

## V. Medicaid

### A. Introduction

Medicaid is a publicly funded health insurance program authorized by Title XIX of the federal *Social Security Act* (42 USC 1396 *et seq.*) and administered by the states. It uses federal and state matching funds to provide medical and related insurance coverage for Americans with low income and other targeted populations, including individuals who are elderly or have disabilities and meet state eligibility requirements. For many individuals with disabilities or with low incomes, Medicaid is an essential resource and support for accessing health and long-term care supports. According to the 2010 Kaiser Family Foundation report, *Medicaid: A Primer*, individuals with disabilities are less likely to have private insurance than the general population, and an estimated 20 percent of non-elderly adults with a chronic disability living in the community are covered by Medicaid.

The federal **Centers for Medicare and Medicaid Services (CMS)** require states to cover certain services under Medicaid. States may also opt to cover additional services; however, federal regulations require that all services covered by a state under Medicaid, whether mandatory or optional, must be available statewide in the same amount, duration, and scope to everyone eligible for benefits and that eligible individuals must be able to choose their own providers for those services. Each state must submit a **Medicaid State Plan** to CMS for approval that describes its available mandatory and optional services. When indicated, states may submit Medicaid State Plan Amendments to CMS, requesting changes to their plans, at the end of each quarter of the calendar year.

Federal Medicaid regulations give states significant flexibility in designing their service systems by allowing them to apply for waivers of one or more of the CMS program requirements for uniform amount, duration, and scope of services in order to provide community service alternatives to institutionalization. **Medicaid Home and Community Based Services (HCBS) Waivers** for specific subpopulations of individuals identified as needing particular services are an example. For a waiver to be approved, the state's Medicaid agency, such as the **Virginia Department of Medical Assistance Services (DMAS)**, must assure CMS that the annual cost to provide community-based services is no more than the cost of comparable care in an appropriate institution, which varies by waiver. Federal regulations also allow states to determine whether to base this assurance on individual cost or average aggregate cost. Virginia uses aggregate cost methodology for its Medicaid HCBS Waivers.

The Virginia Joint Legislative Audit and Review Commission (JLARC) has noted that Medicaid is the second largest expenditure in Virginia's budget. Total Medicaid expenditures grew from \$4.8 billion in state fiscal year (SFY) 2009 to \$6.5 billion in SFY 2010, with much of the increase funded by temporarily enhanced federal matching funds discussed further in the cost and payment section of this chapter. Over the next 20 years, rising medical costs, the growing

elderly population, broadened eligibility criteria included federal health care reform legislation passed in 2010, and other recent initiatives to increase or improve access to publicly funded health care and long-term supports are expected to result in further substantial increases in both Medicaid enrollment and costs for Virginia.

DMAS received a \$1 million, four-year “Maximizing Enrollment for Kids: Making Medicaid and CHIP Work” grant from the Robert Wood Johnson Foundation in February 2009 to increase enrollment and retention of eligible children in public health insurance programs. DMAS is using these funds to improve systems, policies, and procedures; measure the impact of these changes; and thereby increase program effectiveness and efficiency. Under the direction of the National Academy for State Health Policy, each of the eight states receiving one of these grants will receive technical assistance with data collection and analysis to measure progress, a formal assessment of current enrolment and retention systems, and tailored assistance to develop and implement system improvement plans.

In March 2010, the U.S. Congress approved major health care reform legislation, the *Patient Protection and Affordable Care Act* (42 USC 18001). Although it will not be fully implemented until 2014, its expansion of Medicaid eligibility to all adults under age 65 with incomes at or below 133 percent of the federal poverty level is expected to have a significant impact on costs. In Virginia, this change is expected add 270,000 to 425,000 new Medicaid enrollees at an additional cost of \$1.5 billion between 2017 and 2022.

Soon after its passage, the Commonwealth filed a lawsuit challenging the constitutionality of federal health care reform. The following May, recognizing that legal issues could take several years to resolve, Virginia’s Secretary of Health and Human Resources announced a statewide **Virginia Health Reform Initiative** to not only prepare for potential implementation of federal health care reform, but also develop innovative health care practices that could improve access to services, disease prevention, workforce availability, service quality, and cost effectiveness. The *Report of the Virginia Health Reform Initiative Advisory Council* ([www.hhr.virginia.gov/Initiatives/HealthReform](http://www.hhr.virginia.gov/Initiatives/HealthReform)) submitted to the Governor was released on December 20, 2010. Additional coverage of this initiative and its report appears in the Health chapter of this assessment; however, some of its key recommendations related to Medicaid include:

- Funding and implementation of the Virginia Gateway project which would create an automated application and eligibility system across Health and Human Services agencies;
- Convening multiple stakeholders to identify, pilot-test, and disseminate effective models of service delivery and payment reform;
- Piloting the use and payment of telemedicine in underserved areas of the state that would include application of a payer claims data base; and
- Exploring cost-sharing opportunities for the current and future expanded Medicaid population.

The 2011 Virginia General Assembly approved a number of budget items that addressed Health Reform Initiative recommendations and affected Medicaid funding or services relevant to individuals with disabilities. For example, to improve health systems, the legislature approved a Medicaid program that uses 100 percent federal funds to make incentive payments to eligible professionals and hospitals that adopt electronic health records technology. The Department of Medical Assistance Services (DMAS) will administer this program at an estimated cost of \$250 million dollars spread over six years beginning in state fiscal year (SFY) 2012.

The legislature also approved two major proposals from the Governor that will enhance community services. To reduce the waiting list for Medicaid Home and Community Based Services (HCBS) Intellectual Disability (ID) Waivers, it approved \$9.8 million of General Funds for SFY 2012 that will provide waivers for 275 additional individuals. Another \$30 million was approved for the Behavioral Health and Developmental Services Trust Fund that must be used to provide community-based services, including new Medicaid waivers for individuals transitioning from the state's training centers.

In addition, the 2011 General Assembly passed a number of budget amendments, some of which reduced the impact of cuts to Medicaid waiver services proposed by the Governor. Approved budget amendments included the following:

- Agency and consumer-directed personal care hours under the Elderly or Disabled with Consumer Direction (EDCD) Waiver and HIV/AIDS Waiver were capped at 56 hours per week, not to exceed 2,920 hours per year, effective in SFY 2012. The amendment requires, however, that DMAS provide for individual exceptions to this limit "using criteria based on dependency in activities of daily living, level of care, and taking into account the risk of institutionalization if additional hours are not provided." (Budget Item 297, #8c)
- General funds were restored in SFY 2012 to reduce the planned decrease in rates paid to providers of waiver services to one percent rather than five percent. (Budget Item 297, #12c)
- Respite care service hours for the EDCCD, HIV/AIDS, ID, and Individual and Family Developmental Disability (DD) Waivers, which had been limited to 720 hours per year were reduced to 480 hours per year, effective July 1, 2011, rather than 240 hours per year as had been proposed. This change was also applied to respite care hours under the Children's Mental Health Demonstration Grant, and the respite authorization period was changed from calendar year to state fiscal year. The limit applies to agency-directed services, consumer-directed services, or any combination of the two, and any unused hours from one year may not be carried over to the next year. (Budget Item 297, #14c)
- Funding was added beginning in SFY 2012 to support 150 additional DD Waivers. (Budget Item 297, #16c)

Two additional budget amendments will have potentially far-reaching impact on Medicaid State Plan and HCBS Waiver services:

- DMAS and the Department of Behavioral Health and Developmental Services (DBHDS) were tasked with examining ways to improve existing or develop new Medicaid HCBS Waivers for individuals with intellectual or developmental disabilities that would “increase efficiency and cost effectiveness, enable more individuals to be served, strengthen the delivery of person-centered supports, enable individuals with high medical needs and/or high behavioral support needs to remain in the community setting of their choice, and provide viable community alternatives to institutional placement.” These two agencies, in collaboration with appropriate stakeholders and national experts, must report recommendations to the General Assembly by October 1, 2011. (Budget Item 295.1, #1c)
- Setting the stage for eventual expansion of care coordination (managed care) for Medicaid services, DMAS was tasked with seeking necessary waivers or authorizations from the U.S. Centers for Medicare and Medicaid (CMS) to expand care coordination “to all geographic areas, populations, and services” under programs administered by DMAS. To accomplish this, DMAS will involve various stakeholders to develop and implement care coordination projects, which shall include monitoring of service “utilization, quality of care, outcomes, costs, and cost savings.”

In addition, the amendment requires DBHDS to work with stakeholders to develop a “blueprint” for a care coordination model for behavioral health services that includes details on funding, populations served, types of services provided, and a timeframe for project implementation and education of clients and providers. The blueprint must adhere to 18 specific principles of care coordination, and as specifically required by the amendment, targeted case management must remain the responsibility of local Community Services Boards (CSBs).

This amendment also delayed expansion of the state’s Medicaid managed care program, Medallion II, into the western and southwestern areas of the Commonwealth. The care coordination expansion plan must be completed for implementation in July 2012, and DMAS must report progress on this initiative to the General Assembly each year on the first day of November. (Budget Item 297, #21c)

Federal regulations and guidelines for Medicaid are too detailed and complex to cover them fully in this assessment, and the remainder of this chapter will provide only an overview of their implementation in Virginia. For more information, the Kaiser Family Foundation ([www.kff.org](http://www.kff.org)) is a reliable, user-friendly source of basic data on individuals served, costs, eligibility, and covered services for Medicaid and the other federally established public insurance programs, as well as further details on federal health care reform.

## B. Eligibility for Medicaid

Federal Medicaid regulations regarding eligibility, give states the option of using the Social Security Administration's (SSA) Supplemental Security Income (SSI) definition of "disability" or a more restrictive definition. Virginia uses the SSI definition but has very strict eligibility requirements regarding income and other factors. As a result, the Commonwealth's eligibility criteria for Medicaid are among the strictest in the nation, and while the rate of growth for expenditures in Virginia is comparable to that for the rest of the nation, its absolute level of Medicaid expenditures has been, and is, low in comparison to other states.

Populations with low incomes for whom Virginia's Medicaid program covers medical and medically related services include adults with dependent children, children from birth to age 19 and adults with disabilities, non-disabled dependent children up to age 21, the elderly age 65 and older, certain Medicare recipients, and pregnant women. While the Virginia **Department of Medical Assistance Services (DMAS)** is the designated state administrative agency for Medicaid and sets the guidelines for accessing services, local social services departments affiliated with the Virginia **Department of Social Services (DSS)** serve as the "gateways" for Medicaid coverage. Applications can be obtained from those local social services departments or online ([www.dss.virginia.gov/benefit/medical\\_assistance/index.cgi](http://www.dss.virginia.gov/benefit/medical_assistance/index.cgi)). The completed application, signed by the adult or by the parent or guardian of a child needing assistance, is returned to the local department of social services where the individual lives, which then determines eligibility for Medicaid benefits.

To be eligible for Medicaid, an individual must be a legal resident of the Commonwealth and provide documentation of residence, identity, citizenship, and income. In some cases, they must also supply information on other resources and assets. If the applicant is not a U.S. citizen, but otherwise meets eligibility criteria, he or she must provide documents verifying immigration status and date of entry into the country. Information on acceptable documents can be obtained from the local social services department where the individual lives, DSS, or the DMAS website.

Children and youth may be eligible for one of two Virginia Medicaid programs. The state's basic plan, named **FAMIS Plus** but typically referred to just as Medicaid, covers children and youth in families with no or very low income. The **Family Access to Medical Insurance Security (FAMIS)** plan covers children and youth in families that earn too much to qualify for Medicaid (FAMIS Plus) but do not have private insurance. Children and youth under age 21 enrolled in Medicaid (FAMIS Plus) are also eligible for services under the **Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)** program, which requires that their doctor document an existing or emerging physical, behavioral, developmental, or mental impairment or problem that requires treatment to correct it or keep it from getting worse. If their doctor is unable to provide the needed services, they may be referred to specialty care, and certain of these services, such as intensive in-home services, therapeutic day treatment, and therapeutic behavioral services, have more extensive eligibility criteria.

