

# **2014 Assessment of Disability Services in Virginia**

## **Volume 2**

**Virginia Board for People with Disabilities**

*The Commonwealth's Developmental Disabilities Council*

# **2014 ASSESSMENT OF DISABILITY SERVICES IN VIRGINIA VOLUME 2**

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## Preface

### Background

The Virginia Board for People with Disabilities, the Commonwealth's Developmental Disabilities (DD) Council, is pleased to publish the *2014 Assessment of Disability Services in Virginia*. This report was produced in accordance with the Code of Virginia § 51.5-33 [2] and the federal Developmental Disabilities Assistance and Bill of Rights Act (PL 106-402, 2000). This is the fourth edition of the Board's *Assessment*. Previous editions were published in 2006, 2008, and 2011. To improve trend analysis, the 2008 General Assembly lengthened the interval between assessments from two to three years.

This *Assessment* is unique in that it offers a broad, comprehensive examination of how state-funded disability services are accessed, provided, evaluated, and funded. Through this document, the Board hopes to promote new policy discussions on the design and delivery of disability services from a systemic perspective and offers recommendations to resolve some of the major issues found. Now is the time for the Commonwealth to examine and evaluate how well current disability services are delivered and working to create a system with more effective, flexible, efficient, responsive, and cost-effective ways of delivering services.

### Scope of the 2014 Assessment

This report examines and provides a factual description of the status of services at a point-in-time. Agency data are primarily based on annual counts at the end of several state fiscal years, ending in SFY 2013 (June 30). Information on agency policies, initiatives, and services as well as changes (positive and negative) occurring since the 2011 edition of the Board's *Assessment* are included, in most cases through January of 2014, although in several areas, significant information made available more recently also has been incorporated.

This *Assessment* does not, and cannot, address all of the services and programs available to persons with disabilities in the Commonwealth. Pursuant to the Board's federal requirements, authority, and funding, the *Assessment* focuses on services provided to Virginians with developmental disabilities (DD). Developmental disabilities are those that are (1) manifested before the age of 22, (2) result in substantial limitations in at least three key life areas, and (3) are likely to require services and supports across the lifespan. It is important to note, however, that many described services and the associated findings and recommendations are applicable to individuals with all types of disabilities. Examples include the discussion of areas such as housing, employment, and transportation.

The *Assessment* does not specifically cover the services and supports provided to individuals who have a serious mental illness or substance abuse disorder, with the exception of crisis intervention services for individuals with co-occurring disabilities. The report also does not specifically address services for individuals with disabilities who are in juvenile or adult correctional settings, children with disabilities who are in foster care, and military personnel and veterans with disabilities who receive, for the most part, federally funded services.

The Board recognizes that other gaps in the scope may be identified. Despite its best efforts, there may be undetected errors or important issues that have not been fully addressed. Readers are encouraged to bring those oversights to the Board's attention, and efforts will be made to correct them in future editions.

## Development Process

To create this *Assessment*, the Board sought public comment both on changes to and experiences with services since 2011 and also on ways the service system could and should be improved. To maximize feedback, a longer public comment period (March 1, 2013 through August 31, 2013) was held for this edition than was held for the 2010 edition. The Board also regularly solicited public comments through its newsletter, website, e-mail solicitations, and other means during that period. Based on experiences with and feedback from public comment efforts for previous editions, staff recognized that new approaches were needed.

Since January of 2011, transportation costs and time demands on individuals and families have increased, and substantial growth in new communication technologies has occurred. In 2013, the Board held two on-site forums: one in northern Virginia (Franconia), which had two sessions, and one at the annual Arc of Virginia state conference. For the first time, the Board obtained comments through three videoconferences held in collaboration with area Centers for Independent Living (CILs): far Southwest Virginia; Southern Valley area (Roanoke, Christiansburg); and Northwest Valley area (Harrisonburg, Winchester). Additionally, the Board solicited feedback by setting up information booths at several statewide conferences (including the annual Transition Forum and the Arc of Virginia State Convention). All public comments were compiled and analyzed by the Board and helped shape the *Assessment*.

Descriptive information in the *Assessment* was gathered from a wide variety of state resources: agency planning and performance reports, interagency task force and workgroup reports, legislative studies and presentations, state agency websites, direct communications with agency staff, and other available sources. As indicated, data and information were obtained from federal websites and documents as well as policy reports from various national, non-partisan research organizations. A draft of each chapter or relevant chapter sections were forwarded to each state agency for review not only to verify the accuracy of the information and data presented, but also to obtain clarification on factors affecting identified trends.

An ad hoc committee of Board members worked with staff to review and consider all public comment as well as the data and information from chapter drafts. After thorough consideration, the committee identified key findings and developed recommendations for system improvements. These were approved by the full Board at its June 2014 meeting. The Board's findings and recommendations are consistent with the values and tenets of the 2000 Developmental Disabilities Assistance and Bill of Rights Act. Board recommendations are based on the overarching goal of developing disability services statewide that create

*a coordinated, consumer- and family-centered and directed comprehensive system of community services, individualized supports, and other forms of*

*assistance that enable individuals with developmental disabilities to exercise self-determination, be independent, be productive, and be integrated and included in all facets of community life.*

In developing the *2014 Assessment*, the Board relied on information provided either directly by a state agency or indirectly through agency websites and published documents or reports. Over the past three years, the Health and Human Resources (HHR) Secretariat has made agency data improvement a priority. While several agencies made significant strides in tracking meaningful data, some have made little progress since 2010. In general, the primary data collected consistently across state agencies for its programs or services were expenditures and the “number served” (which sometimes is quite broadly defined). In a few instances, program/service data were not available.

The task of ensuring data quality and reliability is challenging but essential. Limited fiscal resources and manpower hinder smaller disability agencies. Obtaining data from larger agencies typically involved multiple staff across various divisions or programs within them. Data submitted to the State by local systems is often inconsistent between jurisdictions in both the manner it is reported and the content. Examination of longitudinal trends over time often was limited by changes in data definitions and collection methodologies. While some changes were due to revised reporting requirements by federal funding sources, sometimes the state agency itself had made the changes. In addition, some state agency websites were significantly out of date.

Throughout the development of the *Assessment*, Board staff consulted, as indicated, with designated agency staff for clarification of information and data. In addition, the Board provided all participating state agencies a draft copy of each *Assessment* chapter that addressed their programs and services for review of content for accuracy.

## Organization and Content Changes

There are several significant format and content changes in this edition. A key change is the separation of the *Assessment* into two volumes. **Volume 1** includes the Board’s **Key Findings and Recommendations**. **Volume 2** contains the detailed information and data on the specific services and supports reviewed that, in addition to public comment, form the basis for the findings and recommendations. These are designed to be companion documents. Due to the length of **Volume 2** and the Board’s limited resources, access to that document will be primarily online in accessible electronic and audio versions. A limited number of hard copies will be made available.

The *Assessment*’s chapters are organized by the core categories of services/supports needed by Virginians with developmental and related disabilities across the lifespan: Early Intervention, Education, Employment, Health Care, Medicaid, Community Living Supports, Institutional Supports, Community Housing, and Transportation. References are included at the end of each chapter. Information on statewide advocacy groups is provided in Appendix A, and information on preparing for emergencies is contained in Appendix B. Appendix C contains a list

of acronyms. Each chapter's introduction provides a summary of key changes made since January of 2011 in regulations, funding, and service design as well as a summary of external forces (the economy, federal government initiatives, etc.). This edition's individual chapters are organized by program or service areas to improve readability and provide a user-friendlier format. When applicable, graphics are used to help depict changes over multiple years. Due to the complexity and length of the *Assessment*, readers are referred to state websites or local agencies for additional information or description throughout the document.

## **Acknowledgements**

The Board expresses its deep appreciation to all those who contributed to the development of its *2014 Assessment*, which was possible only with the information and cooperation provided by a host of individuals from both inside and outside of state government. The Board is especially grateful to the numerous state agency officials and staff who responded to requests for information, data, and content reviews. Their assistance in clarifying or describing data or information and in ensuring content accuracy was invaluable. The guidance of individuals with disabilities, advocates, and others who provided public comments—whether in person or by mail, videoconference, or phone—is greatly appreciated.

## I. Early Intervention

### A. Introduction to Infant and Toddler Services

Early intervention services target infants and toddlers, from birth until their third birthdays, who are not developing as expected or who have a condition that can delay normal development. These services, available under **Part C of the Individuals with Disabilities Education Improvement Act (IDEA)** (20 USC § 1431 et seq.) are designed to meet the development needs of each child and the family. They include therapies and other services that will help the child develop to his or her potential and mitigate the need for long-term services and supports.

The Part C Office of the **Infant and Toddler Connection of Virginia** administers Virginia's Part HC program. It is guided by state law (Code of Virginia § 2.2-5300–5308) as an entitlement program under IDEA. As an entitlement program, all eligible children must receive services regardless of ability to pay. Seven state agencies share responsibility for oversight of Part C services through the **Virginia Interagency Coordinating Council (VICC)**, which is comprised of the Departments for the Blind and Vision Impaired and the Deaf and Hard of Hearing, and the Departments of Education, Health, Social Services, Medical Assistance Services, and Behavioral Health and Developmental Services.

The **Department of Behavioral Health and Developmental Services (DBHDS)** is designated as the lead state agency for Part C early intervention services. It is accountable to the federal **Office of Special Education Programs (OSEP)** of the US Department of Education for quality of service delivery and for ensuring that Virginia's Part C services meet all applicable federal regulations and guidelines. Services are based on current research and best practices that emphasize (1) empowering parents and strengthening their abilities to meet their children's developmental needs, (2) maintaining consistency of intervention, and (3) avoiding over-utilization of therapy.

The Commonwealth's Part C system is based on the following principles:

- Parents and service providers become partners to make the most effective use of activities and learning opportunities that arise normally throughout the child's and family's daily routine.
- The frequency, structure, and level of services are designed to fit each individual family's schedule, environment, and needs for support.
- Support coordinators facilitate access to and timely delivery of Part C and other services and supports and monitor the evolving needs of the child and family.

DBHDS continues to express reservations in its annual reports to the General Assembly, including in its most recent 2013 report about the reliability of the data reported by local lead

agencies responsible for Part C services. DBHDS emphasized in its *2012 Annual Report to the General Assembly* that the numbers provided were estimates and “almost certainly underestimate the number of children receiving each service.” Find the 2012 report at [http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/RD2612012/\\$file/RD261.pdf](http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/RD2612012/$file/RD261.pdf).

In its *2013 Annual Report to the General Assembly*, which can be found at [http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/RD3082013/\\$file/RD308.pdf](http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/RD3082013/$file/RD308.pdf), the following challenges with data were among those reported by DBHDS:

- Child data is collected in the **Infant and Toddler Online Tracking System (ITOTS)** only at entry into the Part C system and is not collected as child status or needs change.
- No financial data is collected through ITOTS, resulting in a burdensome paper process that impedes collection and reporting of reliable, comprehensive data related to costs and revenue sources.
- ITOTS data reports are limited in scope, and available data does not allow for outcome analysis.

DBHDS has embarked on initiatives to improve the data systems. However, fiscal constraints and other priorities led to delays in developing or purchasing a system with the required functionality. In 2011, the State’s Health and Human Resources Secretariat began a state endeavor to develop a consistent, comprehensive, and non-duplicative data system for use across agencies. This work is ongoing. Because of these concerns, comparative analysis of these data would be presumptive. Therefore, the data in this chapter related to Part C are presented *as reported*.

Some Virginia children with disabilities also receive early intervention services through one of eighteen **Early Head Start (EHS)** programs under the authority of the Head Start Act of 2007 (42 USC § 9801 et seq.). EHS programs serve low-income infants, toddlers, pregnant women, and the families of these populations. In addition to supporting parents in their roles, these programs are designed to enhance children’s physical, social, emotional, and intellectual development. The **Virginia Department of Social Services (DSS) Head Start Office** has administrative and oversight responsibility. Head Start and Part C are required to collaborate and, as lead agency, DBHDS is required to participate on the Head Start State Advisory Council on Early Childhood Education and Care.

This chapter discusses the two programs separately with Part C presented first, followed by Early Head Start services. While these programs operate on the **federal fiscal year (FFY)**, October 1 through September 30, some information is reported by **state fiscal year (SFY)**, July 1 through June 30.



## B. IDEA Part C's Early Intervention Services

### 1. Infant and Toddler Screening and Eligibility for Part C

The Individuals with Disabilities Education Improvement Act (IDEA) defines “**early intervention services**” (hereafter interchangeably referred to as “EI” or “Part C services”) as services designed to meet the developmental needs of each child and the needs of the family related to enhancing the child’s development. EI services are available to children from birth to age three who:

- have a 25-percent developmental delay in one or more areas of development,
- have atypical development, or
- are diagnosed with a physical or mental condition that has a high probability of resulting in a developmental delay.

The 2011 federal regulations on Part C, which can be found at <http://www.gpo.gov/fdsys/pkg/FR-2011-09-28/pdf/2011-22783.pdf>, added a **definition of a “child at risk”** as a child younger than three who is at risk of experiencing a substantial developmental delay if EI services are not provided. The regulations also give states the option to serve children at risk. However, Virginia opted not to include “children at risk for delays” in its definition of eligibility. In 2010, Virginia added “**prematurity**” as an automatic eligibility criterion.

Information on **eligibility** can be found on the Infant Toddler Connection of Virginia website at <http://www.infantva.org>, which includes a complete list of eligible conditions at <http://www.infantva.org/documents/pr-PM-PracticeManual.pdf>. Information is also available through the local Part C program, which is included in the Central Directory website at <http://211uwgrp.org/>.

**Referrals** to the Part C system come from a variety of sources, including “self-referral” by a family. Referrals do not require the consent of a child’s parents or legal guardians. Reports from the Department of Behavioral Health and Developmental Services (DBHDS) that cover many years show that the vast majority of referrals have and continue to come from physicians, followed by parents and guardians. With parental consent, all referred children receive a developmental screening using a standardized screening tool unless the child:

- is diagnosed with a physical or mental condition with a high probability of resulting in developmental delay,
- has a documented developmental delay or atypical development, or
- has already received a developmental assessment or screening prior to referral.

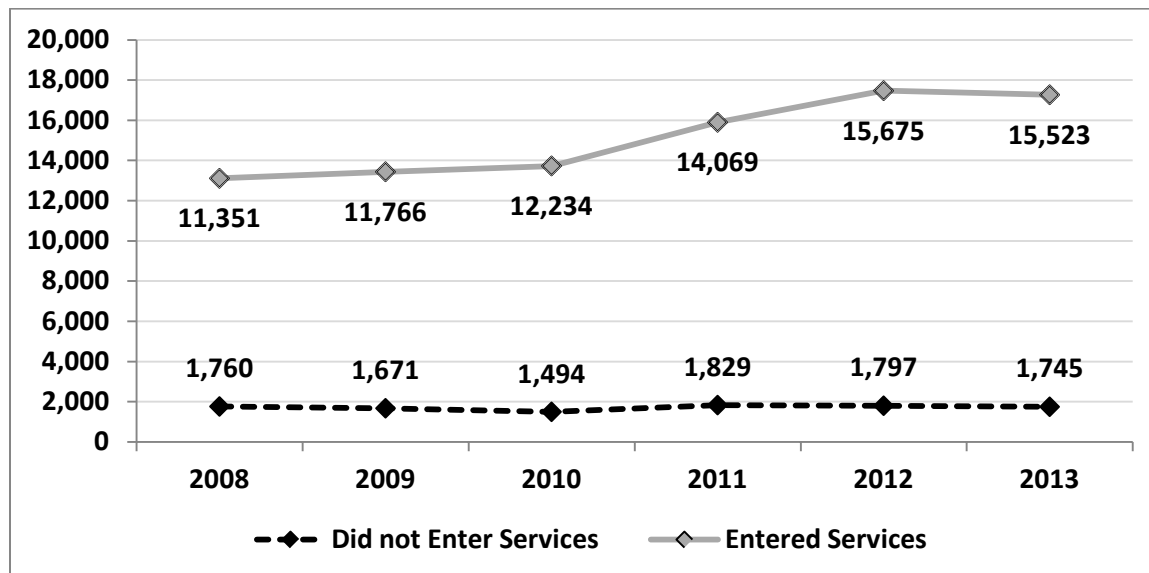
Unless the parent refuses to proceed to an eligibility determination, referred children undergo a multi-disciplinary evaluation that includes a team review of available medical

reports, developmental screening results, parental reports, observations summaries, and any other assessments used. More detailed information on assessments can be found in the “Virginia Part C Policies and Procedures” section of the Individuals with Disabilities Education Improvement Act (IDEA) at <http://www.infantva.org/documents/ovw-PGuideStateDefinition.pdf>.

Annual data on the unduplicated number of infants and toddlers receiving Part C services is calculated two ways: (1) a point-in-time-count required by the federal government, which tallies the number of individual children served on December 1 of each year, and (2) an annualized count that shows the total, unduplicated count of all infants and toddlers who are served over the course of the state fiscal year (SFY), July 1 to June 30.

**Figure 1** shows the number of infants and toddlers being served each year rising significantly and steadily until SFY 2013 when the number of children served decreased by 147 from SFY 2012. There also have been a fairly steady number of infants and toddlers who are found eligible but do not receive services because services are declined, contact is lost, or families choose to obtain private services.

**Figure 1. Eligible Infants and Toddlers who Entered Part C Systems and those who were Eligible but did not Enter Services**



## 2. Access to and Use of Part C Services

As the lead agency, the Department of Behavioral Health and Developmental Services (DBHDS) supervises and monitors Virginia’s Part C early intervention system. The system emphasizes local decision-making and autonomy in service implementation with state-level accountability. Through its **Office of Child and Family Services**, DBHDS establishes regulations and adopts statewide policies and procedures to ensure consistent, equitable access to quality services and compliance with statutory and regulatory requirements. Part C regulations,

statutory provisions, policies, and procedures can be found at <http://www.infantva.org/Overview.htm>.

DBHDS contracts with 40 **local lead agencies** (referred to as “**local Infant and Toddler Connection programs**”) to deliver Part C services. Currently, 30 **Community Services Boards (CSBs)** serve as local lead agencies. Lead agencies for the remaining localities include 2 local education agencies, 4 universities, 2 health departments, and 2 local governments. All local lead agencies are designated by local city or county governments and are responsible for:

- designating a single point of entry for the system (usually itself),
- managing the budget and allocating federal and state Part C funds,
- collecting and reporting data,
- conducting IDEA-mandated **Child Find** activities, including public awareness campaigns, to identify infants and toddlers who may be eligible for services, and
- delivering services, either through their agency or through contractors, or both.

Some Part C local lead agencies determine eligibility and provide service coordination through case managers. Case managers guide families through the early intervention process and facilitate the development and implementation of a required **Individualized Family Services Plan (IFSP)**. An IFSP lists the developmental outcomes that the family and Part C team would like the child to achieve, and it identifies the services and supports needed to meet those outcomes. The IFSP process emphasizes family participation and a holistic approach that brings together medical, developmental, psychosocial, and educational resources to ensure that the needs of the child and family are met in the most effective manner. The frequency of services and supports in the IFSP are adjusted as the needs of the child and family change.

Federal Part C regulations require that early intervention services be provided in “**natural environments**” that meet the needs of the child to the maximum extent possible. Natural environments are defined as the home and other community settings that include children without disabilities and that are typical for the child’s same-age peers. Providing services in other settings is appropriate *only* if outcomes cannot be achieved in natural environments. For more information, see <http://www.infantva.org/ovw-WhatIsPartC.htm>.

Although allowed under federal statute and regulations, Virginia does not provide EI services to children beyond age 3. States are required to ensure “**a smooth and effective transition**” between Part C programs and IDEA Part B (special education) preschool programs, or to Early Head Start, Head Start, childcare programs, or other appropriate services. The regulations require that the local lead agency notify the state and local education agencies no fewer than 90 days before the child’s 3<sup>rd</sup> birthday that the child will be reaching the age of eligibility for Part B services. Currently, Virginia is the only state that makes Part B services available to children ages 24 to 36 months.

A child cannot receive Part C and Part B services concurrently. Parents must decide whether or not to remain in the Part C early intervention system or to transition to the Part B special education system when the child reaches 24 months. If a child requires special education services under Part B, public schools and Part C local agencies must both participate in transition planning and in the development and implementation of an **Individualized Education Program (IEP)**. Transition planning must be completed at least 90 days before, but no sooner than 9 months before, the child's 3<sup>rd</sup> birthday. (For more information about IEPs, see the **Education** chapter of this report).

Local geography, service availability, populations, political jurisdictions served, and organizational structures are among the variables of local systems. In some areas, personnel shortages and the weakening economy have contributed to a wide variability in services between localities. Waiting lists, which are prohibited under the Individuals with Disabilities Education Improvement Act (IDEA) Part C, were used in Virginia in both 2012 and 2013.

**Table 1** compiles information on the number of children who received various types of early intervention services between SFYs 2011 and 2013. Earlier data were not included for the following reasons:

- Between 2008 and 2010, there were significant differences in recorded usage of some services due to (1) how the counts were derived, (2) different naming conventions, and (3) the elimination of the reporting of aggregate services.
- In SFY 2010, the reported data was altered to reflect services actually delivered versus those listed on initial IFSPs. DBHDS stated in its SFY 2010 *Report on Virginia's Part C Early Intervention System* to the General Assembly that these data were more accurate as they looked at actual (versus anticipated) services. However, in SFY 2011 and beyond, the reporting was changed back to its original form.
- Since SFY 2010, DBHDS has continued to state in its annual reports to the General Assembly that because of inconsistencies in local reporting of services-delivered data, it could not ensure a non-duplicative count between services reported by public agencies and private providers.

It is noteworthy that nearly 600 fewer children received initial evaluations in SFY 2013 than in the previous two fiscal years. This is likely due to resource constraints that lessened Child Find activities during that year.

| <b>Table 1. Part C Services Listed on Initial IFSPs by SFY</b> |             |             |             |
|--|-------------|-------------|-------------|
| <b>Service</b>   | <b>2011</b> | <b>2012</b> | <b>2013</b> |
| <b>Assistive technology</b>                                    | <b>42</b>   | <b>19</b>   | <b>16</b>   |
| <b>Audiology</b>   | <b>253</b>  | <b>235</b>  | <b>78</b>   |

| Table 1. Part C Services Listed on Initial IFSPs by SFY |        |        |        |
|---|--------|--------|--------|
| Service   | 2011   | 2012   | 2013   |
| Counseling  | 3      | 2      | 16     |
| Developmental services                                  | 2,532  | 2,947  | 2,717  |
| Initial evaluation/assessment                           | 9,903  | 9,882  | 9,305  |
| Health services   | 0      | 0      | 0      |
| Nursing services  | 0      | 0      | 0      |
| Nutrition services                                      | 14     | 2      | 5      |
| Occupational therapy                                    | 2,110  | 2,163  | 2,226  |
| Physical therapy  | 3,813  | 4,154  | 3,943  |
| Psychological services                                  | 0      | 0      | 5      |
| Service coordination*                                   | 14,069 | 15,676 | 15,523 |
| Sign language and cued language services**              | N/A    | N/A    | 16     |
| Social work services                                    | 11     | 31     | 15     |
| Speech-language pathology                               | 5,276  | 5,534  | 5,076  |
| Transportation  | 4      | 0      | 5      |
| Vision services   | 84     | 91     | 109    |
| Other entitled EI services                              | 98     | 78     | 155    |

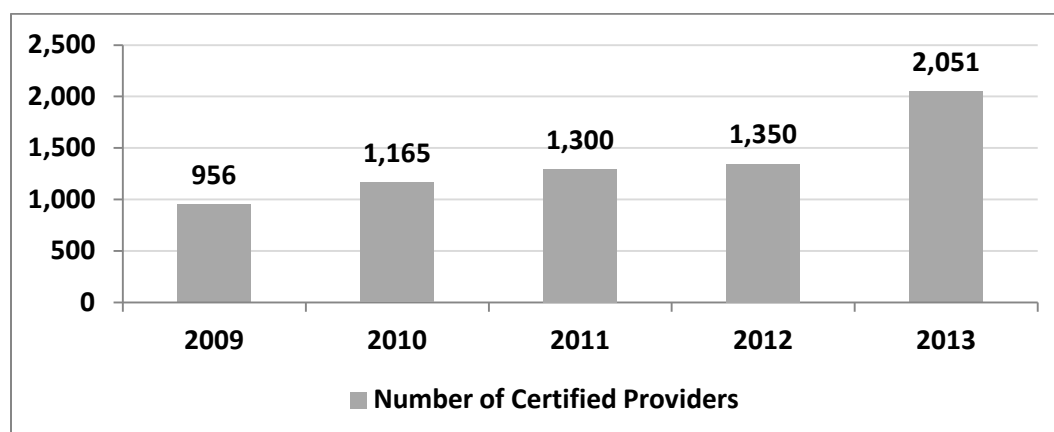
\*All eligible children receive “service coordination.”

\*\*SFY 2013 is the first year in which “sign language and cued language services” were reported as a separate service.

Sources: DBHDS’s *Report on Virginia’s Part C Early Intervention System* (Budget Items 305 H.2, 315 H.2., 2011–2013 Appropriations Acts, respectively).

Although some local systems experienced financial difficulties in SFY 2013, access to Part C service providers has improved since Virginia implemented its **Medicaid Early Intervention Services** program. **Figure 2** depicts this improvement. In just the last year, the number of provider certificates issued has increased by over 59 percent.

**Figure 2. Medicaid-certified Part C Providers by SFY**



As shown in **Table 2**, the number and proportion of children receiving Part C services through the Medicaid Early Intervention Services program also continue to grow. Both measures have more than doubled since 2009.

| Table 2. Children Enrolled in Medicaid Early Intervention Services (annualized numbers) |                 |                |                             |
|---|-----------------|----------------|-----------------------------|
| State Fiscal Year   | # with Medicaid | Total # Served | % of Children with Medicaid |
| 2009  | 2,830           | 11,766         | 24.05%                      |
| 2010  | 5,091           | 12,234         | 36.19%                      |
| 2011  | 7,179           | 14,069         | 51.03%                      |
| 2012  | 8,945           | 15,676         | 57.06%                      |
| 2013  | 9,212           | 15,523         | 59.34%                      |

### 3. Available Part C Services

Services available under Part C Early Intervention are those that the infant or toddler needs in order to meet the goals of the Individualized Family Service Plan. Specific available services are listed in **Table 1**. If the child is Medicaid eligible and participates in the Medicaid Early Intervention Services program, he or she also can obtain all of the acute care and related services available under the **Medicaid State Plan** and its **Early and Periodic Screening, Diagnosis and Treatment (EPSDT)** program. See the **Medicaid** chapter for more information on State Plan services.

### 4. Cost and Payment for Part C Services

This section first describes the various funding sources and program expenditures for the Part C early intervention services system statewide. Following this information is a brief

overview of public (Medicaid) and private health insurance resources for early intervention services.

The Department of Behavioral Health and Developmental Services (DBHDS) manages the budget of Virginia’s Part C early intervention system. While children and families determined eligible for Part C services are entitled to receive those services, not all services are free. Fees may be charged according to ability to pay. Part C federal regulations 34 CFR 303.520 and .521 specify that federal IDEA funds for Part C can be expended only after other sources, such as public (Medicaid) and private insurance, donations, and fees (based on a family’s ability to pay) have been applied.

Virginia’s annual allocation from the federal government to support Part C services is based on the proportion of the state’s population from birth to three years old as compared with the national total for those ages. The Virginia General Assembly also allocates state General Funds to support Part C services; these funds can only be used for **direct services**. While the Code of Virginia does not mandate that localities provide funding for Part C costs, localities are involved in identifying alternative funding sources. Among others, local contributors of cash and in-kind support include community services boards, health departments, and schools as well as the Part C local lead agencies themselves.

An improvement in state funding has been accompanied by a decrease in the number of localities opting to provide local funding. **Table 3** presents the amounts and sources of Part C revenue over a five-year period. The category of “other state General Funds” represents state funds other than those designated for Part C—i.e., funds that were originally state revenue awarded by DBHDS to the Community Services Boards (CSBs), such as for Intellectual Disability services, or other state funds awarded to a non-CSB local lead agency or another participating public agency. Although not designated for Part C, the CSB or other local agency chose to use those state funds for Part C. Prior to SFY 2012, they were reported as “local funds,” “other,” or “aggregated non-Part C revenue.”

| <b>Table 3. Amounts and Sources of Part C Revenues by SFY</b> |             |             |             |             |             |
|---|-------------|-------------|-------------|-------------|-------------|
| <b>Revenue Source</b>   | <b>2008</b> | <b>2010</b> | <b>2011</b> | <b>2012</b> | <b>2013</b> |
| <b>Federal Part C funds</b>                                   | \$9,881,918 | \$9,087,761 | \$8,194,088 | \$9,545,592 | \$8,251,515 |
| <b>Federal ARRA (stimulus) funds</b>                          | N/A         | 4,301,650   | 8,272,737   | 2,251,526   | N/A         |
| <b>State Part C funds</b>                                     | 7,203,365   | 6,861,337   | 4,617,087   | 10,020,426  | 9,602,586   |
| <b>Other state General Funds</b>                              | N/A         | N/A         | N/A         | 712,630     | 1,194,843   |
| <b>Medicaid</b>   | 1,095,727   | 3,656,354   | 13,145,090  | 15,230,981  | 19,733,600  |
| <b>Local funds</b>  | 8,370,228   | 7,727,982   | 8,093,276   | 7,992,093   | 7,970,999   |

| Table 3. Amounts and Sources of Part C Revenues by SFY |                     |                     |                     |                     |                     |
|--|---------------------|---------------------|---------------------|---------------------|---------------------|
| Revenue Source   | 2008                | 2010                | 2011                | 2012                | 2013                |
| Family fees  | 322,915             | 485,983             | 371,738             | 702,005             | 1,040,757           |
| Targeted case management                               | 1,538,804           | 2,576,568           | 4,778,659           | 3,986,948           | 5,665,675           |
| Private insurance                                      | 1,049,697           | 2,512,116           | 1,966,475           | 5,096,825           | 5,283,510           |
| Grants, gifts, donations                               | 293,697             | 22,668              | 4,652               | 12,472              | 149,087             |
| Other  | 624,754             | 2,800,611           | 1,461,622           | 1,575,081           | 1,223,915           |
| Local report of aggregated non-Part C revenue          | 2,066,283           | N/A                 | N/A                 | N/A                 | N/A                 |
| In-kind  | N/A                 | 210,504             | 282,511             | 322,604             | 54,259              |
| <b>TOTAL</b>   | <b>\$32,447,388</b> | <b>\$40,243,534</b> | <b>\$52,683,167</b> | <b>\$57,449,183</b> | <b>\$60,170,745</b> |

Sources: DBHDS's *Report on Virginia's Part C Early Intervention System* (Budget Items 312 K.2, 316 K.2, 305 H.2, and 2008–2013 Appropriations Acts, respectively).

In the October 2010 and 2011 editions of its *Report on Virginia's Part C Early Intervention System*, DBHDS identified the need to change the way in which federal and state Part C funds are allocated to local systems in order to ensure the stability of the Part C funding structure. The change accounted for differences in funding needs for local systems that have a higher population of children dually enrolled in Part C and Medicaid, compared to those that have a higher population of children without insurance or with private insurance that reimburses at a rate lower than Medicaid.

In SFY 2011, local systems initially received 75 percent of their allocations. Fourth-quarter allocations were based on a DBHDS review of the local system's overall child count and the number of children with Medicaid. The new allocation method resulted in major changes in the amount of funding for some local systems. In SFY 2012, allocations were adjusted based on the weight of various factors to allow local systems time to accommodate for the change. The new allocation formula was to be fully implemented in SFY 2013.

In its SFY 2012 *Report on Virginia's Part C Early Intervention System* to the General Assembly, DBHDS warned that the fiscal climate for Part C was less stable due to the end of stimulus funds provided by the **American Recovery and Reinvestment Act of 2009 (ARRA)** and the rapidly increasing number of children receiving services. In that year, DBHDS was able to offset some local system shortfalls with one-time additional funds saved from other areas; however, three local systems reduced or cut services to eligible children and families in violation of federal Part C regulations. Deficits in excess of \$8.5 million were anticipated for SFY 2013. The 2013 report to the General Assembly says that, in SFY 2013, 26 out of 40 systems that requested additional funds could not be helped. Eight of those systems reduced or



completely eliminated services to eligible children and families, and localities were cited for noncompliance.

In recognition of the severity of the situation, not only in terms of compliance with federal requirements but with respect to the impact on children, an additional \$2,250,000 in state General Funds was allocated in SFY 2013, and an additional \$6 million was allocated in SFY 2014. As a result of the increased allotment, at the time of the DBHDS's *2013 Report on Virginia's Part C Early Intervention System* to the General Assembly, only one system remained out of compliance. However, DBHDS notes that unless funding keeps pace with the growth in eligible children, the situation could repeat, putting federal funding and children at risk.

**Figure 3** depicts how the key sources of revenue for Part C have changed over the last five years. (See also **Table 3**.) While the federal allotment has remained relatively stable, the system benefitted from the infusion of ARRA stimulus funds in SFYs 2010 and 2011. Approximately \$2.2 million in ARRA funds were also available for spend down in the first quarter of SFY 2012. Those funds are no longer in the picture. In its *2013 Report on Virginia's Part C Early Intervention System* to the General Assembly, DBHDS reports that the system continues to grow and continues to be stressed.

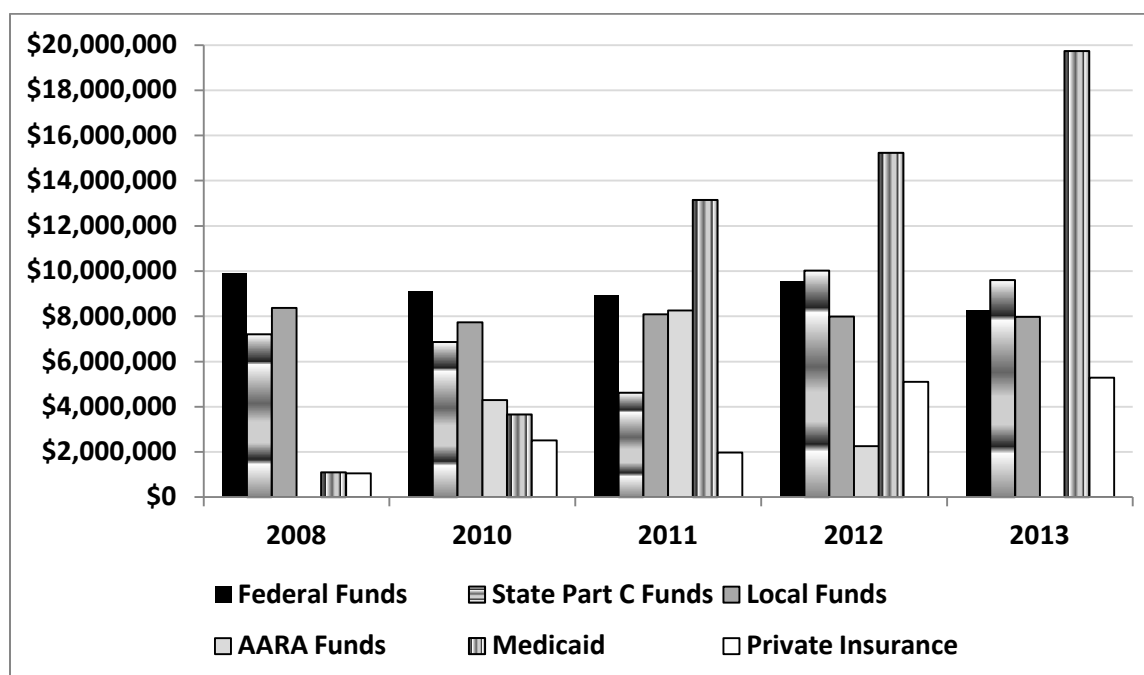
**Federal sequestration** has also affected the system, resulting in a decrease of \$424,650 in federal Part C funds for FFY 2014. DBHDS was able to absorb the cut for SFY 2014 using funding that had been set aside. However, additional sequestration action will result in cuts from allocations to local systems.

Because additional state funds were allocated for SFY 2013 and 2014, Child Find efforts have resumed, and the number of children who will be served will likely increase. The Part C report notes that since April of 2013, the number of children enrolled in early intervention on the first day of each month has been higher than any previous year. Should funding not keep pace with this growth, the Commonwealth may once again end up out of compliance and unable to serve children in need.

The Medicaid Early Intervention Services program continues to have a positive impact, providing an exponential increase in Medicaid dollars to support Part C, and private insurance usage is now steady. The impact of the Affordable Care Act (H.R. 3509) on the use of private insurance will be something to monitor.

It is important to note that some of the changes, including the increased use of Medicaid, may be due to better reporting. DBHDS also notes that non-duplication of revenue reporting (for sources other than Medicaid and Medicaid-targeted case management revenue) cannot be reliably achieved until a statewide mechanism is implemented to collect or import data from local systems on the source and amount of revenue associated with every service delivered.

**Figure 3. Principal Sources of Reported Part C Revenue by SFY**



Sources: DBHDS's *Report on Virginia's Part C Early Intervention System* (Budget Items 312 K.2, 316 K.2, 305 H.2, and the 2006–2010 Appropriations Acts, respectively).

It is important to note that while **revenue** reported as state Part C funds appears to have declined between SFY 2012 and SFY 2013 as shown in **Figure 3**, the amount **allocated** to local systems in SFY 2013 was actually higher than in 2012. In SFY 2012, the allocated amount was \$8,280,219. In SFY 2013, the amount allocated to local systems was \$9,530,044. According to DBHDS, the amount spent was higher in 2012 than in 2013 because, in SFY 2012, some local systems had carried over state funds from previous years, and these carry-over funds are included in the revenue figures. The reported revenue figures (rather than the allocated amounts) are used here to maintain consistency with the amounts reported to the General Assembly by DBHDS.

Part C System expenditures are categorized as direct service or non-direct service expenditures. **Table 4** lists **direct service expenditures** for each Part C category of services in SFY 2008 as compared with SFYs 2010 through 2013.

| Expenditure                      | 2008      | 2010        | 2011        | 2012      | 2013        |
|----------------------------------|-----------|-------------|-------------|-----------|-------------|
| Assessment for service planning* | \$992,858 | \$2,112,026 | \$2,303,261 | 2,425,514 | \$2,337,794 |
| Assistive technology             | 92,554    | 64,222      | 64,600      | 46,784    | 21,453      |

**Table 4. Reported Direct Part C Expenditures by Category and SFY**

| Expenditure                        | 2008                | 2010                | 2011                | 2012                | 2013                |
|------------------------------------|---------------------|---------------------|---------------------|---------------------|---------------------|
| Audiology                          | 14,496              | 8,239               | 10,253              | 11,719              | 4,631               |
| Counseling*                        | 97,339              | 183,757             | 111,785             | 138,152             | 59,702              |
| Developmental services*            | 2,277,328           | 3,514,105           | 3,813,546           | 4,084,723           | 3,732,217           |
| Evaluation for eligibility*        |                     | 370,422             | 687,516             | 799,184             | 971,012             |
| Health                             | 500                 | 32,426              | 55,451              | 138,183             | 68,254              |
| Nursing                            | 500                 | 498                 | 3,555               | 9,346               | 7,203               |
| Nutrition                          | 1,035               | 57,461              | 84,048              | 82,715              | 41,408              |
| Occupational therapy               | 1,157,256           | 3,011,633           | 2,239,431           | 4,965,330           | 1,890,873           |
| Physical therapy                   | 1,947,473           | 4,062,847           | 4,076,249           | 6,376,486           | 2,585,505           |
| Psychology**                       | 2,000               | 0                   | 0                   | N/A                 | N/A                 |
| Service coordination               | 5,295,426           | 8,552,563           | 10,063,508          | 12,307,059          | 11,304,694          |
| Social work                        | 13,160              | 17,579              | 15,041              | 30,260              | 45,047              |
| Speech/language pathology          | 3,187,203           | 8,143,435           | 8,247,839           | 18,107,586          | 8,452,672           |
| Transportation                     | 49,864              | 19,200              | 146,976             | 200,465             | 102,799             |
| Vision                             | 32,240              | 20,912              | 18,313              | 22,112              | 31,815              |
| Other entitled Part C services     | 452,236             | 1,404,581           | 580,472             | 676,539             | 14,441,988          |
| <b>TOTAL DIRECT SERVICES</b>       | <b>\$15,565,389</b> | <b>\$31,575,906</b> | <b>\$32,521,844</b> | <b>\$50,421,958</b> | <b>\$46,737,250</b> |
| <b>TOTAL REPORTED EXPENDITURES</b> | <b>\$33,616,357</b> | <b>\$37,492,250</b> | <b>\$39,527,844</b> | <b>\$57,873,922</b> | <b>\$53,720,994</b> |

\*In 2008, "Counseling" was reported as "family training and counseling," and "developmental services" was reported as "special instruction." In addition, in 2008, these were combined into one category called "evaluation and assessment." These are now divided into "assessment for service planning," and "evaluation and eligibility."

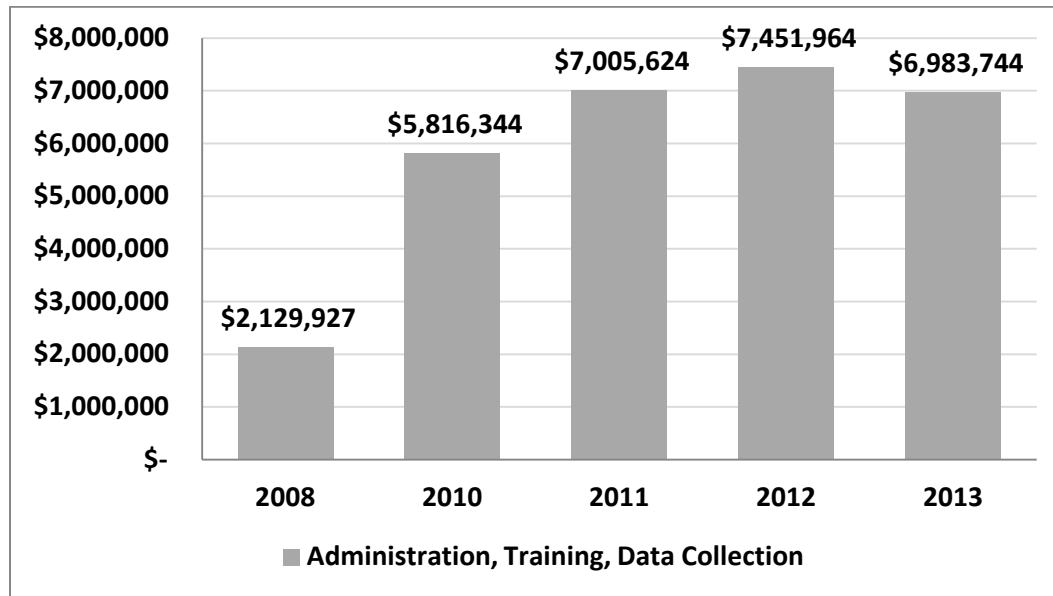
\*\*"Psychology" is no longer reported as a separate service.

Sources: DBHDS's *Report on Virginia's Part C Early Intervention System* (Budget Items 312 K.2, 316 K.2, 305 H.2, 315 H.2, and the 2008–2013 Appropriations Acts, respectively).

**Non-direct expenditures** relate to administration, system management, data collection, and training. DBHDS reported in its SFY 2010 report to the General Assembly that in SFY 2010, ARRA (stimulus) funds were used to address one-time expenses related to improved data collection,

systems management, and training, resulting in higher non-direct costs. However, levels of non-direct spending have continued to trend upward since that time. Other expenses not necessarily reported are local funds used for expenses other than direct services. See **Figure 4**.

**Figure 4. Non-direct Part C Expenditures by SFY**



Sources: DBHDS's *Report on Virginia's Part C Early Intervention System* (Budget Items 312 K.2, 316 K.2, 305 H.2, and 315 H.2, and the 2008–2012 Appropriations Acts, respectively).

The Commonwealth's Medicaid Early Intervention Services program was established through its **Part C Systems Transformation Initiative**, jointly led by the **Department of Medical Assistance Services (DMAS)** and the Department of Behavioral Health and Developmental Services (DBHDS). This program is the only way for Medicaid-eligible families to access funding for most Part C services. Prior to this initiative, DMAS was not able to identify children enrolled in early intervention because providers billed using reimbursement codes for specific therapies (e.g., physical therapy, occupational therapy, etc.). The same was true for children being served through Medicaid's managed care organizations (MCOs). In addition, DMAS did not reimburse for all costs associated with providing services in natural environments and did not reimburse all types of providers eligible to deliver Part C services.

In 2012, the General Assembly appropriated state funds needed to increase the Medicaid reimbursement rate for early intervention targeted case management from \$120 per month to \$132 per month. This rate went into effect July 1, 2012. DBHDS notes in its *2013 Report on Virginia's Part C Early Intervention System* that this change helped reduce—but did not eliminate—the gap between revenue and expenses associated with service coordination for children who have Medicaid.

As a result of the transformation process, Medicaid-funded Early Intervention services are now available for children eligible for Medicaid's Family Access to Medical Insurance Security

(FAMIS or FAMIS Plus) after eligibility screening through those programs. More detailed information on FAMIS and FAMIS Plus, including Early and Periodic Screening, Diagnosis and Treatment (EPSDT) can be found in the **Medicaid** chapter of this report and at [http://www.dmas.virginia.gov/Content\\_pgs/mch-home.aspx](http://www.dmas.virginia.gov/Content_pgs/mch-home.aspx).

Consistent with state and federal law, Part C has **family cost share** provisions, and families may be required to contribute to the cost of some Part C services, such as specific therapies or equipment. Services that are provided at **no cost** to the family include the following:

- identification, eligibility evaluation, and assessments to identify needed services and supports;
- service coordination (case management) with development, review and evaluation of the Individualized Family Services Plan (IFSP); and
- procedural safeguards and all activities related to the rights of the child and family.

Family contributions are made on the basis of a sliding fee scale with a monthly maximum amount for which the family is financially responsible. This monthly cap is the same regardless of how many agencies provide services or whether more than one child in the family is receiving services. Families cannot be denied services if they are unable to pay towards their cost. However, they must be willing to provide financial information to the Part C system if they wish to participate in the sliding-scale fee structure. Otherwise, they are held responsible for the full charges of the services received. Financial cost determinations can be appealed or reevaluated if the family's financial situation changes, and there is an annual reevaluation of each family's cost share.

**Private health insurance** may also cover early intervention services. The state employee health insurance program is required to provide coverage for early intervention services that are medically necessary. There is no dollar maximum for services to be provided; coverage cannot be denied for a pre-existing condition; and the cost of these services cannot be applied to any maximum lifetime benefit [Code of Virginia § 2.2-2818 B(4)]. Find the text of the law at <http://lis.virginia.gov/cgi-bin/legp604.exe?000+cod+2.2-2818>.

The mandate to cover early intervention services also applies to Virginia-regulated accident and sickness insurance policies provided by private companies operating in the state—albeit with a \$5,000 maximum benefit. (The Code of Virginia § 38.2-3418.5 is available online at <http://lis.virginia.gov/cgi-bin/legp604.exe?000+cod+38.2-3418.5>.)

Federal and state Part C funds are used to make up the difference between the lower insurance rates that private insurers pay and the Medicaid rate, and to pay for services not covered, such as service coordination and developmental services. Self-insured companies were exempted from the requirement, but some have elected to include this benefit.

Coverage for treatment of **autism spectrum disorders (ASD)**, including an annual \$35,000 maximum for applied behavior analysis therapy, is addressed in Code of Virginia (§ 38.2-3481-17) and is online at <http://lis.virginia.gov/cgi-bin/legp604.exe?000+coh+38.2-3418.17+700124>.

It is important to note that there may be a number of changes in the required benefits and services offered by the State and private insurers, depending on the benefits specified as **essential health benefits** under § 1302(b) of the federal Patient Protection and Affordable Care Act [(H.R. 3590) as amended the Affordable Care Act]. A number of Virginia Code provisions have changed and will continue to change as a result of the Affordable Care Act. For additional information, see the **Health Care** chapter of this report.

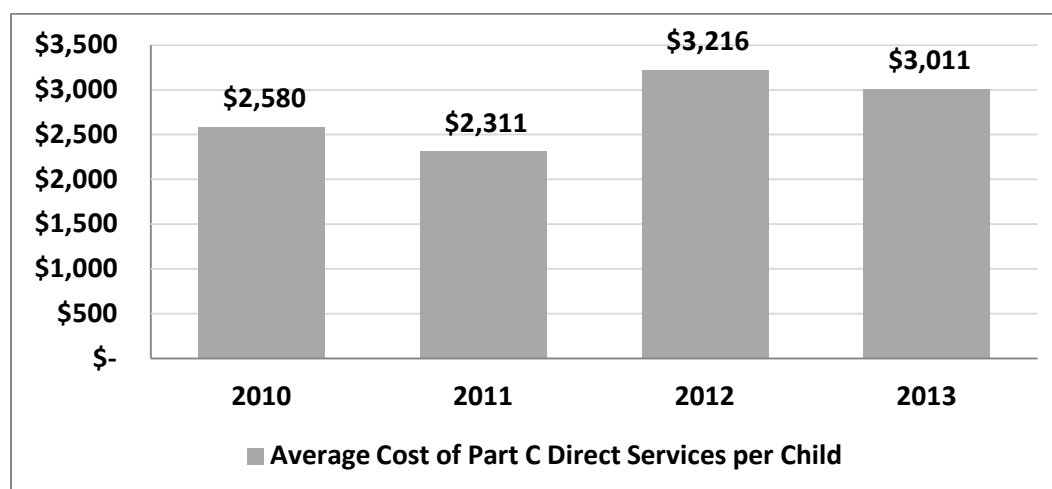
The reported proportion of Part C system **revenues from private insurers** shows significant changes. However, it is unclear how much of this growth is due to increased usage as opposed to new reporting requirements. Effective July 1, 2009, DBHDS required local lead agencies to report revenue by source, including private insurance (rather than aggregate revenue), and it required reporting by private providers. In SFY 2008, private insurance accounted for only three percent of total Part C revenues. It jumped to six percent in SFY 2010 and to nine percent in SFY 2012. DBHDS attributes the increase to more complete and accurate reporting.

## 5. Monitoring, Evaluation, and Outcomes of Part C Services

As noted, Part C is serving significantly more children. Between SFYs 2008 and 2013, the number of children served increased by nearly 37 percent. This increase has been due both to efforts to identify and enroll all eligible children per federal Child Find requirements as well as implementation of Medicaid Early Intervention Services. In previous years (as reported in the 2008 and 2011 editions of this *Assessment*), Virginia had been below national averages and state targets in the identification of eligible infants and toddlers, especially in the birth-to-one-year-old population. As part of efforts to address this weakness, “prematurity” was added as an automatic eligibility criterion in December 2010. The increases in identified children have resulted in and been combined with significant financial stressors on the Part C system as noted by DBHDS in the SFY 2012 and 2013 editions of its *Report on Part C Early Intervention System*.

Reviewing the reported direct-expenditure data and the reported number of children served, the cost per child has fluctuated over the last four years as shown in **Figure 5**. Inadequate fiscal resources that resulted in waiting lists in several localities may have contributed to lower per child costs in SFY 2013. As noted earlier, the accuracy and consistency of data/cost reporting may also be an issue.

**Figure 5. Average Cost of Part C Direct Services per Child by SFY**



Each state receiving federal financial assistance under Part C of the Individuals with Disabilities Education Improvement Act (IDEA) is required to establish an advisory interagency coordinating council to support the lead agency and other agencies in providing and paying for Part C services. The Virginia Interagency Coordinating Council (VICC) fulfills this requirement by providing guidance on implementing and evaluating statewide early intervention system services, including helping toddlers with disabilities make the transition to preschool and other appropriate services. VICC's membership includes parents, public or private providers of early intervention services, state agency representatives, a legislator, and an individual involved in the preparation of personnel who provide early intervention services.

Forty **Local Interagency Coordinating Councils (LICCs)** provide advice and assistance to their respective local lead agencies and help them to identify existing early intervention services and resources, identify gaps in the service delivery system, and develop local strategies to address those gaps. LICCs also assist their local lead agency in facilitating interagency agreements, developing service coalitions, and establishing local policies and procedures in accordance with federal and state laws and regulations.

The Department of Behavioral Health and Developmental Services (DBHDS) monitors all state and local public and private agencies and providers of early intervention services, regardless of whether those services are funded by IDEA Part C. To ensure compliance with state and federal laws and regulations, all public and private early intervention service providers must agree to comply with Part C requirements in writing through an interagency agreement, memorandum of understanding, or contract.

The Medicaid Early Intervention Services program must also meet federal monitoring requirements. Compliance reviews must be conducted to ensure that services are appropriate, obtained from appropriate providers, and medically necessary, a requirement for Medicaid reimbursement. The Department of Medical Assistance Services (DMAS) conducts Quality

Management Reviews (QMRs). Information on QMRs can be found in the **Medicaid** chapter of this report.

The US Department of Education Office of Special Education Programs (OSEP) is the federal program monitor for Part C. Each state must have an approved State Performance Plan (SPP) that evaluates its efforts to implement Part C requirements and describes how the programs are or will be implemented. Each state must also submit an Annual Performance Report (APR) to OSEP.

The APR describes Virginia's system of supervision and monitoring, including how data are gathered and verified. APRs run two years behind, and the latest APR is for FFY 2011, submitted in February of 2013 (<http://www.infantva.org/sup-ReportsOSEP.htm>). The APR also details progress made on targets established in its *State Performance Plan for 2005–2012*. States are required to report publicly on a variety of SPP indicators, including but not limited to:

- timely initiation of services,
- primary service setting,
- family outcomes,
- Child Find,
- 45-day timeline for assessment and IFSP meeting, and
- effective transitions to Part B services.

OSEP reviews the APR information and determines if a state has “met requirements,” “needs assistance,” “needs intervention,” or “needs substantial intervention” in order to meet its targets. Based on submitted data on the above indicators, in 2010 OSEP determined that Virginia “met requirements.” In 2011 and 2012, the determination was that the Commonwealth “needed assistance.” In 2013, the Part C system once again “met requirements.”

These same determinations are made for each local system. The FFY 2011 **Local Early Intervention System Determinations** for data collected between July 1, 2010 and June 30, 2011 can be found online at <http://infantva.org/documents/sup-cqi-DetermStatus2012.pdf>. It shows that 28 local systems “met requirements,” some for multiple years in a row, and 12 local systems “needed assistance,” some for multiple years in a row. For example, **Crater District** and **Henrico** have been in the “needs assistance” category for 6 years, whereas **Goochland-Powhatan** and **Rockbridge** have “met requirements” for 6 consecutive years. During this time period, no local system was found to “need intervention” or to “need substantial intervention.” Local systems not meeting their target or meeting less than 93 percent of their target must develop an **improvement plan**.

All children receiving Part C early intervention services are included in the federally required **System for Determination of Child Progress**, which began in 2006. Under this system, a child's



Individualized Family Services Plan Team rates the child's status using the OSEP's Child Progress Outcomes Indicators 3A through 3C:

- A. Positive social and emotional skills (including positive social relationships)
- B. Acquisition and use of knowledge and skills (including early language and communication)
- C. Use of appropriate behaviors to meet needs

Baseline data were gathered for children who exited the system between July 1, 2008 and June 30, 2009 as well as for infants and toddlers exiting between July 1, 2009 and June 30, 2010. Targets were then set for FFYs 2009 and 2010 through FFYs 2012 and 2013. The baseline data and targets are in the *Part C State Performance Plan for 2005–2012*, which was amended in 2013. Results for FFYs 2011 and 2012 are shown in **Table 5**. The amended plan is online at <http://infantva.org/documents/SPP%20-20amended%20Feb%202013%20clean.pdf>.

| <b>Table 5. Part C Annual Performance Report:<br/>Determinations of Child Progress Outcomes for FFYs 2011 and 2012</b> |   |  |  |
|--|---|--|--|
| <b>Federal Fiscal Year</b>   | <b>Indicator 3 A<br/>Social and Emotional</b> | <b>Indicator 3B<br/>Skills and Knowledge</b> | <b>Indicator 3C<br/>Appropriate Behavior</b> |
| <b>Percent who did not improve functioning</b>   |   |  |  |
| FFY 2011   | 0.60  | 0.50   | 0.50   |
| FFY 2012   | 0.60  | 0.50   | 0.40   |
| <b>Percent who improved but not sufficient to move nearer to functioning of same-age peers</b>                         |   |  |  |
| FFY 2011   | 18.0  | 19.0   | 17.6   |
| FFY 2012   | 16.2  | 17.1   | 16.5   |
| <b>Percent who improved nearer to same-age peers but did not reach same level</b>                                      |   |  |  |
| FFY 2011   | 16.2  | 24.5   | 26.0   |
| FFY 2012   | 15.9  | 25.2   | 26.9   |
| <b>Percent who improved to reach level comparable to same-age peers</b>  |   |  |  |
| FFY 2011   | 28.7  | 39.4   | 46.9   |
| FFY 2012   | 30.1  | 40.8   | 44.6   |
| <b>Percent who maintained functioning at a level comparable to same-age peers</b>                                      |   |  |  |
| FFY 2011   | 36.5  | 16.6   | 10.1   |

| Table 5. Part C Annual Performance Report:<br>Determinations of Child Progress Outcomes for FFYs 2011 and 2012 |                                       |                                      |                                      |
|--|---------------------------------------|--------------------------------------|--------------------------------------|
| Federal Fiscal Year  | Indicator 3 A<br>Social and Emotional | Indicator 3B<br>Skills and Knowledge | Indicator 3C<br>Appropriate Behavior |
| FFY 2012   | 37.3                                  | 16.5                                 | 11.6                                 |

The results show significant improvement, as would be expected for those who participated in early intervention services, with the highest level of improvement in achieving social and emotional skills comparable to same-age peers. Performance on the indicators was stable between FFYs 2011 and 2012 with slight increases on some indicators and decreases on others. In both FFYs 2011 and 2012, actual performance on the indicators did not meet established state targets; about half of the local systems met a number of the established targets, which can be found in the Part C Annual Program Performance Report.

A number of activities have taken place to improve performance, not only on these indicators but on others as well. DBHDS reported in its 2011 and 2012 *Annual Program Performance Reports* that additional resources on evidence-based practices were provided as was support to address quality data collection on the indicators. (Note that these reports run two years behind. The FFY 2012 report was submitted in February of 2014.)

