

## V. Medicaid

### A. Introduction to Medicaid Insurance and Waiver Services

Unlike other services described in this *Assessment*, Medicaid is a **publicly funded health insurance program** that is jointly administered and funded by the **US Centers for Medicare and Medicaid Services (CMS)** and each individual state. For many individuals, Medicaid is an essential resource for accessing health services and long-term care supports. As noted in a presentation to the Senate Finance Committee (Flores, 2013), Virginia’s Medicaid program funds:

- long-term care services not available through commercial payers [Home and Community Based Waiver services, nursing facilities, intermediate care facilities for individuals with intellectual disabilities (ICFs/IID)];
- health care and supports to low-income Medicare enrollees;
- indigent health care and other safety net providers, including behavioral health services and dental services for youth; and
- health care for low-income citizens (primarily youth).

Moreover, according to the Kaiser Family Foundation report, *Medicaid: A Primer* (2013), individuals with disabilities nationwide are less likely to have private insurance than the general population. An estimated 20 percent of non-elderly adults with a chronic disability living in the community are covered by Medicaid.

Authorized by Title XIX of the federal Social Security Act (42 USC § 1396 et seq.), Medicaid provides medical and related insurance coverage for low income Americans and other targeted populations—individuals who are elderly or have disabilities—who meet state eligibility requirements. The federal Centers for Medicare and Medicaid Services (CMS) require (“mandate”) states to cover certain services under Medicaid. States may choose to cover additional (“optional”) services. However, federal regulations require that all services covered by a state under Medicaid, whether mandatory or optional, must be available statewide in the same amount, duration, and scope to everyone eligible for benefits, and that eligible individuals must be able to choose their own providers for those services. Each state must submit a **Medicaid State Plan** to CMS for approval that describes its available mandatory and optional services. When indicated, states may submit Medicaid State Plan Amendments to CMS requesting changes to their plans.

Federal Medicaid regulations give states significant flexibility in designing their service systems by allowing them to develop and apply for “**waivers**” of any core CMS program requirements (i.e., uniform amount, duration, and scope of services) in order to provide

community alternatives to institutionalization. States must ensure that waivers comply with federal guidelines, and CMS must review and approve each Waiver application. **Medicaid Home and Community Based Services (HCBS) Waivers** for specific subpopulations of individuals identified as needing particular services are an example. For a waiver to be approved, the state's Medicaid agency, such as the **Virginia Department of Medical Assistance Services (DMAS)**, must assure CMS that the annual cost to provide community-based services is no more than the cost of comparable care in an appropriate institution, which varies by waiver. Federal regulations also allow states to determine whether to base this assurance on individual cost or average aggregate cost. Virginia uses aggregate cost methodology for its Medicaid HCBS Waivers.

The Virginia Joint Legislative Audit and Review Commission (JLARC) has noted that Medicaid is the second largest expenditure in Virginia's budget. Total Medicaid expenditures grew from \$5.8 billion in state fiscal year (SFY) 2009 to \$7.6 billion in SFY 2013. Part of this growth was related to the recent recession as well as slow job recovery in some parts of the State. Virginians have lost jobs and income, leading many to turn to the Medicaid program for health coverage. In 2011, the Kaiser Family Foundation reported that each 1-percent increase in the national unemployment rate results in 1.1 million more individuals without private health insurance coverage, 1 million more Medicaid enrollees nationally, and a likely decline in state revenues of 3 to 4 percent. Between 2008 and 2012, a US Census report (2013) notes that the percentage of adult Virginians (under age 65) with public health insurance increased from 12.0 to 14.0 percent while the percentage of adults who were uninsured increased from 13.1 percent to 14.3 percent. Concurrently, the number of adults with only private health insurance declined from 74.9 to 71.7 percent. Without Medicaid, the proportion of uninsured Virginians would have been even higher.

For many years, the Virginia General Assembly, similar to other states, has had significant concerns about rising Medicaid costs and, in general, health care costs, which are interrelated. Health care costs have been increasing at a rate higher than the inflation rate for many years, although costs have risen more slowly since the Great Recession. To explore this issue, the Joint Commission on Health Care (JCHC) has explored the environmental factors that impact these costs. As noted in a December 2013 presentation (Flores, 2013), over 1 million Virginians were uninsured in 2013. Of those, an estimated 195,000 citizens who are ineligible for Medicaid due to their income still are too poor to qualify for health insurance through the health exchange or to afford the insurance premiums. These uninsured individuals are considered to be **"the working poor"**: 48 percent of the uninsured had at least one full-time worker in the household; another 22 percent had at least one part-time worker. In Virginia in 2010, the highest rates of uninsured individuals were located in the Southwest and Southside regions of the State as well as in Prince William County. These individuals are more likely to defer health care until the condition worsens significantly, which can be more expensive to treat or can lead to emergency room visits.

Over the next decade, other factors are expected to contribute to further increases in both Medicaid enrollment and costs in Virginia: rising medical costs; growth in the number of elderly as “baby boomers” age; broadened eligibility criteria, if adopted, from the federal Affordable Care Act; and various state initiatives to increase and improve access to publicly funded health care and long-term supports in the community. The issue of Medicaid costs, however, must be considered along with the issue of cost avoidance. For individuals who are elderly or have a lifelong disability, Medicaid can enable them to receive services that not only help maintain their functional abilities and self-sufficiency but also help avoid more expensive treatments or even institutional care.

A critical national context that impacts both Medicaid and health care in Virginia is passage and implementation of major health care reform legislation, the Patient Protection and Affordable Care Act (42 USC § 18001)—commonly referred to as the “**Affordable Care Act**,” the “ACA” or “Obamacare.” Extensive ACA information is provided by the federal website <http://www.healthcare.gov>. In addition, extensive information as well as objective analysis of data and policy trends regarding the ACA, Medicaid, and health care is available from the Kaiser Family Foundation at <http://www.kff.org>.

Passed by Congress in 2010, the ACA has a 10-year implementation timeline. Key provisions of the ACA implemented as of February 2014 include the following:

- removal of pre-existing conditions as a basis for denial of health insurance;
- ability to include adult children up to age 26 years on parental insurance policies;
- eliminates lifetime and annual limits (“caps”) on health insurance benefits;
- adds habilitative and rehabilitative services as covered benefits under private insurance plans in the health exchange;
- creates **health exchanges** to assist individuals and families who are uninsured and who are not eligible for Medicaid or Medicare in locating private health insurance to meet their needs; and
- provides subsidies for the cost of monthly insurance premiums on a sliding scale for individuals and families earning between 100 to 400 percent of **the federal poverty level (FPL)** as well as subsidies to help with the cost of deductibles and copayments for individuals and families earning less than 250 percent of the FPL.

According to the US Centers for Medicare and Medicaid, the FPL in 2014 is \$11,670 in annual income for an individual and \$23,850 in income for a family of 4. In addition, the ACA offers financial incentives to the states for creating **health home services**, a new Medicaid option. The health home service is an enhanced, person-centered model of care that integrates medical and behavioral care for individuals with chronic health conditions.

A focus of intense political debate nationally and in Virginia has been the ACA option, with fiscal incentives, for states to **expand Medicaid eligibility** to all adults under age 65 who have

incomes at or below 138 percent of the FPL. Nationally, in 2012, 17.7 percent of the population lacked health insurance. Of those, 38 percent had incomes of less than 100 percent of the FPL. To encourage Medicaid expansion, the ACA offers a financial incentive to the states: When a state adopts the expansion, the federal government covers 100 percent of Medicaid coverage for 2014 through 2016, then gradually reduces the federal share to 90 percent by 2020 and beyond. Of note is that Virginia's federal "match" for Medicaid has been and remains at 50 percent. One major political concern is that due to its debt levels and revenue trends, the federal government will not be able to sustain that level of financial support over time, causing the costs to revert to the states.

Virginia's **current income eligibility limit** for adults without children or a disability is at only 80 percent of the FPL. As a result, adoption of the broader eligibility for Medicaid expansion is expected to have a significant impact on enrollment, and thus, on costs. The state Department of Medical Assistance Services (DMAS) estimated in 2010 that closing the health coverage gap would add between 270,000 and 425,000 new enrollees at an additional cost of \$1.5 billion between 2017 and 2022.

In 2013, at legislative request, DMAS re-examined cost projections for Medicaid expansion with consideration of the potential cost-avoidance/savings gained by expansion. For example, savings resulting from the increased number of Virginians with private health insurance. Newly available data on enrollment patterns and costs in states that adopted Medicaid expansion were examined. Based on trends in other states, cost projections were developed for various impacts of both implementing the Affordable Care Act (ACA) and Medicaid expansion. Under both, the number of people with private health insurance or Medicaid is expected to increase, thereby reducing their reliance on state-funded services.

The resulting, revised DMAS projections were reported to the legislature by the state Secretary of Health and Human Services and DMAS staff in January of 2014. The estimated number of uninsured Virginians expected to enroll under Medicaid was revised to be 247,923 individuals. Cost savings for the Commonwealth are anticipated for elimination of certain publicly covered programs (e.g., FAMIS MOMS and family planning) and for savings for behavioral health, inmate inpatient hospital care, and hospital indigent care, among others. According to the DMAS analysis, some increase in average per person costs under Medicaid expansion is expected because of initially higher service use to address previously unmet needs.

At that same legislative meeting, DMAS re-examined cost projections that addressed another ACA impact: planned annual reductions in the **federal "disproportionate share"** allocations, slated to begin in federal fiscal year (FFY) 2016. These allocations are made to hospitals, referred to as "**disproportionate share hospitals**" (**DSHs**) that have more than 14 percent of their service utilization covered by Medicaid. For over 30 years, federal DSH funds have been allotted by formula to each state to support health care by private and state-operated hospitals to individuals who are indigent (poor and uninsured or under-insured). In Virginia, the majority of DSH funds have gone to the two state medical teaching hospitals: the University of Virginia (UVA) and Virginia Commonwealth University (VCU). DMAS projected that

future indigent care costs at UVA and VCU would grow at an annual rate of 7 percent, while reductions in federal DSH allocations increased.

In FFY 2016, ACA reductions to DSH for Virginia will be \$10.5 million; and, by FFY 2022, \$34.9 million dollars. Based on its projections, the DMAS predicted a significant shortfall (a “DSH cliff”) of \$75 million at those hospitals due to projected indigent care costs in FFY 2018. To deal with this shortfall, the following options are available to the Commonwealth: (1) adopt Medicaid eligibility expansion, which reduces state costs and provides a payment source for hospital care; or (2) significantly increase state General Funds to cover care previously provided through DSH funds. Without action, UVA and VCU hospitals will experience substantial losses that will grow annually. Substantial legislative opposition to expanding eligibility for Medicaid to close the coverage gap existed in the 2014 session. As of June 1, 2014, a resolution had not occurred, and the legislature had not adopted a state budget.

Responding to a statewide need to address rising health care and insurance costs as well as the ACA, in May of 2011, Virginia’s Governor and the Secretary of Health and Human Resources began the **Virginia Health Reform Initiative (VHRI)**. The VHRI goals were not only to prepare for potential implementation of the ACA and other federal health care reforms, but also to develop innovative health care practices that could improve access to services, disease prevention, workforce availability, service quality, and cost effectiveness. After extensive workgroup meetings, the *Report of the Virginia Health Reform Initiative Advisory Council* was submitted to the Governor and released on December 20, 2010. Key recommendations related to Medicaid included, but are not limited to:

- Funding and implementing the **Virginia Gateway project**, which would create an automated application and eligibility system across Virginia’s health and human services agencies;
- Convening multiple stakeholders to identify, pilot-test, and disseminate effective models of service delivery and payment reform;
- Piloting the use and payment of telemedicine in underserved areas of the State that would include application of a payer claims data base; and
- Exploring cost-sharing opportunities for the current and future expansion of the Medicaid population.

In 2011 and 2012, the Virginia General Assembly approved a number of budget items that addressed Health Reform Initiative recommendations and that affected Medicaid funding or services under the Medicaid State Plan and the Home and Community Based Services (HCBS) Waivers. Budget and statutory language from the legislature supported these initiatives:

- Tasked DMAS and the Department of Behavioral Health and Developmental Services (DBHDS) with examining ways to **improve existing or develop new Medicaid HCBS Waivers for individuals with intellectual or developmental disabilities (ID/DD)** that would “increase efficiency and cost effectiveness, enable more individuals to be served,

strengthen the delivery of person-centered supports, enable individuals with high medical needs and/or high behavioral support needs to remain in the community setting of their choice, and provide viable community alternatives to institutional placement” (2011 Appropriations Act).