To be eligible for full Medicaid (FAMIS Plus) coverage, gross income (total income before deductions and taxes are taken out) and resources (assets) must fall within required limits specified as percentages of the federal poverty level, an index that is adjusted over time. These income and resource limits vary among Medicaid's covered populations; however, individuals and families with incomes of 133 to 200 percent of the federal poverty level are generally covered. In determining resources, the amount of a person's or family's bills and debts is not considered, but in some instances, such as for individuals who are "medically needy," consideration may be given to the impact on a family of exceptionally high medical bills (counted as "spend-down") which work like an insurance deductible.

Children and youth from birth to age 19 with disabilities may qualify for Medicaid (FAMIS Plus) even if their family income exceeds income limits, since parental income and other financial resources are not considered in determining the child's eligibility. When a member of a married couple requires long-term care under Medicaid, special eligibility rules called spousal impoverishment protections are applied to determine resources and income that can be kept by the other spouse. Under the **MEDICAID WORKS** program, individuals who have a disability and who work or are about to start a job may earn more than for standard eligibility and retain more in savings or resources while continuing to receive Medicaid coverage. Additional information on MEDICAID WORKS can be found in the Employment chapter of this assessment, and because all of these income eligibility criteria are complex, it is recommended that individuals contact their local social services department for clarifications.

To receive services under Virginia's **Medicaid Home and Community Based Services (HCBS) Waivers**, an individual must meet both the general and waiver-specific eligibility criteria described below, meet long-term care criteria through a formal clinical assessment, and undergo an assessment of financial need. Financial and nonfinancial criteria for each waiver are covered below. Information on the screening process and accessing services is discussed in later sections of this chapter. Currently, the state has seven approved HCBS Waivers:

- Alzheimer's Assisted Living (AAL) Waiver (or simply, the Alzheimer's Waiver),
- Day Support Waiver,
- Elderly or Disabled with Consumer Direction (EDCD) Waiver,
- HIV/AIDS Waiver,
- Intellectual Disability (ID) Waiver (formerly Mental Retardation Waiver),
- Individual and Family Developmental Disability (DD) Waiver, and
- Technology Assisted (Tech) Waiver.

To be eligible for any of these HCBS Waivers, an adult's total income is limited to no more than 300 percent of the Supplemental Security Income (SSI) benefit limit (\$2,022 per month in 2010), and the adult may have not more than \$2,000 in resources. Parental income and resources are not considered in determining eligibility for minor children. Individuals with income in excess of 100 percent of the SSI benefit limit may be responsible for "patient pay" to

their provider as their share of the cost of care. This copayment is based upon the individual's gross income after subtracting a personal maintenance allowance, an allowance for a spouse or dependent children, and a deduction for medical expenses that are not covered by Medicaid or other third party insurance and remain the liability of the individual to pay. Eligibility requirements for the EDCD, Tech, and HIV/AIDS Waivers allow for a "spend-down" of resources related to income and out-of-pocket expenditures, and individuals eligible for the HIV/AIDS Waiver are allowed to keep more fiscal resources to cover work-related expenses.

To be eligible for the **Alzheimer's Assisted Living (AAL) Waiver**, Virginia's newest, state regulations (12 VAC 30-120-610) require that an individual:

- Be elderly or disabled as defined by Section 1614 of the federal *Social Security Act*,
- Meet the level of care for nursing facility placement,
- Have a diagnosis of Alzheimer's disease or a related dementia by a licensed clinical psychologist or licensed physician, and
- Both receive an Auxiliary Grant and reside in or be seeking admission into an assisted-living facility licensed as a special care unit by the Virginia Department of Social Services (DSS).

Individuals diagnosed with an intellectual disability as defined by the American Association for Intellectual Disability or a serious mental illness as defined in federal regulations (42 CFR 483.102[b]) are not eligible for the Alzheimer's Waiver.

The **Day Support Waiver**, implemented in July 2005, is limited to individuals currently on either the urgent or non-urgent waiting lists for the ID Waiver. A person receiving services under the Day Support Waiver may remain on the ID Waiver waiting list until a "slot" becomes available and is assigned to him or her. The current annual state budget allocates funding for a maximum of 300 Day Support Waiver slots.

Individuals may receive services through the **Elderly or Disabled with Consumer Direction (EDCD) Waiver** while on the waiting list for an ID or DD Waiver. To be eligible for the EDCD Waiver, they must be age 65 or older or, regardless of age, have a disability, and they must meet criteria for nursing facility level of services.

To be eligible for the **HIV/AIDS Waiver**, an individual must be diagnosed by a physician as having the human immunodeficiency virus (HIV), be symptomatic of or diagnosed with acquired immune deficiency syndrome (AIDS), and additionally have symptoms which would require care in a nursing facility or acute care hospital.

Eligibility for the **Intellectual Disability (ID) Waiver** requires a formal assessment by a licensed professional resulting in a diagnosis of intellectual disability or, for a child younger than age six, a determination that the child is at developmental risk. The individual also must require the level of care provided by an intermediate care facility for persons with mental retardation

(ICF-MR). Eligibility determination requires a formal, standardized assessment of the person's current level of cognitive and general functioning, as well as identification of current, relevant medical information. The individual or family must also declare their choice for community-based services rather than institutional (ICF-MR) care.

Because the need for ID Waiver slots exceeds annual state budget allocations, additional criteria are used to prioritize who receives one. Waiting lists are maintained through a partnership between the **Department of Behavioral Health and Developmental Services (DBHDS)** and the local **Community Services Boards (CSBs)** that provide screening and assessment of individuals for the ID Waiver. Based on urgency of need criteria established by DBHDS, each CSB assigns individuals to one of three waiting list categories: urgent, non-urgent, or local planning list. Individuals on the non-urgent waiting list are served only after all individuals on the urgent list have been served, and in effect, they are unlikely to receive an ID Waiver slot unless personal circumstances change significantly for them to meet urgent list criteria. Individuals on the planning list generally qualify for the ID Waiver but do not meet the requirement of being willing to accept services within 30 days. That list is used administratively for future CSB service planning and is not part of the official waiting list.

For placement on the ID Waiver urgent waiting list, an individual must meet the following criteria in addition to the basic waiver requirements.

- The individual meets at least one of the six criteria below:
  - Both primary caregivers are 55 years of age or older or, if there is one primary caregiver, the primary caregiver is age 55 or older;
  - The individual is living with a primary caregiver who is providing the service voluntarily and without pay and who indicates that he or she can no longer continue to do so;
  - There is a clear risk of abuse, neglect, or exploitation;
  - The primary caregiver has a chronic or long-term physical or psychiatric condition significantly limiting his or her ability to provide care;
  - The individual is “aging out” of a publicly funded residential facility or otherwise in danger of becoming homeless (exclusive of youth who are graduating high school); or
  - The individual with ID lives with the primary caregiver, and there is a risk to the health or safety of the individual, primary caregiver, or other resident in the home because either:
    - The individual's behaviors present a risk to himself or others that cannot be effectively managed by the primary caregiver even with supports arranged for or provided by a CSB, or
    - The individual's physical (such as lifting or bathing) or medical needs cannot be managed by the primary caregiver even with supports arranged for or provided by the CSB.

- The individual needs services within 30 days.
- The individual with ID, his or her spouse, or the parent of a minor child with ID will accept the requested service, if offered.

In 2009, following its review of Virginia's ID Waiver renewal application, the U.S. Centers for Medicare and Medicaid (CMS) requested that the state standardize its process for assigning waiver slots. In response, DBHDS partnered with the Virginia Association of Community Services Boards (VACSB) and The Arc of Virginia to develop a uniform, statewide process that became effective in January 2010. Details of this process appear in the later section of this chapter on access to and delivery of services.

Individuals residing in community ICFs-MR or nursing facilities (nursing homes) are not eligible for placement on the urgent waiting list based on the rationale that their health, safety, and welfare needs are being met in the institution. In recent years, however, ID waiver slots have been specifically allotted to residents of DBHDS' training centers and other slots have been made available to nursing home residents with ID through the Money Follows the Person (MFP) initiative to facilitate their transition from institutional to community services.

The **Individual and Family Developmental Disability (DD) Waiver** is targeted to individuals age six years or older who do not have a diagnosis of intellectual disabilities but do have another "related condition." As with the ID Waiver, diagnostic and functional criteria are considered in determining DD waiver eligibility, individuals must meet the level of care criteria for services in an ICF-MR, and individuals or their families must choose community-based services rather than institutional (ICF-MR) care. Children with developmental disabilities who are under the age of six can receive services under the ID Waiver; however, they must transition to the DD Waiver by age six. If they do not transition in a timely manner, they are placed on the DD waiver waiting list.

Unlike the ID Waiver, the DD Waiver has a single, statewide waiting list, and with the exception noted below, slots are assigned from that list on a first-come, first-served basis. Individuals on the list are categorized into one of two "levels" based on the anticipated costs of their service plans, with Level 1 estimated to cost less than \$25,000 per year and Level 2 to cost more than \$25,000 per year. These categories do not generally impact the slot assignment process; however, ten percent of Level 1 DD Waiver slots are designated as "emergency" slots without consideration of the length of time on the waiting list. To be eligible for one of these slots, at least one of four emergency criteria must be met:

- The primary caregiver has a serious illness, has been hospitalized, or has died;
- The individual has behaviors that present a risk to personal or public safety;
- The local social services department has determined that the person has been abused and is in need of immediate waiver services; or
- Home care for the individual presents an extreme physical, emotional, or financial burden that the family or caregiver can no longer bear without the assistance of the waiver.

Individuals needing both a medical device to compensate for the loss of a vital body function and substantial, ongoing skilled nursing care may be eligible for the **Technology Assisted (Tech) Waiver**. Eligibility criteria and screening processes for youth up to age 18 and adults is different, and screening processes are covered along with those for other HCBS Waivers in the next section of this chapter. Eligible adults must be dependent for at least part of the day on a ventilator or meet complex tracheotomy criteria, and the cost effectiveness of technology services is compared to specialized care in a nursing facility. Children and youth younger than 21 must be dependent for at least part of the day on a ventilator, meet complex tracheotomy criteria, or have a daily dependence on some other device-based respiratory or nutritional support, and the cost comparison for their services is to a long-stay hospital.

### C. Access to and Delivery of Medicaid-Covered Services

Once an individual is found to be eligible for Medicaid, the **Department of Medical Assistance Services (DMAS)** mails them a plastic medical assistance card, which is used like any other insurance card. When more than one individual in a family is found eligible for Medicaid, each receives his or her own card. Services under the **Medicaid State Plan** are delivered through a broad array of public providers and private nonprofit or for-profit providers who accept Medicaid as a reimbursement and agree to meet specific guidelines on the scope and documentation of their services. DMAS provides individuals covered by Medicaid with a list of these providers, and extensive information on how to access services is available in its *Guide for Long-Term Care Services in Virginia* ([http://dmasva.dmas.virginia.gov/Content\\_atchs/ltc/ltc-guide\\_srvcs.pdf](http://dmasva.dmas.virginia.gov/Content_atchs/ltc/ltc-guide_srvcs.pdf)).

As mentioned previously, information on the **MEDICAID WORKS** program for individuals with disabilities who are or want to be employed is available in the Employment chapter of this assessment or can be obtained from local social services departments or Work Incentive Planning and Assistance (WIPA) programs. The latter are also described in detail in the Employment chapter.

