Economic Impact Analysis
Virginia Department of Planning and Budget

12 VAC 30-120 – Waivered Services
Department of Medical Assistance Services
December 15, 2010

Summary of the Proposed Amendments to Regulation

The proposed regulations 1) require the use of statewide Supports Intensity Scale form, an assessment instrument, to comprehensively assess individuals' needs for supports and services received through the waiver every three years, 2) require case managers to conduct an annual risk assessment of individuals enrolled in waiver programs, 3) require persons whose services do not start within 30 days to be referred back to the local departments of social services for redetermination of eligibility, 4) make the utilization of a service facilitator by the recipient optional under the consumer directed model, 5) allow involuntary disenrollment from consumer directed model if consumer directed services are not working well for a recipient, 6) modify the process currently used to fill waiver slots to ensure the uniformity of the statewide process, 7) include provisions for electronic information exchange between the local departments of social services, the Department of Medical Assistance Services, and enrolled service providers for determination of the patient pay requirement for waiver services, 8) re-organize the existing requirements, incorporate new terminology, and update name changes and definitions, 9) pursuant to Item 297 YYY, Chapter 297 of the 2010 Acts of Assembly, reduce annual limit an individual can receive from $5,000 to $3,000 for environmental modifications and assistive technology, and 10) revise the prior authorization of respite services from once a year up to 720 hours to once every six month up to 360 hours. Some of these proposed changes have been effective since October 2009 under emergency regulations.

Result of Analysis

The benefits likely exceed the costs for one or more proposed changes. There is insufficient data to accurately compare the magnitude of the benefits versus the costs for other changes.

Estimated Economic Impact

The Mental Retardation/Intellectual Disability (MR/ID) Waiver program is established under section 1915(c) of the federal Social Security Act, which encourages the states to provide home and community based services as alternatives to institutionalized care. The MR/ID Waiver program provides supportive services in the homes and communities of persons with diagnoses of MR/ID or children younger than the age of six years who are at risk of developmental delay. The main purpose of waiver programs is to prevent or delay placement of persons in institutions by providing care for individuals in their homes and communities consequently avoiding high long term care costs. States wishing to implement such waiver programs are required to demonstrate that the costs would be lower under a waiver than the related institutional placement. The MR/ID Waiver program currently supports 8,052 slots.

Department of Medical Assistance Services (DMAS) delegates to the Department of Behavioral Health and Developmental Services (DBHDS) some administrative tasks for this waiver. DBHDS has worked closely with DMAS on the referenced waiver submission as well as these proposed regulations.

Most of the proposed changes are required in order to meet the Centers for Medicare and Medicaid Services (CMS) requirements for the renewal of the MR/ID Waiver. CMS approved the request for the renewal effective July 1, 2009. The current MR/ID waiver will expire June 30, 2014. Some of the proposed regulations have been effective since October 2009 under emergency regulations.

According to DMAS, CMS now requires that states use person centered planning (PCP) in their waiver programs to ensure that individuals enrolled in the state's home and community based waivers fully participate in the planning for their services and supports. Person centered planning goes beyond the traditional individualized planning processes used in the waiver. The person centered approach relies much less on the service system and focuses on the individual

receiving waiver services and supports. To accomplish PCP across Virginia, these regulations incorporate the essential definitions and activities needed to implement PCP.

One of the proposed changes to enhance person centered planning is the use of the Supports Intensity Scale (SIS), an assessment instrument to comprehensively assess individuals' needs for supports and services received through the MR/ID waiver every three years. The form supports the person centered planning process required for waiver approval. The initial supply of this form has been purchased by DBHDS using grant funds. After July 1, 2012, DBHDS will request federal financial participation for the administrative costs associated with the use of this form in the MR/ID waiver. DBHDS estimates that 3,334 to 5,000 forms needed per year at a maximum cost of $100,308 total funds ($50,150 federal share) for fiscal year 2012 and beyond. These estimates may vary based on the number of waiver slots funded by the General Assembly. The main benefit of this form is to ensure consistency across Virginia in identifying individuals' needs for waiver supports and services.

To enhance person centered planning, the proposed regulations also require case managers to conduct an annual risk assessment of individuals enrolled in waiver programs. While this requirement adds an additional task to case managers' duties, no additional compensation is provided. The annual risk assessment is expected to mitigate the health and safety risks to the recipients.