A **Child Indicators Workgroup** was established to determine how to integrate the federal indicators into the Individual Family Service Plan (IFSP) process. Changes to the IFSP form and process were recommended, and a statewide implementation of these changes began on July 1, 2013. As a part of this effort, the IFSP form was revised to integrate child indicators into the assessment section. Seven regional training sessions and three statewide webinars were provided to support focus on the child indicators in each step of the early intervention process. Written resources were provided to assist service providers. Other efforts in FFYs 2011 and 2012 included the following:

- Improved communication and information for families and providers through the expanded use of technology, including social media and changes to the Part C website located at <http://www.infantva.org>. These additions include, but are not limited to, information on evidenced-based practices in early intervention, eligibility, assessment, outcome planning, support strategies for specific disabilities, as well as infant mental health. Both the **Arc of Virginia Family Involvement Project**, funded by Part C, and the **Early Intervention Professional Development Group** are now on Facebook.
- Continued participation in **Communities of Practice in Autism (CoPAs)** of which there are nine around the state. The CoPAs serve as a means of regional problem solving, learning about evidenced-based practices, and building local expertise in the area of individualized services and supports for children with autism spectrum disorders.
- Support by the Part C office to the Arc of Virginia in establishing an Early Intervention Family Support Network through its local chapters, entitled **New Path**. Find New Path

online at <http://new-path.thearcofva.org/>. Two part-time early intervention support specialists were hired for New Path, and a monthly newsletter with resources and information for families was launched. Next steps include a blog and message boards.

- Training sessions on a *Family-centered Approach to Developing Quality Outcomes*, which explored differences between the medical model and a supports-and-service approach to early intervention.
- A year-long focus on coaching, which began in early FFY 2012 to include intensive training and technical assistance follow-up for twenty master coaches who will each mentor colleagues and provide training for additional providers. Training was completed in four of six regions, with the other two scheduled for spring 2014. Regional communities of practice on coaching have started in some regions.
- A statewide webinar on the **Child Outcome Indicators (3A-C)** was presented in early FFY 2012 that included information on measuring each indicator. In addition, a two-sided, laminated, quick-reference card about child outcomes was developed for providers. A child-development indicator booklet was revised and disseminated.

As part of federally required monitoring procedures, the state lead agency (DBHDS) must also conduct an annual **Family Survey**. This survey addresses the Office of Special Education Programs' (OSEP) Indicators 4A-C, which measure the percent of families participating in Part C who report that services have helped:

- A. the family to know their rights,
- B. the family to effectively communicate the child's needs, and
- C. the child to develop and learn.

To accomplish this, each year DBHDS surveys the families who received early intervention services during the month of May. It selects a random sample of respondents, which reflects the race/ethnicity of the total population served, for analysis. The full reports for 2012 and 2013: *Analysis of the Virginia Family Survey Data Addressing Part C SPP/APR Indicator #4* can be found at <http://www.infantva.org/documents/sup-FamilySurvey-2012-expl.pdf> and <http://www.infantva.org/documents/Virginia%20Family%20Survey%20Data%20Addressing%20Part%20C%20SPP%20APR%20Indicator%204%20Final%20Report%202013%20July29.pdf> respectively. The reports contain details on survey methodology.

As shown in **Table 6**, results for those two years show improved performance in the FFY 2013 survey as compared to the FFY 2012 survey. Survey results are used for improvement planning. The 2012 survey results were updated in the 2013 survey and appear here.

| <b>Table 6. Annual Family Survey</b><br><b>Percent of Respondents Meeting or Exceeding Each Standard for Indicator 4</b> |   |   |  |
|--|---|---|--|
| <b>Federal Fiscal Year</b>   | <b>Indicator 4A<br/>Know their rights</b> | <b>Indicator 4B<br/>Effectively communicate<br/>child's needs</b> | <b>Indicator 4C<br/>Help child develop and<br/>learn</b> |
| <b>2012<br/>Survey</b>   | <b>75.4</b>                               | <b>72.2</b>   | <b>84.2</b>  |
| <b>2013<br/>Survey</b>   | <b>76.9</b>                               | <b>74.5</b>   | <b>84.8</b>  |

For many years, OSEP found Virginia to be out of compliance in the number of infants and toddlers ages **birth to one year** identified for early intervention services, reaching far fewer in this age range than the national average. As a result, Child Find identification activities have been targeted as a focus area for monitoring and improvement for quite a few years. In 2011, new federal Part C regulations added a requirement that the Child Find system be coordinated with a variety of state agencies, including those that administer the Children's Health Insurance Program (DMAS), child care programs (DSS), the early hearing detection and intervention system, and the home visiting programs under the Maternal and Child Health program (VDH) and the Child Abuse Prevention and Treatment Act (DSS).

In FFY 2011, Virginia **exceeded its state target** for identifying needs in the birth-to-one-year population. In FFY 2010, 24 local systems had not met the state target. In FFY 2011, 15 of those systems met the target; 7 showed progress, and 2 showed slippage. DBHDS reports that the key factor for the State's improved performance was the focus on referral of premature infants. A variety of efforts contributed to this success, including training and technical assistance to local systems and providers, contact with Neonatal Intensive Care Units at hospitals in Virginia and D.C. regarding the referral of preterm infants, work with the Department of Health to ensure early identification of children with hearing loss or congenital anomalies, as well as addressing insurance-reimbursement barriers with private insurance and TRICARE (health insurance for active, Reserves, National Guard, and retired military). The state target was adjusted upward for FFY 2012 as a result of the progress seen in FFY 2011.

In addition to improvements in identifying needs in the birth-to-one-year population, efforts have been undertaken to increase the percentage of infants and toddlers from **birth to age three** with Individualized Family Services Plans (IFSPs). Virginia's performance in FFY 2011 was above the state target and close to the national figure of 2.79 percent with 2.77 percent of infants and toddlers having IFSPs.

Of the 40 systems in Virginia, 29 "met" the state target; 2 "substantially met" the target and 9 did "not meet" the target. Those 9 systems were required to submit an improvement plan. This represents significant progress from FFY 2010 when 25 local systems did not meet the state target. Of those, 14 reached the target in FFY 2011. Local improvement strategies included the following efforts:

- increasing public awareness through TV, radio, interagency collaboration, and participation in community events,
- reviewing data to determine referral outcome by source and identifying patterns to better focus outreach efforts,
- training referral sources, and
- reviewing instruments being used to determine eligibility.

Additional activities to improve Part C services for infants and toddlers since the 2011 edition of this *Assessment* were reported in the most recent *Annual Performance Report for FFY 2011* and include the following:

- completing statewide training and technical assistance in a variety of venues and formats, including videos, webinars, and in-person training in numerous areas related to provision of quality services to infants and toddlers.
- requiring new local system managers and all managers of systems with identified non-compliance to participate in a webinar on conducting accurate record reviews and using the reviews for ongoing local oversight and monitoring (April, 2012).
- establishing workgroups to address key issues, such as securing private insurance and TRICARE, reimbursement for Part C services, fiscal management of local issues, prematurity, and coaching strategies. The work of these groups resulted in the addition of prematurity as an automatic eligibility criterion, a number of trainings and written documents to support access to insurance reimbursement for EI services, and statewide technical assistance to improve local system managers' skills in fiscal management and oversight.
- implementing the **Targeted Case Management Program** that provides Medicaid reimbursement for service coordination for all children dually enrolled in Medicaid and Part C. The program, which has now been in place for two years, ensures dually enrolled children and their families are getting service coordination (case management) appropriate for infants, toddlers, and their families and that this service is being reimbursed by Medicaid.

As **Table 7** shows, formal complaints in the Part C early intervention system continue to be rare.

| Table 7. Part C Dispute Resolution Utilization |          |          |          |          |          |
|--|----------|----------|----------|----------|----------|
| Resolution Method                              | FFY 2008 | FFY 2009 | FFY 2010 | FFY 2011 | FFY 2012 |
| Due Process                                    | 0        | 0        | 1*       | 0        | 1*       |
| Formal Complaints                              | NA       | 2        | 3        | 2**      | 3**      |

| Table 7. Part C Dispute Resolution Utilization |          |          |          |          |          |
|--|----------|----------|----------|----------|----------|
| Resolution Method                              | FFY 2008 | FFY 2009 | FFY 2010 | FFY 2011 | FFY 2012 |
| Mediation                                      | <10      | 1        | 1        | 0        | 2        |

\*Complaint withdrawn.

\*\*1 of 2 complaints was withdrawn in FFY 2011; the other was resolved within the 60-day-timeframe. In FFY 2012, 2 of 3 complaints were withdrawn within the year. Both FFY 2012 requests for mediation led to mediation agreements. The 1 formal complaint that was not withdrawn was resolved within 60 days and determined to be founded. The noncompliance identified through that complaint has been corrected.

The February 2013 amendment to the *Part C State Performance Plan for 2005–2012* reported activities being undertaken to improve performance with respect to dispute resolution procedures and timelines, and ensuring that families are aware of their rights. Those activities included the following:

- Developing and implementing a mechanism to collect data on the number of potential complaints that are resolved informally through the Part C Office or the Family Improvement Project, to capture any trends emerging from concerns expressed by families, and to document whether families were informed of their options prior to resolution. This included a 2011 plan to explore tracking options used in other states to determine the best electronic tracking option for Virginia.
- Reviewing the results of the **Parent Education Advocacy Training Center (PEATC)** parent survey with staff of the Family Involvement Project and the Virginia Interagency Coordinating Council (VICC). The survey, which was conducted prior to the 2009 verification visit, was reviewed to assess why the concerns expressed by respondents did not lead to complaints and, if necessary, to develop additional strategies to ensure parents are aware of and empowered to use their dispute resolution options. As a result, the Family Involvement Project has developed additional resources on parents' rights, including dispute resolution options.

## C. Early Head Start Services

Head Start is a federally funded program that works directly with localities. The **Virginia Head Start State Collaboration Office (HSSCO)** oversees the program and represents its interests on the state level. According to the Virginia Department of Social Services' HSSCO web page, <http://www.dss.virginia.gov/family/cc/headstart.html>, the **Head Start State Collaboration Grant** was created as a state-level partnership to support development of multi-agency and public-private partnerships. These partnerships are designed to facilitate development of early childhood systems, enhance access to comprehensive services for low-income children, and involve Head Start in state policies affecting low-income families.

Principal goals are to (1) foster working coalitions that include federal **Administration for Children and Families (ACF)** staff, state officials, Virginia Head Start Association members, Head

Start program staff and early childhood professionals; (2) create a link between local Head Start programs and the State's early childhood initiatives; and (3) facilitate a more coordinated approach to service delivery. There are seven priority areas for Virginia's grant:

1. Improve access to health care services.
2. Improve the availability, accessibility, and quality of childcare services.
3. Improve collaboration with social services systems.
4. Expand and improve educational opportunities in early childhood programs.
5. Initiate interaction with the AmeriCorps service program.
6. Improve access to family literacy services.
7. Improve opportunities for children with disabilities.

The purpose of **Early Head Start (EHS)** is to promote healthy prenatal outcomes for pregnant women, enhance early childhood development, and promote healthy family functioning. It is a family-oriented program that provides guidance, information, and direct services in the home. According to the *2012 Virginia Head Start Association Annual Report*, 13 percent of infants and toddlers are eligible for services through the Part C Early Intervention program.

### **1. Infant and Toddler Screening and Eligibility for Early Head Start**

Although criteria for each local Head Start program can vary, child eligibility for **Head Start** is primarily based on:

- the child's **age** (Early Head Start serves children under age 3.),
- the family's **income** (federal poverty guidelines available at <http://aspe.hhs.gov/poverty/12poverty.shtml>), and
- whether the child has a **disability**.

Other factors taken into consideration include the following:

- **Parental status** (emancipated minor, one- or two-parent household, foster care, non-biological custodian, etc.)
- **Social conditions** (terminal illness or death in the family, abuse, substance abuse, other siblings attending Head Start programs, referrals from other agencies, mental health of the parent, homelessness, education of parent, non-English speaking family, etc.)

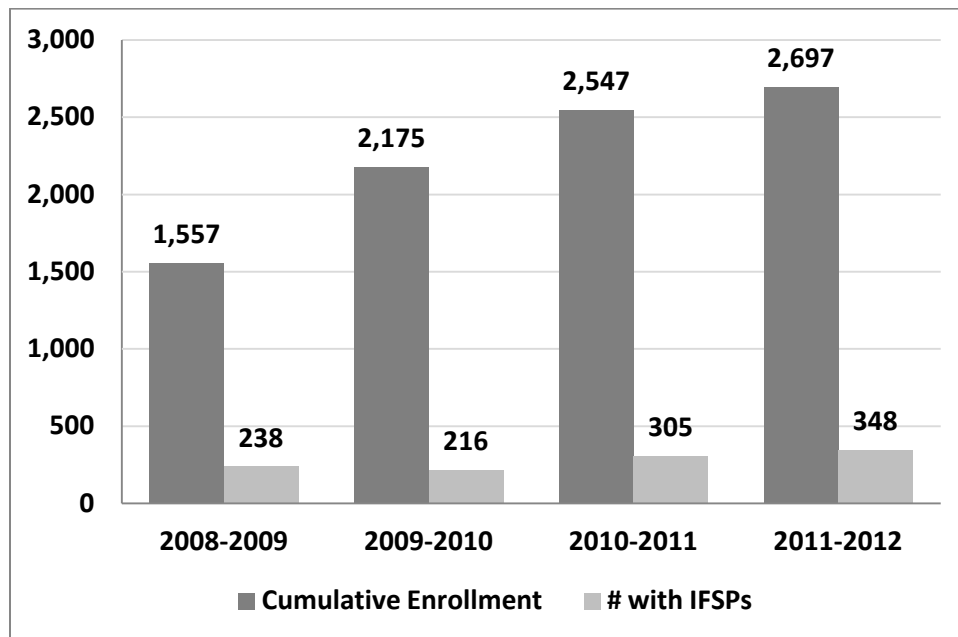
### **2. Access to and Use of Early Head Start**

The Head Start grantee (or the agency delegated by the grantee to deliver Head Start services) is responsible for coordinating with the Part C local lead agency with respect to serving children with disabilities who are eligible for both programs. According to the 2011

through 2012 edition of the *Head Start Program Information Report*, only 18 of the 65 Head Start programs in Virginia provided Early Head Start, thus limiting access to this program by geographic availability. This number has remained the same since 2010 when 5 programs were added to 13 existing programs. Families can find a local Early Head Start program with the locator service at <http://www.headstartva.org/>.

Statewide, Early Head Start programs must make at least **10 percent** of their enrollment opportunities available to children with disabilities who are eligible for Part C early intervention services. As **Figure 6** shows, the program has consistently met this target or slightly exceeded it. In 2008–2009, 15 percent of children in EHS had an Individualized Family Services Plan. That number dropped to 10 percent the following year, rose to 11.9 percent, and rose again to 12.9 percent of the cumulative enrollment figure.

**Figure 6. Early Head Start Cumulative Enrollment and the Number of Children with IFSPs by School Year**



Sources: 2008–2009 *Head Start Program Information Report, Enrollment Statistics Report, State Level*; 2011–2012 *Head Start Program Information Report; Disability Services Multi-Year Report, State Level*.

Federal Head Start Program Performance Standards (45 CFR, Chapter XIII, Part 1308.4) requires each Early Head Start program to develop a **Disabilities Service Plan** to ensure the needs of children with disabilities and their families are met. This plan must be updated annually and include the following components:

- provisions for children with disabilities to be included in the full range of activities and services normally provided to all Head Start children, and provisions for any modifications necessary to meet the special needs of the children with disabilities;



- recognition of the need for small group activities with modifications of large group activities, and individualized special help;
- designation of a disabilities coordinator and arrangement for the preparation of disability service plans;
- procedures for timely screening and making referrals to the local education agency to determine if there is a need for special education and related services for a child as early as the child's third birthday;
- assurances that facilities are accessible along with plans to provide any needed specialized furniture, equipment, and other materials; and
- strategies to ensure the transition of children from Early Head Start (ages 0 to 3) into Head Start (ages 3 to 5) or into their next placement.

The Head Start Act of 2007 requires formal linkages with providers of early intervention services for infants and toddlers with disabilities as established in Part C of the Individuals with Disabilities Education Improvement Act (IDEA) and with the agency responsible for administering section 106 of the Child Abuse Prevention and Treatment Act (42 USC § 5101 et seq., 42 USC § 5116 et seq.).

### 3. Available Early Head Start Services

The federal Early Head Start website provides detailed information about this program. Early Head Start programs serve families through a full-day, full-year program option that best meets the needs of their families. Local programs provide different options that are determined through community needs assessments and dialogue with families. Find it at <https://eclkc.ohs.acf.hhs.gov/hslc/tta-system/ehsnrc/Early%20Head%20Start/about.html>.

The program is meant to be flexible so that as needs change, services offered and programs provided can evolve to support them. EHS programs focus on child and parent development, family education, and increasing family access to available resources. Service options include the following:

- **Center-based services** provide early learning, care, and enrichment experiences in an early care and education setting with family home visits at least twice a year.
- **Home-based services** provide weekly home visits to each enrolled child and family. The home visitor provides child-focused visits that promote the parents' ability to support the child's development. Twice per month, the program offers opportunities for parents and children to come together as a group for learning, discussion, and social activity.
- **Family child care services** provide care and education to children in a private home or family-like setting.
- **Combination services** combine both home- and center-based services.

Direct and indirect (referral) services for infants and toddlers enrolled in Early Head Start in Virginia include early education, medical and dental services, and family supports. Infants and toddlers with disabilities receive all of the services specified by their Individualized Family Services Plan (IFSP) as well as standard Early Head Start services.

The IFSP specifies which services are to be provided directly by Head Start and which will be provided by other agencies. As provided for in federal Head Start Program Performance Standards, IFSP services may include, but are not limited to: audiology, physical and occupational therapy, speech and language services, psychological services, assistive technology, and transportation.

#### **4. Cost and Payment for Early Head Start**

Available information does not differentiate between **Early Head Start** and **Head Start** in terms of cost and payment. For additional information, see page 55 of the **Education** chapter. Available information is included there as many more children are served through Head Start's preschool services than through Early Head Start.

#### **5. Monitoring, Evaluation, and Outcomes of Early Head Start**

Monitoring and evaluation of Virginia's Head Start programs are also covered in the **Education** chapter of this *Assessment* beginning on page 55. There are no separate data available regarding Early Head Start outcomes. A national study was completed in 2006. Outcome information on the national level in terms of the benefits of Early Head Start can be found at <http://www.acf.hhs.gov/programs/opre/resource/early-head-start-benefits-children-and-families-research-to-practice-brief>.

### **D. 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. Websites Referenced**

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<http://infantva.org/ovw-CodeOfVirginia.htm>

##### **Head Start**

###### **About Head Start**

<http://eclkc.ohs.acf.hhs.gov/hslc/About%20Head%20Start>

###### **Fact Sheets**

<http://eclkc.ohs.acf.hhs.gov/hslc/data/factsheets>

**Early Head Start**

<http://eclkc.ohs.acf.hhs.gov/hslc/tta-system/ehsnrc/Early%20Head%20Start>

<https://eclkc.ohs.acf.hhs.gov/hslc/tta-system/ehsnrc/Early%20Head%20Start/about.html>

**Virginia Head Start**

[http://www.headstartva.org/.](http://www.headstartva.org/)

**The Arc of Virginia**

<http://new-path.thearcofva.org/>

**Virginia Department of Behavioral Health and Developmental Services**

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

**Infant and Toddler Connection of Virginia**

<http://www.infantva.org>

<http://www.infantva.org/documents/pr-PM-PracticeManual.pdf>

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**State Definition of Developmental Delay**

[www.infantva.org/documents/ovw-PGuideStateDefinition.pdf](http://www.infantva.org/documents/ovw-PGuideStateDefinition.pdf)

**Virginia Department of Medical Assistance Services**

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

<http://www.dmas.virginia.gov/Content/pgs/mch-home.aspx>

**Virginia Department of Social Services**

<http://www.dss.virginia.gov/family/cc/headstart.html>

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## II. Education

### A. Introduction to Preschool and K–12 Services

All children in the United States are entitled to a publicly funded education. Should they need them, students with disabilities are also entitled to services and supports, referred to as **“special education,”** which ensure that the education they receive is appropriate to their individual needs. Requirements for the provision of a **“free, appropriate public education”** (FAPE) for eligible students with disabilities are established under the **Individuals with Disabilities Education Improvement Act of 2004 (IDEA)** (PL 108-446).

The Virginia Constitution sets forth the State’s responsibility for the education of all students in Article VII, Section 1, and the Code of Virginia delineates the specific responsibility for the education of students with disabilities in Sections 22.1-7 and 22.1-213-215. The **Regulations Governing Special Education Programs for Children with Disabilities in Virginia** (8 VAC § 20-81-10 et seq.) establish the **Virginia Board of Education** requirements regarding special education and related services for children with disabilities. These regulations are applicable to all local school divisions, state-operated programs, including the Virginia School for the Deaf and the Blind at Staunton (VSDB-Staunton), and private schools in the Commonwealth that provide special education and related services for children with disabilities who are placed by a local school division.

The **Early Intervention** chapter of this report addressed the developmental and early learning needs of infants and toddlers from birth to age three. Under federal law, the **transition** of children with disabilities from the early intervention services system (Part C of IDEA) to the public education system begins at age three. Virginia, however, has adopted the option of making the transition to preschool special education services (Part B of IDEA) for eligible children as early as age two.

Some students with disabilities do not require specialized instruction available under IDEA but rather need **reasonable accommodations** in order to be successful in their education. These are provided under **Section 504** of the amended federal **Rehabilitation Act of 1973** (29 USC § 794) and its implementing regulations (34 CFR 504). Section 504 states that

*No qualified individual with a disability in the United States shall be excluded from, denied the benefits of, or be subjected to discrimination under any program or activity that either receives Federal financial assistance or is conducted by any Executive agency or the United States Postal Service.*

This includes local school divisions because they receive federal funds.

Laws and regulations governing education services for students with disabilities are extremely complex; they cannot be fully covered within the scope of this document. This

chapter focuses on the major, publicly funded special education services that individuals with disabilities may be eligible to receive under IDEA Part B from preschool through high school. These services are provided by **Head Start** programs, public school divisions, formally known as **local education agencies (LEAs)**, the **Virginia Department for the Blind and Vision Impaired (DBVI)**, and the **Virginia School for the Deaf and the Blind at Staunton (VSDB-Staunton)**, which is a state agency that operates independently of the **Virginia Department of Education (VDOE)** with its own Board (Code of Virginia § 22.1-346). It has its own Board of Visitors, and the Superintendent of Public Instruction is required to designate a VDOE staff member to serve as a consultant to the Board on matters pertaining to instruction, federal and state special education requirements, and school accreditation.

There are also Virginia children with disabilities who receive special education services in other settings, such as detention centers, local and regional jails, programs operated by the Department of Correctional Education, hospitals, mental health facilities, state-operated training centers, or other residential programs. Discussion of the services provided within those settings is beyond the scope of this *Assessment*. This chapter addresses preschool services followed by services for kindergarteners through 12<sup>th</sup> graders.

## **B. Federal Head Start Program**

### **1. Preschool Screening and Eligibility for Head Start**

Children from birth to age five whose families meet income eligibility requirements may receive services promoting academic, social, and emotional development through federally funded and locally operated Head Start programs. Federal Head Start Program Performance Standards (45 CFR, Chapter XIII, Part 1305.4) set forth the following specific criteria for participation:

- A child must be at least three years old by the date used to determine eligibility for public school in the community in which the Head Start program is located, except in cases where the Head Start program's approved grant provides specific authority to serve younger children. Examples of exceptions include programs serving children of migrant families and **Early Head Start (EHS)** programs.
- At least 90 percent of the children who are enrolled in each Head Start program must be from low-income families.
- Subject to regulation, up to ten percent of enrolled children can be from families that exceed the low-income guidelines, provided that those children (1) meet the selection criteria that the local program has established and (2) would benefit from Head Start services.
- No less than ten percent of the total number of children actually enrolled by each Head Start program and delegate agency must be children with disabilities who are eligible for special education and related services, or early intervention services ... by the state or

local agency providing services [under Section 619 or Part C of the Individuals with Disabilities Education Improvement Act (IDEA) (20 USC §§ 1419, 1431 et seq.)]

Head Start grantees (or the agencies to which the grantee delegates program operations in their area) are required to conduct **outreach activities** that include strategies to actively locate and recruit children with disabilities. They must also ensure that recruitment staff is knowledgeable of the nondiscrimination tenets of the Americans with Disabilities Act (42 USC § 12101) and regulations associated with Section 504 of the Rehabilitation Act (45 CFR § 84).

A Head Start program cannot deny placement on the basis of a disability or its severity when

- the parents wish to enroll the child,
- the child meets Head Start age and income eligibility criteria,
- Head Start is an appropriate placement according to the **Individualized Education Program (IEP)** designed for the child post-evaluation, and
- the program has space to enroll more children, even though it has made ten percent of its enrollment opportunities available to children with disabilities. In this case, children with and without disabilities compete for available enrollment opportunities.

Since funding may not be available for every child who meets these basic eligibility criteria, each Head Start program is required to have a formal process for establishing its own additional criteria for selecting children to participate. These criteria must ensure that all eligible children are considered and, among other requirements, must consider the availability, or lack thereof, of kindergarten or first grade for the child. At the beginning of every program year, each Head Start program is required to develop a **waiting list** of unselected, eligible children that must be maintained throughout that year. Children on the waiting list must be ranked according to the program's selection criteria to ensure that the most needy children are served first as vacancies occur.

## 2. Access to and Use of Head Start

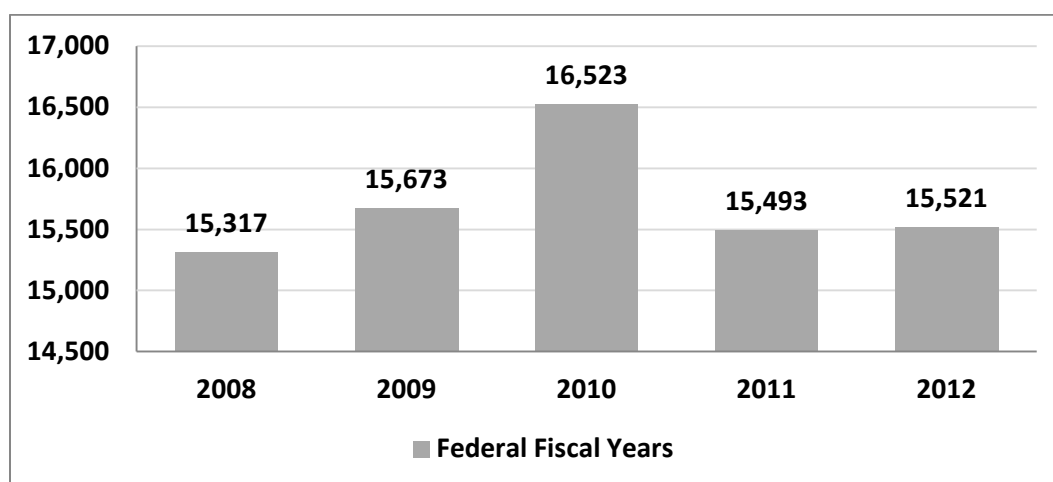
Head Start's mission is to help children who are "at risk" for or have developmental delays or disabilities better prepare for school and later achievement. Achieving this "**school readiness**" involves not only the children but also their families, the schools, and the entire community. Local programs are operated by community action organizations, single-purpose agencies, local governments, and public school divisions. According to the **Virginia Head Start Association's** 2012 annual report, Head Start programs in Virginia have over 300 signed collaborative agreements.

According to the *2011–2012 Head Start Program Information Report (PIR)* and its *Disability Services Multi-Year Report*, in federal fiscal year (FFY) 2010, there were 66 Head Start programs

of which 18 provided Early Head Start (serving pregnant women and children from birth to age 3). In FFY 2012, the report indicates 65 programs with 18 providing Early Head Start services.

**Figure 7** shows **enrollment** in Virginia Head Start over the last five years. *Head Start Program Fact Sheets*, published by the federal Administration for Children and Families, indicate enrollment increased between FFYs 2008 and 2009. It spiked in 2010, then dropped below the 2009 level in 2011 and stayed lower in 2012. This decline in enrollment is likely due to the recession and resulting budget cuts with the 2010 increase likely reflecting the availability of federal stimulus funds from the American Recovery and Reinvestment Act of 2009 (ARRA). In its 2012 annual report, the Virginia Head Start Association expresses significant concern over the impact of federal sequestration on its ability to serve children and families.

**Figure 7. Head Start Enrollment by FFY**



Source: The Administration for Children and Families' *Head Start Program Fact Sheets* (2008–2012).  
<http://eclkc.ohs.acf.hhs.gov/hslc/mr/factsheets>

**Federal Head Start regulations** require Head Start programs to proactively inform families about the program and encourage them to apply. This specifically includes coordinating recruitment activities with other early intervention and special education programs as well as with local health departments and practitioners to identify children with disabilities. Local Head Start programs are required to solicit applications from as many eligible families within their recruitment area as possible and, when necessary, to assist those families in completing the application.

Once a child has been determined eligible for and enrolls in a Head Start program, he or she receives services from the Head Start center staff (and staff from affiliated Community Action Agencies, where applicable), as well as public school divisions (formerly called “local educational agencies”), and a wide variety of other public and private providers. Reflecting the community’s needs and resources, Head Start activities may occur in group settings, in the home, or in a combination of the two. Services may be half- or full-day, and may or may not be integrated with child daycare. Community assessments, which are updated annually, are used

to determine the appropriate design for each setting. **Parental involvement** and support are key aspects of all Head Start activities. While there is no fee for Head Start services, parents are encouraged to volunteer their time and talents to the program.

Each child enrolled in a Head Start program (except those enrolled in a Head Start migrant program) must be allowed to remain in Head Start until kindergarten or first grade is available for the child in the child's community. However, a program can choose not to enroll or re-enroll a child *if* there is a change in family income *and* there is a child with a greater need for services.

Head Start staff works closely with a wide variety of **community resources** to obtain training materials and identify service providers. Instructional programs for children with disabilities must address the child's individual needs, strengths, and developmental potential as well as family circumstances and resources. Developmental assessments are conducted throughout the year. Disability specialists meet monthly with Head Start teachers and work closely with public school service providers to monitor each child's progress and coordinate activities.

The Head Start program information reports for FFYs 2009 through 2012 show that Virginia's programs are consistently serving slightly more children with disabilities than the 10 percent required to have an Individualized Education Program (IEP). Their numbers were highest in FFY 2010, again, likely due to the infusion of ARRA stimulus funds.

**Table 8** shows the primary disabilities of preschool children receiving Head Start services from FFYs 2009 through 2012. The federal *Program Information Reports (PIRs)* contain enrollment statistics but do not provide an analysis of statistics or associated anomalies. The most obvious disparities are the significant decrease in children labeled as having emotional/behavioral disorders, which went from 115 children in 2009 down to 4 children in 2012; children counted as having specific learning disabilities, which went from 29 in 2010 down to 1 in 2012; and the significant increase in children categorized as having traumatic brain injuries, which was zero or 1 from 2009 through 2011, then reported as 52 in 2012. The autism numbers have remained fairly stable, as have speech impairments, since a high enrollment of 1,082 in 2010 (likely due to the infusion of ARRA funds). Another anomaly appears in 2011 when the category of children with multiple disabilities shows only 1 child.

| <b>Table 8. Primary Disabilities of Preschool Children who received Head Start Services in Virginia by FFY</b> |             |             |             |             |
|--|-------------|-------------|-------------|-------------|
| <b>Federal Fiscal Year</b>   | <b>2009</b> | <b>2010</b> | <b>2011</b> | <b>2012</b> |
| <b>Autism</b>  | 14          | 20          | 21          | 24          |
| <b>Developmental delay, non-categorical</b>  | 498         | 563         | 491         | 465         |
| <b>Deafblind</b>   | *           | 0           | 0           | 0           |
| <b>Emotional/behavioral</b>  | 115         | 29          | 14          | 4           |

| <b>Table 8. Primary Disabilities of Preschool Children who received Head Start Services in Virginia by FFY</b> |              |              |              |              |
|--|--------------|--------------|--------------|--------------|
| <b>Federal Fiscal Year</b>   | <b>2009</b>  | <b>2010</b>  | <b>2011</b>  | <b>2012</b>  |
| Health impairment  | 11           | 7            | 4            | 6            |
| Hearing impairment   | 11           | 12           | 5            | 7            |
| Intellectual disability  | 7            | 3            | 3            | 6            |
| Learning disabilities  | 17           | 29           | 11           | 1            |
| Orthopedic impairment  | 4            | 2            | 4            | 6            |
| Speech impairment  | 939          | 1,082        | 838          | 935          |
| Traumatic brain injury   | 1            | 0            | 1            | 52           |
| Vision impairment  | 5            | 5            | 7            | 7            |
| Multiple disabilities*   | 17           | 46           | 1            | 39           |
| <b>TOTALS</b>  | <b>1,639</b> | <b>1,798</b> | <b>1,400</b> | <b>1,552</b> |

Source: Head Start Program Information Report, *Enrollment Statistics Report—State Level* (2009–2012).

\* Does not include deafblind children. As of FFY 2010, “deafblind” is a separate category.

### 3. Available Head Start Services

According to the federal *Head Start Program Fact Sheets*, the vast majority of services are offered in center-based (group) settings, such as preschools. Days per week and hours per day vary by state and locality. Many of the Head Start grantees offer additional services to meet the needs of working families, including full-day, home-based, a combination of center- and home-based, family child care, and locally designated options.

Head Start focuses on **school-readiness** and the development and demonstration of skills in literacy, language knowledge, listening comprehension, mathematics, science, creative arts, social and physical development, and approaches to learning. Key services provided to children with disabilities and their families can include professional medical, dental, mental health, and other diagnostic screenings and referrals to service providers; nutrition programs; and information and training for parents, staff, and service providers on how to better meet the special needs of participating children.

Preschoolers who participate in Head Start and have an Individualized Education Program (IEP) receive all of the services in their IEPs as well as comprehensive Head Start services. Head Start programs are also required to develop plans for the transition of children to public schools. Collaborative agreements exist between Head Start, schools, and other relevant organizations to facilitate that process.

#### 4. Cost and Payment for Head Start

Federal funding for Head Start is provided through the Office of Head Start, Administration for Children and Families (ACF) of the U. S. Department of Health and Human Services (DHHS). **Grants** are awarded directly to local public agencies, private organizations, Native American tribes, and school systems for the purpose of operating Head Start programs at the community level. Any local public, private nonprofit or for-profit agency or organization capable of providing a suitable organizational base is eligible to apply for funding to establish a Head Start program within a specified community, such as a single city or county, a multi-jurisdictional unit within a state, or a Native American reservation.

Nationwide, funding for Head Start was approximately \$7.7 billion in FFY 2012 with \$3 million-plus in additional funds for support activities such as training, research and demonstration projects, program monitoring and evaluation, and other program support. This is up from \$7.3 billion in 2011 and approximately \$7.2 billion in 2010.

Virginia's allotment in FFY 2013 was \$109,243,252, a decrease of 5.2 percent from FFY 2012 and comparable to the FFY 2011 funding level of \$109,393,196. The allotment in 2009 was \$102,461,544, which included an additional allocation of \$2.1 million in federal stimulus (ARRA) funds specifically targeted for Head Start. Federal rules further require that localities provide matching funds equal to 20 percent of federal funding, which must come from non-federal sources either in cash or in-kind contributions such as facilities, equipment, or volunteer services.

#### 5. Monitoring, Evaluation, and Outcomes of Head Start

Head Start is a collaborative program. According to the 2012 *Virginia Head Start Association Annual Report*, the Head Start Collaboration Project was created in 1990. There are over 300 signed agreements with local school districts, early intervention agencies, and child welfare/social services agencies that provide support services for children and families. There is also a statewide memorandum of agreement to support them. Each local program must develop a **Disabilities Service Plan (DSP)** that outlines its strategies for meeting the needs of children with disabilities and their families. These plans must be approved by the federal **Administration for Children and Families (ACF)** and by the local grantee responsible for the program. The DSP must do the following:

- show that children with disabilities and their families are fully integrated into all components of the Head Start program and that resources are used efficiently;
- designate a disabilities coordinator who is responsible for preparation and implementation of the plan;
- contain procedures for timely screening of participating children and for subsequent referrals to the public school division for further evaluation as indicated; and

- show both commitment and specific efforts to develop appropriate interagency agreements and to work with the public school division to ensure that service opportunities and outcomes are maximized.

The ACF reviews the performance of each Head Start program at least once every three years. It uses the Office of Head Start's comprehensive Monitoring Protocol Evaluation Tool in the review. If deficiencies are found, the local grantee is required to develop a **Quality Improvement Plan** to bring the program into full compliance with all Head Start requirements. In addition, Head Start programs are required to develop a system for ongoing monitoring of their DSP.

Comprehensive training and technical assistance is provided to local grantees throughout the Commonwealth to ensure that they are in compliance with federal Head Start regulations. Outcomes are reported annually in a multitude of areas, including but not limited to health (access to health care, oral health care, mental health, medical conditions) and school readiness. The *2012 Virginia Head Start Association Annual Report* provides some notable outcome statistics:

- By the end of the 2011–2012 enrollment year, over 97 percent of children enrolled in Virginia Head Start programs had obtained medical insurance.
- 90 percent of enrolled children received up-to-date immunizations and physical exams, and of those who needed medical treatment, 96 percent received treatment. Obesity and asthma were the two most diagnosed medical conditions.
- More than 82 percent of enrolled children received oral health examinations, and 76 percent of those needing treatment received it.
- 3 percent of children were referred for mental health services, but only 67 percent received services—why this percentage is so low is not known.

Head Start programs are required to track children's development in all developmental domains. The **Virginia Head Start Association** tracks indicators that research identifies as strong predictors of success in kindergarten and elementary schools.

The *2012 Virginia Head Start Association Annual Report* provides statistics that compare school-readiness levels for children who enrolled in the fall of 2011 to their skill levels in the spring of 2012. Children were assessed in the areas of fine motor skills, self-regulation, persistence and attentiveness, reasoning and problem solving, and phonological awareness.

A total of 5,484 children were assessed in the fall with 5,433 reassessed in the spring. Children with disabilities were not disaggregated. In all 5 domains, the percent meeting the expected skill levels in the fall ranged from an average low of 33 percent to an average high of 44 percent. In the spring of 2012, skill levels for these children ranged from an average low of 77 percent to an average high of 86 percent, a significant achievement.



The **Head Start State Collaboration Office (HSSCO)**, located in the Virginia Department of Social Services (DSS), conducted a five-year self-assessment that covers FFYs 2006 through 2011. A key barrier cited in the self-assessment report for that time period was the economic downturn, which has impacted the availability of state and local resources devoted to supporting children and families. The poor economy also resulted in an increase in the number of children experiencing homelessness.

Other challenges included transitions in leadership at the state level; increased degree requirements for Head Start and Early Head Start staff, which made recruitment challenging; and low wages for Head Start, Early Head Start, and other child care programs. Some programs reported difficulty in developing child care coordination partnerships with service providers. With specific respect to services for children with disabilities, the self-assessment notes strong relationships with IDEA Part C and Part B providers and the Virginia Department of Education (VDOE). The report also noted a need to integrate more specialized content related to disabilities into Head Start and Early Head Start training programs and a need to provide more and earlier opportunities for children to receive developmental screenings.

In its *Five Year Grant Renewal Application*, the HSSCO reported the results of a **Needs Assessment Survey** of local Head Start programs conducted from November of 2010 through January of 2011. An 89 percent response rate was reported. Twenty percent of Head Start grantees reported that it was “difficult” or “extremely difficult” to coordinate transportation with public school divisions and to organize and participate in joint training, including transition-related training. Difficulty in establishing partnerships with publicly funded pre-kindergarten programs was also noted. Additional detailed information on activities and projected accomplishments through 2016 can be found in the HSSCO’s *Five Year Strategic Plan: 2012–2016*, which is available at <http://www.headstartva.org>.

Objective 3.4 in this plan is particularly relevant. The objective supports initiatives to infuse best practices for special needs into the Virginia Community College System (VCCS) curriculum through the work of the Virginia Early Childhood Mental Health Committee and through support of the Virginia Paraprofessional Early Childhood Training Project. By increasing the evidence-based, disability-related curriculum at VCCS, human services professionals are projected to better meet the disability-related needs of the children they serve.

The HSSCO is part of Virginia’s **Early Childhood Advisory Council**, a member of Smart Beginnings (an organization focused on connecting private and public school-readiness initiatives in communities), and a supporter of the efforts of the Virginia Head Start Association. It has its own multi-organizational Advisory Council and serves on many other related committees, workgroups, and advisory councils. Data on participation by children and families and the outcomes of specific activities must be provided to the ACF annually. Since the program promotes inclusive practices, outcomes for children with disabilities are not reported separately from those of children without disabilities.

## C. Virginia Preschool Initiative

The 1995 General Assembly provided for expansion of the **Virginia Preschool Initiative (VPI)**. As of 2005–2006, state funds have been available to provide comprehensive preschool programs to 100 percent of Virginia’s four-year-olds who are determined to be “at-risk” (as defined by VPI funding eligibility) and who are not being served by Head Start. This grant-funded program is managed by the Virginia Department of Education (VDOE) and includes services to those with developmental delays.

### 1. Preschool Screening and Eligibility for VPI

Services can be provided to “**four-year-olds at risk**,” including those with developmental delays, in localities that have applied for and received a state VPI grant. The *Guidelines for the VPI Application* (completed by localities) provides sample factors that localities can consider for determination of “at-risk.” These include the following:

- The child lives in poverty and/or is homeless.
- The child’s parents or guardians dropped out of school, have limited education, or are chronically ill.
- The family is under stress as evidenced by poverty, episodes of violence, crime, underemployment, unemployment, homelessness, or incarceration.
- The child has health or developmental problems, including but not limited to developmental delays, low birth weight, or exposure to substance abuse.
- The child is an English language learner.

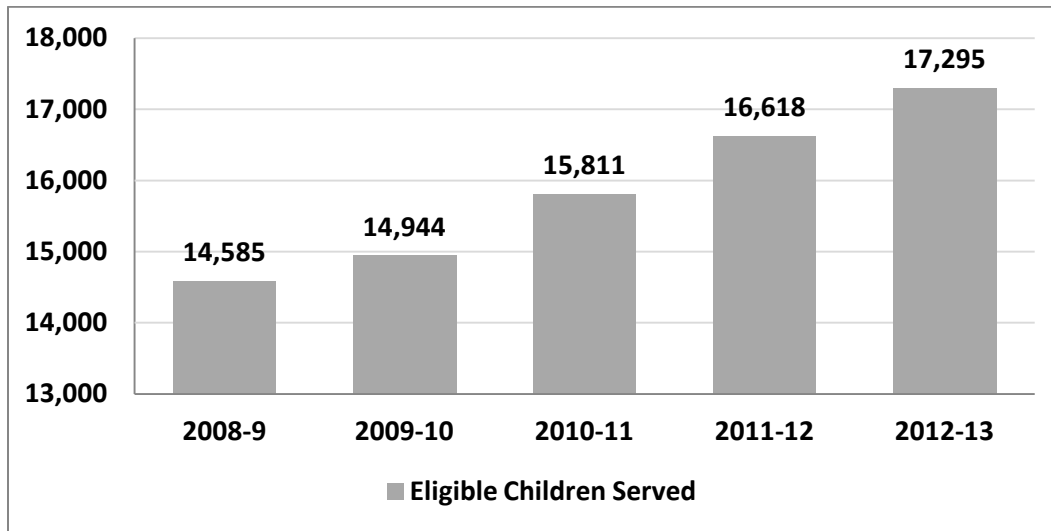
### 2. Access to and Use of VPI

Localities that receive a state **VPI grant** can use these funds to:

- establish or expand quality, comprehensive preschool programs in public schools or community sites,
- purchase quality preschool education programs and services from existing providers for four-year-olds at risk,
- expand existing quality programs to serve more children, and
- upgrade existing programs to the meet criteria for comprehensive, quality preschool programs to serve new children (those not receiving services).

Note that enrollment data for the VPI does not distinguish between the number of children with disabilities and other children at-risk. **Figure 8** shows the continued growth in the number of children served by the Initiative.

**Figure 8. Number of Children Served by Virginia Preschool Initiative by School Year**



Source: Virginia Department of Education, *Virginia Preschool Initiative Briefing*, January 14, 2013.

### 3. Available VPI Services

Information on the VPI page of the VDOE website and the most recent (January 2013) VDOE *Briefing Report* on the VPI both state that getting children prepared for kindergarten is the focus of the VPI. Programs funded through this initiative provide instruction in math, science, history, and social science as well as physical, motor, personal, and social development. Funds can be used for preschool education, health services, social services, parental involvement, and transportation. Funds cannot be used for capital outlay. Programs funded through the grant must provide full- or half-day services. At a minimum, services must be provided during the regular school year.

Localities are required to use a tool called the **Phonological Awareness Literacy Screening-Pre-K (PALS)** during the fall and spring of each school year. As of 2012, the cost of PALS materials and access to its online score entry and reporting system became a local responsibility due to state budget reductions. These costs can come out of the VPI budget.

A local VPI program must align its curriculum with **Virginia's Foundation Blocks for Early Learning**. The Foundation Blocks establish a measurable range of skills and knowledge essential for four-year-olds to be successful in kindergarten. They provide early childhood educators with a comprehensive set of standards, indicative of success for entering kindergarten, that are derived from scientifically based research. Class size cannot exceed 18, and the child/staff ratio cannot exceed 9:1.

Parents are required to be included as much as possible in program planning and activities; and regular, frequent communication with parents is expected to occur individually and as a group. Programs also must provide resource materials to parents on such topics as child behavior and parent-child relationships.

The VDOE's January 2013 *Briefing Report* on VPI notes that health services provided to participating children include full immunizations; vision, hearing and dental screenings; complete physical health evaluations with periodic check-ups; and eyeglasses, hearing aids, or other assistive devices when required. Transportation is provided to every child (to and from the program) and as needed for necessary support services. Social services are provided to families to help identify non-government resources that they may be able to access.

#### 4. Cost and Payment for VPI

**Virginia Lottery proceeds** specifically designated for this initiative are distributed to local schools and community-based programs by the Virginia Department of Education (VDOE). The state fiscal year (SFY) 2010 through 2012 Appropriations Act provided \$67,607,769 for the first year of the biennium and \$68,300,290 for the second year. In SFY 2013, total estimated funding for the program in the 2012 through 2014 biennial budget was \$64,953,097 for 2013 and \$68,569,714 for 2014. These monies come from the Virginia Lottery Proceeds Fund through the Virginia Department of Education.

Funds are granted based on an allocation formula that takes into account the number of four-year-olds at risk who are served in each locality for full- and half-days. The locality receives the full state share of the \$6,000 total grant amount for each child in a full-day, school-year program. Programs that operate half-days receive state funds on a fractional basis determined by the pro rata portion of a full-day, school-year program. Local matching funds are required based on a composite index of the local ability to pay. At least 75 percent of this match must be in cash with in-kind contributions making up no more than 25 percent. Further details on the funding formula can be found in the relevant item of the Appropriations Act at [http://www.doe.virginia.gov/instruction/early\\_childhood/preschool\\_initiative/appropriation\\_act\\_language.pdf](http://www.doe.virginia.gov/instruction/early_childhood/preschool_initiative/appropriation_act_language.pdf).

Under the *Guidelines for the Virginia Preschool Initiative Application*, localities seeking these funds are required to develop a written local plan for programs that include five services:

1. quality preschool education,
2. parental involvement,
3. comprehensive child health services
4. social services, and
5. transportation.

They are expected to coordinate resources and funding streams to serve the greatest number of eligible children. **Local matching funds** are required, and the plan must be submitted by June 15 of each year. The Virginia Department of Education (VDOE) is authorized to expend unobligated balances for grants to qualifying school divisions for one-time expenses (other than capital) related to program start-up or expansion.

In 2008–2009, 112 school divisions participated in the program. In 2012–2013, that number grew to 119, but there were 12 more eligible school divisions that did not participate. That number has remained fairly consistent over the last 5 years. According to the VDOE's *Briefing Report*, reasons for non-participation included

- difficulty or inability to obtain local matching funds,
- insufficient space to house additional classrooms, and
- a small number of eligible students, resulting in a lack of cost-effectiveness to operate the program.

The same report notes that 11 school divisions left 100 or more slots unused in SFY 2013. In FFY 2013, 5 counties were ineligible for funding because they were serving as many or more students through Head Start than the estimated number of children eligible for services through the VPI funding formula.

## 5. Monitoring, Evaluation, and Outcomes of VPI

The Virginia Department of Education (VDOE) and the Council on Child Day Care and Early Childhood programs provide **technical assistance** in the administration of the grant program and to localities to ensure a comprehensive, coordinated, quality preschool program is developed. VDOE is required to provide interested localities information on service-delivery models and methods of coordinating funding streams to maximize funding with existing services. Technical assistance is prioritized for localities where the majority of four-year-olds at-risk are not served.

The January 2013 *Briefing Report* provides recent program-impact data. Results from the fall of 2012 Phonological Awareness Literacy Screening (PALS) administered to kindergarten students show that only 7 percent of children who participated in VPI needed further intervention when they entered kindergarten versus 20 percent who had no pre-kindergarten experience. The VPI results were consistent with those for children who participated in other pre-kindergarten programs, after which only 8 percent required further intervention.

## D. IDEA Part B's Preschool Services

The Individuals with Disabilities Education Improvement Act (IDEA) guarantees a free, appropriate public education to all eligible children with disabilities. The VDOE website ([http://www.doe.virginia.gov/special\\_ed/index.shtml](http://www.doe.virginia.gov/special_ed/index.shtml)) concisely identifies the steps in the special education process. These apply to both preschool and K–12 education and are as follows:

1. identification and referral,
2. evaluation,
3. determination of eligibility,

4. development of an Individualized Education Program (IEP) and determination of services, and
5. reevaluation.

There are timelines for each step in order to prevent delays, and procedural safeguards are provided to families. The services and placement of students with disabilities who need special education, including preschool, are developed through the Individualized Education Program (IEP) process, which is the responsibility of local public school divisions.

### **1. Preschool Screening and Eligibility for Part B**

In Virginia, **Part B preschool services** are available to eligible children with disabilities from age 2 to age 5. While the federal Individuals with Disabilities Education Improvement Act of 2004 (IDEA) mandates that such services be available starting at age 3, Virginia parents have the option of either IDEA Part B preschool or IDEA Part C early intervention services for their child between the ages of 2 and 3. A separate eligibility determination is required for Part B services from that required for Part C. For detailed information on screening, eligibility and local public school division responsibilities for identifying children who may be eligible for preschool services, see page 66, covering Part B Special Education for K–12. The Virginia School for the Deaf and the Blind at Staunton (VSDB-Staunton) offers free services to families with deaf, blind or deafblind children from birth to age 3 as part of the outreach program at the school. Families must live within a 50-mile radius of the school to receive these services.

Eligibility criteria for children seeking preschool services do not differ for children who may receive preschool services through the program operated by VSDB-Staunton. There are, however, additional program admission criteria that are independent of those for determining if a child is eligible for services by a local school district. A student's Individualized Education Program (IEP) team makes the decision, based on the child's needs, whether services should be received at VSDB-Staunton. That decision is reassessed annually. For additional information, go to <http://vsdb.k12.va.us/Preschool/>.

### **2. Access to and Use of Part B Preschool**

Preschool services for eligible children are delivered through local school divisions, formally known as local education agencies (LEAs), and the state-operated programs at the VSDB-Staunton. Public school divisions must provide a full continuum of services, from the least restrictive placement (the regular education classroom), to the most restrictive placement (homebound or hospital-based instruction). The programs operated at VSDB-Staunton are delivered in a separate school and are considered part of the continuum of placements for all children.

### **3. Available Part B Preschool Services**

Part B preschool special education focuses on developing age-appropriate social and emotional skills, including social relationships; the acquisition and use of knowledge and skills,

such as early language and early literacy; and the use of appropriate behavior to meet needs. Eligible preschoolers are provided with all of the services and supports deemed necessary in their Individualized Education Programs (IEPs). Available services are the same as for K–12 special education and are listed beginning on page **74** of this chapter.

The Virginia School for the Deaf and the Blind at Staunton (VSDB-Staunton) offers preschool services for children who are deaf, hard of hearing, blind, vision impaired, or deafblind. For children who are deaf and hard of hearing, the **VSDB-Staunton Audiology Clinic** is an approved diagnostic testing site for Virginia’s Universal Newborn Hearing Screening Program coordinated through the Virginia Department of Health (VDH). Evaluations of public school children are done at the request of local school systems to identify children with hearing loss as early as possible so that needed services and supports can be provided.

**VSDB-Staunton’s preschool services** focus on hands-on, developmentally appropriate instruction designed to achieve maximum development of language, cognition, social and emotional skills, motor skills, speech, and listening skills. The curriculum is based on the child’s interests as revealed through play, conversations, and interactions with their environment. Preschoolers go on regular field trips that help foster overall growth and improved communication. Early literacy development is emphasized. Preschool students also participate in physical education and art classes. Families are an important part of the preschool program and receive daily communications in a variety of forms, as well as monthly home visits from members of their child’s team to share additional information about their child’s needs and progress. Parents participate in various activities with their child throughout the school year and are provided workshops to enhance their learning and interaction with their child. Siblings without disabilities are encouraged to attend the preschool to provide a more inclusive and language-enriched environment.

#### **4. Cost and Payment for Part B Preschool**

See page **80** of this chapter for costs, payments, and program revenue and expense information related to Part B.

#### **5. Monitoring, Evaluation, and Outcomes of Part B Preschool**

By statute and regulations, the Virginia Department of Education (VDOE) has the principal responsibility for monitoring the implementing Part B of the Individuals with Disabilities Education Improvement Act of 2004 (IDEA) in the Commonwealth. VDOE’s **Division of Special Education and Student Services** oversees school divisions; state-operated programs, including the Virginia School for the Deaf and the Blind at Staunton (VSDB-Staunton), hospitals, and juvenile detention and correctional facilities; private day schools; and children’s residential facilities. This implementation and oversight role includes preschool programs. For more specific information on monitoring processes and program results, go to page **84**.

Virginia’s *State Special Education Performance Reports* provides statistics (statewide and by school division) on **outcomes** that the federal Office of Special Education Programs (OSEP)

requires states to report annually. The **Table 9** shows the targets and results for federal Indicators 7A–C, Preschool Outcomes, which measure the percent of preschool children with Individualized Education Programs (IEPs) who demonstrate

- A. improved social/emotional skills (including social relationships),
- B. acquisition and use of knowledge and skills (including early language communication and early literacy), and
- C. use of appropriate behaviors to meet their needs.

| <b>Table 9. Special Education Performance on Indicator 7: Preschool Outcomes</b> |  |  |  |
|--|--|--|--|
| <b>School Year</b>   | <b>Indicator 7A<br/>Social and Emotional<br/>Target/Actual</b> | <b>Indicator 7B<br/>Knowledge and Skills<br/>Target/Actual</b> | <b>Indicator 7C<br/>Appropriate Behavior<br/>Target/Actual</b> |
| <b>Percent who entered below age expectations</b>                                |  |  |  |
| <b>2009–2010</b>   | <b>83.0 / 85.8</b>   | <b>84.0 / 90.3</b>   | <b>83.0 / 86.9</b>   |
| <b>2010–2011</b>   | <b>86.0 / 87.7</b>   | <b>90.0 / 92.0</b>   | <b>87.0 / 89.3</b>   |
| <b>2011–2012</b>   | <b>86.0 / 88.1</b>   | <b>90.0 / 92.3</b>   | <b>87.0 / 89.1</b>   |
| <b>Percent functioning within age expectations</b>                               |  |  |  |
| <b>2009–2010</b>   | <b>56.0 / 58.5</b>   | <b>39.0 / 44.9</b>   | <b>62.0 / 64.1</b>   |
| <b>2010–2011</b>   | <b>56.0 / 60.4</b>   | <b>39.0 / 46.4</b>   | <b>62.0 / 65.9</b>   |
| <b>2011–2012</b>   | <b>56.0 / 57.9</b>   | <b>39.0 / 45.6</b>   | <b>62.0 / 64.8</b>   |

Source: *State Special Education Annual Performance Reports*, 2010, 2011, 2012, and 2013.

**Targets** have been routinely exceeded for all three school years with respect to the preschool indicators reported to the Office of Special Education Programs (OSEP). According to VDOE, targets are set for six-year periods but revised earlier if appropriate. In terms of children functioning within age expectations following preschool, progress in both 2011–2012 and 2012–2013 was slightly lower in all three indicators than in FFY 2010–2011.

Preschool improvement activities conducted in collaboration between school divisions and state early intervention staff and reported in the Part B *2011–2012 Annual Performance Report* included but were not limited to the following:

- Providing training and technical assistance on how to conduct progress reviews, use appropriate assessment instruments, and maintain and report student data.
- Providing training and technical assistance on practicing inclusion, developing functional IEP goals, teaching social and emotional skills, and using curriculum frameworks.



- Developing technical assistance materials related to outcomes for preschool students, including webinars with Part C staff and documents with answers to frequently asked questions about child assessment and progress sharing.
- Continuing work with the National Early Childhood Technical Assistance Center and Early Childhood Outcome Center.
- Disseminating guidance and information on issues related to transitioning from Part C to Part B services.

The following section covers services and supports available to students with disabilities in **K–12** who require special education, including the transition services needed to achieve successful post-school outcomes.

## E. IDEA Part B's K–12 Special Education Services

The Individuals with Disabilities Education Improvement Act (IDEA) defines “**special education**” as

*pecially designed instruction, at no cost to the parent(s), to meet the unique needs of a child with a disability, including instruction conducted in a classroom, in the home, in hospitals, in institutions, and in other settings and instruction in physical education.*

The term includes each of the following when it meets the requirements of the definition of special education (§ 22.1-213 of the Code of Virginia; 34 CFR § 300.39):

- speech-language pathology services or any other related service if that service is considered “special education” rather than a related service under state standards;
- vocational education; and
- travel training.