Shared and specific eligibility criteria for Virginia's **Medicaid Home and Community Based Service (HCBS) Waivers** were detailed in the previous section of this chapter. This section provides additional details on their screening processes and on how services are accessed once eligibility has been determined. Although there are common elements shared by some of the waivers, the complete screening and access process for each is unique. Access to each waiver requires an individualized assessment by professionals who use a standardized evaluation tool, and as reflected through the results of those tools, eligible individuals must meet the level of care for facility placement. Both the assessment tool and alternative placement vary by waiver, and alternative placement criteria were identified in the eligibility section. For all of the waivers, additional documentation of the formal assessments by appropriate professionals of an individual's medical and physical conditions or cognitive functioning is required. There is no charge for eligibility screening for any of the state's HCBS Waivers, and screening

responsibilities for the various state and local agencies and the assessment tools involved are described below.

- Local departments of health and social services complete screenings for the Elderly or Disabled with Consumer Direction (EDCD) Waiver and HIV/AIDS Waiver for youth and adults. They also screen the elderly for the Alzheimer's Assisted Living (AAL) Waiver and adults only for the Technology Assisted (Tech) Waiver. The **Uniform Assessment Instrument (UAI)**, which assesses social, physical, health, and other functional criteria, is used in all of these screenings.
- The state Department of Medical Assistance Services (DMAS) screens children and youth under age 18 for the Technology Assisted (Tech) Waiver using a waiver-specific scoring tool. It also does a follow-up review of an adult's private insurance coverage for adults seeking that waiver.
- Community Services Boards (CSBs) screen youth and adults for the Intellectual Disability (ID) Waiver and the Day Support Waiver using the **Level of Functioning (LOF) Survey**.
- Local health clinics screen adults and Virginia Department of Health (VDH) Child Development Clinics screen youth for the Individual and Family Developmental Disability (DD) Waiver, also using the Level of Functioning (LOF) Survey.

Prior to 2009, in addition to the UAI and LOF Survey assessments, completion of a supplemental screening by local CSBs was often required for individuals with mental illness, intellectual disabilities, or related conditions seeking access to any of the Medicaid HCBS waivers. This screening frequently created delays in accessing the EDCCD, HIV/AIDS, and Tech Waivers, and on January 1, 2009, DMAS eliminated this requirement for applicants seeking those waivers.

There is no **waiting list** for the EDCCD, HIV/AIDS, Tech, and Alzheimer's Waivers, and while there is no separate list for the Day Support Waiver, it is limited to individuals already on either the urgent or non-urgent waiting list for the ID Waiver. Waiting lists, however, would occur for the Alzheimer's and Day Support Waivers if their number of applicants exceeded the maximum number of slots set for those waivers by state regulations (200 and 300, respectively). For youth and adults with intellectual or other developmental disabilities seeking ID and DD Waivers, state funding has not kept pace with need, resulting in large and ever-growing waiting lists.

Individuals on either the urgent or non-urgent waiting list for the ID Waiver gain access to the Day Support Waiver according to their "date of need," defined as the date on which they were determined to be eligible for the ID Waiver. Individuals must be willing to begin services immediately or no later than 30 days from the date of request. Once an individual has been placed on the statewide waiting list, the date of need will never change. According to available data, 287 persons were served through the Day Support Waiver in state fiscal year (SFY) 2010, an increase of 8.3 percent over SFY 2007 when 265 were served.

Once an individual has been determined by the appropriate agency to be eligible for a HCBS Waiver, a list is offered by that agency from which the individual or his or her family can choose service providers. Delivery and management of services vary by waiver. Case management, a Medicaid State Plan service, is available to individuals determined eligible for the ID, Day Support, DD, Tech, and HIV/AIDS waivers as soon as soon as that determination has been made, regardless of whether they have obtained an actual waiver slot. Individuals receiving services through the EDCD waiver do not have access to case management unless they are elderly (subject to geographic and time limitations) or are on the ID or DD Waiver waiting list. As a result, depending on the level of coordination by their providers, those individuals may have more than one **plan of care**.

Under the ID and Day Support Waivers, a case manager or support coordinator from the local CSB or its contracted entity works with an individual, and his or her family if appropriate, to create an **Individual Services Plan (ISP)** detailing the preferred supports to meet that individual's needs and select their providers. Under the ID and Day Support Waivers, if the individual so chooses, the CSB or its contracted entity may also provide those supports.

Unlike the ID Waiver, the DD Waiver's **Consumer Service Plan (CSP)** and related forms are standardized statewide, and the providers selected by an individual, or his or her family if appropriate, for case management or support coordination services and for other direct services cannot be the same organization. Otherwise, the CSP is similar to the ISP and plans of care for other HCBS Waivers, describing the services to be provided and including all supporting documentation.

The table below shows the number of persons served under the **Intellectual Disability (ID) Waiver** in recent years. These counts and those on subsequent tables do not include individuals who had requested waivers but were still awaiting determination of eligibility or individuals who might be eligible for waiver services but are not aware of them and have not applied for them. The data, therefore, may underestimate total demand and need.

#### NUMBER OF INDIVIDUALS SERVED UNDER THE ID WAIVER

<b>State Fiscal Year (SFY)</b>	<b>Number Served</b>	<b>Change</b>	<b>Percent</b>
2005	6,421	-----	-----
2007	6,850	429	6.7%
2010	7,975	1,125	16.4%

Source: Department of Behavioral Health and Developmental Services, Office of Developmental Services.

As the next table shows, while the number of available slots funded by the General Assembly has increased, growth in the number of individuals on the waiting list prior to receiving a slot and services has been much greater and remains a major concern. Despite an increase in the number of slots by 6.7 percent from 2005 to 2007 and by 16.4 percent from 2007 to 2010, the total number on waiting lists increased by 39.4 percent from 2007 to 2010, with that

increase driven significantly more by growth of the urgent list (45.8 percent) than the non-urgent list (32.3 percent).

#### NUMBER OF INDIVIDUALS ON ID WAIVER WAITING LISTS

<b>Waiting List</b>	<b>06/30/2007*</b>	<b>07/01/2010**</b>	<b>Change</b>	<b>Percent</b>
Urgent	2,017	2,946	929	46.1%
Non-Urgent	1,855	2,455	600	32.3%
<b>Total</b>	<b>3,872</b>	<b>5,401</b>	<b>1,529</b>	<b>39.5%</b>

Sources: \*Department of Medical Assistance Services. \*\*Department of Behavioral Health and Developmental Services, Office of Developmental Services.

Moreover, as the table below illustrates, the typical amount of time that individuals spend on ID Waiver waiting lists also continues to grow and be of concern. The length of time reflects the period from placement on the waiting list until the start of actual access to waiver services. Its duration is influenced by the availability of funding for new waiver slots, an individual's priority status, and changes in the number of persons needing services each year. Please note that the "points in time" for year-to-year comparisons in the data below and the total number on the waiting lists indicated by the following and previous tables are not consistent due to limitations of the state's data systems.

#### LENGTH OF TIME ON ID WAIVER WAITING LISTS

<b>Length of Time</b>	<b>Number as of: 12/18/2007</b>	<b>07/01/2010</b>	<b>Change</b>
Less than 1 year	1,009	508	-50%
1 year	757	1,089	44%
2 years	646	981	52%
3 years	460	759	65%
4 years	384	503	31%
5 years	152	454	199%
6 years	112	315	181%
7 years or longer	138	535	288%
<b>Total</b>	<b>3,658</b>	<b>5,144</b>	<b>41%</b>

Source: Department of Behavioral Health and Developmental Services, Office of Developmental Services.

As previously noted, a uniform process for assigning ID Waiver slots by local **Community Services Boards (CSBs)**, with two tiers of review, was implemented statewide in January 2010. Priority is given to individuals found eligible for the urgent waiting list, and information gathered by an individual's support coordinator prior to assignment of an ID Waiver slot include:

- Relevant, current medical information;
- Level of Functioning Survey;

- A recent psychological evaluation or, if under age 6 years, a standardized developmental assessment;
- Documentation that the individual or his or her family or caregiver, as appropriate, chose ID Waiver services over ICF-MR placement; and
- A completed **Critical Needs Summary**, which must be updated at least annually and whenever “critical needs” of the individual change. This form generates a priority needs score that is maintained in a CSB client database.

The first tier of review in the assignment process commences whenever a CSB has any waiver slots available. If five or fewer are available, the CSB identifies the ten individuals on its urgent waiting list who have the highest Critical Needs Summary scores. If more than five slots are available, twice as many individuals as the number of available slots are identified. When two or more individuals have identical scores and are at the cut-off number, all are included in the second tier of review.

A **Waiver Slot Assignment Committee** conducts the second tier of review as soon as possible after a slot becomes available. Committee members, selected by the local CSB, typically include various members of that CSB’s staff as well as staff from neighboring CSBs, family members of individuals already receiving ID Waiver services, legislators, staff from local social services departments and Department of Rehabilitative Services’ field offices, and other stakeholders. A support coordinator who serves on the committee cannot vote when one of the individuals whom he or she supports is being considered for a slot, and no one with a direct or indirect interest in the outcome of the review can be on the committee.

Prior to the second tier review meeting, written summaries prepared by the support coordinators for each of the individuals being considered for an ID Waiver slot are submitted to the members of the assignment committee. Each summary must include the following:

- The individual’s or family’s current need for services including health and safety issues, behavioral challenges, and community integration or social isolation issues;
- Services currently received by the individual;
- Natural supports available to the individual including primary caregiver information and other family, friend, or community supports present;
- Descriptions of any other conditions for urgency; and
- Description of the waiver services determined necessary to relieve the urgency.

After discussing this information, each committee member assigns a numeric score to each of the categories listed above for each individual being considered, and a total of each committee member’s categorical scores is compiled for each of those individuals. An average of all committee members’ total scores for each individual being considered is then calculated, and the individuals with the highest average scores receive the available ID Waiver slots. Further

information on this review and assignment process is available at [www.dbhds.virginia.gov/ODS-MRWaiver.htm](http://www.dbhds.virginia.gov/ODS-MRWaiver.htm).

As described earlier, allocation of **Individual and Family Developmental Disability (DD) Waiver** slots is done statewide on a first-come, first-served basis. The **Virginia Department of Medical Assistance Services (DMAS)** maintains a chronological waiting list based on the date on which an individual was determined to be eligible for the DD Waiver. When funds are allocated for new slots or a current slot becomes available, the individual on the list with the earliest date is assigned the slot. A slot may become vacant because an individual moves out of state, is no longer qualified for the waiver, obtains services through other funding arrangements, or dies.

The following tables, similar to those above for the ID Waiver, depict the number of unduplicated individuals who received services under the DD Waiver or were on the DD Waiver waiting list as of June 30, the end of the state fiscal year (SFY), for selected years between 2005 and 2010. The total and percentage changes for that entire period are also indicated. Waiting list data by level of need was not available for the most recent years.

#### NUMBER OF INDIVIDUALS SERVED UNDER THE DD WAIVER

<u>State Fiscal Year (SFY)</u>	<u>Number Served</u>	<u>Change</u>	<u>Percent</u>
2005	338	----	----
2007	408	----	----
2009	584	----	----
2010	582	244	72.2%

Source: Department of Medical Assistance Services.

#### NUMBER OF INDIVIDUALS ON DD WAIVER WAITING LIST

<u>State Fiscal Year</u>	<u>2005</u>	<u>2007</u>	<u>2009*</u>	<u>2010*</u>	<u>Change</u>	<u>Percent</u>
Level 1 Needs	161	246	----	----	----	----
Level 2 Needs	123	248	----	----	----	----
<b>Total</b>	<b>284</b>	<b>594</b>	<b>757</b>	<b>993</b>	<b>709</b>	<b>250%</b>

\* The distribution between Level 1 and Level 2 Needs was not available for SFYs 2009 and 2010.

