



COMMONWEALTH OF VIRGINIA
Virginia Board for People with Disabilities

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TO: Human Services Research Institute (HSRI)

FROM: Heidi L. Lawyer

CC: Olivia Garland, Deputy Commissioner
Department of Behavioral Health and Developmental Services

RE: Medicaid Waivers Redesign

I am writing on behalf of the Virginia Board for People with Disabilities (the Board) to provide written comment on redesign of the three Medicaid Waivers managed by the Department of Behavioral Health and Developmental Services (DBHDS): the Intellectual Disability (ID) Waiver; the Individual and Family Developmental Disabilities (DD) Waiver and the Day Support Waiver. Two Board staff attended the Comment Forum in Colonial Heights and were impressed by both the level of attendance and the amount of feedback gathered in a short period. We also had the opportunity to participate in an interview with HSRI representatives. The Board has had a long interest in Waiver reform, and wishes to take this opportunity to make additional comments.

The Board has made recommendations to improve the Waivers and related services in each of the three editions (2006, 2008, & 2011) of our comprehensive report, *Assessment of the Disability Services System in Virginia*. In each edition, a consistent recommendation has been that Virginia develop a comprehensive, "universal" waiver based on functional criteria rather than diagnosis. The DBHDS effort to revise the three waivers is a critical step towards that goal. In the long run, a universal waiver can be easier for the public to understand and use as well as more efficient to administer, operate and monitor.

The Board's comments are organized by the heading used at the Comment Forums held by HSRI, which are preceded by key concepts and principles for the redesign.

Recommended Key Waiver Redesign Concepts

The newly designed Waiver must support the vision of community inclusion, citizenship, opportunity, and full participation aspired to in the Department of Justice Settlement Agreement. Features and content of the new waiver should be flexible and result in: promotion of self-direction, individual autonomy, choice and consumer control; effective use of all available resources, including natural and community supports; and creation of a unique, individualized service package that meets his or her needs across the lifespan. The new waiver should better enable Individuals with ID/DD to live the life that they want to live, not one based on what a provider can accommodate. Please refer to the policy principles espoused by the Board in its *Benchmarks for Evaluating Public Policy in Virginia* <http://www.vaboard.org/downloads/VBPD BenchmarksPagebyPage.pdf>.

The Board strongly supports creation of a **single robust, comprehensive “DD Waiver”** from the current three waivers (ID, DD and Day Support) to serve all Virginians with ID/DD, regardless of the complexity, or evolution over time, of their support needs. All services currently in these waivers should be available to those who choose and need that service, including group sponsored residential, small group home (after being given information another support options), and family caregiver training. Although the Elderly and Disabled with Consumer Direction (EDCD) Waiver is not part of the redesign, consideration must be given of the numerous individuals with ID/DD who now receive services under that that Waiver and may or may not be on the ID and DD Waiver wait lists. Many individuals who are on the DD or ID Waiver wait lists may be eligible to receive services from the ED CD waiver, but are unaware of their eligibility. In effect, the ED CD Waiver functions as a support waiver and cannot be ignored as consolidation and redesign are undertaken.

As stated in previous Board *Assessments*, accountability for service quality and effectiveness is essential not only to better individual outcomes and safety but also to ensure prudent use of taxpayer funds. Individuals with ID/DD and their families need reliable, knowledgeable, skilled assistance in navigating the service system across the lifespan. Improved methods for individuals to have complaints or problems addressed are indicated and would assist DBHDS in identifying and resolving problem areas. DBHDS quality assurance/improvement processes and oversight of case management (and when/if applicable, service facilitation) will be needed on an ongoing basis.

The Board additionally recommends that the new waiver design process continue to be transparent: a draft of the new waiver should be made available for public comment prior to application submission to CMS. Communication to stakeholders regarding the rationale for changes as well as implementation plans will be needed. It is also important that fiscal studies of the impact from Waiver redesign should address cost avoidance such as nursing home of ICF/ID diversion.

Waiver Eligibility & Access

Having both the ID and DD Waiver currently results in a bifurcated **definition of developmental disability**. The new Waiver should eliminate this bifurcation by eliminating the requirement to obtain, or rule out, the diagnosis of intellectual disability. An intellectual disability is a developmental disability (one of many), and having a diagnosis of DD should be adequate to determine eligibility. Criteria should be based on functional level of impairments, not diagnosis beyond that of developmental disability.

Eligibility assessment tools. The Universal Assessment Instrument (UAI, used for the EDCD Waiver), the Level of Functioning (LOF, used for the DD and ID waivers) and the Supports Intensity Scale (SIS, used with individuals who have intellectual disabilities) as well as the current processes for eligibility pre-screening should be carefully examined not only for reliability and validity, but also for appropriateness for and consistency with principles of person-centered services.

The current organizational conflict of interest with respect to screening, assessment, eligibility, and service delivery must be eliminated. Eligibility determination should not be made by the same entity that provides case management; case managers and service providers should not be involved in decisions on who obtains a waiver slot or be able to refer to their providers' own services. Once determined eligible for the new DD waiver, individuals should be fully informed of provider choice options, including choice in case management as is currently provided for in the DD Waiver.

