My Life, My Community!

Re-designing Supports for Virginians with Intellectual and Developmental Disabilities

Project Report

November 5, 2013

Project Tasks 1.1, 1.2 & 1.7:

HCBS Waiver Analysis

Human Services
Research Institute

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HCBS Waiver Analysis

Prepared for:

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Introduction

The Human Services Research Institute is under contract to the Virginia Department of Behavioral Health and Developmental Services (DBHDS) to: (a) evaluate the State's current service delivery system for individuals with intellectual and developmental disabilities (I/DD); (b) make recommendations to move the system to a more person-focused/needs-based system of care; and (c) in conjunction with that evaluation, review the existing rates paid to service providers and the current method of allocating resources to support individuals receiving services.

The Request for Proposal included an analysis of the current waivers and recommendations for improvement. Pursuant to the work plan developed, this report addresses Tasks 1.1, 1.2 and 1.7. The tasks are described as:

> Task 1.1 Evaluate the efficiency and effectiveness of current waivers, service definitions, billing rate, available units, documentation requirements, and policies that govern the provision of services in accordance with rules and regulations that govern the Medicaid programs.
>
> Task 1.2 Report on findings including recommendations and strategies for waiver enhancement.
>
> Task 1.7 Recommend system changes and develop a plan for reducing the number of waivers; including the efficacy of one comprehensive waiver and one supports waiver.

What follows next is a description of the methods applied to assess circumstances in Virginia and reach conclusions over what DBHDS might do to streamline and improve the current ID/DD system. Subsequently, information, discussion and recommendations are provided relevant to eight topical areas, beginning with focus on the overarching goal of establishing a cohesive I/DD system under DBHDS. Next we focus on the seven remaining topic areas, including: service eligibility, waiting list issues, the role of Community Services Boards, case management, service array, a special focus on employment, and quality improvement strategies.

Methods

Virginia has three HCBS waivers that specifically serve people with intellectual or developmental disabilities (I/DD): the Intellectual Disability Waiver (ID waiver), the Individual and Family Developmental Disability Supports Wavier (DD waiver), and the Day Supports Wavier (DS waiver). People with intellectual and developmental disabilities who meet level of care and other eligibility requirements may also receive services as part of the Elderly and Disabled-Consumer Directed Waiver (EDCD waiver) as an alternative to these waivers or while they are on the waitlist.

- **Intellectual Disability Waiver (ID waiver)**. The ID waiver is the largest HCBS waiver. The ID waiver serves people with intellectual disabilities (ID) only. This waiver currently serves approximately 8,000 people and has a substantial waitlist. The services available through the ID waiver include: residential services, day supports, employment services (supported employment and prevocational services), respite, personal care, skilled nursing, transportation,

companion care, assistive technology, environmental modifications, therapeutic consultation, crisis services and transition services.

- **Individual and Family Developmental Disability Supports Wavier (DD waiver).** The DD waiver serves people with developmental disabilities (DD) without an intellectual disability. This waiver is small and only serves 800 people. The waiver services offered to people on the DD waiver are similar to those offered on the ID waiver, with the major exception of Residential Services and the addition of Family/Caregiver training. The DD waiver only offers in-home services, and no residential placements. Service definitions vary across somewhat between the ID and DD waivers, but are generally similar.
- **Day Supports Wavier (DS waiver).** The DS waiver serves people with ID who are on the ID waiver waitlist. There are about 300 people served on the DS waiver. The waitlist for the DS waiver is based on date of need, identified as date of eligibility. Each CSB is allocated a number of slots to serve people on the DS waiver. When someone leaves the waiver, the CSB offers services to the next person on the waiting list. This waiver provides limited services—day support, supported employment and prevocational services.

Case Management services are also available through the Medicaid State Plan. There are consumer directed options and supports through which waiver recipients can receive companion care, respite and personal assistance services. Movement off the waiting list is based on urgency of need criteria that is established at a statewide level, with the Community Services Boards (CSBs) making determinations of priority for each of their respective catchment areas. Openings on the waiver are distributed to each CSB based on the percentage of individuals on the statewide waiting list.

To conduct the research for this report, a number of approaches were used, including: (a) document review, (b) interviews with key state staff, (c) analysis of Medicaid claims data for the ID, DS and DD waivers, and (d) a review of comments from public stakeholder forums.

- **Document review**. The project team conducted an extensive review of written materials related to the Virginia waiver system. These include documents produced by government entities such as state statutes, the Virginia Administrative Code, HCBS waiver provider manuals, the ID, DS and DD waiver applications, monitoring protocols and the settlement agreement between the state and the U.S. Department of Justice (DOJ), as well as third party reports with recommendations for improvements to the current system. Finally, HSRI reviewed and considered the input from the 8 stakeholder forums attended by roughly 1,000 people. The forums were held throughout the state between the dates of September 24, and October 2, 2013.
- **Staff interviews.** Interviews were conducted with state staff at DBHDS and DMAS to discuss quality management systems, waiver operations and case management. On September 12 and 13, 2013, Lilia Teninty with HSRI and Robin Cooper with NASDDDS met with DBHDS and Department of Medical Assistance Services (DMAS) management staff to discuss management of the ID/DS and DD waivers. Follow-up telephone and e-mail communications were made to clarify and garner additional information.

  Val Bradley and June Rowe of HSRI met with Dawn Traver, the Community Resource Manager, Kathy Drumwright, the Assistant Commissioner of Quality, Les Saltzberg, Director of the Office of Licensing, and Margaret Walsh, the Director of the Office of Human Rights at DBHDS as well

as Nichole Martin, the Program Manager for the Division of Long-Term Care at DMAS. These meetings occurred on October 8, 2013.

- **Claims data review**. Working in collaboration with HSRI, Burns and Associates in late August 2013 received Medicaid claims data to document service utilization among waiver participants over the past three fiscal years. These data were reviewed by Burns and Associates to illustrate utilization patterns within each of the waivers. Their findings are being provided to DBHDS separately.
- **Review of information collected during public forums**. In September and October 2013, HSRI collaborated with Parent to Parent of Virginia and The Partnership for People with Disabilities at Virginia Commonwealth University to convene 16 public forums at eight sites across the state. Over 1,000 people participated in these forums, with findings compiled and provided to DBHDS under separate cover.[1]

The recommendations that follow over the eight topic areas are presented with the expectation that DBHDS will continue to move to integrate services for people with ID/D into its operational structures and will initiate planning for development of the recommended new waivers. This report also includes shorter term recommendations to address more immediate issues in the Intellectual Disability, Day Supports and Individual and Family Developmental Disability Supports wavers. Although analysis of the Elderly or Disabled with Consumer Direction waiver was not specifically included in this project, the project team learned that roughly 2,400 people with ID and/or DD are using this waiver to access services while they are waiting for services on the ID or DD waiver.[2] General comments on this waiver are included, as well.

Establish a Cohesive ID & DD System under DBHDS

The challenges that DBHDS is facing are daunting, but also provide opportunity to reform and improve the service delivery system. Most significant is the opportunity for the Department to create a cohesive service system for Virginian's with intellectual and developmental disabilities, including those with related conditions, by expanding the role and purpose of DBHDS. The recent move of operations of the DD waiver from DMAS to DBHDS is a significant step in this direction. Of course, as with the ID and DS waivers, Medicaid, as the Single State Agency, will continue its oversight role with the DD waiver. Enhancing and strengthening DBHDS' role as the operating agency responsible for management of services for people with I/DD will require review and modifications to many aspects of the Department's programs. DBHDS will also need to seek revisions to the state statute that governs

[1] Yarbrough, D., Dinora, P., Yoder, T., Kardell, Y., Rojas, R. & Agosta, J. (2013) *Project Tasks 1.3 & 1.4: Public Forum and Interview Results*. Tualatin OR: Human services Research Institute

[2] This information was shared during meetings with DMAS on September 12-13, 2013 and specific numbers were forwarded to HSRI on November 26, 2013. Data specific to the EDCD waiver was not included in analysis for this report.

the functions of the Department since it currently limits DBHDS' role to the provision of services to people with intellectual disabilities.[3]

Continuing efforts to establish DBHDS as the Virginia state agency responsible for services for people with intellectual *and* developmental disabilities will require thoughtful review and planning. Even with operational management of the DD waiver shifting to DBHDS, the service system for people with intellectual disabilities and developmental disabilities will remain bifurcated until steps are taken to integrate services across the two populations and eliminate separations based on diagnosis and/or IQ. Currently, people with ID access the system and case management through CSBs, while people with DD and no intellectual disability access services through Child Development Centers and case management through private case management entities. Maintenance of these two points of access will be confusing for people served and their families. The identification of DBHDS as the agency responsible for services for both of these populations and as well as future steps to unite operation of the ID and DD systems will clarify access issues for people served and their families, and will create an inclusive service system for Virginians with intellectual and developmental disabilities.

As part of this effort, the HSRI project team recommends that the state **initiate the development of two new 1915(c) waivers that include eligibility for people with ID, DD and related conditions**. The first would be a comprehensive waiver, offering a wide array of services including residential services, and the second, a support waiver, offering a full array of similar services, but no 24 hour, in-home or out-of-home residential option. People on the support waiver will live with family, friends or where feasible, independently in apartments.

As explained in the section on Eligibility, these waivers should have consistent eligibility requirements to ensure people with ID, DD and related conditions are able to access services on both waivers. Creation of a comprehensive and a support waiver, with similar eligibility requirements, will provide DBHDS an important additional option through which people can be moved off a waiting list and into services, within the legislatively approved budget. While development of a single waiver that offers a full array of services is also possible, the recommendation to add a support waiver is intended to help the state manage the waiver programs more effectively, while offering services to a greater number of individuals. Waiting list management, case management and other operational issues will need to be addressed in an implementation plan that will be developed to ensure smooth transition from the current waivers to the new waivers.

Service Eligibility

Most states establish system eligibility requirements in statute, such as requiring the individual to have an intellectual disability or including individuals with developmental disabilities and/or related conditions. A review of the DBHDS web site did not yield any specific statement of general eligibility for services in the Virginia developmental disabilities system, although there were references to the AAIDD definition of intellectual disability. Also, it was difficult to ascertain if there are state statutes that specifically describe who is potentially eligible for services in the ID/DD services system. In reviewing

[3] § 37.2-100 Virginia Code

DBHDS eligibility criteria, it appears that eligibility for community-based services in Virginia is connected to specific programs rather than to any overarching system eligibility criteria.

Most of the materials reviewed regarding services in Virginia use the term "intellectual disability" but the Individual and Family Developmental Disabilities Support (DD) program serves individuals who have developmental disabilities, but no intellectual disability. Additionally the current ID waiver includes children ages 0-6 who are at risk of developmental delay (but not necessarily diagnosed as having ID). In addition, there is a new state funded option, called the Individual and Family Support Program that provides up to $3,000 to families. Eligibility for this program is for "individuals with *intellectual or developmental disabilities* on the waiting list for the ID or DD Waiver (and their families) to access short-term person/family-centered resources, supports, and services."[4]

A variety of individuals can gain access to case management services, but eligibility differs for each type of case management (waiver, waiting list or intensive). The lack of clarity about service system eligibility is further confounded in that some CSBs offer locally funded services to a broader group of individuals than those served by statewide programs. For consumers and families it is challenging to navigate a system where entrance criteria are not clear and/or tied to specific programs. This requires that individuals and families understand the ins and outs of the various programs and what is offered locally, as well.