Source: Department of Medical Assistance Services, as of June 30 of each year.

In comparison, recipients of services under the DD Waiver (582) in 2010 were less than a tenth (7.3 percent) of the number served through the ID Waiver (7,975), and even more so than for ID Waivers, growth in the number of DD Waivers (72.2 percent) has been far exceeded by the increase (250%) in the number of individuals waiting for a waiver. A critical factor contributing to this difference has been the relative lack of new appropriations by the General Assembly for DD Waiver slots compared to ID Waiver slots. This is in part due to the much larger number of individuals on the ID Waiver waiting list and a very strong and cohesive advocacy lobby for ID Waiver slots. In addition, until July 1, 2009, there was no single lead

state agency designated for DD Waiver services planning, which made their inclusion in state budget proposals more difficult. A sizeable proportion of individuals with developmental disabilities other than intellectual disabilities have also applied for and received services under the EDCD Waiver that has no capacity limit.

Both the Governor and the legislature have expressed concern that the waiting lists for the ID and DD Waivers continue to increase at a fast pace and have taken action to address this concern. In 2009, the General Assembly expressed its intent to eliminate these waiting lists and tasked the Governor with developing a formal plan to do so (*Code of Virginia*, 32.1-323.2). The administration's response, developed by the Departments of Medical Assistance Services (DMAS) and Behavioral Health and Developmental Services (DBHDS) in late 2009, reported that the waiting lists were growing by approximately 699 individuals per year for the ID Waiver and 154 for the DD Waiver. To eliminate both waiting lists by the end of state fiscal year (SFY) 2020, the legislature would need to fund 1,100 new ID Waiver slots and 220 new DD Waiver slots annually between SFY 2011 and 2020.

As the report to the legislature noted and is show below, the actual number of new slots funded annually for the past eight fiscal years has been well below this level, averaging just 360 per year for the ID Waiver and 38 per year for the DD Waiver. This includes both slots originally legislatively planned plus an additional 110 ID Waiver and 15 DD Waiver slots designated each year for the Money Follows the Person (MFP) demonstration project in 2009 and 2010.

#### ANNUAL NUMBER OF NEW ID AND DD WAIVER SLOTS ALLOCATED

<b>State Fiscal Year (SFY)</b>	<b>New ID Waiver Slots</b>	<b>New DD Waiver Slots</b>
2003	150	0
2004	175	0
2005	860	105
2006	0	0
2007	303	65
2008	468	100
2009	710	15
2010	210	15
<b>Total</b>	<b>2,876</b>	<b>300</b>

Source: Department of Medical Assistance Services and Department of Behavioral Health and Developmental Services' 2009 *Plan for Elimination of Waiting Lists under Medicaid: ID and DD Waivers*.

The national economic recession led to a dramatic decline in state revenues beginning in 2008, and as a result, the 2009 General Assembly eliminated funding for 200 new ID Waiver slots planned for state fiscal year (SFY) 2010. In 2010, the legislature approved funding for 250 new ID Waiver slots over the next biennium; however, this funding was contingent upon extension of **Federal Medical Assistance Percentage (FMAP) Funding**, with restoration at the

discretion of the Governor. After much debate, the U.S. Congress approved the *Education Jobs and Medicaid Assistance Act* that extended FMAP Funding for six months in federal fiscal year (FFY) 2011, but at a rate of only 3.2 percent from January through March and 1.2 percent from April through June. This extension provided Virginia with \$262.6 million, significantly less than the \$430 million that the General Assembly had expected. Nevertheless, the 250 new ID Waiver slots were restored and allocated by DBHDS in 2010. The following year, the General Assembly approved funding for 275 additional ID Waiver slots and 150 DD Waiver slots for SFY 2012.

As funding for the other Medicaid Home and Community Based Services (HCBS) Waivers, especially the ID and DD Waivers, has remained flat, more and more individuals with ID and DD have turned to the **Elderly or Disabled with Consumer Direction (EDCD) Waiver** as a means of receiving needed services. As reflected in the table below, the unduplicated number of individuals served under the EDCD Waiver grew by 9,698 from state fiscal years (SFY) 2005 to 2010, a dramatic 81.5 percent increase with most of that growth occurring toward the end of that period. From SFY 2007 to 2010, the number grew by 7,634 individuals, 64.1 percent.

#### NUMBER OF INDIVIDUALS SERVED UNDER THE EDCD WAIVER

<u>State Fiscal Year (SFY)</u>	<u>Number Served</u>	<u>Change</u>	<u>Percent</u>
2005	11,901	-----	-----
2006	12,588	687	5.8%
2007	13,965	1,377	10.9%
2008	16,159	2,194	15.7%
2009	18,640	2,481	15.4%
2010	21,599	2,959	15.9%

Source: Department of Medical Assistance Services.

The number of individuals receiving services through the remaining three Medicaid HCBS Waivers is relatively small compared to those described above. The following table shows data on the number of unduplicated individuals served under the **Alzheimer's Assisted Living (AAL), Technology Assisted (Tech), and HIV/AIDS Waivers** for selected state fiscal years (SFY) between 2005 and 2010 as well as the amount of change for the entire period.

#### NUMBER OF INDIVIDUALS UNDER THE TECH, AAL, AND HIV/AIDS WAIVERS

<u>State Fiscal Years</u>	<u>2005</u>	<u>2007</u>	<u>2009</u>	<u>2010</u>	<u>Change</u>	<u>Percent</u>
AAL Waiver*	-----	18	32	62	44	204%
HIV/AIDS Waiver	213	384	61	60	-153	-71.8%
Tech Waiver	363	384	400	405	42	11.6%

\* The AAL Waiver was not available until SFY 2006.

Source: Department of Medical Assistance Services.

In contrast to the slow but steady growth in the number of individuals served by the AAL and Tech Waivers between 2005 and 2010, the number served under the HIV/AIDS Waiver decreased significantly, by 71.8 percent. This is generally believed to be due to improvements in medications and treatments that enable individuals with HIV or AIDS to live without the need for nursing facility level of care, decreasing the number of individuals who continue to meet that criterion for this waiver.

While the number of individuals receiving services through the AAL Waiver more than tripled from 2007 to 2010, initial participation since its inception in 2005 has been slow and total participation remains low compared to most of the other waivers. This has largely been due to need for outreach to potential providers and delays in the provider enrollment process.

According to Department of Medical Assistance Services (DMAS), potential providers expressed concern over additional licensing expectations set by the Department of Social Services (DSS), and new regulations have been proposed to improve consistency with waiver requirements in the areas of licensed care professionals, synchronization of medication distribution by registered medication aides, the number of activity hours provided, and the education and certification of direct care staff. In anticipation of the adoption of these proposed licensing regulation changes, provider enrollment has increased significantly.

DMAS has also undertaken targeted marketing efforts to identify potential service providers and recipients for the AAL Waiver. In 2010, the most recent year prior to this assessment, it made presentations at two statewide conferences for operators of assisted-living facilities and conducted multiple trainings for preadmission screeners to clarify admissions and screening issues and to promote the use of the AAL Waiver for long-term care.

As demonstrated by the slow growth for the AAL Waiver, an important factor in accessing all Medicaid supports is having a sufficient local **service capacity** of enrolled providers to meet eligible individuals' needs. Unfortunately, state data limitations currently make it difficult to determine the total number and capacity of Medicaid HCBS Waiver service providers by region. In 2010, the Department of Medical Assistance Services (DMAS) implemented a new provider database, which is used nationally, but as of this assessment, DMAS has not yet been able to generate provider data based on the type of waiver covering a service.

There are two basic ways that individuals can access services under Medicaid HCBS Waivers, **consumer-directed services** which are described in greater detail below and **agency-directed services** available from a variety of governmental, nonprofit, and for-profit organizations. In addition, specific requirements such as professional licenses for staff members or agency licensure by the Virginia Department of Behavioral Health and Developmental Services (DBHDS) or other state agencies may be required for some service providers, and to be enrolled as an in-state provider for the Commonwealth, a service provider must be located no more than 50 miles outside of the state's borders. Case managers or service coordinators can provide information about local service providers. Lists are also available from DMAS, and its

website has a provider search feature at [http://dmasva.dmas.virginia.gov/Content\\_pgs/search-home.aspx](http://dmasva.dmas.virginia.gov/Content_pgs/search-home.aspx).

Implementation of consumer-directed services under several of the Medicaid HCBS Waivers has improved the availability of certain services and enabled individuals, and their families or guardians where appropriate, to retain freedom of choice and control of the direct services that they receive. The concept and practice of consumer-direction is an important component of effective community integration of persons with disabilities and refers to situations in which the individual with the disability who is receiving service, the “consumer,” has responsibility for deciding how and when services will be provided and who will provide them. Both the ID and DD Waivers include consumer-direction for personal and respite care for children and adults and companion services for adults. The HIV/AIDS, EDCD, and Day Support Waivers also cover consumer-directed personal assistance and respite services. Consumer-directed services are currently not available under the Alzheimer’s or Tech Waivers.

As the recipient of consumer-directed services, an individual with a disability (or his or her designated representative) is the **employer of record** with the federal Internal Revenue Service (IRS) and functions as manager of his or her own staff. If desired by the service recipient, facilitators may provide lists of attendants, companion aides, and respite workers and teach individuals with disabilities how to place help-wanted advertisements. DMAS contracts with a fiscal agent that handles payment of these providers on behalf of the individual receiving their services. Several reader-friendly guides developed by self-advocates through Virginia’s **Systems Transformation Grant** to help individuals implement consumer-directed services are available at [www.vcu.edu/partnership/cdservices/pcprb.htm](http://www.vcu.edu/partnership/cdservices/pcprb.htm).

A **Medicaid appeal process** is authorized under both federal (CFR 431 *et seq.*) and state (12 VAC 30-110-10 through 370) regulations when an individual is denied eligibility for Medicaid insurance coverage or for a type of service. Individuals must be notified in writing of an “adverse action” at least ten business days prior to a denial or cancellation of coverage or services. The individual then has 30 days from that notification to file a written appeal request with the **Department of Medical Assistance Services (DMAS) Appeals Division**. “Good cause” exceptions to the 30 day time limit are permissible only in special circumstances such as a personal emergency. Written appeal requests may be in the form of a letter, an e-mail, or a completed appeal request form available from local social services departments, the DMAS website ([www.dmas.virginia.gov](http://www.dmas.virginia.gov)), or by calling 804-371-8488. Telephone and verbal requests for appeal are not accepted, and a copy of the adverse action notification should be included with the written request or request form.

If the appeal is filed before the effective date of the adverse action, Medicaid-covered services may continue during the appeal process if the provider is so willing and the individual so requests. If services are continued or reinstated due to the appeal, the provider can neither terminate nor reduce services until the hearing officer has rendered a decision; however, if the adverse action is later upheld by the hearing officer, the individual will be required to reimburse

DMAS for the cost of the services received during that time period. Because of this, some individuals may choose not to continue services during the appeal process.

At any point during the process, an individual may choose to withdraw his or her appeal, and DMAS may also act to approve or reinstate coverage based on new information or a new evaluation. If the latter occurs, DMAS must notify the individual and the Appeals Division of its decision in writing, and if the Appeals Division determines that there has been an “administrative resolution” of the issue, it can decide to formally close the appeal rather than proceed with a hearing.

If an appeal is not administratively resolved, the Appeals Division reviews the appeal request and any new information provided, then determines whether to validate or to invalidate and dismiss the appeal. An appeal may be invalidated because, for example, it was filed late or it offered no new information. If the appeal is validated, the Appeals Division schedules a hearing and notifies the individual of its location, date, and time by mail two to three weeks in advance.

