

**SECOND ADVISORY COMMITTEE MEETING AT SEVTC GYM  
FEBRUARY 26, 2009  
QUESTIONS POSED BY PARENTS & FRIENDS OF SEVTC PRESENTED BY  
ANN MARIE SIVERTSON**

**These are follow-up questions to the ones presented on January 29<sup>th</sup> at the first AC meeting which were either overlooked or need clarification:**

**Page 2, Question 5, Part 4:**

*How often are group homes inspected?*

- 1. See 2007 Human Rights Annual Report. Some licenses are every 3 years. Who monitors in between this time?**

It depends. If there are complaints, there may be several inspections per year. Generally, providers receive an inspection once during the licensing period. If they have a three year license, and a provider has one home, we inspect it each year. If they have a three year license and have 20 homes, we inspect all of the 20 at least once during the licensing period, some each year. DMHMRSAS is required to provide on-going monitoring and inspections each year.

**Page 3, Question 8:**

To our knowledge there are no citations regarding life safety issues. The cottages are not sprinkled and were not required to be sprinkled when they were constructed and so they predate any recent codes. It is likely that a survey enforcing the new code would cite the buildings for lack of sprinklers. Renovation work would include new sprinklers system.

**Page 3, Question 9:**

***How so? (We know there are issues with pony walls and a roof collapse at other training centers.) Please specify needed repairs, estimated costs/completed times.***

The future costs to maintain SEVTC as it currently stands will be more than other training centers. Maintenance and repair needs at this training center are greater than other training centers simply due to the condition of the physical facilities.

The cottages need to be completely refurbished or renovated to better meet the needs of the population that is residing there.

- The mechanical systems (heating, ventilation and air-conditioning) are beyond its useful life and needs to be replaced.
- The bathrooms need to be made more user friendly accessible and all of the plumbing fixtures need to be replaced.
- The kitchens need to be renovated to better accommodate food service and to make them accessible.
- The interior finishes are of a nature that they are easily damaged and they need to be replaced with finishes that are easier to maintain.
- The doors are beyond their useful life and the thresholds make entry and exit of wheeled devices difficult.

The site around the building has many issues as well.

- The sanitary sewer needs to be replaced.
- The storm drainage makes the walks unusable during and after a rain event.
- The waterline has had repeated leaks and should be replaced.
- The central heating hot water lines have had multiple leaks and need to be replaced or abandoned.
- Paved areas need to be addressed with the potential for replacement.

In short, the cottages need a complete overhaul inside. The buildings were built at a time when the population was much more ambulatory and there were no standards for the accessibility (ADA).

**Page 3, Question 10:**

***How much is the per diem of the Va. Beach ICF/MR? (How can the rate be the same if all the training center rates vary? Please clarify.)***

This answer was clarified in the original set of questions. The rate for ICF/MR varies across the state. The rate for the particular home mentioned is \$478.61.

**Page 4, Question 14:**

**Please revisit this question. The Auditor of Public Accounts report for Fiscal Year 2008 reflects figures that do not agree with your answers. Transfer of excess collections from M/R facilities indicate SEVTC generated revenue of \$4,000,000 more than its expenses. Please explain.**

The additional reimbursement over and above SEVTC's budgeted expenses relates to the inclusion of overhead costs, depreciation expense and capital outlay cost all being included in the Medicaid tentative payment rate of reimbursement for SEVTC services. These additional costs are not included in SEVTC's budget so the facility cannot expend them. In addition, in FY 2008 SEVTC received a positive Medicaid cost settlement related to FY 2007 in the amount of \$2,516,603. This revenue does not relate to the services actually provided in FY 2008 but is included in the recorded revenue of FY 2008.

DMAS does not have adequate appropriation to support reimbursement of Medicaid eligible services at DMHMRSAS training centers. This forces DMHMRSAS to transfer state General Funds to DMAS to cover the shortfall. Because General Funds are needed and because our training centers are funded with very little GF, these funds must come from our MH facilities. Because of this our MR training centers are able to continue to generate Medicaid revenue. The MH facilities are owed back the money that they sent to DMAS so it is returned to them from the training centers in the form of cash transfers.