Nationally it is worth noting that in most states, being eligible does not necessarily *entitle* individuals to immediate services.[5] Eligibility typically defines the "shape" of the services system and gives individuals a clear idea of what state agency supports which individuals. Who actually receives paid services, and when, is ultimately a function of system capacity and eligibility criteria—including urgency of need—for specific programs.

With efforts to bring operations of the ID, DS and DD waivers under DBHDS, it seems an opportune moment to clarify eligibility requirements for access to services. One concern, however, is that under the DD-only waiver, the term "related conditions" appears to have been interpreted very broadly, potentially including children whose needs are only for support of health and medical conditions, not developmental supports as well. In some states these individuals are served in programs for medically fragile individuals or in nursing facility level of care waivers that focus on health and medical conditions. At the federal level 42 CFR 435.1009 "persons with related conditions" are defined as those individuals with a

> severe, chronic disability that meets all of the following conditions and is attributable to:
>
> (1)cerebral palsy or epilepsy or (2) any other condition, other than mental illness, found to be closely related to intellectual disability because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of intellectually disabled and requires treatment or services similar to those required for these persons, (b) it is manifested before the person reaches the age of 22, (c) it is likely to continue indefinitely (d) results in substantial functional limitations in three or more of the following areas of major life activities:

[4] Individual and Family Support Program application found at: http://www.dbhds.virginia.gov/documents/ods/ifsp%20application.pdf

[5] Arizona, California, Idaho, Michigan and Oregon have entitlements to DD services, although in some cases the entitlement is to a limited set of services.

(1) self care; (2) understanding and use of language; (3) learning; (4) mobility; (5) self direction; (6) capacity for independent living.

The definition of related condition is primarily functional, rather than diagnostic, but the underlying condition must have been manifested before age 22 and likely to continue indefinitely. Related conditions have included developmental disabilities which are defined in P.L. 101-496.

How states choose to define related conditions varies. Some states do use the functional definition while others specify certain specific conditions such as autism, epilepsy and cerebral palsy. There are some states that indicate individuals with related conditions but no intellectual disability, such as individuals with cerebral palsy and no cognitive impairments, are not included in their eligibility for HCBS waivers serving individuals with I/DD. These individuals would be served on programs intended for individuals with physical or medical disabilities (nursing facility Level of Care (LOC) or medically fragile waivers) as their needs may more closely align with the supports and services afforded these individuals. At issue is assuring that any decisions made result in the least disruption to those currently served, while properly defining the scope of individuals served by the DBHDS system going forward.

Eligibility Recommendations

Long Term Recommendations

- **Develop and institute guidance (preferably though regulation or statute) defining overarching DBHDS eligibility for services in the state of Virginia.** Based on the groups currently served and the various eligibility criteria, it appears that the system would serve:

  1) Individuals with ID and two adaptive behavior deficits (current standard);
  2) Individuals with DD who meet the federal definition of having a developmental disability;
  3) Individuals with related conditions (as defined in 42 CFR 435.1009), including persons with autism, who are 6 years of age or older and who do not have a diagnosis of intellectual disability.

  Moving to this set of criteria will also provide an opportunity to streamline the eligibility process for children. Including individuals of all ages with ID, DD and related conditions in eligibility requirements eliminates the need to divide eligibility between those five and under and those six and over, based on the waiver program.

- **Evaluate and identify criteria to define related conditions.** DMAS has used a broad interpretation of related conditions, DBHDS may wish to evaluate this standard going forward to assure that they are serving individuals who do meet the above mentioned criteria and are appropriately served by the I/DD system. DBHDS of course will have to carefully consider the impact of any changes to make sure individuals currently are not left without essential services.

Waiting Lists

Virginia's waiver programs have different processes and criteria for how individuals move off of the waiting lists. There is one statewide waiting list for the ID and the Day Support Waivers, but how individuals access these waivers is different. The statewide waiting list is divided into two parts:

individuals who are willing to begin services in 30 days and meet the urgent criteria and those who are willing to begin services in 30 days, but who do *not* meet the urgent criteria. Only those on the urgent portion of the list are eligible for the ID Waiver (until all on the urgent list are served), but individuals with both urgent and non-urgent needs are eligible for the Day Support Waiver. The urgent needs criteria are comparable to those used in other states, prioritizing those who have health, safety or behavioral risks, ageing caregivers or are at risk of homelessness.[6] Individuals are assessed by case managers using the Critical Needs Summary which generates a score. Then the CSB review committee makes the determination of which individuals are eligible for waiver slots as they become available.

Individuals are offered Day Support Waiver services based on their "date of need."[7] This is defined as "the date of the initial eligibility determination assigned to reflect that the individual is diagnostically and functionally eligible for the waiver and is willing to begin services within 30 days".[8]

The DD waiver, according to the approved waiver application notes, "Individuals are placed on the waiting list on a first come, first served basis."[9] Individuals are screened for the DD waiver through Child Development Centers and DMAS maintains the waiting list. DMAS indicated that they also have annual capacity on the DD waiver to use 10% of the newly available waiver slots for individuals meeting "emergency" criteria. The DD emergency criteria are similar, but not identical to the ID and DS waiver criteria. Decisions on emergency status are made by DMAS. Under the DD waiver, emergency criteria are:

- The primary caregiver has a serious illness, has been hospitalized, or has died;
- The individual has been determined by the Department of Social Services to have been abused or neglected and is in need of immediate waiver services;
- The individual has behaviors which present risk to personal or public safety;
- The individual presents an extreme physical, emotional, or financial burden at home, and the family or caregiver is unable to continue to provide care; and
- The individual lives in an institutional setting and has a viable discharge plan in place.

DMAS, which managed this program until October 2013, released the emergency slots once a year, letting people apply for entrance into the DD waiver once a year, with all others on the waiting list served using the first come, first served principle.

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6 Department of Medical Assistance Services, *Intellectual Disability Community Services HCBS Provider Manual.* Chapter IV, page 11 (July 2010). Available at: https://www.ecm.virginiamedicaid.dmas.virginia.gov/WorkplaceXT/getContent?vsId={FE3E54C5-7C76-4EDA-8368-65C5D4FDD721}&impersonate=true&objectType=document&id={C1E6E784-AA2E-4BCD-A943-2F0D2980A815}&objectStoreName=VAPRODOS1

7 Department of Medical Assistance Services, *Intellectual Disability Community Services HCBS Provider Manual.* Chapter VII, page 2 (July 2010). Available at: https://www.ecm.virginiamedicaid.dmas.virginia.gov/WorkplaceXT/getContent?vsId={DFBE6FE7-8782-4329-8C57-F8C2C22D2743}&impersonate=true&objectType=document&id={27F3F829-D666-4F40-8231-03AA25758859}&objectStoreName=VAPRODOS1

8 12VAC30-120-1500

9 Application for 1915(c) HCBS Waiver VA_0358_R03_01 - Jul 01, 2013, Appendix B.3.f.

As noted above, DBHDS recently began the Individual and Family support program targeted to individuals who are on waiting lists for services. Individuals apply directly to DBHDDS and can receive up to a maximum of $3,000 per year to purchase supports and services such as:

- Professionally provided services and supports, such as respite, transportation services, behavioral consultation, and behavior management;
- Assistive technology and home modifications, goods, or products that directly support the individual;
- Temporary rental assistance or deposits;
- Fees for summer camp and other recreation services;
- Temporary assistance with utilities or deposits;
- Dental or medical expenses of the individual;
- Family education, information, and training;
- Peer mentoring and family-to-family supports;
- Emergency assistance and crisis support; or
- Other direct support services as approved by DBHDS.

Eligibility for the Individual and Family Support Program stipend is based on first come, first served basis. Awards are made until the annual appropriation is exhausted. Individuals and families can apply for funds more than once in a year but will not be awarded more than the maximum $3,000 per year. Individuals must reapply every year if they are in need of additional funds.

Individuals on the ID waiting list may currently be getting services through the DS waiver. Individuals on any of the waiver waiting lists (ID, DS or DD) may also be enrolled in the Elderly Disabled with Consumer Direction waiver. The EDCD waiver has no waiting list and is generally being used as a supports waiver for people who meet Nursing Facility LOC, have either ID or DD and are waiting for more appropriate services on other waivers. The system is further complicated because it is unclear how individuals might gain access to other services funded with non-Medicaid state or local funds. As with other aspects of the Virginia system (case management for example) waiting list policies and procedures are tied to specific programs and are managed differently for different programs.

Waiting List Recommendations

Short Term Recommendations

- **The emergency slots on the DD waiver should not be held and allocated annually, but should be available on a continual basis for individuals meeting the emergency criteria.** If the slots are not being used regularly, then DBHDS should reallocate the slots to those on the waiting list without urgent needs.
- **DBHDS and the CSBs should do continual outreach to make sure individuals and families are aware of how to apply for services and how to get on the waiting lists.** This should be monitored by the state and part of the CSB contractual requirements. This will assure that there is equity of access across the state and that the waiting lists accurately reflecting unmet needs.
- **Waiting list data should be reviewed to determine which individuals on the waiting lists are receiving no services, are currently receiving services through other sources, or remain on the waiting list to request additional and/or different services.**

- **Stakeholders should contribute to revised policies that integrate waiting lists across the ID and DD systems.** The recommendations made by stakeholders will also inform development of waiting list policies for future waivers, and possibly other programs.

Long Term Recommendations

- **A single set of waiting list criteria should be created.** Redefining service system eligibility will be the first step in making a more coherent waiting list policy. As DBHDS moves toward an I/DD standard for eligibility, the waiting list processes for the specific waivers and programs can be melded into one process, including potential eligibility for Individual and Family Support funding. A consistent process that includes priority of need as a basis for all waivers will give people in crisis the opportunity to access a lower cost supports waiver, if those services will appropriately meet their needs.

Community Services Boards (CSBs)

Community Services Boards are agents of the local governments that established them and are not part of DBHDS. DBHDS licenses CSBs and other providers, contracts with CSBs for local mental health, developmental and substance abuse services, monitors the operations of CSBs through performance contract reports, and provides funds to CSBs.

There are three types of CSBs – Operating, Administrative Policy, and Policy Advisory CSBs. These classifications are primarily a reflection of the relationship between the CSB and the local government entity. Every city and county must establish or join a CSB. Each CSB has a board that is appointed by, and accountable to, the governing body that established it. There are twenty-seven operating CSBs that directly provide services, employ their own staff and are not city or county departments. Administrative Policy CSBs set policy for and oversee the provision of services by local government staff but do not employ any staff. Nine of the eleven administrative policy CSBs are city or county government departments. Policy advisory CSBs provide advice to the local government department that provides services and have no operational powers or duties. There is one Behavioral Health Authority, in Richmond. It is most similar to an operating CSB, but has additional powers not given to CSBs. There are forty CSBs in the state including one Behavioral Health Authority.[10] (See Table 1 on the following page for a list of the CSBs operating in Virginia.)

CSBs are required by state statute to provide emergency services and case management and to function as a single point of entry into publicly funded mental health, developmental and substance abuse services.[11] Developmental services are defined in statute to include services provided to individuals with intellectual disability. This definition does not include people with developmental disabilities or related conditions.[12] In addition to the services that these entities are required to provide some, but not all CSBs also provide other long term supports and services.