The neutral presiding officer at the hearing allows each side to present facts regarding the adverse action. The individual making the appeal can bring representatives or witnesses, submit new documents or evidence, examine agency documents, and raise questions. The hearing officer makes his or her decision based on questions of evidence, procedure, and law, and may sustain (support), reverse, or remand the denial of coverage or services. A remand requires DMAS to conduct an additional evaluation of the information or to provide new information. The hearing officer’s decision must be made within 90 days of the appeal request date. Both the individual requesting the appeal and DMAS receive a copy of the hearing officer’s decision, and if the individual disagrees with that decision, he or she may appeal to the Circuit Court.

DMAS statistics indicate that approximately 75 percent of all appeals that have hearings and full dispositions are sustained by their hearing officers. Over time, the number of appeals has grown from 2,106 in state fiscal year (SFY) 2005, of which 1,891 (89.8 percent) were validated, to 3,388 in SFY 2010, when 2,970 (87.8 percent) were validated. While the number of validated appeals increased by 1,079 (36.3 percent) during this period, the number of hearing officers statewide has remained constant at 11, and hearing officers have experienced a dramatic increase in workload from an average of 172 validated appeal requests each in SFY 2005 to 270 in SFY 2010.

#### **D. Services Available Through Medicaid**

In compliance with federal regulations, Virginia’s Medicaid program provides for the following **mandatory services** that must be covered for all who meet eligibility criteria:

- Inpatient and outpatient hospital services;
- Emergency hospital services;
- Rural health clinics and federally qualified health centers;

- Physician and nurse midwife services;
- Nursing facility services;
- Applicable durable medical equipment;
- Laboratory and x-ray services;
- Early and periodic screening, diagnosis, and treatment (EPSDT) services for children and adolescents under age 21;
- Home health services (nurses, aides); and
- Transportation services to receive covered services.

Of these, **early and periodic screening, diagnosis, and treatment (EPSDT)** is one of the most critical services for children and adolescents under age 21. EPSDT covers preventative and other health care services including well child examinations, assessments and screenings, immunizations, dental care, vision and hearing services, and “medically necessary” diagnostic and treatment services to correct or improve physical conditions, behavioral issues, and mental illness identified by assessments. Children eligible for EPSDT can receive all services determined to be medically necessary regardless of whether those services are covered under the Medicaid State Plan, and EPSDT is also available to children receiving services under a Medicaid Home and Community Based Services (HCBS) Waiver. Additional information on EPSDT services covered by Medicaid can be found in the Early Intervention chapter.

In addition to the aforementioned federally mandated services, the *Code of Virginia* (32.1 *et seq.*) authorizes the state’s Medicaid program to cover nineteen categories of **optional services** which include, but are not limited to:

- Prescription drugs,
- Rehabilitation services (occupational, physical, speech and related therapies),
- Home health services (physical therapy, occupational therapy, and speech/language pathology),
- Dental services for youth under age 21,
- Skilled nursing facility services for youth under age 21,
- Case management services,
- Some mental health and substance abuse services,
- Hospice, and
- Intermediate care facilities for persons with mental retardation (ICFs-MR) services.

Dental, orthodontics, and limited medically necessary oral surgery services for children are covered under Medicaid (FAMIS Plus) and Family Access to Medical Insurance Security

(FAMIS) by the combined program **Smiles for Children**. Details of this program for both service recipients and providers can be found at [www.dmas.virginia.gov/dental-enrollees.htm](http://www.dmas.virginia.gov/dental-enrollees.htm).

Further information about Virginia's mandatory and optional Medicaid-covered services, their eligibility requirements, and types of approved providers is available in print and online from the Department of Medical Assistance Services (DMAS, [www.dmas.virginia.gov](http://www.dmas.virginia.gov)).

The required mandatory and optional services that apply to basic Medicaid State Plan coverage are also available to all recipients of services under **Medicaid Home and Community Based Services (HCBS) Waivers**. Some services, however, are waiver specific, varying in amount and type between waivers, and the availability of any waiver or waiver service is dependent on, and therefore limited by, annual state appropriations made by the Virginia General Assembly. For example, as noted in the introduction to this chapter, the allowable hours for personal care and respite services for several of the waivers described below were reduced effective July 1, 2011, with potential exceptions based on emergency regulations to be developed by DMAS.

Transition services and coordination have recently been added to several of the HCBS Waivers, as noted below, to assist with moving individuals from institutions to the community under the **Money Follows the Person (MFP)** initiative. Transition services are defined (12 VAC 30-120-2010) as "set-up expenses for individuals who are transitioning from an institution or licensed or certified provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for his own living expenses." Under MFP, DMAS contracts with and trains local or regional providers who serve as transition coordinators that who support individuals and their families or caregivers, as appropriate, in planning and making arrangements associated with transitioning from an institution to the community. Additional information on the MFP initiative appears in the Community Supports chapter of this assessment.

For individuals eligible for Medicaid or both Medicaid and Medicare, the **Alzheimer's Assisted Living (AAL) Waiver** covers services in a safe, secure assisted-living environment. Covered services include assistance with daily living activities, housekeeping, and supervision, administration of medications, and therapeutic and recreational programming based on a person's needs and interests in a safe, secure environment. Nursing evaluations and Medicaid services such as medication, physician's visits, acute care hospitalizations, and certain therapies are also covered. Case management is not covered under this waiver. Services are paid for on a per diem basis, 365 days a year, with a maximum annual allowance of 14 days for home visits.

Services currently available under the **Day Support Waiver** include day support, prevocational services, and supported employment.

The **Elderly or Disabled with Consumer Direction (EDCD) Waiver** funds medication monitoring, agency- or consumer-directed personal care services, adult day health care, personal response systems, respite care, and transition services.

Services covered under the **HIV/AIDS Waiver** include case management, nutritional supplements, private day nursing, personal response systems, agency- or consumer-directed personal and respite care, and transition services. There is no patient pay requirement for services under this waiver.

The **Intellectual Disability (ID) Waiver** provides for assistive technology, attendant services, agency- or consumer-directed companion and respite services, crisis stabilization and supervision, day support, family and caregiver training, environmental modifications, in-home and congregate residential support, personal care services, personal emergency response systems, prevocational services, supported employment, skilled nursing, therapeutic consultation, and transition services.

Similar supports are covered by the **Individual and Family Developmental Disability (DD) Waiver** as for the ID Waiver; however, while ID Waiver funds can be used for supports either in a group residential setting or in an individual or family home, the DD Waiver only funds in-home supports.

The **Technology Assisted (Tech) Waiver** covers personal emergency response systems, durable medical equipment, and transition services for youth and adults as well as personal care services for adults only. Environmental modifications and assistive technology are covered, up to a maximum of \$5,000 a year for each category, but only if medically necessary and cost-effective. Respite care is limited to 360 hours per year. Private duty nursing services are also covered but are limited to 16 hours per day, with the exception that youth age 20 or younger may receive this service for 24 hours per day during their first 30 days of enrollment in the waiver.

## E. Cost and Payment for Medicaid

Medicaid is jointly funded through federal and state tax revenues. Administrative costs are split equally between federal and state funds. Each state sets its own fiscal reimbursement rate for each covered service. A formula is used to determine the percentage of the federal payment for each service covered by a state, and the state is required to cover the remaining service cost, known as “state Medicaid match.” The federal portion, its “match,” varies annually but typically ranges between 50 and 83 percent among the states. For Virginia, the standard federal match is set at 50 percent; however, as noted in the introduction to this chapter, temporarily enhanced federal match of 61.59 percent through the *American Recovery and Reinvestment Act (ARRA)* reduced the Commonwealth’s state match to 38.41 percent for a portion of state fiscal year (SFY) 2009. This enhanced match continues through June 2011 and returns to equal shares of federal funds and state General Funds thereafter. Virginia also receives an increased federal match for individuals participating in the Money Follows the Person (MFP) initiative.

Under the *Code of Virginia* (32.1-325.2), Medicaid is the “**payer of last resort**”; that is, when an individual is covered both by third party private insurance and by Medicaid, the private insurer first must pay for any services covered under its policy. Medicaid also requires adults to contribute a small “copayment” toward the costs of certain medical services such as visits to an

outpatient hospital, clinic, or physician's office, home health visits, rehabilitation services, and inpatient hospitalization. The copayment can be made at the time of the service or billed to the service recipient by the provider. Medicaid Home and Community Based Services (HCBS) Waivers do not require copayment per service from participants for basic Medicaid State Plan services, but a waiver recipient may have a "patient pay" contribution for certain services based on amounts and sources of income. The Department of Social Services (DSS) assesses whether an individual receiving services under a HCBS Waiver is responsible for a patient pay.

The **Department of Medical Assistance Services (DMAS)** is responsible for making and tracking payments made under Medicaid and does so in one of two ways, as a fee-for-service based on specific reimbursement rates or through a managed care system. With fee-for-service, the service provider directly bills DMAS for a service received by a Medicaid client. Within managed care, DMAS operates two distinctly different programs. **Medallion**, administered by DMAS directly, is a primary care case management program in which the individual's primary care physician coordinates medically necessary care that includes referrals to specialists. **Medallion II**, administered through contracted managed care organizations (MCOs), is mandatory for many Medicaid (FAMIS Plus) individuals and is a fully capitated, risk-based program. MCOs provide most Medicaid-covered services for their enrollees in return for a fixed per capita monthly payment that covers a comprehensive set of services regardless of the amount or frequency of services used by each enrollee. For June 2010, DMAS reports that 484,801 individuals, 61.3 percent of its Medicaid clients, received services through managed care, an increase from 443,316 individuals, 59.8 percent, in June 2009.

Growth in the number of Medicaid enrollees, 49 percent from 2000 to 2010 according to DMAS' 2011 *Medicaid At-a-Glance* report, is a driving force behind the increase in Medicaid expenditures. Much of this growth can be attributed to general state population increases, especially among the elderly and those with disabilities. Other sources, however, indicate that most of the recent enrollment increase is directly related to the recession, both in Virginia and in other states. For example, *State Fiscal Conditions and Medicaid*, an issue brief by the Kaiser Family Foundation, reports that each increase of one percent in the national unemployment rate results in 1.1 million more individuals without private insurance coverage, one million more Medicaid enrollees, and a likely decline in state revenues of three to four percent.

While noting these and other factors, presentations to the General Assembly's fiscal committees in November 2010 recognized that much of this growth can be attributed to expanded enrollment of children and adults without disabilities. Enrollments for this population began to increase in state fiscal year (SFY) 2002, which featured program reforms and the beginning of outreach campaigns targeted at uninsured children, then sharply increased between SFY 2008 (two percent annual growth) and 2009 (eight percent annual growth). In comparison, there was a much smaller increase in enrollment growth for individuals categorized by Medicaid as elderly and as blind or disabled between those two years (two percent and 2.4 percent, respectively). This trend continued into SFY 2010 when there was an eight percent increase for adults and youth without disabilities versus three percent for those identified as elderly or as blind or disabled.

The following table comparing data for SFY 2007 and 2010 shows the number of Virginians enrollees by the four population categories tracked by Medicaid, their proportion of the total number of enrollees, and the proportion of total expenditures attributable to each category. It also reflects the recent proportionately larger growth in both number of enrollees who are children and adults without disabilities and the cost for their services described above.

