strengthen their role in quality monitoring. Included in the central office monitoring mechanisms should be means to receive and assess consumer feedback, and methods to receive and analyze information about appeals. Specific training in quality improvement methods for central office staff and for CSB staff would be advisable.

Quality improvement systems should also include specific methods to receive consumer input, such as a help line, a web site, and consumer satisfaction surveys. DMHMRSAS should identify ways in which that information will be utilized in on-going quality efforts, both at the CSB level and at the DMHMRSAS central office level.

4.4.8 Consumer Roles

Finding: Even though consumers express overall satisfaction with the waiver, it appears that there are actually limited ways for consumers to be actively involved with it, except at the individual services planning level. Although consumers do participate on CSB governing boards, there is little evidence of consumer advisory groups at the local level. Additionally, there are no identified methods for the CSBs, DMHMRSAS or DMAS to receive consumer input other than the formal appeals process.

Recommendation: Specific methods should be developed to obtain consumer input into the ongoing operation of the waiver. In a person-centered system, active involvement of the constituency being served should be a high priority. Consideration should be given to requiring the use of such mechanisms in the performance contracts between the state and the CSBs. This information should be made available to CSBs, to DMHMRSAS and to DMAS.

4.5 FINANCIAL MANAGEMENT

4.5.1 Budgeting

Finding: Currently, the state match for MR waiver services is tracked by CSBs, DMHMRSAS, and DMAS, and there is no single identifiable budget for the waiver. Most waiver services are matched by the general fund appropriation for the CSBs. Each CSB has the discretion to devote a portion of the funding to waiver match. There is, however, no uniformity about the percentage of funds utilized as match, and the amount of CSB dollars devoted to match ranges from ten percent up to nearly 100 percent. Eight CSBs have converted less than 25 percent of their State General Funds and the overall average for the state is approximately 60 percent. Although the CSBs that have converted high percentages of dollars to waiver funding have been able to enhance their ability to provide services due to increased revenues, those CSBs also report that they are unable to meet demands for services for local, non-Medicaid recipients because all of their resources are "tied up" in match for Medicaid services. The result is that few additional recipients can be provided with Medicaid services, and there is no ability to serve additional non-Medicaid eligible persons either.

Some waiver services are matched by former Training Center funds which are freed up and transferred to CSB control for persons who are exiting Training Centers and being placed in community settings to receive services funded by the waiver. Additionally, there is a limited amount of match money which was recently allocated to DMHMRSAS as new funding. This money has been authorized to CSBs on an incentive-type basis, to encourage CSBs which have actively pursued conversion of their state and local funds to waiver match.

Recommendation: DMHMRSAS/CSB appropriations should continue to be used as Medicaid match. Any additional match dollars allocated from the General Assembly should be used as incentives to encourage additional conversion of CSB dollars and to reduce waiting lists. A total overall budget should be identified for the budget to enhance state-level management efficiencies.

4.5.2 Flow and Tracking of Funds

Finding: DMAS has general funds and non-general funds that have been placed in its budget over the years to pay claims for services provided to Medicaid beneficiaries on the MR Waiver. These funds have largely come from transfers of General Funds from CSBs and are now part of DMAS' budget. DMHMRSAS has additional State General Funds that are obligated for MR Waiver services, and DMHMRSAS allocates those funds among CSBs. DMHMRSAS transfers dollars several times a year to DMAS for the payment of MR Waiver claims that exceed the amount in the DMAS appropriation. When the funds are transferred to DMAS, they loose the identity of the CSB and become DMAS base budget funds.

While DMAS produces a formal forecast for expenditures under the MR Waiver, DMAS is not responsible for requesting additional funds during the budget process. DMHMRSAS has that responsibility. The DMAS forecast is shared with DMHMRSAS and the Department of

Planning and Budget (DPB) during the annual budget process, but neither DMHMRSAS nor DPB make independent forecasts, and the amount that is included in the Executive Budget results from decisions made at DPB.