Also defined by IDEA, “specially designed instruction” means adapting, as appropriate to the needs of an eligible child, the content, methodology, or delivery of instruction [34 CFR § 300.39(b)(3)] to:

- address the unique needs of the child that result from the child’s disability, and
- ensure the child’s access to the general curriculum, so the child can meet the educational standards that apply to all children within the jurisdiction of the public school division.

While not a focus of this chapter, there are numerous students with disabilities who do not require special education services through an Individualized Education Program (IEP) but may need **accommodations** to be successful. Examples of accommodations include where the student sits in the classroom, the amount of time available for tests, having certain tests read,

the use of a calculator, and more. These students may be eligible for a **504 plan** under Section 4 of the amended Rehabilitation Act of 1973.

The 504 plan is generally developed by a committee consisting of the student with the disability, if appropriate; one or more of the student's parents or guardians; one or more of the student's teachers; and the school's 504 coordinator. A 504 plan, which must be updated annually, documents the student's disability, his or her need for accommodations, and the set of specific accommodations that will be provided by the school. For additional information on requirements for 504 plans in Virginia schools, go to

[http://www.doe.virginia.gov/special\\_ed/tech\\_asst\\_prof\\_dev/section\\_504\\_implementation\\_va.pdf](http://www.doe.virginia.gov/special_ed/tech_asst_prof_dev/section_504_implementation_va.pdf).

## 1. K–12 Screening and Eligibility for Part B Special Education

Virginia children and young adults with disabilities (hereafter referred to as children or students) who have not yet reached their 22<sup>nd</sup> birthday may be eligible to receive special education and related services provided by public school divisions and overseen by the Virginia Department of Education (VDOE). Eligibility for IDEA Part B services at all levels (preschool, elementary, and secondary) involves a standard process. VDOE's *2010 Parent's Guide to Special Education*, while dated, provides a clear, user-friendly, and comprehensive guide to the special education process. The guide can be found at

[http://www.doe.virginia.gov/special\\_ed/parents/index.shtml](http://www.doe.virginia.gov/special_ed/parents/index.shtml).

Outreach activities by school divisions, known as **Child Find**, are the first step in determining eligibility for Part B services, including early childhood preschool services. Through Child Find, Virginia public school divisions must identify, locate, and evaluate children with disabilities who need special education and related services, regardless of citizenship, immigration status, residence, or where they may be receiving services. Specific Child Find activities range from broad-based public awareness campaigns to individual screenings that evaluate whether children need specialized educational services.

Parents may contact their child's teacher or other school professional to request an evaluation. School professionals may ask at any time for a child to be evaluated to determine if the student has a disability that requires specialized education. **School-based teams** are responsible for making referrals for evaluation. These teams focus on avoiding unnecessary referrals to special education. For more information on Child Find processes as well as the role of school-based teams, see

[http://www.doe.virginia.gov/special\\_ed/parents/parents\\_guide.pdf](http://www.doe.virginia.gov/special_ed/parents/parents_guide.pdf).

**Evaluations** for special education and related services require written parental consent. State regulations require evaluations to be completed within 65 business days after receipt of the referral for evaluation by the school division's special education administration, with exceptions for when (1) a parent refuses to make the child available for evaluations, (2) the parent and school division agree that additional data are required, or (3) a child transfers to a

new school division mid-evaluation. An eligibility evaluation must address all areas related to the child's suspected disability. Evaluations are multi-disciplinary and typically involve more than one professional. Based on the results, a team determines whether the child has a disability and whether he or she requires special education and related services as a result of that disability.

To qualify for special education and related services, a child must fall within one of the **disability categories** specified by the Individuals with Disabilities Education Improvement Act (IDEA) and federal implementing regulations, which can be found at <http://www2.ed.gov/legislation/FedRegister/finrule/2006-3/081406a.pdf>. The child must also meet the expanded definitions within the State Regulations Governing Special Education Programs for Children with Disabilities, located online at [http://www.doe.virginia.gov/special\\_ed/regulations/state/regs\\_speced\\_disability\\_va.pdf](http://www.doe.virginia.gov/special_ed/regulations/state/regs_speced_disability_va.pdf).

Once determined eligible, students must be **reevaluated** at least every three years to assess their continued eligibility for services. Reevaluations may not occur more than once a year unless the parent and school division both agree. Reevaluations can be based on existing data, or if existing data are insufficient, the team can gather new data.

If a child's parents disagree with the results of the initial or any subsequent eligibility evaluation, they have the right to request an **Independent Educational Evaluation (IEE)** at the school's expense. Public school divisions have the right to contest the need for an IEE and any other parental appeals. A family can, at all times, obtain an outside evaluation at their own expense if they choose to do so. Independent evaluations must be considered by the school division.

As with Part B preschool services, there are additional program admission criteria for services operated by the **Virginia School for the Deaf and the Blind at Staunton (VSDB-Staunton)** that are independent of the special education eligibility process. The student's IEP team determines whether the student should attend VSDB-Staunton based on individual need and reassesses that decision annually.

## **2. Access to and Use of Part B Special Education**

Once a student is determined to be eligible for special education services, an **Individualized Education Program (IEP)** must be developed for the student within 30 calendar days. The IEP specifies the special education and related services to be received and identifies the settings in which those services will be delivered.

Parents, teachers, other school staff members, and the student, when appropriate, develop the IEP together. The IEP team must examine the student's unique needs and strengths to design an educational program that will (1) support the student's involvement and progress in the general curriculum to the maximum extent possible, and (2) ensure equal access to programs and services. In Virginia, the general curriculum is the **Standards of Learning (SOL)**

curriculum. For more information on IEP requirements, go to [http://www.doe.virginia.gov/special\\_ed/parents/parents\\_guide.pdf](http://www.doe.virginia.gov/special_ed/parents/parents_guide.pdf).

Students who receive services under an IEP are entitled to have those services delivered in the **“least restrictive environment” (LRE)** and must have a **“continuum of placement options”** available to them. LRE means that students with disabilities:

- have the right to be educated with their peers who do not have disabilities and
- cannot be moved to special classes, placed in separate schools, or otherwise removed from the general education environment unless it is demonstrated that, because of the nature and severity of their disabilities, they cannot be educated in a regular education class through the use of supplemental aids and services.

The continuum of services allows for special education and related services to be provided within a general education classroom, a self-contained classroom, a resource room, a private day program, a residential program, a hospital, the home (homebound), or any other approved setting, including the Virginia School for the Deaf and the Blind at Staunton.

A critical part of the IEP process involves **assessment** and **diploma** options. All students must be included in the state’s accountability system and must be first considered for participation in the **Virginia Standards of Learning (SOL) Assessment**. A student’s Individualized Education Program (IEP) must specify whether the student is participating in the SOL Assessment, with or without accommodation, or in one of the Commonwealth’s alternate assessment programs, described below.

The choice of assessment tracks affects the type of diploma that students with disabilities can obtain and, therefore, their postsecondary future. The goal is for the vast majority of students, including those with disabilities, to obtain a **Standard** or **Advanced Studies diploma**. Both of these diplomas:

- are accepted by institutions of higher education,
- enable students to access financial aid for college or vocational school, and
- are considered to be a “high school diploma” by employers.

Students with significant disabilities, particularly cognitive disabilities, who are not achieving academically at grade-level standards and are participating in the **Alternate SOL**, may receive a **Special diploma**, which simply denotes that they have completed their program of study, although efforts are underway by VDOE to make this diploma more skills-related and, thus, more meaningful.

Prior to the 2013–2014 school year, students with disabilities also had been eligible for a **Modified Standard diploma**. This diploma was intended for students with disabilities who, according to the VDOE website, were “unlikely to meet the credit requirements for a Standard

diploma.” Decisions regarding the pursuit of this diploma were made by the IEP team at any point after the student left the 8<sup>th</sup> grade. It is important to note that the Modified Standard diploma was not recognized by most institutions of higher education or by most employers, and it did not enable students to access financial aid.

On July 26, 2013, the VDOE issued Superintendent’s Memo 191-13 to announce the amendment of the Code of Virginia (§§ 22.1-253.13:4 and 22.1-254) by the 2012 General Assembly to strengthen postsecondary education and workplace readiness opportunities for all children. The code change eliminated the Modified Standard diploma beginning with students entering the 9<sup>th</sup> grade in 2013. The legislation requires the Virginia Board of Education to make provisions for students with disabilities to earn a Standard diploma through **credit accommodations**. For more information, go to <http://leg1.state.va.us/cgi-bin/legp504.exe?121+ful+CHAP0454>.

VDOE issued guidance on credit accommodations for students with disabilities in July 2013. See [http://www.doe.virginia.gov/instruction/graduation/credit\\_accommodations.shtml](http://www.doe.virginia.gov/instruction/graduation/credit_accommodations.shtml) for more detailed information. The types of accommodations available to students with disabilities (determined by the student’s IEP team or 504 committee) can include but are not limited to:

- alternative courses to meet the standard credit requirements,
- modifications to the requirements for locally awarded, verified credits,
- additional tests approved by the Board of Education for earning verified credits,
- adjusted cut scores on tests for earning verified credits, and/or
- allowance of work-based learning experiences through career and technical education (CTE) courses.

It will likely take several years to determine if credit accommodations will succeed in terms of meeting the goal of enabling more students with disabilities to obtain a Standard diploma. Information on diploma and certification options can be found at [http://www.doe.virginia.gov/instruction/graduation/other\\_diploma.shtml](http://www.doe.virginia.gov/instruction/graduation/other_diploma.shtml).

Virginia’s Alternate Assessments include the **Virginia Grade Level Alternative (VGLA)**, the **Virginia Substitute Evaluation Program (VSEP)**, the **Virginia Modified Achievement Standards Test (VMAST)**, and the **Virginia Alternate Assessment Program (VAAP)**.

The **VGLA** was designed for students whose disabilities prevent them from accessing Standards of Learning (SOL) content area assessments due to the format of the tests. It is available to students in grades 3 through 8 in specified content areas. Students compile a collection of work samples to demonstrate performance on grade-level content as presented in the SOL test blueprints. Decisions about VGLA participation are made on a test-by-test and individual basis. The VGLA is being phased out.

The **VSEP** is an alternative method of assessing students who, by the nature of their disability, are unable to participate in the SOL assessments even with testing accommodations. The VSEP provides eligible students with the opportunity to earn the requisite verified credits for a Standard or Advanced Studies diploma or to meet the requirements of a Modified Standard diploma through non-traditional means. It is available for SOL end-of-course tests and provides eligible students with the opportunity to earn the required verified credits or a Standard or Advanced Studies diploma. There are a number of other specified circumstances in which certain students may be eligible for the VSEP. Decisions are made on a test-by-test and individual basis.

The **VMAST** is an alternate assessment based on modified achievement standards. It was designed to make tests more accessible to students with disabilities who are instructed in grade-level content but are not likely to achieve proficiency as quickly as their peers without disabilities. The curriculum is the same, but the achievement expectations are modified. The VMAST also is being phased out and, beginning in 2014–2015, scores of students participating in the VMAST will not be included in the participation or the pass-rate calculations for federal accountability.

The **VAAP** is an alternative assessment based on alternative achievement standards. It was designed to evaluate the achievement of students with **significant cognitive disabilities**. Participation is limited and determined by each student's IEP team. Students participating in the VAAP cannot obtain a Standard diploma, making this a significant decision for families. Beginning in third grade, the VAAP is available to students who are working on reduced academic standards called **Aligned Standards of Learning (ASOL)**.

Since the VAAP's inception, and through the 2013–2014 school year, a collection of work samples have been compiled and submitted annually to demonstrate student achievement. However, in 2014–2015, Virginia will implement a new, online alternate assessment program for students with significant cognitive disabilities to replace the current "Collections of Evidence" in reading, writing, and mathematics. The online alternate assessment is being developed by the **Dynamic Learning Maps (DLM) Alternate Assessment System Consortium**.

The DLM Assessment (developed under a US Department of Education grant) is based on research on how students with significant cognitive disabilities learn. The system is designed to map a student's learning throughout the year using items and tasks that are embedded in daily instruction, so that testing occurs as part of instruction. The core belief is that all students should have access to challenging grade-level content. Essential elements of the DLM include (1) linkage to the SOL curriculum, (2) statements on how the content builds skills that provide a bridge for students to achieve grade-differentiated expectations, and (3) appropriate challenge and rigor.

If an IEP team determines that a student's disability prevents him or her from participating in the SOL Assessments even with accommodations, the team is required to provide a written justification and include supporting documentation to explain its determination. The VDOE

website provides comprehensive information on Virginia's Assessment program. See the following web pages.

**Testing participation and inclusion:**

<http://www.doe.virginia.gov/testing/participation/index.shtml>

**Standards of Learning (SOL) scoring:** <http://www.doe.virginia.gov/testing/scoring/index.shtml>

**Alternative assessments:**

[http://www.doe.virginia.gov/testing/alternative\\_assessments/index.shtml](http://www.doe.virginia.gov/testing/alternative_assessments/index.shtml)

**Substitute tests for verified credits needed to obtain a Standard or Advanced Studies diploma:** [http://www.doe.virginia.gov/testing/substitute\\_tests/index.shtml](http://www.doe.virginia.gov/testing/substitute_tests/index.shtml)

Once the team agrees on an IEP, the **public school division** is responsible for ensuring that it is carried out as written, that progress is achieved, and that parents are routinely informed of their child's progress. Special education and related services can only be terminated if a student:

- graduates with a Standard or Advanced Studies (high school) diploma,
- reaches his or her 22<sup>nd</sup> birthday,
- has been reevaluated (with parental consent) and determined to no longer be eligible for services based on existing or new data and assessments, or
- the parent or adult student withdraws consent for services.

Parents may or may not agree with a student's IEP, the location in which services will be delivered, or other decisions regarding the provision of services, assessments, and the like. Further discussions with the IEP team often resolve disagreements. If this is not effective, there are formal dispute resolution practices available. For more information on dispute resolution, see **Monitoring, Evaluation, and Outcomes of Part B** below.

VDOE annually collects data from the school divisions on the number of children receiving services on the same day of each year. This **December 1 Child Count** is a "point-in-time" census and does not represent the total number of children served during the year. **Table 10** shows the number of children with disabilities receiving special education and related services statewide by disability category from 2009 through 2013.

| Table 10. Students receiving Special Education Services in December Child Counts |        |        |        |        |        |
|--|--------|--------|--------|--------|--------|
| VDOE Disability Category   | 2009   | 2010   | 2011   | 2012   | 2013   |
| Autism   | 10,092 | 11,703 | 13,141 | 14,624 | 15,859 |
| Deafblind  | 20     | 25     | 34     | 29     | 32     |

| Table 10. Students receiving Special Education Services in December Child Counts |                |                |                |                |                |
|--|----------------|----------------|----------------|----------------|----------------|
| VDOE Disability Category   | 2009           | 2010           | 2011           | 2012           | 2013           |
| Developmental delay  | 13,226         | 10,425         | 10,911         | 11,191         | 10,982         |
| Emotional disturbance  | 10,125         | 9,589          | 9,474          | 9,414          | 9,051          |
| Hearing impairments  | 1,489          | 1,473          | 1,455          | 1,449          | 1,404          |
| Intellectual disability  | 9,913          | 9,934          | 9,572          | 9,424          | 9,220          |
| Multiple disabilities  | 3,139          | 3,325          | 3,461          | 3,464          | 3,400          |
| Other health impairments   | 27,811         | 28,703         | 29,530         | 30,261         | 31,006         |
| Orthopedic impairment  | 912            | 905            | 834            | 794            | 784            |
| Severe disabilities  | 796            | 465            | 199            | *              | *              |
| Specific learning disabilities   | 57,566         | 56,971         | 55,690         | 54,742         | 54,030         |
| Speech/language impairment   | 29,771         | 28,974         | 27,354         | 26,093         | 25,040         |
| Traumatic brain injury   | 402            | 390            | 395            | 396            | 419            |
| Vision disability  | 612            | 618            | 598            | 594            | 592            |
| <b>TOTAL</b>   | <b>165,874</b> | <b>163,500</b> | <b>162,648</b> | <b>162,475</b> | <b>161,819</b> |

Source: Virginia Department of Education's December Child Count for 2009, 2010, 2011, 2012, and 2013 for school divisions and state-operated programs.

\*The category of "severe disabilities" is no longer used in the Child Count system. It was not a federal *IDEA* category. The VDOE and Board of Education determined that this category caused confusion in the identification process and was an area in which Virginia could align better with the federal categories.

The December Child Count census indicates that the number of children receiving special education services has been on a slow but steady decrease, declining 2.4 percent since 2008. The number of children counted in the **"developmental delay"** category decreased as expected since changes in state special education regulations reduced the age limit for this category from age 8 to age 6 in 2010.

The highest increase was in the category of students with **"autism."** Between 2009 and 2013, the number of children categorized educationally as having autism rose by more than 57 percent. The category of children classified as having **"specific learning disabilities"** has been declining since 2009, and the number of children with **"other health impairments"** has increased. "Other health impairments" and the **"multiple disabilities"** categories may be capturing students who were formally classified as having **"severe disabilities."** It is important to note that a decline in educational classification does not mean that the student does not

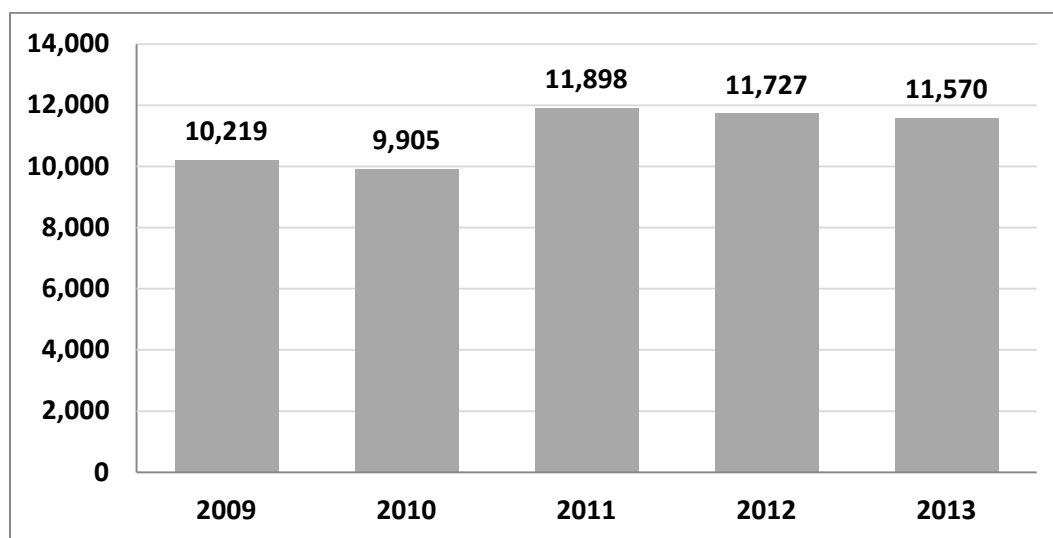


have a specific disability just that he or she is not being educationally classified under this disability category.

The transition of students with disabilities to higher education, employment, or other training continues to be an important area being addressed by VDOE and local school divisions. The 2011 edition of this *Assessment* pointed to a slightly declining proportion of students within the official eligibility range for transition services—those between **age 14 and 22**. Their numbers decreased 3.6 percent from 2004 through 2009. However, during that same time period, students closest to transition, those between **age 18 and 22**, i.e., seniors in high school, increased by 21 percent.

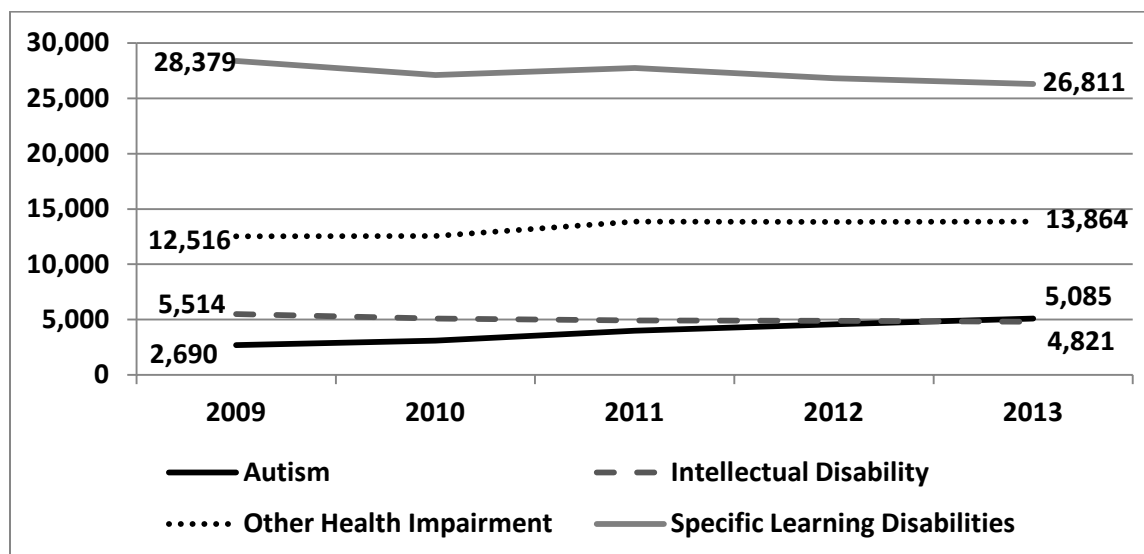
**Figure 9** shows the growth in the number of students with disabilities between the ages of 18 and 22 from 2009 through 2012. During that time period, the number of students closest to transition grew a little over 13 percent. This increase in numbers since 2009 could be the result of a variety of scenarios, including the possibility that more students are remaining in school beyond age 18. There was a slight decline in 2013 from the previous year.

**Figure 9. Students with Disabilities between Age 18 and 22**



With respect to the entire transition age span (ages 14 to 22), the largest increase was, expectedly, students with “autism.” The jump from 2,690 students in 2009 to 5,085 students in 2012, as shown in **Figure 10** below, represents an 89 percent increase. The “other health impairment” category has increased from 12,510 students to 13,864 students, a 10.8 percent increase, while the number of students in transition with an educational label of “intellectual disability” or “specific learning disabilities” has declined. Overall, the counts represent a large number of students, many of whom will require specialized services and supports to successfully navigate post-high-school endeavors.

**Figure 10. Child Counts of Transition-Age Students (between 14 and 22) by Targeted Disability Categories\***



\* As of the December 1, 2011 Child Count, students are counted by grade, not by age. The 2008, 2009, and 2010 counts include students ages 14 through 22. The 2011 through 2013 counts include students in 8<sup>th</sup> through 12<sup>th</sup> grades. Students with disabilities who remain in school through age 22 are counted as 12<sup>th</sup> grade students.

### 3. Available Part B Special Education Services

Services available to students found eligible for special education under Part B of the Individuals with Disabilities Education Improvement Act (IDEA) start with specially designed instruction in **core academic areas**. Additionally, there are a host of related services that may be required for a student with a disability to achieve academically, regardless of placement. For information on these services, go to [http://www.doe.virginia.gov/special\\_ed/parents/parents\\_guide.pdf](http://www.doe.virginia.gov/special_ed/parents/parents_guide.pdf).

Other developmental, corrective, or supportive services may also be provided if they are required for a child with a disability to benefit from special education. The **Department for the Blind and Vision Impaired (DBVI)** consults with Virginia schools to provide comprehensive programming to students who are blind, vision impaired, or deafblind. Services provided by DBVI include educational and developmental materials, vision assessments and eye exams, and adaptive optical aids.

To meet federal requirements for **accessible instructional materials** needed by students with print disabilities, George Mason University operates the Virginia Accessible Instructional Materials (AIM) program. There, textbooks and other instructional materials are transferred into various formats to ensure they are accessible. A list of available resources can be found at <http://kihd.gmu.edu/aim/policies>. These are available to all school divisions at no charge.

The Virginia School for the Deaf and the Blind at Staunton (VSDB-Staunton) provides training in a student's disability areas as well as concentrated instruction in core academic areas that adhere to the Virginia Standards of Learning (SOL). Within VSDB-Staunton is the **Department for the Blind**, a K–12 residential program designed for students with blindness, visual impairments, and multiple disabilities. The program is designed to work collaboratively with families, local school divisions, and the Department for the Blind and Visually Impaired.

In addition to core academic instruction, the school provides additional programs and supports that include but are not limited to: highly trained Teachers of the Visually Impaired in each content area, technology-enhanced classrooms, career exploration opportunities, access to specialized accommodations, such as Braille, large print, Victor Reader Streams, BrailleNote, CCTV, tactile instructional materials, computer labs, and a variety of low-vision aids. Also key are Braille, technology, and orientation and mobility instruction. For additional information, go to the VSDB website at <http://vsdb.k12.va.us/Blind/>.

VSDB-Staunton's **Department for the Deaf** provides services leading to independence for students with severe to profound hearing impairments. The program must adhere to all state standards in content courses. In addition, it provides additional programming and supports that include but are not limited to, direct instruction in American Sign Language (ASL) and English using a bilingual approach; teachers who are highly qualified to teach deaf and hard-of-hearing students with and without additional disabilities; curricula tailored to meet all students' needs; specialists in ASL, audiology, autism, speech and language therapy, occupational therapy, physical therapy, recreational therapy; and access to technology such as Smart Boards, iPads, videophones, laptops, and visual-audio safety alarms. For additional information on academic and extracurricular activities, go to <http://vsdb.k12.va.us/Deaf/>.

The 2013 General Assembly added a provision to the Code of Virginia (§ 22.1-217.02). This provision requires that when developing an Individualized Education Program (IEP) for a child identified as deaf or hard of hearing, the IEP team must consider the:

- child's individual communication mode or language;
- availability of a sufficient number of age, cognitive, academic, and language peers of similar abilities if the parents so desire;
- availability of adult models who are deaf or hard of hearing and proficient in the child's communication mode or language;
- provision of direct and ongoing language access to teachers of the deaf and hard of hearing, interpreters, psychologists, and other professionals who are proficient in the child's primary mode or language;
- provision of communication-accessible instruction, school services, and other components of the educational process as well as equal opportunity to participate in advanced coursework, technical education, and academic classes as determined by the IEP team;

- provision of appropriate assistive technology; and
- that VSDB-Staunton may be the least restrictive environment for the child.

The new code section also stipulates that students who are deaf or hard of hearing cannot be denied the opportunity for instruction on a particular communication mode or language and can receive instruction in more than one communication mode or language (e.g., American Sign Language; English-based manual, or other sign systems; oral, aural, speech-based training; spoken and written language; and communication via assistive technology).

Over the last five years, policymakers have emphasized improving services to individuals with **Autism Spectrum Disorders (ASDs)**. In 2012, the General Assembly passed House Bill 325. The new code section (§ 22.1-298.3), effective September 1, 2014, requires each school board to ensure that aides assigned to work with a teacher who has primary oversight of students with ASDs receive training in **student behavior management** within 60 days of being assigned to work with the student. The school boards also were authorized to provide training to other employees such as transportation employees. The Virginia Department of Education was required to provide training standards. These standards were adopted in January of 2013 and can be found in the document, *Training Standards for Paraprofessionals Assigned to Work with a Teacher who has Primary Oversight of Students with Autism Spectrum Disorders*. The training is available online, free of charge to school divisions at [http://www.vcuautismcenter.org/documents/parapro\\_training\\_standards.pdf](http://www.vcuautismcenter.org/documents/parapro_training_standards.pdf).

In the fall of 2013, the Joint Commission on Health Care released a report on its study of the transition needs of students with ASDs. Numerous programs and initiatives have been undertaken to meet the needs of these students. In 2010, Virginia Commonwealth University established the **Autism Center for Excellence (VCU-ACE)** with funding from the Virginia Department of Education. VCU-ACE focuses on research, training, technical assistance, and collaboration with school divisions, universities, families, and professionals.

Another option, provided by Commonwealth Autism Service (CAS), is an “embedded teaching model” whereby CAS provides staff to work directly with students in school divisions through a contractual arrangement. CAS staff uses the “competent learning model,” which focuses on learner assessments, supplemental curricula with effective teaching strategies, staff training with coaching and collaborative consultation, and coaching and implementation guidelines. More information is available online at <http://www.autismva.org>.

The **Virginia Autism Council (VAC)** is an interagency collaboration. Its role is to develop best practice tools, identify and address systems gaps, and gather and disseminate knowledge. The VAC works in affiliation with VCU-ACE to develop and deliver training for ensuring skill competency in the professionals working with students with autism. More information is available at <http://www.autismtrainingva.org>.

**Transition planning** is a critical component of post-high-school success in higher education, training, and employment. The Individuals with Disabilities Education Improvement Act (IDEA) defines transition services as those that

*promote movement from school to post-school activities, including postsecondary education, vocational training, integrated employment (including supported employment), continuing and adult education, adult services, independent living, or community participation.*

While the federal minimum age for commencement of transition planning is 16, the Virginia Department of Education (VDOE) continues to encourage early transition and has maintained **age 14** as the age at which transition planning should begin and be included in the IEP.

Like any other part of the Individualized Education Program (IEP), transition planning must be based on the individual student's needs, taking into account his or her strengths, preferences, and interests. Transition preparation can include direct instruction, community experiences, development of employment goals and other post-school, adult-living objectives, and other related services. When needed, acquisition of daily living skills and a functional vocational evaluation may be included.

Primary responsibility for planning and implementing transition services rests with the local public school divisions, but other state and local agencies and organizations may be called on to assist and help coordinate services. Examples of relevant agencies that may be involved with transition planning include but are not limited to: community services boards, public and private case managers, centers for independent living, the Department for Aging and Rehabilitative Services (DARS), the Department for the Blind and Vision Impaired, Social Security, and work-incentive planning programs. The VDOE has significant information on transition planning and resources on their website at [http://www.doe.virginia.gov/special\\_ed/transition\\_svcs/index.shtml](http://www.doe.virginia.gov/special_ed/transition_svcs/index.shtml).

In 2014, the **Behavioral Health Care Subcommittee of the Joint Commission on Health Care** released its study report: *Needs of Individuals with Autism Spectrum Disorder Transitioning from Secondary Schools*, which is available at <http://jchc.virginia.gov/reports.asp>. The study found that students with autism had poorer postsecondary outcomes than students with other disabilities. However, most of the other challenges cited are well known and applicable to the broader population of students with developmental and other disabilities. These include:

- inadequate interagency coordination (state and local) and inadequate participation by community partners (listed above) in the transition planning process;
- inadequate preparation for going from an entitlement (IDEA) system to an eligibility system (e.g., for Medicaid waivers, vocational rehabilitation services, etc.);
- family and student difficulty in understanding and navigating the adult system;
- waiting lists for many adult services;

- lack of case management for individuals not receiving waiver or DARS services; and
- inadequate recognition of student abilities and strengths, leading to academic tracking and, therefore, limited higher education and competitive employment opportunities.

The Department for Aging and Rehabilitative Services (DARS) administers the **Postsecondary Education/Rehabilitation Transition (PERT)** program at the Woodrow Wilson Rehabilitation Center (WWRC) in Fishersville. This program is available to all local public school divisions, although not all choose to participate. PERT has an advisory committee that includes parents and former participants. Local PERT teams work with participating school divisions to identify appropriate students, then plan and implement educational and rehabilitative services based on the results of student evaluations.

Students must meet both PERT and WWRC eligibility and admission requirements. These can be found at <http://wwrc.virginia.gov/pert.htm>. PERT has two components. An initial, five-to-ten-day residential evaluation at WWRC determines students' vocational strengths and aptitudes, independent-living and leisure skills, and functional abilities, as well as their social, interpersonal, and personal-adjustment skills. Findings and recommendations resulting from this evaluation are used by local PERT teams to address the school-to-work transition component of the students' Individualized Education Programs (IEPs). Participation in a situation assessment, the second component of PERT, is the result of IEP recommendations made at the local level. Students who undergo this workplace assessment have the opportunity to further refine their vocational interests and skill areas, develop good work habits, and clarify their vocational goals. PERT also carries out other training and assessment activities that are regional or locally based.

In SFY 2013, there were 452 initial evaluations, 61 situational assessments, 21 transition academies, and 7 summer assessments conducted. This combined total of 541 assessments is up about 5.5 percent from 2012 when 513 evaluations were conducted. In the *SFY 2012 PERT Annual Report*, it was noted that the 2012 numbers fell short of those served in 2011 when more funds were allocated to PERT. It was also noted that during that fiscal year (and continuing into SFY 2013), DARS was operating under an Order of Selection due to funding that was insufficient to serve all who were eligible for services. It closed all categories, limiting PERT participation to students already on DARS caseloads. Looking at just initial evaluations and situational assessments, numbers are consistent with SFY 2009 in which PERT conducted 438 initial evaluations and 59 situational assessments. The report is available at <http://www.vadrs.org/formscabinet/Formscabinet.asp?pass=et1&t1=WWRC&pg=>.

Students in 10<sup>th</sup> through 12<sup>th</sup> grade (and adults who are considering resuming their education) who are blind or vision impaired may be eligible to participate in a two-week assessment program by the **Department for the Blind and Vision Impaired (DBVI)** that determines their readiness for college, both in terms of academic and adjustment-to-blindness skills. DBVI also offers a four-week transition program for high school students who are blind that includes the opportunity to participate in community work experiences. Students enrolled

in this program receive training in independent living, cooking, personal management, computer, and orientation and mobility activities to develop their skills in these areas. DBVI also offers Saturday afternoon technology classes three to four times per year that build keyboarding and Braille technology skills, computer literacy and competency with various software applications, and expertise with voice, image enlargement, or Braille access for computer use.

VDOE has devoted significant resources to promote best practices and provide technical assistance for transition. It offers all school divisions an opportunity to participate in the **Virginia Transition Outcomes Project**, which provides a system that school divisions can use to consistently track IEPs and capture outcome data to improve transition services. It sponsors an annual transition conference and provides 16 regional transition specialists to support local public schools. The Transition Outcomes Project was expanded statewide, and VDOE began participating in National Transition Communities of Practice.

The Department continues to grow its successful **I'm Determined** project. This program promotes direct instruction, models, and opportunities to practice skills associated with self-determined behavior beginning in elementary school and continuing throughout the student's school career. According to VDOE, as of 2012, 50 school divisions were participating. The program's website averages 800 unique visitors a week (60 percent new and 40 percent returning). Other states are using the I'm Determined materials and I'm Determined apps are now available for free in the Apple iTunes store. In June 2013, the 7<sup>th</sup> annual Youth and Parent Summit had 190 students and 170 parents in attendance. VDOE also contributes financially to the Virginia Board for People with Disabilities' **Youth Leadership Forum** for rising high school juniors and seniors with disabilities. This annual, week-long program builds leadership and advocacy skills in students and helps them to prepare for their post-high-school futures.

In September 2013, the **Richmond Career Education and Employment Academy**, a new charter school, opened its doors to 10 students. The program can serve up to 40 students in grades 8 through 12. The purpose of the program is to provide

*an intensive functional life skills curriculum that is oriented toward career education and competitive employment for Richmond students, ages 14 to 21.*

The students all have significant cognitive disabilities and significant academic challenges as well as challenges with communication and social skills. Participants are likely to leave school with a Special diploma and likely to experience challenges in developing the skills needed to be competitively employed or engaged in other meaningful postsecondary activity. Anticipated outcomes of this program, which operates within a Richmond City public high school and emphasizes community engagement, is competitive employment, enrollment in a meaningful postsecondary program, or other postsecondary outcomes desired by the student. Outcomes will be available in several years. More information is available online at [http://www.doe.virginia.gov/instruction/charter\\_schools/charter\\_schools.shtml](http://www.doe.virginia.gov/instruction/charter_schools/charter_schools.shtml).

Despite a number of successful initiatives, transition services continue to be an area of concern for students and their parents. More importantly, **student outcomes** in the aggregate have not been positive (see the **Monitoring, Evaluation, and Outcomes of Part B** section of this chapter). Services vary considerably across the State, and families continue to cite challenges in receiving adequate information and the supports needed to ensure success after high school for students seeking employment or higher education options.

In response to many of these challenges, but in particular to the poor post-school outcomes for students with disabilities, in 2013 VDOE announced that it would fund a **Center for Transition Innovations (CTI)**. The Center, which was officially established on April 9, 2014, is a collaborative venture between the VDOE and the VCU School of Education's Rehabilitation and Research and Training Center (RRTC). It will serve as a statewide resource to support school divisions; vocational, rehabilitation, and other service providers; and students with disabilities and their families as they work together to facilitate successful transitions for students with disabilities who are leaving school. The Transition Center will focus on information dissemination through a website, online education modules, webcasts, webinars, and online monthly transition chats for teachers, families, and others. The Center will also help the VDOE implement best practice models such as Project SEARCH and Start on Success. It will develop topical papers and conduct transition-related research and program development.

#### 4. Cost and Payment for Part B Preschool and K–12 Special Education

**Table 11** summarizes the combination of local, state, and federal resources used by local school divisions in Virginia to fund special education services for students with disabilities in SFYs 2011 and 2012. Total expenditures for SFY 2012 increased approximately 1.47 percent over SFY 2011 expenditures and has risen 25.2 percent since SFY 2006 when expenditures were \$1,644,878,544.

| Table 11. Virginia Special Education Expenditures by Source and SFY |                        |             |                        |             |
|---|------------------------|-------------|------------------------|-------------|
| Expenditure Funding Source  | 2011 Amount            | 2011 Share  | 2012 Amount            | 2012 Share  |
| Local funds   | \$1,201,254,137        | 59%         | \$1,283,107,624        | 62%         |
| State appropriations to localities                                  | 467,750,206            | 23%         | 456,106,529            | 22%         |
| Federal payments to State, IDEA Part B                              | 360,339,369            | 18%         | 319,932,402            | 16%         |
| Section 619 (preschool)   | 6,330,001              | –           | 6,150,222              | –           |
| Section 611 (school-age)  | 202,724,528            | –           | 256,052,869            | –           |
| Other federal funding (AARA stimulus funds)                         | 151,275,840            | –           | 57,729,311             | –           |
| <b>TOTAL</b>  | <b>\$2,029,343,712</b> | <b>100%</b> | <b>\$2,059,146,555</b> | <b>100%</b> |



Source: Virginia Department of Education-Division of Special Education and Student Services, October 2013. Note that the “Federal payments to State” category is comprised of the Section 619 and 611 subcategories.

As shown in **Table 12**, total federal funding for special education in SFY 2014 is down 5.1 percent from 2013, a decrease of about \$15 million.

| <b>Table 12. Federal Funding for Special Education in SFY 2014</b> |                    |                    |                      |
|--|--------------------|--------------------|----------------------|
| <b>IDEA Part B Funds</b>   | <b>SFY 2012</b>    | <b>SFY 2013</b>    | <b>SFY 2014</b>      |
| <b>Section 619 (preschool)</b>                                     | <b>8,967,283</b>   | <b>8,952,199</b>   | <b>8,537,211</b>     |
| <b>Section 611 (school-age)</b>                                    | <b>279,025,194</b> | <b>281,531,321</b> | <b>266,858,779</b>   |
| <b>TOTAL</b>   | <b>287,992,477</b> | <b>290,483,520</b> | <b>\$275,395,990</b> |

Source: Virginia Department of Education, Division of Special Education and Student Services, October 2013.

**State funding** to local school divisions is determined by the **Standards of Quality (SOQ) funding formula** and school divisions’ enrollment using a measure referred to as their **Average Daily Membership (ADM)**. The state provides each locality with a base amount of funding for each child counted in its ADM plus “per-child add-ons” for special education and other activities. The special education add-on is determined by calculating the theoretical number of teachers and aides needed to meet special education standards for the number of enrolled children receiving special education and related services counted in the annual December 1 Child Count. The State’s share of this cost is determined according to the SOQ funding formula, which includes a consideration of the locality’s composite index of its ability to pay.

Under this system, each local school division receives an amount of funding from the State for special education that is unique to that locality. The total amount received for special education depends on the total student enrollment of the school division—not on the specific number of students receiving special education services. Further, state payments of the special education add-on are made into the General Fund of each local school board where they are co-mingled with all other state appropriations to localities for education.

**Local funding** involves interaction between municipal school boards and governing bodies. The school board projects the cost for local education programs, subtracts the anticipated receipts from state, federal, and other sources, then submits a budget request to the city or town council or county board of supervisors. These local governing bodies then approve what they believe to be appropriate funding to support their localities’ schools. This amount may be more or less than the amount requested by the school board.

Under certain conditions, eligible students may be served in **public regional special education programs**. Tuition rates charged to school divisions by these locally operated programs are approved by the Virginia Department of Education (VDOE). Students served in these programs are not counted in a locality’s ADM and, therefore, are not included in

determining a locality's per-child basic or add-on funding from the State. At the end of each semester, school divisions may request reimbursement from the State for its share of this tuition. The State's share may not exceed the VDOE-approved rate, and it is based on the same composite index of a locality's ability to pay as for the special education add-on.

**State funding** for children placed in **private special education schools** is provided from an interagency pool under the **Comprehensive Services Act**, which is described in more detail in the **Community Living Supports** chapter of this *Assessment*. Eligible children have either been placed in out-of-home environments by a local public agency such as the courts, social services, or a school division, or are at-risk for such placement. These children are also not counted toward a local school division's ADM, and the State's share of actual costs for services provided by these schools is paid through percentage reimbursement based on a locality's ability to pay. As long as a student is placed in a private facility, the school division receives no state Standards of Quality (SOQ) funding because the SOQs are public school standards.

Funding for special education teachers of **children with vision impairments** in the public schools has been a longstanding challenge called to the attention of the General Assembly in a 2004 report by the **Virginia Department for the Blind and Vision Impaired: Options to Address Salary Reimbursement to Localities for Special Education Teachers of the Visually Impaired**. The report stated, in part,

*Virginia's school divisions receive less state General Fund support for teachers of the visually impaired than they do for the other categories of special education teachers. This inequity exists because teachers of the visually impaired are funded through the Department for the Blind and Vision Impaired (DBVI) rather than the Department of Education's (VDOE) Standards of Quality (SOQ) funding formula.*

The situation was addressed by the 2013 General Assembly, which passed legislation to include students who are visually impaired in the SOQ. They also transferred General Funds from the DBVI to the Virginia Department of Education's SOQ. In the past, DBVI had distributed the General Funds to school divisions as a partial salary reimbursement for the teachers of the visually impaired they employed.

The base amount of **federal funding** for both preschool and K–12 special education programs is determined by a formula that considers past federal funding levels, the triennial school-age census, and state poverty levels. In addition, each year localities may apply to the VDOE for access to **discretionary federal grant funds** that promote statewide special education program improvements. These special federal funds, which may not be comingled with other funds, are used to reimburse localities for actual expenditures incurred in meeting each grant's goals and are subject to state approval.

Local school divisions may also qualify as approved providers of services under the joint state and federally funded **Medicaid** public insurance program. They also may seek

reimbursement of the federal financial participation (FFP) from the Virginia Department of Medical Assistance Services (DMAS) for covered support services provided to eligible students. These services, which must be identified in the students' Individualized Education Programs (IEPs), include physical, occupational, and speech therapies; audiology, nursing, psychiatric, psychological, mental health, and personal care assistance services; medical evaluations; and transportation. Reimbursements are available for students covered by Medicaid or the Family Access to Medical Insurance Securities (FAMIS) program, which are further described in the **Medicaid** chapter of this *Assessment*.

As with any other publicly operated school, there is no cost to the student and his or her family for attending the preschool or K–12 programs at the **Virginia School for the Deaf and the Blind at Staunton (VSDB-Staunton)**. Costs for student attendance are paid by the state, which creates a potential incentive for localities to send students with high needs out of division rather than have to pay for services provided by a private school.

The school's strategic plan reports that VSDB-Staunton's budget for SFY 2013 budget was about 10.2 million, including \$9,070,858 in General Funds and \$1,237,340 in federal funds. In that year, the school also received an additional \$113,802 in appropriations due to budget constraints. However, the SFY 2014 budget shows a decrease in General Funds due to the anticipation that vacated buildings (potentially including a dormitory that will be closed in 2014) will be rented.

**Table 13** provides the most recently audited expenditures by the Department of Accounts for VSDB-Staunton for SFYs 2010 through 2012.

| <b>Table 13. Expenditures for VSDB-Staunton by SFY</b> |                       |                     |                     |
|--|-----------------------|---------------------|---------------------|
| <b>Source</b>  | <b>SFY 2010</b>       | <b>SFY 2011</b>     | <b>SFY 2012</b>     |
| <b>State General Funds</b>                             | <b>\$10,350,652</b>   | <b>\$9,932,396</b>  | <b>\$9,823,171</b>  |
| <b>Special funds</b>                                   | <b>68,456</b>         | <b>59,440</b>       | <b>61,066</b>       |
| <b>Federal funds</b>                                   | <b>711,253</b>        | <b>724,485</b>      | <b>894,977</b>      |
| <b>Capital outlay funds</b>                            | <b>15,500,486</b>     | <b>22,970,657</b>   | <b>22,469,233</b>   |
| <b>TOTAL</b>   | <b>\$26, 630, 847</b> | <b>\$33,686,978</b> | <b>\$33,248,447</b> |

Source: Department of Education, *Direct Aid to Public Education and Virginia Schools for the Deaf and Blind-Report on Audit* for the years ended June 30, 2010 and June 30, 2012.

The VSDB-Staunton Foundation administers gifts, grants, and bequests to VSDB-Staunton to support the school's existing and future enterprises. The school receives income from the Foundation's investment, which is managed by the Foundation. The Foundation operates on a calendar year. As of December 31, 2011, the market value of the Foundation's investment

portfolio was \$3,303,938. Beginning in 2012, the Foundation was required to obtain an audit from a private CPA firm since it is no longer a state agency. The audit is available at <http://www.apa.virginia.gov/reports/VSDB11-12.pdf>.

For the 2010 through 2012 biennium, the VSDB-Staunton strategic plan reported serving 122 students with the budgets detailed in **Table 13**. The strategic plan for 2012 through 2014 reported 108 students with projected stable enrollment, indicating that while the number of students is decreasing, the cost per student continues to rise.

## **5. Monitoring, Evaluation, and Outcomes of Part B Special Education**

The Virginia Department of Education (VDOE) Division of Special Education and Student Services is responsible for general supervision and monitoring of the Individuals with Disabilities Education Improvement Act (IDEA) in accordance with its provisions [34 CFR 300.604(a)(1), and (a)(3), (b)(2)(i) and (b)(2)(v), and (c)(2)] and the Regulations Governing Special Education Programs for Children with Disabilities in Virginia (8 VAC 20-80).

General supervision includes the following components:

- submitting State Performance Plans (SPP) and Annual Performance Reports (APR);
- ensuring effective policies and procedures;
- providing targeted technical assistance and professional development;
- administering an effective dispute resolution system;
- conducting integrated on-site and off-site monitoring activities;
- data verification; and
- planning and implementing improvements and corrective actions, and performing necessary follow-up to ensure timely corrections, not to exceed one year.

Virginia's monitoring of special education involves off-site and on-site compliance reviews of (1) the state's 132 public school divisions; (2) state-operated programs, including education programs in juvenile detention and adult correctional facilities, hospitals, schools for the deaf and the blind; and (3) private schools for students with disabilities.

To receive Part B funding under IDEA, all local public school divisions and state-operated programs, such as VSDB-Staunton, must have in effect and must demonstrate adherence to policies and procedures that are both consistent with federal and state regulations and are consistent with plans approved by the Virginia Department of Education (VDOE). VDOE monitoring and enforcement activities focus on: (1) improved educational results and functional outcomes for children with disabilities and (2) ensuring that school divisions meet the program requirements under IDEA Part B, with particular emphasis on the requirements most related to improving educational results for children with disabilities.

Virginia's **Special Education State Performance Plan (SPP)** evaluates the Commonwealth's efforts to implement Part B requirements and describes how it will improve its implementation. The SPP must be approved by the federal Office of Special Education Programs Monitoring at the US Department of Education (USDOE) and measures performance in the following areas:

- provision of a free appropriate public education (FAPE) in the least-restrictive environment;
- general supervision of special education, including Child Find, effective monitoring, the use of resolution meetings, mediation, and a system of transition services; and
- disproportionate representation of racial and ethnic groups in special education and related services to the extent the representation is the result of inappropriate identification.

Virginia's most recent SPP is for 2005 through 2012. It was revised on May 14, 2013, as the USDOE had not yet completed a planned redesign of the SPP. According to the VDOE, the new plan will be submitted in 2014. The SPP sets forth measurable and vigorous targets that are updated annually. IDEA requires the State to submit an **Annual Performance Report (APR)** to the federal Office of Special Education Programs (OSEP) detailing the progress it has made each year in meeting these performance targets. After review of the APR, the OSEP issues an annual "determination letter" that documents the State's overall progress in meeting the requirements of IDEA. The OSEP released its determinations for FFY 2011 in July of 2013. Virginia was among the states determined to "**meet**" the requirements and purposes of IDEA. The OSEP also does periodic compliance visits. The last compliance visit to Virginia was in 2009. There will be changes to both the SPP and APR in 2015.

In its July 2012 release of state determinations, the USDOE reported that it was redesigning its **IDEA accountability system** to more directly support states in improving results for children with disabilities. This includes the methods by which state determinations are made. A Compliance Matrix is now being used by the OSEP. This matrix includes multiple datasets and a color-coded system (green, yellow, and red) that can visually represent a state's performance. The OSEP has also developed a State Data Display to provide better information to the public. This system will be used beginning in 2014. More information can be found at <http://www2.ed.gov/fund/data/report/idea/sppapr.html>.

The Commonwealth's oversight system has continued its shift from predominantly monitoring compliance with procedural requirements to focusing on educational benefits and student results. School divisions self-report on APR **compliance indicators** to the VDOE's **Division of Special Education and Student Services**, which then works with schools to develop corrective-action plans that address areas of noncompliance and verifies that those corrections are made within one year.

In addition to providing resources and assistance to all school divisions, the Division of Special Education and Student Services' **Office of Federal Program Monitoring** conducts onsite

monitoring visits to between 22 and 25 school divisions per year based on a 6-year monitoring schedule. Adjustments to the annual selection of schools in each of the superintendent's 8 regions are made to include school divisions that fail to demonstrate substantial compliance on the federal APR indicators. The onsite reviews determine causes of noncompliance and provide targeted assistance to school divisions with the greatest need.

Virginia has significant accountability and reporting requirements under the Elementary and Secondary Education Act of 1965 (ESEA) provisions (also known as the No Child Left Behind Act of 2001). ESEA required schools to set annual benchmarks for achievement in reading and math that were to lead to 100-percent proficiency by 2014. Schools, school divisions, and states that met or exceeded their annual benchmarks were rated as having made **"adequate yearly progress" (AYP)**. At least 95 percent of all students were required to be tested, including 95 percent of students in the specific subgroups of white, black, Hispanic, students with disabilities, students with limited English proficiency, and students who are economically disadvantaged. Annual ratings were based on achievement during the previous academic year or combined achievement from the most recent years. Virginia did not make "adequate yearly progress" in the 2009–2010 school year.

The federal accountability system for ESEA was changed in 2011–2012, and achievement of **annual measurable objectives (AMOs)** replaced the targets (AYP) that schools were previously required to meet. In 2012, Virginia applied and received a request for flexibility (known as a **flexibility waiver**) from the US Department of Education (USDOE). This waiver facilitated the establishment of new AMOs for raising achievement within identified subgroups. According to the VDOE's *2011–2012 Annual Performance Report*, the AMOs were determined using a formula based on the federal law and student achievement data from the State's assessment (SOL) program.

Under the approved flexibility waiver, Virginia schools must meet increasing targets (AMOs) in reading and mathematics for all students and for three **"proficiency gap groups,"** which include students with disabilities and other subgroups, in order to meet federal accountability requirements. According to the USDOE's *2013–2014 Summary of Accountability Results*, schools have three ways to meet the AMOs: (1) test results from the most recently completed school year, (2) test results based on a three-year average, or (3) reducing the failure rate by 10 percent.

When Virginia submitted its initial waiver application, concerns were expressed by representatives of students with disabilities and other "gap groups" due to differing starting points for **targets**. Extensive public comment was received and considered. The baseline targets were revised based on results of state assessments from 2011–2012. **Table 14** shows the targets for all students and for the gap groups:

- Gap Group 1 includes students with disabilities, English language learners, and economically disadvantaged students.

- Gap Group 2 represents black students.
- Gap Group 3 represents Hispanic students.

Students with disabilities are not disaggregated from Gap Group 1 in the *2012–2013 Summary of Accountability Results*, but are in the *2011–2012 Annual Performance Report*.

| <b>Table 14. Achievable Measurable Objective (AMO) Targets for the 2012–2013 School Year</b> |                |                    |
|--|----------------|--------------------|
| <b>Population</b>  | <b>Reading</b> | <b>Mathematics</b> |
| <b>All Students</b>  | <b>59%</b>     | <b>64%</b>         |
| <b>Gap Group 1</b>   | <b>52%</b>     | <b>52%</b>         |
| <b>Gap Group 2</b>   | <b>49%</b>     | <b>51%</b>         |
| <b>Gap Group 3</b>   | <b>53%</b>     | <b>56%</b>         |
| <b>Students with Disabilities*</b>   | <b>33%</b>     | <b>41%</b>         |

Sources: VDOE *2012–2013 Summary of Accountability Results* and VDOE *2011–2012 Annual Performance Report*.

Under Virginia’s approved waiver, the “n” size for subgroups to be included in accountability is reduced from 50 to 30. In other words, if a school serves at least 30 students in a subgroup, that subgroup must be included in accountability results. This holds 99 percent of Title I schools accountable. It also means an increase in schools providing services to students with disabilities from 105 schools to 396 schools. The student AMOs in reading and math will increase annually until 2017–2018 when the reading objective will be 78 percent for all groups, and the mathematics AMO will be 73 percent for all groups.

As noted earlier, in order to graduate with a Standard or Advanced Studies diploma, Virginia students must pass certain Standards of Learning (SOL) Assessments. In 2010, Governor Bob McDonnell issued **Executive Order No. 9 (EO 9)** establishing the Governor’s Commission on Higher Education Reform, Innovation and Investment. EO 9 was designed to improve college and career readiness for all Virginia students. As a part of its response to the Commission, the Virginia Board of Education (VBOE) adopted revised SOLs in mathematics (2009) and in English (2010). The new, **higher standards** resulted in a drop in SOL scores in 2011 and 2012 due to the new rigor and the resulting need for curriculum and teaching strategy adjustments.

As **Table 15** and **Table 16** show, the **disparity** between SOL pass rates for students with and without disabilities continued to be nearly 30 percent in the 2012–2013 school year. The 2011 edition of this *Assessment* pointed to a reduction in the achievement gap between all students and students with disabilities from 2006 through 2010, but this trend has reversed. While all scores in reading and math have dropped since 2011, the aggregate scores for students with disabilities have decreased at a higher rate than for other students taking the 8<sup>th</sup> grade SOL test.

| Table 15. Proficiency (Pass) Rate on SOL Tests - 8 <sup>th</sup> Graders |           |           |           |           |
|--|-----------|-----------|-----------|-----------|
| 8 <sup>th</sup> Grade English Reading and Mathematics                    |           |           |           |           |
| School Year  | 2009–2010 | 2010–2011 | 2011–2012 | 2012–2013 |
| All students   | 90%       | 90%       | 87%       | 71%       |
| Students with disabilities   | 70%       | 72%       | 61%       | 42%       |
| 8 <sup>th</sup> Grade Mathematics Only                                   |           |           |           |           |
| School Year  | 2009–2010 | 2010–2011 | 2011–2012 | 2012–2013 |
| All students   | 87%       | 82%       | 58%       | 62%       |
| Students with disabilities   | 66%       | 60%       | 30%       | 35%       |

Source: Virginia Department of Education, *School, School Division and State Report Card*, Customized reports by school year, [http://www.doe.virginia.gov/statistics\\_reports/school\\_report\\_card/index.shtml](http://www.doe.virginia.gov/statistics_reports/school_report_card/index.shtml).

| Table 16. Proficiency (Pass) Rate on SOL Tests - All Grades |           |           |           |           |
|---|-----------|-----------|-----------|-----------|
| All Grades English Reading and Mathematics                  |           |           |           |           |
| School Year   | 2009–2010 | 2010–2011 | 2011–2012 | 2012–2013 |
| All Students  | 89%       | 89%       | 87%       | 75%       |
| Students with disabilities                                  | 75%       | 73%       | 67%       | 53%       |
| All Grades Mathematics Only                                 |           |           |           |           |
| School Year   | 2009–2010 | 2010–2011 | 2011–2012 | 2012–2013 |
| All Students  | 88%       | 88%       | 63%       | 71%       |
| Students with disabilities                                  | 74%       | 71%       | 41%       | 49%       |

Source: Virginia Department of Education, *2013–2104 Summary of Accountability Results*, <https://p1pe.doe.virginia.gov/reportcard/report.do?division=All&schoolName=All>.

The **performance** of students with disabilities continues to be the lowest among the subgroups tracked, including those who are economically disadvantaged or who have limited English proficiency. In reading, the gap between these three subgroups on the 8<sup>th</sup> grade SOL was only about 6 percentage points. In mathematics, the gap was larger with a 40-percent pass rate on the 8<sup>th</sup> grade math SOL for those with limited English proficiency, a 34-percent pass rate for economically disadvantaged students, and a 25-percent pass rate for students with disabilities.



The **Virginia School for the Deaf and the Blind at Staunton** (VSDB-Staunton) follows all Virginia Assessment mandates. According to VSDB-Staunton, students often come to the school without current SOL scores, or the scores are inflated based on the results of testing at VSDB-Staunton. In 2012–2013, the Virginia Alternative Assessment Program (VAAP) and SOL scores indicate a 29.4-percent pass rate. Phonological Awareness Literacy Screening (PALS) is used to test elementary and middle-school students.

PALS is given in the fall and spring to determine individual, longitudinal growth for each student. In 2012–2013, 12 students in elementary and 12 middle-school students were tested. Of the students tested, 89 percent showed improvement in their reading scores. Of those who improved, 17 percent improved .5 year in reading level, 33 percent improved 1 year in reading level, and 17 percent improved 2 years in reading level. The Qualitative Reading Inventory (QRI) is a test given annually to high-school students in the Deaf Department. This test is used primarily for teachers to measure the student’s narrative and expository reading.