#### COMPARISON OF MEDICAID ENROLLEES AND EXPENDITURES

Population Category	SFY 2007			SFY 2010		
	Number of Enrollees	% of All Enrollees	% of All Expenditures	Number of Enrollees	% of All Enrollees	% of All Expenditures
Elderly	81,541	9%	21%	80,016	8%	18%
Blind/Disabled	182,636	20%	47%	196,952	20%	47%
Children	487,929	55%	22%	563,379	56%	24%
Adults	142,180	16%	10%	164,814	16%	11%
<b>Total</b>	<b>894,286</b>	<b>100%</b>	<b>100%</b>	<b>1,005,1661</b>	<b>100%</b>	<b>100%</b>

Source: Department of Medical Assistance Services (DMAS).

While those categorized as elderly and blind or disabled comprised only 29 percent of enrollees in SFY 2007 and 28 percent in SFY 2010, expenditures attributed to those two populations made up 68 percent and 65 percent, respectively, of the total costs for those two years, indicating that those two groups have the highest per capita use and cost of services. In contrast, children and adults without disabilities comprised 71 percent of enrollees and accounted for only 32 percent of costs in SFY 2007, and they comprised 72 percent of enrollees and accounted for only 35 percent of costs in SFY 2010.

The legislative presentations further noted that Virginia's Medicaid costs have risen from approximately \$2.7 billion in SFY 2000 to \$6.5 billion in SFY 2010 (140 percent), even more rapidly than its enrollment (49 percent, as noted above), and that the reasons for this increase are numerous and complex. The table below compares expenditures over that period for several service categories.

#### COMPARISON OF VIRGINIA MEDICAID EXPENDITURES

(in millions of dollars, with percentages of total)

Service Category	SFY 2000		SFY 2010	
Acute Care	\$1,601.2	59%	\$3,382.5	53%
Nursing Facilities	470.9	17%	793.4	12%
Medicaid Waivers	256.6	9%	955.3	15%
MH/ID Facilities	251.6	9%	419.3	6%
MH/ID Community	73.4	3%	589.7	9%
Medicare Premiums & Other Payments	78.9	3%	\$408.6	6%
<b>Total</b>	<b>\$2,732.6</b>	<b>100%</b>	<b>\$6,548.8</b>	<b>100%</b>

Source: Massart, Susan E. (November 17, 2010). *Costs and Trends in the Virginia Medicaid Program*. Presentation to the House Appropriations Committee of the Virginia General Assembly. Richmond, Virginia.

Medicaid expenditures for acute care services include medical and dental outpatient services, durable medical equipment, inpatient hospital care, and prescription drugs. The expenditures in this category also more than doubled over the past ten years. Factors contributing to this growth were increases in enrollment of children and adults, inflation, policy decisions to increase rates, and use of higher cost services related to pregnancy, childbirth, and neonatal care.

Mental health (MH) and intellectual disability (ID) community services includes mental health outpatient services and supports for adults and youth, inpatient supports for youth, and case management by Community Service Boards for individuals with mental illness and intellectual disabilities. The amounts and proportions of expenditures for this category and for services under Medicaid HCBS Waivers both increased. In contrast, while expenditures grew dramatically for nursing facilities and MH/ID facilities, their proportion of total expenditures declined. This reflects increased enrollment for waiver services, expansion of waiver slots, and greater reliance on community care rather than institutions. Other factors included inflation and increased use of personal care services, especially consumer-directed care.

Despite the recent substantial growth in its Medicaid expenditures, Virginia still spends relatively less than other states. In its report *Virginia Compared to Other States*, the Joint Legislative Audit and Review Commission (JLARC) examined all of the state's Medicaid expenditures, including all medical assistance payments as well as state and local administrative costs but excluding payments under the Children's Health Insurance Program (CHIP), and determined that Virginia ranked near the bottom (47<sup>th</sup>) among the states in **per capita Medicaid expenditures** for federal fiscal years (FFY) 2007 and 2008. In FFY 2007, Virginia expended \$645 per capita (an increase of only \$26 from FFY 2005), compared to the national average of \$1,023. For FFY 2008, Virginia spent \$691 versus \$1,082 nationally.

Both in Virginia and nationally, individuals with disabilities rely on Medicaid to fund **long-term care services**. Virginia funds several broad categories of these services through Medicaid. The following table shows the relative proportions of these expenditures for state fiscal years (SFY) 2008 and 2010, including both state and federal funds, versus the total amount spent in the state for Medicaid long-term care services during those years.

#### **DISTRIBUTION OF MEDICAID LONG-TERM CARE EXPENDITURES**

<b><u>Long-Term Care Category</u></b>	<b><u>SFY 2008</u></b>	<b><u>SFY 2010</u></b>
Intermediate Care Facilities for Persons with Mental Retardation (MR)	14.5%	13.2%
Mental Health Facilities	3.2%	2.9%
Nursing Facilities	41.1%	38.1%
Home Health, Personal Care, and HCBS Waivers	41.2%	45.8%
<b><u>Total</u></b>	<b><u>100%</u></b>	<b><u>100%</u></b>

Source: Department of Medical Assistance Services (DMAS).

As the above table shows, Virginia's spending for institutional long-term care services has declined in recent years relative to spending for services in community settings, including **Medicaid Home and Community Based Services (HCBS) Waivers**. The next table details expenditures and funding sources for each of the state's HCBS Waivers during state fiscal year (SFY) 2009. Since providers have up to a year to file for reimbursements for services, more recent data on SFY 2010 was not available at the time of this assessment.

**SFY 2009 VIRGINIA EXPENDITURES FOR  
MEDICAID HOME AND COMMUNITY BASED SERVICES (HCBS) WAIVERS**

<b>Medicaid HCBS Waiver</b>	<b>Number Served<sup>A</sup></b>	<b>Waiver- Specific Costs<sup>B</sup></b>	<b>Acute Care Costs<sup>C</sup></b>	<b>Total Cost</b>	<b>State Funds<sup>D</sup></b>	<b>Federal Funds<sup>D</sup></b>	<b>Per Capita Cost<sup>E</sup></b>
Alzheimer's Assisted							
Living (AAL) .....	32	\$477,316	\$17,060	\$494,376	\$211,148	\$283,228	\$15,485
Day Support .....	283	\$3,369,954	\$3,020,091	\$6,390,045	\$2,729,188	\$3,660,857	\$22,694
Developmental							
Disability (DD) .....	584	\$15,372,085	\$6,615,647	\$21,987,732	\$9,390,960	\$12,596,772	\$37,768
Elderly or Disabled with Consumer							
Direction (EDCD) .....	18,640	\$296,402,695	\$104,181,884	\$400,584,579	\$171,089,674	\$229,494,905	\$21,893
HIV/AIDS .....	61	\$872,354	\$860,996	\$1,733,319	\$740,301	\$993,018	\$28,650
Intellectual							
Disability (ID) .....	7,748	\$485,106,855	\$93,446,137	\$578,572,992	\$247,108,525	\$331,464,467	\$74,727
Technology							
Assisted (Tech) .....	400	\$30,391,914	\$21,234,973	\$51,626,887	\$22,049,843	\$29,577,044	\$129,200

- A. Total number of individuals receiving services under each waiver at any time in SFY 2009.
- B. Costs only for those services specifically provided under each waiver.
- C. Costs for Medicaid State Plan acute care medical services (doctor visits, X-rays, medications, etc.) and transportation, for which recipients of waiver services are also eligible, that were received by individuals under each waiver.
- D. Reduced state match at an annualized rate of 42.71% for SFY 2009 for both waiver-specific and acute care costs due to temporarily enhanced federal match at an annualized rate of 57.29% through the *American Recovery and Reinvestment Act* (ARRA). The enhanced federal match applied only for a portion of the year.
- E. As calculated by DMAS, the sum of per capita cost for waiver-specific services plus per capita cost for acute care services for each waiver. Since different numbers of individuals received waiver-specific and acute care services under each waiver, this is not the same as the total cost for both waiver-specific and acute care services divided by the total number of individuals served for each waiver. The latter calculation may be higher for some waivers and lower for others.

Source: Department of Medical Assistance Services (DMAS).

As can be clearly seen above, per capita costs for the seven waivers vary widely due to the differences in the scope and types of services covered. For example, per capita cost for the Tech Waiver is significantly higher because eligible individuals have more complex medical needs, such as dependence on a ventilator for at least part of the day, and rely on more expensive medical services. As noted earlier, while services are generally similar under the ID and DD waivers, the former covers supports provided both in-home and in group homes or other

congregate residential settings, and the latter is restricted to in-home supports which are typically less costly.

A more meaningful context for examining the costs of Medicaid HCBS Waivers is to compare the actual cost for serving individuals who are currently supported through waivers in community settings to the estimated cost of serving those individuals in their designated alternative institutional placements. These estimates, calculated by the Department of Medical Assistance Services (DMAS) for SFY 2009 using data for the same individuals counted in the table above, appears in the table below.

**COST ESTIMATES OF ALTERNATIVE PLACEMENTS  
FOR INDIVIDUALS SERVED BY MEDICAID HCBS WAIVERS IN SFY 2009**

<b>Alternative Placement Institution</b>	<b>Applicable Waivers</b>	<b>Estimated Number Served</b>	<b>Estimated Per Capita Cost</b>
Nursing Home/Facility	Alzheimer's, EDCD, and HIV/AIDS	24,406	\$51,428
Intermediate Care Facility for Persons with Mental Retardation (ICF-MR)	Day Support and ID	1,897	\$168,532
Specialized Care Nursing Facility or Long-Stay Hospital	Tech	172	\$185,558

Source: Department of Medical Assistance Services (DMAS).

It must be emphasized that future Medicaid enrollment and costs are difficult to project since numerous variables are beyond the control of the Commonwealth and its Department of Medical Assistance Services (DMAS). The duration and full impact of the current recession is unknown, as are future shifts in Medicaid policy and regulations and the implications of federal health care reform, most notably the *Patient Protection and Affordable Care Act* mentioned briefly in this chapter's introduction and in more detail in this assessment's Health Care chapter. Other variables affecting Medicaid in Virginia will include growth in the elderly population, especially those with chronic health conditions; an increase in the number of individuals with disabilities, new requirements such as electronic medical records; and continuing increases in health care costs. Regarding the latter, a 2010 presentation by the Congressional Budget Office (CBO) to the Institute of Medicine, titled *Health Costs and the Federal Budget*, noted that per capita health care costs rose faster than per capita gross domestic product during the past decade and that rising costs per enrollee will have the most long-term impact on Medicaid spending.

## **F. Monitoring and Evaluation of Medicaid Expenditures**

As administrator of the state's Medicaid program, the **Department of Medical Assistance Services (DMAS)** is responsible for ensuring that taxpayer funds are spent wisely and efficiently. To do so, it has established internal fiscal processes and an extensive "real time"

database for monitoring expenses and guaranteeing legal and regulatory compliance. It has also maintained a very lean administration, reducing administrative costs from 2.36 percent of expenditures in 1999 to 1.7 percent in 2009. In addition to improved administrative productivity, the DMAS emphasis on cost effectiveness has included initiatives such as:

- Cost-containment for pharmaceuticals,
- Fraud prevention,
- More effective data systems,
- An enhanced Help Line and expanded online and electronic systems for service pre-authorization and claims submission, and
- Expansion of managed care and integration of acute and long-term care.

The DMAS Commissioner is required to certify annually to the Virginia **Department of Accounts (DOA)** and **Auditor of Public Accounts (APA)** that the agency's internal control system has been maintained and evaluated, and both the DOA and APA conduct external reviews to ensure the integrity of all DMAS fiscal processes. As a part of its reviews, the APA develops an annual report on all of the state's Health and Human Resources agencies. In its January 2010 report, the most recent, the APA not only had no audit "findings" for DMAS, it gave an "unqualified opinion" on the agency's 2009 financial statements. In laymen's terms, this meant that the fiscal information was represented fairly in accordance with generally accepted accounting principles and was free from material misstatements.