[10] Virginia Office of Community Contracting, 2012 Overview of Community Services in Virginia. (2012, page 10).

[11] § 37.2-500 Virginia Code

[12] § 37.2-100 Virginia Code

Table 1: CSB Designation Status

Name of CSB	Type	Name of CSB	Type
Alexandria	Admin Policy	Highlands	Operating
Alleghany Highlands	Operating	Loudoun County	Admin Policy
Arlington County	Admin Policy	Middle Peninsula-Northern Neck	Operating
Blue Ridge	Operating	Mount Rogers	Operating
Central Virginia	Operating	New River Valley	Operating
Chesapeake	Admin Policy	Norfolk	Admin Policy
Chesterfield	Admin Policy	Northwestern	Operating
Colonial	Operating	Piedmont	Operating
Crossroads	Operating	Planning District One	Operating
Cumberland Mountain	Operating	Portsmouth DBHS	Policy-Adv.
Danville-Pittsylvania	Operating	Prince William County	Admin Policy
Fairfax-Falls Church	Admin Policy	Richmond BHA	BHA
Goochland-Powhatan	Operating	Rockbridge Area	Operating
Hampton-Newport News	Operating	Southside	Operating
Hanover County	Admin Policy	Valley	Operating
Harrisonburg-Rockingham	Operating	Virginia Beach	Admin Policy
Henrico Area	Admin Policy	Western Tidewater	Operating

Oversight

Community Services Boards were initially funded through grants from the state. Through several process changes, the primary funding authorization for CSBs is now a performance contract. This performance contract is generally standardized across CSBs. The performance requirements are the same across all CSBs, while the financial details, board membership, and some details of the joint agreements vary across CSBs. The performance contract specifies the roles, responsibilities of the Department, state hospitals, Training Centers and CSBs.

The FY 2013-2014 performance contract covers the scope of services, resources, CSB responsibilities, Department responsibilities, terms and conditions and areas for future resolution. There is one amendment to the contract that addresses the settlement agreement reached with the US Department of Justice. The performance contract specifies the reporting requirements for CSBs, which include accounting for all services, revenues, expenses, and costs through CARS and CCS.

The extent to which DBHDS is able to effectively monitor and manage waiver related activities of the CSBs is unclear. While contracts with the CSBs include performance related indicators, it is unclear the extent to which CSBs meet those benchmarks and how the requirements of the performance contract are enforced when or if a CSB falls below acceptable standards. CSBs are required to report data on the services provided to individuals and financial data through the CCS and CARS systems. However, it was learned that CSBs do not report the information in a consistent manner, which likely makes it difficult to use the data to monitor program and fiscal activities. Further, concerns were expressed in several of the stakeholder meetings about the consistency of the application of eligibility requirements and

waiting list processes across CSBs. Finally, at present, CSBs collect and enter ID and DS waiver eligibility information and enter it into the IDOLS system. Interviews with state staff indicate that DMAS does quality management reviews of a sample of eligibility decisions. As the service system evolves to include people with DD and related conditions, it is expected that DBHDS will want to have stronger oversight of eligibility determinations across CBSs.

Option to Claim FFP for CSB Local Funds

It is understood that in some CSBs there is substantial local tax levy used to provide services to individuals with I/DD.[13] These local tax levy funds could potentially be used as match for federal funding.[14] Currently these funds are used to support individuals on waiting lists and individuals who at present are not eligible for the ID or DS waivers, specifically individuals with developmental disabilities. As the state redefines system eligibility to include individuals with DD as well as ID, a portion of these individuals will likely become waiver eligible. Additional information on a model for this type of waiver that has been implemented in Missouri is in Appendix A.

Community Service Board Recommendations

Short Term Recommendations

- The CSBs that provide services with local funds do so outside of an HCBS waiver program, and thus those funds are not able to receive a federal match. To secure federal funds, this report recommends that **the state and CSBs pursue a "local match" and seek waiver of state wideness similar to the Partnership for Hope program in Missouri**.

Long Term Recommendations

- **The oversight role of the state as it relates to Medicaid funded activities, should be clarified and strengthened both in the contract with CSBs and in practice.** As discussed in additional sections of the report, CSBs play a significant role in the ability of the state to meet the requirements of the Medicaid waiver program. As such, activities of the CSBs should be effectively monitored to ensure consistency of activities across the state and adherence to quality and performance measures related to waiver roles and functions. The extent to which this occurs today was unclear in this review.
- **The role of the CSB as the single point of entry for developmental services, including services for people with DD and related conditions, should be clarified in statute and stressed at the state and local levels.**
- **The role of CSBs as case management entities should be expanded to provide case management to people with ID, DD and related conditions both on waivers and on waiting**

[13] For example, Fairfax County spends over $3 million in local funds for day and vocational services for individuals who are currently waiver eligible and on the waiting list. Other CSBs spend local funds also on day programs, employment and transportation services for waiver eligible individuals as well—including Henrico, Rappahannock and Virginia Beach.

[14] "The non-Federal share of computable waiver costs must be provided exclusively by the state or by the state and local governmental entities (e.g., counties), as provided in 42 CFR §433.5." Application for a §1915(c) Home and Community-Based Waiver [Version 3.5], Instructions, Technical Guide and Review Criteria, Release Date: January 2008, p. 263.

lists. When general system and program eligibility requirements are modified to include people with ID and DD, the CSBs should assume responsibility for gathering assessments for both general system and specific program eligibility, under oversight and review of DBHDS and DMAS, as required for Medicaid waiver programs.

- **Develop a long-term plan for transitioning CSBs that provide waiver funded developmental services into entities that provide case management services only.** CSBs that provide waiver services create conflicts of interest between their primary role as case managers and their role as service providers. This will be discussed in greater detail in the Case Management section below. Understanding that CSBs provide 16% of all non-case management services across all waivers, a long-term plan for transitioning CSBs into entities that provide case management only, and not other Medicaid waiver funded I/DD services, should be developed and implemented with the involvement and in-put of people served, families and the CSBs.[15]

Case Management

Case management is a pivotal service. Case managers have essential roles in assuring the health and well-being of consumers, assuring that individuals have good lives that result in the outcomes they set for themselves. Case managers act both as an agent of the state human services system *and* an agent of the individual (first) and family. Case management is needed to keep the system running and individuals and families rely on case management to help them build and sustain their lives.

As an agent of the state, case managers are the front line on monitoring, quality compliance, outcomes and safety acting as the "eyes and ears" for the system, and the person too. Case managers play essential roles in upholding key Medicaid requirements. Case managers have central responsibility for assuring that the paperwork is done, which in turn assures the resources (for example, Medicaid funds) keep flowing which of course means people have the support resources they need.

Case managers are typically the central individual with whom people with disabilities and their families develop relationships. In fulfilling their role as an agent of the person they are relied upon as to assist the individual and family to understand the services system and help make informed choices about services and supports, and to engage in high quality, person-centered planning. How case managers engage with individuals and families is critical to setting expectations about the services system and the opportunities--and limitations--within the system.

Currently case management for individuals in Virginia's services system is complex. Case management providers and systems vary by waiver program, and for those not enrolled in the waivers there are other approaches to case management. Case management, rather than being designed to support the individual throughout the system, has been designed around specific programs and eligibility, with different providers and practice standards dependent on individual programs. While it is certainly sensible to "tailor" case management to the specific needs and situation of the individual, the recent addition of the DD waiver under DBHDS has added yet another type of case management to the mix.

[15] B&A Background Claims Analysis

Current Case Management Approaches

Individuals with ID and ID Waiver Case Management

The targeted case management State Plan Amendment (SPA) covering individuals under the ID waiver indicates that the target group is "Medicaid eligible individuals who are mentally retarded as defined in state law" and does not confine the target group to individuals enrolled on the ID waiver. The SPA does note that there must be a "Plan of care in effect which requires regular direct or client-related contacts or communication or activity with the client, family, service providers, significant others and others including at least one face-to-face contact every 90-days."

It was explained that any individual with ID can get case management services but that the intensity of the involvement of the case manager differs for individuals enrolled on the waiver. The SPA does not indicate that there is any distinction between waiver and non-waiver case management, although interviews with CSB and state staff indicate that the non-waiver individuals get case management for emergencies or if they make contact with the CSB. They do not get "routine" case management although the SPA indicates face-to-face contact every 90 days. Further complicating the issue is that at least some CSBs provide "follow along" case management for people with ID who do not qualify for State Plan Option Targeted Case Management for various reasons. It was difficult to determine how this standard is in force. Interestingly the provider qualifications indicate that, "The provider must demonstrate the ability to serve individuals in need of comprehensive services regardless of the individual's ability to pay or eligibility for Medicaid reimbursement" seemingly indicating an entitlement to both case management and other services beyond Medicaid eligible individuals and beyond the waivers.

DD Waiver Case Management

DBHDS has just taken over the management of the DD waiver, inheriting the current private case management approach associated with that waiver. Under the SPA relating to the waiver, "…Medicaid-eligible individuals with related conditions who are six years of age and older and who are on the waiting list or are receiving services under the Individual and Family Developmental Disabilities Support (IFDDS) Waiver." This SPA clearly articulates a different standard of case management for individuals enrolled on the DD waiver and those on the waiting list. Although the qualifications and duties for the DD case managers are similar to the ID case managers, the organizational capacity is different since DD case management can be provided by independent individuals. The SPA standards require DD case managers who are independent to get supervision every three months from another individual who is not a case manager. Unlike the ID waiver case managers, DD case managers may also provide service facilitation for the self-directed option as long as they meet the qualifications for service facilitation.

Case management has grown with each new program whether through DBHDS or DMAS. Case management options were created to meet the needs of specific populations as these populations were added to the services system. The significant and continuing growth of the service system due to the DOJ settlement and the movement of the DD waiver to DBHDS provide an opportune moment to review and structure case management, building on the current approaches.

Case Management Recommendations

Short Term Recommendations

- **Increase the ability of case managers on the ID and DD waivers to participate in transition planning for those in institutions from 30 days prior to transition to six months prior to transition, as it permissible under Medicaid Targeted Case Management.** The current 30 day case management limit described in the operational manuals limits the case manager's involvement in the transition planning process, which can have detrimental effects on the outcome. Note the DOJ settlement requires a final transition plan be in place 30 days prior to transition. This requirement, along with the billing restriction on ID case managers, creates a scenario under which the case manager may only meet the person and become involved in the transition process after detailed transition planning has occurred. Case management on the DD waiver is allowed to be billed for 60 days prior to transition for individuals moving on to that waiver.
- **Administration of the Supports Intensity Scale® (SIS) should be done by an independent entity.** In line with the discussion above, administration of the SIS should be conflict free. This is further discussed in the report on Task 1.5 that addresses policies and procedures that govern administration of the SIS. At this point, CSB case managers administer the SIS for the individuals on their case load. The Task 1.5 report recommends establishing a dedicated and conflict free statewide team for conducting SIS interviews, which would eliminate the potential conflict for case managers and other CSB staff.