**Page 4, Question 15:**

**This answer is not real clear. Who is keeping tack and is the information available for review? For example:**

- |                         |  |
|-------------------------|--|
| <b>Since discharge:</b> | <b>Number that had to be relocated?</b>                    |
|                         | <b>Number with police encounters?</b>                      |
|                         | <b>Number with hospitalizations?</b>                       |
|                         | <b>Number that requested readmission and were refused?</b> |

This information is monitored by Community Services Boards through the provision of case management services to individuals that transition from a training center to the community. If specific data is available related to these questions, then it would be maintained by individual CSBs and is not tracked systemically by DMHMRSAS.

**Page 5, Question 16:**

**Isn't it true that if a resident's level changes, they can be on an urgent list for years? What is the average waiting list period?**

Once a resident is discharged from a training center to a community placement funded by a waiver slot, the slot & funding are connected to that individual. Changes in the level of need for a person do not constitute loss of a waiver slot and placement on a waiting list, unless the person's level of need NO LONGER MEETS the level of functioning criteria for a waiver slot. In this case, there would be no waiting list placement because the person no longer qualifies for the Medicaid waiver funding.

The average waiting time for individuals on the MR Waiver Urgent Waiting List is 2.7 years. An individual does not go on the waiting list for a Waiver slot if they are in a training center. An individual will not be discharged from a training center unless that are assigned a waiver slot to receive community-based services (group home) or they transfer to a community ICF/MR.

**Additional questions from Mrs. Sivertson given on February 26, 2009**

- 1. My understanding is that waivers that are matched with federal funds must not exceed the costs of the current "institutional rate." Since SEVTC has the second lowest rate of the Training Centers and is lower than some of the private ICF-MR facilities, how will this requirement be met? Will the state have to come up with the match for the community ICF-MR facilities and is it a 50/50 match?**

The "cost effectiveness" requirement for CMS that the cost of a waiver slot not exceed the cost of the institution is determined in the aggregate which means the average cost of all waiver slots cannot exceed the average cost of all institutional services. Therefore, SEVTC having a lower rate compared to other training centers only impacts that state average in calculating "cost effectiveness" for CMS. No matter how the costs are determined, the state is responsible for its portion of the 50/50 match regardless of where services are delivered if funded by Medicaid.

- 2. Will there be increased oversight for new providers/homes?**

Additional oversight is not planned to supplement the oversight already in place in the community. There are several agencies that license or provide oversight of community-based providers. The first level of monitoring of community-based services is the CSB case manager. He or she is responsible for meeting with you at least every 90 days and reviewing all your needed and provided services quarterly. If you are unhappy with a service provider, your case manager is available to help you work through the problem or find another provider.

- DMAS will provide oversight through the provider enrollment process and ongoing reviews of services rendered by waiver and state plan providers.
- DMHMRSAS licenses all providers of Mental Retardation services and conducts preauthorization (a preliminary review to ensure that services to be provided match individuals' needs) for all MR Waiver services.

- Community services board case managers will assist in ongoing monitoring of your providers as they will maintain contact with you and your family about your services and if you are satisfied with the supports you receive. Equally important, you and your family play an important role in evaluating the quality of all providers and your voices help the two state agencies and the community services boards provide oversight.

Primary responsibility for home and community based waiver resides within DMAS. DMHMRSAS is responsible for daily operation, licensing, human rights and some of the quality management components of the Mental Retardation Waiver. The Home and Community-Based Services system includes the ability to evaluate your access, provider capacity and capabilities, and your satisfaction on a limited basis. Virginia is committed to making sustainable improvements across all levels of the service system with input from you and other individuals using the services.

**3. What are the requirements for getting people out of their homes into the community? Ex. # of recreational activities, shopping, beauty shop, exercise, movies, etc.**

There are no specific requirements for leisure and recreational activities. The amount of time individuals engage in these activities is dependent upon the needs and preferences outlined in the individuals' service plan. Providers are required to implement the activities as documented in the plan and are encouraged (and most often do) exceed this amount.