- Authorized **expansion of Medicaid Managed Care** statewide under the Medallion II model for children and for adults with expansion for children beginning in calendar year 2012. In addition, DMAS was authorized to develop and expand **care coordination programs** statewide for special populations, including (1) those receiving services under the **Elderly and Disabled with Consumer Direction (EDCD) Waiver**, (2) waiver recipients who receive acute care medical services, (3) individuals in need of behavioral health services, and (4) individuals who are “**dually eligible**” for Medicaid and for Medicare.
- Enhance program integrity and **fraud prevention** activities.
- **Improve oversight** with greater emphasis on service quality, which is linked to payments.
- **Did not renew the HIV/AIDS Waiver**, effective July 1, 2012. This decision was made based on longitudinal analysis of DMAS data on the number of individuals being served and types of services received. Over the past 20 years, because of medical advances (especially with medications), an increasing number of individuals with a diagnosis of HIV or AIDS have been able to maintain independence, stable health, and employment. Individuals who still required services were provided a choice of other Medicaid Waivers and services appropriate to their needs.

Subsequent legislative sessions continued to support Medicaid reform and to explore options for private insurance coverage. The 2012 Appropriations Act further directed DMAS to expand **care coordination** principles “to all geographic areas, populations, and services” under Medicaid programs. In doing so, the Act required that care coordination expansion include shared financial risk, performance benchmarks, and improved quality of care through outcome measurement and expenditure monitoring. Additionally, it tasked DMAS with providing a formal report to the legislature each fall on implementation progress. By SFY 2016, DMAS is to expand coordinated (managed) care to all individuals who receive long-term care and Waiver services.

**Managed care for Medicaid services** is not new in Virginia. The Commonwealth, in fact, has been a leader among the states in adoption of managed care, which was started in 1996. The Medallion II program uses **managed care organizations (MCOs)** to deliver care, which became statewide in 2012. As of April of 2014, there are 7 MCOs in Virginia. According to DMAS, it is the role of MCOs to provide and improve access to and coordination of primary and acute health care services as well as case management and care coordination services. MCOs are also required to provide a medical home and offer credentialed provider networks. Under Medallion II, primary care physicians assume responsibility for providing and coordinating care based on the medical needs of patients. MCOs are paid on a capitated basis (receiving a set fee per patient regardless of treatment) with the MCO assuming all risk for patient care. Over time, the

legislature authorized expansions to the Medallion model due to improved medical outcomes and cost effectiveness.

The program currently operates as **Medallion 3.0** under CMS § 1915(b) waiver program authority in accordance with Federal Managed Care regulations (42 CFR Part 438) and through a CMS-approved managed care contract. This Medicaid 1915 (b) waiver allows DMAS more flexibility and options for the delivery of services to qualified, eligible individuals under a MCO. This includes demonstrating cost effectiveness of the alternative programs and delivery models to provide community service alternatives to institutionalization. As of July 1, 2012, a total of 682,638 Medicaid recipients in Virginia were enrolled in a Medallion II managed care plan; and, as of July 1, 2013, a total of 696,008 were enrolled in a managed care plan, a 2 percent increase.

In 2011, DMAS successfully applied to the Centers for Medicare and Medicaid Services (CMS) to participate in the **Financial Alignment Model Demonstration Grant for Medicare/Medicaid Enrollees (FAD)**. The “dual-eligible” individual is one who is enrolled or eligible for both Medicare and Medicaid programs. Nationally, over 9 million Americans are dual enrollees; of those, 58.8 percent are age 65 or older; 41.2 percent are adults, typically with a disability; and many have multiple, complex health needs. Obtaining the array of needed services under each program is challenging due to fragmented services that result from the different sets of service benefits. The grant’s purposes are to:

- improve care coordination, thereby reducing or eliminating service fragmentation;
- ensure timely access to needed care providers and appropriate care;
- promote wellness and independent living;
- improve service quality; and
- reduce expenditures.

As of January of 2014, Virginia was one of only nine states to sign a Memorandum of Understanding (MOU) with CMS to participate in the FAD.

Virginia’s demonstration grant program is known as **Commonwealth Coordinated Care (CCC)**. Extensive information about the program and the participating managed care organizations is available online at [http://dmasva.dmas.virginia.gov/Content\\_pgs/altc-enrl.aspx](http://dmasva.dmas.virginia.gov/Content_pgs/altc-enrl.aspx). As noted in the DMAS application and enacted since signing the *MOU*, CCC design and operations are based on person-centered principles and on promoting home- and community-based, long-term services. Through extensive outreach, DMAS staff engaged stakeholder groups and self-advocates in both CCC planning and implementation. In 2013, a **CCC Advisory Council** of stakeholders was created and meetings began. For more information, go to [http://dmasva.dmas.virginia.gov/Content\\_pgs/mmfa.aspx](http://dmasva.dmas.virginia.gov/Content_pgs/mmfa.aspx).

Under CCC, enrollees have all the benefits currently available from Medicaid and Medicare and a single program for coordinating primary, preventive, acute, behavioral, and long-term services. Each CCC enrollee has a single insurance card for all services, rather than separate cards for Medicaid, Medicare Parts A and B (hospital and professional services), and Medicare Part D (drug benefit). However, CCC offers additional benefits beyond those under Medicaid and Medicare:

- a 24/7 toll-free number for technical assistance about benefits;
- expanded tele-health services (which may vary by health plan);
- a “behavioral health home,” to improve physical health, psychiatric, and behavioral services through a new partnership between the health plan providers and local Community Service Boards (CSBs);
- comprehensive Health Risk Assessments (which address medical, psycho-social, cognitive and functional status) for all enrollees; and
- a single, unified appeals process.

As of December of 2013, approximately 78,600 “dual-eligible” Virginians in 5 regions are eligible for CCC. Eligible individuals must be age 21 or older. Additional CCC eligibility criteria require that the individual:

1. be a full benefit Medicare/Medicaid enrollee (i.e., entitled to Medicare Part A benefits, enrolled in Medicare Parts A and B and receiving full Medicare benefits, and eligible to receive full Medicaid benefits);
2. live in a Demonstration Region (Northern Virginia, Tidewater, Richmond/Central, Charlottesville, or Roanoke); and
3. be enrolled and participating in the Elderly or Disabled with Consumer Direction (EDCD) Medicaid Waiver.

Individuals who meet the above criteria and who reside in a nursing facility may be eligible for CCC. Participants in the **Program of All-inclusive Care for the Elderly (PACE)** may choose to opt into CCC, but are not required to do so. At time of this assessment, CCC *excludes* Virginians who are dual-eligible but:

- are enrolled in any Waiver other than the EDCD Waiver;
- reside in either a state psychiatric facility or Training Center;
- reside in a community intermediate care facility for individuals with intellectual disabilities (ICF/IID);
- are served in a long-stay hospital;
- are enrolled in the Money Follows the Person (MFP) program;

- receive the Medicare End Stage Renal Disease benefit, or
- receive hospice services at the time of initial eligibility to enroll in CCC.

Enrollment into CCC has two phases and is staggered in time across the five regions. First is a period of two to three months for “voluntary enrollment,” during which time an individual pro-actively enrolls; second is a period of “passive enrollment” (automatic enrollment) if the person has not contacted CCC about his or her preference. Under automatic enrollment, CCC assigns the person to a managed care organization (MCO) in their region based on consideration of previous health plan enrollment or the current health plan network (which includes any adult day health provider or nursing facility utilized by the individual, if applicable). Individuals eligible for CCC may choose to “opt-out” of the program at any time during the enrollment periods and afterwards but must formally notify CCC of that decision. All CCC dis-enrollments occur at the end of the month. The individual who opts-out remains in or returns to traditional Medicare and Medicaid.

Moreover, once enrolled with a chosen MCO health plan provider, if at any time an individual becomes dissatisfied with the services, he or she may request either re-assignment to another CCC plan provider or opt-out of CCC entirely. Voluntary enrollment began in March of 2014 in the Tidewater and Richmond/Central Regions. DMAS staff reported that over 1,400 individuals had enrolled as of the end of that month. Voluntary enrollment in other CCC pilot regions began in May of 2014. In all affected regions, coverage begins a month after the opening of the voluntary enrollment period. By October 2014, CCC services will be initiated for all participating enrollees in the demonstration area.

Concurrent with the application and planning for the CCC program, the Department of Medical Assistance Services (DMAS) developed and implemented expansion of managed care to additional Medicaid populations and those participating in the Family Access to Medical Insurance Securities (FAMIS) program. In compliance with the 2012 Appropriations Act, DMAS expanded managed care to enrollees in the Roanoke/Alleghany region and the far Southwest region by December 2012, thereby making managed care operational statewide. In addition, DMAS completed a pilot project to enroll foster care youth under the custody of the City of Richmond Department of Social Services in June of 2012 and reported outcomes to the legislative oversight committees.

In compliance with legislative budget requirements to implement a coordinated care model for behavioral health services not currently under managed care, DMAS developed and issued a competitive Request for Proposals (RFP) in December of 2011 to contract for an organization to serve for three years as the **Behavioral Health Services Administrator (BHSA)**. The overall goals of this care coordination model are two-fold: (1) improve the coordination of care for individuals receiving behavioral health services as well as acute and primary services, and (2) improve the value of behavioral health services purchased by the Commonwealth without compromising access to those services for vulnerable populations. Responsibilities of the BHSA include, but are not limited to the following:

- Develop, implement, and operate an enhanced behavioral health network for Virginia's Medicaid program.
- Manage enrollment and credentialing of fee-for-service behavioral health providers in the Medicaid network based on both DMAS regulations and access needs by region.
- Ensure provider network adequacy based on geographical access needs, establishing the needed level of provider participation and satisfaction.
- Ensure that Medicaid/FAMIS Plus and FAMIS members receive high quality, appropriate, and cost-effective behavioral health services.
- Provide effective, efficient operations that (1) coordinate complex behavioral health care, including acute and primary health services, (2) reduce the administrative burden on behavioral health providers and members, (3) maximize the use of current information technology, (4) provide flexible operations that allow the Commonwealth to react to program changes in a timely manner, and (5) implement provider and member outreach.
- Develop outcome measures for provider performance and assist DMAS in development of a quality improvement strategy, to include implementation of quality outcome measures and outcomes reporting.
- Conduct regularly scheduled outreach activities designed to educate Medicaid/FAMIS Plus and FAMIS members regarding behavioral health services, including but not limited to availability and access.
- Ensure that input from individuals and families who use behavioral health services and interested stakeholders is considered in the ongoing development, administration, and implementation of behavioral health services.

The full RFP, fact sheets, and additional information regarding BHSA responsibilities are available on the DMAS website at [http://dmasva.dmas.virginia.gov/Content\\_pgs/obh-home.aspx](http://dmasva.dmas.virginia.gov/Content_pgs/obh-home.aspx).

DMAS awarded the BHSA contract to **Magellan Health Services** (referred to as "Magellan") in May of 2013. In October of 2013, DMAS sent letters to all eligible Medicaid and FAMIS enrollees to announce the transition to Magellan and to provide information on obtaining technical assistance during the transition. During the transition phase, Magellan conducted outreach to advocacy groups and stakeholder organizations to recruit members for its Governance Board. This Board is comprised of Magellan staff, advocates, and other stakeholders. Magellan offers information on its activities, its organization, and its Governance Board online at <http://www.magellanofvirginia.com>.

Moreover, the 2013 Appropriations Act tasked DMAS to develop a **blueprint for implementation of a care coordination model for all individuals needing behavioral health services**, which are not now provided by an MCO. DMAS must collaborate with Community Services Boards (CSBs) and other stakeholders to develop the blueprint, which may include one

or more models as options. DMAS reports that it will present a formal plan as part of its fall 2014 report to the legislative Medicaid Innovation and Reform Commission (MIRC).

The 2013 Appropriations Act (Item 307.DDD) authorized DMAS to expand managed care on a regional basis to **youth in foster care and in adoption assistance programs statewide**. That initiative is underway. DMAS has provided training sessions on Medicaid managed care to foster care and adoptive parents in the expansion regions. DMAS is moving 7,200 children in foster care into managed care over a 12-month period. The goal is to provide access to a delivery system that can ensure children receive appropriate services to meet developmental, medical, dental, and behavioral health needs. This is a partnership project with state and local Departments of Social Service, DMAS, health insurance plans, and foster and adoptive parents. The transition of these youth into managed care will be completed statewide in June of 2014. More information is available on the DMAS website at [http://www.dmas.virginia.gov/Content\\_atchs/altc/altc-prsnt1.pdf](http://www.dmas.virginia.gov/Content_atchs/altc/altc-prsnt1.pdf).