As the state's Medicaid administrator, DMAS also approves, contracts, or otherwise arranges for other entities to conduct most screening, case management, service, and billing-related activities. While others may be the direct providers of these activities, DMAS remains ultimately responsible for ensuring that:

- The full scope of Medicaid services is available for covered individuals,
- An adequate supply of qualified providers has been enrolled in the program to meet their demand and offer them a choice of providers,
- Services paid for by Medicaid are of good quality and are added or changed as needed to protect recipients' health, safety, and welfare, and
- All providers operate in compliance with state and federal laws and regulations.

To comply with federal regulations, DMAS conducts periodic quality management reviews and evaluations of all programs and services paid for by the publicly funded insurance programs that it administers, including their utilization by both providers and recipients. This includes surveying service recipients and providers to determine the quality and responsiveness of those programs and services. Additional compliance reviews occur whenever it is indicated that providers are delivering services in excess of or outside of established norms and after receipt of complaints from agencies or individuals. Results of these quality assurance activities reported to the administration, legislative committees, federal oversight agencies, and the public

at-large by DMAS cover enrollment and expenditure trends, survey outcomes, and the programs' success in reaching appropriate participants, including people with disabilities. Many of those reports are cited throughout the chapters of this assessment.

DMAS uses a prior authorization process, program integrity activities, and audits of paid provider claims to ensure proper payments. Prior authorization determines that services are medically necessary before they are approved for reimbursement, and providers participating in Medicaid must ensure that requirements for services rendered are met in order to receive payment. Then before any payment is made, DMAS reviews eligibility of providers and ensures that the payment is for an eligible recipient, the appropriate service, and the correct amount.

Under their required Medicaid participation agreements, providers must make records and facilities available in response to reasonable requests for access from DMAS representatives, the Attorney General of Virginia and his or her authorized representatives, and authorized federal personnel or designees. When potential fraud by a provider is identified, DMAS refers the information to the state's **Medicaid Fraud Control Unit of the Office of the Attorney General (OAG)** for prosecution. Similarly, when fraud by a recipient is identified, the local Commonwealth Attorney is notified. The state Department of Social Services (DSS) and local social services departments are involved with investigation of potential recipient fraud as well. The OAG Medicaid Fraud Control Unit's report for state fiscal year (SFY) 2010 stated that the unit achieved 13 legal convictions and total recoveries of \$25,390,467 from criminal and civil investigations that year, and recoveries have averaged \$198,032,584 annually for the past three years.

The 2010 General Assembly (HJR 127) tasked the **Joint Legislative Audit and Review Commission (JLARC)** to study and report on the nature and extent of fraud, waste, abuse, and inefficiency in Virginia's Medicaid program and compare Virginia's activities to address these problems with those of other states. JLARC's Interim Report: *Fraud and Error in Virginia's Medicaid Program* (<http://jlarc.state.va.us/reports/Rpt404.pdf>) was released in December 2010 and identified the following most frequent types of improper Medicaid payments:

- Using incorrect medical codes,
- Failing to bill a third party such as Medicare,
- Billing for an item or service without adequate documentation,
- Billing for medically unnecessary services, and
- Billing for costs or services not reimbursable under Medicaid.

The interim report further notes that improper Medicaid payments in state fiscal year (SFY) 2009 totaled \$38.9 million, of which 52 percent (\$20,220,016) was attributable to fraud and the remainder to errors, mostly provider claim errors. For that year, DMAS avoided up to \$50.3 million in potentially fraudulent or incorrect claims by blocking improper claims before they were paid. While its report acknowledged the multiple methods already in use by DMAS, JLARC found that the case sample used by DMAS and DSS for Medicaid Eligibility Quality

Control (MEQC) reviews was not sufficiently large enough to ensure that provider reimbursement claims are valid. JLARC recommended that DMAS and DSS initiate a pilot project to better identify error rates in eligibility determination by local social services departments and report their findings by October 1, 2011.

The **Office of Licensure and Certification (OLC) of the Virginia Department of Health (VDH)** is responsible for licensing, monitoring, and managing compliance for a wide range of public and private health care facilities and service providers such as hospitals, outpatient clinics, nursing facilities, hospice programs, home care organizations, certain laboratories, and other testing facilities. OLC is also responsible for certification of managed care health insurance plans, and under Titles XVIII and XIX of the federal *Social Security Act*, it is the state's official certification agency for service providers eligible for reimbursement under Medicaid and Medicare. Specific certification, inspection, monitoring, and compliance requirements, set by federal regulation, vary by type of service. Details, as well as procedures for submitting and resolving service complaints, can be found at [www.vdh.virginia.gov/olc](http://www.vdh.virginia.gov/olc), and information on OLC's quality assurance activities for direct services for people with disabilities can be found in the Community Supports and Institutional Services chapters of this assessment.

For Virginia's **Medicaid Home and Community Based Services (HCBS) Waivers**, DMAS conducts **Quality Management Reviews (QMRs)** to ensure the health, safety, and welfare of waiver service recipients and ensure compliance with federal and state regulations. Because of waiver differences, DMAS review processes are specific to each waiver. For waivers that cover case management or support coordination services, DMAS monitors whether individuals are eligible for waiver-specific services, whether those individuals have an appropriate Individualized Service Plan (ISP) based on a comprehensive, regular assessment of their needs, and whether services are being delivered, reviewed, and modified as required by their plans. It also reviews provider qualifications, checks whether services are consistent with billing limitations and documentation of need, and conducts annual level of care reviews. Following completion of a review, DMAS staff share findings with a provider in an "exit conference" that includes technical assistance and education. A written report of DMAS findings is also sent to the provider. Providers not in compliance may face a variety of sanctions including repayments to DMAS or termination of their provider agreements.

While DMAS is ultimately responsible for ensuring the health, safety, and welfare of Medicaid service recipients, regardless of whether it contracts out administration or management of those services, the **Department of Behavioral Health and Developmental Services (DBHDS)** is responsible for ensuring that its licensees comply with safety, quality, human rights, and other relevant policies and regulations. This includes additional oversight for the Day Support and Intellectual Disability (ID) Waivers administered by DBHDS. Staff members from its Office of Developmental Services periodically review ISPs for persons receiving services through those two waivers, whether those services are provided by local Community Services Boards (CSBs), other public providers, or private nonprofit or for-profit providers.

In addition, DBHDS Community Resource Consultants monitor the new two-tiered ID Waiver slot assignment process described earlier to ensure statewide consistency. Each time a CSB assigns available ID Waiver slots, it must send its assigned consultant a copy of the computer spreadsheet identifying the individuals to whom the slots were assigned and listing the Critical Needs Summary scores for all individuals on the CSB's urgent waiting list considered during each tier of the assignment process. The consultant then confirms that the correct individuals were considered by the Waiver Slot Assignment Committee and received the available slots. The consultants also provide periodic training and technical assistance for case managers and service providers as a part of their regular operations, at the request of a provider, or in response to problems identified by the DBHDS Office of Licensing or DMAS Quality Management Review staff.

Over the past two years, a major concern for DBHDS has been the need to develop a data system that will enable it to gather information on critical incidents in such a manner that it can be analyzed for patterns and trends. The results of this analysis would improve decision-making about changes in policies, monitoring, and training to enhance the department's overall performance and reporting to the federal Centers for Medicare and Medicaid (CMS).

## **G. Medicaid Sources Referenced in This Chapter**

Links to websites and online documents reflect their Internet addresses in March 2011. Some documents retrieved and utilized do not have a date of publication.

### **Websites:**

Code of Federal Regulations (CFR):

[www.gpoaccess.gov/cfr/index.html](http://www.gpoaccess.gov/cfr/index.html)

Kaiser Family Foundation:

[www.kff.org](http://www.kff.org)

State Health Facts:

[www.statehealthfacts.org](http://www.statehealthfacts.org)

National Academy for State Health Policy:

[www.nashp.org](http://www.nashp.org)

Office of the Attorney General for Virginia:

[www.vaag.com](http://www.vaag.com)

Medicaid Fraud Control Unit:

[www.vaag.com/consumer/medicaid\\_fraud/index.html](http://www.vaag.com/consumer/medicaid_fraud/index.html)

Office of the Inspector General for Behavioral Health and Developmental Services,  
Commonwealth of Virginia:

[www.oig.virginia.gov](http://www.oig.virginia.gov)

OIG Reports – DBHDS Operated Facilities:

[www.oig.virginia.gov/rpt-Facilities.htm](http://www.oig.virginia.gov/rpt-Facilities.htm)

Office of the Secretary of Health and Human Services (SHHR), Commonwealth of Virginia:

[www.hhr.virginia.gov](http://www.hhr.virginia.gov)

Health Reform Initiative:

[www.hhr.virginia.gov/Initiatives/HealthReform](http://www.hhr.virginia.gov/Initiatives/HealthReform)

Systems Transformation initiatives:

[www.hhr.virginia.gov/Initiatives/SystemsTransformation](http://www.hhr.virginia.gov/Initiatives/SystemsTransformation)

Partnership for People with Disabilities, Virginia Commonwealth University:

Systems Transformation Grant Resource Bank:

[www.vcu.edu/partnership/cdservices/pcprb.htm](http://www.vcu.edu/partnership/cdservices/pcprb.htm)

Robert Wood Johnson Foundation, National Academy for State Health Policy:

Maximizing Enrollment for Kids:

[www.maxenroll.org](http://www.maxenroll.org)

U.S. Centers for Medicare and Medicaid (CMS):

[www.cms.gov](http://www.cms.gov)

Children's Health Insurance Program (CHIP):

[www.cms.gov/home/chip.asp](http://www.cms.gov/home/chip.asp)

Medicaid:

[www.cms.gov/home/medicaid.asp](http://www.cms.gov/home/medicaid.asp)

Virginia Department of Behavioral Health and Developmental Services (DBHDS):

[www.dbhds.virginia.gov](http://www.dbhds.virginia.gov)

Intellectual Disability (ID) Waiver Services:

[www.dbhds.virginia.gov/ODS-MRWaiver.htm](http://www.dbhds.virginia.gov/ODS-MRWaiver.htm)

Office of Developmental Services:

[www.dbhds.virginia.gov/ODS-default.htm](http://www.dbhds.virginia.gov/ODS-default.htm)

Virginia Department of Health (VDH):

[www.vdh.virginia.gov](http://www.vdh.virginia.gov)

Division of Long-Term Care:

[www.vdh.virginia.gov/OLC/LongTermCare](http://www.vdh.virginia.gov/OLC/LongTermCare)

Laws, Regulations & Guidelines:

[www.vdh.virginia.gov/OLC/Laws/index.htm](http://www.vdh.virginia.gov/OLC/Laws/index.htm)

Office of Licensure & Certification:

[www.vdh.virginia.gov/olc](http://www.vdh.virginia.gov/olc)

Virginia Department of Medical Assistance Services (DMAS):

[www.dmas.virginia.gov](http://www.dmas.virginia.gov)

Appeals Division:

[www.dmas.virginia.gov/app-home.htm](http://www.dmas.virginia.gov/app-home.htm)

Long-Term Care & Waiver Services:

[http://dmasva.dmas.virginia.gov/Content\\_pgs/ltc-home.aspx](http://dmasva.dmas.virginia.gov/Content_pgs/ltc-home.aspx)

Maternal and Child Health Programs:

[http://dmasva.dmas.virginia.gov/Content\\_pgs/mch-home.aspx](http://dmasva.dmas.virginia.gov/Content_pgs/mch-home.aspx)

Smiles for Children:

[www.dmas.virginia.gov/dental-enrollees.htm](http://www.dmas.virginia.gov/dental-enrollees.htm)

## Virginia Department of Social Services (DSS):

[www.dss.virginia.gov](http://www.dss.virginia.gov)

## About Medical Assistance Programs:

[www.dss.virginia.gov/benefit/medical\\_assistance/index.cgi](http://www.dss.virginia.gov/benefit/medical_assistance/index.cgi)

## FAQs About Medical Assistance:

[www.dss.virginia.gov/files/division/bp/medical\\_assistance/Intro-page/faq/eligibility.pdf](http://www.dss.virginia.gov/files/division/bp/medical_assistance/Intro-page/faq/eligibility.pdf)

## Medicaid Forms/Processes:

[www.dss.virginia.gov/benefit/medical\\_assistance/forms.cgi](http://www.dss.virginia.gov/benefit/medical_assistance/forms.cgi)

## Virginia General Assembly:

<http://legis.state.va.us/homepage.html>

*Code of Virginia:*

<http://leg1.state.va.us/cgi-bin/legp504.exe?000+cod+TOC>

## State 2011 Budget:

<http://leg2.state.va.us/MoneyWeb.NSF/sb2011>

## Virginia Administrative Code:

<http://leg1.state.va.us/cgi-bin/legp504.exe?000+men+SRR>

**Documents:**

Brown, Richard D., Secretary of Finance, Commonwealth of Virginia. (August 19, 2010).