Another proposed change requires that persons whose services do not start within 30 days must be referred back to the local department of social services for redetermination of eligibility. While this change has the potential to increase the administrative costs in terms of redetermination of eligibility, the number of cases where services do not start within 30 days is expected to be very low. This is because the individuals are unlikely to risk their eligibility by failing to initiate their services within 30 days due to long waiting list for this waiver's services. In addition, income limits for redetermination of eligibility is lower making it more difficult to qualify for the waiver services. On the other hand, this requirement will ensure that services available through this waiver are utilized by recipients on a timely manner.

Another change makes the utilization of a services facilitator by the recipient optional under the consumer directed model. Certain waiver services such as personal care assistance, respite care, and companion services are allowed to be provided in a consumer directed model in

addition to the historically provided agency directed model. The agency directed model uses enrolled provider companies who hire nurses, nurse aides, and assistants to render services to recipients according to a provider developed schedule and staffing assignments. The consumer directed model permits the recipient to be the employer (hiring, training, and firing) of his own assistant and schedule the assistant's services (work schedule) consistent with the recipient's needs, as they are documented in the recipient's approved plan of care.

Previously, regulations have required that an individual choosing the consumer directed model for the delivery of personal care assistance, respite care and companion care services also must receive the services of a services facilitator. In CMS' most recent review of Virginia's MR/ID Waiver application for renewal, CMS instructed the Commonwealth that because services facilitation is a waiver service, waiver individuals have the right to choose whether or not to receive services facilitation. Therefore, the proposed changes removed the requirement from the waiver.

To ensure that the essential tasks related to the delivery of consumer directed services continue to be performed, these regulations propose that the individual or the family/caregiver, as appropriate, may perform those tasks (e.g., development of a plan of supports, submission of the plan for prior authorization, record documentation, etc.) themselves when services facilitation is not chosen by the individual or his family/caregiver. Also, "services facilitation" is included in the waiver renewal as an optional service rather than as an administrative activity.

DMAS expects the number of individuals who may opt out of services facilitation to be between 0.5% and 1% of the total waiver recipients, or between 40 and 80 people. Since October 2009 when the emergency regulations have become effective, only one person has opted out of services facilitation. If an individual opts out of services facilitation, a reduction in expenditures may be expected as no reimbursements for this service will be made.[1] However, there is not a readily available estimate for the potential fiscal impact of this change.

The proposed changes also allow involuntary disenrollment from consumer directed model if consumer directed services are not working well for a recipient. Currently, DMAS does

[1] The rates for facilitation services are as follows: Initial Comprehensive Visit $232.81 for Northern Virginia and $179.34 for the rest of the state; Routine Visit $72.41 for Northern Virginia and $55.70 for the rest of the state; Employee Management Training/Consumer Training $231.70 for Northern Virginia and $178.23 for the rest of the

not have the ability to move recipients into the agency directed model if the recipient fails to comply with the requirements of the consumer directed model or if there are health and safety risks to the recipient under the consumer directed model. For example, if the recipient is consistently unable to manage the assistant and has a pattern of discrepancies in time sheets of his or her assistant, DMAS will have the authority to provide services to that individual under the agency directed model.

Currently, there are about 1,200 people in this waiver who are using the consumer directed model of service delivery. DMAS expects the number of persons being removed involuntarily to be very small, 0.5% to 1.0% of those persons who use this service model. Consequently, it is estimated that 6 to 12 persons may be affected by this change. Generally, the rates for agency directed services are higher than the rates paid in consumer directed services.[2] Thus, removing individuals from consumer directed model to agency directed model has the potential to increase expenditures. However, prevention of non-compliance with the requirements of consumer directed model may create fiscal savings and/or improve health and safety of recipients.

CMS further directed Virginia to modify the process currently used to fill MR/ID waiver slots to ensure the uniformity of the statewide process. CMS is now requiring that Virginia, through DBHDS, develop uniform, statewide guidelines to be applied by community services boards (CSBs) and behavioral health authorities (BHAs) to identify those urgent waiting list individuals who are most in need of services when waiver slots become available. These proposed regulations create the DBHDS' authority to accomplish this federal directive. This change is expected to provide consistency in eligibility determinations throughout the Commonwealth. On the other hand, some administrative costs associated with the development and the implementation of uniform criteria statewide may be expected.

The proposed regulations also include DMAS' conversion to an electronic information exchange between the local departments of social services, DMAS, and enrolled MR/ID service

state; Management Training $28.96 for Northern Virginia and $22.28 for the rest of the state; and Reassessment Visit $116.97 for Northern Virginia and $89.12 for the rest of the state.

