Department of Medical Assistance Services
Virginia’s Medicaid 1915c Waivers
Overview

Presented to Senate Finance Committee
HHR Subcommittee
Terry A. Smith, Division Director, LTC
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Outline

- Long Term Care Funding
- Medicaid 1915c Home and Community-Based Waivers
- Eligibility
- Cost of Waivers vs. Institutions
- Changing Waivers
Medicaid Is the Primary Funding Source for Long-Term Care

- Medicaid is the single largest source of financing for long-term care
- Medicaid accounts nationally for 67% of financing for institutional care
- Medicaid waivers permit a shift from institutional to a home-and-community based service delivery
- In FY 2010
  - 24,703 Virginians received care in a nursing facility
  - 1,843 in an intermediate care facility for the mentally retarded (ICF/MR)
  - 31,027 in their homes and communities
Medicaid Provides LTC Services through Multiple Models

- **Institutional Services**
  - Nursing Facility; includes Specialized Care
  - Intermediate Care Facilities for persons with ID
  - Long-Stay Hospitals

- **Community Services**
  - Program of all Inclusive Care for the Elderly (PACE) (8)
  - Home and Community Based Care Waiver Programs (7)
Service Trend is Moving to Community

Community-Based Services as a % of Total Virginia Medicaid Long-Term Care Spending

State Fiscal Year

- 2001
- 2002
- 2003
- 2004
- 2005
- 2006
- 2007
- 2008
- 2009
- 2010

$Millions

- $0
- $500
- $1,000
- $1,500
- $2,000
- $2,500

- Total Institutional LTC Services
- Total Community LTC Services

Provided by DMAS Division of Budget
Outline

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  - Cost of Waivers vs. Institutions
  - Changing Waivers
What is a 1915c Waiver?

- Waivers are:
  - Optional programs that provide States flexibility to develop and implement alternatives to more costly institutional care (NF, ICF/MRs) and target specific populations (aged, persons with disabilities).
  - Provides Virginia a 50-50 match from federal funds
  - Approved by Centers for Medicare and Medicaid Services (CMS) initially for 3 years, and then renewed in 5 year.
  - A partnership between the family and Medicaid providers to safely support an individual living in their home and community

- Waivers must:
  - Waiver must offer choice to all participants: Between community or institution, between providers, and services received
  - Waiver must be cost effective compared to the alternative institutional placement
Important Advantages of Waivers

- Diverting individuals from institutional care if they can be served in the community and offers choice of settings
- Objective assessment is used to determine care needs
- Applicant must meet same criteria used for admission to institution
- Cost savings

Facts about Virginia Waivers

- Virginia’s waiver eligibility criteria is amongst the strictest in the Nation
- Virginia, since 1977 has had a Mandated by Code of Virginia (§ 32.1-330) a nursing facilities preadmission screening program
What are Virginia’s Seven Waivers?

- Elderly or Disabled with Consumer Direction Waiver *(Originated 1982 {one of the first in the nation} added CD in 2005)*
- Technology Assisted Waiver *(1988)*
- HIV/AIDS Waiver *(1991)*
- Intellectual Disability (Mental Retardation) Waiver *(1991)*
- Individual and Family Developmental Disabilities Support Waiver (DD Waiver) *(2000)*
- Day Support Waiver *(2005)*
- Alzheimer’s Waiver *(2006)*
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Eligibility
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What makes one Medicaid Waiver Eligible?