The VDOE also publishes annually the ***Special Education Performance Report***, regarding the performance of students with disabilities on federal OSEP indicators. Data on two key indicators from the latest four annual reports appear in **Table 17**. Not all indicators were required to be reported (N/R) each year.

| <b>Table 17. Special Education Performance on Indicators 1 and 2 by School Year</b> |                                      |                                      |                                      |                                      |
|---|--------------------------------------|--------------------------------------|--------------------------------------|--------------------------------------|
| <b>Outcome Indicator</b>  | <b>2009–2010<br/>Target / Actual</b> | <b>2010–2011<br/>Target / Actual</b> | <b>2011–2012<br/>Target / Actual</b> | <b>2012–2013<br/>Target / Actual</b> |
| <b><u>Indicator 1</u></b><br><b>Graduation with regular diploma</b>                 | <b>N/R</b>                           | <b>44.40% / 52.76%</b>               | <b>49.96% / 48.41%</b>               | <b>53.57% / 49.12%</b>               |
| <b><u>Indicator 2</u></b><br><b>Drop-out rate for grades 7-12</b>                   | <b>1.85% / 1.63%</b>                 | <b>2.25% / 1.53%</b>                 | <b>2.10% / 1.52%</b>                 | <b>2.00% / 1.49%</b>                 |

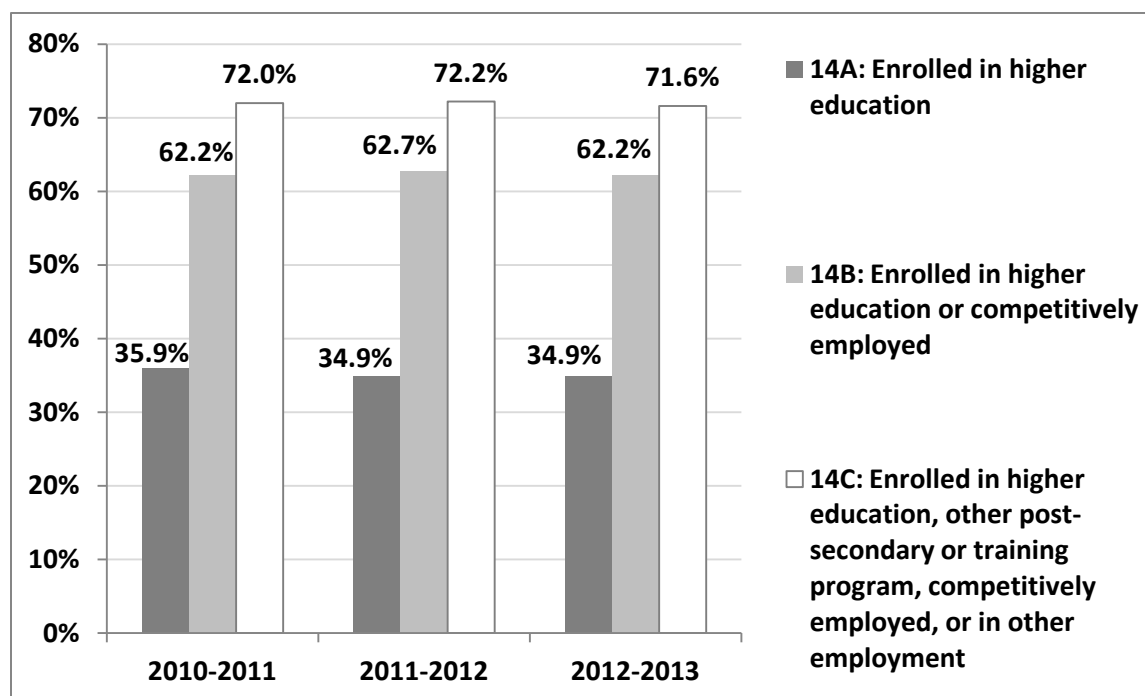
Although the targets (which are quite low) have been met, the **graduation rate** declined by over 4 percentage points in 2011–2012 as compared with 2010–2011. The 2012–2013 graduation rate was higher than in 2011–2012. The higher cut scores of certain Standards of Learning (SOL) tests implemented by the Virginia Board of Education may have contributed to this decline. The drop-out rate for students with disabilities has remained stable, dropping just slightly in 2012–2013 but meeting the target.

The requirement for serving children in the least restrictive environment (LRE) is an area of considerable concern to parents and was a principal issue for due process hearing requests. The targets since 2009 have been met but have not increased. As shown in **Table 18**, despite a requirement for access to the general curriculum and education with non-disabled peers, the number of children spending most of their day in a regular classroom remains below 70 percent, while the number of students served in separate programs increased 0.6 percent from 2010–2011 to 2011–2012 and remained at that same level in 2012–2013.

| Table 18. Special Education Performance on Indicators 5A-C by School Year |                              |                              |                              |                              |
|---|------------------------------|------------------------------|------------------------------|------------------------------|
| Least Restrictive Environments in K-12                                    | 2009–2010<br>Target / Actual | 2010–2011<br>Target / Actual | 2011–2012<br>Target / Actual | 2012–2013<br>Target / Actual |
| 5A: 80% or more time in regular classroom                                 | 66.0% / 59.0%                | 68.0% / 55.3%                | 68.0% / 61.8%                | 68.0% / 62.2%                |
| 5B: 40% or less time in regular classroom                                 | 9.0% / 11.0%                 | 8.0% / 18.5%                 | 8.0% / 12.5%                 | 8.0% / 12.6%                 |
| 5C: Served in separate public or private program                          | <1.0% / 3.5%                 | < 1.0% / 3.0%                | < 1.0% / 3.6%                | < 1.0% / 3.6%                |

**Transition to higher education and/or integrated competitive employment** is the ultimate goal for students with and without disabilities. The state achieved 100 percent performance in writing appropriate transition goals and involving students in transition planning. However, actual **post-school outcomes** do not match this paper achievement. As shown in **Figure 11**, the percentage of students achieving post-school success is way too low. Indicator 14B is more positive, although it still means that nearly 40 percent of students are neither in higher education nor competitively employed one year after high school. Indicator 14C includes individuals in non-competitive (sheltered) employment.

**Figure 11. Indicators 14A–C: Post-High-School Outcomes for Students with Disabilities**



Source: *Special Education Performance Report, Indicators and Targets Information*, 2009–2010, 2010–2011, 2011–2012, and 2012–2013.

[http://www.doe.virginia.gov/info\\_management/data\\_collection/special\\_education/](http://www.doe.virginia.gov/info_management/data_collection/special_education/)

Rates of **suspension and expulsion** are also an increasing concern. The target for this indicator (Indicator 4B) is 0. According to the VDOE, in 2009–2010, 10 of Virginia’s 132 school divisions (7.57 percent) had a significant discrepancy in the rate of suspensions and expulsions of more than 10 days in a school year for children with Individualized Education Programs (IEPs). Data for 2010–2011 (reported in the *2011–2012 Annual Performance Report*) shows that the number of schools with a significant discrepancy increased from 10 to 14 divisions (10.6 percent). In 2011–2012, this was reduced to 12 divisions, and in 2012–2013, there were 11 divisions with a significant discrepancy. As part of its work to improve Indicator 4B, the VDOE responded to the 2010–2011 increase by providing a self-assessment instrument that details requirements and a guidance document. Following a further review, only 1 of the 14 divisions with discrepancies remained non-compliant. However, numbers from the next two years indicate that performance in this area is still problematic.

In addition to initiatives discussed in earlier sections of the report, the VDOE’s improvement efforts related to services and supports for children with disabilities include the following:

- In 2012, the General Assembly passed HB 755, amending the Code of Virginia (§ 22.1-298.3) to require instructional aides working with students who have an autism spectrum disorder to receive **behavior management training** within 60 days of their assignment.
- The 2012 General Assembly also amended the Code of Virginia to add section § 22.1-129.1. This change allows school divisions that have purchased an **assistive technology device** for a student with a disability to sell, lease, donate, or loan the device. The purpose of this amendment is to enable devices that are specialized to the child to move with the child under certain circumstances or to go to a state or local agency that the student may be working with upon graduation. In support, the VDOE offers training and technical assistance regarding the role of assistive technology in improving access to the general curriculum and supporting students with disabilities in general education classrooms. Guidelines on the transfer of assistive technology were published in August of 2013 and can be found at [http://www.doe.virginia.gov/administrators/superintendents\\_memos/2013/239-13a.pdf](http://www.doe.virginia.gov/administrators/superintendents_memos/2013/239-13a.pdf).
- Proposed changes to **licensure regulations** for school personnel were presented to the Board of Education in June of 2013. The regulations are currently under the executive branch review process. Among the changes proposed is the establishment of **add-on endorsements** for special education general curriculums for K–6, middle school, and secondary teachers. The proposed endorsements are designed to increase the number of general education teachers who are knowledgeable and trained to work effectively with students with disabilities in the general education classroom. More information is available at [http://www.doe.virginia.gov/boe/meetings/2013/06\\_jun/agenda\\_items/item\\_i.pdf](http://www.doe.virginia.gov/boe/meetings/2013/06_jun/agenda_items/item_i.pdf).

- VDOE continued to improve **new teacher preparation** programs, including its **Vision Impairment Consortium** (initiated with Old Dominion, George Mason, Norfolk State, and James Madison Universities) and the **Aspiring Special Education Leaders Program**. The Aspiring Leaders program is now in its 6<sup>th</sup> cohort, training about 30 school staff per year. According to VDOE, the promotion rate of participating staff is about 25 percent. This includes teachers promoted to administrative leadership positions or lower level administrators promoted to positions of greater responsibility. A formal evaluation of the program will be coordinated with George Mason University.
- VDOE continued to work with local school divisions on the implementation of **Response to Intervention (RTI)**, which seeks, among other goals, to avoid unnecessary referrals to special education through its **Virginia Tiered System of Supports (VTSS)**. According to the *Guide for School Divisions* (2013), the goal of the model is to create a division-wide approach to systems change by improving instructional decision-making at all levels (from pre-kindergarten through 12<sup>th</sup> grade) and in the classroom through the division level. The VTSS model cannot be used to deny or delay an initial evaluation under *IDEA*. The school must make a referral for an initial evaluation whenever it is suspected that a child may have a disability to determine eligibility for special education and related services. In addition, the VTSS does not supersede or circumvent the parents' right to request an initial evaluation under *IDEA* at any time. For more information on the tiered supports, go to [http://www.doe.virginia.gov/instruction/virginia\\_tiered\\_system\\_supports/resources/vtss\\_guide.pdf](http://www.doe.virginia.gov/instruction/virginia_tiered_system_supports/resources/vtss_guide.pdf).
- VDOE developed the **Virginia Education Wizard Academic and Career Planning** online tool. Pursuant to Virginia regulations (8 VAC § 20-131-140), beginning with the 2013–2014 academic year, all schools were required to begin developing personal Academic and Career Plans for each 7<sup>th</sup> grade student with completion by the fall of the student's 8<sup>th</sup> grade year. The components of the Plan include, but are not be limited to, the student's program of study for high school graduation and a post-secondary career pathway based on the student's academic and career interests. For more information on the plans, go to [http://www.doe.virginia.gov/instruction/graduation/academic\\_career\\_plan.shtml](http://www.doe.virginia.gov/instruction/graduation/academic_career_plan.shtml).
- Tutorials were developed to help students and teachers prepare for **SOL assessments**, including tutorials for students who need additional preparation for retakes of SOL tests, which are required for high-school-verified credit courses.
- VDOE launched a new website in August of 2013 by VDOE to provide information on special education issues and practices and services for families who have children with disabilities in the Commonwealth. The new website is called the **"Virginia Family Special Education Connection"** and can be located at <http://vafamilysped.org/>.
- VDOE continued its technical assistance, data analysis, monitoring, and participation in conferences and meetings regarding the **disproportionate representation** of black males in Virginia's special education program.

- Parents and professionals were able to access training and technical assistance on how to use the **dispute resolution system**, conduct functional behavioral assessments, develop positive behavior intervention plans, and maintain effective school-wide discipline.

The **State Special Education Advisory Committee** (SSEAC) serves as an advisor to the State Board of Education and provides additional oversight for the Commonwealth's special education system. Membership is comprised of stakeholders defined by the federal Individuals with Disabilities Education Improvement Act of 2004 (IDEA) and Regulations Governing Special Education in Virginia (8 VAC § 20-80-30). SSEAC members are appointed by the Board of Education and include parents, individuals with disabilities, advocates, and representatives of public and private schools and postsecondary education, among others. A majority of members must be individuals with a disability or parents of children with disabilities who are eligible to receive services under IDEA. The SSEAC is charged with the following:

- defining plans for identifying children with disabilities;
- formulating and developing long-range plans that will provide services for children with disabilities;
- determining the unmet needs of children with disabilities within the State;
- developing priorities and strategies for meeting identified needs of children with disabilities;
- reviewing and making public comment on the State Improvement Plan, the procedures for distributing funds under Part B of IDEA, and any rules or regulations proposed by the State regarding the education of children with disabilities;
- reviewing findings and decisions regarding due process procedures for parents and children;
- advising the State in developing corrective-action plans to address issues identified in Federal monitoring reports; and
- preparing and submitting an annual report to the Virginia Board of Education.

The SSEAC's annual reports summarize each year's efforts and provide recommendations to the Board of Education. These reports are available at [http://doe.virginia.gov/boe/committees\\_advisory/special\\_ed/index.shtml](http://doe.virginia.gov/boe/committees_advisory/special_ed/index.shtml).

The *2012–2013 Virginia State Special Education Advisory Committee Annual Report* (hereafter referred to as SSEAC annual report) made the following recommendations to the Board of Education:

### **Diplomas and Assessments**

- That the VDOE increase the requirements to obtain the **Special diploma** to better support successful post-secondary outcomes in areas such as employment, education, training, and independent living.
- That the VDOE develop a guide to explain testing and its impact on **diploma options** and that the guide be required to be distributed no later than the second grade and annually thereafter.

### **Inclusive Education**

- That the VDOE create a checklist or similar document that identifies **exemplary inclusive practices** and allows schools to assess themselves in this area for the purpose of increasing the percentage of students with disabilities spending 80 percent or more of their day in a regular education setting (in line with federal OSEP Indicator 5A).
- That VDOE work to ensure that all documents and communication use **people-first language**, so that it becomes a model for localities.

### **Transition**

- That, considering the centralized location of the **Center for Transition Innovations**, the Center address the needs of all regions of the Commonwealth. In supporting the need to address transition as early as possible across all areas in a student's school career, the SSEAC recommended the exploration of diverse and coordinated fiscal resources in partnership with multiple agencies to support transition.

In its 2011–2012 report, the SSEAC recommendations focused on the VDOE implementing and supporting activities with regard to:

- preventing bullying,
- educating families on assessment decisions and diploma options,
- ensuring that students with disabilities participate in school emergency evacuation drills and safety procedures, and
- facilitating school divisions' development of strategies and plans to ensure that school playgrounds and external school property provide full inclusion and accessibility for all students, teachers, guests, and staff.

The SSEAC reports for the last two years represent a significant increase in the Committee's focus on policy and programmatic improvements. While both the 2009–2010 and 2010–2011 reports provided information on presentations received, issues reviewed, and the Committee's concerns, the SSEAC did not make any formal recommendations to the Board of Education in either of its earlier reports, a key function of the Committee as an advisory body.

Although not mandated by the IDEA, state regulations (8 VAC § 20-80-90) require that local school divisions establish **Local Advisory Committees**, referred to as either "**LACs**" or "**local**

**Special Education Advisory Committees (SEACs).**” These committees, members of which are appointed by local school boards, advise these boards in much the same way that the SSEAC advises the State Board of Education. **State-operated programs (SOPs)** do not establish LACs/SEACs but, in collaboration with an assigned subcommittee of the State Special Education Advisory Committee (SSEAC), they conduct annual reviews of their programs’ policies and procedures.

LACs or local SEACs vary greatly in their operational processes and effectiveness. Working with education and advocacy partners, the VDOE has developed tools to help ensure that LACs function in a meaningful manner. In 2011–2012, at the request of the SSEAC, VDOE’s Office of Dispute Resolution and Administrative Services conducted eight regional trainings for local special education directors and LAC chairs to educate them about the work of the SSEAC and provide an opportunity for LAC chairs to meet and network. Additional information and the referenced tools can be found at [http://www.doe.virginia.gov/boe/committees\\_advisory/special\\_ed/local\\_sped\\_advisory\\_committees/index.shtml](http://www.doe.virginia.gov/boe/committees_advisory/special_ed/local_sped_advisory_committees/index.shtml).

VDOE’s Office of Special Education and Student Services also monitors education programs in **private residential facilities** under the applicable federal and state requirements regarding the provision of special education services. At the time of this assessment, new regulations for the operation of private schools for students with disabilities were under development to provide a single set of regulations for both private day and residential schools, with a goal of greater accountability for educational programs in these settings.

The **Virginia School for the Deaf and the Blind at Staunton (VSDB-Staunton)** has a Board of Visitors in charge of school supervision, appointment and removal of officers and faculty, and certain funding initiatives. The Board of Visitors consists of 11 members, including 4 legislative members, and 7 non-legislative citizen members. One of the non-legislative members must be a parent from the eastern region of the Commonwealth, one must be a parent from the western region, and one must be a representative of the Virginia School for the Deaf and the Blind Alumni Association. The non-legislative representatives are appointed by the Governor. A VDOE staff member, appointed by the Superintendent of Public Instruction, provides the Board of Visitors with technical assistance regarding instruction, federal and state special education requirements, and school accreditation.

The **VSDB-Staunton residential program** is regulated by the Virginia Department of Behavioral Health and Developmental Services (DBHDS), while its education program remains under Virginia Department of Education (VDOE) oversight. Overall responsibility for ensuring that students are appropriately served in compliance with state and federal regulations rests with the school divisions that placed the students at VSDB-Staunton. Staff at VSDB-Staunton who teach students are licensed by the VDOE or another licensing agency appropriate to their service delivery area and, as in public school divisions, must meet the standard of “highly qualified” under the federal Elementary and Secondary Education Act (ESEA).

According to the VSDB's strategic plan for 2010 through 2012, school staff must be highly trained in the fields of deafness, blindness, and multiple disabilities. The plan notes that recruitment and retention of highly qualified staff is a continual issue due to low salaries, the specialized qualifications required to work at the school, and heavy workloads caused by staffing shortages. The plan also reports inadequate staff levels in outreach, maintenance, housekeeping, security, and interpreters. Providing sufficient training in American Sign Language (ASL) is a further challenge. Because about 94 percent of VSDB-Staunton's budget is spent on salaries, there are no funds available from other cost areas for pay increases that would encourage staff to remain at the school.

Accountability for the Department for the Blind and Vision Impaired (DBVI) Educational Services described earlier is the responsibility of the DBVI Educational Services program director who is assisted by six regional managers. Each regional manager provides direct supervision for the education coordinators. The program director and regional managers observe and evaluate staff performance, review records, and receive input from customers and consumer groups. Corrective actions resulting from a review may include individual training, casework correction, or other personnel actions.

VDOE's **Office of Dispute Resolution and Administrative Services (ODRAS)** manages a number of programs and processes, providing options for parents who are unable to resolve issues with the provision of special education services for their child at the local school division level. These include the following:

- The **Ombudsman for Special Education** serves as a resource to parents in non-legal special education matters. The ombudsman acts as an informal source of information and referral, and helps individuals to get questions answered and to resolve concerns and issues. For more information and to contact the ombudsman, go to [http://www.doe.virginia.gov/special\\_ed/resolving\\_disputes/ombudsman/index.shtml](http://www.doe.virginia.gov/special_ed/resolving_disputes/ombudsman/index.shtml).
- **Mediation** is voluntary procedure whereby a neutral, trained mediator can be sought by parents or school division staff to assist in negotiations and help reestablish productive working relationships. Both parties must agree to mediation. For more information on the role of the mediator and preparing for mediation, go to [http://www.doe.virginia.gov/special\\_ed/resolving\\_disputes/mediation/index.shtml](http://www.doe.virginia.gov/special_ed/resolving_disputes/mediation/index.shtml).
- **Complaints** are investigated by ODRAS, and valid complaints are resolved. Typically a complaint alleges a violation of state or federal law or regulations and most often involves procedural issues. However, issues related to a child's right to the provision of a free appropriate public education (FAPE) also are considered. For help or more information, go to [http://www.doe.virginia.gov/special\\_ed/resolving\\_disputes/complaints/index.shtml](http://www.doe.virginia.gov/special_ed/resolving_disputes/complaints/index.shtml).
- **Due process** involves an informal, administrative hearing process conducted before a hearing officer to resolve disagreements over issues related to a child's eligibility for special education and related services, evaluation of a child with a disability,



appropriateness of a child's services and/or placement, or any other matter under the right to a free, appropriate public education, including disciplinary matters. For help or more information, go to

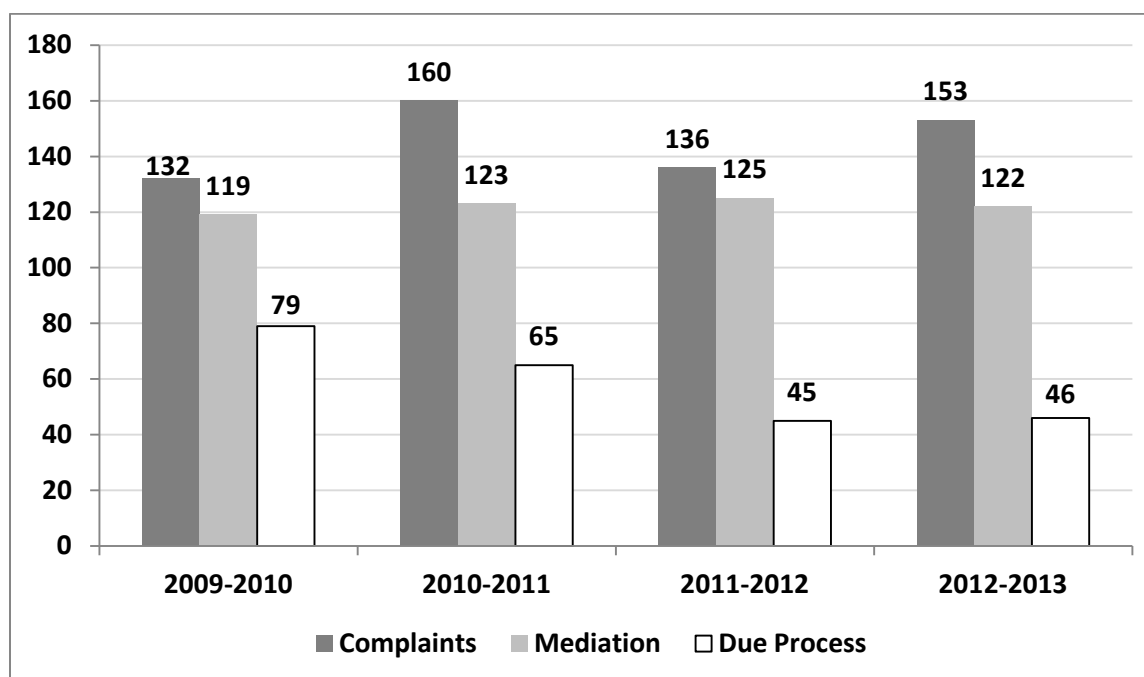
[http://www.doe.virginia.gov/special\\_ed/resolving\\_disputes/due\\_process/index.shtml](http://www.doe.virginia.gov/special_ed/resolving_disputes/due_process/index.shtml).

ODRAS also coordinates IDEA **training and parental involvement initiatives**, and responds to inquiries regarding the application of federal and state regulations that govern special education.

The *Parents' Guide to Special Education Dispute Resolution*, which was developed in 2008, helps parents navigate the intricacies of the dispute resolution system. It can be found at [http://www.doe.virginia.gov/special\\_ed/resolving\\_disputes/parents\\_guide\\_dispute\\_resolution.pdf](http://www.doe.virginia.gov/special_ed/resolving_disputes/parents_guide_dispute_resolution.pdf). Additional resources for parents seeking legal and non-legal help can be found on the VDOE website at [http://www.doe.virginia.gov/special\\_ed/resolving\\_disputes/index.shtml](http://www.doe.virginia.gov/special_ed/resolving_disputes/index.shtml).

The ODRAS produces an Annual Report on the Dispute Resolution Systems and Administrative Services that can be found at [http://www.doe.virginia.gov/special\\_ed/resolving\\_disputes/](http://www.doe.virginia.gov/special_ed/resolving_disputes/). The report identifies and addresses systemic compliance issues affecting local school divisions. While the report for 2012–2013 was not posted at the time of this assessment, the data set forth for that year had been compiled and made available to stakeholders and is included in **Figure 12**. It provides the number of complaints and requests for mediation and due process hearings that were filed by parents in each school year from 2009 through 2013.

**Figure 12. Special Education Dispute-resolution Mechanisms by School Year**



Source: Virginia Department of Education's *Annual Report of the Dispute Resolution Systems and Administrative Services*, 2008, 2009, 2010, 2011, 2012.

The number of **due process** requests has steadily decreased. Requests for hearings are down 42 percent, from 79 in the 2009–2010 school year to 46 in 2012–2013. **Mediation** requests have remained fairly steady over the same four years, but **complaints** have been more erratic. Complaints reached a high of 160 during the 2010–2011 school year, then dropped by 15 percent to 136 the following year before rising 12.5 percent to total 153 in 2012–2013. The VDOE does not know of any specific reason why complaints rose in 2012–2013. However, there are instances in which the same party or parties file multiple complaints. **Table 19** illustrates the disposition of various dispute-resolution mechanisms over the last five years.

| Table 19. Status of Special Education Complaints, Mediations, and Due Process |           |           |           |           |
|---|-----------|-----------|-----------|-----------|
| School Year   | 2009–2010 | 2010–2011 | 2011–2012 | 2012–2013 |
| Complaints  |           |           |           |           |
| Resolved through mediation or settlement                                      | 11        | 13        | 9         | 17        |
| Withdrawn   | 20        | 37        | 12        | 20        |
| Dismissed   | 2         | 1         | 1         | 38        |
| Decision/findings issued  | 99        | 88        | 101       | 61        |

| <b>Table 19. Status of Special Education Complaints, Mediations, and Due Process</b> |                  |                  |                  |                  |
|--|------------------|------------------|------------------|------------------|
| <b>School Year</b>   | <b>2009–2010</b> | <b>2010–2011</b> | <b>2011–2012</b> | <b>2012–2013</b> |
| <b>Complaints</b>  |                  |                  |                  |                  |
| <b>Pending *</b>   | <b>0</b>         | <b>21</b>        | <b>13</b>        | <b>17</b>        |
| <b>Mediations</b>  |                  |                  |                  |                  |
| <b>Resolved</b>  | <b>56</b>        | <b>68</b>        | <b>81</b>        | <b>83</b>        |
| <b>Unresolved</b>  | <b>20</b>        | <b>19</b>        | <b>26</b>        | <b>18</b>        |
| <b>Request withdrawn</b>   | <b>22</b>        | <b>24</b>        | <b>18</b>        | <b>19</b>        |
| <b>Pending *</b>   | <b>21</b>        | <b>12</b>        | <b>0</b>         | <b>2</b>         |
| <b>Due Process</b>   |                  |                  |                  |                  |
| <b>Dismissed/request withdrawn</b>   | <b>60</b>        | <b>55</b>        | <b>37</b>        | <b>35</b>        |
| <b>Decision rendered after hearing</b>   | <b>12</b>        | <b>9</b>         | <b>5</b>         | <b>6</b>         |
| <b>Decision pending *</b>  | <b>7</b>         | <b>1</b>         | <b>0</b>         | <b>5</b>         |

\* As of June 30 of the reporting year.

**Due process requests** in 2011–2012 involved 19 school divisions, down from 31 divisions in 2010–2011. Two large divisions, Fairfax and Virginia Beach, accounted for 18 (about 39 percent) of the requests. These divisions serve approximately 21 percent of the special education students in the Commonwealth.

The number of actual hearings continues to be low. There were 46 requests for due process in 2012–2013, but only 11 went to a hearing. Decisions in **due process hearings** continued to predominantly be rendered in favor of the school division. While the parent was the initiating party in all 6 cases for which a decision has been rendered, the school division prevailed in 5 of the cases. The 6<sup>th</sup> case resulted in a split decision. The number of distinct issues addressed by these cases was up significantly from 4 different issues in 2011–2012 to 16 issues in 2012–2013. The predominate issue in these cases involved the appropriateness of a student’s IEP. Decisions are pending on the 5 additional cases that went to hearing.

In 2012–2013, 35 of 46 due process requests were dismissed or withdrawn. When a due process request is dismissed or withdrawn, it can be due to mediation, a settlement agreement, or simply a request to withdraw. Cases also may be closed if a hearing officer dismisses the case for technical reasons, such as the statute of limitations running out or failure to provide sufficient notice, among other reasons.

The addition of **resolution sessions** to the due process hearing system was mandated in the 2004 amendment and reenactment of the Individuals with Disabilities Education Improvement Act (IDEA). School divisions must schedule a resolution session with parents to provide both parties with an opportunity to come to agreement over an issue. Both parties can waive resolution, opt for mediation, or chose to move forward with due process. In 2012–2013, 30 resolution sessions were held with respect to the 46 due process requests. Agreements were reached in 17 of these cases. The VDOE does not identify any trends with respect to the decrease in due process hearings. There are many reasons why the numbers of hearing requests may have decreased, including the cost of proceeding to a due process hearing, the use of resolution sessions and/or mediation, lack of knowledge about how to use dispute resolution mechanisms, or better communication in some school divisions between parents and school personnel.

With respect to **complaints**, the highest rate of noncompliance findings was for Individualized Education Program (IEP) issues. This is consistent with previous editions of this *Assessment*. There were 72 IEP issues in 2012–2013 out of 207 total complaint issues. The VDOE deemed that the school division was out of compliance in 25 issues. Of those 25 issues, 10 were in IEP implementation, and 4 were in IEP development, review, and revision. However, school divisions were found compliant in 19 IEP implementation issues, and in 24 IEP development review and revision issues.

Other key issues for which parents filed complaints included placement, parent participation in IEP meetings, extended school year, prior written notice, eligibility and evaluation procedures, and discipline. In the 2012–2013 cases where **Mediation** was sought, there was a successful outcome in 82 percent of cases, up from 76 percent the previous year.

Of the 122 requests for mediation in 2012–2013, 16 were involved in a due process proceeding. Mediation can be requested while awaiting a due process hearing with no negative effect on due process timelines. There were 189 issues addressed through mediation that were related to IEPs. The predominant issues involved the sufficiency and type of services in the IEP, the child’s placement, and IEP goals. These issues are typical in the sense that they have been fairly consistently raised since 2008–2009.

The VDOE is in the process of developing a **facilitated IEP model**. Details on this program will be developed in the next several years. While not directly related to dispute resolution, it is hoped that the presence of an impartial facilitator to help guide some IEP meetings (this individual would not be a member of the IEP team) might help prevent and resolve IEP issues. Stakeholders are being involved in the development of this improvement process.

## F. 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. Websites Referenced

### **Auditor of Public Accounts**

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

### **Commonwealth Autism Service**

<http://www.autismva.org>

Legislative Information System: Code of Virginia §§ [22.1-253.13:4](#)

<http://lis.virginia.gov/cgi-bin/legp604.exe?000+coh+22.1-253.13:4+500268>

### **Joint Legislative Audit and Review Commission**

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

### **US Department of Health and Human Services**

Administration for Children and Families

<http://www.acf.hhs.gov>

Office of Head Start

<http://www.acf.hhs.gov/programs/ohs/>

### **Virginia Autism Council**

<http://www.autismtrainingva.org>

### **Virginia Commonwealth University Autism Center for Excellence**

<http://www.vcuautismcenter.org>

### **Virginia Department for the Blind and Vision Impaired**

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

### **Virginia Department of Education**

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

Dispute Resolution

[http://www.doe.virginia.gov/special\\_ed/resolving\\_disputes/index.shtml](http://www.doe.virginia.gov/special_ed/resolving_disputes/index.shtml)

Early Childhood

[http://www.doe.virginia.gov/special\\_ed/early\\_childhood/index.shtml](http://www.doe.virginia.gov/special_ed/early_childhood/index.shtml)

**ESEA Flexibility**

[http://www.doe.virginia.gov/federal\\_programs/esea/flexibility/index.shtml](http://www.doe.virginia.gov/federal_programs/esea/flexibility/index.shtml)

**Grants and Funding**

[http://www.doe.virginia.gov/special\\_ed/grants\\_funding/index.shtml](http://www.doe.virginia.gov/special_ed/grants_funding/index.shtml)

**Information for Parents**

[http://www.doe.virginia.gov/special\\_ed/reports\\_plans\\_stats/index.shtml](http://www.doe.virginia.gov/special_ed/reports_plans_stats/index.shtml)

**I'm Determined Project**

<http://www.imdetermined.org>

**Monitoring and Part B**

[http://www.doe.virginia.gov/special\\_ed/monitoring/index.shtml](http://www.doe.virginia.gov/special_ed/monitoring/index.shtml)

**Regulations, Laws and Policies**

[http://www.doe.virginia.gov/special\\_ed/regulations/index.shtml](http://www.doe.virginia.gov/special_ed/regulations/index.shtml)

**Secondary Transition**

[http://www.doe.virginia.gov/special\\_ed/transition\\_svcs/index.shtml](http://www.doe.virginia.gov/special_ed/transition_svcs/index.shtml)

**Section 504**

[http://www.doe.virginia.gov/special\\_ed/tech\\_asst\\_prof\\_dev/section\\_504\\_implementation\\_va.pdf](http://www.doe.virginia.gov/special_ed/tech_asst_prof_dev/section_504_implementation_va.pdf)

**Special Education**

[http://www.doe.virginia.gov/special\\_ed/index.shtml](http://www.doe.virginia.gov/special_ed/index.shtml)

**Special Education Child Count**

[http://www.doe.virginia.gov/special\\_ed/reports\\_plans\\_stats/child\\_count/index.shtml](http://www.doe.virginia.gov/special_ed/reports_plans_stats/child_count/index.shtml)

**Specific Disabilities**

[http://www.doe.virginia.gov/special\\_ed/disabilities/index.shtml](http://www.doe.virginia.gov/special_ed/disabilities/index.shtml)

**State Special Education Advisory Committee**

[http://www.doe.virginia.gov/boe/committees\\_advisory/special\\_ed/index.shtml](http://www.doe.virginia.gov/boe/committees_advisory/special_ed/index.shtml)

**Statistics and Reports**

[http://www.doe.virginia.gov/special\\_ed/reports\\_plans\\_stats/index.shtml](http://www.doe.virginia.gov/special_ed/reports_plans_stats/index.shtml)

**Testing and Standards of Learning**

<http://www.doe.virginia.gov/testing/index.shtml>

**Virginia Family Special Education Connection**

<http://vafamilysped.org/>

**Virginia Preschool Initiative**

[http://www.doe.virginia.gov/special\\_ed/disabilities/index.shtml](http://www.doe.virginia.gov/special_ed/disabilities/index.shtml)

**Virginia Department for Aging and Rehabilitative Services**

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

**Virginia Department of Social Services**

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

**Head Start**

<http://www.dss.virginia.gov/family/cc/headstart>

**Virginia Head Start Association**

<http://www.headstartva.org>

**Virginia School for the Deaf and the Blind at Staunton**

<http://vsdb.k12.va.us/>

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### III. Employment

#### A. Introduction to Vocational Rehabilitation and Other Employment Services

According to the US Department of Labor's Bureau of Labor Statistics (BLS), in 2012 the employment rate for people with a disability who are ages 16 through 64 was 27.7 percent, compared to 70.9 percent for those without a disability. These employment rates, also known as the "proportion of the population employed" or the "employment population ratio," have declined for both groups since 2009 when 29.7 percent of people with a disability were working and 77.8 percent of those without a disability were employed.

In 2012, the unemployment rate for people with disabilities was 14.8 percent, compared to 7.4 percent for people without disabilities. These numbers are lower than they were in 2009 when 15.6 percent of people with disabilities were unemployed as were 9.2 percent of those without disabilities. Unemployment rates are determined based on the number of individuals who are jobless, looking for work, and available for work. The 2009 rates represented the first annual statistics available on the **employment status of persons with a disability**.

The BLS obtained data to calculate these statistics using the monthly *Current Population Survey (CPS)*. The survey collects employment and unemployment information from a sample of approximately 60,000 households in the United States. Questions in the *CPS* identify persons with a disability in the civilian, non-institutionalized population who are age 16 and over. The *CPS* considers individuals to have a disability if they have **a physical, mental, or emotional condition that causes serious difficulty with daily activities**. The following insights are highlights from the BLS' June 12, 2013 news release on *Persons with a Disability Labor Force Characteristics—2012*:

- For all age groups, the employment rate was much lower for persons with a disability than for those with no disability.
- The unemployment rate for persons with a disability declined from 2011 to 2012, as did the rate for persons without a disability.
- In 2012, 33 percent of workers with a disability were employed part time, compared with 19 percent of those with no disability.
- Employed persons with a disability were more likely to be self-employed than those with no disability.

The ***American Community Survey***, a large continuous demographic survey by the US Census Bureau that profiles communities each year, also collects employment data on people with and without disabilities. In this survey, like the *CPS*, people are determined to have disabilities if they have long-lasting physical, mental, or emotional conditions or limitations that affect their

ability to perform major life activities. Nationally, the survey for 2011 reported that 6.5 million or 32.6 percent of the 19.9 million individuals with disabilities who were between the ages of 18 and 65 and living in their communities were employed. For the comparable population of individuals without disabilities, 72.8 percent (127.4 million) of 174.9 million individuals were employed. The employment rate for people with disabilities was highest in North Dakota (49.8 percent) and lowest in West Virginia (24.3 percent).

According to the *2012 Annual Disability Statistics Compendium*, in 2011 only 33.4 percent (150,089) of the 458,657 individuals with disabilities in Virginia were employed while 76 percent (3.5 million) of the 4.6 million Virginians without disabilities were working. The gap between the employment rates for Virginians with and without disabilities was 42.6 percentage points. The national average **employment gap for people with disabilities** was 40.2 percent in 2011.

Employees with disabilities are a rich talent pool that is often overlooked. When employers hire individuals with disabilities, they discover untapped skills, talents, and abilities. Employers gain workers who are qualified, have a strong work ethic, are dependable, and are likely to stay on a long-term basis. These workers contribute to the economy, are self-sufficient, and are committed to their jobs. Furthermore, they are subject to the same performance standards as all other employees.

The Virginians with Disabilities Act (Code of Virginia § 51.5-1) states that,

*It is the policy of this Commonwealth to encourage and enable persons with disabilities to participate fully and equally in the social and economic life of the Commonwealth and to engage in remunerative employment.*

Under this statute, the General Assembly directs state agencies to provide the services necessary to ensure equal employment opportunities to Virginians with disabilities. Currently, there are some exciting employment initiatives in Virginia.

In August 2008, the **US Department of Justice (DOJ)** initiated an investigation of the Central Virginia Training Center (CVTC) pursuant to the Civil Rights of Institutionalized Persons Act (CRIPA). In April 2010, the DOJ notified the Commonwealth that it was expanding its investigation to focus on Virginia's compliance with the Americans with Disabilities Act (ADA) and the US Supreme Court's 2009 *Olmstead* ruling. The *Olmstead* decision requires that individuals be served in the **most integrated settings appropriate** to meet their needs consistent with their choice. In February of 2011, the DOJ submitted a summary of findings to Virginia, concluding that the Commonwealth failed to provide services to individuals with intellectual and developmental disabilities in the most integrated settings appropriate to their needs. In addition, the findings stated that

*the State appears to be overly reliant on segregated, sheltered workshops and day programs that offer little opportunity for real community integration, even*



*though the State also offers more integrated supported employment opportunities.*

The resulting **Settlement Agreement** entered into by the DOJ and the Commonwealth includes a strong focus on employment. (Other aspects of the Agreement are covered in the relevant chapters of this *Assessment*.) The Agreement requires that the Commonwealth, to the greatest extent possible, provide individuals in the target population who receive services under the Agreement with integrated day opportunities, including supported employment. The Settlement also requires the Commonwealth to maintain its membership in the State Employment Leadership Network (SELN) and to establish a state policy on **Employment First** for the target population.

An Employment First policy includes individual supported employment in integrated work settings as the first and highest priority service option for individuals with intellectual or developmental disabilities. This includes individuals currently receiving day program or non-competitive employment services from or funded by the Commonwealth. It also sets forth an important expectation that service providers working with students who are transitioning from secondary school must focus on supporting employment in integrated work settings where individuals are paid minimum or competitive wages.

In 2009, the Virginia Department of Behavioral Health and Developmental Services' (DBHDS) Office of Developmental Services joined the **State Employment Leadership Network (SELN)**, a cross-state cooperative of agencies serving individuals with intellectual disabilities (ID) and other developmental disabilities (DD). This network helps those agencies enhance their states' capacity to develop, implement, and support effective, integrated employment initiatives that improve employment outcomes for individuals with ID/DD.

In 2010, DBHDS issued a strategic plan entitled *Creating Opportunities: A Plan for Advancing Community-Focused Services in Virginia* that identified a number of targeted initiatives that DBHDS would address. This strategic plan was the groundwork for implementation of the DOJ Settlement plan and can be found at <http://www.dbhds.virginia.gov/CreatingOpportunities/Backgrounder.pdf>.

Under this plan, DBHDS spearheads a statewide Employment First initiative that promotes integrated, competitive employment as an option before day support or other services for individuals with developmental and other disabilities are considered. From 2011 to 2013, DBHDS and DARS conducted a statewide awareness and education campaign to implement an Employment First policy statewide. Through multiple regional trainings and statewide summits, technical assistance was provided to organizations, including Community Service Boards (CSBs) and Employment Support Organizations (ESOs). These trainings will continue in 2014.

**Executive Order No. 55 (EO 55)** was signed in November 2012 by then Governor McDonnell. EO 55 directs the relevant agencies to work together to better promote the benefit of employing individuals with disabilities. The order called upon the Virginia Workforce Council

to work in conjunction with the Virginia Employment Commission (VEC), the Workforce Development Services Division of the Virginia Community College System (VCCS), the Departments for Aging and Rehabilitative Services (DARS), Blind and Vision Impaired (DBVI), Veterans Services, Behavioral Health and Developmental Services (DBHDS) and other experts in the employment of persons with disabilities. The goal is to identify and develop strategies for expanding the employment of individuals with disabilities in the Commonwealth's private sector.

A kick-off summit was held in June of 2013 to introduce EO 55 to key stakeholders: state agencies and the Virginia Workforce Council. Between September and December of 2013, eight regional workshops were held to educate private and public sector employers on the benefits of hiring and accommodating people with disabilities in the workplace and connecting employers to the regional points of contact for information and service coordination.

The most recent report of the Court appointed Independent Reviewer acknowledged the Commonwealth's efforts in the area of employment and found it to be in compliance with requirements to participate in the SELN and with respect to the provision of regional trainings (28 trainings were provided to more than 500 individuals). The Reviewer also found the Commonwealth to be in compliance with the provision of employment-related baseline information and the setting of employment-related targets. The Commonwealth did not provide supported employment earnings information and was out of compliance in that area. A Reviewer finding on whether targets were appropriate or being met as determined by Regional Quality Councils was deferred, as it was not able to take place within the quarter addressed by the June 6 report.

There are many employment initiatives within the State to address multiple populations beyond the Settlement Agreement population. There are a number of new transition services and employment initiatives in the Commonwealth that support the Employment First policy. **Project SEARCH** is an innovative high school transition program that meshes workforce and career development for Virginia youth with intellectual and developmental disabilities. Through a partnership between Virginia Commonwealth University's Research Rehabilitation Training Center, the Department for Aging and Rehabilitative Services (DARS), the Virginia Department of Education (VDOE), and several public school divisions, nearly 90 students participated in Project SEARCH in 2012–2013 school year in 11 locations throughout Virginia, including multiple hospitals.

The goal for student participants, who are typically in the last year of their special education programs, is full-time employment earning at least minimum wage and benefits. The program provides up to three, 10-week long, real-world work internships that are based on the students' interests and combined with training in employability and independent living skills. Project SEARCH is conducted in a classroom at a host business to help youth with significant disabilities make successful transitions from school to living productive adult lives. In many cases, students are offered full-time jobs with their host hospital, the Project SEARCH site, or in local businesses nearby. In state fiscal year (SFY) 2013, five Project SEARCH sites placed more than 60 percent of

their Project SEARCH interns in competitive jobs. DARS expended \$425,627 on Project Search from vocational rehabilitation (VR) grant funds in SFY 2013.

In SFY 2014, Project SEARCH involves approximately 15 local field offices from DARS, the Virginia Department of Education (VDOE), 17 local school divisions, and is hosted by 13 hospitals—all of which came together in a partnership to implement this unique team approach to transition services. Each site has enrolled approximately 8 to 12 student interns and is staffed by an instructor from the local school system and at least one full-time job coach from a local Employment Service Organization (ESO) to meet the education and on-the-job training needs of the students.

Virginia Commonwealth University's (VCU's) Department of Physical Medicine and Rehabilitation, in collaboration with DARS, has implemented a study to determine the efficacy of a nine-month hospital-based internship intervention for transitioning young adults with Autism Spectrum Disorders (ASDs). The internship program, **School 2 Work**, is based on the Project SEARCH model and is currently being tested and evaluated in a randomized clinical trial at two Bon Secours Hospitals in Richmond, Virginia. VCU is replicating this intervention in two new Virginia hospitals: Bon Secours Maryview Medical Center in Portsmouth and Bon Secours Memorial Regional Medical Center in Hanover. The intervention consists of two components: (1) 900 hours of onsite training over 9 consecutive months at the host hospital site; and (2) training and support provided by employment specialists with expertise in autism, applied behavior analysis, supported employment, and business networking.

The current Bon Secours, St. Mary's Hospital site in Richmond, will serve as the study's hub program for expanded data collection, training, and support of the two replication sites. DARS will partner with the project by assisting with enrollment and placement of the participants.

In an effort to support the Commonwealth's implementation of the DOJ Settlement Agreement and the Employment First policy, in June of 2013, the Virginia Board for People with Disabilities (VBPD) awarded a two-year grant to VCU Rehabilitation Research & Training Center for **Employment for All Citizens of The Arc of Southside**. The grant is being used to convert the Hatcher Employment Program, a sheltered workshop administered by The Arc of Southside, to a community-integrated employment program focused on competitive employment outcomes.

The initiatives above are just a small sample of the publicly funded employment services available in Virginia to assist individuals with disabilities in acquiring the knowledge and skills required to obtain, maintain, and advance in employment. Some innovative and successful projects are improving employment outcomes for Virginians with disabilities. However, a broader and more comprehensive employment policy that benefits all individuals with disabilities is needed.

The employment rate for individuals with disabilities in Virginia has been flat at approximately 33 percent for many years. This is slightly higher than the national average of 27.9 percent. As stated in the **Education** chapter, the Virginia Department of Education's data

show that 38 percent of students with disabilities are not in higher education or competitive employment one year post high school. It also shows that 28 percent of students with disabilities are not in higher education, other post-secondary education, a training program, competitive employment, or some other type of employment one year after high school. As too many people remain unemployed, the Order of Selection imposed by DARS, due to insufficient funds, limits access to employment services for individuals with disabilities.

The remainder of this chapter presents specific employment services for individuals with disabilities, as well as services that educate employers about the valuable pool of workers with disabilities and help them make reasonable accommodations for employees who need them. Employment services, most of which are time limited, encompass a wide range of activities such as vocational counseling and guidance, education, vocational training, work skills development, assistive technology, and job development and placement. These services are designed to focus on abilities and skills, rather than disabilities, and to promote choice and self-determination with respect to job training and employment options.

The employment programs and services described in this chapter are organized according to four primary programs that assist individuals with disabilities:

1. Virginia's vocational rehabilitation programs,
2. the Virginia Workforce Network,
3. federal Work Incentive Programs, and
4. Home and Community Based Services (HCBS) Waivers.

Two agencies located within the Health and Human Resources Secretariat have the lead responsibility for **vocational rehabilitation (VR) services** in Virginia under the federal Rehabilitation Act of 1973, as amended (PL 93-112). This statute authorizes grants to states for employment-related services for eligible individuals with disabilities and gives priority to those categorized as having the most significant disabilities. The **Department for Aging and Rehabilitative Services (DARS), Division of Rehabilitative Services** is responsible for providing vocational rehabilitation services for individuals with disabilities unless the individual has a primary disability of blindness, vision impairment or deafblindness. In that case, the **Department for the Blind and Vision Impaired (DBVI)** provides vocational rehabilitation services. The Code of Virginia (§ 51.5-60 et seq.) prescribes the responsibilities and duties of the DBVI. The responsibilities of DARS are prescribed in Code of Virginia (§ 55.5-117 et seq.).

## **B. Department for Aging and Rehabilitative Services Vocational Rehabilitation**

The mission of the Department for Aging and Rehabilitative Services (DARS) is to work in partnership with people with disabilities and their families and to collaborate with the public and private sectors to provide and advocate for the highest quality services, including

vocational rehabilitation services that empower individuals with disabilities to **maximize their employment, independence, and full inclusion** into society. DARS has numerous public and private partners. These include, but are not limited to, state agencies such as the Virginia Department of Education (VDOE), the Department of Behavioral Health and Developmental Services (DBHDS), and the Department of Social Services (DSS). They also include Employment Service Organizations (ESOs) [also referred to as Community Rehabilitation Programs (CRPs)], Community Services Boards (CSBs), Centers for Independent Living (CILs), local school divisions, and institutions of higher education.

The federally mandated State Rehabilitation Council provides advice and guidance to DARS on its vocational rehabilitation and supported employment programs. The Employment Service Organization Advisory Council provides advice on supported employment services, and the Long-Term Employment Support Services Steering Committee provides advice and guidance on long-term support programs.

## **1. Screening and Eligibility for DARS VR Services**

The *VR Policy & Procedure Manual* on the DARS website identifies the steps in its vocational rehabilitation process, including but not limited to: referral procedures, the application process, eligibility, assessment, vocational evaluation, and job placement. The policy manual can be found at <http://www.vadars.org/frsmanual.asp>.

To be eligible for vocational rehabilitation services from DARS, an individual must:

1. have a physical, mental, or emotional disability that constitutes a substantial impediment to employment;
2. require vocational rehabilitation services to prepare for, secure, or regain employment;
3. be able to benefit from vocational rehabilitation services; and
4. be legally eligible to work in the United States and be present in the state.

Individuals receiving Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) benefits are presumed to be eligible for rehabilitation services if they intend to work.

## **2. Access to and Use of DARS VR Services**

Vocational rehabilitation (VR) services are delivered to eligible individuals by DARS through 35 local field offices across Virginia. Vocational rehabilitation counselors at these offices determine an applicant's eligibility for services. Counselors work with eligible recipients to develop an agreed upon **Individualized Plan for Employment (IPE)** that includes services necessary for achieving and/or maintaining employment. Vocational services may be provided directly by the counselors or by public and private service providers.

The IPE is reviewed at least annually and is amended as needed. Service recipients may be required to contribute to the cost of certain services based on DARS' financial participation

policy. Diagnostic, evaluation, counseling, and similar services are available at no cost to applicants and eligible individuals. Consideration of comparable benefits and alternate sources of funding may be required for certain services. Other services, such as assistive technology, are exempt from the comparable benefit requirement.

When DARS is unable to serve all eligible customers because of insufficient resources, an **Order of Selection**, based on relative need for services, must be implemented. When an Order of Selection is in effect, DARS must give the highest priority for service to individuals categorized as having the most significant disabilities. The individual's placement in a priority category is determined after eligibility for vocational rehabilitation services is established. Individuals in closed categories are provided referral services to the One-Stop Workforce Centers or other appropriate resources and are placed on a waiting list until resources allow the category to be opened.

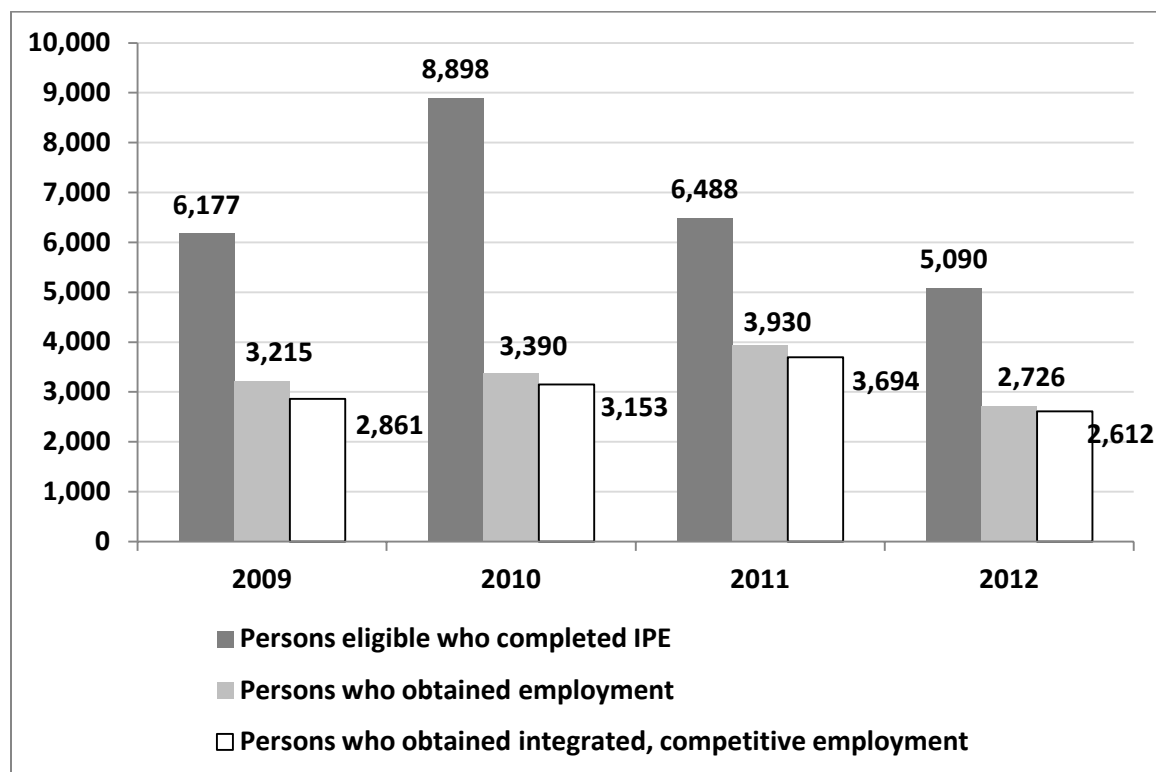
Since 2011, DARS has only had sufficient funds to serve those in Category 1: Most Significantly Disabled. Effective February 14, 2014, DARS announced that it had sufficient funds available to serve all eligible individuals in Category 2: Significant Disabilities. At the time of this assessment, DARS was continuing to serve people in both Categories 1 and 2, but Categories 3 and 4 remained closed with all those individuals on a waiting list.

The DARS state rehabilitation annual reports provide information on the number of individuals served in the VR system and those who obtain employment. The number served reached a high of 32,143 people in federal fiscal year (FFY) 2010. In FFY 2012, the most recent year for which data were available, the total number served stood at 28,889. The total number of individuals served refers to those who received some level of service (intake, assessment, developed a plan, participated in vocational rehabilitation services, etc.). According to DARS information, an average of 75 percent of its VR service recipients are in Category 1: Most Significantly Disabled.

**Figure 13** shows the number of eligible individuals who completed an Individual Plan for Employment (IPE), the number who achieved employment, and the number placed in **competitive employment** (in an integrated setting in the community and being paid at least minimum wage). The total number of individuals who completed an Individualized Employment Plan (IPE) has decreased steadily since FFY 2010, due in large part to implementation of the Order of Selection and funding issues.

The total number of those who obtained integrated, competitive employment dropped 8.7 percent between FFYs 2009 and 2012 and 29 percent from FFY 2011 to 2012. This was not unexpected based on the economic problems facing Virginia and the nation. In a positive trend, in FFY 2009, 89 percent of those employed obtained integrated, competitive employment. In FFY 2012, that figure increased to 96 percent. Although the overall number of people who obtained employment was lower between FFY 2009 and 2012, the percentage of those who achieved competitive employment has increased from 89 percent to 96 percent.

**Figure 13. Individuals receiving Vocational Rehabilitation Services and those who Obtained Employment**



Source: Department for Aging and Rehabilitative Services, *State Rehabilitation Council Annual Report* (2009, 2010, 2011, and 2012).

### 3. Available DARS VR Services

Services identified in the Individualized Plan for Employment (IPE) may include the following:

- Vocational and career guidance and counseling;
- Evaluations to determine vocational rehabilitation needs;
- Job and behavioral skills training and postsecondary education;
- Job search and placement assistance;
- Communication accommodations, when they are not available from another legally obligated source;
- Assistive telecommunications, sensory, and other technological aids and devices;
- Rehabilitation technology services, including assistive technology devices as well as home, vehicle, and workstation modifications;
- Tools, equipment, and occupational licenses not typically provided by an employer;

- Transportation and personal assistance services needed to participate in DARS services;
- Medical services not otherwise covered by insurance that are needed to be employed;
- Unpaid work experience; and
- Postemployment services.

The list above is not all inclusive. Additional services may be provided as required by an individual's IPE, and services vary between programs.

#### 4. Cost and Payment for DARS VR Services

DARS and the Department for the Blind and Vision Impaired (DBVI) receive state and federal funds to support vocational rehabilitation activities. Federal funds are provided by the **Rehabilitation Service Administration (RSA)** within the US Department of Education. The RSA provides grant funds both on a formula and on a discretionary basis. The federal Rehabilitation Act Title I and Title VI grant programs, which provide funds for employment-related services for individuals with disabilities, require state matching funds. State General Funds supply this match, underwrite administrative costs, and pay for various DARS state-funded programs, such as Personal Assistance Services, Long-Term Rehabilitation Case Management Services, Long-Term Employment Support Services, and others. DARS also receives federal Title VI funds for its Supported Employment Services. Funding for Long-Term Employment Support (follow along) Services is distributed among approved Employment Service Organizations (ESOs).

Approximately \$67 million was expended in state fiscal year (SFY) 2013 on vocational rehabilitative services. This includes the federal VR grant and state funds. The figures in **Table 20** provide the number of participants in the basic VR program for SFY 2013. Funding includes personal, non-personal, and case service expenditures. (See **Table 21** for specialized VR programs that are also funded by the federal VR grant and state funds.) Figures for the VR program and specialized programs may overlap because people who apply for vocational rehabilitation services may also be eligible for other DARS services.

| Table 20. DARS Vocational Rehabilitation Program |               |              |             |
|--|---------------|--------------|-------------|
| State Fiscal Year                                | Number Served | Waiting List | Total Funds |
| 2013   | 28,113        | 1,144        | \$17,379,27 |

Source: Department for Aging and Rehabilitative Services.