As of September of 2007, any person enrolled in a managed care organization who later became enrolled in any Medicaid Home and Community Based Services (HCBS) Waiver remained in their MCO for acute and medical services. Individuals who enrolled in a HCBS Waiver and were not enrolled in a MCO at that time could receive all medical and Waiver services on a fee-for-service payment basis. As additionally authorized by the 2013 Appropriations Act, DMAS has been exploring **expansion of MCO enrollment for acute and medical services to all HCBS Waiver participants** (with certain exceptions).

Another action of the 2013 legislature was establishment of the **Medicaid Innovation and Reform Commission (MIRC)**, which was initiated later that year. MIRC, established under Code of Virginia § 30-347, is comprised of members from both the House and Senate of the General Assembly. MIRC's purpose is to "review, recommend and approve innovation and reform proposals" affecting the Medicaid programs, which include eligibility criteria, benefit design, service delivery, quality outcomes, payment reform, and cost containment. The MIRC held three meetings and one public hearing during 2013, and will continue meetings in the next biennium. MIRC monitors and makes recommendations about all Medicaid reform initiatives for Virginia, and reviews successful initiatives in other states for Medicaid reform as well as options for private health insurance coverage for uninsured, low income adults. The MIRC presentations are online at <http://mirc.virginia.gov>.

A legislative mandate for Medicaid reform includes improving coordination of long-term services and supports under select Waivers. In November of 2013, responsibility for daily operations for the **Individual and Family Developmental Disabilities Support Waiver (DD Waiver)** transferred from the Virginia Department of Medical Assistance Services (DMAS) to the Virginia Department of Behavioral Health and Developmental Services (DBHDS). As required by federal law, DMAS will retain oversight for administration of the waiver. A full list of administrative tasks roles is provided in the announcement letter available on both the DMAS and DBHDS websites.

DBHDS, in collaboration with DMAS, is in the process of **redesigning the Intellectual Disability, Developmental Disability, and Day Support Waivers**. This effort is intended to address legislative mandates and advocates' requests for application and administrative streamlining, improved care coordination and service quality, and improved oversight. The redesign is also needed to contribute to components of the Commonwealth's Settlement Agreement with the Department of Justice regarding compliance with the Americans with Disabilities Act and the Supreme Court *Olmstead* decision. (The *Olmstead* decision requires that individuals be served in the **most integrated settings appropriate** to meet their needs consistent with their choice.)

In 2012, DBHDS contracted with the **Human Services Research Institute (HSRI)** to:

1. conduct public comment hearings to get ID/DD waiver stakeholders' input;
2. conduct research on the current design and operation of Virginia's waivers; and
3. conduct national research to identify "best practices" in waiver service delivery for individuals with ID or DD.

During 2013 and 2014, having completed Phase one, the Institute submitted its reports on public comments and on Virginia's waivers. These HSRI reports are available on the DBHDS website at <http://www.dbhds.virginia.gov/ODS-default.htm>. A study of Medicaid Waiver reimbursement rates (Phase two) began in January of 2014. A **Provider Advisory group** provided input to develop a rate study survey for distribution to all ID and DD waiver providers in the spring of 2014. A **Waiver Design Advisory Committee (WDAC)** and four additional stakeholder sub-committees were formed to examine waiver redesign, including potential consolidation of the aforementioned waivers. The WDAC will complete its work by September of 2014. The study's final recommendations will be brought to the 2014 General Assembly. The anticipated implementation date for changes to the three waivers is dependent on CMS approval.

Concerns exist about the adequacy of the provider network under Medicaid for health care and related services. For a number of years, self-advocates, families, and advocacy organizations have been vocal about the challenges of provider availability and service access. Legislation in 2012 tasked the **Joint Legislative Audit and Review Commission (JLARC)** to review the impact of Medicaid payment policies for community health care providers, including hospitals, physicians, and nursing facilities; identify any impact of payment on access to services; and propose metrics to measure enrollees' access to care over time. Excluded were personal care and habilitative care under the Medicaid Home and Community Based Services (HCBS) Waiver as well as intermediate care facilities for individuals with intellectual disabilities (ICF/IID) services.

Access to care, statewide and by region, was measured by analyzing DMAS service utilization data using both the absolute and per capita numbers of each type of health care provider. The JLARC's report (*Senate Document #8, 2013*) noted that Medicaid payment rates

have been relatively stable over the past decade, while payment rates by private insurers increased and care costs increased. Key JLARC findings were as follows:

- Medicaid enrollees statewide had the highest level of access to prescription drugs, acute hospital-based care, and nursing facility care. However, individuals with very complex medical needs and behavioral challenges have difficulty finding nursing facility care.
- Although Medicaid enrollees generally could access primary care, outpatient hospital care, and hospital-based psychiatric care, some regional variation was found.
- Overall, Medicaid enrollees who have more difficulty accessing most health care services live in 4 Planning Districts (PDs): Accomack-Northampton, West Piedmont, Region 2000, and Southside. Access to health care in these areas consistently ranked in the bottom third of all Planning Districts for 5 or more services examined. Having a total just over 10 percent of all Medicaid enrollees, all 4 PDs are rural localities, have high proportions of poverty and of elderly populations, and have high infant mortality rates. Of the 4 PDs, 3 are designated as Health Provider Shortage Areas for primary, dental, and mental health care by the federal Health Resources and Services Administration (HRSA).
- Medicaid enrollees have the lowest level of access to specialty care, especially outpatient mental health care and dental care due to lack of participating providers. Access varies widely for specialty care by region.
  - Exceptions are access to obstetricians/gynecologists (OB/GYNs), ophthalmologists, and ear/nose/throat specialists. These professions participate in Medicaid at rates nearly as high as that for primary care physicians.
  - Less than half of all medical specialists statewide participate in Medicaid. Dentists statewide have the lowest participant rate in Medicaid—only 34 percent. The number of Medicaid enrollees has grown, and continues to grow, at a rate higher than the growth in specialists participating in Medicaid.
  - Youth under Medicaid have difficulty accessing dental care, but access has improved since implementation of DentaQuest services in 2005.
  - Medicaid enrollees who have psychiatric or behavioral needs have difficulty accessing outpatient care. The far Southwest region has the least access to psychiatrists, other mental health providers, and in-patient hospital beds.
- Examination of the impact on access by Medicaid payment rates was based on a review of national research and state provider surveys as well as impact from the limited Medicaid payment rate increases in the past decade. The JLARC concluded that Medicaid rate increases have a modest effect on increasing provider participation: A 10 percent reimbursement rate increase was found to increase the number of providers by 3 to 4 percent.

Both the legislative Joint Commission on Health Care and the Medicaid Innovation and Reform Commission have had, and continue to have, an interest in monitoring service access and the adequacy of the Medicaid health care provider network.

One other Medicaid initiative in recent years has been the **Money Follows the Person (MFP)** program. Administered by DMAS, MFP is a federal demonstration grant project that assists individuals living in nursing facilities and other institutions who express a desire to transition back to homes in their communities. Begun in 2008, MFP transition services and coordination are provided to the individual, and designated “slots” are available under several Medicaid Waivers to address the person’s needs when relocated in the community. Transition services are defined (12 VAC § 30-120-2010) as

*set-up expenses for individuals who are transitioning from an institution or licensed or certified provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for his own living expenses.*

Under MFP, DMAS contracts with and trains local or regional providers who serve as transition coordinators. Detailed information on the MFP initiative appears in the **Institutional Supports** chapter of this *Assessment*.

Federal regulations and guidelines for Medicaid are too detailed and complex to cover them fully in this *Assessment*. The remainder of this chapter provides an overview of their implementation in Virginia, including both the Medicaid State Plan and the Medicaid Waivers. While the Virginia Department of Medical Assistance Services (DMAS) provided most of the data, some waiver information was provided by the Virginia Department of Behavioral Health and Developmental Services (DBHDS). Readers should keep in mind that Medicaid reform in Virginia will continue and that efforts are underway to redesign three Medicaid Waivers: the Intellectual Disability (ID) Waiver, the Individual and Family Developmental Disabilities Support Waiver (DD Waiver), and the Day Support Waiver. DBHDS is collaborating with DMAS and stakeholders to develop plans for a streamlined waiver. As of April of 2014, discussions by DBHDS and stakeholders have focused on development of a Comprehensive Waiver and a Supports Waiver. Details on this initiative are provided later in this chapter.

Additional information on the Medicaid program is available at the federal Centers for Medicare and Medicaid website at <http://www.cms.gov>. Another reliable source is the national **Kaiser Family Foundation** website at <http://www.kff.org>. Kaiser provides user-friendly data and policy analysis (state and national) on Medicaid covered services, service utilization, costs, and eligibility as well as details on federal health care reform.

## **1. Screening and Eligibility for Medicaid**

The Virginia **Department of Medical Assistance Services (DMAS)** is the designated state administrative agency for Medicaid, responsible for implementing operational and policy guidelines that comply with federal and state laws as well as for monitoring expenditures and

provider contracts. Federal Medicaid regulations regarding eligibility give states the option of using either the Social Security Administration's (SSA) Supplemental Security Income (SSI) **definition of "disability"** or a more restrictive definition. Virginia uses the SSI definition, and has eligibility requirements regarding income and criteria that are among the strictest in the nation. Information on eligibility and Medicaid covered services is on the DMAS website at [http://dmasva.dmas.virginia.gov/Content\\_pgs/rcp-home.aspx](http://dmasva.dmas.virginia.gov/Content_pgs/rcp-home.aspx).

In SFY 2014, to be eligible for **Medicaid** in Virginia, an individual must meet all core criteria: (1) be a legal resident of the Commonwealth; (2) have a limited income at or below a specific percentage of the current Federal Poverty Level (FPL) guidelines; and (3) belong to one of these mandatory coverage populations:

- low-income families with dependent children,
- children from birth to age 19 (if non-disabled) whose family income is at or below 133 percent of the current FPL,
- children from birth to age 21 who have a disability,
- adults who are blind or disabled who meet covered group requirements,
- age 65 and older, and
- pregnant women (single or married) whose family income is at or below 133 percent of the current FPL.

**Local Departments of Social Services (LDSS)** serve as the "gateways" for determining Medicaid eligibility. Individuals must complete an application and must provide documentation of residence, identity, citizenship, and income. In some cases, they must also supply information on other resources and assets. Information on acceptable documents can be obtained from the local DSS office where the individual lives or from the state DSS or the DMAS websites. If the applicant is not a US citizen, but otherwise meets eligibility criteria, he or she must provide documents verifying immigration status and date of entry into the country. Financial eligibility criteria are somewhat complex, having some variation between mandatory coverage groups; individuals should contact their local DSS office for guidance.

Applications can be obtained either from the local social services department or online at [http://www.dss.virginia.gov/benefit/medical\\_assistance/index.cgi](http://www.dss.virginia.gov/benefit/medical_assistance/index.cgi). The completed application, signed by the adult or by the parent or guardian of a child needing assistance, is returned to the local department of social services where the individual lives, which then determines eligibility for Medicaid benefits.

**Children and youth** may be eligible for either the Medicaid program or the **Family Access to Medical Insurance Security (FAMIS) Plus** program. **FAMIS Plus** covers children and youth whose family has no or very low income and limited resources and who meet criteria for a mandatory Medicaid population group. Youth with a documented disability may qualify for

Medicaid or FAMIS Plus even if their family income exceeds income limits because parental income and other financial resources are *not* considered in determining the child's eligibility.

In 2013, DMAS changed the financial eligibility rules for children using long-term care Medicaid services (including waivers) in order to comply with new federal regulations. Each child's countable resources (any asset that can easily be converted to cash) are now considered for eligibility: Each child can have only \$1,000 in countable resources under his/her name. Certain assets are not countable resources under the new rule. A child may own a car, the home in which he/she lives, furnishings, and personal items. Income eligibility is based on the child's income, which cannot exceed \$2,163 a month (child support, investment income, or wages). Parental income still is not considered for eligibility. This rule became effective in October of 2013 for new Medicaid applicants and in April of 2014 for youth renewing their applications. DMAS sent out notification about this change to all local departments of social services prior to the rule change.

For **adults** to be eligible for Medicaid coverage, generally his or her gross income (total income before deductions and taxes are taken out) and resources (assets) must fall within required limits specified as percentages of the Federal Poverty Level (FPL), an index that is adjusted annually. Income and resource limits vary among Medicaid's covered populations. In Virginia, adults with dependent children with incomes of 133 to 200 percent of the current FPL are generally eligible at least for limited, if not full, Medicaid benefits. Adults who are childless and do not have a disability, however, cannot have gross income above 80 percent of the FPL. In determining resources, the amount of a person's or family's bills and debts generally is not considered, but there are exceptions. For example, for individuals who are determined to be "medically needy," consideration may be given to the impact of exceptionally high medical bills on a family or individual. Such costs may be counted as "spend-down," which is similar to a deductible under private insurance. When a **member of a married couple** requires long-term care (such as a nursing facility) under Medicaid, special eligibility rules called *spousal impoverishment protections* are applied to determine resources and income that can be kept by the spouse while residing in the community.