The current arrangement for the flow and tracking of waiver funds is very cumbersome. An elaborate, detailed spread-sheet tracking system has been developed in DMHMRSAS. Tracking is done by recipient, by CSB, and by origin of the match dollars. This tracking mechanism follows the approved hours/dollars. DMAS maintains the claims processing system and produces reports on the actual expenditures.

Typically the State match is identified by the CSB, either from their own local funds, from funds which originated with the Training Center(s) or hospitals and followed the individual to the CSB, or from the portion of the State General Fund appropriation that is designated for that CSB for MR Waiver services. Once the match money is identified for a CSB's Waiver consumer(s), it is transferred from DMHMRSAS to DMAS and used to draw down the federal share. Following delivery of waiver services, DMAS pays the provider the combined State and federal shares. The provider may be the CSB itself, or may be a private organization serving CSB-area recipients.

Through fiscal year 1997, over $42 million of DMHMRSAS State General Funds for CSBs have been transferred to DMAS for Medicaid State match.[1] DMAS has made expenditures for MR Waiver services through fiscal year 1998 of $268 million of which $134 million was State funds. The money is significant enough that the method by which the funds are placed in DMAS's budget should be consistent with State budgeting practices for the provision of General Fund match for other Medicaid providers such as hospitals, nursing homes, physicians, and pharmacists.

Recommendation: The current practice of providing Medicaid Waiver match through transfers from CSB appropriations should be ended. Match funds should be appropriated in the DMAS budget.

Recommendation: CSBs should be provided with adequate General Fund monies to provide individualized packages of services and supports to people who are not eligible for the MR Waiver. DMAS should be provided with sufficient General Fund monies to pay claims for individuals receiving MR Waiver services and those on the waiting list up to the maximum number of approved slots. The MR Waiver funds should be used for services and supports with only a small amount of funds used for administrative costs to support the direct care services.

Recommendation: DMAS and DMHMRSAS should work together to acquire any necessary additional appropriations for expansion up to the designated waiver capacity.

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[1] Report of the Joint Subcommittee, *Studying the Future Delivery of Publicly Funded Mental Health, Mental Retardation and Substance Abuse Services (HJR 240),* House Document No. 77, Commonwealth of Virginia, Richmond 1998.

4.5.3 Reimbursement Methodology and Rates

Finding: The current reimbursement method is a rate-based payment, paid per unit of service. Payments are based on units of services delivered to individual consumers, up to an authorized level for each waiver service. Rates were established several years ago, and have not been adjusted since that time. The initial rates were apparently not actually cost based, and there is no current indication that they are much related to the actual cost of delivering the service. A "rate study" conducted in recent years caused controversy because of the methods by which it was conducted, and most of the intended rate adjustments did not occur as planned. An external audit is now underway, and it is possible that the audit will result in eventual adjustments in rates.

Recommendation: Rates paid for units of service under the current reimbursement system should be adjusted based on the results of the CSB cost audit currently underway.

Finding: DMHMRSAS has also begun developing a means to identify priority populations to be served through the mental retardation system. Through this methodology, consumer needs can be identified, based on both the level of impairment and on the life circumstances of the individual. Such methods of identification are useful for establishing case-rate payments for groups of consumers based on their general levels of need. This permits case payments which can be used for more flexible types of supports for individual consumers, rather than payments for units of prescribed service which tend to be less adaptable for individuals. It is DMHMRSAS' goal to use such case-rate payments once there is sufficient experience with the methodology. This will ultimately permit the CSBs to better manage waiver services for groups of consumers.

Recommendation: DMHMRSAS should continue development and subsequent implementation of the priority populations, case-rate reimbursement methodology. This work should be done in cooperation with DMAS.

Finding: DMHMRSAS does not use trending calculations to develop their budget for state appropriations for the coming year. Currently DMHMRSAS, in conjunction with the CSBs, prepares the Departmental budget request for appropriations for State General Funds for MR services. DMAS prepares the HCFA report on the budget/expected expenditures for the coming year for MR services.