Long Term Recommendations

- **Address conflicts of interest within the current case management system.** The current case management system presents some fundamental conflicts of interests. Over time, CSBs should divest themselves of direct service provision, retaining the roles of system managers and providers of case management services only. Analysis of expenditure data indicates that this may take considerable time and planning given the extent of services provided by CSBs in some catchment areas.[16] While there is no one "correct" answer as to how case management systems should be structured, independence from direct services provision is a best practice, that positions case managers to most effectively act in their roles as agents of the person and agents of the requirements of the services system. The guidance below provides a description of principles for conflict-free case management:
  - **Full separation of case management from direct services provision**. Structurally or operationally this means that the case manager is not an employee of any provider organization that provides direct services to the individual for whom they are the case manager. This prevents the possibility of conflict of interest in making referrals for services or creating a situation that may compromise the case managers' ability to exercise oversight and monitoring responsibilities. The "purest" form of conflict free case management is stand-alone case management organizations or entities that provide no other direct services.

[16] B&A Background Claims Analysis

- **Separating case management from service provision also includes separating services facilitation for self-directed services from case management**. The role of a service facilitator is different than the role of a case manager. Services facilitation is intended to support individuals who choose to self-direct. This is really a "hands-on" direct service aimed at teaching individuals and families the roles and responsibilities needed to effectively direct their own services. This type of direct service, such as teaching individuals how to conduct a hiring interview or how to evaluate an employee, is usually beyond the capacity of case managers to deliver just in terms of time and effort.
- **Case managers should not establish eligibility**. Eligibility for services is ideally established separately from case management as case managers may feel pressure to make individuals eligible as this potentially could increase business for their organization. Case managers may provide information about an individual that informs the eligibility decision, but would have no authority to deem any individual eligible. In some systems, supervisors or an eligibility committee within the managing entity that may also employ the case managers (such as a CSB) makes the determinations, but these determinations are routinely sampled and reviewed by state officials to assure consistency and accuracy across managing entities in how eligibility is being determined. In some states, the managing entity has no role in the determination—it is made by state officials either in regional of central state offices—removing any possibility of conflict of interest.
- **Case managers do not establish funding levels for the individual.** The case manager's responsibility is to develop a plan of supports and services based on the individual's assessed needs. Decisions as to the amount of resources (individual budget or resource allocation) cannot be made by the case manager if the system is to be free of conflicts of interest. Making funding decisions would put the case manager in a gate-keeping position and may compromise case manager's ability to act as an agent for the person.
- **Additionally, at least in determinations for Medicaid funded HCBS, individuals performing evaluations, assessments and plans of care cannot be:**
  - Related by blood or marriage to the individual
  - Related by blood or marriage to a paid caregiver of the individual
  - Financially responsible for the individual, and/or
  - Empowered to make financial or health-care related decisions for the individual.

- **Build on the public system already in place, shifting all case management to the CSBs, eliminating the duplication of case management efforts between private and state case managers on the DD waiver.**
- **Develop two new SPAs, one for case management for people on the I/DD waivers and one for people with who are Medicaid eligible on the I/DD waiting lists and others not receiving waiver services.** The rationale for this is case management for people receiving services on a waiver is more intensive and comes with waiver-specific requirements as compared to case management for people waiting for services. Caseload size will also differ. The purpose of establishing two separate SPAs is to set appropriate standards and expectations for each type of case management.

Service Array

The depth and array of services available to people with I/DD through home and community based service programs has a direct impact on their ability to live full lives in their local communities. In Virginia, ensuring that everyone served, including those with high medical and/or behavioral support needs, are able to gain access to services that effectively and appropriately meet their needs will be critical to the success of implementation of the DOJ settlement agreement. The challenge faced by state leadership is balancing the ability to make available an array of services to meet the variety of needs and goals identified by people served, within the fiscal realities of the state budget.

In the second phase of this project, HSRI and Burns & Associates will work with the state to develop an assessment informed, resource allocation model. Implementation of a resource allocation model will assist DBHDS as it balances program budgets, with the need to make available a wide array of services to help people meet their personal goals. The phased approach to this project provides an opportunity to identify services that may need to be added to the array, develop appropriate provider qualification requirements, recruit providers and identify adequate rates for those services.

When considering the service array available to people with I/DD, the transition of individuals from Training Centers to community settings should take precedence. The ability of the state to meet the needs of these individuals will be critical -- both in terms of ensuring that people have successful transitions to full lives in the community and in terms of the DOJ settlement agreement and resulting monitoring. It is very likely that there are people currently living in community settings and moving off the waiting list in the coming years whose needs reflect those served in the Training Centers. Enhancing access to qualified providers and services designed to meet the needs of people transitioning from the Centers who may have medical and/or behavioral challenges will improve the community service system for all people with ID and DD in Virginia.

The DBHDS web-site includes a link to an Excel spreadsheet entitled “List of Individuals Seeking Community Services Providers”.[17] While no Protected Health Information (PHI) is included on the spreadsheet, it does include a significant amount of information about individuals seeking service providers. Many of the individuals on the list are identified as transitioning from Training Centers and the other individuals have received approval to be on the waiver (or in an ICF/IID) but have yet to find a provider or providers to meet their needs.

A review of the list generated on October 18, 2013 indicates that there are over 600 people currently seeking service providers across nearly every CSB area in the state. In addition, the list includes information on each person’s chronic and intensive medical needs, as well as behavioral challenges. The list is dominated by individuals who have medical issues, such as seizures and feeding issues, and individuals with behavioral challenges including PICA, self-directed destructiveness and externally directed destructiveness. This list sheds light on the ability, or inability, of the community service system to adequately support people with medical and behavioral challenges. It is commendable that the list is being used to help identify providers to meet individual needs, however, consideration should be given to whether this approach comports with the principles of person-centered practices.

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

Another reality that must be considered is the state's ability to fund services for the additional 2,915 people with ID and 450 people with other developmental disabilities that will be coming on to the waiver from waiting lists in order to avert institutional placement. Currently, DBHDS reports that 20% of people receiving HCBS live at home with family.[18] This is in contrast to the national average of 51%, a percentage that has increased steadily year to year over the past decade. It is likely that Virginia will follow this trend and shift toward a system that serves people with high support needs in 24-hour residential settings and supports others in their family home or other independent living settings. This will require that services on the I/DD waivers provide a depth and array of services that support the ability of people who live with family to be as independent and engaged in their community, as possible.

Strong community service systems must include a variety of components to support people with ID/DD and their families. Feedback from the recent stakeholder forums, interviews with state staff and key stakeholders, and a review of documents including the ID, DS and DD waiver service standards indicate that there are areas in which community capacity can and ultimately must be improved. The recommendations that follow are intended to support the state's efforts to effectively meet the needs of all people with I/DD and their families.

Service Array Recommendations

Short Term Recommendations

- **In keeping with encouraging positive behavioral supports, review and revise the criteria for the Suspension of Day Support or Prevocational Services**. Suspension of Day Service if the individual is receiving Behavioral Consultation and "suspension is an agreed upon consequence stipulated in the individual's support plan" indicates tacit approval of behavioral plans that use consequences. Review and revision of this criterion will be an important component of strengthening and enhancing the use of PBS.
- **Streamline the process for preventing and addressing crisis for people served in the community**. Steps in this direction are being taken, for example DBHDS has initiated the START program and Crisis Stabilization and Supervision services are available on the ID and DD waivers. An analysis of claims data indicate that Crisis Stabilization and Supervision services represent a miniscule portion of total claims on the ID and DD waivers (less than .1%).[19] This low utilization rate, and the call for the state to develop mobile crisis teams and crisis stabilization programs in the DOJ settlement agreement, demonstrate the need for development of a cohesive system to prevent crisis and, when that is not possible, support those in crisis in their local communities.
- **Ensure access to skilled nursing services is available to those with significant medical issues. Skilled Nursing services (RN and LPN) are available on the ID and DD waivers for those with serious conditions and complex health care needs.** Access to this service will be important for

[18] Larson, S.A., Salmi, P., Smith, D., Anderson, L. and Hewitt, A.S. (2013). *Residential Services for Persons with Intellectual or Developmental Disabilities: Status and trends through 2011.* Minneapolis: University of Minnesota, Research and Training Center on Community Living, Institute on Community Integration.

[19] B&A Background Claims Analysis

those who require medical treatments and monitoring in order to avoid institutionalization or hospitalization. This recommendation is included because an analysis of the claims data shows a low level of billing to this service, 1.7% of total waiver claims.[20] Recommendations to improve access to this service were also included in stakeholder forum and advocate comments. A review of access to this service where appropriate, i.e. in line with the state's Nurse Practice Act and when Medicaid State Plan nursing or Home Health services are not available, should be undertaken.

- **Continue to support the self-directed service options**. Claims analysis indicates that the majority of people that use personal support services chose the consumer directed option.[21] This is an important option for people who live independently or live with families. Consideration should be given to expanding the availability of consumer direction to other services, as well.

Long Term Recommendations

- **Enhance and encourage positive behavioral support (PBS) services.** Behavioral Consultation is a covered service under the Therapeutic Consultation service on the ID and DD waivers. The service definition is not specific to Behavioral Consultation and as such, it does not define standards or expectations for a positive behavioral approach. The Behavioral Consultation provider requirement includes endorsement as a Positive Behavioral Supports Facilitator, which indicates an understanding of the importance of a positive behavioral approach by the state. In order to meet the needs of individuals with I/DD who have behavioral challenges, a standalone service definition and an adequate rate for the service should be developed. Creating a standalone service definition for Applied Behavioral Analysis (ABA) may also encourage use of this service. As part of the process, requirements for positive approaches to behavioral support and ABA should be identified and articulated in the service standards.
- **Remove restrictions on "general supervision" from the Residential Support Services definition and the In-Home Residential Support Services definition in the ID and DD waivers.** This restriction may be tied to historical comparisons of HCBS waiver services with the "active treatment" standard established for institutional settings. Appendix B is a letter dated March 6, 1997 from the Health Care Financing Administration (now CMS) that clarifies issues of active treatment in HCBS settings in comparison to institutions. It is likely this restriction causes challenges for people served, who want to spend time in leisure activities and 'just hanging out' at home and their providers, who are required to ensure the health and safety of people served even during times when no specific activity is occurring. In addition, technology based supports are becoming more prevalent in community settings because they provide a level of independence for people served while ensuring health and safety in a cost effective manner. It is difficult to see how Virginia will be able to follow this trend if the restriction on general supervision remains in the service standards.