In Virginia, adult Medicaid enrollees who have a disability are provided incentives to obtain and maintain employment through the DMAS **MEDICAID WORKS** program. Once the person's application has been accepted, adults starting or working in a job may earn substantially more than the standard income limits for Medicaid eligibility as well as retain more in savings or other resources while continuing to receive Medicaid coverage. More detailed information on MEDICAID WORKS can be found in the **Employment** chapter of this *Assessment*.

To receive services under Virginia's **Medicaid Home and Community Based Services (HCBS) Waivers**, an individual must meet the eligibility criteria for Medicaid or FAMIS Plus and, additionally, must (1) meet waiver-specific eligibility criteria, (2) meet long-term care criteria based on a formal assessment, and (3) undergo an assessment of financial need. Currently, Virginia has **six approved HCBS Waivers**:

1. Alzheimer's Assisted Living (AAL) Waiver,
2. Day Support Waiver,
3. Elderly or Disabled with Consumer Direction (EDCD) Waiver,
4. Intellectual Disability (ID) Waiver,
5. Individual and Family Developmental Disabilities Support Waiver (DD Waiver), and
6. Technology Assisted (Tech) Waiver.

DMAS has made available *Fact Sheets* on each waiver that summarize key features. They are available online at [http://dmasva.dmas.virginia.gov/Content\\_pgs/ltc-home.aspx](http://dmasva.dmas.virginia.gov/Content_pgs/ltc-home.aspx).

As with Medicaid and FAMIS Plus, income criteria for waivers vary by mandatory coverage groups. To be eligible for any of these Medicaid Waivers, an adult's total income is limited to no more than 300 percent of the current Supplemental Security Income (SSI) benefit limit; and the adult may have not more than \$2,000 in resources. Individuals with income in excess of 100 percent of the SSI benefit limit may be responsible for "**patient pay**" (or "**co-pay**") to their provider as their share of the cost of care. This co-payment is based upon the individual's gross income after subtracting a personal maintenance allowance, an allowance for a spouse or dependent children, and a deduction for medical expenses that are not covered by Medicaid or other third-party insurance and are the responsibility of the individual to pay. Eligibility requirements for the EDCD and Tech Waivers allow for a "**spend-down**" of resources related to income and out-of-pocket expenditures for medical services and supports.

In contrast, parental income and resources are not considered in determining eligibility for qualifying children and youth. As noted earlier, the new eligibility rules consider each child's countable assets and monthly income. If a child's monthly income exceeds the maximum limit of \$2,163 and the child is enrolled in the EDCD or Tech Waivers, then he/she may "spend-down" income above that limit. Youth enrolled in the DD, Day Support, or ID Waivers cannot use spend-down.

Beyond financial eligibility, each Medicaid Waiver has specific eligibility criteria based on an individual's medical and physical conditions or cognitive functioning, which must be documented through a formal assessment by appropriate professionals. Additional eligibility criteria specific to each waiver follow.

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

1. be elderly or disabled as defined by Section 1614 of the federal Social Security Act,
2. meet the level of care for nursing facility placement,
3. have a diagnosis of Alzheimer's disease or a related dementia by a licensed clinical psychologist or licensed physician, and

4. receive an Auxiliary Grant and either reside in or be seeking admission into an assisted-living facility licensed as a special care unit by the Virginia Department of Social Services (VDSS).

Eligibility for the Alzheimer's Waiver excludes individuals diagnosed with this disorder who have either an intellectual disability (as defined by the American Association for Intellectual Disability) or a serious mental illness [as defined in federal regulations 42 CFR § 483.102(b)].

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

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

Eligibility for the **Intellectual Disability (ID) Waiver** requires meeting *all* of the following criteria:

1. have a documented diagnosis of intellectual disability (ID)—or, for a child younger than age 6, a determination that the child is at developmental risk—through a formal assessment by a licensed professional;
2. have a determination through a formal, standardized assessment that the individual needs the level of care provided by an intermediate care facility for individuals with intellectual disabilities (ICF/IID); and
3. have written declaration by the individual (or his/her parents or guardian) of their choice for community-based services rather than institutional care at an intermediate care facility for individuals with intellectual disabilities (ICF/IID).

Due to assessment limitations, national diagnostic criteria do not allow a diagnosis of intellectual disability (ID) for children under the age of 6 who have a developmental disability (DD). These children are eligible for Medicaid services under the ID Waiver up to their 7<sup>th</sup> birthdays. Upon turning age 6, however, the child must be scheduled for a psychological evaluation to confirm a diagnosis of intellectual disability (ID). The child's case manager has responsibility for identifying each child receiving ID Waiver services who will be 6 years old the following year. If the evaluation confirms an intellectual disability, the child is transitioned to an

ID Waiver “slot.” If there is not a diagnosis of ID, the child must transition, subject to availability of slots, to the Individual and Family Developmental Disabilities Support Waiver (DD Waiver). Transition of a child must be completed by age 7. For children with a documented intellectual disability, failure to submit the completed evaluation and complete transition before the age-7 deadline results in placement on the ID Waiver Wait List.

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

While the redesign of the ID/DD waivers may result in new criteria, at the time of this assessment, to be placed on the **ID Waiver Urgent Waiting List**, an individual was required to meet the following three criteria.

4. The individual meets at least one of the six criteria below:
  - a. Both primary caregivers are 55 years of age or older or, if there is one primary caregiver, the primary caregiver is age 55 or older;
  - b. The individual is living with a primary caregiver who is providing the service voluntarily and without pay and who indicates that he or she can no longer continue to do so;
  - c. There is a clear risk of abuse, neglect, or exploitation;
  - d. The primary caregiver has a chronic or long-term physical or psychiatric condition that significantly limits his or her ability to provide care;
  - e. The individual is “aging out” of a publicly funded residential facility or otherwise in danger of becoming homeless (exclusive of youth who are graduating high school);  
or
  - f. The individual lives with the primary caregiver, and there is a risk to the health or safety of the individual, primary caregiver, or other resident in the home because either:

- i. The individual's behaviors present a risk to himself or others that cannot be effectively managed by the primary caregiver even with supports arranged for or provided by a CSB; or
  - ii. The individual's physical (such as lifting or bathing) or medical needs cannot be managed by the primary caregiver even with supports arranged for or provided by the CSB.
5. The individual needs services within 30 days; and
  6. The individual with ID, his or her spouse, or the parent of a minor child with ID will accept the requested service, if offered.

The Department of Behavioral Health and Developmental Services (DBHDS) provides extensive information about the ID and Day Support Waivers online at <http://www.dbhds.virginia.gov/ODS-MRWaiver.htm>.

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

The **Individual and Family Developmental Disabilities Support Waiver (DD Waiver)** is targeted to individuals age 6 or older who do not have a diagnosis of intellectual disabilities but do have another type of developmental disability or "related condition." As with the ID Waiver, diagnostic and functional criteria are considered in determining DD Waiver eligibility. Individuals must meet the level of care criteria for services in an ICF/IID, and individuals or their families must choose community-based services rather than institutional (ICF/IID) care.

The DD Waiver has a single statewide waiting list, and available slots are assigned to individuals on that list on a first-come, first-served basis, based on the date of application. Another difference from the ID Waiver is that 10 percent of Level 1 DD Waiver annual slot allocations are designated as "**emergency slots**," which can be assigned without consideration of the length of time on the waiting list. At least 1 of the following 4 emergency criteria must be met to receive a DD Waiver emergency slot:

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

## 2. Access to and Use of Medicaid-covered Services

Two state agencies have responsibilities for managing daily operations of the six Home and Community Based Medicaid Waivers. Listed below are the waivers that each manages.

- **Department of Behavioral and Developmental Health Services (DBHDS):** the Intellectual Disability (ID) Waiver, the Day Support Waiver, and (effective November 12, 2013) the Individual and Family Developmental Disabilities Support Waiver (DD Waiver)
- **Department of Medical Assistance Services (DMAS):** the Alzheimer’s Assisted Living (AAL) Waiver, the Elderly or Disabled with Consumer Direction (EDCD) Waiver, and the Technology Assisted (Tech) Waivers

Each respective agency is the point of contact for issues regarding service access, delivery, appeals, and other processes. Both agencies collaborate on policy and regulatory development. By federal and state statute, as the single state agency for Medicaid, DMAS maintains final administrative authority over all waivers, and must review all policies, waiver applications, and regulations to ensure compliance with federal regulations.

Similar to private health insurance, once an individual is found to be eligible for Medicaid, the **Department of Medical Assistance Services (DMAS)** mails them a plastic medical assistance (insurance) card. When more than one individual in a family is found eligible for Medicaid, each receives his or her own card. Services under the Medicaid State Plan are delivered through a broad array of public providers and private nonprofit or for-profit providers who formally agree to accept Medicaid as a reimbursement and meet specific guidelines on the scope and documentation of their services. DMAS provides individuals covered by Medicaid with a list of these providers.

Each individual has responsibility for selecting and contacting providers for services or an appointment when indicated. As noted in the **Introduction to Medicaid Insurance and Waiver Services** at the beginning of this chapter, increasing numbers of Medicaid enrollees now receive care coordination through a managed care organization (MCO). Each MCO has its own network of providers from which the individual may choose. The DMAS website has extensive information on how to access services. Of particular usefulness to individuals with a disability is its *Guide for Long-Term Care Services in Virginia*, which is available at [http://dmasva.dmas.virginia.gov/Content\\_atchs/ltc/ltc-guide\\_srvcs.pdf](http://dmasva.dmas.virginia.gov/Content_atchs/ltc/ltc-guide_srvcs.pdf).

Determination of eligibility of an individual for most of Virginia’s **Medicaid Home and Community Based Service (HCBS) Waivers** does not ensure immediate coverage for services. There must be an available “slot” (funded by the legislature) for the waiver in which the individual is enrolled, and the number of slots available varies each year. For all HCBS waivers, an assigned slot may become vacant/available for other eligible individuals during a state fiscal year for one of several reasons: a waiver recipient moves out of state, is no longer qualified for the waiver (e.g., income changes), obtains services through other funding arrangements, or

dies. When a waiver slot is not available, eligible individuals are placed on a **waiver waiting list**, and still receive Medicaid State Plan services.

Three Medicaid Waivers do *not* have a **waiting list** for slots: the **Elderly and Disabled with Consumer Direction (EDCD)**, the **Technology Assistance (Tech)**, and **Alzheimer's Assisted Living (AAL)**. For the Tech Waiver, the potential pool of individuals statewide who have the specific medical/functional needs and meets other eligibility criteria is limited. The Tech Waiver annually has served less than 500 individuals a year. The AAL Waiver has an annual maximum capacity of 200 slots and has not, to this point, approached capacity.

The **Day Support (DS) Waiver** has an annual maximum capacity of 300 slots, which has never exceeded capacity although all individuals on the Intellectual Disability (ID) Waiver Wait List are eligible for this waiver. Individuals on either the urgent or non-urgent waiting list for the ID Waiver gain access to the DS Waiver according to their "date of need," defined as the date on which they were determined to be eligible for the ID Waiver. The individual's date of need will never change. When offered a DS Waiver slot, individuals must be willing to begin services immediately or no later than 30 days from the date of request. Since very limited services are available under this waiver, some individuals on the ID Waiver Wait Lists apply for and receive services under the ED CD Waiver, which offers a wider service array and has no enrollment limit or "cap."

Home and Community Based Services Waiver supports primarily are primarily funded on a *fee-for-service* basis. For all waivers, once an individual has been determined to be eligible for a HCBS Waiver, a list of service providers is offered by the case manager, service facilitator, or the home care agency providing services. The individual or his or her family can choose providers from this list.

Access procedures and delivery of services vary by waiver. Case management, a Medicaid State Plan service, is available to individuals determined eligible for the ID, Day Support, DD, and Tech Waivers as soon as soon as that determination has been made, whether or not they have obtained an actual waiver slot. Individuals receiving services through the ED CD Waiver do not have access to case management unless they are elderly (subject to geographic and time limitations). Individuals under the ID and Day Support Waivers must receive case management through the local Community Services Board (CSB). Under the DD Waiver, care planning and coordination is provided by private or nonprofit, agency-based Service Facilitators, and individuals can select their provider.

Consistent with federal regulations, under all the waivers, the case manager or care coordinator works with an individual, and his or her family if appropriate, to create an **Individual Services Plan (ISP)**. This requirement applies to managed care organizations (MCOs) as well as Community Service Boards (CSBs) and other care coordination entities. The ISP details the supports needed and preferred by the individual as well as their choice of providers. When changes in health or life circumstances occur, the case manager or care coordinator is responsible for updating the ISP in collaboration with the individual and family (if appropriate).