- **Categorical Eligibility**
  - Must be in a Covered Group
    - Aged, blind and disabled (*Most Common*)

- **Financial Eligibility**
  - Must meet established Income limits
  - Income limits vary by group and are related to
    - current SSI limits
    - some percentage of the federal poverty level (FPL)

- **Waiver Eligibility**
  - Meet age criteria
  - Meet diagnosis/functional criteria
  - Meet alternate institution criteria
## Eligibility and Enrollment by Waiver

<table>
<thead>
<tr>
<th>Waiver</th>
<th>Alternate Institutional Placement</th>
<th>Functional Eligibility Criteria</th>
<th>Eligibility Determination</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS/HIV</td>
<td>Nursing Facility/ Hospital</td>
<td>No age limit Diagnosis of HIV</td>
<td>DSS/VDH/Hosp (UAI)</td>
</tr>
<tr>
<td>EDCD</td>
<td>Nursing Facility</td>
<td>No age limit, meet NF criteria</td>
<td>DSS/VDH/Hosp (UAI)</td>
</tr>
<tr>
<td>Alzheimer's</td>
<td>Nursing Facility</td>
<td>55 and older, Diagnosis of Alzheimer's or related dementia (NO MR/ID)</td>
<td>DSS/VDH/Hosp (UAI)</td>
</tr>
<tr>
<td>Tech</td>
<td>&lt; age 21 Hospital</td>
<td>21 and under - meet criteria based on various methods of respiratory or nutritional support. (tracheotomy, oxygen, tube feeding)</td>
<td>DSS/VDH/Hosp (UAI)</td>
</tr>
<tr>
<td></td>
<td>&gt; age 21 Specialized Care</td>
<td>21 and older - dependent at least part of each day on a mechanical ventilator to meet complex tracheotomy criteria.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nursing Facility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Developmentally Disabled</td>
<td>Intermediate Care Facility for the Mentally Retarded ICF/MR)</td>
<td>Age 6 and above diagnosis of Dev. Disability (NO MR/ID)</td>
<td>VHD Child Development Clinic (LOF)</td>
</tr>
<tr>
<td>MR/ Intellectual Disability</td>
<td>Intermediate Care Facility for the Mentally Retarded (ICF/MR)</td>
<td>Under Age 6 at developmental risk or Above age 6 diagnosis of MR/ID</td>
<td>CSB (LOF)</td>
</tr>
<tr>
<td>Day Support</td>
<td>Intermediate Care Facility</td>
<td>Diagnosis of MR/ID &amp; on MR/ID waiver wait list</td>
<td>CSB (LOF)</td>
</tr>
</tbody>
</table>
## Service Plan Development and Authorization by Waiver

<table>
<thead>
<tr>
<th>Waiver</th>
<th>Develops Service Plan (Initial and Annual Updates)</th>
<th>Service Authorization</th>
<th>Quality Management Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS/HIV</td>
<td>Provider of Services Individual/ Family (Case management optional)</td>
<td>KePRO</td>
<td>DMAS</td>
</tr>
<tr>
<td>EDCD</td>
<td>Provider of Services Individual/ Family (No case management)</td>
<td>KePRO</td>
<td>DMAS</td>
</tr>
<tr>
<td>Alzheimer’s</td>
<td>Assisted Living Facility Individual/ Family</td>
<td>KePRO</td>
<td>DMAS</td>
</tr>
<tr>
<td>Tech</td>
<td>DMAS Case Manager Provider of Services Individual/ Family</td>
<td>KePRO</td>
<td>DMAS</td>
</tr>
<tr>
<td>Developmentally Disabled</td>
<td>Private Case Manager Individual/Family</td>
<td>KePRO</td>
<td>DMAS</td>
</tr>
</tbody>
</table>

### Waivers

- **MR/ Intellectual Disability**
  - **Day Support**: CSB Case Manager Individual/Family
  - **Service Authorization**: DBHDS
  - **Quality Management Review**: DMAS

- **KePRO DMAS**
- **EDCD**
- **AIDS/HIV**
- **Alzheimer’s**
- **Tech**
- **Developmentally Disabled**
- **DBHDS DMAS**
Two Delivery Models for Waiver Services

Consumer Directed
- **Staff**
  - Participant employed, trained & supervised
- **Participation level**
  - 9,500
- **FY 2010 Expenditures**
  - $166 million

Agency Directed
- **Staff**
  - Agency employed, trained & supervised
- **Participation level**
  - 23,600
- **FY 2010 Expenditures**
  - $251 million

Pie chart showing 40% for Consumer Directed and 60% for Agency Directed.
EDCD waiver’s unique role

EDCD waiver can provide services while an individual is on another waiver wait list if the individual meets the criteria for both waivers.

