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Premier Mental Health, Mental Retardation, and Substance Abuse Services in Virginia's Communities

Policy and Funding History: The MR Waiver

Mary Ann Bergeron
VACSB
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MR Services/Waiver Oversight

- DMHMRSAS licenses MR Waiver services. Licensed providers bound by Human Rights law and regulations
- DMHMRSAS licenses MR/ID case management as a service under State Plan
- All CSBs have DMAS provider agreements
- All CSBs sign DMHMRSAS performance contracts
- DMAS and DMHMRSAS share management

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MR Waiver-1990s

- As it began in 1991-filled budget gaps, preserved services-no service increase
- Recession forced VA to convert GF for match through CSB/facility $$$$
- Match requirements limited slots to what CSBs /facilities could convert for slots
- Resulted in severely limited services for those not in a Waiver slot
- CSBs only providers required to convert dollars to state match

MR Waiver During 2000s

- General Assembly directed match provided through GF and DMHMRSAS transferred all funds permanently
- General Assembly, through Hall-Gartlan, realized benefit to individuals and families and funded MR Waiver slots. System succeeded in utilizing significant numbers of MR Waiver slots
- Providers services became more robust and viable as a result of rate increases
- General Assembly mandated shared management by DMAS/DMHMRSAS through an agreement

MR Waiver in 2000s-Summary

- Wait list is growing but managed
- Slot allocation accomplished at the local level with families and individuals themselves, based on need as approved by CMS
- Health and safety-bottom-line issues in allocation of slots
- Rate issues continue to impede provider capacity and ability to create more intensive services as facility alternatives
- MR Waiver services not indexed for inflation

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2000s-Summary

- Case management provided for all consumers, Medicaid eligible or not, has been target for budget conversions to assist with state deficits
- CSB revenue from Medicaid CM used to address program gaps in all services
- Implementation of CMS regs (now on moratoria) will mean loss of revenue for CM and service gaps
- A plan for slots is needed to eliminate the wait list for MR and DD Waivers
- A dedicated reliable funding stream needed for all “core services”

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Additional Information-MR Waiver

- By 1970s, the cost of state training centers (ICFs-MR) was shared by federal Medicaid
- Late 1980s, policy movement toward a community based Waiver began as an add-on to increase existing services and service capacity individuals with MR/ID

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MR Waiver History

- 1990-91, state budget deficit required alternative approach, using CSB-allocated GF from “Make Waves” initiative to generate match for services in order to preserve service capacity, no longer increase in services
- Significant budget reductions within system alleviated state budget deficit.

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MR Waiver History

- Waiver developed in conjunction with DMAS but managed through DMHMRSAS, funding source for match
- Case management, an existing service at the time, is not a Waiver service but , as a Medicaid service, was limited to CSBs as responsible entities for single point of entry, assessment and local management and accountability

MR Waiver Limitations in 1990s

- The conditions: CSBs or state facilities were required to put forth the match for Medicaid rehab, Medicaid case management, and Waiver services
- Result: Budget conversions of GF to Medicaid match took place within CSB and DMHMRSAS budgets-no longer allowable now

MR Waiver Limitations in 1990s

Impacts:

- Available funding for conversion limited the number of MR Waiver slots
- Slots assigned based on need and Waiver eligibility
- No other Medicaid providers were required to provide match

Results of 1990s Approach

- CSBs and private providers struggled to develop, maintain, and expand services
- Services for individuals with MR/ID not Waiver eligible became more and more limited as dollars converted to match for Waiver slots

Results of Approach

- This budget driven approach missed dental services for example, still not covered in the Waiver (nor by regular Medicaid!)
- 1996-2000-Hall-Gartlan Subcommittee examined the practice of conversion of CSB dollars to fund MR Waiver slots and found it unacceptable.

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MR Waiver 2000 Changes

- 2000, all the match funds shifted from DMHMRSAS to DMAS
- CSBs and state training centers no longer responsible for match conversions
- DMAS assumed management of the MR Waiver

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Results of Changes Enacted

- Multiple issues ensued for consumers, families, and providers
- JLARC report of the transition critical of facets of DMAS MR Waiver administration
- General Assembly acted to fund large numbers of MR Waiver slots by 2001

MR Waiver Agreement

- Advocates requested the General Assembly to require an interagency agreement between DMAS and DMHMRSAS
- Defined and delineated the roles and responsibilities each agency would have addressing the MR Waiver

MR Waiver-Agreement

- DMAS as the single state agency administering the MR Waiver
- DMHMRSAS has leadership in well-defined management functions
- CSB responsibility for the local slot assignment and local wait list
- Criteria for Urgent Care Wait List developed in partnership

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MR Waiver

- CSBs are bound by Performance Contracts with DMHMRSAS
- CSBs assess and assign individuals to the local Urgent Care Wait list, which DMHMRSAS tracks
- CSBs have local protocols for slot consideration and allocation
- Overall process approved by CMS

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