Details on service access and delivery vary between MCOs, CSBs, and other service networks, and each makes information available for its clients both by regular mail and online. For the purposes of this report, more attention is given to the waivers managed by the Virginia Department of Behavioral Health and Developmental Services (DBHDS).

Access to a slot for the **Intellectual Disability (ID) Waiver** is based on a standardized process that was developed by DBHDS in collaboration with local **Community Services Boards (CSBs)** in January of 2010. Further information on this review and assignment process (including the guidance, *Navigating the ID Waiver: A Family Handbook*) is available online at <http://www.dbhds.virginia.gov/ODS-MRWaiver.htm>. Priority for assignment of ID Waiver slots to individuals found eligible for the *urgent* waiting list is determined through a two-tier review process. Review begins whenever a CSB has any waiver slots available. Information reviewed for slot assignment includes both waiver eligibility documentation and the following information:

- relevant, current medical information;
- a Level of Functioning Survey; and
- a completed **Critical Needs Summary**, which must be updated at least annually and whenever “critical needs” of the individual change. This form generates a priority needs score that is maintained in a CSB client database.

If 5 or fewer ID Waiver slots are available, the CSB identifies the 10 individuals on its urgent waiting list who have the highest Critical Needs Summary scores. If more than 5 slots are available, 20 individuals are so identified. If 2 or more individuals have identical scores and are at the cut-off number, all are included in the second tier of review.

The second tier review is conducted by the CSB’s **ID Waiver Slot Assignment Committee**, which typically is comprised of members of that CSB’s staff as well as staff from neighboring CSBs; family members of individuals already receiving ID Waiver services; legislators; staff from local social services departments and Department of Rehabilitative Services’ field offices; and other stakeholders. A case manager serving on the committee cannot vote when one of the individuals whom he or she supports is being considered for a slot and no one with a direct or indirect interest in the outcome of the review can be on the committee.

Prior to the second tier review meeting, written summaries are prepared and submitted to the Assignment Committee by case managers for each individual being considered for an ID Waiver slot. Each summary must include the following:

1. the individual’s or family’s current need for services, including health and safety issues, behavioral challenges, and community integration or social isolation issues;
2. services currently received by the individual;

3. natural supports available to the individual (including primary caregiver information and other family, friend, or community supports);
4. descriptions of any other conditions for urgency; and
5. description of the waiver services determined necessary to relieve the urgency.

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

By contrast, allocation of slots for the **Individual and Family Developmental Disabilities Support Waiver (DD Waiver)** is done statewide on a first-come, first-served basis. Under approval of the Centers for Medicare and Medicaid Services (CMS) regulations and procedures, the agency responsible for managing the DD Waiver (now DBHDS, and formerly DMAS) maintains a chronological waiting list based on the date that an individual was determined to be eligible for the DD Waiver. When funds are allocated for new slots or a current slot becomes available, the individual next on the list is assigned the slot. All others are placed on the DD Waiver Wait List.

For both the ID and the DD Waivers, DBHDS maintains a database system for tracking waiver slot allocations and assignments as well as the waiting lists. Each CSB must report information—both on the individuals receiving a waiver slot and on those vacating a slot to DBHDS—and must update the information with any changes in the waiver waiting lists.

Under the EDCD, ID and DD Waivers, services may be delivered using one of two models: **consumer-directed or agency-directed services**. The eligible individual may select the service delivery model that he or she prefers. Agency-directed services are provided through a variety of governmental, nonprofit, and for-profit organizations. The selected agency provides the staff for the needed service. For some waiver services, agency staff must meet specific requirements, such as professional licenses, or the agency must be licensed by the Virginia Department of Behavioral Health and Developmental Services (DBHDS) or other state agencies. To be enrolled as a Medicaid in-state provider for the Commonwealth, the agency "home office" must be located no more than 50 miles outside of the State's borders. Agency case managers or support coordinators provide information and referrals to the waiver enrollee about available services to meet their needs. Lists of local service providers are available through either the person's managed care organization or from their CSB case manager. DMAS also has a provider search feature on its website at [http://dmasva.dmas.virginia.gov/Content\\_pgs/search-home.aspx](http://dmasva.dmas.virginia.gov/Content_pgs/search-home.aspx).

The **consumer-directed model** for waiver services gives the individual enrolled in the waiver responsibility for deciding how, when, and by whom services will be provided. For several

waiver services (personal care, respite, and companion), the individual with a disability becomes an **“employer of record”** with the federal Internal Revenue Service (IRS) and can recruit, screen, train and hire (or fire) their attendant. The individual is responsible for filing timesheets for reimbursement of the attendant with the DMAS designated fiscal agent. The C-D model can enable the elderly and individuals with disabilities (or their families or guardians, when appropriate) to retain freedom of choice and control of the direct services that they receive. More information on using the C-D model may be obtained by individuals enrolled in a waiver from the applicable managing state department (DBHDS or DMAS) websites, an individual’s case manager or support coordinator, or staff at local Centers for Independent Living (CILs). In addition, several reader-friendly guides to help individuals implement C-D services are available at <http://www.vcu.edu/partnership/cdservices/pcprb.htm>. Self-advocates developed these guides as part of Virginia’s now-ended federal Systems Transformation Grant initiative.

A **Medicaid appeal process** is authorized under both federal and state regulations (42 CFR Part 431 et seq. and VAC § 30-110-10 through 370, respectively) when an individual is denied eligibility (referred to as an **“adverse action”**) for Medicaid insurance coverage or for a type of service. Individuals must be notified in writing of an adverse action at least 10 business days prior to a denial, suspension, or termination of coverage or services. The individual then has 30 days from that notification to file a written appeal request with the **Department of Medical Assistance Services (DMAS) Appeals Division**. **“Good cause”** exceptions to the 30-day time limit are permissible only in special circumstances such as a personal emergency. Written appeal requests may be in the form of a letter, an e-mail, or a completed appeal request form available from local social services departments or from DMAS. A copy of the adverse action notification should be included with the written appeal request form. Telephone and verbal requests for appeal are not accepted.

If the appeal is filed before the effective date of the adverse action, Medicaid-covered services may continue during the appeal process *if* the individual so requests. If services are continued or reinstated due to the appeal, the provider can neither terminate nor reduce services until the hearing officer has rendered a decision. However, if the adverse action is later upheld by the hearing officer, the individual may be required to reimburse DMAS for the cost of the services received during that time period. Because of this, some individuals may choose not to continue services during the appeal process.

At any point during the process, an individual may choose to withdraw his or her appeal. In addition, the relevant agency may act to approve or reinstate coverage based on new information or a new evaluation. If the latter occurs, the relevant agency must notify the individual and the Appeals Division of its decision in writing; and if its Appeals Division determines that there has been an **“administrative resolution”** of the issue, it can decide to formally close the appeal rather than proceed with a hearing. For example, if the Department of Social Services reconsiders the results of an evaluation or conducts a new evaluation that is decided in the individual’s favor, the appeal on that issue would no longer be needed. If an

appeal is not administratively resolved, the Appeals Division reviews the appeal request and any new information provided, then determines whether to validate or to invalidate and dismiss the appeal. An appeal may be invalidated because, for example, it was filed late without good cause or the proper authorization to represent an individual was not received. If the appeal is validated, the Appeals Division schedules a hearing and notifies the individual of its location, date, and time by mail two to three weeks in advance.

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

Current DMAS statistics indicate that approximately 67 percent of all appeals that have hearings and full dispositions are sustained by their hearing officers. Over the past decade, both the number of appeals and the proportion of validated appeals have increased, but the number of hearing officers has not increased proportionately.

There is also a Medicaid **appeals process for providers**. Medicaid providers that have already provided services and seek payment have the right to appeal adverse actions affecting payment. The DMAS provider appeal process is conducted in accordance with the Virginia Administrative Process Act (Code of Virginia § 2.2-4000 et seq.) and the DMAS provider appeals regulations (12 VAC § 30-20-500 et seq.). The entity that took the adverse action must inform providers of (1) their right to appeal to DMAS the timeframes for appeals, and (2) the DMAS address to be used for filing a request for appeal.

There are two levels of administrative appeals for providers challenging an adverse action: the informal level and the formal level. For a timely **informal appeal**, the provider must file its notice of informal appeal with the DMAS Appeals Division within 30 calendar days of the provider's receipt of the final denial letter. The entity that made the denial is then responsible for filing a case summary with DMAS that explains the basis for the denial and meets the content requirements set forth in 12 VAC § 30-20-540. The informal appeal decision is issued in writing and contains instructions on how to request a formal appeal. If a **formal appeal** is elected, a hearing officer appointed by the Virginia Supreme Court hears it. After evidence is taken and the parties are offered the opportunity to submit legal briefs, the hearing officer files a recommended decision with the DMAS director. Both parties are then afforded the opportunity to submit written exceptions to the recommended decision. The formal appeal concludes with the issuance of the Final Agency Decision by the DMAS director.

As noted previously, **availability of services** in any locality or region is based on the scope and array of service providers that are enrolled as participants under Medicaid, whether through a managed care organization (MCO) or on a fee-for-service basis. Rather than repeat that discussion, this chapter section describes “availability of services” in terms of the number of unique individuals enrolled in and receiving services through Medicaid.

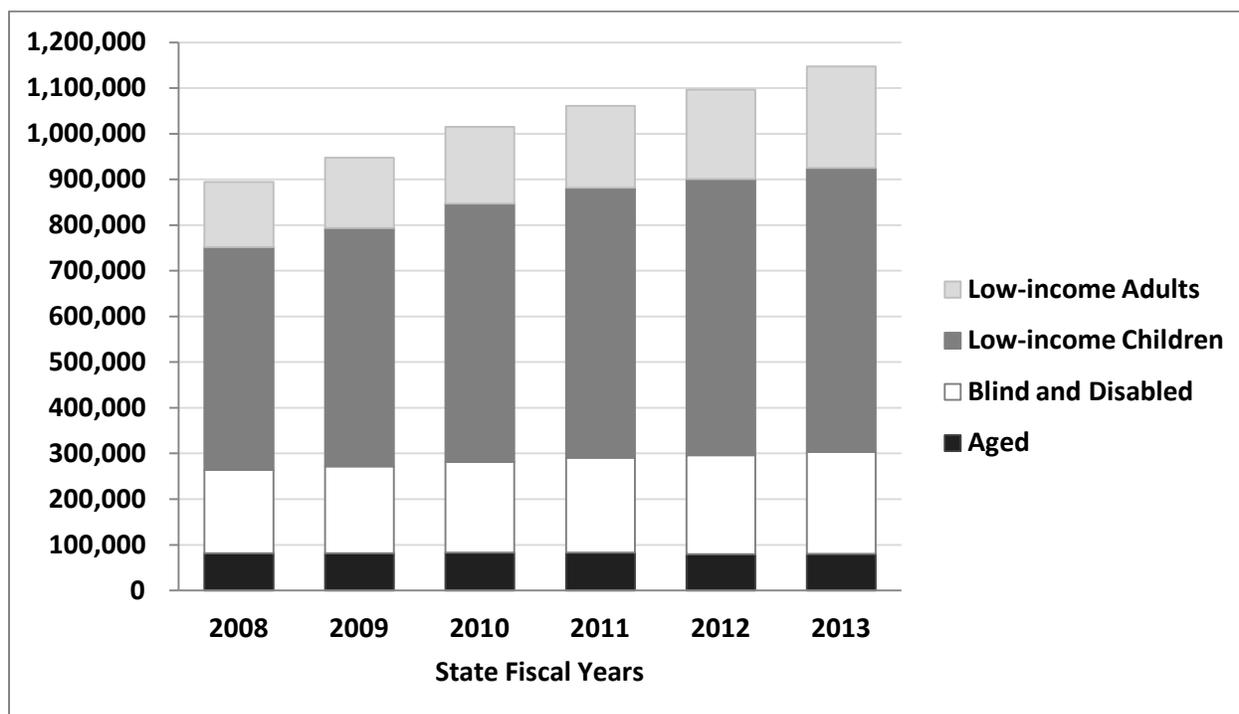
Of necessity, the Department of Medical Assistance Services (DMAS) maintains a vast database of information, which includes the:

1. number of enrollees;
2. type and frequency of services provided;
3. number of enrollees receiving each service type; and
4. expenditures by service and enrollee populations.

For legislative reports and for oversight purposes, DMAS staff analyzes the data annually. Readers of this report are encouraged to review DMAS reports, which are available online on its website or through the state Legislative Information Services. This section provides selected data on enrollment that were deemed most useful for decision-makers as well as policy advocates. Enrollee counts are “unduplicated,” meaning that an individual was counted only once during a state fiscal year (SFY), although he or she may have lost Medicaid eligibility during the year and later became eligible again due to income or other changes.