#### 5. Monitoring, Evaluation and Outcomes of DARS VR Services

The commissioner of DARS is responsible for oversight of the agency's vocational rehabilitation program and ensuring compliance with both federal (34 CFR § 361.1, et seq.) and state (22 VAC § 30-20-10 to 200) regulations. Specific federal performance Standards and Indicators (34 CFR § 361.80-89) have been established by the national **Rehabilitation Services**



**Administration (RSA)**, US Department of Education, Office of Special Education and Rehabilitative Services.

DARS is required to submit a number of monitoring and evaluation reports to the RSA. Quarterly RSA 113 Reports include the number of applicants, the number of people determined eligible for services, the number on waiting lists under the Order of Selection, the number and types of case closures, and other data. The annual RSA 911 Report contains raw, detailed demographic data on the number and type of vocational rehabilitation case closures, and the RSA A2 Report describes budget expenditures for different services.

The RSA conducts Section 107 Monitoring and Technical Assistance Reviews to ascertain whether the DARS vocational rehabilitation program meets its federal goals and objectives. If DARS is found to be noncompliant with RSA performance Standards and Indicators, its vocational rehabilitation program must develop and implement a performance improvement plan consistent with the RSA's recommendations for improvement.

In April, 2011, DARS submitted a **corrective action plan** to the Rehabilitation Services Administration (RSA) to address noncompliance findings from the March 2011 RSA report on their 2010 review of DARS' vocational and supported employment programs. On October 3, 2012, the RSA determined that DARS had met the criteria for affirming that the corrective actions resolved all of the FFY 2010 findings of noncompliance that were identified in the 2011 report and covered in the corrective action plan.

DARS is currently under a **performance improvement plan** for not meeting RSA standards and performance indicators for FFY 2012. DARS will be relieved of the obligation to submit a performance improvement plan once it meets all RSA Standards and Indicators for two successive years. Preliminary figures show that DARS met these requirements for FFY 2013.

The DARS state agency strategic plan includes agency goals, objectives, and performance measures. Annual evaluations of vocational rehabilitation counselors are based, in part, on individual objectives tied to these performance measures. If individual objectives are not met, appropriate corrective actions occur. In addition, case audit reviews of sample cases are conducted to ensure that appropriate policies and procedures are being followed and that high quality services are being provided.

DARS also conducts an annual survey of its clients to determine their level of satisfaction with the services they received. According to the Virginia State Rehabilitation Council's *Annual Report of 2012*, in FFY 2011, the overall satisfaction rate for rehabilitated and non-rehabilitated vocational service recipients was 77 percent. Of those employed, 83 percent expressed satisfaction with their jobs. Ninety percent of service recipients continue to have a fairly strong belief that DARS staff treats them well. Additionally, 83 percent agreed that they would tell a friend to go to DARS for services, and 81 percent indicated that they would definitely come back to DARS if they needed additional help.

## C. DARS Specialized Vocational Programs

Descriptions of some specialized programs operated within the overall DARS vocational rehabilitation program follow. Additional information on them, and all DARS services, is available at <http://www.vaDARS.org>, the DARS central office, or any of its local field offices.

### 1. Screening and Eligibility for DARS Specialized Programs

Specialized programs use the same screening and eligibility process as the basic vocational rehabilitation program administered by DARS. An individual must have a physical, mental, or emotional disability that constitutes a substantial impediment to employment; require vocational rehabilitation services to prepare for, secure, or regain employment; and be able to benefit from vocational rehabilitation services. In addition, the individual must be legally eligible to work in the United States and be present in the State. Individuals receiving Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) benefits are presumed to be eligible for VR services if they intend to work.

### 2. Access to and Use of DARS Specialized Programs

Individuals with a serious mental illness may receive services from the **DARS Serious Mental Illness Program** staff. Individuals with developmental disabilities and substance abuse disorders are excluded from these services unless they have been diagnosed with a co-occurring serious mental illness. DARS counselors with special training in this area are assigned to 11 local Community Services Boards (CSBs) and provide vocational rehabilitation services to eligible individuals from those localities.

Similarly, DARS counselors with special training in substance abuse provide vocational rehabilitation services as a part of treatment programs operated by 18 CSBs. The **DARS Substance Abuse Program** is operated jointly with the Department of Behavioral Health and Developmental Services (DBHDS) and local CSBs. It provides VR services for individuals who are actively involved in alcohol or substance abuse treatment or who have completed treatment.

In other areas of the State, services are provided to persons with serious mental illness and substance abuse problems by vocational rehabilitation counselors at local DARS field offices as part of their general caseloads. Participants in these specialized services may be referred to DARS by CSBs or directly by family members, physicians, and others. The DARS specialty counselors do not provide different services for their respective populations; rather, they have specialized technical expertise based on their experience, knowledge, and training in their specialty area.

The **DARS Deaf and Hard of Hearing Program** works in partnership with the Virginia Department for the Deaf and Hard of Hearing (VDDHH), the Department for the Blind and Vision Impaired (DBVI), and the Department of Behavioral Health and Developmental Services' (DBHDS) Program for Individuals Who Are Deaf, Hard of Hearing, Late Deafened, and Deafblind. These agencies collaborate to provide vocational rehabilitation services for individuals with

these specific disabilities. The four agencies have established both a Statewide Interagency Team and regional teams to address gaps in services and to strengthen agency programs. Information on related services provided by the VDDHH, including assistive technology, outreach, and sign language interpreters, can be found in the **Community Living Supports** and **Health Care** chapters of this *Assessment*.

The DARS Deaf and Hard of Hearing Program provides VR services for persons who are deaf, hard of hearing, late deafened, or deafblind. Ten regional vocational rehabilitation counselors and staff at Woodrow Wilson Rehabilitation Center's (WWRC) Special Population Services Unit who are fluent in American Sign Language (ASL) ensure communications access for people who are deaf and hard of hearing. In all other respects, access to and delivery of services through this program are the same as for other DARS vocational rehabilitation services.

DARS has vocational rehabilitation clients who are recipients of **Temporary Assistance to Needy Families (TANF)**. The General Assembly appropriates funds to DARS for specialized employment services for TANF recipients with disabilities, and DARS works in close partnerships and financial agreements with state and local social services agencies. Currently, DARS has grant funding from the Virginia Department of Social Services (DSS) to support three vocational rehabilitation counselors with dedicated TANF caseloads. These counselors serve Fairfax County, the city of Alexandria, the city of Charlottesville and its surrounding counties, the city of Richmond, Henrico County, and Chesterfield County. All of these areas have a high volume of TANF cases.

Clients are referred to statewide DARS field offices by their respective local DSS offices, and services are provided by first utilizing any available grants that include funds for case services. TANF clients are required to be gainfully employed or face the possibility of losing their TANF benefits, so DARS services are valued. General caseload counselors are strongly encouraged to work closely with the TANF recipient's case manager to gain additional insight into the individual's needs, to share the cost of service provision, and to coordinate services more effectively.

**DARS Supported Employment Services** are provided to individuals with the most significant disabilities (federal Category 1) who require ongoing workplace supports. Ongoing support services are generally provided by employment specialists who are associated with DARS-approved vendors. These specialists typically provide initial job skills training on an intensive, one-to-one basis and gradually decrease supports as individuals become more proficient. Supported Employment Services are usually limited in duration to 18 months or less. After that period, if needed, the individual may transition to **Extended Employment Services (EES)** or **Long-Term Employment Support Services (LTESS)** provided through **Employment Service Organizations (ESOs)**. Individuals may also transition to Medicaid **Home and Community Based Services (HCBS) Waiver supports**, if applicable. (Information on the HCBS supports begins on page 151 of this *Assessment*.)

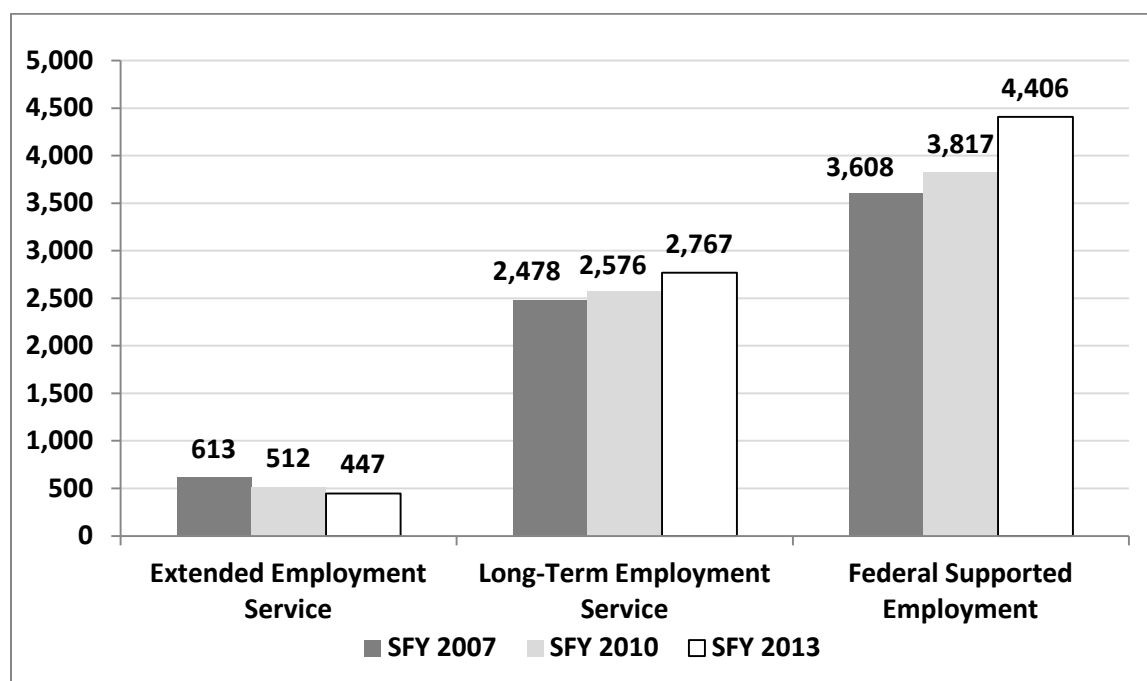
Neither EES nor LTESS are time-limited, and both enable individuals with disabilities to maintain employment. Through EES, Employment Service Organizations (ESOs) provide structure, supervision, and supports in the following settings:

- an individual, supported employment job;
- an enclave or mobile crew; or
- a facility-based (sheltered) workshop.

LTESS, usually referred to as long-term **“follow-along services,”** are provided after time-limited Supported Employment Services sponsored by DARS are completed. LTESS services can only be provided to individuals employed in an integrated, competitive work setting. Through LTESS, ESOs provide a full array of employment services, including the individually supported, facility based, enclave, and mobile crew models. Of the more than 2,700 people served through LTESS funds, 80 percent earn at or above minimum wages in their jobs.

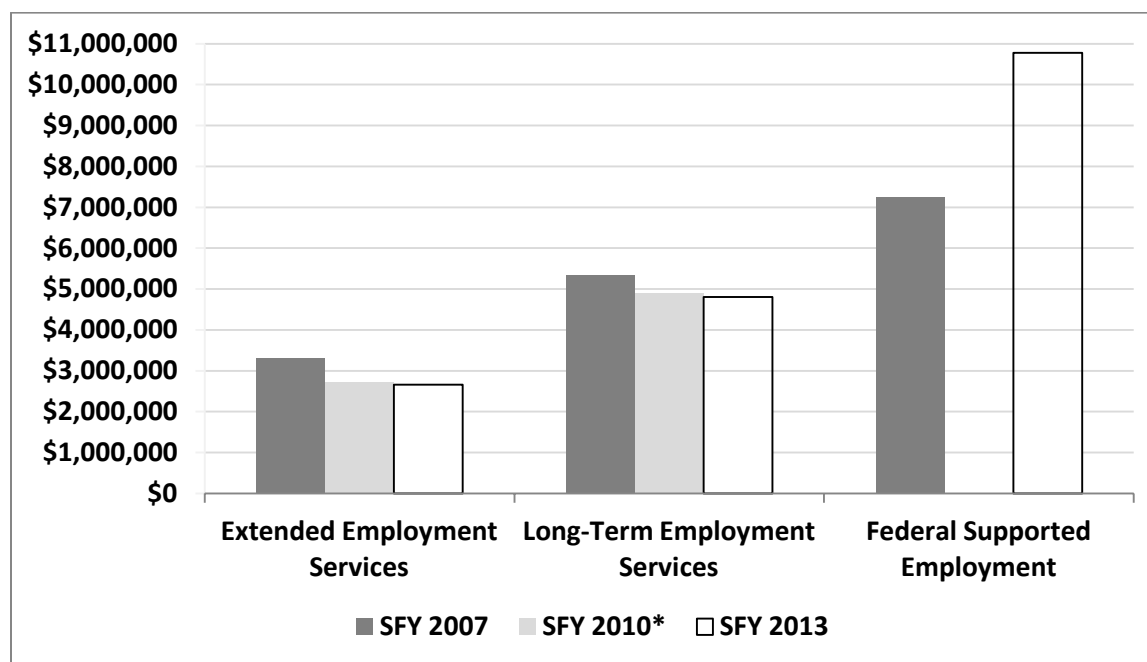
**Figure 14** provides the number of individuals served in selected years by the federal grant for supported employment and by the state-funded Extended Employment Services (EES) and Long-Term Employment Services (LTESS) sponsored by DARS. It shows that 27 percent fewer people received services through state-funded EES services in SFY 2013 as compared with 2007. EES program funding decreased 19.6 percent over those years. (See **Figure 15.**) The number of people working in integrated, competitive jobs who were served through state-funded LTESS increased 11.6 percent, comparing SFY 2007 to SFY 2013, although there was a 10-percent decrease in funding. The number of people served in the federal supported employment program increased 22 percent from 3,608 in SFY 2007 to 4,406 in 2013; however, there was a near 50-percent increase in federal funding over those same years.

**Figure 14. Number Served by State and Federal Employment Support over Time**



Source: Department for Aging and Rehabilitative Services. Note that figures for 2007 and 2010 came from the 2008 and 2011 editions of this *Assessment* but were originally provided by DARS.

**Figure 15. Total Employment Support Funds by SFY**



\* In 2010, the data provided did not disaggregate the federally supported employment program from the vocational rehabilitation program as a whole.

Source: Department for Aging and Rehabilitative Services. Note that figures for SFY 2007 and SFY 2010 came from the SFY 2008 and 2011 editions of this *Assessment* but were originally provided by DARS.

### 3. Available DARS Specialized Programs

DARS counselors in the **Serious Mental Illness Program** and **Substance Abuse Program** provide services in ways that respond to the special needs of their respective target populations. Vocational rehabilitation counselors, drawing on their specialized training and expertise, partner with local Community Services Boards (CSBs) to focus services on vocational development, work habits, job readiness, and employment follow-along.

In addition to providing direct services for eligible individuals, vocational rehabilitation counselors in the DARS **Deaf and Hard of Hearing Program** are involved in community outreach and education, providing technical assistance to organizations involved with job training, job placement, and employment of persons with hearing loss.

To help them sustain employment once their DARS cases are closed, participants in the **TANF** Program work with both DARS vocational rehabilitation counselors and local social services caseworkers. DARS counselors coordinate their vocational rehabilitation services while social services caseworkers assist them with other transportation, child care, food stamps, and other benefits and supports.

Specialists who work for DARS-approved vendors provide ongoing **Supported Employment Services** including job site training, transportation, family supports, and other services necessary to provide and maintain employment for persons with severe disabilities in integrated and competitive work settings. Initial supports must include at least twice monthly contacts between a specialist and supported employee and, to create a system of natural supports within the workplace and community, may also include services provided by skilled job trainers, co-workers, or other qualified individuals.

To ensure job retention in supported employment placements, DARS may use funds from LTESS to purchase ongoing support services. LTESS job coaches provide direct, face-to-face supports with supported employees and their employer, and follow up at least monthly with telephone calls and other communications to ensure job retention and compliance with supported employment program requirements.

### 4. Cost and Payment for DARS Specialized Programs

**Table 21** provides an overview of the number of individuals served by program, the number on the waiting list, and the total funds for SFY 2013.

| Table 21. DARS Specialized Employment Services by Program or Service for SFY 2013 |               |              |             |
|---|---------------|--------------|-------------|
| State Funded Specialized Programs:  | Number Served | Waiting List | Total Funds |
| Extended Employment Services  | 447           | 0            | \$2,658,198 |

| Table 21. DARS Specialized Employment Services by Program or Service for SFY 2013 |               |              |              |
|---|---------------|--------------|--------------|
| State Funded Specialized Programs:  | Number Served | Waiting List | Total Funds  |
| Long-Term Employment Support Services   | 2,767         | 0            | \$4,809,292  |
| Federal Funded Specialized Programs:  | Number Served | Waiting List | Total Funds  |
| Services to Individuals with Serious Mental Illness <sup>A</sup>                  | 6,065         | 824          | \$4,043,910  |
| Substance Abuse Services <sup>B</sup>   | 3,194         | 546          | \$1,526,893  |
| Deaf and Hard of Hearing Program <sup>C</sup>                                     | 1,572         | 217          | \$2,226,035  |
| Temporary Assistance to Needy Families Program <sup>D</sup>                       | 1,050         | 148          | \$630,945    |
| Supported Employment <sup>E</sup>   | 4,406         | 0            | \$10,779,919 |

A. This is for client case services expenditures paid from the federal Rehabilitation Act, Title I, Section 110 grant funds.

B. This funding is for client case services expenditures paid from federal Section 110 grant funds. The total funds also include a *Memorandum of Understanding* with the DBHDS totaling \$195,541.

C. Funding for the DHH Program includes only case services dollars from federal Section 110 grant funds.

D. Funding is for personal and case services, some of which also includes federal Section 110 grant funds.

E. This includes federal Title I funding and Title VI (\$497,133) funding.

## 5. Monitoring and Evaluation of DARS Specialized Programs

The specialty vocational rehabilitation (VR) counselors who provide services for clients through the **Serious Mental Illness Program** are directly supervised by the manager of their respective field offices and also receive indirect and programmatic supervision from the program specialist for serious mental illness. To monitor service quality and effectiveness, the program specialist makes regular site visits to the local Community Services Boards (CSBs) that participate in this program, and compiles statistical summaries of the employment outcomes and expenditures for case services. In addition, statewide meetings are convened several times a year to strengthen programming and enhance the consistency of services offered across the State. Similar quality control procedures apply to the **Substance Abuse Program**.

The program specialist for the DARS **Deaf and Hard of Hearing Program** is responsible for the quality and effectiveness of its services, and in general, oversight practices are the same as for other DARS specialty programs. The program specialist also holds periodic community meetings to obtain direct feedback from service recipients, and program staff participates in quarterly meetings to receive ongoing training and to address service issues to enhance service delivery to this population.

Standard oversight practices apply to the TANF Program. Program specialists use site-monitoring visits to provide technical assistance, training, and other guidance to the staff of the

collaborating local social services departments. DSS conducts onsite audits of these local departments to monitor their fiscal management of TANF funds.

DARS maintains formal vendor agreements with ESOs that outline specific expectations and standards for Supported Employment Services. In addition, ESOs must be accredited by the national **Commission on Accreditation of Rehabilitation Facilities (CARF)**. Program accreditation must be reviewed and renewed by CARF every three years. When applicable, ESO vendor agreements also include specific standards for the provision of EES and LTES. These programs are further monitored through a quality assurance review developed by DARS in cooperation with the **DARS Employment Services Organizations Advisory Committee**.

The DARS **Office of Technology and Employment Support Services** is responsible for the Department's specialty programs and works within the Field Rehabilitation Services Division to ensure the overall quality and effectiveness of service delivery.

## **D. Additional DARS Employment Programs and Services**

In 2007, DARS developed and implemented the **Work Incentive Specialist Advocates (WISA)** program. This program augments the **Work Incentives Planning and Assistance (WIPA) Program** to increase the use of existing Social Security Administration (SSA) work incentives by Virginia's vocational rehabilitation services recipients. There are 47 WISAs providing assistance to Ticket to Work recipients who are eligible to use work incentive programs such as Medicaid While Working (1619b), the Student Earned Income Exclusion, the Impairment Related Work Program, and the Plan for Achieving Self-Support. (More information on Ticket to Work and other federal work incentives begins on page **144** of this chapter.) An additional 30 people are participating in the training process to become fully credentialed WISAs. From October 1, 2012, through February 21, 2014, DARS has paid for 924 WISA services to 28 different vendors for vocational rehabilitation service recipients. In addition, there are currently 383 WISA services that have been authorized and are in process for vocational rehabilitation service recipients. During this time period, a total of 1,483 clients have been referred for WISA services.

**WISAs** are trained and certified by DARS. Once qualified, WISAs apply to provide work incentives services for vocational rehabilitation (VR) customers as DARS vendors. WISAs must abide by DARS standards for such providers and must agree to accept the agency's fees for work incentives services. During this reporting period, two additional WISA services have been approved and are currently being used by VR service recipients. The new WISA services address overpayments and the process of obtaining a Benefits Planning Query (BPQY) from the Social Security Administration. From FFY 2013 through February 21, 2014, 1,483 individuals were served through the program, with a cost of \$387,550 from the vocational rehabilitation grant.

DARS also administers the web-based **WorkWORLD HELP/Information System** and **WorkWORLD for the Web**. The WorkWORLD HELP/Information System is a comprehensive compilation of topics related to federal and state work incentives and benefits. The software is



a useful resource for people with disabilities, advocates, work incentive and benefit counselors, and others seeking help to find employment-based paths that lead to higher net income through the best use of federal and state work incentives and benefits. Users can access information by clicking on items in the system's table of contents, index, or by using a search function to find information by a word or phrase. The Help/Information System's extensive hyperlinks allow users to jump back and forth between related topics. It is at <http://wwhelp.wwrc.net/>.

The HELP/Information System can be used alone or concurrently with WorkWORLD for the Web, a separate application that takes into account the complex interaction of earnings, benefit programs, and work incentives to provide individualized recommendations for safe options as well as alerts to possible problems. WorkWORLD for the Web calculates the effects on net income of trying different paths to independence, and provides text, numeric, and graphic results.

WorkWORLD was initially developed by the Employment Support Institute (ESI) at Virginia Commonwealth University (VCU) with funding from the federal Social Security Administration (SSA). The program has been continuously enhanced and updated over 13 years and now contains more than 4,400 topics with 26,000 hyperlinks and over 10,000 keywords (index topics).

The WorkWORLD HELP/Information System is currently maintained through a partnership of state agencies in Virginia: the Department for Aging and Rehabilitative Services (DARS), the Virginia Board for People with Disabilities (VBPD), the Virginia Department of Education (VDOE), the Department of Behavioral Health and Developmental Services (DBHDS), and the Department of Social Services (DSS).

**WorkWORLD for the Web (WW-Web):** The current version of the software is designed for Virginians with disabilities who receive or are applying for any or all of the following benefits:

- Supplemental Security Income (SSI)
- Social Security Disability Insurance (SSDI)
- Medicaid
- Medicare

WW-Web assists in determining what will happen to a recipient's benefits if he or she earns different amounts using the various "work incentives" that the benefit programs provide, so they can find a safe path toward more financial independence—a path in which the recipient keeps the benefits needed until the need for those benefits can be reduced or eliminated. The site is at <http://workworld.wwrc.net/pages/home>.

## E. Woodrow Wilson Rehabilitation Center Vocational Rehabilitation

The **Woodrow Wilson Rehabilitation Center (WWRC)** is a part of the Department for Aging and Rehabilitative Services (DARS). Located in Fishersville, Virginia, its mission is to provide people with disabilities comprehensive, individualized services to realize personal independence through employment. This includes specialized vocational rehabilitation services in both residential and outpatient settings.

### 1. Screening and Eligibility for WWRC VR Services

To be eligible for vocational rehabilitation services from DARS' Woodrow Wilson Rehabilitation Center (WWRC), an individual must meet the specific criteria listed below, and primary consideration is given to DARS vocational rehabilitation clients working under an Individualized Plan for Employment (IPE).

- Applicants must be medically, physically, and psychologically stable and have a favorable prognosis for completing and benefiting from the services requested. Current documentation may be requested from physicians, mental health professionals, or other professionals providing treatment or diagnostic services.
- Applicants with a psychiatric diagnosis must show a minimum of six consecutive months of stability in the community. Exceptions to this requirement may be considered if the applicant is willing to participate in an outpatient evaluation at WWRC to determine feasibility for services and admission contingencies.
- Applicants with a history of substance abuse must have at least six consecutive months of documented abstinence or demonstrated completion of intense substance abuse treatment and active participation in a substance abuse aftercare program. Participation in only Twelve Step support groups does not meet this requirement. As above, exceptions may be considered if the applicant is willing to participate in an outpatient evaluation at WWRC to determine feasibility for services and admission contingencies.
- Applicants' current behavior will not jeopardize the health and safety of themselves or others at WWRC and must not disrupt the rehabilitation programs.

Applicants must be 18 years of age or older to be admitted for residential services. WWRC programs specifically targeted to youth, such as the transition programs discussed in the **Education** chapter of this *Assessment*, are exceptions to this rule.

- Applicants must be willing and able to comply with WWRC community living standards (rules and regulations).
- Applicants must have a viable discharge plan, developed in collaboration with their referral source, for community reintegration services that address residential options as well as support service needs.

- Applicants must have an identified funding source. All funding sources (Medicare, Medicaid, Anthem, and any other third-party insurers) must be identified, even if the applicant is being sponsored by DARS.
- Applicants who have any outstanding court charges must have them settled prior to seeking admission. Those with cases pending adjudication by the judicial system will not be considered. WWRC is not an alternative placement option.

## 2. Access to and Use of WWRC VR Services

WWRC provides vocational rehabilitation and employment services for individuals with disabilities in both residential and outpatient settings. Once enrolled in a WWRC program, a client is assigned a WWRC rehabilitation counselor who provides case management and guidance for the client, his or her sponsor, and family while the client remains in the WWRC program. The WWRC counselor coordinates implementation of the service plan (IPE) agreed upon by the individual with a disability and his or her DARS counselor prior to WWRC enrollment and approves expenditures of DARS funds for services during the client's training period.

The WWRC and local DARS counselors stay in close contact throughout the client's stay and discuss any needed changes to the program of services. Throughout the program, the WWRC counselor also works closely with the client and his or her rehabilitation team to develop plans for transition back into the community at the conclusion of training.

## 3. Available WWRC VR Services

The ultimate goal for each student at WWRC is the successful use of independent living and work skills in his or her home community. Following initial student and sponsor consultations, WWRC Vocational Evaluation Services offers a comprehensive and systematic process to identify and assess vocational interests, abilities, strengths, weaknesses, aptitudes, and functional limitations related to a student's preferred rehabilitation and employment goals. The evaluation report is used to develop a holistic service plan that will maximize the student's potential for successful, sustained employment.

While not strictly an employment program, the WWRC **Life Skills Transition Program's** pre-employment activities build the independent living skills needed to maintain successful employment. It is part of a comprehensive approach to teaching individuals the job of daily life and living with others within WWRC's living and learning residential environment. The program takes advantage of the social aspects of campus life and provides activities on and off campus to assess needs and provide instruction across five domains.

1. **Pre-employment skills:** basic work behaviors, attitudes, and habits; job seeking skills; basic customer service and effective communication with others; and vocational exploration
2. **Basic workplace literacy:** reading, math, GED assessment, and skill development

3. **Interpersonal skills:** disability awareness, self-advocacy, interpersonal communication, initiative and dependability, anger management, conflict resolution, self-esteem, and self-confidence
4. **Independent living skills:** money management, clothing care, time management, route finding and information seeking, personal health care, and healthy relationships
5. **Leisure skills:** exploration of interests and community resources

WWRC **Vocational Skills Training Programs** prepare individuals with disabilities for competitive entry-level employment in more than 100 occupational career fields. Training is offered onsite at WWRC, through the community-based External Training Option Program in surrounding geographic locations, and through distance education courses for selected information technology careers. A student internship program provides opportunities to determine if trainees are job ready, and academic support services, such as GED preparation and trade-related academic instruction, are also available.

To promote positive work environments and change negative attitudes toward people with disabilities in the workplace, DARS staff at WWRC conducts **Corporate Disability Awareness Training** for employers. These free programs dispel misconceptions and teach best practices for working with people who have disabilities. Topics covered include individual attitudes and perceptions toward people with disabilities, historical and societal perspectives, research and statistics, the Americans with Disabilities Act (ADA), resources for more information, and practical tips on interviewing, accommodating, and communicating with employees with disabilities.

#### 4. Cost and Payment for WWRC VR Services

As shown in **Table 22**, the WWRC program for VR had an average cost of about \$8,422 per person served in SFY 2013, up 8.6 percent from SFY 2010 when the average cost per person was \$7,754.

| Table 22. Expenditures and Numbers Served at Woodrow Wilson Rehabilitation Center by SFY |               |              |              |
|--|---------------|--------------|--------------|
| State Fiscal Year  | Number Served | Waiting List | Total Funds  |
| 2013   | 2,706         | 400          | \$22,790,083 |
| 2010   | 3,074         | 400          | \$23,838,295 |

Note: Capital expenditures to maintain the campus are funded in a separate budget and not shown.  
Source: The Department for Aging and Rehabilitative Services.

#### 5. Monitoring and Evaluation of WWRC VR Services

Vocational training programs at the WWRC are formally accredited by the **Accrediting Commission of the Council on Occupational Education**, which conducts Accreditation Team site visits every six years. In addition to the typical DARS oversight mechanisms described

above, WWRC distributes an annual report to the general public and provides annual outcome data to its accrediting organization, the state Department of Planning and Budget, and the state Workforce Investment Board.

WWRC also collects satisfaction information from sponsors who refer individuals for its employment services. A computer-based survey is sent out to each sponsor after case closures for clients receiving vocational rehabilitation, rehabilitation counseling, and life skills transition services. Questions cover the usefulness of vocational evaluation recommendations, overall case management satisfaction, and the timeliness of reports. Additional consumer satisfaction surveys and focus groups of service recipients provide WWRC with their comments and suggestions for improvements.

## **F. Department for the Blind and Vision Impaired Vocational Rehabilitation**

Under the federal Rehabilitation Act of 1973 (as amended PL 93-112), the Department for the Blind and Vision Impaired (DBVI) has the lead responsibility for vocational rehabilitation services in Virginia for individuals with a primary disability of blindness, vision impairment, or deafblindness. DBVI's mission is to empower these individuals to achieve their maximum level of education, employment, and personal independence.

### **1. Screening and Eligibility for DBVI VR Services**

To be eligible for DBVI vocational rehabilitation services, an individual must be blind or have a visual impairment that interferes with finding or maintaining employment and must require vocational rehabilitation services to prepare for, secure, or regain employment. DBVI defines blindness, visual impairment, and deafblindness under the Code of Virginia (§ 51.5-60), which is as follows.

#### **Blindness**

*An individual having not better than 20/200 central visual acuity in the better eye measured at twenty feet with correcting lenses or having visual acuity greater than 20/200 but with the widest diameter of the visual field in the better eye subtending an angle of no greater than twenty degrees, measured at a distance of thirty-three centimeters using a three-millimeter white test object, or a Goldman III-4e target, or other equivalent equipment. Such blindness shall be certified by a duly licensed physician or optometrist.*

#### **Visual Impairment**

*An individual with (1) 20/100 to 20/200 distance vision in the better eye with correcting glasses or a field limitation to 30 degrees or less in the better eye, if the person has been unable to adjust satisfactorily to the loss of vision and needs the specialized services available through DBVI Vocational Rehabilitation Program, or (2) night blindness or a rapidly progressive eye condition that, in the*

*opinion of a qualified ophthalmologist, will reduce the distance vision to 20/200 or less.*

### **Deafblind**

*An individual with a combination of blindness and a chronic hearing impairment so severe that most speech cannot be understood with optimum amplification or progressive hearing loss having a prognosis leading to this condition and for whom the combination of impairments cause extreme difficulty in attaining independence in daily life activities, achieving psychological adjustment, or obtaining a vocation.*

VR services, including those provided by the **Virginia Rehabilitation Center for the Blind and Vision Impaired (VRCBVI)** in Richmond, are available to eligible individuals ages 14 or older. Services provided by other DBVI programs are available to individuals of all ages. Additional information regarding other DBVI programs and services may be found in the **Community Living Supports** and **Health Care** chapters of this *Assessment*.

As noted above for DARS VR services, individuals seeking VR services from the DBVI who are receiving Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) benefits are presumed to be eligible for services if they intend to work. Individuals must also be legally eligible to work in the United States and be living or working in Virginia or moving to the State.

DBVI's partners in these efforts include individuals who are blind and vision impaired, their families, local school systems, Community Rehabilitation Providers (also called Employment Services Organizations), Community Services Boards (CSBs), the Department for Aging and Rehabilitative Services (DARS), and the Department of Behavioral Health and Developmental Services (DBHDS). The DBVI also partners with the DBVI State Rehabilitation Council, the Statewide Independent Living Council, Virginia Industries for the Blind, the DBVI Board for the Blind and Vision Impaired, and consumer advocacy groups.

## **2. Access to and Delivery of DBVI VR Services**

Eligibility is determined and vocational rehabilitation (VR) services are delivered through six regional DBVI offices across the state. Additional prevocational and adjustment to blindness services are provided in a residential setting at the VRCBVI in Richmond. After VR services, individuals may be eligible to receive supported employment or long-term follow-along supported employment services once their VR cases are closed.

Procedures for access and delivery of DBVI VR services are similar to those described above for the DARS. VR counselors partner with individuals who are blind, deafblind and visually impaired to develop and implement an Individualized Plan for Employment (IPE) based on the individual's abilities, needs, and choices. IPEs are reviewed by the individual and the VR Counselor at least once a year and are updated as appropriate.

Diagnostic and evaluation services, guidance and counseling, and similar services are free of charge for eligible applicants. Other services may be provided based on financial need and a service recipient's financial contribution may be based on his or her resources. Consideration of comparable benefits and alternate funding sources are required for most services. Vocational guidance and counseling, evaluation, reader services, and assistive technology services are among those that do not require comparable benefits consideration.

DBVI operates under an **Order of Selection**, meaning that if the agency has insufficient funds to serve all individuals, those with the most significant disabilities are served first. DBVI's Order of Selection has three categories based on the individual's disability, functional limitations, and duration of services. Since January of 2010, all three categories have been open, and DBVI has been serving all individuals who meet the basic VR eligibility criteria.

In addition to VR, DBVI provides comprehensive programs and services to eligible individuals, including orientation and mobility, low vision, deafblind services, education services, rehabilitation engineering (services to design, test, and adapt technology solutions for persons with disabilities), and rehabilitation teaching. Details on access to and delivery of services vary by program. Specific information may be obtained at <http://www.vdbvi.org> or by contacting the DBVI central office in Richmond or any of its six regional offices. Additional information on DBVI programs related to **Community Living Supports** and **Health Care** services can be found in those chapters of this *Assessment*.

DBVI also operates a **Library and Resource Center** adjacent to the VRCBVI in Richmond and has affiliated libraries at other locations statewide. Another component of the DBVI is its Enterprise Division, which includes the Virginia Industries for the Blind (VIB) and entrepreneurial opportunities through the Business Enterprise Program (BEP), also known as the Randolph-Sheppard program.

**Virginia Industries for the Blind (VIB)** operates two manufacturing facilities, one in Richmond and one in Charlottesville, in addition to service and supply operations across the state in federal government buildings and on military bases. VIB also provides key opportunities to eligible individuals, including transitional employment, situational assessment, summer work for transition-age students, and marketable skill development.

The **Business Enterprise Program (BEP)** program trains eligible individuals as food service managers who will manage vending facilities across the state. These opportunities may generate jobs for other blind individuals in areas where they rarely existed in the past, and it is anticipated that such opportunities will continue to increase.

### 3. Available DBVI VR Services

The basic list of vocational rehabilitation services and supports described in the **Available DARS VR Services** section of this chapter are also provided by the DBVI for those with visual impairments. Other services provided by the DBVI include independent living skills training specific to its target populations and access to specialized equipment to enhance personal

responsibility and independence. The DBVI helps people with partial sight to learn how to fully utilize their remaining vision, creates employment for individuals with vision impairment, and provides special library materials in recorded and other accessible formats.

Services provided at the VRCBVI in Richmond include prevocational training in personal adjustment and independent living skills, use of adaptive computer equipment, and preparation for competitive employment. VRCBVI evaluates trainees' potential for employment as vending stand operators in the BEP program. Participants in residential programs typically remain at the Center for three to four months, but the training period is flexible and based on need.

In addition to the vocational rehabilitation services described above, DBVI provides transition services to eligible **students transitioning** from school to postsecondary activities, including higher education and employment. Transition consultation is provided through cooperative agreements between the DBVI and public school divisions, formally referred to as **local education agencies (LEAs)**. LEAs have primary responsibility for transition services under the federal Individuals with Disabilities Education Improvement Act (IDEA). A student who is found eligible to receive vocational rehabilitation services must be provided those services in accordance with an Individualized Plan for Employment (IPE).

Additional information on the role of the DBVI in planning for and providing transition services may be found in the **Education** chapter of this *Assessment*. Since the DBVI's role in coordinating education services for students with visual impairments begins well before the start of transition services, information on related vision services may also be found in the **Early Intervention** chapter of this *Assessment*.

#### 4. Cost and Payment for DBVI VR Services

**Table 23** shows the number of individuals served and the total cost of vocational rehabilitation services for the Department for the Blind and Vision Impaired's VR program during federal fiscal year (FFY) 2013. This includes a portion of the services provided at the VRCBVI in Richmond, which also serves individuals participating in other DBVI programs. A comparison of previous fiscal years is not possible because the data provided in previous years were not consistent with the data provided in 2013 in terms of what was covered by the expenditures.

| Table 23. Number Served and Expenditures by the DBVI for FFY 2013 |              |             |
|---|--------------|-------------|
| Number Served   | Waiting List | Total Funds |
| 1,449   | 0            | \$3,027,957 |

Source: The Department for the Blind and Vision Impaired, AWARE case management system.



## **5. Monitoring and Evaluation of DBVI VR Services**

Federal **Rehabilitation Services Administration (RSA)** reporting, monitoring, performance evaluation, and corrective processes for DBVI's vocational rehabilitation programs are equivalent to those for DARS. The DBVI's commissioner is responsible for oversight of the agency and its compliance with federal regulations (34 CFR § 361.1 et seq.) and the Code of Virginia (§ 51.5-60 et seq.). RSA performance Standards and Indicators (34 CFR § 361-80-89) also apply.

DBVI's most recent RSA Section 107 Monitoring and Technical Assistance Review occurred in 2010. The RSA's resulting report, available at <http://www.rsa.ed.gov>, identified compliance findings and corrective actions that DBVI was required to undertake. The DBVI state agency strategic plan includes its goals, objectives, and performance measures. The DBVI's annual evaluations of its vocational rehabilitation counselors are based, in part, on individual objectives tied to these measures. The deputy commissioner, vocational rehabilitation director, agency analysts, and regional managers monitor case activities at the state and local level. At the state level, the DBVI vocational rehabilitation director is responsible for direct monitoring of the VR programs. DBVI's headquarters staff reviews case work by regional offices annually and conducts telephone and mail surveys to determine recipients' satisfaction with the services they received.

DBVI provides individuals receiving VR services with the opportunity to participate in a customer satisfaction survey. For the 2013 federal reporting year, 337 customers completed their DBVI VR program; 31 of those were unreachable due to relocation, incorrect contact information, or had recently been deceased. Of the 306 contactable customers, 68 (22 percent) responded either by phone (4 percent), by mail (90 percent) or by online survey (6 percent).

Among the responding customers, 79 percent rated their overall satisfaction with the VR services they received from the DBVI as either "satisfied" or "very satisfied"; 13 percent rated their overall satisfaction as "dissatisfied" or "very dissatisfied"; and 8 percent rated their overall satisfaction as "neither satisfied nor dissatisfied." For delivery of VR services and service items in a timely manner, 87 percent of customers were "satisfied" or "very satisfied"; 9 percent were "dissatisfied" or "very dissatisfied"; and 4 percent were neutral. In addition, survey results indicated 40 (59 percent) of the respondents reported that they were currently employed; 14 (21 percent) reported that they were seeking employment; 9 (13 percent) indicated they were unemployed but function better as a homemaker; and 5 (7 percent) described that they are not seeking employment or other circumstances exist.

## **G. Virginia Workforce Centers**

A variety of programs are funded under the federal Workforce Investment Act (WIA) (PL 105-220). The mission of Virginia's WIA program is to improve the quality of the State's workforce, reduce welfare dependency, and enhance the productivity and competitiveness of the Commonwealth. It supports workforce investment activities, through statewide and local

systems, that increase employment, retention, earnings, and occupational skills of participants. The **Virginia Workforce Network** is the “brand” name for Virginia’s WIA-funded activities and its system of “one-stop” career centers known as **Virginia Workforce Centers**.

The Governor of Virginia, or a designee from the Governor’s office, serves as the State’s Chief Workforce Development Officer (Code of Virginia §§ 2.2-435.6 and 2.2-435.7). The Virginia Workforce Council advises the Governor on workforce training matters and serves as the State’s Workforce Investment Board (Code of Virginia § 2.2-2669). The Virginia Community College System (VCCS) is the state agency with primary responsibility for coordinating workforce training at the postsecondary-to-associate-degree levels. It also provides staffing for the Virginia Workforce Council, and administers the WIA program in Virginia.

The Virginia Workforce Network is comprised of multiple state-administered workforce development programs and services, including vocational rehabilitation and services provided by the **Virginia Employment Commission (VEC)** among others. The VEC promotes economic growth and stability by delivering and coordinating workforce services and, as specified by the Code of Virginia (§ 60.2-113), its responsibilities encompass **Job Seeker and Employer Services** for all Virginians, including those with disabilities. These include policy development, job placement services, temporary income support, workforce information, and transition and training services for displaced workers.

The WIA requires programs administered by the federal Departments of Labor, Education, Health and Human Services, and Housing and Urban Development to participate in One-Stop Workforce Centers. Participation by additional partners, such as the Virginia Department for Aging and Rehabilitative Services (DARS) and Department for the Blind and Vision Impaired (DBVI), is encouraged. The Virginia Employment Commission’s (VEC) Job Seeker and Employer Services are available universally to anyone eligible to work in the United States and are the same for people with and without disabilities. There are no income, geographic, or other restrictions to receiving these services.

## **1. Screening and Eligibility for Virginia Workforce Center Programs**

To be eligible for Workforce Investment Act **Title I adult programs**, an individual must:

1. be at least 18 years of age;
2. have the right to work in the United States; and
3. be registered with military Selective Service, if male.

Participants in **youth programs** must:

1. be low-income; and
2. have at least one identified barrier to employment.

Dislocated workers are those who are unemployed through no fault of their own, such as plant closures, layoff events, and other related circumstances.

Employers, workers, and job seekers are all customers of the **One-Stop Workforce Centers**. This includes businesses, students, people with disabilities, veterans, Temporary Assistance for Needy Families (TANF) recipients, migrant and seasonal farm workers, unemployed, underemployed, and employed individuals. Eligibility for services, however, can vary. For example, a Supplemental Security Income (SSI) beneficiary with a Ticket to Work may be able to use the ticket for services only if his or her Workforce Center is a participant in a Ticket to Work Employment Network as described beginning on page **144** of this chapter.

## **2. Access to and Use of Virginia Workforce Centers**

There are also levels of services available through the One-Stop Workforce Centers and, depending on their needs, customers may move from one level to the next or receive services from more than one level. Core services, such as access to computers and other equipment, and assistance with job searches, are available for all customers and are self-directed. Intensive training and career education is contingent upon the provider's eligibility requirements and available funding. For additional information, local One-Stop Workforce Centers should be contacted directly. Contact information is available at <http://vwn.vccs.edu/job-seekers/one-stop-centers/>.

Multiple One-Stop Workforce Centers operate in 15 local Workforce Investment Board areas across the State. They simplify access by bringing employment services from multiple providers together under one roof. Each One-Stop provides a single point of access for a wide array of job training, education, and employment services designed to meet the unique needs of their local community. One-Stops also provide employers with a single point of contact where they can list job opportunities and provide information about current and future skills needed by their workers.

The Workforce Investment Act (WIA) requires that One-Stop customers with disabilities have equal access to services and that One-Stops be physically and programmatically accessible. During SFY 2013, approximately 9 percent of new enrollees in WIA Title I programs (1,240 out of 14,076) identified themselves as having a disability. Self-reporting is the only manner in which disability information is captured, and this data represents only one of multiple programs operating within the One-Stop system.

## **3. Available Virginia Workforce Center Services**

Multiple agencies partner to provide services through One-Stop Workforce Centers. Core services include public outreach; initial assessments of workers' skill levels, aptitudes, abilities, and supportive service needs; job search and placement assistance; career counseling; various group workshops; and labor market information. More intensive services can include comprehensive and specialized assessments, development of an Individualized Plan for Employment (IPE), individual and group counseling and career planning, case management for

participants seeking training services, and short-term prevocational services. For those still unable to find employment, direct occupational training services are available. Additional information is available at <http://vwn.vccs.edu/job-seekers/one-stop-centers/>.

#### 4. Cost and Payment for Virginia Workforce Centers

Implementation of the Workforce Investment Act (WIA) is supported by federal funds received from the US Department of Labor. For state fiscal year (SFY) 2013, \$35,505,206 was expended to provide services for 14,673 Virginians, with and without disabilities. Costs were not tracked separately for participants with disabilities.

#### 5. Monitoring and Evaluation of Virginia Workforce Centers

As required by the national Workforce Investment Act (WIA), the **Virginia Workforce Council (VWC)** assists the Governor in developing a five-year strategic plan detailing how Virginia will meet the requirements of this statute and how special populations will be served. VWC membership includes representatives from organized labor, the business community, the Virginia Community College System (VCCS), local governments, and the General Assembly, as well as the Secretaries of Commerce and Trade, Education, and Health and Human Resources (HHR). There is no requirement for VWC membership to include people with disabilities; however, the Secretary of HHR represents the Department for Aging and Rehabilitative Services (DARS), the Department for the Blind and Vision Impaired (DBVI), and the Department of the Deaf and Hard of Hearing (DDHH), which are members of that secretariat.

As the state's WIA administrative agency, the VCCS ensures that the Commonwealth complies with all applicable federal and state laws and regulations. Fifteen local **Workforce Investment Boards (WIBs)**, each serving a designated area, work with the VWC and the VCCS to guide operations of the state's One-Stop Workforce Centers. Community representation varies between WIBs. It is based on local needs and services but typically includes area employers, educational institutions, labor unions, economic development agencies, One-Stop partners including the DARS and the DBVI, and other community-based organizations. The local WIBs provide a forum to ensure that workforce training and employment initiatives meet local economic development and business needs. The VCCS conducts annual reviews of WIB activities, the delivery of services by the One-Stops and youth programs, and the management of WIA funds.

To ensure that hard-to-serve populations, including people with disabilities, are served, the VWC's **One-Stop Committee** is responsible for:

- reviewing and proposing changes to the certification process for the One-Stops,
- developing a certification and credentialing course for their staffs,
- strengthening their overall accessibility survey process, and
- finding ways to increase the number of General Educational Development (GED) certificates acquired by One-Stop customers in the pursuit of their employment goals.

There are approximately 35 comprehensive One-Stops in Virginia. Some need to be certified for the first time, and others need to be recertified.

To become certified, the VWC requires One-Stops to be physically and programmatically accessible. The Council's **One-Stop Committee** has discussed changes to strengthen the certification process by increasing the frequency of accessibility surveys conducted by DARS and the other disability services agencies. In addition, the process will include participation by individuals with disabilities. DARS, in partnership with the **Disability Program Navigator** initiative and other interested agencies and organizations, will be instrumental in writing an up-to-date accessibility policy and protocol to be used as part of the One-Stop certification process. VCCS is in the process of hiring a One-Stop services coordinator whose responsibilities will include a lead role in certifying One-Stops, and DARS will collaborate closely with that coordinator on accessibility certification standards.

The WIA also requires that the Workforce Investment Boards (WIBs) negotiate an annual agreement with the State on individual performance measures covering services for adults, minors, and dislocated workers. Two customer satisfaction measures are based on the results of surveys asking quarterly samples of employers and individuals who are exiting employment programs about the services they received. The Virginia Community College System (VCCS) reports this information to the US Department of Labor, but it could not be used for this *Assessment* because all programs are aggregated by WIB, not by service. In addition, the survey methodology generates a single score that does not translate into a typical customer satisfaction score, and the number of survey respondents is too small to accurately represent One-Stop customers.

## H. Virginia Employment Commission Job Seeker and Employer Services

The **Virginia Employment Commission (VEC)** is one of multiple state-administered workforce development programs within the Virginia Workforce Network that include vocational rehabilitation services. The VEC promotes economic growth and stability by delivering and coordinating workforce services and, as specified by the Code of Virginia (§ 60.2-113), its responsibilities encompass **Job Seeker and Employer Services** for all Virginians, including those with disabilities. These include policy development, job placement services, temporary income support, workforce information, and transition and training services for displaced workers.

### 1. Screening and Eligibility for VEC Services

All Individuals, with and without disabilities, may access the Virginia Employment Commission's (VEC) **Job Seeker Services**.

## 2. Access to and Use of VEC Services

Job Seeker Services may be accessed through the VEC website at <http://www.vec.virginia.gov> or by visiting VEC offices or a One-Stop Workforce Center. (Some VEC offices are also One-Stops.) Numerous local, state, and national databases of available jobs may be searched through the website, and it also allows users to access the application for State of Virginia positions and to post a resume online where it can be reviewed by potential employers.

| Table 24. VEC Job Seekers with Disabilities Entering Employment |   |   |   |
|---|---|---|---|
| State Fiscal Year   | Number of Registered Participants with Disabilities | Number of Participants with Disabilities Receiving Staff Assistance | Number of Participants with Disabilities who Entered Employment |
| 2012  | 15,196  | 8,011   | 6,246   |
| 2010  | 14,164  | 11,593  | 4,046   |

In state fiscal year (SFY) 2012, the VEC reported that a total of 15,196 participants with self-declared disabilities registered in its job services database. This is a 7.2-percent increase in participants from SFY 2010. In SFY 2012, the number of individuals with disabilities who received staff-assisted services decreased nearly 30 percent from SFY 2010. Also in SFY 2012, 1,106 individuals received career guidance, 3,777 participated in job search activities, and 1,319 were referred to *Workforce Investment Act (WIA)* services. These numbers are down sharply from SFY 2010 when 3,591 individuals received career guidance, 4,780 participated in job search activities, and 5,362 were referred to WIA services. Despite the decrease in the number of people served, the percentage of VEC participants who entered employment SFY 2012 increased by 54 percent when comparing SFYs 2010 and 2012. In another way of looking at these figures, 41.1 percent of total registered participants entered employment in SFY 2012 as compared to 28.6 percent in SFY 2010. This is likely due, in part, to the beginning of the economic recovery.

## 3. Available VEC Services

The Virginia Employment Commission (VEC) provides a range of services to improve job search skills and bring workers and employers together. Job Seeker Services include registration for job fairs that build job search skills, referrals to job training, employment workshops, resource rooms and support materials, job referral and placement, labor market information, and tools that help job seekers assess their job skills. The **Virginia Workforce Connection** is a new, web-based One-Stop system containing a wealth of employment and labor market information with access to thousands of available jobs. It may be accessed at <https://www.vawc.virginia.gov/vosnet/Default.aspx>.

VEC staff also offers **Employer Services** to help employers find qualified workers by screening and referring applicants for job vacancies and by coordinating or providing interview facilities. They refer employers to customized training programs, provide information on labor markets, salaries, and other workforce issues, and offer guidance on starting or expanding businesses and improving employee retention. The Commission also provides information on workplace accommodations and tax credits for hiring new employees with disabilities. Additionally, it administers the Work Opportunities Tax Credit, Trade Act Assistance, Agricultural Labor Certification, the Migrant and Seasonal Farmworkers Program, and Veterans' Services.

#### **4. Cost and Payment for VEC Services**

The US Department of Labor provides funds under the federal Wagner-Peyser Act to support the Virginia Employment Commission's Unemployment Insurance program and Job Seeker and Employer Services. Information on the cost of services for persons with disabilities is not tracked separately.

#### **5. Monitoring and Evaluation of VEC Services**

Oversight of the Virginia Employment Commission's (VEC) federally funded programs is the responsibility of the US Department of Labor's **Employment Training Administration (ETA)**. Each program has its own negotiated and prescribed performance measures, and the VEC is required to provide quarterly reports on outcomes. As noted in previous sections of this chapter, VEC reporting does not segregate data on its Job Seeker and Employer Services programs for individuals with and without disabilities.

### **I. Disability Employment Initiative**

In October 2013, the US Department of Labor awarded the Virginia Community College System–Workforce Development Services [as administrator of the Workforce Initiative Act (WIA) in Virginia] another grant for the **Disability Employment Initiative (DEI)**. This DEI builds on the strengths and lessons learned through Virginia's first grant under the DEI in 2010. The overall purpose of Virginia's DEI grant is to engage the workforce system to improve employment outcomes for adults (25 years and older) with disabilities. The Virginia Department for Aging and Rehabilitative Services (DARS) serves as a strategic partner in the implementation of this initiative.

Two local Workforce Investment Boards (WIBs 2 and 15) will participate in the DEI as pilot sites, employing disability resource coordinators (DRCs) and becoming Employment Networks (ENs) under the Ticket to Work and Work Incentives Improvement Act of 1999 (PL 106-170). These WIBs will actively participate in the Ticket to Work program. DRCs will provide disability expertise to fulfill the goals and service delivery components of the DEI as listed below, and to promote programmatic, physical, and communications access at the local Virginia Workforce Centers (VWCs). DRCs will provide assessment, case management, and employment services for Social Security Administration beneficiaries who are ready to work. Two additional WIBs (4 and

9) will participate as comparison sites. All four of the WIBs will participate in data collection and program evaluation activities that will focus on job seekers with disabilities receiving Virginia Workforce Center (One-Stop) services. The outcomes for job seekers with disabilities will be compared to those for people without disabilities as a function of this evaluation.

The goals for the pilot WIB sites are to:

- Enhance the capacity of Virginia Workforce Center services for job seekers with disabilities.
- Increase the number of job seekers with disabilities who access Virginia's One-Stop system (e.g., core or intensive training services).
- Engage businesses to ensure One-Stop services meet their needs to promote employment of job seekers with disabilities and to increase employer knowledge and use of effective hiring practices and accommodations.
- Increase the use of asset-building strategies among job seekers with disabilities.
- Increase the use of the Employment Networks within the One-Stop system to increase access to and use of the Ticket to Work program to serve job seekers who receive Social Security Disability Insurance (SSDI) benefits.

The pilot WIB sites will focus on the following strategic service delivery components:

- Partnerships and collaboration (coordination across multiple state-level systems and local-level programs);
- Integrated Resource Teams (collaborative case management to bring partner resources and services together to promote successful employment outcomes for job seekers with disabilities); and
- Asset Development Strategies (e.g., financial literacy and asset management).

## J. Social Security Ticket to Work Incentive Program

Special rules make it possible for people with disabilities who receive Social Security Disability Insurance (SSDI) or Supplemental Security Income (SSI) to work and still receive monthly payments and Medicare or Medicaid. Social Security calls these rules “**work incentives**.” There are quite a few work incentives available to individuals with disabilities who receive Social Security benefits. Its Ticket to Work program is one of two key programs included in this *Assessment*. Information on the full list of incentives can be found at <http://www.socialsecurity.gov/disabilityresearch/wi/generalinfo.htm>.

**Ticket to Work (TTW)**, authorized under the Ticket to Work and Work Incentive Improvement Act of 1999 (PL 106-179), is a program of the federal Social Security Administration (SSA). It serves individuals who receive Supplemental Security Income (SSI) or



Social Security Disability Insurance (SSDI) benefits and is designed to help individuals with significant disabilities who have been receiving these benefits to make the transition back into the workforce. It helps these individuals overcome barriers, such as concerns about the loss of cash payments or health care benefits, which may negatively influence their decisions about seeking employment. It also increases the opportunities and choices for SSI and SSDI beneficiaries to obtain employment, vocational rehabilitation, and other support services from public and private providers, employers, and other organizations. An advantage of this program is that the SSA does not conduct a medical review of a person receiving disability benefits if that person is using a Ticket to Work to pursue employment.

### **1. Screening and Eligibility for Ticket to Work**

To be eligible for a Ticket to Work, an individual must:

1. be age 18 or over and not have reached age 65; and
2. be receiving Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) benefits.

Exceptions and other qualifications may apply and, as manager of the program, the Social Security Administration (SSA) determines which recipients of SSI or SSDI are eligible to participate.

### **2. Access to and Use of Ticket to Work**

The SSA provides eligible recipients of Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) benefits with a Ticket to Work that they can use to obtain services from **Employment Networks (ENs)**. ENs are awarded unlimited, noncompetitive contracts by the SSA to provide those services through an ongoing, open-ended Request for Proposal process. Any agency or political subdivision of a state or a private entity that takes responsibility for the referral, coordination, or delivery of services is eligible to apply to be an EN. Applicants may be a single entity, a partnership, an alliance of public or private entities, or a consortium of organizations that combine resources and collaborate to serve individuals within the Ticket to Work program. EN participants vary, but include state vocational rehabilitation agencies and other providers of rehabilitation services for people with disabilities, One-Stop Workforce Centers, employment agencies, state and local government human services providers, and other public and private entities. The specific services available from individual ENs vary widely.

### **3. Available Ticket to Work Services**

Participation in the Ticket to Work (TTW) program is flexible and voluntary. The SSA does not mandate participation by SSI and SSDI beneficiaries and, in most cases, ENs can choose the services they want to provide, where they will be provided, and to whom. "Ticket Holders" may contact more than one EN to discuss services, and once an agreement has been reached between a Ticket Holder and an EN, they work together to develop and implement a plan that

will help the individual reach his or her employment goal. If a Ticket Holder becomes dissatisfied with the chosen EN, he or she can select another from which to obtain services. Ticket Holders also are eligible for extended Medicaid insurance coverage and benefits planning assistance, including how to utilize work incentive benefits most effectively.