- 26% of MR/ID waitlist is actively receiving services
- 36% of DD waitlist is actively receiving services
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- Eligibility

Cost of Waivers vs. Other Institutions

- Changing Waivers
## Enrollment and Expenditures by Waiver

<table>
<thead>
<tr>
<th>Waiver</th>
<th>Enrollment (Dec10)</th>
<th>FY 10 Waiver Expenditures</th>
<th>FY 10 Acute Expenditures*</th>
<th>FY 10 Total Cost of Waiver</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS/HIV</td>
<td>38</td>
<td>$847,876</td>
<td>$1,248,408</td>
<td>$2,096,284</td>
</tr>
<tr>
<td>Alzheimer’s</td>
<td>50</td>
<td>$755,565</td>
<td>$47,429</td>
<td>$802,994</td>
</tr>
<tr>
<td>Tech</td>
<td>364</td>
<td>$32,216,898</td>
<td>$20,103,143</td>
<td>$52,320,041</td>
</tr>
<tr>
<td>Developmentally Disabled</td>
<td>555</td>
<td>$17,457,451</td>
<td>$6,414,948</td>
<td>$23,872,400</td>
</tr>
<tr>
<td>EDCD</td>
<td>19,902</td>
<td>$369,820,850</td>
<td>$122,837,387</td>
<td>$492,658,237</td>
</tr>
</tbody>
</table>

| Day Support             | 272                | $3,512,660                 | $3,020,091                | $6,532,751                 |
| MR/ Intellectual Disability | 8,175             | $518,836,076               | $97,095,271               | $615,931,347               |
Leading Service Cost % by Waiver

AAL: 100%
- Clinical: 80%
- Personal Care: 15%
- Respite Care: 15%

AIDS: 100%
- Personal Care: 52%
- In Home Supports: 23%

DD: 100%
- Personal Care: 23%
- Respite Care: 15%

ID/MR: 100%
- Residential Services: 65%
- Day Support: 15%
- Pre Voc: 21%

Day Support: 100%
- Day Support: 73%

Tech: 97%
- Private Duty Nursing: 78%

EDCD: 100%
- Personal Care: 18%
- Respite Care: 18%
Waiver Are Less Costly Than Institutional Care

<table>
<thead>
<tr>
<th>Service</th>
<th>Per Person Institution $</th>
<th>Per Person Waiver $</th>
</tr>
</thead>
<tbody>
<tr>
<td>AAL</td>
<td>$15,486</td>
<td>$29,956</td>
</tr>
<tr>
<td>AIDS</td>
<td>$30,153</td>
<td>$70,133</td>
</tr>
<tr>
<td>DD</td>
<td>$156,527</td>
<td>$156,527</td>
</tr>
<tr>
<td>ID/MR</td>
<td>$156,527</td>
<td>$156,527</td>
</tr>
<tr>
<td>Day Support</td>
<td>$156,527</td>
<td>$156,527</td>
</tr>
<tr>
<td>Tech</td>
<td>$185,558</td>
<td>$129,200</td>
</tr>
<tr>
<td>EDCD</td>
<td>$29,956</td>
<td>$21,893</td>
</tr>
</tbody>
</table>

Difference:
- AAL: $14,471
- AIDS: $1,502
- DD: $118,759
- ID/MR: $81,800
- Day Support: $133,833
- Tech: $56,358
- EDCD: $8,062
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How do you Change Waivers?

Key area’s

**General Assembly**
Request Budget amendments as needed to fund changes

**CMS**
Submit amendment specifically describe details of the change
Ensure all changes meet with CMS and Omstead requirements
Assure MOE met
Typical processing time for amendments is 90 days approval

**Infrastructure**
Draft & process regulatory changes
Update current waiver manuals
Automated Systems Changes
Rate Changes
Educate Stakeholders
Inform Medicaid members
Any questions?