Waiver Wait Lists: Ideally, Virginia would fund Medicaid so that all those now on the ID or DD wait list would be awarded a slot or otherwise receive services. That level of funding is not likely at the present time. Waiting list processes and criteria therefore need to be reconsidered, to include review of methods used in other states, to determine the best way to ensure that those individuals with the greatest need are served first on a statewide basis. Having thousands of people on an "Urgent" Waiver wait list for long periods of time weakens the credibility of the current method. Development of a clearer hierarchy of needs as well as emergency criteria is indicated. After a review of past allocations, a percentage of the Waiver slots each year should be set aside for emergency cases as well as for individuals in the hospital or other acute care settings as part of nursing home/institutional diversion.

Individualized Budgets. Medicaid HCBS policy recognizes two basic types of self-direction: employer authority and budget authority. Participants exercising employment authority are authorized to hire, fire, and supervise personal support workers. The more comprehensive form of self-direction, referred to by CMS as budget authority, allows participants to purchase goods and services as well as supervise personal support workers and manage expenditures within the limits of a specified budget allocation. Currently VA Waivers offer consumer direction which, as designed and managed, falls in the employment authority definition.

The National Council on Disability, in its report *The Case for Medicaid Self-Direction: A White Paper on Research, Practice and Policy Opportunities* <http://www.ncd.gov/publications/2013/05222013A/>, describes the budget authority model (often referred to as individualized budgets) as one where participants are allowed to use their funding allotment to not only hire personal support workers, but also to purchase other goods or services designed to meet disability-related needs. Some of these goods and services may substitute for human assistance or otherwise enhance the individual's independence (e.g., assistive technology, home modifications, transportation services, laundry services, meal services, and personal care supplies). Participant-directed goods and services usually include items that would not be covered under traditional home and-community-based (HCBS) programs and that may be purchased from non-traditional sources. The Waiver design study should include an in-depth and comprehensive review of state models of implementation and outcomes of individualized budgets.

Virginia's new DD Waiver should be one that addresses today's needs but also the needs of a service system that is building increased capacity and competency in the years to come. The new Waiver should reflect opportunities for increased individual control of service dollars and budgets. Prior to implementation, pilot projects of the most promising models for Virginia should be funded to avoid known and identify unexpected problems or misuse of resources. Individualized budgets in the Waiver should not be funded to serve in effect as a supports waiver with low fixed caps on service plan authorization amounts that don't meet the service and support needs of recipients.

Waiver Services & Service Delivery

Case Management: As mentioned previously, the new system should require choice in case management, not only within providers but between providers (public and private). The National Council on Disability (NCD) endorses these core characteristics of conflict-free case management (which were identified in the Balanced Incentive Program guidelines and regulations for long term care by the Centers for Medicare and Medicaid Services):

- ✓ *"Responsibility for providing case management services is separate from responsibility for providing direct services and supports. Case managers are not employed by the entity providing services. Case managers are not responsible for determining individual funding levels.*
- ✓ *Persons performing evaluations and assessments or developing individual plans of care cannot be related by blood or marriage to the individual or any of the individual's paid caregivers."*

The role of case managers should be to effectively coordinate service provision in collaboration with the individual and their family. Doing so requires up-to-date knowledge of state, regional and local resources that can support the individual, and a true understanding and commitment to the culture of person centeredness, community integration, and community inclusion.

Service facilitation, while important under the EDCD waiver because there is no case management support, should be optional for the new comprehensive waiver as it now is for the ID waiver. Service facilitation can be provided by the case managers under the new waiver; and in cases in which services are stable, service facilitation can be redundant and constitute wasteful Medicaid spending as well as unnecessary intrusion for service recipients. Whether optional or required, if service facilitation is maintained under the new waiver, there must be increased efforts on training and quality improvement of the service facilitation service. Currently, numerous anecdotal reports indicate that the quality of service facilitation is extremely uneven and variable.

Dental Coverage/Services. The new Waiver should cover routine preventative dental services for adults. This can result in reduced Medicaid expenditures over time through: avoiding more invasive, expensive procedures that might have been prevented through routine dental care and avoiding emergency room use for dental problems. The state Joint Commission on Health Care this year conducted a study on policy options for doing so under the Medicaid State Plan, and will be making recommendations for legislative action later this fall.

Live-In Caregiver. As mentioned under Key Concepts, the new Waiver needs to be flexible enough to allow for a variety of living and support options. One enhancement to Virginia's new Waiver, which would allow for such flexibility, is the inclusion of the Live-In Caregiver provision in the Waiver design and application (See section 441.310, 2.ii, Code of Federal Regulations):

2) The cost of room and board except when provided as—(i) Part of respite care services in a facility approved by the State that is not a private residence; or (ii) For waivers that allow personal caregivers as providers of approved waiver services, a portion of the rent and food that may be reasonably attributed to the unrelated caregiver who resides in the same household with the waiver beneficiary. FFP for a live-in caregiver is not available if the beneficiary lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services (the caregiver). For purposes of this provision, "board" means 3 meals a day or any other full nutritional regimen and does not include meals provided as part of a program of adult day health services as long as the meals provided do not constitute a "full" nutritional regimen

The Live-in Caregiver provision allows Medicaid reimbursement for a portion of the costs of room and board for a live-in care giver in an individual's own home. Including the Live-In Caregiver provision in the redesigned Waiver provides increased flexibility to accommodate individual choices and circumstances and promotes community integration.