**4. Can a task force be assigned to follow each person upon discharge to ensure the level of care meets or exceeds what they were receiving at SEVTC for at least one year?**

For individuals participating in the MFP project, there are specific times for follow-up outlined in the approved contract with CMS each year for three years following discharge. All other individuals receive annual follow-up, and more frequently if needed, through their case manager. The Commissioner will consider the idea of a special task force.

**5. Can the parent's questions and answers be incorporated into the minutes and posted on the website for all interested parties?**

Yes.

**6. We believe it is a conflict of interest to include legislatures and others that stand to benefit financially from the closure of SEVTC and ask that you reconsider the membership.**

The advisory committee was formed to include a variety of stakeholders.

**7. What additional task groups have been established and who are the members? Are the families represented?**

Groups have been established to address the Capital Investment, Workforce, and Individual Placement and Provider Development. The membership of these groups includes different stakeholders that can best assist with the purpose of the group and overall mission of the project. The listing of these groups and participants will be included on the website. Yes, some families are participating with the groups.

**8. If the House plan is adopted which includes funding for a smaller facility, would it be rebuilt on this property?**

No specific building site has been identified in the event of a smaller, newly built SEVTC. The budget language does specify that priority consideration should be given to state property.

**9. The families would like to be notified prior to any needs assessment conducted by the case manager or any other designated person so we can participate. Who will ensure our involvement in the process?**

Facility staff and case managers are responsible for including those individuals most knowledgeable of the individual's needs and preferences. Every effort will be made to include family members and authorized representatives.

**Additional questions from Mrs. Reid given on February 26, 2009**

**1. Could you tell us what are the major repairs needed here at SEVTC?**

The future costs to maintain SEVTC as it currently stands will be more than other training centers. Maintenance and repair needs at this training center are greater than other training centers simply due to the condition of the physical facilities.

The cottages need to be completely refurbished or renovated to better meet the needs of the population that is residing there.

- The mechanical systems (heating, ventilation and air-conditioning) are beyond its useful life and needs to be replaced.
- The bathrooms need to be made more user friendly accessible and all of the plumbing fixtures need to be replaced.
- The kitchens need to be renovated to better accommodate food service and to make them accessible.
- The interior finishes are of a nature that they are easily damaged and they need to be replaced with finishes that are easier to maintain.
- The doors are beyond their useful life and the thresholds make entry and exit of wheeled devices difficult.

The site around the building has many issues as well.

- The sanitary sewer needs to be replaced.
- The storm drainage makes the walks unusable during and after a rain event.
- The waterline has had repeated leaks and should be replaced.
- The central heating hot water lines have had multiple leaks and need to be replaced or abandoned.
- Paved areas need to be addressed with the potential for replacement.

In short, the cottages need a complete overhaul inside. The buildings were built at a time when the population was much more ambulatory and there were no standards for the accessibility (ADA).

**2. How do you plan to identify the 75 residents that will qualify to stay at SEVTC?**

No plan has been developed at this point. It will first be important to determine the purpose and role of the smaller SEVTC in the service continuum.

**3. Why downsize a training center that daily cost per day is the next to the lowest cost per day of Virginia's training centers?**

The efforts to downsize training centers are not based on cost, but rather the opportunity to offer more person-centered, integrated services for individuals with intellectual disabilities.

**4. Given the number of beds available in the community, why do we have a long waiting list?**

There is a long waiting list for Medicaid Waiver slots that enable access to services because the General Assembly has not allocated enough funding to provide services for all those that have requested it.

**5. If the state will build 10-14 community ICF/MRs with 6-8 bed homes at a cost of \$1M each and 15-22 waiver group homes with 4-6 beds at a cost of \$850,000 each and provide the same type of services as the residents are receiving at SEVTC, what is the advantage of moving the residents of SEVTC to the community?**

The efforts to downsize training centers are not based on cost, but rather the opportunity to offer more person-centered, integrated services for individuals with intellectual disabilities.