Recommendation: DMHMRSAS should work with DMAS to develop and coordinate trending calculations for the estimate of expenditures for MR waiver services. The DMHMRSAS budget request should reflect the HCFA budget report.

4.5.4 Caps on Services

Finding: Virginia Medicaid policy specifies service/payment limits for some Medicaid waiver services, by category of service. This is commonly done for Medicaid services, however, it can at times result in more costly services. For example, the limit on Assistive Technology is $5,000 per year. A special lift or motorized wheelchair or vehicle could exceed the $5,000 limit, but if

provided, would reduce other service costs by more than the limit.

Recommendation: After the cost audit study is completed, DMAS should revisit the service limits placed on MR Waiver services and evaluate them in the context of any new/revised rate methodologies that are developed.

4.5.5 Coverage for Leave

Finding: There is no accommodation in the payment methodology to allow the continuation of payment for residential services when a resident is able to visit his/her family or go to camp, or the resident must go to an inpatient hospital. With small group homes, this becomes a very difficult staffing and cost issue.

Recommendation: Medicaid programs frequently have some accommodation to continue payment during a resident's temporary leave. The number of "leave" days varies with the type provider and the state, but generally range from a few days to two or three weeks per year. If the State considered such a policy, the reasons for "leave" would need to be defined and the limit on the number of days would have to be specified. This change could be considered after the cost audit study has been completed and more data are available.

4.5.6 Patient Pay

Finding: Under the MR Waiver, recipients whose income exceeds 100 percent of the Supplemental Security Income level must pay the balance of their unearned income toward the cost of their waiver services. Those consumers involved in a planned habilitation program, carried out as a supported employment or pre-vocational or vocational training, may keep an additional amount "not to exceed the first $75 of gross earnings each month, and up to 50 percent of any additional gross earnings up to a maximum personal needs allowance of $575 per month (149 percent of the SSI payment level for a family of one with no income.)" This regulation provides a disincentive to consumers in the planned habilitation program to increase their earnings from employment beyond $575 per month, since this will only be paid to the provider as patient pay. There is an additional problem caused by the multiple recalculations required for recipients with frequent changes in earned income. The consumer (or other designee – often the provider) must notify Social Services, verify earnings, wait for a recalculation of patient pay and collect the correct patient pay amount.

Recommendation: Consideration should be given to increasing the earned income limit to a more reasonable figure so that fewer individuals would be limited in their earning capacity and patient pay changes would be less frequent.

4.6 ADDITIONAL FINDINGS

4.6.1 Values-Based Policies

Finding: Nearly all of the discussions with stakeholders revealed very positive aspects to the waiver. These included a strong desire to support individuals with mental retardation in their own homes and communities, to offer flexible individualized services and supports, to encourage and facilitate consumer control of their own services and resources where possible, etc. However, these laudable goals are not always reflected in state policy and procedures, especially concerning the waiver.

Recommendation: A concerted effort should be made to assure that state Medicaid policy and DMHMRSAS' policies for persons with mental retardation are based on values mutually held by the MR community and by the state agencies. The identification of these values should be the basis for early discussions of the recommended DMAS and DMHMRSAS interagency work group. Methods to obtain consumer input into the identification of those values should also be developed.

4.6.2 Staff Development and Training

Finding: DMHMRSAS reports that their field-based staff has as one of their responsibilities the training and technical assistance for CSBs. However, due mostly to reductions in staff numbers and increases in waiver enrollments and the accompanying responsibilities, now they have little time for technical assistance and almost no time for training. It does not appear that much training for CSBs is occurring in other areas either. Private providers also report that they see a regular need for training, especially in programmatic or policy/values areas such as Person Centered Planning. Other topics where training would be beneficial could be easily identified by providers and CSBs.