Environmental Modifications. The new DD Waiver should allow an individual's environmental modification dollars to be used to improve accessibility and other needed modifications in their chosen living environment, including small group homes. (See funding section below for additional information on this.) Doing so could improve available housing so individuals may "age in place" as needs change and increase the accessibility of current homes.

Cost/Rates/Funding

Current Waiver reimbursement rates are arbitrarily set and do not reflect the reasonable, customary reimbursement for the costs of providing services. The current Waiver rate structure does not take into account individual living choices, needs, or natural and community supports. Reimbursement should reflect the costs of providing the Waiver services. Rates should allow for reimbursement for general supervision during overnight hours and during hospitalizations when a provider must have staff at the hospital. They cannot be reimbursed under the current system. Rates should incentivize inclusive —not segregated— options not only for residences but also for competitive work (rather than day support or sheltered workshops). Providers should not be penalized for providing person centered services that promote social and family relationships and employment

Consistent with the goals outlined in the Department of Justice (DOJ) Settlement Agreement, the new Waiver should incentivize in-home supports and separation of housing and services. While this concept may be new to some service providers or some people receiving ID Waiver services, individuals receiving DD Waiver services have been using these services to live in their own apartments or homes for years. This is not a new model and should not be promoted as such. DD Waiver recipients, case managers, and providers can help educate state and local agencies and providers on how this has been successfully done.

Medicaid reimbursement rates for complex **dental care** now covered for adults, such as surgical procedures, remain below the costs for such services: specialized equipment, instruments, or staff with additional training are needed in such instances, and dental practices may experience higher liability insurance rates for providing complex procedures. Medicaid reimbursement rates should be set at levels that cover the costs of any dental services for individuals with disabilities. Additionally, funding should be made available for preventative and routine dental services, which takes into account staff training and extra time needed to deliver the dental care and education appropriately. As reported to the Commonwealth's Joint Commission on Health Care this month, routine dental care can generate cost saving to the Medicaid program by preventing use of Emergency Rooms to address tooth infection or pain resulting from lack of regular teeth cleaning and care.

Service Caps. Arbitrary service or financial caps should be avoided. Examination of funding caps for current Waiver services that promote independent living and "aging at home" (such as assistive technology or environmental modifications) should be conducted to ensure appropriate levels exist. An

essential part of such examination is a longer view cost/benefit analysis which considers the cost-avoidance of institutional or more labor intensive services. An individual may need \$10,000 in environmental modifications, rather than the current \$5,000 cap, in order to successfully live in the community and avoid more expensive settings or labor intensive supports.

Relatedly, as technology continues to improve, funding for technology (e.g., “smart” homes) that promotes aging in place, independence and inclusion should be available. New waiver design and funding should enable individuals with ID/DD to receive the services/supports that they need, no more and no less, in a timely fashion and be flexible and responsive to functional changes over time that are natural to aging.

At the same time, services should only be authorized for as long as they appear to be efficacious. For example, some individuals receive “pre-vocational” services for years. Pre-vocational services are meant to be time limited with the goal of moving an individual into employment. After a reasonable period of time, an individual should be employed if they choose to be or, if they do not desire or are unable to obtain employment, the pre-vocational service should be ended and the individual should receive the supports needed to participate in activities that are meaningful to him or her.

Leveraging Available Resources and Opportunities: During implementation of the DOJ Settlement Agreement, the Commonwealth will experience significant growing pains as it develops a more robust community-based system for people with ID/DD. The task ahead will require strong, consistent leadership and ongoing resources. Leveraging all available fiscal opportunities is essential to meeting the Settlement Agreement requirements. Accessing all available resources and federal policy initiatives that could bring resources to Virginia should be a priority. Examples include the feasibility of accessing **Community First Choice 1915 (k) Option** established under the Affordable Care Act of 2010. The “Community First Choice Option” lets states provide home and community-based attendant services to Medicaid enrollees with disabilities under their state plan. It provides a 6% increase in Federal matching payments to states for expenditures related to this option. Another possibility is the use of a **Section 1115 Demonstration Grant**. The Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and CHIP programs. The purpose of these demonstrations, which give States additional flexibility to design and improve their programs, is to demonstrate and evaluate new policy approaches.

Thank you again for the opportunity to provide comment. We hope to be able to provide additional input during the course of waiver revisions. I am available to answer any additional questions or discuss with you any of our recommended changes. I can be reached by phone at 804-786-9369 or by email at Heidi.Lawyer@vbpd.virginia.gov.