The goal of employment service providers that participate in the TTW program is to assist disability beneficiaries to become financially independent through sustained work at or above the Substantial Gainful Activity (SGA) level. SGA for 2014 is earnings of \$1,070 per month for Ticket Holders with disabilities other than blindness and \$1,800 per month for Ticket Holders who are blind or visually impaired.

#### **4. Cost and Payment for Ticket to Work**

The TTW program is an **outcome-based** employment program. Under the outcome/milestone payment system, the SSA pays an EN when a Ticket Holder attains certain milestones and outcomes that move the individual toward self-supporting employment. As of November 1, 2013, there were 307,802 eligible Ticket Holders in Virginia, and 77 ENs providing services in Virginia. Of the 77 ENs, 46 are based in the State, and the remaining 31 are located out-of-state across the nation. There are 1,117 Tickets assigned to ENs that serve Virginia, and another 5,484 Tickets that are considered in use with Virginia's Department for Aging and Rehabilitative Services (DARS) and Department for the Blind and Vision Impaired (DBVI). There are an additional 53 Tickets assigned to DARS that are considered assigned and in use for milestone or outcome.

Approved Employment Networks (ENs) submit for payments based on the earnings of Ticket Holders who have assigned their Tickets to the EN. Once the Social Security Administration (SSA) approves an EN's application, the EN must choose between two options for receiving payments: the Outcome Payment System or the Milestone/Outcome Payment System. When earned, milestone and outcome payments are directly deposited into an EN's bank account. These funds represent unrestricted revenue for the EN because the SSA does not place requirements or restrictions on how ENs use revenue generated under the Ticket to Work program. Specific information on TTW expenditures in Virginia is not available.

#### **5. Monitoring and Evaluation of Ticket to Work**

The SSA is responsible for oversight of the Ticket to Work Program. MAXIMUS is its program manager. The SSA expects that Employment Networks (ENs) will provide employment support services that afford Ticket Holders the opportunity and support to prepare for, obtain, and retain career-ladder jobs that will realistically enable them to leave and remain off federal cash benefits. In helping disability beneficiaries on the road to self-sufficiency, ENs must offer opportunities and supports that enable a Ticket Holder to achieve financial independence.

The SSA finds it unacceptable for an EN to limit its business model to assisting Ticket Holders in engaging in part-time employment only. ENs that purposefully engage in such practices are terminated. The SSA also requires ENs to provide actual services to Ticket Holders

to help them reach their employment goals before any payment is made. ENs must certify to the SSA which services were provided before certain payments are made.

The SSA tracks Ticket Holders with **Timely Progress Reviews (TPR)** in which Ticket Holders are expected to make progress towards self-sufficiency while their tickets are assigned. The TPR is based on the Timely Progress Guidelines that the SSA established under federal regulations that went into effect in July of 2008 (CFR 411-100 et seq.). Operation support managers conduct reviews at the end of every 12-month period to determine if the Ticket Holders are making the expected progress towards self-sufficiency. ENs are responsible for explaining these reviews and providing counsel and advice while developing an Individual Plan for Employment (IPE) for each participant.

## K. Work Incentives Planning and Assistance Program

The **Work Incentives Planning and Assistance (WIPA) Program** was created through the Ticket to Work and Work Incentives Improvement Act of 1999. This Act authorized Social Security to award grants, contracts, or cooperative agreements to provide technical assistance and support relating to community-based work incentives to beneficiaries of Social Security benefits that are based on disability.

The goal of the WIPA Program is to increase emphasis on work incentives, return-to-work supports, and jobs for SSI and SSDI beneficiaries. Local community organizations, known as **Work Incentive Planning and Assistance (WIPA) Projects**, help individuals who receive SSA disability benefits to learn how employment can affect those benefits and provide them with information and planning services about work and work incentives. The SSA currently contracts with **the Virginia Association of Community Rehabilitation Programs (vaACCSES)** to administer the WIPA Program.

Examples of work incentives include but are not limited to:

- **Section 1619** (a) and (b) of the Social Security Act allows a working Supplemental Security Income (SSI) recipient to earn income at the Substantial Gainful Activity (SGA) level while receiving both a SSI payment and Medicaid at no cost with 1619 (b) status occurring when the income level eliminates a SSI cash benefit but Medicaid eligibility is retained at no cost to the recipient. The SGA for 2014 is earnings of \$1,070 per month for people with disabilities other than blindness, and \$1,800 per month for those who are blind or visually impaired.
- The **Plan for Achieving Self-Support (PASS)** is an earned income and resource exclusion that allows a person with a disability who receives SSI benefits to set aside income or resources to reach an occupational goal.
- The **Impairment Related Work Expense (IRWE)** incentive allows an individual to deduct certain work related items and services that are needed to enable the SSI beneficiary to work.

## 1. Screening and Eligibility for WIPA Services

To be eligible for **WIPA** services, an individual must be an SSI or SSDI beneficiary age 14 through 64. Individuals do not have to be working or even to have decided to pursue work. WIPA services are available for individuals who:

- plan to start working, plan to return to work or plan to start a business;
- plan to accept or seek a higher paying job;
- are concerned about stopping work;
- have questions about Ticket to Work or need a referral to an Employment Network; or
- have other questions about how work will impact disability benefits.

## 2. Access to and Delivery of WIPA Services

**Community Work Incentive Coordinators (CWICs)** manage the WIPA Program. CWICs provide information on work incentives and related benefits planning assistance. The goal of the WIPA Program is to enable SSI and SSDI beneficiaries with disabilities, including transition-to-work youth, to make informed choices about work and to take advantage of the many work incentives available to them. WIPA services are available in every state and US territory.

Individuals may call vaACCSES at 1-877-822-2777 or go to <http://www.vaaccses.org/wipa> for information on contacting a local Community Work Incentive Coordinator (CWIC). The website includes a list of CWICs, provides their contact information, and indicates the areas they serve.

A CWIC will consult with individuals initially by phone to determine if an in-person appointment is needed. CWICs are able to meet with individuals at any of the local DARS field offices throughout Virginia (listed at <http://www.vadars.org/offices.aspx>). They also will meet “virtually,” via Skype, for example, if needed. The WIPA project also has American Sign Language and bilingual staff available.

## 3. Available WIPA Services

CWICs will assess the array of services available for individuals and advise them, not only on what happens to their SS benefits if and when they work, but also on how all of their benefits are tied together. CWICs also assist individuals in obtaining benefits and making the best use of them by:

- Providing information on how part-time, full-time, or seasonal work would affect an individual’s disability benefits and other benefits received from federal, state, and local programs (such as TANF, SNAP, or Workmen’s Compensation);
- Providing information on how work affects health care benefits, such as being the primary contact for Virginia’s MEDICAID WORKS buy-in program;

- Providing information on work incentives offered by the Social Security Administration (SSA) and other sources;
- Discussing individual employment goals and helping identify resources and services to overcome possible barriers to reaching them;
- Helping individuals plan how to use work incentives or other benefits to successfully return to work and provide follow-along assistance once they are working to monitor work incentives and ensure compliance;
- Working with local Social Security offices to implement needed work incentives; and
- Helping individuals use the Ticket to Work program to find appropriate Employment Networks (ENs).

Once an individual is a client of the WIPA Program, services are available for an indeterminate amount of time. In other words, cases do not close; the CWIC maintains a full caseload.

#### **4. Cost and Payment for WIPA Services**

The Social Security Administration (SSA) makes grant awards for community **WIPA Projects** covering a five-year period; however, recipient organizations must submit annual requests for continuation of funding. In 2012, the WIPA Projects in Virginia were vaACCSES and the Endependence Center. For calendar year 2012, approximately \$563,778 was expended in WIPA funds. In this period 3,857 new clients (with no waiting list) were served: 1,778 individuals were provided with information and referrals; and 2,079 individuals were provided advanced WIPA services. In addition, WIPA Projects maintained a full caseload.

#### **5. Monitoring and Evaluation of WIPA Services**

The SSA is responsible for oversight of the WIPA Program. WIPA Projects must apply for funds annually and submit quarterly program and semiannual financial reports to SSA, which also conducts periodic site visits and onsite audits. The details of these processes are too lengthy and complex to include in this *Assessment*, and the SSA should be contacted directly for additional monitoring and evaluation information.

### **L. Virginia's MEDICAID WORKS Program**

**MEDICAID WORKS** is Virginia's Medicaid Buy-In Program for individuals with disabilities who are employed or who want to become employed. To remove barriers to employment, a Medicaid Buy-In Program allows working people with disabilities to participate in their state's Medicaid program by paying a premium, if required, while earning a higher income and retaining more in savings or other resources than is usually allowed by Medicaid. MEDICAID WORKS continues to be premium free for Virginia enrollees in 2014. Receiving continued Medicaid health care coverage as they work and save enables individuals with disabilities to gain greater independence. Additional information on Virginia's Medicaid program can be found in the **Medicaid** chapter of this *Assessment*.

## **1. Screening and Eligibility for MEDICAID WORKS**

Local Departments of Social Services determine who qualifies for MEDICAID WORKS. To qualify, applicants must meet income, asset, and eligibility requirements for the Aged, Blind, and Disabled Medicaid covered group (80 percent of the Federal Poverty Level). Current and new Medicaid enrollees who are blind or disabled, as defined by the Social Security Administration (SSA), may have a total income in 2014 of no more than \$778 per month for a single individual or \$1,049 for a couple and resources of no more than \$2,000 if single and \$3,000 if a couple. An applicant must also be:

1. at least 16 years of age and less than 65 years of age;
2. employed or have documentation from an employer establishing the date when employment will begin;
3. a resident of the Commonwealth; and
4. a US citizen, US national, or qualified non-citizen.

Individuals currently receiving Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) benefits from SSA satisfy the condition for disability. Any applicant without this SSA documentation must be evaluated by the State's Disability Determination Services program before eligibility is established.

## **2. Access to and Use of MEDICAID WORKS**

To enroll in MEDICAID WORKS, applicants must first establish a Work Incentive (WIN) account at a bank or other financial institution where earned income will be deposited. Additional information is available in the *MEDICAID WORKS Handbook* at [http://www.dmas.virginia.gov/Content\\_atchs/mbi/mbi-wmdi2.pdf](http://www.dmas.virginia.gov/Content_atchs/mbi/mbi-wmdi2.pdf).

To continue enrollment in MEDICAID WORKS, participants must continue to be disabled, employed, less than 65 years of age, and must meet earning and resource requirements. Eligibility is reviewed at least annually, and enrollees are required to inform their eligibility worker of changes that may affect their coverage, including but not limited to changes in employer or loss of employment. Enrollees must provide periodic documentation of their employment status, employer, earned income, and WIN accounts. In 2014, MEDICAID WORKS enrollees may have annual earnings as high as \$47,460 and may keep resources up to \$33,862.

The 2011 General Assembly passed House Bill 2384, raising the maximum allowable gross earnings for MEDICAID WORKS enrollees to be "equivalent with the maximum gross income amount allowed under the Ticket to Work and Work Incentives Improvement Act of 1999 that does not trigger collection of mandatory premiums." At the time of passage, this change equated to a maximum individual gross income of up to \$75,000. Currently, this change is under review with the Centers for Medicare and Medicaid Services (CMS). The bill did not change eligibility requirements for MEDICAID WORKS. As of November 16, 2013, there were 58 enrollees in Virginia's MEDICAID WORKS program. At the time of this assessment, local WIPA

programs were able to provide information on the program. To apply for MEDICAID WORKS, individuals should contact the Department of Social Services in the city or county where they live. A list of local offices can be found at <http://www.dss.virginia.gov/localagency>.

### **3. Cost and Payment for MEDICAID WORKS**

Costs for the **MEDICAID WORKS** program are covered along with other Medicaid expenditures in the **Medicaid** chapter of this *Assessment*.

### **4. Monitoring and Evaluation of MEDICAID WORKS**

A member of the **Department of Medical Assistance Services' (DMAS) Program Operations Division** is responsible for monitoring MEDICAID WORKS enrollment and working with local Department of Social Services offices, when necessary, to assist with enrollment and eligibility issues. This staff member also serves as a resource for both the Work Incentive Specialist Advocates (WISA) authorized by the Department for Aging and Rehabilitative Services (DARS) and the Community Work Incentive Coordinators at the Social Security Administration's designated WIPA Projects in Virginia. DMAS monitors new enrollment and cancellation reports and contacts all new enrollees, soon after their enrollment and periodically thereafter, to welcome them to the program and request information about their employment. In applying for MEDICAID WORKS, enrollees agree to keep DMAS informed of where they are employed, what their jobs are, their hours worked, and their incomes. DMAS uses this information to report monthly on the total number of enrollees, how many are self-employed, their age and hourly wage ranges, the average number of hours worked per week, and the number of enrollees in each of the five geographic regions tracked by DMAS.

## **M. Home and Community Based Services Waivers Employment Support Services**

Three of Virginia's six HCBS Waivers provide employment support services: the Individual and Family Developmental Disabilities Support Waiver (DD Waiver), the Intellectual Disability (ID) Waiver, and the Day Support Waiver. The DD, ID and Day Support Waivers are administered by the Virginia Department of Behavioral Health and Developmental Services (DBHDS) under an agreement with the Department of Medical Assistance Services (DMAS), the Commonwealth's Medicaid agency.

### **1. Screening and Eligibility for HCBS Waiver Employment Services**

Specific information on eligibility for HCBS Waivers appears in the **Medicaid** chapter of this *Assessment*. Individuals who are found eligible for the DD, ID and Day Support Waivers may receive employment supports, including prevocational training and individual or group models of supported employment, if that service is included in their **Individual Services Plan (ISP)**. To qualify for supported employment services, the individual must:

1. have a demonstrated need for training, specialized supervision, or assistance in paid employment;
2. be someone for whom competitive employment at or above minimum wage is unlikely without this support; and
3. need ongoing support because of his or her disability.

The individual's need for special services is reassessed annually.

## **2. Access to and Delivery of HCBS Waiver Employment Services**

Specific information on access and delivery of employment services appears in the **Medicaid** chapter of this *Assessment*.

## **3. Available HCBS Waiver Employment Services**

**Prevocational services**, which are not job-task oriented, are available through the Intellectual Disability (ID) and Day Support Waivers. These services provide training and assistance to prepare an individual for paid or unpaid employment. They teach fundamental skills such as accepting supervision, getting along with co-workers, and using a time clock. To be covered, the individual's assessment and service plan must clearly reflect the individual's need for this training and support. Prevocational services are intended to be time limited to prepare an individual for employment. However, often that is not the case, and the Department of Behavioral Health and Developmental Services is examining this issue as it makes changes to Virginia's HCBS waivers. (More information is provided in the **Medicaid** chapter of this *Assessment*.)

**Supported employment** can be provided via a group or individual model. It includes training in specific skills related to paid employment and the provision of ongoing or intermittent assistance and specialized supervision to enable an individual with a disability to maintain paid employment. The group model provides continuous staff support for eight or fewer individuals with disabilities in an enclave, work crew, or bench work/entrepreneurial setting. The individual model involves intermittent, one-on-one support by a job coach for an individual with disabilities in integrated, community-based employment after an initial intensive period of on-the-job training. The individual supported employment model is considered best practice.

## **4. Cost and Payment for HCBS Waiver Employment Services**

**Table 25** provides the number of people served and funding sources and amounts for prevocational and supported employment services provided under HCBS Waivers during state fiscal year (SFY) 2013. Disaggregated data by type of service was not readily available for previous fiscal years.

Combined spending for prevocational and supported employment services under all three HCBS Waivers rose by 11.6 percent from \$18,903,763 in SFY 2010 to \$21,094,662 in SFY 2013.



Likewise, the number of individuals receiving these services under HCBS Waivers rose by 10.2 percent from 1,738 to 1,915 during that same period.

| <b>Table 25. Prevocational and Employment Support Services Provided Under HCBS Waivers in SFY 2013</b> |                      |                    |
|--|----------------------|--------------------|
| <b>Individual and Family Developmental Disabilities Support Waiver (DD Waiver)</b>                     | <b>Number Served</b> | <b>Total Funds</b> |
| Prevocational Services   | 9                    | \$62,614           |
| Supported Employment*  | 44                   | \$393,196          |
| <b>Intellectual Disabilities (ID) Waiver</b>   | <b>Number Served</b> | <b>Total Funds</b> |
| Prevocational Services   | 889                  | \$9,531,036        |
| Supported Employment*  | 889                  | \$10,146,131       |
| <b>Day Support Waiver</b>  | <b>Number Served</b> | <b>Total Funds</b> |
| Prevocational Services   | 56                   | \$615,315          |
| Supported Employment*  | 28                   | \$346,370          |

\* Supported Employment services include individual and enclave models. While unusual, the Department of Medical Assistance Services verified that the number of individuals served in prevocational services and in supported employment were identical in SFY 2013.

Sources: Department of Behavioral Health and Developmental Services and Department of Medical Assistance Services.

## 5. Monitoring and Evaluation of HCBS Waiver Employment Services

The **Department of Medical Assistance Services (DMAS)** is required to ensure the health, safety, and welfare of all individuals served by HCBS Waivers and to ensure that providers comply with all federal and state regulations. The **Department of Behavioral Health and Developmental Services (DBHDS)** directly administers and provides additional oversight for the **ID, DD and Day Support Waivers**. Information on monitoring and evaluation of these waivers is included in the **Medicaid** chapter of this *Assessment*.

As noted in the **Introduction to Vocational Rehabilitation and Other Employment Services** section at the beginning of this chapter, the Independent Reviewer found in his June 6, 2014 *Quarterly Report* that the Commonwealth was substantially in compliance with the implementation actions related to integrated employment activities. For this compliance examination the Reviewer contracted with an expert consultant who made a variety of recommendations related to her findings. With respect to HCBS Waivers, the consultant stated:

*DBHDS will need to concentrate its efforts on completing its waiver redesign plan to address employment service definitions and revise its rate structure, focus on building provider capacity, considering offering individuals the opportunity to self-direct their employment supports, and ensure case managers are trained in*

*the Employment First policy and using the principles of person-centered planning to help individuals and their families identify and pursue their employment goals and aspirations.*

The consultant also recommended that the State Employment Leadership Network (SELN) review data on the growth of group-supported employment and pre-vocational services, so that it can determine strategies to incorporate in waiver redesign that

*will start to turn the curve in Virginia away from other vocational options and towards greater individualized employment for the target population.*

Additional recommendations related to the need for more case manager training; family education and outreach; tracking outcomes separately for individuals receiving individual supported-employment services in the ID and DD Waivers to determine if the Commonwealth has been successful with both groups. The full report is available at <http://www.dbhds.virginia.gov/settlement/ODS-140606IRReport.pdf>.

## **N. 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. Websites Referenced**

#### **Code of Virginia**

<http://lis.virginia.gov/cgi-bin/legp604.exe?000+coh+51.5-1+500809>

<http://lis.virginia.gov/cgi-bin/legp604.exe?000+cod+51.5-60>

<http://lis.virginia.gov/cgi-bin/legp604.exe?000+cod+51.5-117>

<http://lis.virginia.gov/cgi-bin/legp604.exe?000+cod+2.2-2669>

<http://lis.virginia.gov/cgi-bin/legp604.exe?000+cod+60.2-113>

#### **US Department of Labor**

##### **Bureau of Labor Statistics Current Population Survey**

<http://www.bls.gov/cps>

#### **US Social Security Administration**

##### **Ticket To Work**

<http://ssa.gov/work/overview.html>

<https://yourtickettowork.com/web/ttw/resource-documents>

<https://yourtickettowork.com/web/ttw/en-about-ticket-to-work>

<http://www.chooseworkttw.net/about/index.html>

<http://www.yourtickettowork.com/web/ttw/en-timely-progress-review>

<http://www.yourtickettowork.com/web/ttw/en-payments>

<http://www.maximus.com/services/workforce-solutions/ticket-work>

**Work Incentives Planning and Assistance Projects**

<http://www.socialsecurity.gov/work/WIPA.html>

**vaACCSES (Virginia Association of Community Rehabilitation Programs)**

<http://www.vaaccses.org>

**Endeppendence Center**

<http://www.endeppendence.org>

**Virginia Commonwealth University**

**Rehabilitation Research & Training Center on Workplace Supports and Job Retention**

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

**Project SEARCH**

<http://www.worksupport.com/projects/projsearchmcv.cfm>

**School 2 Work**

<http://www.worksupport.com/school2work/>

**Virginia Community College System**

<http://www.vccs.edu>

**Virginia Department for Aging and Rehabilitative Services**

<http://www.vaDARS.org>

**Woodrow Wilson Rehabilitation Center**

<http://wwrc.virginia.gov>

**WorkWORLD**

<http://workworld.wwrc.net/pages/home>

**Virginia Department of Behavioral Health and Developmental Services**

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

**Virginia Department for the Blind and Vision Impaired**

<http://www.vdbvi.org>

**Virginia Rehabilitation Center for the Blind and Vision Impaired**

<http://www.vrcbvi.org>

**Virginia Industries for the Blind**

<http://www.vibonline.org>

**Virginia Department of Medical Assistance Services**

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

**Virginia Department of Social Services**

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

**Local Department of Social Services offices**

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

**Virginia Employment Commission**

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

**Virginia Workforce Network (One-Stop Workforce Centers)**

<http://vwn.vccs.edu>

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## IV. Health Care

### A. Introduction to Health Care Services and Resources

Virginians, with or without disabilities, who have health insurance (private or Medicaid or Medicare) can receive direct health services from a variety of providers and practitioners, both private and not-for-profit. Regional differences do exist in the availability and accessibility of providers. Notable “safety net” resources for health and dental care include Federally Qualified Community Health Centers, which are nonprofit organizations; and local Free Clinics, which are staffed by volunteers and primarily serve adults.

This chapter focuses on the direct health care services administered, funded, or operated by two state agencies that serve Virginians who are under-insured or have no insurance:

- **The Virginia Department of Health (VDH)**, as authorized by the Code of Virginia (§ 32.1), provides services that are open to the general population rather than specifically targeted to those with disabilities.
- **The Department of Behavioral Health and Developmental Services (DBHDS) - Regional Community Support Centers (RCSCs)**. Through state fiscal year (SFY) 2014, the RCSCs will continue to operate through state Training Centers to fill regional service gaps for individuals with intellectual and other related developmental disabilities.

In August 2008, the **US Department of Justice (DOJ)** initiated an investigation of the Central Virginia Training Center (CVTC) pursuant to the Civil Rights of Institutionalized Persons Act (CRIPA). In April 2010, the DOJ notified the Commonwealth that it was expanding its investigation to focus on Virginia’s compliance with the Americans with Disabilities Act (ADA) and the US Supreme Court’s 2009 *Olmstead* ruling. The *Olmstead* decision requires that individuals be served in the **most integrated settings appropriate** to meet their needs consistent with their choice. In February of 2011, the DOJ submitted a summary of findings to Virginia, concluding that the Commonwealth failed to provide services to individuals with intellectual and developmental disabilities in the most integrated settings appropriate to their needs.

As part of the DBHDS implementation plan for the Department of Justice (DOJ) **Settlement Agreement**, the RCSCs are being transformed into community-based services that will be known as the **Developmental Disability Health Support Network**. Because this transition has not been completed and the information provided here is historical in nature, this chapter refers to these as RCSCs for ease of reference. After an overview of current health care issues and needs and of the Commonwealth’s legislative efforts to address them, the remainder of this chapter provides details on services provided through the VDH and RCSCs.

Over the past century, advances in sanitation, food safety, disease prevention, and medical treatment have significantly improved the health and well-being of all Americans. As a result, life spans have increased, most notably for individuals with a developmental or other disability. Having a disability, whether congenital or acquired, does not mean an individual does not have good health. A growing body of medical research, however, indicates that persistent health disparities exist in service access and outcomes for various populations, especially minorities and individuals with disabilities who historically have experienced discrimination, segregation, or exclusion. The US Department of Health and Human Services defines a **“health disparity”** as

*a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage.*

**Healthy People 2020**, a national initiative of the Department, notes that varieties of interrelated factors (or determinants) affect personal health and wellness, and thus contribute to health disparities. These determinants fall into the following broad categories:

- biology and genetics;
- individual behaviors (smoking, lack of exercise, overeating, alcohol/drug abuse);
- social (race, ethnicity, disability, economic status);
- environment (home and neighborhood);
- health services (quality, availability, accessibility);
- geography (rural vs. urban); and
- local and state policies.

Additionally, Healthy People 2020 reports that local and state policies can directly affect individuals’ access to and the availability of (1) types of services, (2) affordable, reliable transportation, and (3) affordable health insurance. More information on the initiative is available at <http://www.healthypeople.gov/2020/about>.

According to the US Surgeon General and Healthy People 2020, individuals with developmental or other disabilities often face the additional risks of **secondary health conditions** related to their disability. For example, individuals with mobility impairment who rely on wheelchairs have a greater risk of pressure sores, lost muscle tone and obesity. Those with spina bifida can have greater risk for gait instability and falls. Certain developmental disabilities tend to be associated with a predisposition to respiratory infections or other pulmonary problems, or to cardiovascular diseases. Overall, research indicates that, as a group individuals with physical and/or intellectual disabilities are in worse health than the general population.

**Systems barriers** are recognized as a key factor negatively impacting wellness and health for individuals with disabilities. These barriers may be encountered as:



- inaccessible medical facilities and equipment (such as lack of height adjustable examination tables, lifts, or adaptive mammography equipment);
- inaccessible gyms and recreational exercise facilities;
- inadequate numbers of trained staff; and
- limitations or lack of insurance coverage for assistive technology, equipment, medications, or dental care.

Many of these barriers persist, despite the expectations sets forth by the Americans with Disabilities Act (ADA). A 2011 report by the University of New Hampshire Institute on Disability points out:

*Many of the health challenges experienced by people with disabilities are preventable given access to medical care, attention to health promotion and disease promotion, and improved social circumstances.*

Tracking of health care to citizens, with and without disabilities, has increased over the past decade. Nationally, in addition to the Healthy People 2020 project, the **US Centers for Disease Control (CDC)** monitor the prevalence of various developmental and other disabilities as well as major chronic health conditions, and access to health care. The CDC posts national and state findings from the **Behavioral Risk Factor Surveillance System (BRFSS)**, which monitors numerous health indicators for adults with and without disabilities.

Begun on a national level in 1993, the BRFSS is a phone survey of a random sample of adults (ages 18 and older) who are not residing in any type of institution. The survey, which is conducted over a two-year period by each state, collects self-reports of health-related behaviors, chronic health conditions, and the use of preventive services. While the BRFSS has a core questionnaire, each state can administer optional question modules. To improve representativeness and reduce selection bias, the CDC uses various statistical methods to weigh the survey data against numerous demographic variables. As a result, the published reports have at least a four-year time lag from the time of collection.

Limitations in generalizing the findings for methodological reasons must be noted. The BRFSS excludes all adults residing in any institution (health care and correctional) and anyone who does not have a phone. The survey categorizes respondents very broadly as “with disability” or “no disability” and “don’t know” or “refused.” The latter two groups were not included in the analysis. The self-report of a disability was broadly defined using one question, “Are you limited in any way in any activities because of physical, mental, or emotional problems?” Both local and state health departments use BRFSS data to monitor progress on agency objectives, implement health promotion and disease prevention activities, and to monitor health trends. More information on the survey is available at <http://www.cdc.gov/brfss/>.

The most recent BRFSS data available on Virginians with disabilities is found in the report, *Health Status of Virginians with Disabilities, 2007–09*. The survey was conducted by the Division of Chronic Disease Prevention and Control at the Virginia Department of Health (VDH) with staff at the Partnership for People with Disabilities (PPD) at Virginia Commonwealth University (VCU) providing data analysis. Across numerous indicators, poor health status or more severe conditions were most frequently reported by individuals who had annual incomes of less than \$35,000 or were over age 65. The survey also found that:

- Individuals with a disability reported their health as “fair” or “poor” (43.5 percent) six times more frequently than those with “no disability” (7.3 percent)—a statistically significant difference.
- Compared to those with no disability (10.0 percent), individuals with a disability were twice as likely (20.6 percent) to report not seeing a doctor when needed because of cost in the past year—a statistically significant difference.
- Lack of dental insurance was sizeable for both populations with 42.8 percent of individuals with a disability and 26.8 percent of those with no disability lacking dental insurance.
- Individuals with a disability were more likely to report having a diagnosis of arthritis, asthma, high blood pressure, and heart disease (e.g., angina, heart attack, stroke, or coronary heart disease).
- Individuals with a disability had higher rates of receiving a flu vaccine (51.4 percent) and the pneumonia vaccine (38.5 percent) than those with no disability (39.0 percent and 21.4 percent, respectively).

The relationship of good **oral health** to overall physical well-being has been well documented. The US Surgeon General issued a major report on oral health in 2000, followed by a national “Call to Action” plan in 2003. The 2000 report points out the importance of good dental hygiene for one’s general health. For example, the oral membrane (which covers tissue in the mouth) and the salivary glands are key parts of the body’s immune system. Severe tooth decay leads to intense toothaches. If a tissue abscess develops, the jawbone can be damaged and infection can spread into the bloodstream, resulting in systemic infection. Pregnant women with tooth decay are at more risk for premature birth and for having a low birth weight child. Higher risk of oral problems also is associated with having diabetes (Type I or II), having a weakened immune system, being poor, or smoking regularly.

The US Centers for Disease Control (CDC) points out that millions of work hours are lost annually due to oral health problems by employed adults. CDC studies indicate that a little over 30 percent of adults reported not having a dental appointment in the past 12 months. The CDC notes that

*for every adult 19 years or older without medical insurance, there are 3 without dental insurance.*

More CDC information on oral health is available at  
[http://www.cdc.gov/OralHealth/children\\_adults/adults.htm](http://www.cdc.gov/OralHealth/children_adults/adults.htm).

Over the last decade, health reform efforts at both the national and state levels have increased due to many factors. The most significant are as follows:

- Costs for health care and health insurance rose significantly higher than inflation and incomes.
- During the Great Recession and slow recovery, many citizens who lost health insurance with their jobs became eligible for Medicaid, causing higher state expenditures.
- Implementation of the Affordable Care Act (ACA) (H.R. 3590 as amended).

Increased attention has been given to identifying the underlying factors that contribute to high health care costs and effective health care reform strategies to both improve service quality and reduce costs. Reform discussions and planning have begun to include preventative dental care, which often is not covered by either public or private insurers.

In 2010, the Commonwealth began the **Virginia Health Reform Initiative (VHRI)**. The VHRI has been led by the Secretary of Health and Human Resources and conducted by a Governor-appointed Advisory Council comprised of leaders from health care, insurance, legislators, and businesses. Its purpose has been to develop and recommend to the legislature a comprehensive strategy for implementing health care reforms that promote Virginia's economic growth as well as more effective, efficient delivery of high quality health care at lower costs. Six VHRI Advisory Council Taskforces are organized around six health care issues and conducted fact-finding meetings on their respective issues, which are as follows:

1. Medicaid reform (see the **Medicaid** chapter for details),
2. health insurance reform,
3. capacity (workforce),
4. service delivery and payment reform,
5. technology, and
6. purchasers.

The VHRI Purchasers Taskforce addressed business strategies to improve choice, flexibility, quality, and the cost of employee health insurance. Both the VHRI Advisory Council and each Taskforce was charged to:

*go beyond federal health reform and identify other innovative health care solutions for Virginia.*

Since their formations, each VHRI entity met regularly, obtained public comment and information from a wide array of stakeholders, including employers, insurance companies,

citizens, health care providers, and medical associations, among others. VHRI efforts included research on health care innovations occurring in other states on each taskforce topic.

Pursuant to House Bill 2434, in November 2011, the VHRI Advisory Council released its report on recommended legislative actions to address the Affordable Care Act requirement for states to either create their own Health Benefit Exchange (HBE) or contract with the federal Department of Health and Human Resources to operate one. The VHRI Council recommended that Virginia establish its own exchange, and identified key components and issues for its creation. The recommendation was opposed by then Governor McDonnell. During the 2012 and 2013 legislative sessions, bills were proposed to create a state-operated HBE, but the proposals were not enacted. Similar bills were proposed in the 2014 General Assembly, but at the time of this assessment, no decision had been made. Nevertheless, the research and reports from the VHRI form an important legislative context for future decision-making regarding health services.

Current Governor McAuliffe supports eliminating the coverage gap. Passage of the SFY 2015–16 state budget was delayed due to the controversy of Medicaid expansion with the House and Senate disagreeing over whether the discussion of Medicaid expansion should be part of budget negotiations or considered separately. In mid-June of 2014, the General Assembly passed a budget without Medicaid expansion in order to address an unanticipated significant budget shortfall. A further provision was included that requires full General Assembly approval of Medicaid expansion. The budget will go to the Governor for his review.

Individuals with chronic health conditions too often contend with fragmented services and poor communication between providers. Complications from and acute exacerbations of chronic health conditions often can be prevented with appropriate, timely medical treatment. In turn, appropriate medical care can reduce costs through prevention of hospitalizations and emergency room visits. The 2010 General Assembly, through House Joint Resolution 82, tasked the **Joint Commission on Health Care (JCHC)** to “study the feasibility of developing chronic health care homes in the Commonwealth” and to include identification of service standards, certification standards, and estimated costs of a demonstration program. A chronic health care home (often referred to as “medical home”) is a team-based, person-centered model of care that is led by a personal physician and plans and delivers health care to address the needs of individuals with multiple chronic conditions.

In its 2012 report of findings (House Document #9 available at <http://leg2.state.va.us/dls/h&sdocs.nsf/4d54200d7e28716385256ec1004f3130/7f6815bd7a3826d585257738006fc1a0?OpenDocument>), the Joint Commission on Health Care (JCHC) identified several person-centered models of primary care that demonstrated both improved individual health and reduced health care costs. Key features of these models were (1) leadership by a primary care physician, (2) a team approach, and (3) ongoing, coordinated care. JCHC found that several initiatives were underway in Virginia to promote “health care homes.” Among these is a grant made to the state Department of Medical Assistance Services (DMAS) from the National Academy of State Health Policy to develop and implement policies to

increase access to quality “medical homes” for Medicaid and Children’s Health Insurance Program (CHIP) participants. The JCHC report noted that a number of family medicine physicians statewide had either begun, or were about to begin, implementation of chronic health care homes. The JCHC decided to continue monitoring the progress of these efforts and related health care innovations.

The 2010 legislature additionally charged the JCHC to conduct a study on the volume and costs of hospitals statewide in serving individuals who were financially indigent (“**charity care**”); and to identify incentives to encourage services to that population (House Joint Resolution #27). As of January 2014, the Affordable Care Act requires all individuals to obtain health insurance coverage, which could impact the need for charity care. The final report, published in 2011, found that not-for-profit hospitals provided more charity care as a percentage of revenues than for-profit hospitals. Problematic, however, is that no state standard exists to define the calculation of charity care, resulting in different methods used for calculations by different hospitals. The JCHC, in collaboration with hospitals, will continue to explore a potential standardized definition of hospital charity care and to discuss trends over time.

As the VHRI progressed, legislative concerns about health care costs expanded to the issue of public costs that result from untreated **dental disease**, an issue that also has received national attention over the past decade. In 2011, as a cost-reduction strategy, the **Virginia Department of Health (VDH)** proposed to the administration and legislature that its clinical dental services be restructured to align better with an evolving agency mission of more preventive and population-based programs. The 2012 General Assembly special session enacted a budget requirement (Item 296-F in Chapter 3) that tasked the VDH, in collaboration with the Department of Medical Assistance Services (DMAS), to create a dental advisory committee of community individuals and dental organizations to address that proposal. The legislature requested a report to:

- evaluate “the sustainability and efficiency” of current VDH-operated dental clinics;
- evaluate the feasibility of transitioning VDH dental services to a prevention-only model; and to
- develop a comprehensive oral health plan.

The advisory committee was convened and held several meetings to examine the fiscal, utilization, and client demographic data of current VDH-operated dental clinics statewide as well as distribution of other “safety net” dental providers. The resulting *VDH Oral Health Plan*, submitted in October of 2012, concluded that the current system of VDH dental clinics was not sustainable without a significant influx of state General Funds (GF). In state fiscal year (SFY) 2012, 40 percent of dental clients were indigent and received free services; another 11 percent paid a minimal fee based on a sliding scale; and the remainder was children on Medicaid. State compensation policies additionally made recruitment and retention of qualified dental staff very difficult in some localities. The plan recommended that a “targeted regional approach” be adopted, which would selectively transition some dental clinics to a prevention model based on

analysis of community needs and available dental resources, especially safety net providers. The VDH plan also requested an additional year of General Fund support for existing dental clinics to allow appropriate transition planning.

The VDH plan, which includes communication with and input by local stakeholders, was approved. Over the next year, VDH collaborated with the Virginia Dental Association, the Virginia Oral Health Coalition, and other stakeholders to develop implementation plans. The Stakeholders Advisory Committee reviewed extensive data on local populations, dental resources, and other factors. In October of 2013, the VDH submitted its legislative report, **Dental Transition Plan**. This plan proposes a major restructuring of the VDH-operated dental clinic system. The plan identified district VDH dental programs that would be maintained as being “critical” to their communities: Mount Rogers, Norfolk, and Western Tidewater. Others would be transitioned to a prevention model through an expanded dental hygienist workforce within the VDH Office of Family Health Services. Dental hygienists work under “remote supervision” in local schools (as outlined under Code of Virginia § 54.1-2722).

The VDH deputy commissioner for Community Health Services has provided plan templates for activities to close or modify local dental clinics, including efforts to assure care continuity for current dental clients. However, the plan notes that remaining VDH dental clinics will need significant state funding after SFY 2014 for local VDH dental clinics to maintain current professional standards for staffing and infrastructure.

A related 2012 legislative proposal (Senate Joint Resolution 50) recommended a study of the financial impact and availability of dental services. Although not passed by the legislature, this study was initiated in 2013 by the Joint Commission on Health Care (JCHC). The JCHC study examined (1) the financial impact of untreated dental disease on Medicaid expenditures, (2) uncompensated dental-related care provided through hospital emergency rooms, and (3) both the scope and value of dental services from safety net providers, such as local health clinics and Free Clinics. In November of 2013, the JCHC presented its findings in its *Study on the Cost of Untreated Dental Disease on the Commonwealth*. Based on its findings, the JCHC adopted the following as legislative recommendations:

- The JCHC will propose a budget amendment to expand Medicaid to include full dental services for pregnant women with appropriations of \$3,627,804 each in General Funds and Non-General Funds per year.
- The 2014 JCHC work plan will include a targeted study of the service capacity and educational priorities of dental safety net providers. The study will include an in-depth exploration of proactive strategies to divert individuals from emergency room use to community providers and will address “alternative settings where additional providers (such as registered dental hygienists) can provide access to more individuals.”

Of note is that, based on public comments, the 2014 JCHC dental study will engage a broader array of oral health stakeholders—including the Virginia Dental Hygienists Association

and the VCU School of Dentistry, among others—in examining the long-term actions and resources needed to “... improve education, awareness and pro-activity for changing oral hygiene habits.” A final report will be available in 2015.

The United States continues to have the highest per capita health care costs of any industrialized nation. This reality, along with the many factors discussed herein, will keep the interest-level high for improving the quality and efficiency of health care services for years to come. As noted above, the Commonwealth’s Joint Commission on Health Care will remain engaged in examining ways to improve services and reduce costs.

## **B. Virginia Department of Health Programs**

The Virginia Department of Health (VDH) is the primary state agency focused on public health for residents of the Commonwealth. Its mission is “to promote and protect the health of all Virginians” with a vision of “Healthy People in Healthy Communities.” By state and federal law, the VDH is responsible for 41 “service areas” included in the following broader categories:

- Maternal and child health
- Communicable disease prevention and control
- Environmental health hazards protection
- Drinking water protection
- Medical examiner services
- Emergency preparedness response and recovery
- Vital records and health statistics
- Health assessment, promotion and education
- Quality oversight of health services

To achieve its mission, the VDH provides leadership and expertise to localities in a wide variety of areas, most of which affect all citizens:

- Community Nutrition and the Women, Infants and Children (WIC) nutrition programs
- Maternal and infant health (for reduced Mortality rates and improved pre-natal maternal care)
- Dental services
- Emergency Medical Services and emergency preparedness
- Public health nursing

- Chronic disease prevention (including immunization programs and maintenance of the Virginia Immunization Information System as well as prevention of rabies, HIV/AIDS, tuberculosis, sexually transmitted diseases, and others)
- Health equity (to address disparities in the availability of and access to quality health care for rural and other underserved populations)
- Injury and violence prevention
- Drinking water protection (involving waterworks owners, operators, laboratories, consumers)
- Environmental health (including restaurant inspections, sewage and water services, food safety, lead monitoring, and shellfish sanitation)
- Birth, death and marriage certificates
- Health statistics
- Licensure and certification of nursing facilities, medical facilities and services, and intermediate care facilities for individuals with intellectual disabilities (ICFs/IID)

VDH activities are highly decentralized. Services are provided through a network of 35 local health districts that support 119 individual, municipal health departments. While localities with high population densities have dedicated districts, some health districts, especially in rural areas, cover multiple localities.

Each local health department prioritizes services based on assessments of municipal health needs and conditions. The availability and nature of services at public health clinics across Virginia varies based on local needs, funding, and differing public risk levels for certain health problems. Unless otherwise indicated, the VDH health services listed in this chapter operate through this network, either by directly providing services or by contracting with local service providers. This network collects data on local health care needs and service levels, which is reported to VDH. Only two health districts, Fairfax County and Arlington, manage their own local department and district. The other thirty-three health districts are staffed with state VDH employees.

The full scope of VDH services and activities can be viewed on its website at <http://www.vdh.virginia.gov>. For this *Assessment*, only those VDH programs that provide direct services and are likely to be used by Virginians with disabilities are addressed. Many of the VDH's programs are administered by the **Office of Family Health Services within the Division of Child and Family Health**. Information about all programs and services under this division is available online at <http://www.vdh.state.va.us/ofhs/childandfamily/>. Data on the number of individuals who have disabilities and who received these services is generally not available. Wherever specific access, enrollment, and participation information on a VDH service is available, it is included under the appropriate program. Services provided through VDH programs are described, as much as possible, in order of the target population's age.



## 1. Eligibility for VDH Services

Generally, all Virginians (with and without disabilities) are eligible for health department services. Eligibility for Virginia Department of Health (VDH) programs typically are based the individual's age, family income, and insurance coverage, as well as whether the individual belongs to a group that is at special risk for a specific health problem now or in the future. However, variation exists based on the purpose of various programs. Prevention and education services often are provided to individuals at no cost. Since local health departments vary in the services offered, not all programs are universally available statewide. Individuals can explore eligibility and program information by contacting their local health department or visiting the VDH website, which includes enables users to find local health services by county. It is at <http://www.vdh.virginia.gov/VDHprograms.htm>.

## 2. Access to and Delivery of VDH Services

With a few exceptions, the public health programs under VDH primarily provide information on local nonprofit or private health care providers, support citizens in accessing them, or coordinate the delivery of services between them. Access points for specific publicly provided health care assessment, management, and support services targeted specifically at people with disabilities are described below.

## 3. Available VDH Services

The **Division of Child and Family Health** within the **VDH Office of Family Health Services** administers a number of the programs most relevant to Virginians with disabilities. Within this division are three major units, each of which has multiple programs and services:

1. Child Health,
2. Dental Health, and
3. Reproductive Health.

The broad goals of these programs are to improve both maternal health (perinatal and post-natal) and infant/child health and also to promote wellness and prevent disease. Information about services available under the VDH Division of Child and Family Health is online at <http://www.vdh.state.va.us/ofhs/childandfamily>. The services described here are presented in a rough chronological order that anticipates how a child or family member might use them.

Located within the Child Health Unit are two programs of the **Virginia Genetics and Newborn Screening**: the **Newborn Screening Program** and the **Virginia Early Hearing Detection and Intervention Program (VEHDIP)**. The Virginia Genetics and Newborn Screening unit is responsible for ensuring that newborns are screened for potentially disabling or life-threatening conditions. Through its programs, services, and partners, the unit works with a multi-layered network of local public and private service providers that are linked by particular health conditions or disabilities. Direct services provided through its programs vary considerably as they focus on various, specific genetic conditions. The screening programs are aggressive in

their outreach to the general population as well as to local health care professionals and organizations. Extensive educational materials on a wide variety of genetic and other developmental disorders are made available to parents and primary health physicians.

The **Newborn Screening Program** is a comprehensive system of diagnostic services, medical treatment, and dietary management and treatment. Working in partnership with three regional genetic centers operated by Virginia's medical schools (University of Virginia, Virginia Commonwealth University Health System, and Eastern Virginia Medical School), this program aims to ensure early identification of congenital conditions as well as to link families to appropriate resources for health and disability services. The efforts of this program enable newborns to receive treatments that may improve or prevent more serious health and functional impairments that may occur if intervention is not started soon after birth. Newborn screening also supports optimal child development and promotes the health and wellness of children.

In general, Newborn Screening Program staff work with hospitals, physicians, and families to ensure that physicians and hospitals statewide collect necessary blood samples for testing by the Virginia Department of General Services' Division of Consolidated Laboratories, which are under contract with the VDH. Every newborn in Virginia is tested a few days after birth unless a parent or guardian objects on the grounds that the test conflicts with their religious practices. When screening identifies a serious condition, as required by state law, program staff then assures notification of the child's parents and primary care provider about the abnormal screening results. Newborns diagnosed through the screening program are referred to the Care Connection for Children for follow-up services and supports.

Newborn screening results and follow-up activities are also reported to the **Virginia Congenital Anomalies Reporting and Education System (VaCARES)**. VaCARES, a VDH registry of children under age two who have a birth defect. It collects data on birth defects to evaluate both their prevalence and possible causes as well as to have a mechanism for informing families of children with birth defects and their physicians about available health resources. As required by Code of Virginia § 32.1-69.1, hospitals must report cases of birth defects to VaCARES. Birth defects can be reported and reviewed without prior written consent of the family. VaCARES data are kept strictly confidential, and VDH only uses aggregate data for research to evaluate patterns and causes of birth defects. The VaCARES webpage includes a brochure listing key disability resources for families of an infant with special needs and numerous fact sheets on various types of birth defects and developmental disabilities. It is located at <http://www.vahealth.org/gns/vaCares.htm>.

Newborn Screening Program staff also may assist with referrals to appropriate resources for follow-up through the regional genetic centers and identified specialists. When a child's genetic condition requires metabolic treatments or special foods, families are referred to one of three regional metabolic treatment centers located at Virginia's three medical schools (UVA, VCU-HS, and EVMS). Physicians and nutritionists there help to develop and implement a plan of care for infants whose families are medically indigent. In addition, the program offers a

Food/Supplement Reimbursement Plan to Virginia residents who meet the financial and medical eligibility criteria. This plan provides limited reimbursement for certain necessary low-protein modified foods, formulas, and/or metabolic supplements.

When screening identifies a hearing impairment or loss or the potential for such, the **Virginia Early Hearing Detection and Intervention Program (VEHDIP)** serves as a primary source for referrals for follow-up services. VEHDIP goals are to ensure that:

- all infants are screened for hearing loss by one month of age;
- any diagnosis of hearing loss is made by three months of age; and
- diagnosed infants receive early intervention services by six months of age.

Staff follow-up is conducted on newborns who either have negative results from their hearing screen or do not have a reported screening. They work with the family, the primary care providers, and audiologists to confirm the child's hearing status. VEHDIP staff also provides parents with explanatory information on the importance of early intervention and discuss what to expect in the future as well as available local resources. Parents are directly assisted in arranging follow-up assessments, as indicated; in obtaining communications support (including assistive technology) and educational support; and with referrals to appropriate resources of the **Virginia Department for the Deaf and Hard of Hearing (VDDHH)**.

In collaboration with VDDHH, VEHDIP staff develops policies and procedures, identifies best practices, and recruits additional community providers to address the needs of these children. VEHDIP training and guidance is supplied in localities to ensure that physicians and hospitals: (1) perform required hearing screenings for children in a timely manner, (2) provide all prospective parents with information on auditory screening requirements, and (3) provide the screening results to VaCARES and to parents.

The Virginia Department of Health (VDH) reports that, due to VEHDIP activities, in 2011, 98.2 percent of infants born in Virginia were screened for hearing loss prior to hospital discharge. Upon further diagnostic evaluation, 147 children were identified with a permanent hearing loss, and 49 percent of those children were diagnosed before 3 months of age. Documentation on linkage to services is incomplete and varies widely between years; however, in 2011, 21.8 percent of children with permanent hearing loss were documented as receiving **Part C Early Intervention** services by 6 months of age, and 26 percent of these children also received other early intervention services by 6 months of age.

VDH is currently implementing data system changes to allow for more thorough tracking of Part C early intervention services. While these percentages have declined from a high point reached in 2006, VDH staff believes that the data represent an undercount because information on enrollment in IDEA Part C Early Intervention Services [pursuant to the Individuals with Disabilities Education Improvement Acts (IDEA)] cannot be shared without parental consent. (See the **Early Intervention** chapter of this *Assessment* for more information.)

The **VDH Loving Steps Program**, a Virginia Healthy Start Initiative, employs nurses, dietitians, and community health workers to provide case management services for women and infants who are at risk for poor perinatal outcomes. This initiative targets localities that have high rates of low birth weights, premature deliveries, and infant deaths. Many of these localities also have high rates of poverty or of having little or no health insurance coverage. Loving Steps services currently are provided in Westmoreland County and the cities of Norfolk and Petersburg. Loving Steps strives to reduce infant mortality and reduce significant perinatal health disparities.

Intensive case management and care coordination for the mother and infant is conducted by a multi-disciplinary team (nurses, dietitians, and community health workers). Local case managers arrange screenings for medical, nutritional, social, economic, and environmental risks, identify service gaps, develop a plan of care, and make referrals to other services and resources to improve participants' health. Ongoing follow-up ensures that services and supports are being accessed. Outreach, health education, and depression screening are also available.

The VDH administers several federally funded **community nutrition programs** through its Division of Community Nutrition, located in the Office of Family Health Services. The largest of these programs is the VDH **Special Supplemental Nutrition Program for Women, Infants and Children (WIC)**, which is authorized and funded through the US Department of Agriculture. The WIC program aims to improve the health of pregnant women, infants, and children under age five through better nutrition and access to health care. Applicants must meet categorical, residential, income, and medical/bio-chemical risk requirements to be eligible for services.

WIC offices at local health departments screen potential participants for eligibility. The WIC Program ensures that eligible families, who might otherwise be unable to afford to eat properly, have access to healthy diets during pregnancy, breast-feeding, infancy, and early childhood to age five. Eligible participants are directed to WIC staff and peer counselors who provide: nutrition education and counseling, supplemental nutritious foods, breast-feeding promotion and support, and screening and referrals for other health, welfare, and social services. Program and eligibility information are available online <http://www.vdh.virginia.gov/ofhs/DCN/wic>.

Immunizations are critical to disease prevention and, ultimately, to public health. The **Virginia Vaccines for Children program** is a local health department program that partners with both public and private local practitioners to increase immunization levels for at-risk children. All vaccines required by law for school attendance may be obtained from local health departments, and vaccinations are available at no cost for individuals who are under the age of 19 and are uninsured, under-insured, enrolled in Medicaid, or are a Native American or Native Alaskan. The program conducts outreach and provides supplies of free vaccines to practitioners who then make them available to children with and without disabilities. The VDH central office, local health departments, and their community partners distribute information about the

program to the public, coordinate vaccine distribution to participating practitioners, and provide contact information on local participants.

The **Children and Youth with Special Health Care Needs (CYSHCN) program**, located within the Division of Child and Family Health under the VDH Office of Family Health Services, administers multiple service programs that work with families, service providers, and local communities to identify children with serious, persistent health care needs and to promote their optimal health and development. Its key network programs are described briefly below. Current core programs include, but are not limited to: Care Connection for Children, Child Development Services, the Bleeding Disorders Program, and the Sickle Cell Awareness Program. More information is available online at <http://www.vdh.virginia.gov/ofhs/childandfamily/childhealth/cshcn/>.

**Care Connection for Children (CCC)** is a network of six, regional **CCC Centers of Excellence** for children with special health care needs. The CCCs are located at the following sites.

- Washington County Community Services in Bristol
- Blue Ridge CCC at the University of Virginia Health System in Charlottesville
- Northern Virginia CCC at Inova Hospital in Fairfax
- Hampton Roads CCC at Children's Hospital of the Kings Daughters
- Central Virginia CCC at VCU Health System
- Roanoke Area CCC at Carillion Medical Center

The CCC provides leadership to enhance specialty medical services, care coordination, medical insurance benefits evaluation and coordination, management of a limited CYSHCN (Children and Youth with Special Health Care Needs) pool of funds, information and referral to CYSHCN resources, family-to-family support, and training and consultation with community providers on CYSHCN issues.

Children with special health care needs who are eligible for CCC services have disorders that have a physical basis, have lasted (or are expected to last) at least 12 months, and produce one of more of the following:

- Need for health care and ancillary services over and above the usual for the child's age, or for special ongoing treatments, interventions, or accommodations at home or school
- Limitation in function, activities, or social role in comparison with healthy age peers in the general areas of physical, cognitive, emotional, and social growth and development
- Dependency on one of the following to compensate for, or minimize limitation of, function, activities, or social role: medications, special diet, medical technology, assistive devices or personal assistance

CCC staff directly assists families of children diagnosed with qualifying medical disorders to obtain health care assessments and specialty medical care. Care Connection staff identifies, trains, and consults with potential community resources—particularly specialty medical services—to expand the available supply of providers and to establish family-to-family support networks.

The CYSHCN **Child Development Services Program** currently is a specialized program for children and adolescents suspected of having any one of, or a combination of, the following: a developmental delay or disability, learning problems, attention or hyperactivity disorders, and behavioral/emotional disorders. This program is financed by state and federal (Maternal and Child Health Block Grant-Title V) funds. At the time of this assessment, only five CDS clinics were in operation:

- the Southwest Virginia Child Development Clinic (Gate City),
- the Pediatric Neurodevelopmental Clinic at Carillion Medical Center for Children (Roanoke),
- the Shenandoah Valley Child Development Clinic (at James Madison University in Harrisonburg),
- the Virginia Commonwealth University Health System Clinic (Richmond), and
- the Child Development Clinic (Norfolk), which recently transitioned to the Children's Hospital of Kings Daughters.

Each clinic has an interdisciplinary team consisting of these professionals: a pediatrician, a nurse, a social worker, an educational consultant, and a psychologist. Core services provided by each clinic include diagnostic assessment and treatment/care planning, follow-up care coordination, and referrals to local providers. Consultations are available from other pediatric specialists as needed. Throughout the communities served, clinic professional staff also offers consultation, training, and advocacy focused on promoting the healthy growth and development of children. More information is available at <http://www.vdh.virginia.gov/ofhs/childandfamily/childhealth/cshcn/care.htm>.

The **VDH Bleeding Disorders Program** within the CYSHCN serves Virginia residents of any age who have a congenital bleeding disorder, such as hemophilia A, hemophilia B, or von Willebrand Disease. These disorders may co-occur with other types of disability. Any Virginia resident diagnosed with a bleeding disorder may apply for the program, regardless of age or income, but financial criteria must be met to receive services at no cost. The state legislature enacted this program in recognition that the ongoing medical costs to treat such disorders often exceed the insurance coverage and household financial capacity of the individual and his/her family.

This program supports a system of coordinated, family-oriented services from multi-disciplinary teams, located at four regional **Comprehensive Bleeding Disorder Centers**. At this

time, three pediatric Comprehensive Centers exist statewide. They are located in Norfolk, Falls Church, and Charlottesville. A Center serving both children and adults is located in Richmond. Each Center's team consists of specialists from various professions: physicians, nurses, social workers, physical therapists, orthopedic surgeons, dentists, genetic counselors, nutritionists, and educators. The teams develop and implement plans that address the individual's array of needs, and they assist families in coping with emotional, social, financial, educational, and workplace concerns. While outreach, direct services, and referrals are aimed at the general population, a program emphasis is on outreach to health care professionals to promote identification of and care for Virginians with these inherited conditions. Reciprocal referrals between the Comprehensive Bleeding Disorder Centers and disability service agencies occur as a result. More information is available at <http://www.vdh.virginia.gov/ofhs/childandfamily/childhealth/cshcn/bleedingdisorders/index.htm>.

Another important VDH service within the CYSHCN program is the **Sickle Cell Awareness Program**, which offers detection and treatment of sickle cell disease for all Virginians. All Virginia newborns are screened at birth for sickle cell disease through the Virginia Newborn Screening Program (described earlier), which includes sites at local health departments. Screening results are typically provided to the parents through their pediatrician. These and other referral sources direct families to **Pediatric Comprehensive Sickle Cell Clinics**, located in four major regional medical centers, for education, counseling, care coordination, and treatment. Additional community and professional educational and support services are offered through Community-Based Sickle Cell Programs. Although there are no financial eligibility requirements to receive services, each clinic offering services may charge fees for direct services based on income. For more information, go online to <http://www.vdh.virginia.gov/ofhs/childandfamily/childhealth/cshcn/sickleCell/>.

As noted in the introduction to this chapter, oral health is important to everyone's overall health and wellness. Maintaining good oral hygiene should begin in infancy and continue throughout a person's life. The **VDH Dental Programs** website offers online visitors numerous fact sheets and educational materials on how to maintain good dental hygiene as well as on local dental resources. It is located at <http://www.vdh.virginia.gov/ofhs/childandfamily/dental/>.

Local health departments are the point of contact for services through their dental clinics or staff. Although historically VDH-supported dental clinics have been a "safety net" resource, most are now transitioning to a model of prevention-only services. A VDH directory of dental programs from January of 2010 noted that clinical dental services were provided in 25 health districts at 54 different locations. A 2012 VDH presentation reported that dental clinics in 17 health districts were in operation. According to the current Dental Transition Plan, only three health districts will continue to have full dental clinic operations in the future. The localities in those districts were identified as having a "critical, unmet need" due to a lack of "safety net" dental services. (Details of this transition are described in the Introduction to this chapter, beginning on page 159, and progress reports are listed in the **Chapter References**.)