Recommendation: Training in programmatic and other areas should be conduced according to a specified plan. The training plan should be developed as a collaborative effort of DMHMRSAS, DMAS, the CSBs, and private providers. The Virginia Association of Community Services Boards and the network of private providers could also play a role in such as endeavor.

4.6.3 Education and Communication

Finding: Some of the CSBs are struggling to adapt to the changing health care and human services environments, and to perform as part of a comprehensive state-wide system. Other CSBs seem to behave as though they are not part of a larger system at all, and they see little or no need to make changes to the ways they have always done business.

If the CSB system is to survive and be competitive in today's market, it must improve its skills and abilities, especially in management areas. The future of public agencies is very likely as system managers rather than service providers. And, to be good managers, agencies need better education in numerous administrative and managerial areas including financial management.

Public agencies also need to have good communication networks so that, even though they are located in dispersed locations, they can perform as a unified system.

Recommendation: DMHMRSAS and DMAS should work collaboratively with the CSB system to make the improvements necessary for the CSBs to perform effectively and efficiently in today's health care market through training plans and performance contract specifications. CSBs must closely examine their own roles, and develop a specific plan for system improvements, to be addressed uniformly in all areas of the state.

4.6.4 Information Systems and Management

Finding: At the current time, CSBs each have their own data collection and management system, many of which do not produce information in common formats. Additionally, there is little consistency in the timeliness, accuracy or basic performance of the CSBs regarding information reporting requirements. This, of course, results in less than useful planning and management information at the central office DMHMRSAS level.

Recommendation: Information systems should be modified as necessary so that uniform reporting of information to DMHMRSAS can occur. CSBs should be required through performance objectives to report all information in a timely, accurate and useful manner. There should be penalties for non-compliance. The State could consider common cost reporting requirements. Also, the capability to bill electronically could be considered when the State has sufficient resources available to make such a change.

4.6.5 Licensure

Finding: In order for most CSB programs and services to operate in the state, they must be licensed by the DMHMRSAS Licensing Division. The Licensing Division, as a regulatory arm, does not operate as part of the programmatic or service mission of the Department. Additionally, since their work is carried out according to regulations and related implementing guidelines, changes to keep pace with the state-of-the-art in services are difficult. As a result, tension exists between the goals of the licensure functions, the service/program areas of the Department, and providers trying to provide more flexible, consumer-directed services.

Recommendation: DMHMRSAS administration should assure that there are workable methods of on-going communication between the Licensing Division and the program areas of the Department, so that licensing staff understand programmatic directions. Feedback mechanisms related to quality monitoring should also be developed and utilized. The Licensing Division should review its operating guidelines and procedures to assure that they facilitate Departmental policy direction, yet fulfill the regulatory responsibilities which they hold.

4.6.6 Consumer Issues

In the consumer interviews, consumers and their families shared a wide array of perspectives regarding MR services and the MR Waiver. Some consumers were satisfied, saying their lives

were improved as a result of the MR Waiver. Others stated that MR Waiver services did not adequately meet their needs. Below is an overview of these problematic issues:

- **Insecurity of Services Provided:** Consumers and their families have trouble securing appropriate services, or retaining the ones that they were provided initially. For example, one consumer was very unhappy living in an inappropriate setting, but alternative residential options were not available. The situation may have affected the consumer's ability to get a job and threatened his independence. Another consumer's family said that initially they received 8 hours a month of respite, but a few years ago, it was decreased to four hours a month. Recently funds were decreased further, which will further limit the hours of respite services. Such service reductions may substantively result in an inadequate plan of care. All recipients whose services are denied, reduced, or terminated must have advance notice and an opportunity for a fair hearing.

- **Transition Period:** There is often a lag time between the time a recipient leaves special education in the schools and the time MR Waiver services are initiated. Generally, this happens because of the lack of match funding. The mother of one school-aged consumer expressed concern regarding the period of transition from public school into MR Waiver services. After graduation, some students languish at home with no meaningful activity in which to engage. Often, as a result, skills which students have spent years learning begin to diminish, behaviors begin to manifest themselves due to a lack of structured and interesting activities, and families begin to have a difficult time providing adequate supervision without assistance.