*Review of General Fund Revenues and the Virginia Economy for Fiscal Year 2010.* A presentation to the Senate Finance, House Appropriations, and House Finance Committees. Richmond, Virginia. Retrieved from:

<http://sfc.virginia.gov/archives/2010/2010committeemeetings.shtml>.

Elmendorf, Douglas, U.S. Congressional Budget Office (CBO). (May 26, 2010). *Presentation*

*to the Institute of Medicine: Health Costs and the Federal Budget.* Washington, D.C.

Retrieved from: [www.cbo.gov/ftpdocs/115xx/doc11544/Presentation5-26-10.pdf](http://www.cbo.gov/ftpdocs/115xx/doc11544/Presentation5-26-10.pdf).

Finnerty, Patrick, Director, Virginia Department of Medical Assistance Services (DMAS).

(October 22, 2009). *Update on Medicaid Issues.* Presentation to the Senate Finance Committee of the Virginia General Assembly. Richmond, Virginia. Retrieved from:

<http://sfc.virginia.gov/archives/2009/2009committeemeetings.shtml>.

Joint Legislative Audit and Review Commission (JLARC) of the Virginia General Assembly.

(October 12, 2010). *Interim Report: Fraud and Error in Virginia's Medicaid Program* (Draft). Richmond, Virginia: Retrieved from:

<http://jlarc.virginia.gov/meetings/October10/Medicaid.pdf>.

Joint Legislative Audit and Review Commission (JLARC) of the Virginia General Assembly.

(October 12, 2010). *Interim Report: Fraud and Error in Virginia's Medicaid Program.* Richmond, Virginia. Briefing by Hal Greer, Deputy Director. Retrieved from:

<http://jlarc.virginia.gov/meetings/October10/Medicaidbrf.pdf>.

Joint Legislative Audit and Review Commission (JLARC) of the Virginia General Assembly.

(2010). *Virginia Compared to Other States: National Rankings on Taxes, Budgetary Components, and Other Indicators, 2010 Edition.* Richmond, Virginia. Retrieved from:

<http://jlarc.state.va.us/reports/rpt396.pdf>.

- Joint Legislative Audit and Review Commission (JLARC) of the Virginia General Assembly. (2011). *Virginia Compared to Other States: National Rankings on Taxes, Budgetary Components, and Other Indicators, 2011 Edition*. Richmond, Virginia. Retrieved from: <http://jlarc.state.va.us/reports/rpt410.pdf>.
- Kaiser Family Foundation, Kaiser Commission on Medicaid and the Uninsured. (2010). *Medicaid: A Primer*. Washington, D.C. Retrieved from: [www.kff.org/medicaid/7334.cfm](http://www.kff.org/medicaid/7334.cfm).
- Kaiser Family Foundation, Kaiser Commission on Medicaid and the Uninsured. (February 2010). *State Fiscal Conditions and Medicaid*. Washington, D.C. Retrieved from: [www.kff.org/medicaid/upload/7580-06.pdf](http://www.kff.org/medicaid/upload/7580-06.pdf).
- Kaiser Family Foundation, Kaiser Commission on Medicaid and the Uninsured. (2010). *State Profile: Virginia*. Washington, D.C. Retrieved from: [www.statehealthfacts.org/profileglance.jsp?rgn=48&rgn=1](http://www.statehealthfacts.org/profileglance.jsp?rgn=48&rgn=1).
- Massart, Susan E. (November 17, 2010). *Costs and Trends in the Virginia Medicaid Program*. Presentation to the House Appropriations Committee of the Virginia General Assembly. Richmond, Virginia. Retrieved from: [http://hac.virginia.gov/Committee/files/2010/11-17-10/VA\\_%20Medicaid\\_Program\\_Costs\\_and\\_Trends.pdf](http://hac.virginia.gov/Committee/files/2010/11-17-10/VA_%20Medicaid_Program_Costs_and_Trends.pdf).
- Office of the Attorney General for Virginia, Medicaid Fraud Control Unit. (2010). *Medicaid Fraud Control Unit's 2010 Annual Report*. Richmond, Virginia. Retrieved from: [www.oag.state.va.us/CONSUMER/MEDICAID\\_FRAUD/MedicaidFraud\\_Annual\\_Report10.pdf](http://www.oag.state.va.us/CONSUMER/MEDICAID_FRAUD/MedicaidFraud_Annual_Report10.pdf).
- Schneider, A.; Elias, R., and Garfield, R. (eds.), Kaiser Family Foundation, Kaiser Commission on Medicaid and the Uninsured. (2002). *The Medicaid Resource Book*. Washington, D.C. Retrieved from: [www.kff.org/medicaid/2236-index.cfm](http://www.kff.org/medicaid/2236-index.cfm).
- United Cerebral Palsy. (2010). *A Case for Inclusion: An Analysis of Medicaid for Americans with Intellectual and Developmental Disabilities*. Washington, D.C. Retrieved from: <http://medicaid.ucp.org/download.php>.
- Virginia Department of Behavioral Health and Developmental Services (DBHDS). (November 2007). *Comprehensive State Plan, 2008-2014*. Richmond, Virginia. Retrieved from: [www.dbhds.virginia.gov/documents/reports/opd-StatePlan2010thru2016.pdf](http://www.dbhds.virginia.gov/documents/reports/opd-StatePlan2010thru2016.pdf).
- Virginia Department of Behavioral Health and Developmental Services (DBHDS). (December 2008). *Comprehensive State Plan, 2010-2016*. Richmond, Virginia. Retrieved from: [www.dbhds.virginia.gov/documents/reports/opd-StatePlan2010thru2016.pdf](http://www.dbhds.virginia.gov/documents/reports/opd-StatePlan2010thru2016.pdf).
- Virginia Department of Behavioral Health and Developmental Services (DBHDS). (2009). *Navigating the MR Waiver: A Workbook for Families* (PowerPoint). Retrieved from: [www.dbhds.virginia.gov/ODS-MRWaiver.htm](http://www.dbhds.virginia.gov/ODS-MRWaiver.htm).
- Virginia Department of Behavioral Health and Developmental Services (DBHDS), Office of Developmental Services. (August 5, 2010). *Intellectual Disability Waiver Slot Assignment Process*. Richmond, Virginia. Retrieved from: [www.dbhds.virginia.gov/documents/ODS/ods-wvr-Slot-AssignProcess.pdf](http://www.dbhds.virginia.gov/documents/ODS/ods-wvr-Slot-AssignProcess.pdf).
- Virginia Department of Behavioral Health and Developmental Services (DBHDS), Office of Developmental Services. (2009). *Request for Renewal for a §1915(c) Home and Community-Based Services Waiver*. Application to the U.S. Centers for Medicare and

- Medicaid. Richmond, Virginia. Retrieved from: [www.dbhds.virginia.gov/documents/ODS/omr-WaiverApplication-1915\(c\)-HCBS-Waiver-VA\\_0372\\_R02\\_00-Jul-01-09.htm](http://www.dbhds.virginia.gov/documents/ODS/omr-WaiverApplication-1915(c)-HCBS-Waiver-VA_0372_R02_00-Jul-01-09.htm).
- Virginia Department of Medical Assistance Services (DMAS). (2010). *Agency Strategic Plan, 2010-2012*. Richmond, Virginia. Retrieved from: <http://vaperforms.virginia.gov/agencylevel/stratplan/spReport.cfm?AgencyCode=602>.
- Virginia Department of Medical Assistance Services (DMAS). (December 2006). *Blueprint for the Integration of Acute and Long-Term Care Services*. Richmond, Virginia. Retrieved from: [http://dmasva.dmas.virginia.gov/Content\\_pgs/altc-home.aspx](http://dmasva.dmas.virginia.gov/Content_pgs/altc-home.aspx).
- Virginia Department of Medical Assistance Services (DMAS). (2006). *Issue Brief: The Future Direction of Medicaid Long Term Care Services in Virginia*. Richmond, Virginia. Retrieved from: [http://dmasva.dmas.virginia.gov/Content\\_pgs/altc-home.aspx](http://dmasva.dmas.virginia.gov/Content_pgs/altc-home.aspx).
- Virginia Department of Medical Assistance Services (DMAS). (January 2010). *Medicaid and FAMIS-Plus Handbook*. Richmond, Virginia. Retrieved from: [http://dmasva.dmas.virginia.gov/Content\\_atchs/atchs/medbook-eng.pdf](http://dmasva.dmas.virginia.gov/Content_atchs/atchs/medbook-eng.pdf).
- Virginia Department of Medical Assistance Services (DMAS). (September 2009) *Plan for the Elimination of Waiting Lists under Medicaid: Intellectual Disabilities and Individual and Family Developmental Disabilities Supports Waivers (RD 216)*. Richmond, Virginia. Retrieved from: [www.dmas.virginia.gov/ab-studies\\_reports.htm](http://www.dmas.virginia.gov/ab-studies_reports.htm).
- Virginia Department of Medical Assistance Services (DMAS). (January 2009). *The Virginia Medicaid Program At-a-Glance*. Richmond, Virginia. Retrieved from: [www.dmas.virginia.gov/downloads/pdfs/ab-VA\\_MedPrgAtGlance.pdf](http://www.dmas.virginia.gov/downloads/pdfs/ab-VA_MedPrgAtGlance.pdf).
- Virginia Department of Medical Assistance Services (DMAS). (January 2010). *The Virginia Medicaid Program At-a-Glance*. Richmond, Virginia. Retrieved from: [www.virginiamanagedcare.com/English/pdfs/Medicaid%20At%20a%20Glance%20091510.pdf](http://www.virginiamanagedcare.com/English/pdfs/Medicaid%20At%20a%20Glance%20091510.pdf).
- Virginia Department of Medical Assistance Services (DMAS). (July 2007). *Virginia's Medicaid Waivers for Persons with Disabilities, Their Parents and Caregivers*. Richmond, Virginia. Retrieved from: [http://dmasva.dmas.virginia.gov/Content\\_atchs/ltc/ltc\\_md\\_waiver.pdf](http://dmasva.dmas.virginia.gov/Content_atchs/ltc/ltc_md_waiver.pdf).
- Virginia Department of Medical Assistance Services (DMAS), Division of Long-Term Care. (August 2009). *A Guide for Long-Term Care Services in Virginia*. Richmond, Virginia. Retrieved from: [http://dmasva.dmas.virginia.gov/Content\\_atchs/ltc/ltc-guide\\_srvcs.pdf](http://dmasva.dmas.virginia.gov/Content_atchs/ltc/ltc-guide_srvcs.pdf).