The dental clinics that remain in operation have provided and will continue to provide services primarily for pre-school and school-age children based on income eligibility. Eligibility for these services may be determined by school lunch status and/or family income. Dental services may be provided at health department clinics or at dental trailers placed on school property. Adult dental care may be available on a limited basis in certain localities. According to a VDH presentation, in SFY 2011, VDH dental clinics had over 35,000 visits. Of the total services provided, 31 percent were diagnostic; 44 percent were preventive; and 25 percent received treatment. A total of 20,350 individuals were served that year, and 72.3 percent of those patients were children/youth and 27.7 percent were adults. Of the total number of people served, 48.6 percent were enrolled in Medicaid.

Within the VDH Division of Child and Family Health, preventive education initiatives are conducted for various populations. The **Bright Smiles for Babies** program specifically targets children from birth to age three who are at highest risk for dental decay. Services include dental screening and risk assessment, fluoride varnish application, and oral health education and guidance to parents. This program also provides training and education specifically for parents/guardians and caregivers of children with special health needs, including youth with developmental and other disabilities.

To promote improved oral health at elementary, middle and high schools, the Dental Health Unit has developed an oral health curriculum. It is comprised of six modules with lesson plans that complement the health education Standards of Learning (SOLs). The curriculum goal is to promote positive health behaviors by students. The curriculum is available for use by health or physical education teachers, school nurses, and other school staff as well as by School Health Advisory Boards.

In addition, to educate Virginia's adults about maintaining good oral hygiene across the lifespan, the VDH Division of Dental Health provides dental hygiene education for adults and the elderly through its initiative, ***Beyond the Smile: The Campaign for Adult Oral Health***. This program provides training programs, presentations, educational materials and resources on oral health both to the general public as well as to health care and other professionals. Current educational programs include, but are not limited to:

- Virginia's Oral Cancer Project
- Diabetes and Oral Health
- Oral Health for the Elderly and Disabled
- Senior Smiles
- Oral Health and Overall Health-A Healthy Body Begins Here

Both VDH and local health departments provide training and educational resources for dentists and other health care providers to increase their skills in caring for young children and



others with special needs. A searchable database of Virginia dentists who provide care for individuals with special needs can be found at <http://www.vahealth.org/dental/>.

Since the mid-1980s, the spread of HIV and AIDS has been a growing health concern. An infant may be exposed to and contract HIV in utero through his/her infected mother. Men and women of any age may contract HIV through unprotected sex with an infected partner. As noted on the VDH website, individuals with cognitive and learning disabilities are at greater risk for contracting and spreading HIV/AIDS and have been identified by VDH as a population of special interest in its efforts to prevent spread of this disease.

The **VDH HIV Care Services** program provides outreach, referrals, and assistance to individuals of any age with HIV or AIDS. This program is funded through the federal Health Resources and Services Administration as authorized by the Ryan White Treatment Extension Act. A major program within the larger program is the **AIDS Drug Assistance Program (ADAP)**. ADAP provides medications for low-income, uninsured individuals with HIV/AIDS. The remaining funds provide HIV care services that are specifically targeted to deliver medical care and support services to eligible individuals living with HIV/AIDS. The Ryan White Treatment Extension Act's Part B funding is the payer of last resort.

The income requirement for HIV Care Services and the ADAP is currently 400 percent of the Federal Poverty Level (FPL). Program coordination is provided centrally by VDH HIV Care Services and regionally by "consortia" working in collaboration with local health departments and community partners. Three Health Regions (Northern, Northwest, and Southwest) in Virginia have a Regional Consortium that coordinates and facilitates Ryan White **Part B funds**. The Regional Consortia are a point of contact for accessing information on all Ryan White funding, not only in their respective region, but also throughout the State. In the Central and Eastern Regions, services are provided through a network of direct service providers. Information on the Central and Eastern Regions, as well as the rest of the State, can be accessed by calling HIV Care Services at (855) 362-0658. **Table 26** provides data on the number of individuals served under each program.

| <b>Table 26. Number Served by VDH HIV/AIDS Programs</b> |                         |   |
|---|-------------------------|---|
| <b>Year</b>   | <b>ADAP Medications</b> | <b>Ryan White Care and Support Services</b> |
| <b>April 2010 - March 2011</b>                          | <b>3,952</b>            | <b>6,807</b>                                |
| <b>April 2011 - March 2012</b>                          | <b>3,468</b>            | <b>6,936</b>                                |
| <b>April 2012 - March 2013</b>                          | <b>4,647</b>            | <b>6,962</b>                                |

To reduce the risk of cancer among low-income women who are uninsured or underinsured and age 18 through 64, **Every Woman's Life (EWL), the Breast and Cervical Cancer Early**

**Detection (BCCED) Program**, provides clinical breast exams, mammograms, Pap tests, and pelvic exams. Services are available from a network of 32 public and private nonprofit providers that serves over 7,600 women annually. The EWL program provides follow-up to ensure that participants receive the recommended screenings and appropriate services. Women can locate the nearest screening sites for the Every Woman's Life (EWL) program by calling 866-395-4968 (toll-free) or e-mailing the program through its website at <http://www.vahealth.org/ewl/>. This program is located within the Division of Prevention and Health Promotion of the Office of Public Health Services.

In addition to the direct health care services described, VDH operates numerous **education and outreach programs** for wellness and disease prevention through eight **Area Health Education Centers (AHECs)**, coordinated by Virginia Commonwealth University. Each AHEC is a unique, regional partnership of statewide and local educational resources, professional networks, public and private health care providers, VDH health districts, and municipal health departments. Their projects and resources are specific to the communities that they serve and primarily target areas that have shortages of health care providers and large populations of Virginians at risk for poor health habits and chronic health conditions. Individual projects undertaken by AHECs vary, but generally, they seek to increase the number of health care providers in underserved areas, address educational, physical, and attitudinal barriers that restrict access to health and wellness services, and identify underserved members of the community and direct them to appropriate services. As a result, expanded and improved health care service for people with disabilities is frequently a goal and outcome of AHEC activities.

Child and family health services programs at the Virginia Department of Health (VDH) collaborated to create **Bright Futures Virginia**, an information resource for families and health professionals. While Bright Futures does not specifically target families of children with disabilities, its "Guidelines" increase general awareness of what is developmentally appropriate and encourage routine, periodic screening for developmental delay. Its framework can then be used to assess the physical and mental health needs of children from birth through adolescence, determine if their progress is developmentally appropriate, and promote healthy growth and a smooth transition from pediatric to adult health services. The Bright Futures Virginia website provides information in video and printable formats that parents, caregivers, and health and human services professionals can access for up-to-date information on developmentally based well child care and anticipatory guidance. Launched in 2009, VDH reports that this webpage now receives more than 20,000 visits per month. Infant growth, toilet training, discipline, and behavior are the top video topics accessed. It is at <http://www.vahealth.org/brightfutures>.

The VDH **School Health Program** collaborates with the Virginia Department of Education (VDOE) in the supervision and coordination of school health nursing services in the Commonwealth. State school health specialists develop and promote guidelines, educational materials, training programs, and other resources for all public school divisions as well as

private and parochial schools. These guidelines and resources address health services for all students, with and without disabilities.

VDH's **Youth Suicide Prevention** program produces and distributes educational materials and conducts training for families, educators, and local service providers to raise public awareness and reduce the incidence of youth suicide. These materials include important referral information for Virginia's disability services and are available free of charge from the program's website at <http://www.vahealth.org/Injury/preventsuicideva/index.htm>, the VDH central office, and the program's community partners.

#### 4. Cost and Payment for VDH Services

Numerous sources, such as the Kaiser Family Foundation and the US Surgeon General, report that individuals with disabilities are typically poorer and are less likely to have private health insurance than the general population, making them necessarily more reliant on public insurance programs and other government-subsidized services. Health services provided and expenditures under the Commonwealth's Medicaid and CHIP health insurance programs are described in detail in the **Medicaid** chapter of this *Assessment*. Focus here is on funding revenue and expenditures for the **Virginia Department of Health (VDH)**.

In general, individuals pay for health care costs in several ways:

- directly out-of-pocket (in-full or as co-payment);
- indirectly through private health insurance purchased by an individual or family;
- private insurance through employers; or
- through public insurance programs (Medicaid, Medicare and the Children's Health Insurance Program, or CHIP).

Depending on income or if they are uninsured or underinsured, individuals may access various government-operated medical or dental services, such as those provided by local health department clinics. These providers may require co-payments or have sliding scale fees. Fees for VDH-supported services are based on medical and income criteria. These services typically are funded through a mixture of federal, state, and local public monies. The Commonwealth's General Assembly may allocate monies for health services by state fiscal year either from its General Funds or from dedicated revenue sources (such as user fees).

VDH received a total of:

- \$574,648,398 in appropriations in SFY 2012;
- \$621,434,928 in SFY 2013; and
- \$626,963,628 in SFY 2014.

It is important to note that, in conducting its multiple, mandated functions, VDH typically spends 88 percent of its annual budget in local communities. VDH funding to local, mandated health services is based on a complex formula set through collaborative planning between VDH and localities.

Budget allocations for selected categories of community health services that directly impact the lives of citizens for SFYs 2013 and 2014 illustrate the economic impact of VDH services. For both SFY 2013 and 2014, the annual budget was stable for:

- Local Dental Services, \$7,036,703 each year;
- Local Immunization Services, \$10,986,239 annually;
- Local Communicable Disease Investigation, Treatment, and Control, \$17,644,195 annually.

Appropriations decreased 1.7 percent for:

- Local Maternal and Child Health Services.

Funds for health services targeted at pregnant women and children went from:

- \$42,299,966 in SFY 2013 to
- \$41,582,329 in SFY 2014.

The *2013 VDH Agency Strategic Plan Executive Progress Report* notes that local health departments are funded jointly by VDH and local governments—a funding model unique among state agencies. VDH and the local government have a contractual agreement for local health clinic operations. A formula based on each locality’s capacity for revenue generation by a clinic determines the amount of each locality’s match payment, which may vary from 18 to 45 percent of total clinic operational costs. The report is available online at [https://solutions.virginia.gov/pbreports/rdPage.aspx?rdReport=vp\\_Agency&rdAgReset=True&Agency=601](https://solutions.virginia.gov/pbreports/rdPage.aspx?rdReport=vp_Agency&rdAgReset=True&Agency=601).

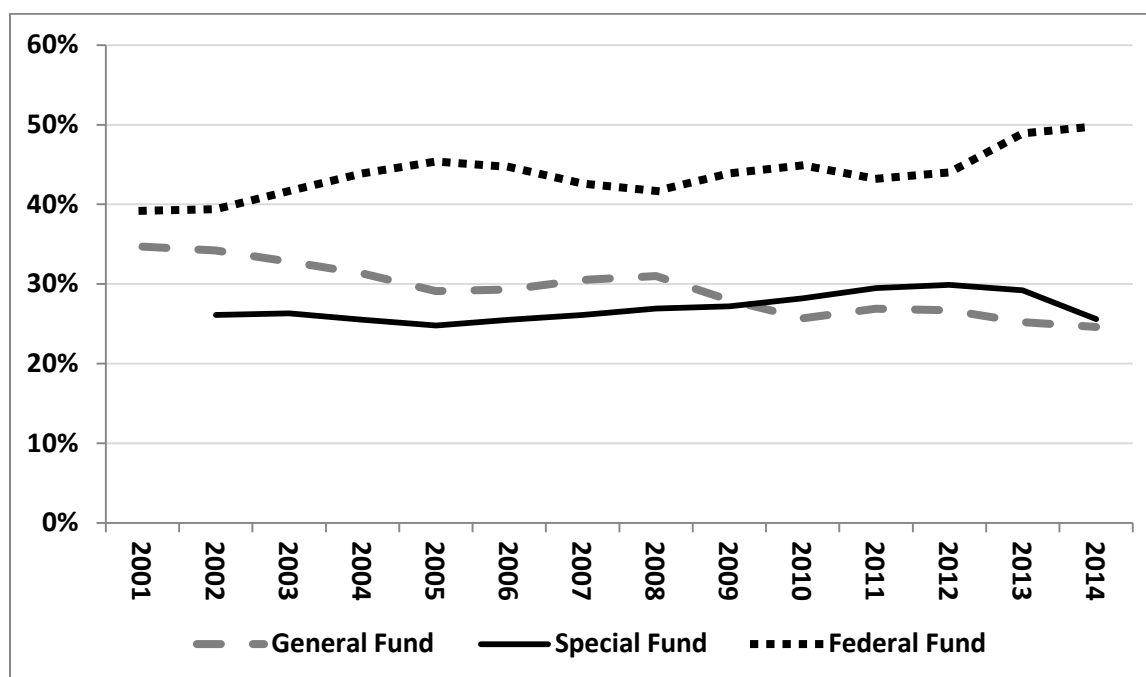
That same *Progress Report* points out that half of the annual VDH budget now comes from the federal government. In SFY 2014, VDH funding came from the following sources:

- 50 percent from federal grants and contracts;
- 25 percent from state General Funds;
- 13 percent from service fees and charges;
- 9 percent from local government funds for local health departments;
- 3 percent from dedicated special revenues (such as non-VDH-related fees and fines); and

- less than 1 percent from private grants, donations, and gifts.

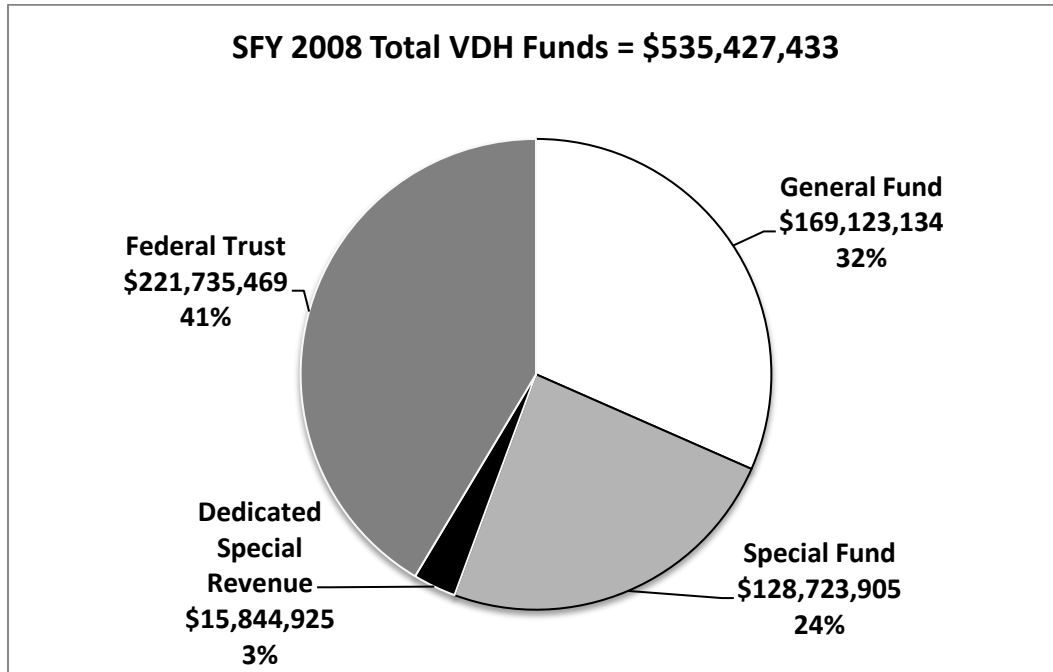
Since 2001, VDH reports that the agency has become increasingly reliant on federal funding, which increased as state General Fund allocations decreased. This funding pattern, in turn, caused VDH service priorities to shift more toward those set by the federal government than to state priorities. Since the terrorist attacks of 9/11 in 2001, federal funds increased for services such as epidemiology, disease prevention/control, and immunization. Based on data provided by the VDH Budget Office, **Figure 16** depicts this historical trend. It shows the percentage of the annual appropriations provided by each funding source by category.

**Figure 16. Proportion of VDH Appropriations for SFYs 2001–2014**

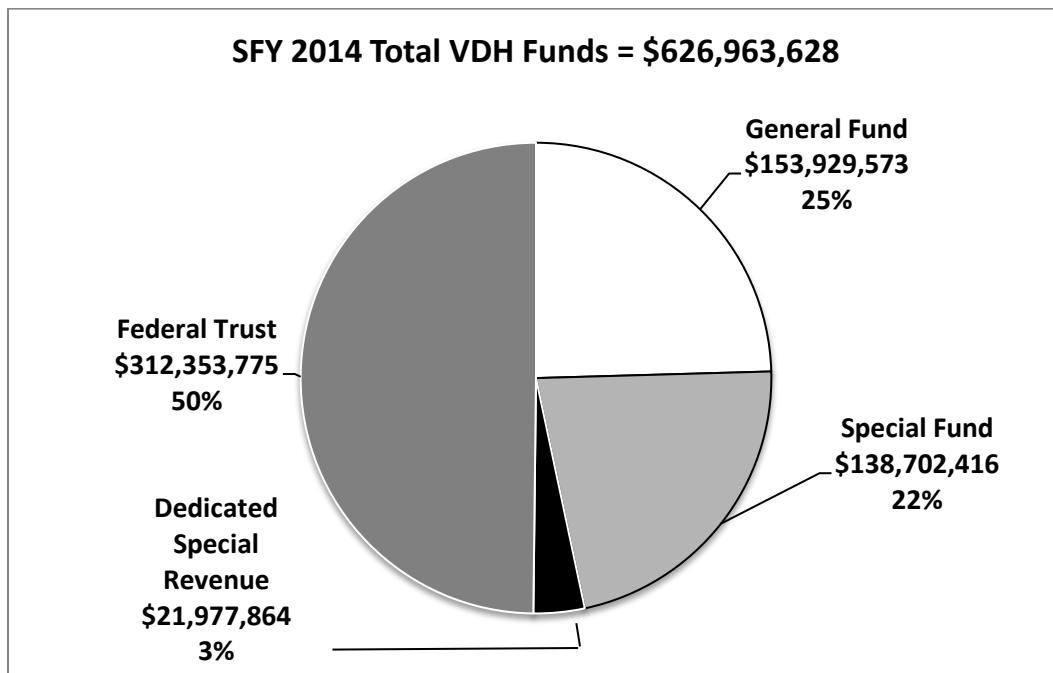


Between state fiscal years (SFYs) 2008 and 2014, total VDH funding actually increased, but most of the increase was from federal funds. Part of the federal increase, according to the VDH Budget Office, was due to VDH assumption of responsibility for administration of two food programs from the US Department of Agriculture: the Child and Adult Care Food Program and the Summer Food Service Program. **Figure 17** and **Figure 18** show the increasing federal role in the VDH annual budget for services between SFYs 2008 (**Figure 17**) and 2014 (**Figure 18**). Fiscal data were provided by the VDH Budget Office. Special funds are revenue from various service fees and charges, a large portion of which is from fees for environmental, medical, and personal care services provided by local health departments. Other fees come from waterworks operations, health care facilities, vital records, and other sources. As the charts indicate, the share of federal funding grew 29 percent over these years while state General Fund appropriations decreased by 8 percent.

**Figure 17. VDH Funding by Source for SFY 2008**



**Figure 18. VDH Funding by Source for SFY 2014**



During the same SFYs, staffing levels at the Department of Health (VDH) were more reliant on Non-General Funds (NGF)—federal funds and special revenue from fees and grants—than on state General Funds (GF).

| Table 27. Number of VDH Staff Positions by Funding Source |                     |                      |                         |
|---|---------------------|----------------------|-------------------------|
| SFY 2008  | GF: 1,664 positions | NGF: 2,107 positions | Total = 3,771 positions |
| SFY 2014  | GF: 1,544 positions | NGF: 2,215 positions | Total = 3,759 positions |

Growing reliance on federal funds is problematic. For example, the federal government shut down in the fall of 2013, creating a significant threat to VDH operations. The VDH commissioner (then Cynthia Romero, M.D.) advised the state House Appropriations Health and Human Resources subcommittee:

*Had the debt ceiling not been resolved, the resulting cash flow problems presented VDH with the potential furlough of approximately one third of our workforce.*

In turn, both services to Virginians in need and local economies would have been negatively impacted.

## 5. Monitoring and Evaluation of VDH Services

It is not possible to address the entire system for monitoring and evaluating the performance and responsiveness of the health care system in this *Assessment*. What follows is a general description of quality assurance mechanisms related to the services described previously. More information, including detailed monitoring and complaint procedures and compliance reports, where available, may be found using the **Chapter References**.

The **Virginia Department of Health (VDH) Office of Licensure and Certification** is responsible for licensing, monitoring, and managing compliance for a wide range of public and private health care facilities and service providers such as hospitals, outpatient clinics, certain laboratories and other testing facilities, nursing facilities, home care organizations, and hospice programs. Information on its quality assurance activities relative to direct services for people with disabilities may be found in the **Community Living Supports** and **Institutional Supports** chapters of this *Assessment*.

The VDH Office of Licensure and Certification is also responsible for certification of managed care health insurance plans under Titles XVIII and XIX of the federal Social Security Act (42 USC §§ 1395 and 1396 et seq., respectively). This office is also the state's official survey agency for providers that are eligible for reimbursements under Medicaid and Medicare. Specific certification, inspection, monitoring, and compliance requirements vary by type of service, and details can be found on the office's website at <http://www.vdh.virginia.gov/OLC/index.htm> along with procedures for submitting and resolving service complaints. The **Virginia Department of Medical Assistance Services (DMAS)** is charged with monitoring expenditures, preventing fraud and abuse, and providing quality assurance for the State's public health insurance programs. Information on these agencies' functions can be found in the **Medicaid** chapter of this *Assessment*.

The **Virginia Department of Health Professions (DHP)** administers, supports, and coordinates 13 DHP regulatory boards that set, monitor, and enforce standards of practice in 80 different health-related professions, which include over 350,000 health care workers statewide. Health professions regulated through the DHP include, but are not limited to:

- audiology and speech language pathology,
- counseling,
- psychology,
- social work,
- physical therapy,
- optometry,
- dentistry,
- medicine,
- nursing,
- pharmacy, and
- long-term care administrators.

As noted on the DHP website, each board works

*to ensure safe and competent patient care by licensing health professionals, enforcing standards of practice, and providing information to health care practitioners and the public.*

These boards develop regulations, receive complaints, and make case decisions regarding whether a provider is in violation of requirements for obtaining or retaining a license.

The DHP grants licenses, certifications, and registrations, handles concerns and complaints about service providers, and collects workforce data. To assist the public, the DHP has an online system for checking the current licensure status of health professionals, practitioners' records in the Board of Medicine's database, and the results of recent case decisions on complaints. Lists of covered professions, information on professional standards, complaint procedures, and forms are available on its website at <http://www.dhp.virginia.gov> or by contacting the DHP directly.

### **C. DBHDS Regional Community Support Centers**

In 1998, the Department of Behavioral Health and Developmental Services (DBHDS) began efforts to increase health care availability and capacity for persons with intellectual disabilities (ID) through creation and expansion of Regional Community Support Centers (RCSC). The RCSCs were intended to offer clinical services that were otherwise unavailable or not accessible from



community health care providers and other resources. RCSCs, supported by state General Funds, have offered outpatient services through clinics located in and operated by each of the five DBHDS Training Centers. The Training Centers are state-operated intermediate care facilities for individuals with intellectual and developmental disabilities. For more information on the Training Centers and other institutions in Virginia, see the **Institutional Supports** chapter of this *Assessment*.

The first RCSC was a demonstration pilot at the Northern Virginia Training Center, which obtained annual appropriations. Facility staff (or sometimes contractors) provided the services. Although each facility periodically offered services to individuals in the community, state funding to establish and maintain an RCSC at each facility did not occur until several years later. In state fiscal year (SFY) 2006, DBHDS received legislative appropriations to begin operating RCSCs at Central Virginia and Southwestern Virginia Training Centers; and in 2008, appropriations were made for Southside Virginia and Southeastern Virginia Training Centers.

Service priorities for each RCSC were based on regional service needs and gaps for individuals with ID through collaborative planning with local Community Services Boards and other stakeholders. As a result, the scope and type of RCSC services being provided have varied somewhat by facility. In addition, in partnership with colleges and universities, the RCSCs can provide training to students pursuing health care careers, thereby potentially expanding a trained community workforce available to serve individuals with ID and developmental disabilities (DD).

Through the 2012 Settlement Agreement with the US Department of Justice (DOJ), DBHDS and the Commonwealth made a commitment to expand community service capacity and to strengthen efforts to ensure individual health and safety in communities statewide. At the time of this assessment, DBHDS plans to transform the RCSCs by moving them into the community and by developing public-private partnerships for expanded outpatient services under the new name, the **Developmental Disability Health Support Network**. This transition is in process. An initial report on the transition was released in the spring of 2014, but it did not contain comprehensive details. More comprehensive information on the transition and future network configuration will be released later in 2014.

## **1. Eligibility for RCSC Services**

The RCSCs provide diverse clinical services and consultation to individuals with ID/DD and their families who either (1) have been discharged from a Training Center to a community residence, or (2) are community residents who have been referred by a local Community Services Board (CSB) or Behavioral Health Authority (hereafter referred to as CSBs). Priority for the limited services has been to provide key supports that are not otherwise available to enable participants to live successful lives in their communities. Residential service providers and health care professionals in the community may be eligible to receive clinical consultations or staff training from RCSC staff to improve services to individuals. They, too, must contact their local CSB to request RCSC training or consultation services.

## 2. Access to and Delivery of RCSC Services

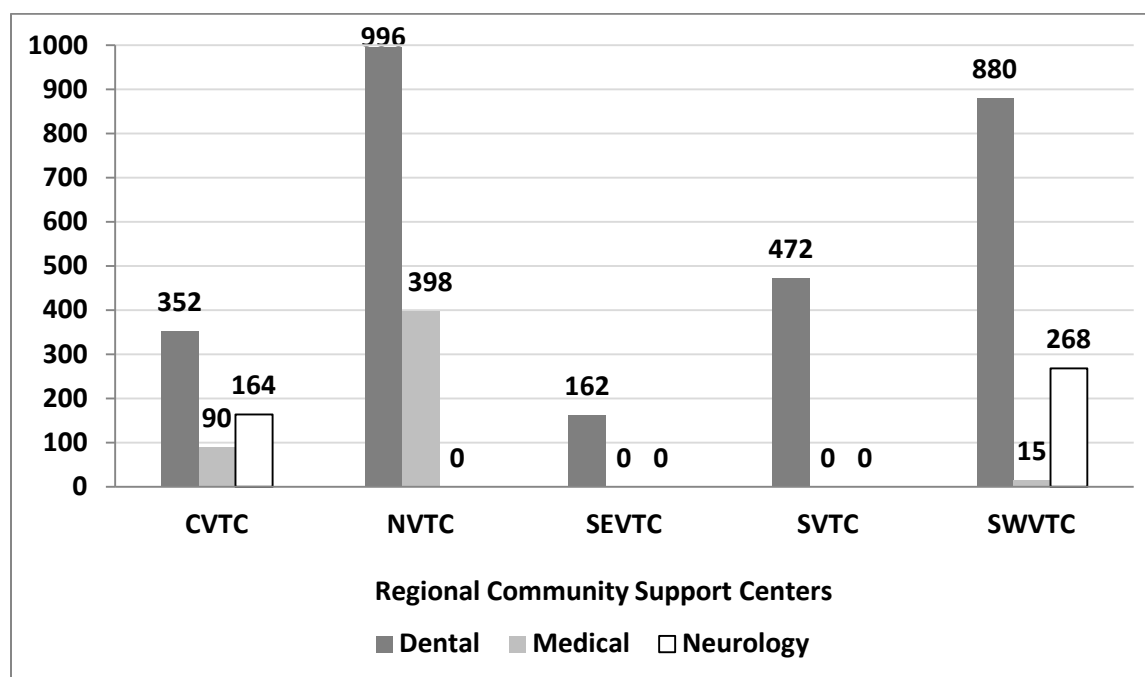
The DBHDS only had RCSC utilization data available for SFY 2012, which was prepared as part of its transition plans. That year the five RCSCs provided clinical and related services to a total of 4,894 individuals (unduplicated) in their communities. Because of regional prioritization for RCSC services and funding levels, variation across RCSCs has existed in both the total number of persons served and the type of services received. The total number served at each RCSC in SFY 2012 is as follows:

- 369 at Southside Virginia Training Center (SVTC) RCSC,
- 454 at Southeastern Virginia Training Center (SEVTC) RCSC,
- 739 at Central Virginia Training Center (CVTC) RCSC,
- 1,550 at Southwestern Virginia Training Center (SWVTC) RCSC, and
- 1,782 at Northern Virginia Training Center (NVTC) RCSC.

Of the total served, the SVTC RCSC served 7.5 percent that year; the SEVTC RCSC, 9.3 percent; the CVTC RCSC, 15.1 percent; the SWVTC RCSC, 31.7 percent; and the NVTC RCSC, 36.4 percent.

The data for each RCSC identify the number of people receiving various types of clinical services. The following graphs (**Figure 19** and **Figure 20**) illustrate the difference in RCSC service levels in each region that year. Individuals typically received more than one service at an RCSC during the year, so counts are duplicative across services. The NVTC RCSC was the only facility that provided therapeutic recreation, serving 191 individuals in SFY 2012; and that count is *not* included in either chart. **Figure 19** depicts the number of individuals who received dental, medical, or neurological services at each RCSC.

**Figure 19. Number Provided with RCSC Health Services in SFY 2012**



**Preventative dental care for adults** is not covered by Medicaid in Virginia, and reimbursement rates for **complex medical care**, which is covered, may not be sufficient to encourage providers to serve the ID/DD population. Not surprisingly, all RCSCs provided dental care in SFY 2012. For the SVTC RCSC, dental care was the only direct health service provided. Statewide, the RCSCs provided dental care to 2,862 individuals, 65.5 percent of whom were served at the NVTC and SWVTC RCSCs. NVTC served 996 dental patients, and the SWVTC RCSC served 880.

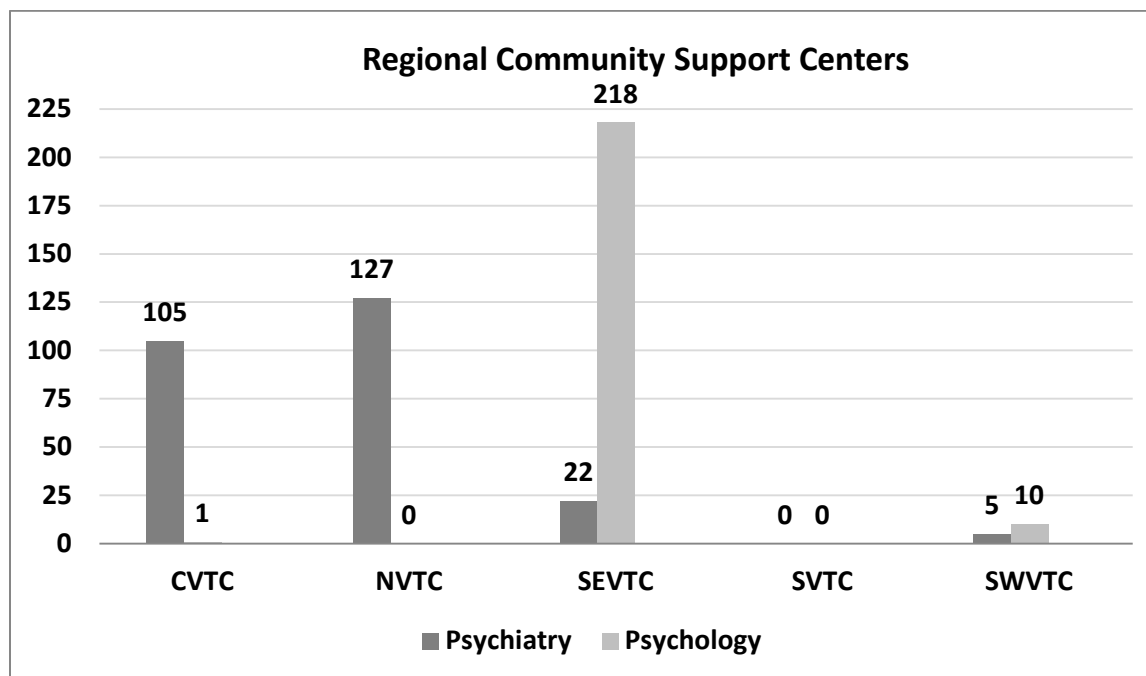
To expand dental service capacity in the community and offer dental services to adults with ID/DD, over the last several years the Northern Virginia Training Center has partnered with the ARC of Virginia, the VCU Health System School of Dentistry, the Virginia Dental Association, and the Virginia Oral Health Coalition. NVTC or its partners have successfully applied for grants and donations to expand these capacities.

Also in SFY 2012, a total of 503 individuals received some type of **medical care** and 432 received **neurological services** through the RCSCs. The NVTC RCSC also had the highest number of individuals receiving medical services with 398 patients, accounting for 79.1 percent of all RCSC medical services provided that year. Only CVTC and SWVTC, both located in more rural and underserved areas, provided neurological services.

**Psychological and psychiatric services** provided through RCSCs, with the exception of the SVTC, included assessment, consultation, and treatment. A total of 229 individuals received psychological services among four RCSCs in SFY 2012; and a total of 259 received psychiatric services. As shown in **Figure 20**, the SEVTC RCSC provided the vast majority of psychological

services with 218 cases that year, and the RCSCs at CVTC and NVTC provided most of the psychiatric services with 105 and 127 cases, respectively.

**Figure 20. Number Receiving RCSC Psychological and Psychiatric Services in SFY 2012**



In addition, each RCSC offered training of community providers and, in partnership with colleges and universities, training for students through internships. In SFY 2012, a total of 925 staff working in residential and health care settings were trained by RCSCs to improve community services and supports to individuals with ID/DD, and a total of 177 interns in various fields were trained, which may increase service capacity and quality in the future. **Table 28** provides the number trained by each RCSC location in SFY 2012.

| Table 28. Number of Staff/Interns Trained in ID/DD by RCSCs in SFY 2012 |                   |           |
|---|-------------------|-----------|
| RCSC  | # Community Staff | # Interns |
| CVTC  | 688               | 101       |
| NVTC  | 62                | 62        |
| SEVTC   | 40                | 8         |
| SVTC  | 57                | 2         |
| SWVTC   | 78                | 4         |
| TOTALS  | 925               | 177       |

The RCSC at CVTC trained 74.4 percent of the 925 community provider staff members trained and 57.1 percent of the interns trained system-wide. NVTC trained 35 percent of the 177 interns trained at RCSCs in SFY 2012.

### 3. Available RCSC Services

In collaboration with the local Community Service Boards (CSBs), families and other stakeholders, each RCSC developed a service array that best addressed unmet needs in the region. Limitations in the range and scope of services provided have existed due to different funding levels through state appropriations. (See the **Funding for RCSC Services** section below for more details.) The RCSCs are staffed by Training Center personnel as well as by private clinicians under contract with the facility. In general, clinical services provided by the RCSCs in recent years have included the following:

- psychological or behavioral consultation and psychological testing;
- dental procedures;
- laboratory, medical and preventative medical services;
- pediatric neurology;
- nursing and nutrition consultation;
- physical therapy;
- rehabilitative engineering;
- speech and language therapies; and
- therapeutic recreation services (only at NVTC).

Over the past ten years, a unique regional program at Southwestern Virginia Training Center (SWVTC) RCSC—**Pathways**—has existed to serve individuals with ID who are in communities and have either a co-occurring mental illness or have severely challenging behaviors that threaten their continued community residence. Begun in August of 2003, the Pathways program provides diagnostic consultation, treatment (medical, behavioral, and psychiatric), and short-term stabilization for that population. The Pathways program includes both outpatient services and short-term residential care, which is at a designated unit of eight beds certified as an intermediate care facility for individuals with intellectual disabilities (ICF/IID). The maximum length of stay in a Pathways residential unit is 90 days. All referrals must be made by a local Community Services Board (CSB). Pathways oversight is provided by a regional Pathways Council comprised of representatives from the CSBs (ID and mental health staff), the SWVTC, and Southwestern Virginia Mental Health Institute (a state DBHDS psychiatric facility).

### 4. Funding for RCSC Services

Started as a pilot project at Northern Virginia Training Center (NVTC) in 1998, the RCSCs spread slowly across the system. Each developed different levels of capacity based on state funding and on regional service gaps to be addressed. Some services, especially preventative

dental care to adults, are not reimbursed by Medicaid or some private insurers, and thus have been dependent on state General Funds (GF) through legislative appropriations. Each Training Center provides various in-kind services, such as use of its dental clinic, and either provides or contracts for professional staff to provide services. From SFY 2006 through 2013, the RCSC at NVTC received \$350,000 annually in state GF; and the other four RCSCs received \$200,000 each.

As reported by DBHDS, in SFY 2012, total expenditures for RCSC services were \$1,447,257 system-wide. By facility, the RCSC at SVTC spent the least amount on services (\$167,631); and the RCSC at NVTC, the most (\$893,614). RCSC SFY 2012 expenditures at CVTC were \$214,211 and \$171,801 at SEVTC.

## **5. Monitoring of RCSC Services**

Like any other health care service, professional clinical services at the RCSCs are licensed and monitored by the Virginia Department of Health; and individual clinical professionals must meet the licensing standards as set forth through the Department of Health Professions and their individual professions. (See the previous section on **Monitoring and Evaluation of VDH Services** for details.)

In addition, as part of the state Training Center staff, RCSC clinicians provide health care services to facility residents as well as individuals living in communities. The RCSC program must meet any applicable facility, staffing, professional, and equipment standards required by the US Centers for Medicare and Medicaid Services (CMS) for intermediate care facilities for individuals with intellectual disabilities (ICF/IID). More information is available about monitoring of ICFs/IID in the **Institutional Supports** chapter of this *Assessment*.

## **D. 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**

#### **Area Health Education Centers**

<http://www.ahec.vcu.edu>

#### **Association of University Centers on Developmental Disabilities**

<http://www.aucd.org>

#### **Healthy People 2020**

<http://www.healthypeople.gov/2020/default.aspx>

#### **Kaiser Family Foundation State Health Facts**

<http://www.statehealthfacts.org>

**Partnership for People with Disabilities at Virginia Commonwealth University**

<http://www.partnership.vcu.edu/>

**US Centers for Disease Control (CDC)**

<http://www.cdc.gov>

**Adult Oral Health**

[http://www.cdc.gov/OralHealth/children\\_adults/adults.htm](http://www.cdc.gov/OralHealth/children_adults/adults.htm)

**Behavioral Risk Factor Surveillance System**

<http://www.cdc.gov/brfss>

**Disability and Health**

<http://www.cdc.gov/ncbddd/disabilityandhealth/>

**US Office of the Surgeon General**

<http://www.surgeongeneral.gov>

**Reports**

<http://www.surgeongeneral.gov/library/reports/oralhealth/index.html>

## **2. Virginia State Websites Referenced**

**Code of Virginia**

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

**Department of Health**

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

**Division of Child and Family Health**

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

**Behavioral Risk Factor Surveillance System**

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

**Child Health Programs**

<http://www.vdh.virginia.gov/ofhs/childandfamily/childhealth>

**Children and Youth with Special Health Care Needs (CYSHCN)**

<http://www.vdh.virginia.gov/ofhs/childandfamily/childhealth/cshcn/>

**Bleeding Disorders Programs**

<http://www.vdh.virginia.gov/ofhs/childandfamily/childhealth/cshcn/bleedingDisorders/>

**Care Connection for Children**

<http://www.vdh.virginia.gov/ofhs/childandfamily/childhealth/cshcn/care.htm>

**Child Development Services**

<http://www.vdh.virginia.gov/ofhs/childandfamily/childhealth/cshcn/developmentServices.htm>

**Sickle Cell Awareness Programs**

<http://www.vdh.virginia.gov/ofhs/childandfamily/childhealth/cshcn/sickleCell/index.htm>

**Dental Health**

<http://www.vahealth.org/dental>

**Early Childhood Health Programs**

<http://www.vahealth.org/childadolescenthealth/EarlyChildhoodHealth/>

**Genetics and Newborn Screening**

<http://www.vahealth.org/gns/>

**Newborn Screening Program**

<http://www.vahealth.org/vnsp/>

**Virginia Cares**

<http://www.vahealth.org/gns/vaCares.htm>

**Virginia Early Hearing Detection and Intervention**

<http://www.vdh.virginia.gov/ofhs/childandfamily/childhealth/hearing/>

**Loving Steps (Healthy Start Initiative)**

<http://www.vdh.virginia.gov/ofhs/childandfamily/ReproductiveHealth/pregnancy/lovingSteps/>

**Prevention and Health Promotion**

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

**School Health**

<http://www.vahealth.org/childadolescenthealth/schoolhealth/>



**Division of Health Statistics**

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

**Division of Immunization**

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

**HIV/AIDS Programs**

<http://www.vdh.virginia.gov/epidemiology/DiseasePrevention/Programs/HIV-AIDS/index.htm>

**Virginia Vaccines for Children**

<http://www.vdh.virginia.gov/epidemiology/Immunization/VFC/index.htm>

**Office of Licensure and Certification**

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

**Office of Minority Health and Health Equity**

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

**Department of Health Professions**

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

**Joint Commission on Health Care**

<http://jchc.virginia.gov>

**Virginia Administrative Code**

<http://leg1.state.va.us/000/reg/TOC.HTM>

**Virginia Performs**

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

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US Office of the Surgeon General. (2005). *Call to Action to Improve the Health and Wellness of Persons with Disabilities*. Rockville, Maryland: US Department of Health and Human Services. Retrieved from <http://www.ncbi.nlm.nih.gov/books/NBK44667/>

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## 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 EDCD 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 EDCD 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.

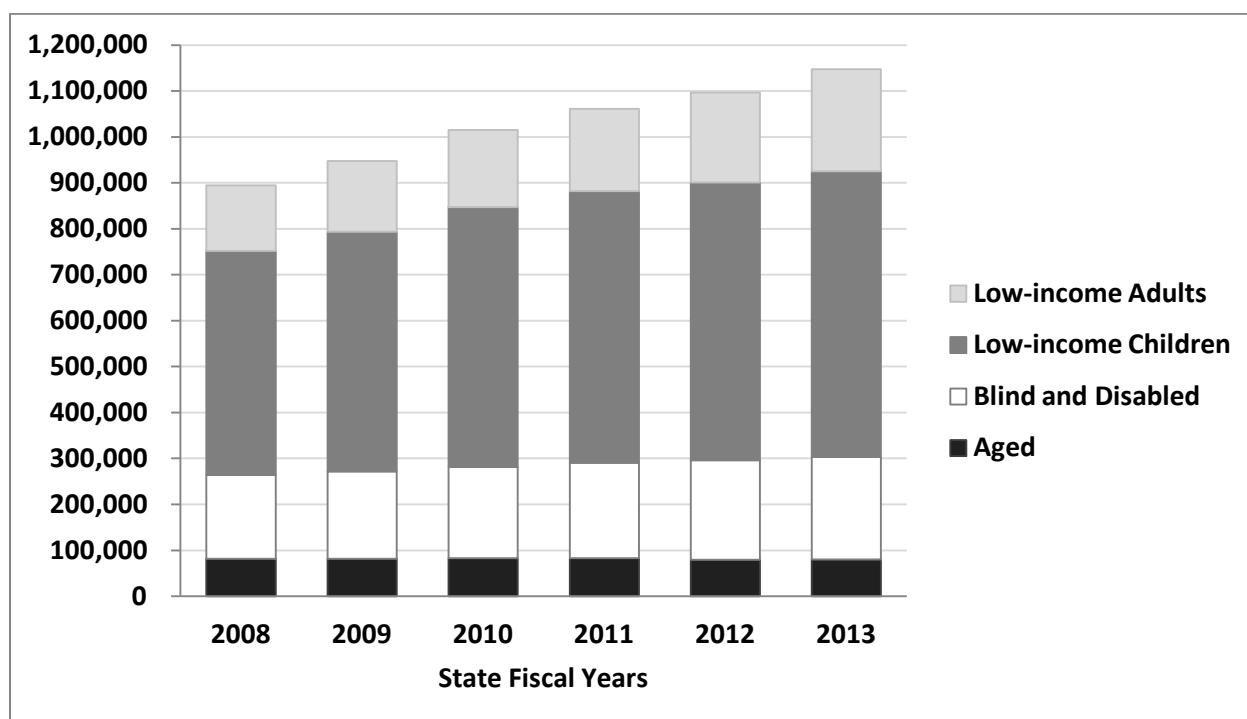
Of necessity, the Department of Medical Assistance Services (DMAS) maintains a vast database of information, which includes the:

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.

| Table 29. Proportion of Medicaid Enrollees by Category for Selected SFYs |       |       |       |       |       |         |
|--|-------|-------|-------|-------|-------|---------|
| 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 |



| Table 29. Proportion of Medicaid Enrollees by Category for Selected SFYs |       |       |       |       |       |         |
|--|-------|-------|-------|-------|-------|---------|
| 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.

| Table 30. Number Served Under Medicaid AAL, Tech, and Day Support Waivers |      |      |      |      |      |
|---|------|------|------|------|------|
| 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 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 wait 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 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 wait 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).

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

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.)

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

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 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.magellanoftexas.com/>

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

<http://www.magellanoftexas.com/about-magellan-of-texas.aspx>

##### **Governance Board**

<http://www.magellanoftexas.com/about-magellan-of-texas/governance-board.aspx>

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

<http://www.nashp.org>

#### **Robert Wood 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>

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

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## VI. Community Living Supports

### A. Introduction to Support Services for Community Living

The programs and services in this chapter, broadly referred to as “community supports,” enable individuals with disabilities to be as independent as possible and to be fully integrated into all facets of community life. State agencies operate, administer, license, or pay for services and supports using state General Funds or other financial resources (including matching Medicaid funds). Details concerning services that can be accessed through the Medicaid State Plan and Medicaid Home and Community Based Services (HCBS) Waivers are covered in the **Medicaid** chapter of this *Assessment*.

Several key factors impact the scope and availability of community-based disability services in the Commonwealth:

- the State’s economy;
- federal budget decisions (and indecision), especially regarding Medicaid and Medicare;
- state Medicaid reform, such as expansion of managed care; and
- Virginia’s Settlement Agreement with the US Department of Justice.

In this **Settlement Agreement with the US Department of Justice (DOJ)**, Virginia committed to numerous actions that would transform services for people with Intellectual Disabilities (ID) and Developmental Disabilities (DD) from institutions and institutional-based services to a focus on community living and community-based services. The target populations covered under the Agreement include individuals with ID or DD who reside in state-operated Training Centers or in private/nonprofit nursing facilities. It also includes all individuals who are already living in the community and are eligible for or on waiting lists for Medicaid ID or DD Waivers. Virginia made a 10-year commitment to these goals:

- significant expansion of community services available to individuals with intellectual (ID) and related disabilities;
- improved service oversight and quality assurance; and
- closure of 4 of the 5 Training Centers.

The **Department of Behavioral Health and Developmental Services (DBHDS)**, which leads implementation of the Agreement, took action in 2011 to address DOJ findings. In February of 2012, DBHDS presented a formal plan to the General Assembly. It set up interagency workgroups and internal project teams to ensure completion of the Agreement’s required actions. A court-appointed **Independent Reviewer** monitors progress made by DBHDS and the Commonwealth in fulfilling the system changes identified in the Agreement. The legislature

additionally requires regular formal reports on activities and progress by DBHDS. DBHDS regularly posts information online, including operational changes for case management, internal and legislative progress reports, Independent Reviewer reports, and many other Agreement documents, which can be accessed at <http://www.dbhds.virginia.gov/settlement.htm>.

As required by the Settlement Agreement, DBHDS worked to develop a new, regional **crisis intervention service** for adults (ages 18 or older) with ID and/or DD who also have either (1) a psychiatric condition or (2) challenging behaviors that negatively affect their quality of life. DBHDS contracted with the Institute on Disability (University Center for Excellence in DD) at the University of New Hampshire to implement a **Systematic, Therapeutic Assessment, Respite and Treatment** crisis model known as “**START**.” This evidence-based model emphasizes early intervention and crisis prevention for individuals with ID/DD through an integrated, statewide service system. Goals of the crisis program have been to enhance local service capacity and provide collaborative, cost-effective, person-centered supports based on comprehensive assessment, planning, and technical assistance, and to improve the clinical outcomes for these individuals. START consultants assisted DBHDS in program development and in training both Community Service Boards (CSBs) staff and new, regional crisis team members. Training included best practices for assessment, crisis intervention and treatment planning.

By late fall of 2013, all 5 regions had in operation both START mobile teams to respond to crises on a 24-hour, 7-days-a-week basis and centers for short-term, therapeutic respite care on either an emergency or planned basis. The mobile teams additionally engaged the individual and his/her family or caretakers to develop personal crisis prevention and support plans, and provided training to them for implementation of those plans. These regional teams conduct follow up on individuals over time to monitor service effectiveness and to address any emergent issues. An annual evaluation report, developed by the **University of New Hampshire Center for START (UNHC/START)**, states that 517 individuals were referred to the regional START programs during SFY 2013. A noted accomplishment was that the mobile teams achieved an average response time of less than 2 hours for face-to-face evaluations and immediate telephone response for on-call systems.

As part of program evaluation, DBHDS requires data collection by the mobile teams on the following for each individual:

1. demographics,
2. psycho-social factors,
3. psychiatric diagnoses (if any),
4. medical history,
5. history of psychiatric hospitalizations in the last 1-5 years,
6. presenting behaviors and issues, and

## 7. service utilization.

Data are analyzed at the regional and state levels. DBHDS provides program descriptions, information, and reports online at <http://www.dbhds.virginia.gov/ODS-default.htm>.

As of January 9, 2014, based on experiences and outcomes thus far, DBHDS renamed and modified the crisis service as the **Regional Educational Assessment Crisis Response and Habilitation (REACH) program**. Building on key tenets and features of the START model, DBHDS has established planning workgroups to create a comprehensive, coordinated, and more flexible crisis response system for individuals with ID or DD. Regional REACH programs will continue to be evidence-based and to meet expectations set forth in the DOJ Settlement Agreement. UNHC/START consultants are providing technical assistance to DBHDS to develop standards and performance measures as well as to provide regional training for REACH until the end of its contract (June 30, 2014). The DBHDS planning report, *Developmental Disabilities Crisis Response System: A Road Map to Creating a Community Infrastructure*, is online at <http://www.dbhds.virginia.gov/documents/ODS/DD%20Crisis%20Response%20System%20Plan%201%206%2014.pdf>.

Released in June of 2014, the fourth quarterly report by the court's Independent Reviewer (covering October 7, 2013 through April 6, 2014) complimented the Commonwealth on its compliance with many Settlement Agreement requirements. Noteworthy accomplishments that the report recognized included the following:

- Virginia funded and assigned more than the minimum required Medicaid Waiver slots for individuals with ID and DD on the Medicaid ID and DD Waiver Wait Lists;
- the number of individuals who transitioned to community settings from Training Centers, including a "well organized and effectively implemented" discharge planning and transition process;
- implementation of the mobile crisis teams for crisis support and stabilization services with trained staff in all five regions; and
- expanded case management services and licensure oversight.

However, the Independent Reviewer also cited the following areas of significant non-compliance with the Agreement:

- Case reviews of individuals with histories of challenging behaviors who lived in Region IV (Richmond metro area) or Region V (Tidewater) were conducted. The reviews found that language assessments were not offered to individuals for whom communication aids might reduce disruptive behaviors. For other individuals, recommendations for needed assessments were not made. When behavioral supports were provided, they lacked critical features, specifically, a Functional Behavioral Analysis, skill acquisition objectives, and data collection for measuring progress.

- Crisis intervention services for youth have not been developed. Current regional plans each lack 1 or more program components required by the Agreement, such as in-home services, mobile crisis response, and short-term alternatives to institutionalization. According to available DBHDS data, 4 of the 5 regions may not be offering in-home, crisis support for up to 3 days.
- Few individuals with a developmental disability (DD) other than intellectual disability (ID) used crisis services, and there existed no plan for outreach to individuals with DD and their families.
- Virginia has not implemented plans to facilitate the transition of children with ID and DD from nursing facilities and large intermediate care facilities for individuals with ID (ICFs/IID) to community homes.
- Providers rarely offered individuals who were not employed opportunities for integrated day activities. The Reviewer found the DBHDS implementation plan to expand day activities, which DBHDS labeled “preliminary,” to “lack specificity and depth about how to achieve those goals” and to delay actual creation of activities for another 2 years.

The Independent Reviewer stated that making progress in areas of non-compliance would require not only **increased resources** and expertise but also continued **expansion of inter-agency collaboration and problem solving**.

In 2013 DBHDS created and initiated the **Individual and Family Support Program (IFSP)** to help individuals on the Medicaid ID or DD Waiver Wait Lists to access needed services and supports that will enable them to remain in their own or family homes, including assisted living facilities (ALFs). Funded entirely through State appropriations, the IFSP can support up to 1,000 individuals statewide annually through 2021. The maximum funding level for any individual’s request is \$3,000 for the year. Each September, DBHDS announced the application period. Funding requests were processed on a first-come, first-served basis until program funds were fully committed. Due to the large volume of applications, DBHDS typically ended the application period within 1 to 2 months. Family members or caregivers of eligible individuals may apply for IFSP funds.

During state fiscal year (SFY) 2013, 825 individuals received funding for services under the IFSP, which averaged \$1,800 per person. As of February 20, 2014, that number had risen to 1,293 individuals. (At the time of this assessment, the SFY 2014 average per person funding was not available.) According to DBHDS, these were the most common purposes for which IFSP funds were used in both years:

- respite care;
- specialized therapies (speech, physical and occupational therapy, applied behavioral analysis, vision, water, and hippo [equestrian]);
- environmental modifications; and

➤ assistive technology.

To better align the IFSP with the intended goal of institutional diversion per the Settlement Agreement, DBHDS is reviewing the purchases made thus far and is considering further clarification of the types of services or supports to be funded prior to the September 2015 application period. Detailed information on IFSP eligibility and procedures is described in state regulation (12 VAC 35-230 et seq.) and in various documents available online at <http://www.dbhds.virginia.gov/ODS-IFSP.htm>.

In November of 2013, responsibility for daily operations for the **Medicaid Individual and Family Developmental Disabilities Support Waiver (DD Waiver)** transferred from the state Department of Medical Assistance Services (DMAS) to DBHDS. As required by federal law, DMAS will retain oversight responsibility for: paying DD Waiver provider claims; contract monitoring of the prior authorization process; handling appeals; and ensuring compliance of all policies and regulations with federal regulations. DMAS and DBHDS will jointly develop the DD Waiver budget, funding priorities and provider rates. All other operational tasks will be done by DBHDS. A full list of administrative tasks roles is provided in the announcement letter available at both the DMAS and DBHDS website.

At the present time, DBHDS is limited in its responsibilities for services to Virginians with a developmental disability (DD) other than an intellectual disability (ID). Under Code of Virginia § 37.2-203, DBHDS has responsibility

*to ensure the development of long-range programs and plans for mental health, developmental, and substance abuse services provided by the Department, community services boards, and behavioral health authorities.*

However, by statute (Code of Virginia § 37.2-100), “developmental services” are still defined as being those provided only to individuals with an intellectual disability. In addition, the state legislature has neither provided a regulatory mandate nor funding for DBHDS to provide services to Virginians with other types of developmental disabilities.

With respect to other state agencies with a mandate to serve individuals with disabilities, as a result of Governor McDonnell’s Government Reform initiative, the 2010 General Assembly approved the **consolidation** of two agencies and several programs: the Virginia Department for Aging (VDA); the Department of Rehabilitative Services (DRS); Adult Protective Services and Adult Services divisions from the Virginia Department of Social Services; and the state Long-term Care Ombudsman program. To allow for appropriate operational and programmatic planning, the consolidation occurred in stages over a 2-year period. Prior to the consolidation, each entity’s staff engaged in extensive cross training about their roles and functions as well as in strategic planning to improve services across the lifespan. On July 1, 2012, as authorized by Code of Virginia § 51.5-116 et seq., the **Department for Aging and Rehabilitative Services (DARS)** was implemented, in which VDA was renamed as the “**Virginia Division for the Aging.**”

The Adult Protective Services, Adult Services Divisions, and the Ombudsman program were incorporated into DARS effective July 1, 2013.

Although core responsibilities of each entity did not change, new responsibilities related to aging services and adult services were added to the powers and duties of the DARS commissioner (Code of Virginia, 51.5-131). The new DARS mission, which is detailed online at <http://www.vadrs.org/downloads/DARS2014E-flier.pdf>, is as follows:

*In collaboration with community partners, provides and advocates for resources and services to improve the employment, quality of life, security, and independence of older Virginians, Virginians with disabilities, and their families.*

Under state statute (Code of Virginia § 51.5-137), DARS has administrative responsibilities for long-term care services for the elderly to

*develop appropriate fiscal and administrative controls over public long-term care services in the Commonwealth.*

Enabling legislation (Code of Virginia § 51.5-143) additionally gave DARS statutory responsibility for publicizing and distributing guidelines on universal design and visitability features

*to make structures and dwellings accessible for older Virginians and people who develop mobility impairment.*

A new oversight resource for all state-funded services is the **Office of the State Inspector General (OSIG)**, which was created by the legislature in 2012 (Code of Virginia § 2.2-307 et seq.). With the Office, the legislation also created the new position of State **Inspector General (IG)**. The OSIG incorporates the inspector general offices for these state Departments:

- Behavioral Health and Developmental Services,
- Corrections,
- Juvenile Justice,
- Transportation, and the
- State Internal Auditor.

All functions and duties of each Department's IG will continue under the new agency. The OSIG is charged to investigate complaints alleging fraud, waste, abuse or corruption by a state agency or a non-state agency (those supported entirely or principally by state funds).

Authorizing legislation empowers the OSIG to investigate the management and operations of state and specified, non-state agencies as well as to conduct performance reviews. The OSIG must provide semi-annual reports to the General Assembly and the Governor regarding its investigative and monitoring activities, which are posted on its website at

<http://www.osig.virginia.gov>. The Governor may request a special OSIG investigation to address a significant event (e.g., Virginia Tech shootings) or information regarding state agency services or operations. Parts or all of an investigative report may not be made public, however, due to: executive privilege; the privacy rights of individuals served or their caregivers; or pending legal action. The State Inspector General is appointed by the Governor, subject to confirmation by the legislature, for a four-year term. By statute, the SIG must have experience or expertise in accounting, public administration or audit investigations.

Numerous state agencies fund, license, provide, or contract for services and supports that promote community inclusion and integration. Their sources of funds and the regulations governing their application impact eligibility for, access to, and availability of those services and supports. As a result, disability services are often designed to address the specific needs of one or more populations for which an agency or organization is funded, resulting in disability- or age-specific services. The number and diversity of public or private nonprofit and for-profit service providers across the State adds to this complexity.