[20] B&A Background Claims Analysis

[21] B&A Background Claims Analysis

- **Consider feedback on transportation services received in the stakeholder forums and take appropriate action to monitor the Medicaid transportation service provider.** Comments and concerns about the Medicaid transportation provider were heard in nearly every forum. Generally, participants complained that it was insufficient, often unreliable and sometimes substandard. Access to transportation is critical to ensure people with I/DD are able to live and engage in their communities. Monitoring of the quality of service provided and adherence to expectations established in the contract will ensure people are not trapped in their homes, without the ability to access their communities.
- **Consider adding Caregiver Retention payments to the waivers, if vacancy factors are not included in development of rates.** Providers indicate that they are unable to provide support to people who are admitted to hospitals. It is standard Medicaid policy not to allow billing for multiple services during the same time period and so, in some states, vacancy factors are included in rate calculations to assist with covering costs when a person is admitted for a short stay in a hospital or other Medicaid funded setting. If no vacancy factor is included in the rate, the state can add a Caregiver Retention payment to its service definitions to support staff who work with an individual during a hospital stay.[22] There is no question that the individual benefits if someone that knows them can assist them while they are in the hospital.
- **To support people with efforts to engage in their local community, add a Community Guide service to the waivers**. This service has been added to waivers in other jurisdictions in order to help people with I/DD develop social networks and connections within their local community. An example of a Community Guide service definition used in another jurisdiction is attached in Appendix C.
- **Dental services should be added to the waivers to provide an avenue for people to receive dental care appropriate to their needs.** Procuring dental services for people with I/DD is often challenging. Dentists who serve people with I/DD often need additional training and staff assistance. In addition, the time it takes to perform basic dental procedures is often extended. For a person with I/DD, dental issues can be at the core of sudden behavioral changes. This may be especially important in Virginia where 55% of adults responding to the National Core Indicator (NCI) Adult Consumer Survey in the reporting period of 2011 – 2012 indicate having a dental exam in the past year, as opposed to the national average of 80%.[23]

Employment

The Department of Justice settlement agreement calls for Virginia to address the intent of American's with Disabilities Act by supporting integrated day and employment services. However, there is limited consensus across the state in regard to integrated employment as the priority outcome for working age adults with disabilities in Virginia. The Virginians with Disabilities Act establishes a policy base for a focus on employment as an outcome of service delivery stating, "It is the policy of this Commonwealth

[22] State Medicaid Director letter dated July 25, 2000. Olmstead Update Number 3.

[23] NCI Adult Consumer Survey 2011-2012

to encourage and enable persons with disabilities to participate fully and equally in the social and economic life of the Commonwealth and to engage in remunerative employment." Fully implementing this policy, with a focus on integrated employment as an outcome for working age adults with disabilities, will go far in ensuring deliverables under the DOJ settlement agreement are met.

Virginia's development of a person centered practice approach provides a platform for changing the conversation about individual outcomes, including employment. Currently, integrated employment as an outcome is addressed late in the person centered planning process and subsequent authorization of waiver services. This along with other factors, have resulted in the State's largest investment in employment services being in "group supported employment" which include enclaves and affirmative industry.[24] The 2007 Office of Disability Services Employment Focus Team report indicated individual employment declined, while group supported employment increased from 230 to 511. Ultimately, people served under the state's Medicaid waiver programs are not seen as being able to "work" by many and are "targeted to enclaves" and other group employment or day program settings.

Community Services Boards (CSBs) greatly influence access to both waiver and non-waiver services. Some CSBs have local resources that allow them to negotiate rates for non-waiver services at higher levels than are rates paid for same or similar services through the waivers. Many CSB's are direct service providers which can naturally, without specific intent, lead to development of their services over other approved providers. This enhances the sustainability of congregate employment services over expanding capacity for supported employment services. Substantial waiting lists exist for all waivers. As described in the Waiting List section above, access to services from the waiting list is prioritized by urgency of need for the ID waiver, and employment is rarely an identified priority for individuals.

Waiver recipients may have a "patient pay" contribution for certain Medicaid and Medicaid Waiver services based on amounts and sources of income, which discourages individuals with intellectual and developmental disabilities from seeking employment. Virginia has addressed this concern by implementation of the MEDICAID WORKS program which allows individuals who have a disability and who work to retain up to $33,747 in a WIN account. A WIN account is a regular checking or savings account in a bank in which only earned incomes is deposited. Under the MEDICAID WORKS program and individual may earn up to $46,740 annually without jeopardy of losing ID waiver services.

It is important to consider the impact of post eligibility treatment of income under home and community based services when seeking to prioritize employment as an outcome of services for working age adults. The Virginia ID Waiver uses a more restrictive eligibility requirement than SSI and uses the post-eligibility rules at 42 CFR 435.735 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act; this is a disincentive to the states priority to increase number of individuals with disabilities working in integrated jobs.

The Department of Aging and Rehabilitative Service (DARS) practice of 'no general supervision' requirement to access vocational rehabilitation services, prior to access of HCBS waiver services is not an effective policy and limits collaboration between State agencies to effectively use state and federal resources for employment services. This requirement may have been influenced by the unnecessary restriction on general supervision in the Residential Service definition for the ID waiver.

[24] B&A Background Claims Analysis

Provider capacity to deliver quality individual supported employment services is limited, both in quantity of available providers and competency of staff to deliver evidence or best practice employment services. Currently there is no systematic approach to training and staff development requirements for I/DD providers of employment services. Providers providing employment services under the waiver must be an approved vendor for the Department of Rehabilitative Services as a vendor of supported employment services (including CARF accreditation). Department of Rehabilitation Services manages the number of providers/venders deemed efficient to meet the demand for employment services.

Provider qualifying standards are currently driven by the Department of Rehabilitation Services provider approval process which requires CARF accreditation. This accreditation requirement appears to hinder development of new and nontraditional service providers. While CARF accreditation is a good standard to assure provider overall management practices, it does not directly address standards to assure direct employment staff have the competencies to deliver evidence based or best practice employment services. Requiring education and training based on a set staff competencies will more effectively assure consistency and quality of service delivery.

States across the country are recognizing the need to develop and require direct employment staff to demonstrate completion of, at a minimum, an approved statewide curricula in delivery of employment services. Maine, Florida and New Mexico, for instance, have a statewide curricula that addresses competency in APSE standards (http://www.apse.org/about/, n.d.) to deliver employment services.

Shared responsibility and limited collaboration across DBHDS, DMAS, DARS and local CSBs for financing of employment services make policy and goal formation more complex. There is limited investment in using available waiver funds for employment services; the low rate paid for supported employment with waiver resources is often cited as the reason. Stakeholders including providers and CSBs, express concerns about the viability of current HCBS rates for supported employment because activities that take place without the consumer, such as travel, job development or phone calls, are not billable under the waiver or adequately accounted for in the rate methodology; although they are billable activities for Department of Aging and Rehabilitative Services. There is also inconsistent implementation of eligibility for vocational rehabilitation supported employment services, long term employment services, and employment supports through the waiver.

DARS maintains limited resources for long term employment services for individuals with severe disabilities. This funding is provided to allow individuals with severe disabilities to access and maintain employment choices. The funds cannot be used to supplant current funding for long-term employment support services, which includes individuals with intellectual and developmental disabilities receiving long term supported employment services under the VA Medicaid waivers.

Data management systems are fragmented and do not collect consistent data regarding employment outcomes to determine effectiveness of either short term employment services from Department of Rehabilitation Services or long term employment services under the waiver programs.

Employment Recommendations

Short Term Recommendations

- **Promote the MEDICAID WORKS program that allows individuals to earn up to $46,740 annually without jeopardy of losing ID waiver services throughout the service planning process.**

Long Term Recommendations

- **Agreement by stakeholders around key employment outcomes and priorities should be pursued by DBHDS, CSBs, DARS and the system at large.** Agreement is needed on employment service definitions and support alternatives furnished through Medicaid waiver, state-only and local funds.
- **Elevate the influence and authority of the lead position within DBHDS that has been created to address development of the state's capacity to implement the necessary system changes to increase integrated employment services and outcomes.**
- **In order to establish current performance and identify future benchmarks for employment of people with disabilities, development and implementation of a data system to display employment outcome data (not just service data) on a state wide and local level is critically needed.**
- **Revise employment service definitions to align with the CMCS September 2011 Employment informational bulletin; separate supported employment services into individual supported employment and group supported employment, and establish a time limit on prevocational services, etc.** Once service definitions are established review provider qualifying standards to deliver services. DBHDS should consider requiring direct employment staff to minimally hold a certificate based on a set of competencies, i.e. provided by a trainer whose curriculum is approved by ACRE (http://interwork.sdsu.edu/acre/members.htm)
- **An individual's career interest and the services the individual needs to achieve integrated employment must be the priority discussion before determining what type of HCBS day or employment services the individual is authorized to receive.** Following that discussion, the person should have the opportunity to choose between providers to deliver the determined service need.
- **Create a more prominent focus on employment in the state's person centered planning process, and increased training for service coordinators to improve their ability to support service recipients reach their employment goals.**
- **As with Residential Services on the ID waiver, remove the "no general supervision" restriction as a requirement to access employment services through DARS.**
- **For individuals currently in state centers, consideration regarding each individual's career interest should be determined prior to any discussion of where the person will live.** Jobs in every career interest or employment opportunity exist in all Virginia communities. If a person moves to a particular community and then begins the job search they may be limited in employment opportunities.

- **Improvements to waiver provider requirements that directly address workforce development are warranted.** In addition, revise DARS and waiver provider requirements to allow for best practice and individualized approaches to employment, rather than reliance on CARF standards.
- **Develop and implement a plan to limit availably of congregate day and employment services to current capacity.** All increased or expansion of provider capacity should be in integrated employment services and individual and small group inclusive community habilitation.
- **Given historical usage and the new impetus for improving and increasing access to integrated employment services for people with I/DD, consideration must be given to the process for developing a rate methodology for pricing employment services.** Use State Employment Leadership Network Funding tool kit as a reference for determining rate assumptions.

Quality Improvement Strategies

The Department of Behavioral Health and Disability Services (DBHDS) has substantially improved the overall infrastructure of the quality improvement system (QIS) for people with intellectual and developmental disabilities including the launch of the automated incident management system – CHRIS, the creation of human rights committees to oversee behavioral interventions, the implementation of the National Core Indicators (NCI), the application of the "supervisory review" and the improved computer access to licensing information. DBHDS has also formed regional quality councils and an internal Quality Improvement Committee and is in the process of developing "dashboards" of aggregate data to be reviewed. Another important step has been the development of a mortality review process – a key ingredient of any robust quality improvement strategy. Given these important initiatives, next steps should be to integrate the review of the data coming from these multiple sources in order to gain a more holistic picture of system performance. To accomplish this, it will be important to create an internal quality review process, and to explore ways to include the Community Services Boards in the larger quality improvement effort. Following are recommended enhancements for the Virginia Quality Improvement System (QIS).

Quality Improvement Strategy in the Waiver Applications

The performance measures that now govern the submission of evidence to CMS for the Day Support Home and Community-Based Waiver for Persons with Intellectual Disability and the Intellectual Disabilities (ID) Waiver have been substantially streamlined. It appears that most of the performance measures align well with the six CMS Assurances. There are some exceptions, most notably in Health and Welfare and Service Plan where some key measures are missing especially given the continued importance of these two assurances in the draft guidance already provide by CMS. Specifics are provided in the recommendations below[25].

In addition, the primary data source for almost all of the measures is the DMAS Quality Management Review (QMR) tool. There are some exceptions especially in the Qualified Provider and Health and Welfare Assurances, where some data is extracted directly from the Office of Office of Licensing

[25] Crosswalk: Current vs. Revised Assurances/Subassurances for Medicaid 1915(c) Home and Community Based Waivers, August 2013

database for all providers reviewed. Further, the current QIS appears to lack cohesion and seems more like a variety of QA/QI silos developed to respond to the Department of Justice (DOJ) and the Centers for Medicare and Medicaid Services (CMS) rather than an integrated approached designed to assess the entire system.