Within federal and state regulations, four broad population groups (or “categories”) are mandated for Medicaid coverage: the “blind and disabled”; the aged (age 65 and older); low-income children; and low-income adults. **Figure 21** depicts the total (unduplicated) number of individuals enrolled in Medicaid in Virginia by these federal population categories.

**Figure 21. Virginia Medicaid Enrollees by Population Categories**



Between state fiscal years 2008 and 2013, the total number of enrollees in Medicaid grew from 894,286 to 1,147,788 individuals, an increase of 37.5 percent. As noted in the 2011 edition of this *Assessment* and various legislative reports, substantial increases in enrollment occurred during SFYs 2008 through 2010 as a result of higher unemployment during the Great Recession. While economists declared the recession technically “over” in 2011, job recovery has been slower than expected statewide and uneven across regions in Virginia. Between SFYs 2011 and 2013, total enrollment grew more slowly at 8.1 percent, which amounts to almost 87,000 individuals. Nevertheless, annual comparative reports by the Joint Legislative Audit and Review Commission (JLARC) since 2009 have consistently ranked Virginia among the ten states with the lowest per capita Medicaid enrollment.

A comparison of the number of Medicaid enrollees by federal population category between SFYs 2005 and 2013 indicates several trends. **Table 29** provides the percentage of enrollees in each category based on the total number of Medicaid enrollees in each SFY. Note that the number of enrollees by category was added and available only for SFY 2013.

Category	2005	2007	2010	2011	2013	
Aged	10.0%	9.3%	8.2%	7.8%	7.0%	79,811
Blind and Disabled	19.6%	20.2%	19.6%	19.6%	19.5%	223,306

Category	2005	2007	2010	2011	2013	
Low-income Adults	15.1%	16.0%	16.5%	16.9%	19.4%	222,872
Low-income Children	55.2%	54.5%	55.7%	55.7%	54.2%	621,799

Source: Virginia Department of Medical Assistance Services.

Between SFYs 2005 and 2013, the largest proportion of enrollees have been low-income children, comprising over half of all Medicaid enrollees in each SFY. The enrollee proportion for the aged category declined by 3 percent, which may be due to demographic factors. Concurrently, the proportion of enrollees in the category of low-income adults increased by 4.3 percent. Demographic and economic trends may be contributing factors for those two populations. The proportion of enrollees who are “blind or disabled” has been relatively stable at around 20 percent of all enrollees.

The number of Medicaid enrollees who receive services through **the Home and Community Based Services (HCBS) Waivers** is relatively small compared to the total enrolled. Rather than the number of enrollees, however, most of the waiver data provided here are the unduplicated number of individuals who *received services* during a SFY. (A Medicaid enrollee may apply for a waiver in one SFY and not begin services until the next or another SFY.) The smallest number of enrollees are under the **Alzheimer’s Assisted Living (AAL), the Technology Assisted (Tech), and Day Support Waivers**. As noted in the previous section, the AAL and Day Support Waivers each have a set “cap” on the number of available slots, while the both the Tech and AAL Waivers are targeted to specific, small sub-populations of Medicaid enrollees.

**Table 30** provides data on the number of (unduplicated) individuals served under those three waivers for selected state fiscal years (SFY) between 2009 and 2013. Of note is that the AAL Waiver was implemented in SFY 2006. Between SFY 2009 and 2013, the number of Medicaid enrollees served under these waivers has been relatively stable.

Waivers	2009	2010	2011	2012	2013
AAL Waiver*	32	62	63	61	56
Tech Waiver	400	405	417	409	397
Day Support	283	274	276	267	264

Sources: Department of Medical Assistance Services for AAL & Tech Waivers; Dept. of Behavioral Health and Developmental Services for Day Support Waiver.

Among all six of Virginia’s waivers, the largest number of individuals served annually has been those under the **Elderly and Disabled Consumer-Direction (EDCD) Waiver**. As shown in **Table 31**, the unduplicated number of individuals served under the EDCD Waiver grew by 115.4 percent (16,113 individuals) between SFYs 2007 to 2013. During the Great Recession (SFYs 2008 through 2010), annual increases in the number served under the EDCD waiver peaked, ranging from 15.4 to 15.9 percent. As the recovery began in SFYs 2011 and 2013, the annual rate of increase decreased from 14.5 percent in SFY 2011 to 8.8 percent in SFY 2013. Nevertheless, the *total* increase in the number served under the EDCD Waiver over these last three years was 21.7 percent (5,335 individuals).

<b>Table 31. Unduplicated Number of Individuals Served under the EDCD Waiver by SFY</b>							
<b>State Fiscal Year</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>
<b>Number Served</b>	<b>13,965</b>	<b>16,159</b>	<b>18,640</b>	<b>21,599</b>	<b>24,723</b>	<b>27,634</b>	<b>30,078</b>

Contributing factors likely include the recession and subsequent slow job growth, utilization of the EDCD Waiver by individuals who were/are on wait lists for the ID or DD Waivers, and enhanced communication (social media, list serves, etc.) that provide ongoing support and information to individuals and families.

Created in 2005, state General Fund allocations for slots under **the Individual and Family Developmental Disabilities Support Waiver (DD Waiver)** have had more limited annual state allocations than the ID Waiver and have a smaller waiting list. The DD Waiver Wait List is automated, and the number of individuals on the list is available at any point in time. **Table 32** depicts the number of **new** state-funded slots funded by the legislature for SFYs 2007 through 2014 for both the ID and DD Waivers.

<b>Table 32. Number of New ID and DD Waiver Slots Allocated by SFY</b>								
<b>SFY</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>
<b>ID Waiver</b>	<b>303</b>	<b>468</b>	<b>710</b>	<b>110</b>	<b>250</b>	<b>585</b>	<b>460</b>	<b>735</b>
<b>DD Waiver</b>	<b>65</b>	<b>100</b>	<b>15</b>	<b>15</b>	<b>15</b>	<b>180</b>	<b>50</b>	<b>130</b>

There are dramatic differences between the ID and DD Waivers in both the unduplicated number served and the number on each respective waiting list each fiscal year. Those numbers for SFYs 2009 through 2013 are provided in **Table 33** below. The waiting list numbers for both waivers varies daily because of changes in the number of new applicants found eligible for a waiver and the number of waiver recipients who become ineligible, move-out-of-state, or die. As soon as a slot becomes available, it is assigned to another individual. According to DBHDS staff, Community Services Boards (CSBs) typically initiate the ID Waiver slot assignment process for new slots 30 to 60 days prior to the beginning of the next SFY. At that time, funding for new

waiver slots and required funding to support already assigned slots are made available through the Virginia General Assembly. As a result, the wait list counts decline at that time.

The numbers provided below for both waivers' waiting lists are derived from DBHDS data on those for whom waiver services were billed during the year. Due to limitations of the DBHDS database, the ID Waiver Wait List counts are based on the first business day in July in each SFY. The ID Waiver counts are the total of all those placed on the urgent and non-urgent waiting lists. The number of unduplicated enrollees for the ID Waiver was not available. The DD Waiver Wait List is based on the end of each SFY (June 30).

<b>Table 33. ID and DD Waivers by SFY</b>					
<b>SFY</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>
<b>ID Waiver</b>					
<b>Number served</b>	<b>7,748</b>	<b>8,010</b>	<b>8,341</b>	<b>8,771</b>	<b>9,245</b>
<b>Number on waiting list</b>	<b>N/A</b>	<b>5,401</b>	<b>5,785</b>	<b>6,338</b>	<b>6,684</b>
<b>DD Waiver</b>					
<b>Total number of enrollees</b>	<b>592</b>	<b>592</b>	<b>791</b>	<b>837</b>	<b>971</b>
<b>Number served</b>	<b>584</b>	<b>582</b>	<b>581</b>	<b>716</b>	<b>773</b>
<b>Number on waiting list</b>	<b>757</b>	<b>993</b>	<b>719</b>	<b>1,047</b>	<b>1,177</b>

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

Both waivers had an increase in the number served since SFY 2010 due to the significant increase in state funding for new waiver slots.

Self-advocates and their family members have complained to the legislature about the long waits for the ID and DD Waivers for a number of years. Until 2013, DBHDS annually tracked the length of time spent on a wait list, but did not obtain systemic data on the types of services for which individuals were waiting. A survey conducted by the Community Services Boards for DBHDS during 2013 found that individuals on the ID Waiver Wait List most frequently needed the following services (listed in order of frequency):

1. respite care;
2. in-home residential supports;
3. day supports;
4. assistive technology; and
5. personal attendant services.

In 2009, the General Assembly expressed its intent to eliminate the ID and DD Waiver Wait Lists and tasked the Governor with developing a formal plan to do so (Code of Virginia § 32.1-323.2). A study report later that year, developed collaboratively by the DMAS and DBHDS, projected that the waiting lists were growing by 699 individuals per year for the ID Waiver and 154 individuals for the DD Waiver. To eliminate both waiting lists by the end of state fiscal year (SFY) 2020, the report concluded, the legislature would need to fund 1,100 new ID Waiver slots and 220 new DD Waiver slots annually between SFY 2011 and 2020. The Commonwealth committed to funding that number of ID and DD slots annually as part of the DOJ Settlement Agreement. However, out of concern over increasing Medicaid costs, the 2014 General Assembly proposed that anyone receiving a new ID or DD Waiver slot in SFY 2015 and thereafter would have to have care coordination as well as certain other services provided through a managed care organization.

### 3. Types of Services Covered under Medicaid

The Medicaid State Plan includes both mandatory (required) services and optional services that the State has chosen to cover. In compliance with federal regulations, Virginia’s Medicaid program covers the following **mandatory services** for all individuals who meet Medicaid eligibility criteria and who are determined to be “medically needy.”

- hospital services (inpatient, outpatient, and emergency services)
- rural health clinics and federally qualified health centers
- physician services
- pediatric and family nurse practitioner services
- nursing facility services for individuals ages 21 and older
- applicable durable medical equipment
- laboratory and x-ray services
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services for children and adolescents under age 21
- home health services (nurses, aides), if eligible
- transportation services (non-emergency) to receive covered services

Of these mandatory services, **Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)** is one of the most critical services for children and adolescents. EPSDT covers preventative and other health care services, including well-child examinations, assessments and screenings, immunizations, dental care, vision and hearing services, and “medically necessary” diagnostic and treatment services to correct or improve physical conditions, behavioral issues, and mental illness identified by assessments.

In addition to the aforementioned federally mandated services, state statutes and regulations authorize Virginia's Medicaid program to cover 19 categories of **optional services** that include but are not limited to:

- prescription drugs
- rehabilitation services (occupational, physical, speech and related therapies)
- home health services (physical therapy, occupational therapy, and speech/language pathology)
- dental services
- durable medical equipment
- case management services
- outpatient mental health and substance abuse services
- hospice services
- skilled nursing facility or inpatient psychiatric services for youth *under* age 21
- services related to the Home and Community Based Services (HCBS) Waiver
- intermediate care facilities for individuals with intellectual disabilities (ICFs/IID) services

Further information about Virginia's mandatory and optional Medicaid-covered services, their eligibility requirements, and types of approved providers is available in print and online from the Department of Medical Assistance Services (DMAS) at <http://www.dmas.virginia.gov>. The section below covers **Virginia's Home and Community Based Services Waivers**, which provide critical supports to individuals with developmental disabilities.

The required mandatory and optional services that are provided through the Medicaid State Plan are also available to all enrollees in any of the six Medicaid Home and Community Based Services (HCBS) Waivers. Certain services, however, are waiver specific or vary in amount and duration between waivers. The availability of any waiver service is dependent on and, therefore limited by, annual state appropriations and policy decisions made by the Virginia General Assembly. A useful comparative chart of services covered under each waiver is available on the DMAS website at [http://dmasva.dmas.virginia.gov/Content\\_atchs/ltc/ltc-omfs12.pdf](http://dmasva.dmas.virginia.gov/Content_atchs/ltc/ltc-omfs12.pdf). The following provides a summary of key services provided under each waiver. Readers should keep in mind that Virginia is continuing Medicaid reform and redesign of several waivers, which will be ongoing at least through SFY 2016 and possibly longer.

For individuals eligible for Medicaid or both Medicaid and Medicare, the **Alzheimer's Assisted Living (AAL) Waiver** is unique in that it covers services provided in an assisted living environment. Services provided at an Assisted Living Facility (ALF) are based on individual needs and interests. Covered services under the AAL Waiver include the following:

- assistance with activities of daily living (ADLs),

- supervision,
- medication administration,
- therapeutic and recreational programming,
- housekeeping,
- supervision, and
- nursing assessments.

Case management is not available under this waiver. Services are paid by Medicaid on a per diem basis, 365 days a year, with a maximum annual allowance of 14 days for home visits.