- **Consumer Choice:** Another concern individuals and their families expressed involved choice of providers. If a consumer has access to a Day Support Program but the consumer's needs are not met by that provider, frequently there are no other alternative programs.

- **Transportation:** Transportation issues arose for a family living in a remote rural area. There is only one Day Support provider in the family's area and the bus ride takes two hours. The consumer has been suspended from riding the van many times because of behavioral problems arising from his being teased by college students who also ride the bus. The consumer's mother was told that regardless of the problems, no funds are available for alternative transportation.

- **Emergency Medical Plan:** The mother of one consumer expressed concern regarding a lack of respite care to address her son's needs should she have a medical emergency. The consumer's mother is a diabetic, and has been hospitalized for treatment in the past. She is afraid she will get sick again and no one will care for her son.

- **Behavioral Consultation:** As a resource management practice, a maximum of 30 hours a year of behavioral consultation is approved on initial authorization through the MR Waiver. Additional hours may be approved, if justified. However consumers

report that additional behavioral supports requires alternative funding which is not always available. Additional services or units of services always will require additional match funding.

- **Preference for ICF/MR:** The mother of two consumers residing in an ICF/MR expressed concern regarding Virginia's increasing reliance on the provision of MR services in a community setting. She does not want her children to lose their ICF/MR services and reside in the community. For a short time, waiver-services were provided, but they did not meet the complex medical needs of her children. The mother is pleased that in the ICF/MR services are guaranteed, whereas access to, and the level of services are not entitlements under the MR Waiver. It should be noted that ICF/MR services are only guaranteed to the extent they exist. DMHMRSAS is concentrating on converting community ICF/MR beds to waiver and is reducing the number of beds in the State facilities while building community resources.

- **Aging of Consumers and Caregivers:** The aging of consumers and caregivers has begun to put a strain on the current delivery system for MR services. Those families that chose to care for their loved-ones in the home and community are now getting older and less capable of being the direct caregivers. However, alternatives for those caregivers, many of whom are in their 60s, 70s, and 80s, are very limited. This is principally related to the level of funding available for MR services in the community.

Recommendation: Recommendations for the consumers' issues have been included in the relevant sections of the report and are not repeated here.

4.6.7 Systemic Issues

Finding: Virginia currently relies heavily on institutional settings to provide a significant proportion of the services to persons with mental retardation. In 1997, Virginia's utilization rate for 16+ bed ICFs/MR per 100,000 population was 28.8 compared to the national average of 20.0. Virginia tied with North Carolina for 39th out of 50 states and the District of Columbia.[2] Additionally, the institutional system and the CSB system do not seem as coordinated as they could be. As discussed previously, there is little or no incentive for a CSB to avoid admitting someone to a Training Center. In fact, it may be a convenient way to avoid costs and serving more difficult consumers at the local level.

Recommendation: Planning should be on the basis of the total mental retardation system. Institutional and HCB services must be seen as two parts of a whole in order for state resources to be used as effectively as possible. As discussed above, expansion of community services is limited until the state reduces its reliance on institutional care.

Finding: Communications between DMAS and DMHMRSAS and CSBs and private providers

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[2] College of Education and Human Development. *Residential Services for Persons with Developmental Disabilities.* University of Minnesota, 1998.

and consumers/families and other State agencies with related programs have not been particularly effective in the past, although steps have been taken recently to improve communications. Consumers reported good communications with their case managers, but limited or no knowledge about the MR Waiver.

Recommendation: Communications can be improved through preparation of internal and external written materials, better training of all involved, and more attention and intent on the part of all parties. As discussed previously, State and local staff levels are very limited and it is difficult to have time to communicate with limited resources.