At this point in time CMS has not yet issued final guidance specifying revisions to the QIS for 1915c waivers. However, since the waiver renewal must be submitted in April 2014 a recommendation is that DMAS and DBHDS conduct a cross walk of the current measures for all the waivers to create a unified set that align with the draft guidance presented by CMS to the states in August 2013. Note there might be some waivers that require additional measures based on the services and target population. For example, the ID waiver should include measures aimed at medications whereas the Day Supports waiver may not.

Following are the performance measures for the Health and Welfare Assurance in the most current ID and Day Supports evidence reports[26]:

1) The number and percent of Day Support Waiver individuals who did not have instances of identified risk or restraint usage. (ID and Day Supports waivers)
2) The number and percent of Day Support Waiver individuals who did not have instances of abuse, neglect or exploitation. (ID and Day Supports waivers)
3) Number of providers with an emergency plan in place (ID waiver only)
4) Number of providers that demonstrate compliance with approved medication administration procedures (ID waiver only)
5) Number of individuals who receive face-to-face contacts completed by the case manager according to policy (ID waiver only)

These measures should be rewritten to more adequately capture potential issues of harm to individuals. For example, the current set does not measure whether follow-up for serious incidents was completed as required. Nor are there measures related to serious medication errors, unexplained/suspicious deaths/mortality review, and adequate measures to track the inappropriate/illegal use of restraints for all individuals. Further individual level data for the first two performance measures are based on a sample derived from the QMR reviews. It is recommended that data from Comprehensive Human Rights Information System (CHRIS) and VDSS be drawn for all participants to use as the denominator for the health and welfare measures.

It is recommended that the State add a performance measure in the Service Plan Assurance that addresses whether the service plan has been reviewed (and updated when needed) to reflect the individual's changing needs. This measure is a CMS requirement and will likely remain one once final CMS guidance on the QIS changes is issued. The DBHDS Supervisory Review[27] would be a good data source for this measure. Also, the Supervisory Review is potentially a good data source for a number of the Service Plan performance measures but is under-utilized in the QIS for the ID and Day Services applications. To resolve these issues, the following steps are recommended:

[26] Final Quality Assessment Report - Day Support Home and Community-Based (HCBS) Waiver, CMS Control #0430, June 15, 2012. CMS Final Assessment Report for Virginia's Home and Community Based Intellectual Disability (ID) Waiver, CMS Control #0372)

[27] FY'14 Waiver Record review Form: CMQ QA Compliance

1) Currently, to facilitate the Supervisory Review, each CSB receives a sample number from DBHDS but not the names of the individuals to be selected. The CSB Support Coordinator Supervisor decides which people to select. In the future, the DBHDS should consider sending the individual names to the CSB since the Supervisor can always add to the list if he or she wants review additional individuals in order to focus on specific Support Coordinators.
2) If not already done, consider reliability studies to determine if the tool is being completed as intended.

    - Changes to the Supervisory Tool:
      Question #7 - needs, risk factors, desired outcomes and preferences being addressed in the person's plan are all in one question. A suggestion that it be split into separate questions.
    - Question #9 - "Individual Support Plan was updated/revised when individual's needs changed." It is suggested that this be divided into separate questions. For example: Has there been changes in the person's need over the past year: Yes/No. If Yes, has the plan been reviewed and revised if needed. Once this is completed it would be an excellent data source for the a performance measure in the Service Plan assurance that addresses whether the service plan had been reviewed (and updated when needed) to reflect the individuals changing needs
    - Consider adding questions about the use of restrictive interventions, if there is a behavior plan to address challenging behaviors and if the behavior plan has been reviewed the human rights committee as required.

It is recommended that DMAS and DBHDS review all of the current data sources to determine where there is overlap and what data source is the best to use for each waiver performance measure. While some overlap is an important safeguard, streamlining some of the monitoring processes will make the QIS more efficient and eliminate potentially conflicting standards. For instance, DMAS and DBHDS are both reviewing providers.

In a similar vein, a strong suggestion is to strengthen DBHDS' role and responsibility to monitor the quality of the waiver programs and to use the QMR to determine if DBHDS is fulfilling its purpose to operate the program as specified in the approved waiver. A recommended way to do this is to have DMAS draw a small statewide sample of *individuals* in licensed and non-licensed facilities as a "look behind" to ensure that DBHDS is monitoring the waiver programs, taking action to remediate issues it discovers and using data to implement improvement strategies. The Office of Licensing would continue to focus on provider compliance. Finally other DBHDS monitoring processes/data sources should then be enhanced or developed to oversee the program that aligns with the performance measures. If not already being used, DBHDS should develop an "individual review tool/process" to oversee the waiver programs that conforms with CMS sampling expectations.

To enhance the cohesion of the system, it is recommended that DMAS and DBHDS create a unified QIS designed to safeguard individuals and improve their quality of life.

1) Use the 8 domains that have been established for the DOJ Settlement Agreement as the framework for the reformed QIS. This framework could then serve as the structure for collecting and analyzing data <u>across</u> the various monitoring processes and for describing an integrated QIS that would be meaningful to everyone in the system. Following are the domains:

- Safety and Freedom From Harm
- Physical, mental and behavioral health and well being
- Community Inclusion
- Stability
- Avoiding Crisis
- Choice of services and providers
- Access to Services
- Provider Capacity

2) Schedule a regular time to review trend reports from the wealth of data that is being collected by DMAS and DBHDS including year to year QMR and licensing aggregate findings, FMS satisfaction survey results, CHRIS trends (when the system is fully up and running), etc. A review of minutes of the QRT meetings indicates that DBHDS and DMAS currently review some data pertaining to the waiver programs. However, discussions appear to focus more on data collection for evidence reports, remediation and less on reviewing various patterns and trends from a variety of sources in order to make statewide improvements in the waiver program.

The revised QIS should be described in Appendix H of the waiver applications. Following are some suggestions to consider for improving Appendix H and moving the state forward in implementing an integrated, values based, data driven approach to quality improvement:

1) Describe the ways in which everyone in the system is responsible for quality (e.g., providers, CSBs, Regions, DBHDS and DMAS Central Office, etc.).
2) Describe the DBHDS Regional Quality Councils (being developed as a result of the DOJ Settlement Agreement.)
3) Describe agency specific internal committees (including the risk mitigation and prevention group discussed in H. below) that make recommendations for improvement as well as interagency quality collaboration between DMAS and DBHDS through the Quality Review Team (QRT) quarterly meetings
4) Describe the type of data reviewed (e.g., CHRIS, DMAS QMR, Licensing, Supervisory Review, QSR/NCI surveys, FMS consumer surveys, IDOLS. etc.) by the Quality Councils and internal committees and how recommendations emanating from the groups are prioritized and what entity is responsible for approving/implementing system wide QI initiatives.

Incident Management Systems/Risk Management

As already stated, the completion of the CHRIS system has greatly enhanced DBHDS ability to take action when serious incident occur. The Office of Human Rights and Licensing also both have a significant role protecting individual rights and freedom from harm. While positive, these improvements have resulted in the need to better clarify everyone's role and responsibility for risk mitigation and prevention throughout the system. This includes clarifying (and in some instances where possible re-defining) the responsibilities of APS, CPS, licensing and providers for incident reporting and investigation, strengthening the role of support coordinators for addressing risk issues

with individuals and members of their team, making additional improvements to the mortality review process and furthering the use of data for system wide risk prevention. It should be noted that the following recommendations pertain to all three waivers including the DD waiver.

There are a number of entities involved in reporting/investigating serious incidents of abuse, neglect and exploitation including Adult Protective Services (APS), Child Protective Services (CPS), DBHDS Office of Licensing, and DBHDS Office of Human Rights. Law enforcement is also involved where warranted. This can lead to confusion for everyone in the system, most especially for providers as to the reporting/investigation authority and has the potential for serious health and safety issues to fall between the cracks. It is strongly recommended that the various entities collaborate to better define their roles and responsibilities. These assignments should be formalized in written agreements of understanding between the various entities. A critical incident manual should be refined/developed that describes reporting, triage, investigation and follow-up as well as clarify the various roles and responsibilities for everyone in the system (e.g., support coordinators, providers, CSBs, Regions, etc.). The manual could in part be drawn from the protocols developed by human rights and licensing regarding their respective roles in investigating abuse, neglect and exploitation[28]. The manual should include some of the following:

1) The types of incidents that are reported to each entity
2) Reporting timelines
3) Entity responsible for conducting investigations for specific types of incidents. Discussions should include potential opportunities for the investigation including conducting collaborative investigations
4) Entity responsible for monitoring follow-up

Currently providers have a primary responsibility for conducting investigations of most serious incidents reported to DBHDS. Provider investigators are required to be trained but there are no specific requirements for the type/content of training. It is recommended that DBHDS define the specific training content. Further, while it is acceptable for providers to investigate certain incidents, a sub-set should always be investigated (on-site) by the state including unusual deaths, sexual abuse, accidents/injuries resulting in hospitalization, etc. It should be noted that the Office of Licensing includes a priority list for conducting on-site investigations but it is not clear if licensing automatically conducts certain on-site investigations or reviews the provider's investigation and then makes a decision. It is recommended that there should be certain situations in which licensing (or another designated entity) automatically conducts the investigation.

Support Coordinators have a primary role and responsibility for risk management/ protection from harm on an individual level. Through individual assessments, visits, and other communication with the individual and family, they can be attuned to any issues that warrant a review (and perhaps revision) of the person's plan. While there may be ad hoc communication with the Support Coordinator on serious incidents, mandatory notification to the Support Coordinator has not been formalized. It is recommended that the Support Coordinator is automatically notified regarding any reported incident. It is also recommended that there be triggers established -- based on the number and type of incidents

[28] Revconsolidated5.doc

-- that signal the need to convene the individual's team in order to determine whether additional or new supports are needed. Currently triggers are being planned on a provider and statewide basis (via the DOJ Settlement Agreement) but it is not clear if the triggers will be used by each Support Coordinator for individual planning purposes.

Human Rights Information System (CHRIS):

1) Currently CHRIS includes only data on incidents reported on individuals living in licensed programs and state operated services (e.g., training centers). DBHDS should consider expanding the CHRIS system to include reporting incidents for any waiver participant regardless of where he or she lives. It is also recommended that missing persons should be added as reporting categories.
2) It appears that deaths and serious injuries must be reported to both the Office of Licensing and the Office of Human Rights. A suggestion is to automate distribution of incident reports to the appropriate entity if this is not a feature in the current online system.

Restrictive Interventions: It is not clear that discrete data are being collected on the use of restraints, seclusion and other restrictions except under the rubric of abuse and neglect. Discussions are underway in the Office of Human Rights about how best to collect this data. It is important that these plans be implemented and so that they result in improved safeguards for individuals. Further, currently state regulations do not define "qualified professional" for the purpose of developing/monitoring restrictive interventions. In subsequent revisions of the regulations it would be important to define the qualifications for these professionals. (It should be noted that the Provider Participation Requirements do have specific standards for therapeutic consultants.)