The **Elderly or Disabled with Consumer Direction (EDCD) Waiver** funds the following services:

- adult day health care,
- agency- or consumer-directed (C-D) options for personal care services,
- respite care services,
- personal emergency response systems (PERS), and
- medical monitoring systems.

Adult day health care is a community-based day program that offers health, therapeutic and social services to meet the needs of individuals who are elderly or have a disability that puts them at-risk of institutional placement. Adult day health care services must be provided by an enrolled Medicaid provider that is licensed by the Virginia Department of Social Services.

Services currently available under the **Day Support Waiver** include the following:

- day support services,
- prevocational services, and
- supported employment.

The latter two services are described in detail in the **Employment** chapter of this *Assessment*. Day support services typically offer each individual various opportunities for skill development, completing activities of daily living (ADLs), being active in the community, and enhancing social networks. Supports also are provided to ensure an individual's health and safety.

The **Intellectual Disability (ID) Waiver** provides coverage for a wide range of services:

- assistive technology,
- agency- or consumer-directed companion and respite services,

- crisis stabilization and supervision,
- day support,
- family and caregiver training,
- environmental modifications,
- in-home and congregate residential support,
- personal care services,
- personal emergency response systems,
- prevocational services,
- skilled nursing services,
- supported employment, and
- therapeutic consultation.

Services under the ID Waiver may be provided to individuals living in a group residential setting, in an individual's home, or in a family home.

With two exceptions, the same services are covered by the **Individual and Family Developmental Disabilities Support Waiver (DD Waiver)** as for the ID Waiver. The most significant exception is that the DD Waiver *only* funds in-home supports—not services in congregate residences. This decision was consistent with the input provided by stakeholders at the time of development to support individuals in their own homes. The second difference is that the DD Waiver funds family/caregiver training. Data from DMAS indicate that in 2013, the most frequently used services under the DD Waiver were consumer-directed (C-D) personal care, C-D respite care, and service facilitation.

To address the complex medical needs of those eligible, the **Technology Assisted (Tech) Waiver** covers a different set of services:

- personal emergency response systems/medical monitoring systems,
- durable medical equipment,

and *with limitations*,

- environmental modifications,
- assistive technology,
- nursing services,
- agency-directed respite care, and
- agency-directed personal care services.

Unlike other waivers, both skilled nursing and private-duty nursing services are available, and only agency-directed respite care services are covered. Adults additionally can receive agency-directed personal care services. Medicaid regulations, however, set limitations on the number of hours for respite care and private duty nursing services, and set annual expenditure limits for environmental modifications and assistive technology.

#### 4. Cost and Payment for Medicaid

As required by federal regulations, Medicaid is jointly funded through federal and state tax revenues from their businesses and citizens. While program administrative costs are split equally between federal and state funds, a formula is used to determine the percentage of the federal payment (“share”) for each service covered by a state, and the state is required to cover the remaining service cost (known as its “state Medicaid match”). The federal portion varies annually by state but typically ranges between 50 and 83 percent among the states. For Virginia, the standard federal share is set at 50 percent. However, Virginia and other participating states do receive an increased federal match for individuals enrolled in the **Money Follows the Person (MFP)** initiative. Each state has authority to set its own fiscal reimbursement rate for each covered Medicaid service. In recent years, the federal Centers for Medicare and Medicaid Services (CMS) began requiring states to provide a written justification/explanation related to service costs for any significant changes in reimbursement rates.

Under the Code of Virginia (§ 32.1-325.2), Medicaid is the “**payer of last resort.**” This means that when an individual is covered both by third-party health insurance (private insurers, CHAMPUS, Tricare or others) as well as Medicaid, the private insurer first must pay for any services covered under its policy. Medicaid also requires adults to contribute a small “copayment” toward the costs of certain medical services such as visits to an outpatient hospital, clinic, or physician’s office, home health visits, rehabilitation services, and inpatient hospitalization. The copayment can be made at the time of the service or billed to the service recipient by the provider. Medicaid Home and Community Based Services (HCBS) Waivers do not require copayment per service from participants for basic Medicaid State Plan services, but a waiver recipient may have a “patient pay” contribution for certain services based on amounts and sources of income. The Department of Social Services (DSS) assesses whether an individual receiving services under an HCBS Waiver is responsible for a patient pay.

The **Department of Medical Assistance Services (DMAS)** is responsible for making and tracking payments made under Medicaid. DMAS contracts with **external fiscal agents** to handle payments. For consumer-directed (C-D) services, DMAS has contracted with PCG Public Partnerships, LLC (known as PPL) to provide reimbursement payments for services provided through the consumer-directed model (for companion, personal assistance, and respite services). To provide reimbursement payments to providers, DMAS contracted with Xerox State Health Care, LLC (known as Xerox) as the external fiscal agent. Some services (including all waiver services except those covered by the EDCD Waiver) are reimbursed on a fee-for-service basis using fixed reimbursement rates. Under the fee-for-service program, the service provider

sends “bills” (payment requests) directly to the fiscal agent (Xerox) for each service delivered to a Medicaid client.

For Medicaid services provided through a managed care organization (MCO), the contract between DMAS and each MCO specifies a fixed per member/per month capitation payment for a comprehensive set of covered services regardless of the amount or frequency of services used by each enrollee. MCO rates are consistent with federal requirements (42 CFR Part 438) that capitation rates be actuarially sound and appropriate for the population covered by the program. **Table 34** provides the total annual Medicaid expenditures for SFYs 2009 through 2013 (in billions). Expenditures include all Medicaid program services, including those covered by Medicaid Waivers, regardless of the setting (outpatient clinics, institutions, in-home, and residential community services).

Table 34. Total Medicaid Expenditures by SFY				
2009	2010	2011	2012	2013
\$5,772,295,365	\$6,548,828,116	\$7,166,169,226	\$7,033,372,355	\$7,634,426,339

Between SFYs 2009 and 2013, total Medicaid expenditures increased by 32.3 percent. As noted by DMAS, the rate of expenditure growth in Virginia is comparable to that for the rest of the nation (*Virginia Medicaid Program At-a-Glance*, 2014). Expenditures, moreover, are most attributable to individuals who are elderly or who have disabilities. These groups have long-term care needs that require use of more expensive, acute care services and other services and supports. The *Virginia Medicaid Program At-a-Glance* publication is online at [http://www.dmas.virginia.gov/Content\\_atchs/atchs/va-medprg.pdf](http://www.dmas.virginia.gov/Content_atchs/atchs/va-medprg.pdf).

**Table 35** compares data for SFYs 2010 and 2013 for Medicaid enrollment and expenditures in Virginia for the four population categories. For each population, the percentages are based on all Medicaid enrollees and total expenditures. (These figures are rounded to the nearest whole number, so percentages do not necessarily equal 100 percent.)

Table 35. Medicaid Enrollees and Expenditures by Population Category and SFYs				
Population Category	SFY 2010		SFY 2013	
	% of All Enrollees	% of All Expenditures	% of All Enrollees	% of All Expenditures
Elderly	8%	18%	7%	17%
Blind and Disabled	20%	46%	19%	48%
Children	56%	25%	54%	23%
Adults	17%	10%	19%	11%

Source: Department of Medical Assistance Services.

Although children are (and have been) the largest proportion of Medicaid enrollees (54 percent), expenditures for services to children in SFY 2013 comprised only 23 percent of total expenditures, and service expenditures to adults, only 11 percent. Services during SFY 2013 to those in the blind and disabled category comprised almost half of all Medicaid expenditures, and services to the elderly comprised only 17 percent.

Through DMAS data, one can examine Medicaid expenditures by service categories. **Table 36** compares expenditures for select years from SFY 2000 to 2013 for major service categories. Some clarification for certain expenditure categories is necessary, and is as follows:

- **Acute care services** include medical and dental outpatient services, durable medical equipment, inpatient hospital care, and prescription drugs.
- **MH/ID (mental health and intellectual disability) facilities** include the state psychiatric hospitals, Regional Community Support Centers (RCSCs) located at State Training Centers, geriatric facilities, and Hiram W. Davis Medical Center.
- **MH/ID community** includes mental health outpatient services and supports for adults and youth, inpatient supports for youth, and case management by Community Service Boards for individuals with both mental illness and intellectual disabilities.

Table 36. Medicaid Expenditures by Service Category and SFY						
Service Category	2000		2010		2013	
Acute care	\$1,601.2	59%	\$3,382.5	52%	\$3,993.4	52%
Medicaid Waivers	256.6	9%	955.3	15%	\$1,231.5	16%
Nursing facilities	470.9	17%	793.4	12%	\$836.9	11%
MH/ID community	73.4	3%	589.7	9%	672.5	9%
MH/ID facilities	251.6	9%	419.3	6%	453.1	6%
Medicare premiums and other payments	78.9	3%	\$371.9	6%	446.7	6%

Source: Department of Medical Assistance Services. (Percentages are rounded.)

The largest Medicaid expenditures over time have been for **acute care services**, which increased by 149.4 percent since SFY 2000. However, the acute care proportion of total Medicaid expenditures declined by 7 percent since SFY 2000. Reflective of the Commonwealth's policy shift from institutional care to community care, is that even though expenditures by category have risen dramatically over the years, the proportion of Medicaid expenditures for both **nursing facilities and MH/ID facilities** has declined over time by 6 percent each. Concurrently, Medicaid expenditures for **Medicaid Waivers and for MH/ID community services**

rose as did their proportion of total expenditures. Since SFY 2000, MH/ID community services rose from 3 to 9 percent, and those covered by Medicaid Waivers rose from 9 to 16 percent.

Medicaid expenditures can be examined in more depth through comparisons of various **long-term care services**. These are services that are provided on a regular, and even daily, basis over long periods of time and may be based in institutions or in communities. Both in Virginia and nationally, individuals with disabilities as well as the elderly rely on Medicaid for these services. **Table 37** shows the relative proportions of Medicaid expenditures specifically for these major categories of long-term care for three recent state fiscal years (Due to rounding, total percentages may not equal 100 percent.)

<b>Table 37. Medicaid Expenditures for Long-Term Care by Facility Type and SFY</b>			
<b>Long-Term Care Category</b>	<b>2008</b>	<b>2010</b>	<b>2013</b>
<b>Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)</b>	<b>14%</b>	<b>13%</b>	<b>13%</b>
<b>Mental Health Facilities</b>	<b>8%</b>	<b>7%</b>	<b>5%</b>
<b>Nursing Facilities</b>	<b>39%</b>	<b>37%</b>	<b>33%</b>
<b>Home Health, Personal Care, and HCBS Waivers</b>	<b>39%</b>	<b>44%</b>	<b>49%</b>

Source: Department of Medical Assistance Services.

As the data indicate, Medicaid expenditures for Waiver services have grown by 10 percent since SFY 2008 as a proportion of total long-term care (LTC). While the proportion of Nursing Facilities fell by 6 percent during this period, those expenditures remain the second largest proportion. The proportion of LTC expenditures for ICFs/IID has remained relatively stable. The decline (3 percent) in LTC expenditures for Mental Health Facilities is likely due to the declining number of elderly served.

It must be emphasized that future Medicaid enrollment and costs are difficult to project since numerous variables are beyond the control of the Commonwealth. A 2010 presentation by the Congressional Budget Office (CBO) to the Institute of Medicine, titled *Health Costs and the Federal Budget*, noted that per capita health care costs rose faster than per capita gross domestic product during the past decade and that rising costs per enrollee will have the most long-term impact on Medicaid spending. Major unknowns include the scope of job and economic recovery from the Great Recession as well as federal policy decisions regarding federal budget, health care reform in general and the Patient Protection and Affordable Care Act. Other variables unique to the Commonwealth that are likely to impact Medicaid in the future will include (1) legislative policy and budget decisions; (2) general population trends, including growth in the elderly population, especially those with chronic health conditions; and (3) progress towards closing ID facilities. Both DMAS and legislators have been monitoring expenditure trends closely and will continue to do so in the future.

## 5. Monitoring and Evaluation of Medicaid-covered Services

As administrator of the state's Medicaid program, the **Department of Medical Assistance Services (DMAS)** has statutory responsibility to ensure that taxpayer funds are spent wisely and efficiently. To do so, DMAS has established extensive internal fiscal processes and a real-time database for monitoring expenses and for and guaranteeing that services are delivered in compliance with federal and state laws and regulations. In doing so, DMAS has also maintained a very lean administration: Administrative costs comprised only 1.7 percent of all expenditures in state fiscal year (SFY) 2009 and 1.9 percent in SFY 2013.