[2] The rates for Companion Care, Personal Care, and Respite Care under consumer directed model for Northern Virginia are $11.47 and the rates under agency directed model for Northern Virginia are $15.20; the rates under consumer directed model for the rest of the state are $8.86 and the rates under agency directed model for the rest of the state are $12.91.

providers for determination of the patient pay requirement for waiver services. Electronic exchange of patient pay information is expected to reduce administrative costs associated with distribution of paper copies.

In addition, the proposed regulations re-organize the existing requirements, incorporate the use of current terminology (e.g., replace "mental retardation" with "mental retardation/intellectual disability"), change the name of the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) to the Department of Behavioral Health and Developmental Services (DBHDS), add definitions for person centered terms such as "Person Centered Planning (PCP)," "Individual Support Plan," and "Plan for Supports."

Furthermore, pursuant to Item 297 YYY, Chapter 297 of the 2010 Acts of Assembly, the proposed regulations reduce annual limit an individual can receive from $5,000 to $3,000 for environmental modifications and assistive technology. The main benefit of this change is the expected approximately $1.2 million savings per year in total funds starting with fiscal year 2010 and beyond. One half of these funds would represent savings in state funds. On the other hand, the main cost of this change is the expected reduction in the utilization of this service and its affects on the recipients.

Finally, one of the proposed changes revises the prior authorization of respite services from once a year up to 720 hours to once every six month up to 360 hours. Since the annual limit for the respite care hours stays the same, DMAS does not expect a significant reduction in the utilization and consequently in the expenditures for respite care. However, an increase in administrative costs of providers may be expected as they will be required to obtain additional prior authorizations for the same number of respite care hours. Due to the added costs and administrative requirements, there may be a small reduction in the prior authorization requests.

Businesses and Entities Affected

Currently, approximately 8,052 individuals are utilizing waiver services. The waiver services are provided by about 1,825 providers which include home health agencies, community services boards, and private providers of crisis stabilization, day support, in-home residential support, personal care, durable medical equipment, prevocational services, respite care, skilled nursing, supported employment, therapeutic consultation, and transition services.

Also, there are 122 local departments of social services making eligibility determinations. The waiver services are primarily administered by the Department of Behavioral Health and Developmental Services and paid through the Department of Medical Assistance Services.

Localities Particularly Affected

The proposed regulations apply throughout the Commonwealth.

Projected Impact on Employment

Some of the proposed changes are expected to increase the need for labor and add to the demand for labor. These changes include the required use of supports intensity scale, conducting a risk assessment every year, and the added prior authorization requirements.

Moreover, the providers are expected to see a decrease in demand for their services due to the reduced maximum expenditure limits for environmental modifications and assistive technology and making the use of service facilitator optional which may reduce providers' demand for labor.

On the other hand, the printing of required supports intensity scale forms may add slightly to the demand for labor.

Effects on the Use and Value of Private Property

No direct effect on the use and value of private property is expected. However, added labor costs coupled with reduced revenues may have a negative impact on the asset value of affected providers.

Small Businesses: Costs and Other Effects

Approximately 1,621 of the affected 1,825 providers are estimated to be small businesses. The costs and other effects described above for all providers are the same for the providers that are small businesses.

Small Businesses: Alternative Method that Minimizes Adverse Impact

There is no known alternative method that minimizes adverse impact on small businesses while accomplishing the same goals.

Real Estate Development Costs

No significant impact on real estate development costs is expected.

Legal Mandate

The Department of Planning and Budget (DPB) has analyzed the economic impact of this proposed regulation in accordance with Section 2.2-4007.H of the Administrative Process Act and Executive Order Number 107 (09). Section 2.2-4007.H requires that such economic impact analyses include, but need not be limited to, the projected number of businesses or other entities to whom the regulation would apply, the identity of any localities and types of businesses or other entities particularly affected, the projected number of persons and employment positions to be affected, the projected costs to affected businesses or entities to implement or comply with the regulation, and the impact on the use and value of private property. Further, if the proposed regulation has adverse effect on small businesses, Section 2.2-4007.H requires that such economic impact analyses include (i) an identification and estimate of the number of small businesses subject to the regulation; (ii) the projected reporting, recordkeeping, and other administrative costs required for small businesses to comply with the regulation, including the type of professional skills necessary for preparing required reports and other documents; (iii) a statement of the probable effect of the regulation on affected small businesses; and (iv) a description of any less intrusive or less costly alternative methods of achieving the purpose of the regulation. The analysis presented above represents DPB's best estimate of these economic impacts.