Death Reporting/Mortality Review: Currently the DBHDS is conducting mortality reviews for individuals included in the Settlement Agreement and in licensed programs. DBHDS should expand the review to include any waiver eligible participant whose death is unanticipated or unexplained. HSRI reviewed a report of the aggregate 2012 and 2013 mortality data for ID waiver participants in licensed services. Reviewing death data is certainly an excellent practice. Recommendations for continued enhancements include:

1) Consider expanding the current report to show cause of death for deaths that were unexpected versus expected.
2) The report shows that 41 of the 67 unexpected deaths were investigated. If not already being done, develop criteria for when unexpected deaths should be investigated and require that all unexpected deaths in the criteria be investigated by DBHDS (not providers).
3) Consider additional reports that display year to year comparisons for all individuals served by DBHDS (e.g., training centers, non-licensed providers, etc.) and include aggregate data for cause of death overall, cause of death by gender and age categories. This would be helpful as the state considers improvements in the system.

Critical Incident Data Sharing: There appears to be great deal of information on critical incidents currently available from the DSS Data Bridge and CHRIS is just beginning to generate data. A recommendation is for DMAS and DBHS (as well as the other entities involved in abuse/neglect reporting/investigations) collaborate on the type of data reports/frequency to share on a regular basis with one another.

Risk Mitigation and Prevention: There is an increasing amount of risk related data being collected that potentially reveals health and risk issues from a variety of perspectives including the CHRIS, the DSS Data Bridge, mortality reviews, NCI Surveys, Supervisory Review, Licensing, etc. DBHDS should develop standard aggregate reports from these various data sources for a "risk mitigation and prevention group" that reviews trends at the CSB, Regional, and Central Office level in order to identify strategies for short and long term improvements. (This was included in the DOJ Settlement Agreement.) As a part of an overall risk mitigation prevention strategy it is recommended that DBHDS train a select group of staff who would be responsible for conducting a root cause analysis should en extremely serious incident warrant a deeper review.

Appendix G (Health and Welfare) of the ID and Day Supports waiver applications:

The QIS for all of the waivers have been updated through the routine renewals and a number of amendments. As a result Appendix G or Health and Welfare has not fully kept pace with administrative or procedural changes in both DMAS and DBHDS. Following are some inconsistencies in the current Day Supports and ID waivers that should be reviewed and updated for the April 2014 renewal:

Section G-1.b in the Day Supports waiver defines reporting requirements to Adult Protective Services (APS) but not to the Child Protective Services (CPS) entity. Since this waiver also serves children it is recommended that CPS reporting be included in the application. (Note: CPS reporting is defined in the ID waiver application that is currently under review by CMS.)

In the Day Supports and ID waivers Section G-1.d says that "If the Office of Licensing detects noncompliance with any licensing regulations, DMHMRSAS issues a licensing report (the regulations do not contain a deadline for this report) requiring that the provider submit a corrective action plan to DMHMRSAS[29] within 15 business days of the issuance of the licensing report. Extensions may be granted when requested but are not to exceed an additional 10 business days." The regulations do not, however, include a deadline for the submission of the corrective action plan for approval by DBHDS. Licensing protocols require complaints to be triaged and that the most serious complaints should be investigated within 5 days or immediately. It is recommended that timelines be established for issuance of the licensing report and approval of the corrective action plan.

Section G-1.e of the Day Supports waiver says that: DMAS is responsible for monitoring the report of and response to critical incidents/events affecting individuals receiving DS waiver through a review of reports provided by VDSS. DMAS received the first report in October 2007 and will receive reports two and three in April 2008. These reports, which will be monitored quarterly, look at investigations of critical incidents and events from the VDSS transitioning to oversight conducted on a quarterly basis by a QIT in the Division of Long-Term Care at DMAS. Data reports will be compiled by waiver, indicating the type of incident investigated and the disposition of the investigation, as well as waiver participant demographics. The QIT will review incident trends or sentinel events and will make recommendations to the Long-Term Care Division Director for action.

The ID waiver has some additional information but is not updated to include implementation of CHRIS. For both waivers this section should be updated to more fully define DBHDS roles and responsibilities

[29] Now called DBHDS

for oversight of critical incidents and events since they have day-to-day responsibilities for operation of the waiver.

Section G-3.b.i (medication) defines medication monitoring as follows: "The DBHDS Office of Licensing conducts frequent monitoring in connection to complicated medication regimens. A large percentage of the negative actions (i.e., provisional licenses and pursuit of license revocation) taken by the Office of Licensing have been due to medication-related issues. Medication toxicity is considered an injury to the body and, as such is a reportable event, under the Human Rights regulations." A recommendation is the waiver also define the types of medication errors that are reported to DBHDS and the process for follow-up when reports are made.

Section G-3.c.iii on medication error reporting defines provider responsibilities for "recording" medication errors but not both recording and reporting errors. The Office of Human Rights issued revised guidance in May 2013 requiring the type of medication errors that must be reported to DBHDS. This section of the waiver should be updated to reflect the types of errors that must be reported in CHRIS.

An overall recommendation is to update Appendix G and create a standard description that would apply to all of the waivers. When considering sequencing changes in this appendix another overall suggestion is to first implement the recommendations described in the 'Incident Management Systems/Risk Management' section above and then finalize Appendix G.

Provider Monitoring

From a review of the most recent licensing protocol (reconsolidated5) the DBHDS Office of Licensure appears to have a mature and well-developed system for provider licensure. A best practice is the recent addition of the "Enhanced Visit Schedule" for such issues as unexpected deaths/serious incidents and significant health and safety CAPs. Overall recommendations that follow focus on re-thinking the overlapping provider monitoring roles and responsibilities between DMAS and DBHDS and to more sharply define some of the Office of Licensing protocols such setting timelines for aspects of the licensing process, sampling approach and conducting renewal surveys.

Both DMAS and the DBHDS Office of Licensing oversee providers. It is recommended that there be ongoing communication between these two entities regarding provider performance and especially providers with egregious citations and/or repeat deficiencies. It is also suggested that the two entities review their respective tools to determine if there is significant overlap and/or conflicting requirements.

Based on a review of the draft revisions of the Office of Licensing procedures (reconsolidated5) the following are suggested enhancements:

1) There appear to be few timelines for completion of significant steps in the provider application and licensure process. Established timelines are important for holding the provider, licensing staff and other entities accountable for completing required actions. For example, timelines are specified for provider submission of a corrective action plan (CAP) but not when the licensing staff must respond if the CAP is acceptable/not acceptable.
2) The protocol defines the number of locations that must be visited during a licensing survey but, with some exceptions, the selection appears to be somewhat open-ended (e.g., "representative sample (more than two) of client records and staff records, including records of staff hired since

the last inspection"). It is suggested that protocol should include a more specific indication of the number of individual and staff records that must be reviewed during a visit. The current practice potentially could cause wide spread differences in the application of the protocol among licensing staff.

3) The protocol does not include any mention of denial to renew or revocation of a license.

4) Letters of Good Standing are issued "when the Department is overdue in issuing a renewal. These letters verify that the service continues to be licensed." Consider setting a timeline for when the licensing survey must be conducted since, irrespective of the letter, waiting a long time period for re-survey leaves individuals and DBHDS potentially vulnerable.

QIS Recommendations

Quality Improvement Strategy for the Waivers

Short Term Recommendations

- **The state should proceed with revisions to the QIS for the HCBS April 2014 renewal, based on guidance on draft updated requirements issued by CMS in August 2013.** Specifically:
  - The Health and Welfare Assurance performance measures for the ID and DS waivers should be re-written to more adequately capture potential issues of harm to individuals.
  - The state should add a performance measure in the Service Plan Assurance that addresses whether the service plan has been reviewed (and updated when needed) to reflect the individual's changing needs.
  - DMAS and DBHDS should review all of the current data sources to determine where there is overlap and what data source is the best to use for each waiver performance measure.

Long Term Recommendations

- **To enhance the cohesion of the system, it is recommended that DMAS and DBHDS create a unified QIS for the two new waivers designed to safeguard individuals and improve their quality of life.** Work on the performance measures for the renewal will simplify this effort. DBHDS should enhance its role and responsibility to monitor the waiver program and align with the performance measures in keeping with the specific recommendations on page 29 above. To the degree possible the monitoring processes should dovetail with those being used to monitor individuals transitioning from the training centers as a part of the DOJ Settlement Agreement. The revised monitoring processes/data sources should be identified in the two new waivers.

Incident/Risk Management

Short Term Recommendations

- **For the renewal in April, Appendix G should be revised to better describe the current health and welfare system in Virginia.**

Long Term Recommendations

- **A critical incident manual should be refined/developed that describes reporting, triage, investigation and follow-up as well as clarify the various roles and responsibilities for everyone in the system (e.g., support coordinators, providers, CSBs, Regions, etc.).** The manual should be the result of collaboration between all the entities involved in incident management to better define, clarify and streamline where possible their roles and responsibilities.
- **Support coordinators should be automatically notified regarding any reported incidents in CHRIS and triggers should be established that signal the need to convene the individual's team.**
- **The DBHDS role and responsibility (instead of providers) for conducting certain types of investigations should be clarified and, if needed the capacity for the state to conduct investigations should be improved.**
- **Training expectations and content for investigators should be improved.**
- **DBHDS should complete the work already started to improve reporting of restraints and other restrictive interventions.** Along with this the regulations should better define who is considered a "qualified professional" for the purpose of developing/monitoring restrictive interventions.
- **DBHDS should expand Death Reporting and Mortality Reviews to include all waiver eligible participants whose death is unanticipated or unexplained.**
- **DBHDS and DMAS should implement the above recommendations section and finalize them in Appendix G for the two new waivers.**

Short Term Recommendations

- **DMAS and DBHDS Office of Licensing should have ongoing communication regarding provider performance and especially providers with egregious citations and/or repeat deficiencies.**
- **Consider enhancements to the licensing protocols such as sharpening timelines for specific licensing activities such as making improvements to the sample, and reviewing the protocol for the re-licensing survey.**

Concluding Remarks

The recommendations contained in this report provide the opportunity to improve and enhance the community service system for people with intellectual and developmental disabilities in Virginia. Implementation of the primary recommendation, creating a cohesive approach to serving people with ID/DD under the Department of Behavioral Health and Developmental Services in statute, regulation, policies and operational practice, will be a significant and fundamental step in this direction. The structure of the current system divides eligibility, access, case management functions and services on the basis of diagnostic and programmatic criteria and is confusing for individuals and families to navigate and understand.

Once a unified approach to serving people with ID/DD is adopted, action on the additional recommendations identified in this report will necessarily follow. Whether under the two new waivers recommended here, a comprehensive waiver and a support waiver, or under another construct, planning that includes people with ID/DD, families, CSBs, providers and other advocates should be initiated to ensure the system that results meets the needs of those it serves, to the fullest extent possible. Issues for consideration within DBHDS, DMAS and with stakeholders include revision of current eligibility requirements for people with I/DD, developing uniform waiting list procedures, clarifying the role of the Community Services Boards, strengthening case management, enhancing the service array, fully supporting employment initiatives and ensuring the quality improvement system is comprehensive and reflective of CMS' new guidance. This daunting undertaking will be worth the effort because it will result in improved lives for Virginians with I/DD and their families.