In addition, for a number of years DMAS has had several ongoing initiatives to improve cost effectiveness of services, including the following:

- cost-containment for pharmaceuticals;
- fraud prevention;
- more effective data systems;
- an enhanced Help Line and expanded online and electronic systems for service pre-authorization and claims submission; and
- expansion of care coordination through managed care organizations to better integrate acute and long-term care.

Through DMAS, the Commonwealth also was one of the first states to require that all Medicaid managed care organizations (MCOs) be accredited by the National Committee for Quality Assurance (NCQA). NCQA accreditation requires each MCO to meet and maintain high, performance-based standards and to engage in continuous quality improvement for health care processes and outcomes.

The DMAS director is required to certify annually to the Virginia **Department of Accounts (DOA)** and **Auditor of Public Accounts (APA)** that the agency's internal control system has been maintained and evaluated, and both the DOA and APA conduct external reviews to ensure the integrity of all DMAS fiscal processes. As a part of its reviews, the APA develops an annual report on all of the State's Health and Human Resources agencies. Over the years, the APA consistently has found that DMAS fiscal information was represented in accordance with generally accepted accounting principles and was free from material misstatements.

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

- the full scope of Medicaid services is available for covered individuals;
- an adequate supply of qualified providers has been enrolled in the program to meet their demand and offer them a choice of providers;

- services paid for by Medicaid are of good quality and are added or changed as needed to protect recipients' health, safety, and welfare; and
- all providers operate in compliance with state and federal laws and regulations.

The **US Centers for Medicare and Medicaid Services (CMS)** requires each state to “assure” that quality standards are met in the provision of all Medicaid services, including those delivered under the Home and Community Based Service Waivers. DMAS conducts periodic **Quality Management Reviews (QMRs)** and evaluations of all programs and services paid through Medicaid to examine service utilization, quality, and timely delivery. The purpose of QMRs is to ensure the health, safety, and welfare of service recipients and service compliance with federal and state regulations. DMAS conducts surveys of both service recipients and providers and analyzes the results. Additional QMRs occur whenever a review/evaluation or data indicate that providers are delivering services in excess or outside of established norms; and they occur after receipt of complaints about service quality from agencies or individuals.

During QMRs for the HCBS Waivers, the review processes include drawing samples from each approved waiver to provide evidence to CMS of the State’s compliance with Medicaid rules. For waivers that offer Medicaid State Plan case management or support coordination services such as with the ID and DD Waivers, DMAS monitoring examines whether individuals are eligible for waiver-specific services; whether the individuals have appropriate Individualized Service Plans (ISPs) based on a comprehensive, regular assessment of their needs; and whether services are being delivered, reviewed, and modified as required by their plans. DMAS also reviews provider qualifications, checks whether services are consistent with billing limitations and documentation of need, and conducts annual level-of-care reviews.

Following completion of a review, DMAS staff shares findings with a provider in an “exit conference” that includes technical assistance and education. A written report of DMAS findings is also sent to the provider. Providers found not in compliance may face a variety of sanctions, which are based on the severity of the deficiency. The most serious deficits may ultimately result in repayments to DMAS and termination of their provider agreement. Results of quality assurance activities regularly are reported to the state administration, legislative committees, federal oversight agencies, and are made available to the public. These reports cover enrollment and expenditure trends, survey outcomes, and the programs’ success in serving appropriate participants, including people with disabilities. DMAS reports are posted online on its websites and on the legislature’s website.

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

In Virginia as nationwide, increased concerns about episodes of **fraud and other misuse of Medicaid** funds have grown in recent years. Within DMAS, the **Office of Program Integrity (OPI)** has primary responsibility for fiscal and service monitoring to prevent and identify waste, abuse, and fraud by Medicaid enrollees or providers. However, all DMAS divisions are actively engaged in program integrity efforts, which include coordination with a variety of outside partners. Under their required Medicaid participation agreements, all service providers must make records and facilities available in response to reasonable requests for access from DMAS representatives, the Attorney General of Virginia or authorized representatives, and authorized federal personnel or designees. As noted in a recent legislative presentation, at the end of 2013, the DMAS Office of Program Integrity had 48 full-time employees, 15 wage/part-time employees, and 7 contractors. During every budget cycle, DMAS evaluates its resource needs, including technology, to address the evolving oversight demands of OPI.

When potential fraud by a provider is identified, DMAS OPI refers the information to the state's **Medicaid Fraud Control Unit (MFCU) of the Office of the Attorney General** for investigation and prosecution. Similarly, when fraud by a recipient is identified by DMAS, the local Commonwealth Attorney is notified. The state Department of Social Services (DSS) and local social services departments are involved with investigation of potential recipient fraud as well. After receiving a referral, the MFCU conducts an assessment to determine if the allegation of wrongdoing is sufficiently credible to open an investigation, which may be civil or criminal. If MFCU does not open an investigation, staff reports the decision and rationale to the DMAS Office of Program Integrity. Since 2008, the MFCU has operated a special unit (**Patient Abuse and Neglect Squad**) to investigate neglect and physical abuse of adults determined to be incapacitated.

Over the past three years, MFCU investigative efforts have intensified, and new positions were added. In SFY 2011, 25 new positions were added; in SFY 2012, 5 positions were added; and in SFY 2013, 10 positions were added. Medicaid fraud cases typically take 2 to 3 years to complete, but investigations of pharmaceutical fraud can take up to 5 years to complete. According to the Office of the Attorney General Medicaid Fraud Control Unit's annual report for SFY 2013, the unit successfully obtained the following **cash recoveries** from civil and criminal cases, all of which were returned to the state General Fund:

- \$9,702,039 in SFY 2011,
- \$6,951,808 in SFY 2012, and
- \$18,737,646 in SFY 2013.

As noted earlier, the **Department of Behavioral Health and Developmental Services (DBHDS)** has operational responsibility for the **ID, DD, and Day Support Waivers**. Staff members from the DBHDS Office of Developmental Services, moreover, periodically review Individual Service Plans (ISPs) for persons receiving services through those waivers, whether those services are provided by local Community Services Boards (CSBs), other public providers, or private nonprofit or for-profit providers. In addition, DBHDS **Community Resource**

**Consultants** monitor the new, two-tiered ID Waiver slot assignment process (described earlier) to ensure statewide consistency. Each time a CSB assigns available ID Waiver slots, it must send its assigned consultant a copy of the computer spreadsheet identifying the individuals to whom the slots were assigned and listing the Critical Needs Summary scores for all individuals on the CSB's urgent waiting list who were considered during each tier of the assignment process. The consultant then confirms that the correct individuals were considered by the Waiver Slot Assignment Committee and received the available slots.

There has been longstanding concern by some advocates and families regarding the objectivity of this process and the variability in slot-allocation processes depending on the locality in which the individual resides. These concerns are being examined as part of the earlier referenced waiver redesign process, which includes the need to develop a uniform slot allocation process for the combined ID/DD Waiver. The community resources consultants also provide periodic training and technical assistance for case managers and service providers as a part of their regular operations, at the request of a provider, or in response to problems identified by the DBHDS Office of Licensing or the DMAS Quality Management Review staff.

DBHDS additionally is responsible for ensuring that the service providers it licenses comply with safety, quality, human rights, and other relevant policies and regulations. Its **Office of Licensing** and **Office of Human Rights** lead those efforts. (Details on this role are found under the **Monitoring and Evaluation of (Non-Waiver) ID Services** section of the **Community Living Supports** chapter of this *Assessment*.)

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

The **Office of Licensure and Certification (OLC/VDH) of the Virginia Department of Health (VDH)** is responsible for licensing, monitoring, and managing licensure compliance for a wide range of public and private **health care facilities** and service providers. OLC/VDH oversight includes both outpatient and inpatient services. Outpatient services licensed by OLC/VDH include, but are not limited to: health clinics, hospice programs, home care organizations, certain laboratories, and other testing facilities. Inpatient and residential facilities under its purview include ICFs/IID, nursing facilities, skilled nursing facilities, and long-term care hospitals. OLC/VDH is also responsible for certification of managed care health insurance plans; and under Titles XVIII and XIX of the federal Social Security Act, it is the State's official certification agency for service providers eligible for reimbursement under Medicaid and Medicare. Set by federal regulation, specific certification, inspection, monitoring, and compliance requirements vary by type of service. Details, as well as procedures for submitting and resolving service complaints, can be found at <http://www.vdh.virginia.gov/olc>. Details on OLC/VDH quality assurance activities for various community-direct services for people with

disabilities can be found in the **Community Living Supports** and **Institutional Supports** chapters of this *Assessment*.

## **B. Chapter References**

Links to websites and online documents reflect their Internet addresses in June of 2014. Some documents retrieved and utilized do not have a date of publication.

### **1. Non-state Websites Referenced**

#### **Code of Federal Regulations (CFR)**

<http://www.gpoaccess.gov/cfr/index.html>

#### **Kaiser Family Foundation**

<http://www.kff.org>

#### **State Health Facts**

<http://www.statehealthfacts.org>

#### **Magellan Health Services**

<http://www.magellanofvirginia.com/>

##### **About Magellan of Virginia**

<http://www.magellanofvirginia.com/about-magellan-of-virginia.aspx>

##### **Governance Board**

<http://www.magellanofvirginia.com/about-magellan-of-virginia/governance-board.aspx>

#### **National Academy for State Health Policy**

<http://www.nashp.org>

#### **Robert Woods Johnson Foundation, National Academy for State Health Policy, Maximizing Enrollment for Kids**

<http://www.maxenroll.org>

#### **US Centers for Medicare and Medicaid Services (CMS)**

<http://www.cms.gov>

##### **Children's Health Insurance Program (CHIP)**

<http://www.cms.gov/home/chip.asp>

Medicaid

<http://www.cms.gov/home/medicaid.asp>

## 2. State Websites Referenced

### Department of Behavioral Health and Developmental Services (DBHDS)

<http://www.dbhds.virginia.gov>

#### Intellectual Disability (ID) Waiver Services

<http://www.dbhds.virginia.gov/ODS-MRWaiver.htm>

#### Office of Developmental Services

<http://www.dbhds.virginia.gov/ODS-default.htm>

### Department of Health (VDH)

<http://www.vdh.virginia.gov>

#### Division of Long-Term Care

<http://www.vdh.virginia.gov/OLC/LongTermCare>

#### Laws, Regulations and Guidelines

<http://www.vdh.virginia.gov/OLC/Laws/index.htm>

#### Office of Licensure and Certification

<http://www.vdh.virginia.gov/olc>

### Department of Medical Assistance Services (DMAS)

<http://www.dmas.virginia.gov>

#### Appeals Division

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

#### Behavioral Health Services

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

#### Commonwealth Coordinated Care (CCC)

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

#### Long-Term Care and Waiver Services

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

**Managed Care**

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

**Maternal and Child Health Programs**

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

**Medicaid Reform and the Patient Protection and Affordable Care Act**

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

**Medicaid Waivers and Rates**

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

**Studies and Reports**

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

**Department of Social Services (DSS)**

<http://www.dss.virginia.gov>

**About Medical Assistance Programs**

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

**FAQs About Medical Assistance**

[http://www.dss.virginia.gov/files/division/bp/medical\\_assistance/intro\\_page/faq/about.pdf](http://www.dss.virginia.gov/files/division/bp/medical_assistance/intro_page/faq/about.pdf)

**Medicaid Forms/Processes**

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

**Office of the Attorney General for Virginia**

<http://www.vaag.com>

**Medicaid Fraud Control Unit**

[http://www.oag.state.va.us/Programs%20and%20Resources/Medicaid\\_Fraud/](http://www.oag.state.va.us/Programs%20and%20Resources/Medicaid_Fraud/)

**Office of the Secretary of Health and Human Services (HHR), Commonwealth of Virginia**

<http://www.hhr.virginia.gov>

**Office of the State Inspector General**

<http://www.osig.virginia.gov>

## **Partnership for People with Disabilities, Virginia Commonwealth University**

Systems Transformation Grant Resource Bank

<http://www.vcu.edu/partnership/cdservices/pcprb.htm>

## **Virginia General Assembly**

<http://viriniageneralassembly.gov/>

Code of Virginia

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

House Appropriations Committee

<http://hac.state.va.us/>

Health & Human Resources Subcommittee

[http://hac.state.va.us/subcommittee/health\\_human\\_resources/health\\_human\\_resources.htm](http://hac.state.va.us/subcommittee/health_human_resources/health_human_resources.htm)

Joint Commission on Health Care (JCHC)

<http://jchc.virginia.gov/>

Medicaid Innovation and Reform Commission (MIRC)

<http://mirc.virginia.gov/>

Senate Finance Committee

<http://sfc.virginia.gov/committee.shtml>

State Budget

<http://leg2.state.va.us/MoneyWeb.NSF/sb2014a>

Virginia Administrative Code

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

## **Virginia Performs**

<http://vaperforms.virginia.gov/>

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