Appendices

APPENDIX A

Information on Missouri Partnership for Hope

Missouri Partnership for Hope

§1902(a)(1) of the Social Security Act requires that the Medicaid state plan be in effect in all political subdivisions of the state. This requirement is known as "state wideness" and means that the state must assure that there is similar access to the program throughout the state. But the HCBS waiver regulations permit states to ask for a waiver of state wideness that allows the state to operate the program differently in different areas. For example, the state may request a waiver of state wideness in order to limit the geographical areas where the program is available. This waiver of state wideness would allow a HCBS waiver program to be available in some CSBs catchment areas and not in others. Virginia could seek permission to operate a new waiver program that uses these local funds as match for eligible individuals. This would have to be a new and separate program from other statewide waivers, but could build off of other waivers in terms of eligibility and could provide a service array that mirrors what the CSBs are currently providing using local funds.

This type of "local match" HCBS waiver is already operational in Missouri. The program is called the Partnership for Hope waiver and operates using local county mill taxes.[30] Missouri anticipates enrollment to reach more than 2,800 in 2013 with 96 of the 115 counties (including the City of St. Louis) in Missouri participating. This waiver is capped at $12,000 per person per year with average expenditures are about $9,000 per person per year.[31] As can be seen from the table at right, the Partnership waiver covers a substantial array of services but does not include residential services other than on a temporary basis. The program is operated by the counties (with oversight from the state), who establish eligibility. In the Missouri system, the state sets maximum allowable rates for services, which are approved by the state Medicaid agency. What individual providers are to be paid is overseen by the state regional office during the initial contracting process. The rates vary between providers up to the maximum allowable rate.

Missouri Partnership for Hope Services	
Assistive Technology	Personal Assistant
Behavior Analysis Service	Physical Therapy
Community Specialist	Person Centered Strategies Consultation
Co-Worker Supports	Professional Assessment and Monitoring
Dental	Specialized Medical Equipment and Supplies (Adaptive Equipment)
Environmental Accessibility Adaptations/Vehicle Modifications	Speech Therapy
Group Community Employment	Support Broker
Independent Living Skills Development	Temporary Residential
Individual Community Employment	Transportation
Job Discovery	
Job Preparation	
Occupational Therapy	

Missouri officials report that without the Partnership waiver, many of the individuals served would remain on waiting lists. The addition of the waiver brought new funding to the participating counties and expanded the number of individuals they are able to serve. Virginia may want to consider working with CSBs that use local funds to ascertain interest in creating a new waiver that allows the CSBs to capture FFP for expenditures they are already making and permitting expansion to individuals who are waiting for services.

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30 In Missouri Senate Bill 40 authorizes counties to generate a mill tax to pay for services for persons with developmental disabilities and gives counties flexibility as to how they can use the tax. Most, but not all, levy this tax.

31 A copy of the waiver can be found at: http://dmh.mo.gov/dd/progs/waiver/partnership.htm

APPENDIX B

Letter Dated March 6, 1997 from the Health Care Financing Administration (now CMS) That Clarifies Issues of Active Treatment in Institutional Settings in Comparison to Community Services

Region III

Health Care Financing Administration

P.O. Box 7760, Mailstop 13

Philadelphia. P4 19101

DEPARTMENT OF HEALTH and HUMAN SERVICES

March 6, 1997

MEDICAID LETTER NUMBER: 97-10

SUBJECT: Guidelines Regarding What Constitutes an ICF/MR Level of Care Under a Home and Community-Based Services Waiver

The flexibility afforded under the waiver program has allowed States to pursue strategies for controlling costs and utilization. One such strategy is reducing or limiting funding for institutional care by expanding the availability of home and community-based services programs to care for individuals in less restrictive settings. This enables states to offer a broader range of services at a lower per capita cost.

Prior to 1981 , the only long term care available under the Medicaid Program to individuals with mental retardation or a developmental disability was provision of services in an intermediate care facility for the mentally retarded or persons with related conditions (ICF/MR). Prior to the inception of the waiver program, individuals in institutions exhibited a broad range of functional abilities. As the balance of care has subsequently shifted from institutional to home and community-based care, the more severely disabled have tended to remain in institutions. Moreover, because community-based services tend to be more accessible to higher functioning individuals, these consumers have been more inclined to choose community-based care services over institutional care. As a result, the profile of individuals receiving home and community-based care may differ from those served in institutions. However, it would be a mistake to conclude that certain high functioning individuals would not require ICF/MR services merely because their functional abilities exceed the levels ordinarily seen in ICFs/MR nowadays.

It is important to note that Section 1915(c) of the Social Security Act does not require that individuals served under the waiver "resemble" individuals who remain in the institution. Section 1915(c) requires that "home and community-based services ... are provided …to individuals with respect to whom there has been a determination that but for the provision of such services the individuals would require the level of care provided in (an) intermediate care facility for the mentally retarded the cost of which would be reimbursed under the State plan." (emphasis added.) Thus, the basic question is whether the individual applicant requires an ICF/MR level of care (LOC) which would be reimbursed under the State plan.

The state establishes the ICF/MR LOC consistent with regulations at 42 CF 440 150 and 483.440. For purposes of the waiver, an evaluation of whether the individual requires an ICF/MR LOC under the State plan is made by using the same LOC assessment criteria used to determine the need for care in an institution. A state may use an evaluation form which differs from that used in the institution to make this determination.

If, however, the State uses a different form, regulations at 42 CFR 441303(c)(2) require the State to describe how and why it differs and provide an assurance that the outcome of the new evaluation form is reliable, valid, and fully comparable to the form used for institutional placement. Thus, evaluation for ICF/MR LOC under the waiver can be no less stringent than that used for institutional placement.

A State does not necessarily need to use the same persons to make the LOC determinations under the waiver that it uses to make determinations for the institution (in many cases this would be impractical). However, the State should utilize evaluators who are comparably educated and trained to make LOC determinations. In addition, evaluators making LOC determinations under the waiver should employ the same guidelines used to determine LOC for placement in an institution. We recommend that states monitor these processes to ensure that consistent determinations of LOC are being reached for both ICF/MR and community-based care.

Federal regulations for the ICF/MR program require that individuals residing in ICFs/MR receive a continuous active treatment program. Active treatment is defined as aggressive consistent implementation of a program of specialized and generic training, treatment, health services and related services that is directed toward the acquisition of the behaviors necessary for the individual to function with as much self determination and independence as possible; and the prevention or deceleration of regression or loss current optimal functional status. Active treatment does not include services to maintain generally independent individuals who are able to function with little supervision or in the absence of a continuous active treatment program. While regulations in 42 CFR 483 Subpart I are cross-referenced through §441.302(c) and §440.150, there is no requirement for implementing regulations that an individual in need of ICF/MR services receive active treatment under the 1915(c) waiver. The active treatment concept is based on the assumption that an individual is a resident in an institution (which is required to provide all necessary care and services for that individual). The applicability of active treatment, therefore, is limited to the institutional setting. Federal Law requires that individuals served under the waiver would be eligible, in the absence of the waiver, to receive active treatment in an institution (in this case, an ICF/MR).

Under a home and community-based services waiver, the State must assure that necessary safeguards have been taken to protect the health and welfare of the recipients of waiver services (441.302(a)). Therefore, we believe it is reasonable to conclude that a person with developmental disabilities (who would receive active treatment if institutionalized) could only receive care and services which ensure his or her health and welfare when a program of activities is made available which meets his or her developmental needs and provides the individual the opportunity and encouragement to progress to or maintain his or her highest attainable level. Accordingly, the State must be able to demonstrate that through the use of waiver services and other community-based resources, the needs of the individual in the waiver program are being met. As in the institution, determining what the individual's needs are and how they should be met should take into consideration the individual's age and include opportunities for client choice and self-development.

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In conclusion, we believe waiver programs should assure that:

- the process for evaluating an individual's need for an institutional LOC under the waiver is comparable to the process used by the State for evaluating an individual's need for institutional services, and that the process is likely to achieve the same outcome as the process used for institutional placement,
- the care plan process identifies the individual service needs, and those needs are appropriate for the individual's age/life stage, and
- individuals served under the waiver program receive the appropriate supports and services to achieve the goals identified in their individual plans of care.

If we can be of any assistance in this area, please contact Bill Davis at (215) 596-1020.

Dennis Gallagher

Chief Medicaid Operations Branch

Division of Medicaid

APPENDIX C

Community Service Guide Definition

Community Guide: Individual-T2041

Community Guide Services provide support to individuals and planning teams that assist individuals in developing social networks and connections within local communities. The purpose of this service is to promote self-determination, increase independence and enhance the individual's ability to interact with and contribute to his or her local community. Community Guide Services emphasize, promote and coordinate the use of natural and generic supports (unpaid) to address the individual's needs in addition to paid services.

These services also support individuals, representatives, Employers of Record and Managing Employers who direct their own waiver services by providing direct assistance in their individual direction responsibilities. Community Guide Services are intermittent and fade as community connections develop and skills increase in self-direction; however, a formal fading plan is not required. Community Guides assist and support (rather than direct and manage) the individual throughout the service delivery process. Community Guide Services are intended to enhance, not replace, existing natural and community resources.

Specific functions are:

1. Assistance in forming and sustaining a full range of relationships with natural and community supports that allows the individual meaningful community integration and inclusion
2. Support to develop social networks with community organizations to increase the individual's opportunity to expand valued social relationships and build connections within the individual's local community
3. Assistance in locating and accessing non-Medicaid community supports and resources that are related to achieving Individual Support Plan (ISP) goals; this includes social and educational resources, as well as natural supports
4. Instruction and counseling which guides the individual in problem solving and decision making
5. Advocacy and collaborating with other individuals and organizations on behalf of the individual.
6. Supporting the person in preparing, participating in and implementing the ISP
7. Providing training on the Individual and Family Directed Supports Option, if the individual is considering directing services and supports (Agency With Choice and Employer of Record)
8. Guidance with management of the Individual & Family directed budget Agency With Choice and Employer of Record (Self Direction)
9. Coordinating services with the Financial Support Services provider, if the individual is self-directing services under the Employer of Record Model, including guidance on use of the individual and family directed budget (self-directed budget)
10. Providing information on recruiting, hiring, managing, training, evaluating, and changing support staff, if the individual is self-directing services (Agency With Choice and Employer of Record)
11. Assisting with the development of schedules and outlining staff duties, if the individual is self-directing services (Agency With Choice and Employer of Record)
12. Assisting with understanding staff qualifications and record keeping requirements, if the individual is self-directing services (Agency With Choice and Employer of Record)
13. Providing on-going information to assure that individuals and their families/ representatives understand the responsibilities involved with self-direction, including reporting on expenditures and other relevant information and training (Agency With Choice and Employer of Record)
14. Coordinating services with the Agency with Choice if the individual is directing services under

	the Agency with Choice Model 15. Assistance in locating options for renting or purchasing a personal residence, assisting with purchasing furnishings for the personal residence 16. Informing and coordinating community resources including coordination among primary, preventative and chronic care providers
Exclusions	1. This service does not duplicate care coordination. Care coordination under managed care includes: assisting the individual in the development of the ISP, completing or gathering evaluations inclusive of the re-evaluation of the level of care, monitoring the implementation of the ISP, choosing service providers, coordination of benefits and monitoring the health and safety of the individual consistent with 42 CFR 438.208(c). 2. The provider of Community Guide Services may only additionally provide Community Transition, Individual Goods and Services and Financial Support Services to the same individual. The Community Guide may provide Agency With Choice Services to the same individual. 3. Community Guide Services are only to be used to provide support for Self-Direction activities as approved in this waiver, Individual and Family Directed Supports: Employer of Record and Agency With Choice Models.