A description of all community-based programs and supports available to individuals with developmental and other disabilities is beyond this *Assessment*. The community supports covered here are organized by the following key programs and services and listed by their sections in this chapter:

- B. Assistive Technology and Related Services**
- C. Brain Injury Services**
- D. Spinal Cord Injury Services**
- E. Community Rehabilitation Case Management Services**
- F. Comprehensive Services Act for At-risk Youth and Families**
- G. Centers for Independent Living and Related Services**
- H. Independent Living Services for the Blind and Vision Impaired**
- I. Intellectual Disability Services (Non-Medicaid Waiver)**
- J. Interpreter and Other Services for the Deaf and Hard-of-Hearing**
- K. Omnibus Budget Reconciliation Act Services**
- L. Personal Assistance Services (Non-Medicaid Waiver)**
- M. Services for the Elderly Population**

Interested readers can find additional information on various state websites. Extensive funding information on state agency programs can be found in the state appropriations bill and other documents available through the Department of Planning and Budget's (DPB) website (<http://www.dpb.virginia.gov>). Additional information about services provided and performance goals for various programs are found in agency biennium strategic plans posted on the Virginia Performs website (<http://www.vaperforms.virginia.gov>). Details concerning

services that can be accessed through the Medicaid State Plan and Medicaid Home and Community Based Services (HCBS) Waivers are covered in the **Medicaid** chapter of this *Assessment*.

## B. Assistive Technology and Related Services

As defined by State regulation (22 VAC 30-20-10), **assistive technology (AT)** is

*any item, piece of equipment, or product system ... that is used to increase, maintain or improve the functional capabilities of an individual with a disability.*

AT devices range from “reachers” and other simple, mechanical aids to devices as complex as electric wheelchairs that respond to breath controls or adaptive environmental controls that respond to voice commands. AT services are defined as

*any service that directly assists an individual with a disability in the selection, acquisition or use of an AT device.*

These services may include the following:

- needs and functional evaluations of an individual in his or her natural environment;
- purchasing, leasing or otherwise providing for AT devices;
- selecting, designing, customizing, adapting, maintaining, repairing, or replacing AT;
- coordinating and using other therapies, interventions, or services with AT devices, such as education and rehabilitation programs;
- training or technical assistance in using AT for an individual with a disability and, as appropriate, for his or her family, guardian, or authorized representative; or
- training or technical assistance to professionals, employers, or others who employ, serve or “are substantially involved in the major life functions of individuals with disabilities” in order to achieve an employment outcome.

### 1. Screening and Eligibility for AT Services

State-funded AT services are available through 3 state disability service agencies. The largest of these, the **Department for Aging and Rehabilitative Services (DARS)**, serves individuals with disabilities of all ages and levels of ability with two AT programs:

- **Virginia Assistive Technology System (VATS)**. Eligibility information is available online at <http://www.vats.org> or by phone (800-552-2435 or 552-8490). VATS provides an array of AT services and technologies to enable Virginians to participate more actively in their communities. One of their services is a reuse program for durable medical equipment. Gently used, donated equipment may be available through the **Virginia Reuse Network (VRN)**, which is coordinated by VATS and is online at



<http://www.vats.org/atrecycling.htm>. VRN prioritizes individuals with disabilities who lack resources to purchase AT equipment on their own.

- **Woodrow Wilson Rehabilitation Center (WWRC)**. Located in Fishersville, WWRC provides AT through outpatient clinics and residential programs. Priority is given to current DARS clients who need AT to obtain or keep a job; therefore, eligibility criteria follow any Vocational Rehabilitation Order of Selection category in effect. Detailed eligibility information for outpatient and residential services is available on WWRC's website at <http://www.wwrc.virginia.gov/admissions.htm> or by contacting WWRC by phone [800-345-9972, Ext. 7065; or 540-332-7065; or (for TTY) 800-811-7893].

Another source of AT and related services is the **Virginia Department for the Deaf and Hard of Hearing (VDDHH)**, which serves individuals who are deaf, hard of hearing, deafblind or otherwise both hearing and vision impaired. VDDHH's two AT programs currently are the **Technology Assistance Program (TAP)** and **Virginia Relay**. TAP provides telecommunication equipment to qualified applicants whose impairments prevent them from using a standard phone. Since October of 2012, VDDHH revised TAP eligibility guidelines to increase services to Virginians who are veterans and have a hearing or speech loss. Eligibility information and an application form for TAP services is available online at <http://www.vddhh.virginia.gov/TechIntro.htm> or at one of the local VDDHH outreach offices listed at <http://www.vddhh.org/orproviders.aspx>; or by phone [(800) 552-7917 (V/TTY)].

**Virginia Relay**, a federally mandated service, provides traditional and captioned telephone relay services to persons who are deaf, hard-of-hearing, deafblind, or speech impaired. Relay services, which are available all day, year-round, enable individuals to communicate with standard telephone users with the strictest confidentiality.

For individuals needing assistance, VDDHH staff and local **outreach contractors** provide information and referral on available services as well as topics related to hearing loss and deafness, and they collaborate with the TAP and Virginia Relay Services to help them obtain needed assistive technology. VDDHH additionally conducts outreach to provide information and training for state and local agencies (including public safety), businesses, and civic organizations. VDDHH outreach staff and local contractors provide education and awareness on topics such as sign language skills, using interpreters effectively, obtaining assistive technology, and coping with hearing loss. In SFY 2013, outreach was provided to 31,820 individuals statewide.

When an individual has been denied **interpreter services** by private providers or other organizations covered by the Americans with Disabilities Act (ADA), VDDHH encourages the individual to have the entity contact them directly for additional information and assistance in locating a qualified interpreter. While the agency does not have enforcement authority for the ADA, VDDHH staff will discuss options with the entity for effective communication, including fact sheets.

## 2. Access to and Available AT and Related Services

AT services may be provided on an outpatient basis in an office, in the individual's home, or within a residential program. Sources of AT services and equipment include local school divisions, vocational rehabilitation agencies, private vendors on a fee-for-service basis, and other local programs. Each AT provider or agency has its own eligibility criteria and procedures for: service access and delivery; scope and duration of service provided; mediation or appeals; and user fees, if any. An individual with a disability may have access to AT through multiple programs at different times based on evolving needs and eligibility criteria.

The Department for Aging and Rehabilitative Services' (DARS') **Virginia Assistive Technology System (VATS)** provides services through its central office in Richmond and three regional sites:

1. Southwest VATS at Virginia Tech in Blacksburg,
2. Southeast VATS at Old Dominion University in Norfolk, and
3. Northern VATS at George Mason University in Fairfax.

Available AT devices, services, and funding sources vary among the VATS regional sites, but generally include AT loans, training and demonstrations, information and technical assistance, and public awareness outreach. To help individuals make informed decisions about AT, staff at the sites can provide more detailed guidance about the application and benefits of specific devices or services. The AT devices most frequently demonstrated or loaned by VATS are iPod Touch with applications for cognition and communication and Livescribe Smart Pens.

**Table 38** describes the number of services provided by VATS during state fiscal years (SFYs) 2010 and 2013. Note that between these years, the number of short-term AT equipment loans and demonstrations increased while the number of trainings, informational, and other types of assistance declined.

| <b>Table 38. Assistive Technology Services Provided by VATS in SFYs 2010 and 2013</b> |              |              |
|---|--------------|--------------|
| <b>VATS Services Provided</b>   | <b>2010</b>  | <b>2013</b>  |
| <b>AT Short-term equipment loans made</b>   | <b>51</b>    | <b>144</b>   |
| <b>AT demonstrations conducted</b>  | <b>128</b>   | <b>145</b>   |
| <b>AT trainings conducted</b>   | <b>2,098</b> | <b>1,837</b> |
| <b>Information or other assistance provided</b>                                       | <b>2,096</b> | <b>318</b>   |

Source: Department for Aging and Rehabilitative Services.

VATS staff attributes the shift in service utilization to changes in the federal law (Assistive Technology Act) and federal program requirements. A larger percentage of funding was mandated for state-level activities such as the AT equipment loans and demonstrations rather

than trainings and outreach. In addition, over the past five years, significant technological improvements have occurred and been made available to meet the AT needs of individuals with disabilities, including:

- the introduction of smart phones,
- tablet computing with touch screens, and
- a growing selection of applications that assist people with disabilities.

**Table 39** lists the total number of unduplicated individuals who received some type of AT service through VATS for SFYs 2009 through 2013. Over this period, the number of people served by VATS steadily declined, decreasing by 4,981 individuals, or 58.4 percent. DARS staff attributes the decrease to several factors: loss of Goodwill Industries as a reuse partner in 2009; the loss of dedicated federal funding for AT reuse programs; and changes in service priorities in compliance with the current federal AT Act.

| <b>Table 39. Individuals receiving Assistive Technology Services through VATS in SFYs 2009–2013</b> |              |              |              |              |              |
|---|--------------|--------------|--------------|--------------|--------------|
| <b>State Fiscal Year</b>  | <b>2009</b>  | <b>2010</b>  | <b>2011</b>  | <b>2012</b>  | <b>2013</b>  |
| <b>Total (unduplicated) persons served</b>  | <b>8,534</b> | <b>5,914</b> | <b>6,511</b> | <b>4,786</b> | <b>3,553</b> |

Grant funds in SFY 2010 enabled VATS, WWRC, and the Foundation for Rehabilitation Equipment and Endowment (F.R.E.E.) to collaboratively build and administer a statewide **Virginia Reuse Network (VRN)** to help meet the rehabilitation equipment needs of individuals with disabilities. Local public and private partners supply VRN with volunteers and generate donations of gently used rehabilitation equipment as well as funds. Donated equipment is sanitized, repaired or refurbished, and distributed through regional recycling centers listed at <http://www.vats.org/atrecycling.htm>. **Table 40** provides the number of individuals who received recycled AT equipment through the VRN since SFY 2009.

| <b>Table 40. Individuals receiving Recycled Assistive Technology Equipment from the VRN by SFY</b> |              |                |                |                |                |
|--|--------------|----------------|----------------|----------------|----------------|
| <b>State Fiscal Year</b>   | <b>2009</b>  | <b>2010</b>    | <b>2011</b>    | <b>2012</b>    | <b>2013</b>    |
| <b>Number of individuals</b>   | <b>2,534</b> | <b>502</b>     | <b>603</b>     | <b>696</b>     | <b>966</b>     |
| <b>Amount change from prior SFY</b>  |              | <b>- 2,032</b> | <b>+ 101</b>   | <b>+ 93</b>    | <b>+ 270</b>   |
| <b>Percent change from prior SFY</b>   |              | <b>- 80.2%</b> | <b>+ 20.1%</b> | <b>+ 15.4%</b> | <b>+ 38.8%</b> |

Source: Department for Aging and Rehabilitative Services.

As noted above, there was a significant decline in the number of individuals receiving reused AT from VRN. After a low of 502 individuals in SFY 2010, however, the number of AT equipment recipients increased each year but has not achieved the level of SFY 2009. DARS

reports that the most frequent VRN requests are for recycled durable medical equipment, specifically manual wheelchairs, tub benches, walkers, and bariatric equipment.

DARS' Woodrow Wilson Rehabilitation Center (WWRC) provides comprehensive AT assessments and customized technology services through a variety of outpatient and residential clinics and programs. Policies and procedures vary among the programs, some of which serve specific disabilities. WWRC program teams may include rehabilitation and computer systems engineers, physical and occupational therapists, speech/language pathologists, and social workers, as needed. WWRC also provides the specialized training in AT use critical to successful daily independent functioning. For example, its 10-day, intensive residential **Empowerment through Communication (ETC)** program assists individuals in improving their communicative competence using **alternative/augmentative communications (AAC) devices**.

In SFY 2013, **WWRC residential services** increased its bed capacity. As a result, the average daily census increased 7.2 percent, from 290 in SFY 2012 to 311 in SFY 2013; the number of cases increased 3.7 percent (96 cases) from 2,613 in SFY 2012 to 2,706 in SFY 2013. In addition to providing AT to inpatients, **WWRC outpatient programs** provide a variety of AT services for eligible adolescents and adults with disabilities, including the following:

- specialized and individualized computer technology;
- vehicle modification recommendations;
- customized rehabilitation engineering and fabrication;
- augmentative or alternative communication;
- customized seating systems and mobility enhancement;
- assistive listening devices; and
- adaptive devices for daily living and recreation.

**Table 41** below shows the number of individuals receiving AT services through WWRC programs for SFYs 2011 through 2013.

| <b>Table 41. Individuals receiving Assistive Technology Services by WWRC Program for SFYs 2012–2013</b> |             |             |             |
|---|-------------|-------------|-------------|
| <b>State Fiscal Year</b>  | <b>2011</b> | <b>2012</b> | <b>2013</b> |
| <b>Residential program</b>  | <b>74</b>   | <b>79</b>   | <b>73</b>   |
| <b>Outpatient program</b>   | <b>429</b>  | <b>313</b>  | <b>321</b>  |

Source: Department for Aging and Rehabilitative Services.

Due to its bed capacity, the WWRC residential programs provided AT services to a relatively stable number of persons during that time. The number served in WWRC outpatient clinics,

however, declined by 27 percent between SFYs 2011 and 2012 due to budget cuts since 2010. The numbers increased slightly in SFY 2013.

Individuals seeking information/referral or technical assistance services from the Virginia Department for the Deaf and Hard of Hearing's (VDDHH) **Technology Assistance Program (TAP)** may contact either VDDHH or one of its local **Loan-To-Own (L2O)** providers. TAP provides equipment to qualified individuals through its L2O programs, which distribute TTYs, captioning telephones, amplified phones and handheld devices, signalers, and speech amplifiers as well as specially requested equipment for persons with both a hearing and vision loss. Eligible applicants are served on a first-come, first-served basis based on available funds. In times of fiscal restraint, VDDHH may give priority to new applicants or to recipients who have not received AT equipment in the previous 4 years and who do not have functioning equipment as verified by VDDHH or a vendor. Financial eligibility for TAP devices is based on incomes at or below 250 percent of the Federal Poverty Level (FPL). Service fees are determined by a sliding scale.

Through **TAP L2O**, a qualified individual with hearing loss has the opportunity to test various technologies and AT devices designed to enhance independence and quality of life. At the end of a 30-day loan period, if a device meets his or her communications needs, ownership is permanently transferred. During the loan period, if the device is not meeting the individual's needs, he or she may exchange it for a different device to test in the home or workplace for an additional 30 days. TAP may provide more than one AT device to an individual based on needs. All devices carry a 1-year warranty, and qualified TAP participants can apply for new equipment every 4 years. Since SFY 2010, the TAP L2O program has been fully operational online with an electronic application submission system and a decentralized equipment inventory. Outreach Specialists now deliver the equipment to qualified applicants to test and install, reducing the waiting time for receipt of equipment from 4 to 6 weeks, to same day. **Table 42** provides utilization data for select SFYs between 2007 and 2013.

| <b>Table 42. TAP Loan-To-Own Assistive Technology Program Use by SFY</b> |             |              |              |              |
|--|-------------|--------------|--------------|--------------|
| <b>State Fiscal Year</b>   | <b>2007</b> | <b>2011</b>  | <b>2012</b>  | <b>2013</b>  |
| <b>Number served</b>   | <b>523</b>  | <b>1,098</b> | <b>1,174</b> | <b>1,538</b> |
| <b>AT devices distributed</b>  | <b>n/a</b>  | <b>1,318</b> | <b>1,836</b> | <b>2,018</b> |

Source: Virginia Department for the Deaf and Hard of Hearing.

As the data indicate, the number of individuals receiving AT services through TAP more than doubled between SFYs 2007 and 2011, with an increase of 31 percent between 2012 and 2013. The number of distributed AT devices increased by 53.1 percent between SFYs 2011 and 2013, with the largest increase between 2011 and 2012. These increases resulted from several factors: efficiencies realized by implementation of a L2O database, decentralization of equipment inventory, and implementation of the TAP Veterans program.

Administered by VDDHH, the **Virginia Relay** telecommunications service for individuals with hearing or speech loss can be accessed by dialing 7-1-1 on any phone. Virginia Relay provides an intermediary communications assistant who confidentially relays text messages created on a Teletype (TTY) or similar device-to-voice (and vice versa) equipment. Special features are available for individuals who are speech-disabled, are Spanish speaking, or use American Sign Language (ASL). Relay users are encouraged to complete a Relay Choice Profile that automatically notifies the communications assistant of the person's calling preferences. By law, the communications assistants must maintain strict confidentiality.

Use of TTY-based relay services has declined in Virginia from 1.4 millions calls in SFY 2004 to less than 350,000 in SFY 2014, a 75 percent decrease. This trend is directly attributable to the availability of alternative Internet and wireless relay services that allow individuals to communicate directly using text messaging, video relay, captioned phone services, and other technologies. With newer technology such as the captioned telephone (**CapTel**) service, Virginia Relay can transmit both voice and text for hard-of-hearing or late-deafened adults. Also growing in use has been **Video Relay Service (VRS)**, which enables sign language users to communicate in their native sign language using a special video device. VDDHH outreach providers across the State can provide information, demonstrate the use of CapTel and videophones, and provide technical assistance for these services.

These newer relay technologies are not without challenges. Video Relay Services (VRS) have remained unavailable in rural areas where broadband or DSL infrastructure does not exist; and where available, its use is often blocked by a business' Internet security firewall. CapTel services are often not compatible with VoIP or server-based phone services used by public and private entities. Also, much of the equipment available to state equipment distribution programs such as TAP are analog based and may not be compatible with newer, wireless home phone services.

In October of 2013, AT&T, the Commonwealth's current relay contractor, announced it would exit the relay industry during the summer of 2015. This exit will require VDDHH to issue a Request for Proposal for a new relay provider effective August 1, 2015, the ending date of the current contract with AT&T. Recent modification of VDDHH's relay budget language by the 2014 General Assembly is expected to result in significant cost savings with the new contract.

VDDHH additionally provides **outreach services** through its Resource Centers at locations statewide: Richmond, serving central Virginia; Fredericksburg area; Fairfax County area; Eastern Shore; Southwest/Western area (Abingdon, Roanoke, New River Valley, Lynchburg, and Staunton); Norton/Grundy area; and Norfolk/Hampton Roads areas. For referral to an outreach provider, either contact VDDHH directly by phone or by e-mail ([frontdesk@vdhh.virginia.gov](mailto:frontdesk@vdhh.virginia.gov)). VDDHH Outreach services include training, technical assistance, and information/referral on AT and other services to Virginians with hearing impairments to enhance independent living, and to caregivers, service providers, public safety officials, and business professionals to improve communication.

The total number of outreach contacts has decreased significantly over time.

- SFY 2007 had 71,141 contacts;
- SFY 2010 had 37,779 contacts; and
- SFY 2012 had 28,484 contacts.

Between SFYs 2007 and 2010, a significant decrease in contacts (46.9 percent) occurred, primarily because of a 30-percent cut in state funds for outreach. The VDDHH Resource Library was closed due to both budget reductions and declining circulation. At this time, most of the VDDHH Outreach staff works part time and schedules small-group appointments to conserve limited resources.

In 2011, through a competitive application process, the VDDHH was selected as the certified entity statewide to receive federal funding for participation in a pilot program, the **National Deaf-Blind Equipment Distribution Program** (also referred to as the “iCanConnect” program). This national pilot program, which was mandated by Section 105 of the 21<sup>st</sup> Century Communications and Video Accessibility Act, is to enable access to modern telecommunication tools and technology by low-income individuals who have both a hearing and vision loss. Federal grants in each state are to support local activities (outreach, assessments, equipment installation and maintenance, and training) as needed for the target population at no cost, so they can engage fully in society. Based on a federal formula, VDDHH received an annual award of \$226,000 to provide this service to qualified individuals. In collaboration with the state Department for the Blind and Visually Impaired (DBVI) and the Helen Keller National Center Office at Virginia Commonwealth University, VDDHH began services in 2012; the grant is funded through June of 2015.

### **3. Cost and Payment for AT and Related Services**

For individuals, AT equipment and services may be paid for in one of several ways. Private insurance carriers as well as public insurance (Medicaid or Medicare) may cover AT costs. Some state agency programs directly provide AT or services to individuals who are uninsured or under-insured or have needs exceeding their available resources at no cost or on a sliding fee scale. Funding sources for each AT programs administered by a state agency typically include some combination of federal and state government monies as well as foundation grants and user fees (when applicable) or insurance co-payments.

As noted earlier, the **Department for the Aging and Rehabilitative Services (DARS)** administers the Virginia Assistive Technology System (VATS), the Virginia Reuse Network (VRN), and the Woodrow Wilson Rehabilitation Center (WWRC). Federal monies primarily fund DARS itself. In SFY 2012, only 17 percent of its total annual budget was from state General Funds. An exception, however, is DARS Community-based Services Division, which receives over 60 percent of its annual budget from state General Funds. DARS distributes federal and state fund appropriations to each of its programs based on the respective legislative mandate.

**Table 43** shows the total expenditures across state fiscal years (SFY) for **VATS** and **VRN**, both of which obtain additional funds from other sources. VATS regularly seeks grant funds

from foundations as well as government sources. The VRN pools money and in-kind services from its partners who assist in soliciting donations of funds and used AT equipment.

| <b>Table 43. DARS Assistive Technology Program Expenditures for SFYs 2009 - 2013</b> |                  |                  |                  |                  |                  |
|--|------------------|------------------|------------------|------------------|------------------|
| <b>Program</b>   | <b>2009</b>      | <b>2010</b>      | <b>2011</b>      | <b>2012</b>      | <b>2013</b>      |
| <b>VATS</b>  | <b>\$785,715</b> | <b>\$605,673</b> | <b>\$604,865</b> | <b>\$604,472</b> | <b>\$574,644</b> |
| <b>VRN</b>   | <b>N/A</b>       | <b>\$75,000</b>  | <b>\$75,000</b>  | <b>\$75,000</b>  | <b>\$126,000</b> |

Source: Department for Aging and Rehabilitative Services.

WWRC, which provides AT services both to vocational residents and clinic outpatients, does not track expenditures by type of service. WWRC's funding is discussed in more detail in the **Employment** chapter of this *Assessment*.

In its *2013 Agency Strategic Plan Executive Progress Report*, the Virginia **Department for the Deaf and Hard of Hearing (VDDHH)** notes that its primary source of funding is special revenues, which comprised 92 percent of its annual budget in SFY 2013 and almost 93 percent in SFY 2014. Total VDDHH appropriations for SFYs 2013 and 2014 are listed in **Table 44**.

| <b>Table 44. VDDHH Appropriations by Source for SFYs 2013 and 2014</b> |                     |                     |
|--|---------------------|---------------------|
| <b>Source</b>  | <b>2013</b>         | <b>2014</b>         |
| <b>State General Fund</b>  | <b>\$844,985</b>    | <b>\$844,994</b>    |
| <b>Federal, Special Funds</b>  | <b>\$10,561,124</b> | <b>\$10,938,174</b> |

Special Funds include designated revenues from the Communications Sales and Use tax, which became effective in January 2007. This tax is collected by the state Department of Taxation, on all phone landlines, wireless, Internet, cable and satellite services in Virginia. The tax revenues support VDDHH's TAP, Virginia Relay, and associated administrative services. Federal regulations mandate provision of Virginia Relay services, related equipment distribution program, and oversight.

Total expenditures for the Technical Assistance Program (TAP) and Virginia Relay are listed by state fiscal year in **Table 45**.

| <b>Table 45. VDDHH Expenditures for Assistive Technology for SFYs 2007 - 2013</b> |                  |                  |                  |                  |                  |
|---|------------------|------------------|------------------|------------------|------------------|
| <b>Program/Service</b>  | <b>2007</b>      | <b>2010</b>      | <b>2011</b>      | <b>2012</b>      | <b>2013</b>      |
| <b>TAP</b>  | <b>\$381,540</b> | <b>\$410,069</b> | <b>\$397,692</b> | <b>\$374,986</b> | <b>\$432,399</b> |



| <b>Table 45. VDDHH Expenditures for Assistive Technology for SFYs 2007 - 2013</b> |                     |                     |                    |                    |                    |
|---|---------------------|---------------------|--------------------|--------------------|--------------------|
| <b>Program/Service</b>  | <b>2007</b>         | <b>2010</b>         | <b>2011</b>        | <b>2012</b>        | <b>2013</b>        |
| <b>Virginia Relay</b>   | <b>\$14,364,229</b> | <b>\$10,226,176</b> | <b>\$8,632,713</b> | <b>\$9,133,989</b> | <b>\$8,729,488</b> |

Source: Virginia Department for the Deaf and Hard of Hearing.

While there is no cost to use the Virginia Relay service, individuals must still pay the usual long-distance call/service fees of their telecommunications provider.

Some Virginians with disabilities who need AT equipment do not have insurance coverage or are not eligible for conventional loans. They may obtain financial assistance for AT through the **Assistive Technology Loan Fund Authority (ATLFA)**, a State Authority created with public funds. The ATLFA provides affordable financing alternatives (such as no down payments and longer repayment terms) to help make adaptive equipment a possibility for those individuals. Regardless of income, any Virginia resident with a disability or a caregiver of a person of any age with a disability can apply for a loan. Credit history, income, and debts are considered in loan approval; special consideration is given to disability and medically related credit issues. Any type of equipment can be financed as long as it relates to an individual's disability such as vision aids, communication devices, hearing devices, and home or vehicle modifications. Loans for home-based businesses are limited to business-related equipment, inventory, or supplies.

Individuals who meet the ATLFA lending criteria can borrow up to \$30,000 (with no minimum amount) at a 5-percent interest rate for equipment and older vehicles. The interest rates for new vehicles or vehicles no more than 2 years old (based on the current model year) are indexed quarterly by the Board of Directors. Exceptions are made on a case-by-case basis for direct loans greater than \$30,000. ATLFA no longer guarantees loans to a bank. Its former partner, SunTrust Bank, decided to terminate its business agreements with all alternative financing programs nationwide. Beginning in January of 2014, the ATLFA became a direct lender with no banking partner; and all loan requests are processed and closed directly by the Authority. To apply for a loan, call 1-866-835-5976 or obtain a loan application form online at <http://www.atlfa.org>.

Over the past seven years, ATLFA has received and processed over 200 loan applications annually. Typically, half or more of the loan applications are approved. Since SFY 2006, the lowest loan approval rates occurred during the recession: 45.3 percent in SFY 2007 and 43.4 percent in SFY 2009. In SFY 2010, ATLFA processed 231 loan requests, of which 50.2 percent were approved. In SFY 2011, 251 were processed and 54.5 percent were approved. In SFY 2012, 209 were processed and 51.6 percent were approved, and in SFY 2013, 226 were processed and 55.7 percent were approved.

**Table 46** shows the number of loans approved by ATLFA during SFYs 2009 through 2013 for each loan category. Loans made through SunTrust Bank may be guaranteed by ATLFA or non-guaranteed. Direct loans are those made and managed by ATLFA.

| Table 46. ATLFA Loans Provided for Assistive Technology by SFY |      |      |      |      |      |
|--|------|------|------|------|------|
| Types of Loans Approved  | 2009 | 2010 | 2011 | 2012 | 2013 |
| Direct loans   | 74   | 92   | 101  | 88   | 114  |
| Non-guaranteed loans   | 6    | 15   | 24   | 11   | 12   |
| Guaranteed loans   | 9    | 9    | 12   | 9    | 0    |

Source: Assistive Technology Loan Fund Authority.

As the data indicate, the majority of ATLFA loans over time have been direct loans, which have increased as a proportion of total approved loans. Since SFY 2006, in fact, the proportion of direct loans has dramatically increased: in SFY 2006, they were 59.1 percent of all loans approved. By SFY 2010, they were 79.3 percent, and, in SFY 2013, they represented 90 percent of all approved loans.

**ATLFA annual funding** is comprised entirely of federal monies provided through the federal Rehabilitation Services Administration (RSA). Loan issuances for AT equipment through ATLFA loans have been as shown in **Table 47**.

| Table 47. Total ATLFA Funds Loaned for Assistive Technology by SFY |             |             |             |             |             |
|--|-------------|-------------|-------------|-------------|-------------|
| State Fiscal Year  | 2009        | 2010        | 2011        | 2012        | 2013        |
| Loan Issuances   | \$1,052,140 | \$1,045,062 | \$1,059,278 | \$1,033,952 | \$1,447,999 |

During SFY 2013, these were most commonly purchased AT services with ATLFA loans:

- adapted or modified vehicles (72 loans),
- hearing or communication devices (16), and
- home/environmental modifications (12).

This pattern of purchases has been consistent for a number of years.

Oversight for the Assistive Technology Loan Fund Authority (ATLFA) is provided by a Board of Directors whose role and membership is set in Code of Virginia § 51.5-55. The Board members include the state Secretary of Health and Human Resources (or designee), an employee of the Woodrow Wilson Rehabilitation Center (WWRC), an experienced consumer lender, a certified public accountant, two individuals with investment finance experience, and six individuals with disabilities. In addition to ATLFA's statutory responsibilities, policies and procedures for consistent delivery of the loan program are set forth in the *Alternative Financing Program Manual*, the *Telework Loan Manual*, and ATLFA's *Governance Manual* and bylaws, which are approved by the ATLFA Board. The ATLFA also complies with reporting requirements

of the federal Rehabilitation Services Administration (RSA) grant, which is a funding source: ATLFA submits an annual report describing program activities, both the types and amounts of loans issued, and the demographic characteristics of loan applicants. The state auditor of public accounts audits ATLFA's fiscal records and accounts of loans as well as any loan fund or loan guarantee fund that the Authority administers or manages. The most recent routine audit (2012) by the auditor of public accounts of the ATLFA reported that all transactions had been properly recorded and reported, and there were no internal control matters or instances of non-compliance that needed to be reported.

#### **4. Monitoring and Evaluation of AT and Related Services**

Administered by the Department for Aging and Rehabilitative Services (DARS), **Virginia Assistive Technology System (VATS)** and the **Virginia Reuse Network (VRN)** each are guided by the Department's three-year plan that must be submitted for approval to the **US Rehabilitation Services Administration (RSA)**, VATS' federal funding source. The RSA sets annual performance measures and targets for both VATS and VRN. Performance measures center on client self-reports from individuals with disabilities and others (family members, guardians, employers, various professionals) on their ability to access or acquire appropriate AT equipment through VATS, and used durable medical equipment (DME) through VRN.

Information is collected and compiled on a routine weekly, monthly, quarterly, and annual basis. VATS receives reports from its regional sites and the Virginia Reuse Network on:

- how many individuals received recycled AT devices;
- the retail value of AT received and the resulting cost savings; and,
- each quarter, a summary of evaluations from large training programs or conferences.

As part of VATS' annual program report to RSA, this information plus the results of client follow-up and satisfaction surveys are compiled at the state level and are compared to VATS' three-year plan. The state plan can be amended annually to reflect services offered and compliance with federal mandates. In SFY 2013, both VATS and VRN exceeded RSA performance goals, and both had high satisfaction ratings from individuals served.

AT services provided by the Durable Medical Equipment (DME) Program at DARS' **Woodrow Wilson Rehabilitation Center (WWRC)** are accredited by the national Accreditation Commission for Health Care (ACHC), which sets clinical, operational, and facility standards. The WWRC AT program routinely collects information on specific individual satisfaction measures by surveys and from calls to individuals who have received wheelchairs or other DME. Based on the customer feedback, therapists are assigned to contact those individuals for troubleshooting and other follow-up. All quality assurance information, which is tracked in a database, is reviewed by program managers semi-annually to determine ways to improve service delivery and further reviewed annually by the WWRC AT Center of Excellence Focus Group.

The **Department for the Deaf and Hard of Hearing's (VDDHH) Technology Assistance Program (TAP)** routinely conducts satisfaction surveys of its customers. Responses are routinely documented, and concerns are forwarded, as needed, to the appropriate outreach specialist, program coordinator, or the VDDHH director, who is responsible for quality assurance. Procedural changes in the TAP Loan-to-Own (L2O) program have significantly reduced the time required to receive equipment from up to 6 weeks to several days. The VDDHH agency strategic plan reports that customer feedback has approached 100 percent as “satisfied” or “very satisfied” with services received.

By state statute (Code of Virginia, § 56-484.7), VDDHH is responsible for managing and monitoring telecommunications contracts for all **Virginia Relay** services and for annual reports to the Federal Communications Commission (FCC) on contractor performance and consumer feedback, including a log of all consumer complaints. The FCC must certify that relay services meet federal standards. Virginia Relay service contracts include specific steps to ensure vendor compliance and to ensure responsiveness to individual complaints. User comments are compiled daily by Virginia Relay contractors and reported monthly to VDDHH. VDDHH oversight includes routine test calls by agency staff and by external, independent testers on contract, onsite quality assurance visits, and reviews of monthly performance and statistical reports as well as feedback from system users and members of the Virginia Relay Advisory Council.

### C. Brain Injury Services

How medical conditions or functional impairments are defined in state regulations and law impact service eligibility. Typically, state law adopts definitions as required by the federal law authorizing the funds for services to address a particular condition/impairment or category of impairments. Both the Virginia Administrative Code (12 VAC 35-46-10 and 12 VAC 35-105-20) and Code of Virginia (§ 37.2-403) define **brain injury (BI)** as

*any injury to the brain that occurs after birth, but before age 65, that is acquired through traumatic or nontraumatic insults. Nontraumatic insults may include, but are not limited to, anoxia, hypoxia, aneurysm, toxic exposure, encephalopathy, surgical interventions, tumor, and stroke. Brain injury does not include hereditary, congenital, or degenerative brain disorders, or injuries induced by birth trauma.*

Under Code of Virginia § 51.5-119, the Department for Aging and Rehabilitative Services (DARS) is Virginia's lead agency for planning, coordinating, and promoting rehabilitative services for individuals with “**significant physical or sensory disabilities.**” Legislation passed in 2014 (HB 1076), which became effective July 1, 2014, changed terminology in the Code of Virginia. The previous term of “functional and central nervous system disorders” was changed to “physical or sensory disability” under the amended § 51.5-116 but retains the same definition as the previous term:

*a disability resulting in functional impairment or impairment of the central nervous system, which may include but is not limited to brain injury, spinal cord injury, cerebral palsy, arthritis, muscular dystrophy, multiple sclerosis, Prader-Willi syndrome, and systemic lupus erythematosus (lupus).*

DARS administers brain injury services through two programs: the DARS **Brain Injury Services Coordination (BISC) Unit**, operated within the DARS Community Based Services Division; and the **Woodrow Wilson Rehabilitation Center (WWRC)** in Fishersville.

The DARS BISC Unit is composed of a director, a part-time program specialist, and a part-time administrative staff person. The following are included in the BISC Unit's responsibilities:

- Provide outreach, information, and referrals on available community services for persons with an acquired brain injury or neurotrauma, their family members and caretakers, and to other DARS personnel and external customers.

Administer contracts with private or nonprofit agencies to provide brain injury (BI) services and administer state or federal grants for brain injury services. (See the next section, **Screening and Eligibility for Brain Injury Services.**)

- Promote service quality and provide training for public and private providers of BI services as well as vocational rehabilitation field staff. In collaboration with DARS field staff, resolve concerns/complaints by customers regarding agency-funded BI services.

Administer the Brain Injury Direct Services (BIDS) Fund, which pays for short-term services for a small number of eligible individuals with acquired brain injury. (See the **Cost and Payment for Brain Injury Services** section below.)

- Administer a federal system change grant project, "Closing the Gap," provided through the Traumatic Brain Injury Implementation Partnership Act. Begun in 2009 and ending in June 2014, project activities included a comprehensive statewide needs assessment and implementation of BI assessment training for staff at residential facilities for youth in the Department of Juvenile Justice.
- Provide staff functions for the Virginia Brain Injury Council and manage the Commonwealth Neurotrauma Initiative Trust Fund, which supports clinical and other research.

## **1. Screening and Eligibility for Brain Injury Services**

To be eligible for services through the DARS **Brain Injury Services Coordination (BISC) Unit**, an individual must have an acquired brain injury. Program information is available online at <http://www.vadrs.org/cbs/biscis.htm>.

Administered by DARS, the **Woodrow Wilson Rehabilitation Center (WWRC)** has specialized services targeting two populations: those who need **Brain Injury Services (BIS)** and individuals requiring **Spinal Cord Injury (SCI) Services**. (See the **Spinal Cord Injury Services**

section of this chapter for more information on the latter.) Available on a residential or outpatient basis, both programs give priority for services to DARS clients who are pursuing vocational goals. All applicants must be at least 16 years old. Individuals may self-refer by contacting the WWRC admissions office either by phone at (800) 345-9972, Ext. 7065 or online at [AdmissionsInfo@wwrc.virginia.gov](mailto:AdmissionsInfo@wwrc.virginia.gov). Individuals also may seek admission through their local office of DARS. As a part of the application and referral process, an individual must typically complete a one-day feasibility outpatient evaluation at WWRC to clarify his or her current neuro-behavioral functioning levels and service needs.

As noted online (<http://www.wwrc.virginia.gov/braininjuryservices.htm>), the **WWRC Brain Injury Services** program treats individuals with either a traumatic or non-traumatic acquired brain injury who have demonstrated potential for rehabilitation or employment. To be eligible, an individual must be

*medically, physically, and psychologically stable with a favorable prognosis for participating in, completing, and benefiting from the services.*

Applicants with a co-occurring psychiatric diagnosis or a history of substance abuse must be able to demonstrate six consecutive months of stability.

## **2. Access to and Available Brain Injury Services**

Services for persons with brain injuries encompass a wide array and are designed to facilitate community reintegration and personal independence to the maximum extent possible. The DARS' **Brain Injury Services Coordination (BISC) Unit** manages specialized brain injury (BI) services offered in communities through contractual agreements. During SFY 2013, BISC had contracts with 10 provider organizations that operated 13 BI programs statewide. Three core BI services have been a funding priority by DARS:

1. comprehensive case management, which includes needs assessment, service referral/coordination, and service monitoring;
2. clubhouse or day programs to improve social/behavioral skills, independent living skills, and employability; and
3. regional resource coordination, which provides public education/awareness, outreach, and provider recruitment.

A full list of available brain injury (BI) services by geographic area is provided in the DARS *Annual Report to the General Assembly on Brain Injury and Spinal Cord Injury Services*. This report identifies the providers in each area as well as funding levels and services provided by each. It is available online at [http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/RD842014/\\$file/RD84.pdf](http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/RD842014/$file/RD84.pdf).

The DARS BISC Unit has a collaborative relationship with the **Woodrow Wilson Rehabilitation Center's (WWRC) Brain Injury Services (BIS)** program. A WWRC staff member

serves on the Virginia Brain Injury Council and another is involved in WWRC's strategic planning for brain injury services.

**WWRC Brain Injury Services** has experienced, interdisciplinary teams, comprised of WWRC staff and community partners, to provide medical rehabilitation as well as vocational assessment and training, and treatment planning. All services emphasize development or improvement of (1) self-sufficiency, (2) personal responsibility, and (3) vocational preparation. Assessments and services may include the following based on individual needs:

- home and work accessibility;
- assistive technology;
- independent living skills;
- driving skills;
- physical, occupational, and speech/language therapy; and
- neuro-psychological testing and psychiatry consultation.

The BIS staff may also refer an individual to the **WWRC Life Skills Transition Program**, which is a comprehensive educational opportunity to develop interpersonal skills, independent living, and basic workplace literacy, among others as indicated. **WWRC's Brain Injury Clinic** is a one-day outpatient service consisting of neuropsychological and physical medicine evaluations.

As noted earlier, DARS develops and publishes an annual report to the General Assembly on brain injury services delivered during the state fiscal year (SFY). Using data from the most recent annual report, the list below highlights the number of individuals with BI who received direct services in SFY 2013 by provider and program. Please refer to the DARS annual report for details on other BI services (training, awareness/outreach) delivered by these providers. Some counts may be duplicative for each program because an individual may participate in or receive more than one service during the year.

- **Brain Injury Association of Virginia or BIAV (statewide):** The DARS BISC Unit funds BIAV to implement the Virginia Statewide Trauma Registry Outreach Program. This outreach provides newly injured Virginians with information on BI and available resources by mail.
  - Consultations and information/referral, 828 individuals
  - Support groups, 112 with 631 participants
- **Brain Injury Services, Inc. (northern Virginia area):**
  - Adults
    - Westwood Clubhouse (Fredericksburg), 18 members
    - ADAPT Clubhouse, 48 members

- Adult case management, 352 individuals
- Children
  - Pediatric case management, 65 children
  - Consultations, 50 children
  - Support groups, 11 with 150 participants
- **Brain Injury Services of Southwest Virginia (BISSWVA):**
  - Case management, 266 individuals
  - Consultations, 115 individuals
  - Life skills services, 25 individuals
- **Community Futures Foundation (Tidewater and Richmond areas):**
  - Tidewater area - Denbigh House
    - Members, 58 (with an average daily census of 15)
    - Consultations, 9 individuals
  - Richmond area - The Mill House
    - Members, 60 (with an average daily census of 17)
    - Consultations, 50
    - Case management, 73 individuals with 28 consultations
- **Crossroads to Brain Injury Recovery or CBIR (Greater Shenandoah Valley area):**
  - Case management, 72 individuals
  - Consultations 73
- **Eggleston Services (Tidewater area):**
  - Beacon House
    - Members, 42 (with an average daily census of 16)
    - Consultations, 8
- **MWS-Brain Injury Services of MARC Workshop, Inc. (Danville/Martinsville area):**
  - Case management, 39 individuals
  - Support groups, 12 (no attendee counts)
- **Virginia NeuroCare, Inc., (Region 10):**
  - High Street Clubhouse
    - Members, 17 (with an average daily census of 16)
    - Consultations, 4 individuals



➤ **No Limits Eastern Shore or NLES:**

- No Limits Day Program
  - Members, 27 (with an average daily census of 12)
  - Consultations, 4

➤ **Virginia Supportive Housing or VSH:**

- Case management, 25 individuals

In addition to direct services to individuals, the DARS BISC Unit reports that each program conducts professional training on the evaluation and treatment of brain injuries in its region or locality and provides BI outreach and education to individuals, family members and caregivers.

**Table 48** lists the total number of individuals who received any type of service (including training and outreach) from the BI contractors in state fiscal years (SFYs) 2009 through 2013. Between SFYs 2010 and 2011, a significant increase in the number of people served occurred. The increase peaked in SFY 2012.

| <b>Table 48. Number of Individuals receiving Brain Injury Services by SFY</b> |              |               |               |               |               |
|---|--------------|---------------|---------------|---------------|---------------|
| <b>State Fiscal Year</b>  | <b>2009</b>  | <b>2010</b>   | <b>2011</b>   | <b>2012</b>   | <b>2013</b>   |
| <b>Number served</b>  | <b>9,917</b> | <b>11,800</b> | <b>20,700</b> | <b>23,268</b> | <b>19,744</b> |

Source: Department for Aging and Rehabilitative Services.

In 2013, the Commonwealth Neurotrauma Initiative Trust Fund Advisory Board awarded a one-year contract of \$150,000 to Brain Injury Services, Inc. in northern Virginia to implement a community-based model of wrap-around supports and intervention services for individuals with brain injury and challenging behaviors. The services will be delivered in two localities: one rural (Harrisonburg and surrounding areas) and one urban (Northern Virginia region). This grant, which will serve up to 20 individuals in each program, requires an evaluation of each program's effectiveness. This grant program will begin services during 2014.

**Table 49** shows the number of individuals served by the DARS **Woodrow Wilson Rehabilitation Center's (WWRC) Brain Injury Services** for selected years between SFY 2005 and 2013.

| <b>Table 49. Number of Individuals receiving Brain Injury Services through WWRC by SFY</b> |             |             |             |             |             |             |
|--|-------------|-------------|-------------|-------------|-------------|-------------|
| <b>State Fiscal Year</b>   | <b>2005</b> | <b>2007</b> | <b>2010</b> | <b>2011</b> | <b>2012</b> | <b>2013</b> |
| <b>Number served</b>   | <b>123</b>  | <b>132</b>  | <b>132</b>  | <b>199</b>  | <b>165</b>  | <b>159</b>  |

Source: Department for Aging and Rehabilitative Services, Woodrow Wilson Rehabilitation Center.

### 3. Cost and Payment for Brain Injury Services

The **Brain Injury Services Coordination (BISC) Unit** manages the state and federal funding designated for brain injury services that is received annually by the Department for Aging and Rehabilitative Services (DARS). State appropriations for BISC Unit operations have been relatively stable for the past 15 years, which has been approximately \$181,000 annually for the past few years. State appropriations to fund contracts with BI service providers are listed by state fiscal year in **Table 50**.

| Table 50. State Appropriations to Brain Injury Service Contractors by SFY |           |             |             |             |             |
|---|-----------|-------------|-------------|-------------|-------------|
| State Fiscal Year   | 2010      | 2011        | 2012        | 2013        | 2014        |
| BIS contracts   | 3,881,000 | \$3,881,000 | \$3,821,333 | \$3,886,466 | \$3,991,466 |

The Brain Injury Services Coordination (BISC) Unit at DARS additionally administers a “fund of last resort” for eligible individuals with an acquired brain injury: the **Brain Injury Direct Services (BIDS) Fund**. The BIDS Fund is available to applicants who have no other public or private source of funds available (Medicaid or Medicare, private insurance, or other DARS assistance) to pay for needed technology or services that will enhance independence and recovery. The BIDS Fund supports services typically provided on an outpatient basis in community settings such as:

- neuropsychological assessment or counseling;
- neurobehavioral assessment and intervention;
- medical, speech, physical, occupational, cognitive, and other rehabilitation therapies;
- assistive technology (AT) assessments and purchase of recommended AT equipment; and
- life skills training, among others.

Eligibility criteria are available on the DARS website at <http://www.vadrs.org/formscabinet/documents/public/bids%20fund%20eligibility%20criteria%20cbs204.pdf>. Before completing the required BIDS Funds application, individuals are urged to first contact the BISC Unit to see if funds are available. Call the Unit toll-free at (800) 552-5019 or check online at <http://www.vadars.org/cbs/biscis.htm>.

BIDS funds come solely from state General Fund appropriations, which have been very limited and currently are \$151,324 a year. Of that amount, \$65,000 annually is designated for used by the DARS contract BI service providers (\$5,000 each in SFY 2013) to use only for direct (“case”) services to individuals. Each provider must monitor and report use of the BIDS funds at the end of each state fiscal year. In addition, BIDS funds may be used periodically as the “state cash match” for the DARS federal Traumatic Brain Injury Grant.

The BIDS Fund data shown in **Table 51** provide the total number served, wait list numbers, and total expenditures for select SFYs between 2009 and 2013. Data are based on reports by brain injury service providers under contract with DARS. “Recipients” refers to all those who received direct BI services during the SFY. As the data indicate, the number of recipients increased in SFY 2013. Prior to that SFY, the number of individuals receiving BI services through the BIDS Fund was reported in aggregate as part of the total number served by the BI provider. Beginning in SFY 2013, DARS asked its contract BI providers to account separately for service recipients supported through the BIDS Fund.

| <b>Table 51. BIDS Fund Expenditures by SFY</b> |                             |                               |                           |
|--|-----------------------------|-------------------------------|---------------------------|
| <b>SFY</b>                                     | <b>Number of Recipients</b> | <b>Number On Waiting List</b> | <b>Total Expenditures</b> |
| <b>2009</b>                                    | <b>28</b>                   | <b>n/a</b>                    | <b>\$96,325</b>           |
| <b>2010</b>                                    | <b>15</b>                   | <b>8</b>                      | <b>\$140,343</b>          |
| <b>2011</b>                                    | <b>45</b>                   | <b>n/a</b>                    | <b>\$95,343</b>           |
| <b>2012</b>                                    | <b>30</b>                   | <b>n/a</b>                    | <b>\$55,451</b>           |
| <b>2013</b>                                    | <b>224</b>                  | <b>40</b>                     | <b>\$131,325</b>          |

Source: Department for Aging and Rehabilitative Services.

The wait list number is the count of those eligible and waiting for funds to become available at the end of each SFY (June 30). Due to limited funding and staff, wait list data are sometimes not available or reported. BIDS Fund expenditures varied considerably from year-to-year during the past five SFYs. Although some variation is attributed to differing levels of BI service needs for individuals each year, most of the variability is attributed to state budgetary limits.

As noted earlier, the **Woodrow Wilson Rehabilitation Center (WWRC)** provides services to individuals with brain injury on both a residential and outpatient basis. WWRC reports that annual expenditures for these specific services are not delineated in the overall facility operational budget. An individual with brain injury, for example, receives varied rehabilitative services from several programs within the Center. The entire WWRC had a total annual budget of almost \$26 million dollars each year in SFYs 2013 and 2014, of which only 19 percent was from state General Funds. The remaining 81 percent was from federal funds.

#### **4. Monitoring and Evaluation of Brain Injury Services**

The manager of the Department for Aging and Rehabilitative Services’ (DARS) **Brain Injury Services Coordination (BISC) Unit** is responsible for oversight of Brain Injury (BI) services and other related DARS programs, including the 13 contracted BI direct services programs statewide. Expenditures, activities, and outcomes are routinely monitored; the BISC manager reports issues of significance or concern to the Community Based Services (CBS) Division director and DARS commissioner on a weekly basis. Written reports are submitted annually to

the DARS commissioner via the **Virginia Brain Injury Council**, for which the BISC Unit provides staff, as well as to the Virginia Disability Commission and the General Assembly. These required annual reports cover the number of people served, types of services provided, and success in leveraging non-state resources.

The Virginia Brain Injury Council meets quarterly and, as a policy advisory group, makes recommendations to the commissioner on how best to distribute allocated state funding. Two additional groups, the Virginia Alliance of Brain Injury Service Providers and the Brain Injury Association of Virginia (BIAV), also work closely with the Council and BISC staff to ensure accountability in the expenditure of funds for brain injury services. This Council considers formal suggestions and concerns raised by these organizations and other community partners or those raised internally by DARS staff. As indicated, the Council brings this information and any recommendations to the attention of the CBS Division director and DARS commissioner so that policy and procedure changes or other appropriate actions, if feasible, can be taken. The BI Council annually develops a “Priorities Letter” for legislative funding and actions that is sent to the DARS commissioner. Since 2010, the top priority has been creation of neuro-behavioral services. Other priorities identified in 2013 are access to specialized case management, and an effective, affordable system of transportation to access services. For more information on the Brain Injury Council, go online to <http://www.vadrs.org/vbic.asp>.

Organizations contracted by DARS to provide brain injury services are required to comply with state fiscal policies and procedures, including submission of financial and narrative progress reports on a monthly, quarterly, and annual basis. Annual reports must include evaluations, such as consumer satisfaction surveys, available to the contractors either from internal or external efforts. In addition, in recent years the BISC Unit has required all BI contractors to be accredited by the national **Commission on Accreditation of Rehabilitation Facilities (CARF)**.

Since SFY 2008, the BISC Unit has been conducting programmatic and fiscal evaluations on a minimum of two providers each year, as Unit staff level allowed. Evaluations focus on contractual compliance and service quality. In SFY 2011, BISC Unit staff found several areas of non-compliance by one organization, which ultimately led to the provider ending the contract with DARS. DARS was successful in soliciting new contractors who were able to provide BI services without disruption to consumers. During SFY 2013, staff from the BISC Unit and the DARS Office of Policy and Planning conducted site visits for program evaluation, which will be continued as staffing allows. The BISC Unit now requires the board of directors of each contract provider to complete an annual *Control Self-Assessment Document*. Each board and executive director must use this tool to assess its agency’s internal controls for fiscal and personnel management, among others. DARS additionally initiated mandatory information to and training of all boards on a quarterly basis. DARS now holds an annual Commissioner’s Board/Council retreat for not only the governing and advisory boards of the BISC programs but also for all programs under the agency’s administration.

Since 2007, the **BISC Unit** has required all providers to submit expenditure and outcome data quarterly through an online **SCORECARD system**. The SCORECARD enables DARS to routinely monitor contract compliance, efficiency, and effectiveness in a more structured manner. The SCORECARD system requires programs to submit data and information to the BISC Unit manager on progress towards performance goals and client outcomes, and it requires documented reasons for any performance measures that are below expectations. In 2013 DARS began extensive revision of the SCORECARD system to include client indicators for social, emotional, and behavioral health, and new financial reporting. This will be operational in SFY 2015.

The **Brain Injury Direct Services (BIDS) Fund** is monitored by the BISC Unit manager, who annually submits reports to the DARS commissioner on the number of individuals served as well as the types and costs of services funded.

Internal processes at DARS' **Woodrow Wilson Rehabilitation Center (WWRC)** govern program capacity and resource allocation for the Brain Injury Services (BIS) and all other programs. Guidance on services provided is solicited from other management teams in the agency as well as from community partners and stakeholders. Reports summarizing the numbers served and service outcomes are shared monthly with the WWRC's director and the director of the Medical Division. Additionally, the WWRC Medical Division's Compliance Program audits individual case records to review admissions procedures, service provider documentation, medical coding, and billing practices. The Compliance Program regularly educates staff on compliance issues and provides quarterly reports to the WWRC executive team.

WWRC has maintained accreditation for its programs from various national organizations, which set professional standards for clinical services, vocational services, and facility/equipment of both residential and outpatient programs. Included here are accreditations cited in the 2013 WWRC annual report. Its Medical Rehabilitative Division has been certified as a Comprehensive Outpatient Rehabilitation Facility (CORF) provider. In March of 2012, this division received recertification for four years with no deficiencies. The WWRC Durable Medical Equipment (DME) Department has full accreditation from the Accreditation Commission for Health Care (ACHC), which was recertified in November of 2012 for three years. The WWRC Vocational Training Department is accredited by the Commission of the Council on Occupational Education (CCOE), which recertified the program in 2013 for five years.

## **D. Spinal Cord Injury Services**

This section focuses solely on the outpatient and residential services provided to individuals with spinal cord injuries at the **Woodrow Wilson Rehabilitation Center (WWRC)**, located in Fishersville, Virginia. The goal of these services is to provide individualized, comprehensive evaluations and rehabilitation services that promote functional recovery, self-sufficiency, and vocational preparation.

## **1. Eligibility for Spinal Cord Injury Services**

Eligibility for the **WWRC Spinal Cord Injury Services** has similar requirements as the brain injury services program: individuals must have potential for rehabilitation or employment and must be medically and psychiatrically stable. Priority is given to individuals who are receiving vocational services through DARS. (For complete information, go to <http://www.wwrc.virginia.gov/spinalcordinjury.htm>.) To be admitted into the WWRC for residential SCI services, an individual with a spinal cord injury must be 18 years of age or older.

Individuals served by the outpatient **Spinal Cord Injury (SCI) Clinic**, held once a month, typically includes those who:

- have a recent injury;
- have had a SCI for several years and have experienced gains in functioning since they received rehabilitation; and
- are able to do less for themselves than when they first returned home from rehabilitation.

## **2. Access to and Delivery of Spinal Cord Injury Services**

Residential SCI services at WWRC are provided by an interdisciplinary team of experienced clinicians who provide a wide variety of evaluations, medical rehabilitation, vocational assessment and training programs to maximize each individual's neurological and functional recovery. The SCI clinical team includes a physiatrist; nurses; personal care assistants; physical, occupational, and speech therapists; psychologists; vocational evaluators; vocational educators; and case managers. Residential services are broad in scope and include, but are not limited to:

- assistive technology (AT) evaluation and training,
- attendant care training,
- counseling,
- driver's evaluation and training,
- health promotion,
- independent living skills,
- family education,
- wheelchair evaluation and adaptation, and
- community re-entry.

Upon completion of their medical rehabilitation programs, residential clients are referred to either WWRC's outpatient Spinal Cord Injury Clinic or to community resources for follow-up evaluations and services. The outpatient clinic is held monthly.

Individuals may contact either the WWRC Admissions Office or the Spinal Cord Injury program coordinator by email at [SCIProgramInfo@wwrc.virginia.gov](mailto:SCIProgramInfo@wwrc.virginia.gov) or by phone at (800) 345-9922, Ext. 7118 or (TTY) (800) 811-7893. The clinic is staffed by a multi-disciplinary team of experienced rehabilitation professionals (physiatrist, nurse, occupational therapist, and physical therapist). The SCI Rehabilitation Team provides evaluation and assessment of each client's needs and potential in the following areas:

- bowel and bladder care,
- skin integrity and pressure sores,
- posture,
- range of motion,
- strength,
- functional mobility skills (such as transfers),
- wheelchair mobility,
- assistive technology (in some cases), and
- activities of daily living (in some cases).

### 3. Availability of Spinal Cord Injury Services

Listed in **Table 52** is the number of individuals with SCI served by the DARS **Woodrow Wilson Rehabilitation Center's (WWRC) Spinal Cord Injury Services** for selected years between SFY 2010 and SFY 2013. Prior to SFY 2010, the SCI services counts did not include individuals with spinal cord injuries who may have been served in other programs at WWRC. Improvements to WWRC's data system that year allowed it to track individuals with spinal cord injuries receiving services from its programs other than SCI services, which in SFY 2010 totaled 27 individuals in addition to the 200 reported below. Since then, according to WWRC staff, counts have been impacted by changes to the diagnostic categories and definitions required by its federal funding agency as well as budget reductions at the state and federal levels.

| Table 52. Individuals Receiving Spinal Cord Injury Services through WWRC by SFY |      |      |      |      |
|---|------|------|------|------|
| State Fiscal Year   | 2010 | 2011 | 2012 | 2013 |
| Number Served   | 200  | 153  | 111  | 111  |

Source: Department for Aging and Rehabilitative Services, WWRC

### 4. Cost and Payment for Spinal Cord Injury Services

Expenditures for SCI services alone are not available. The WWRC *Agency Strategic Plan for 2012–2014* notes that 81 percent of its annual allocations during that period were from Non-General Funds (Non-GF), i.e., federal funds. The annual total WWRC budget for SFYs 2013 and 2014 has been the same for each year: \$4,856,457 in state General Funds (GF) and \$21,098,757

in Non-GF. Of the total allocation in each of those SFYs, Medical Rehabilitative Services, which includes clinical/rehabilitative services and assistive technologies, received \$1,958,567 in state GF and \$6,328,969 in Non-GF.

## 5. Monitoring and Evaluation of Spinal Cord Injury Services

Oversight activities for SCI services are the same as those described in the **Monitoring and Evaluation of Brain Injury Services** section above.

## E. Community Rehabilitation Case Management Services

Code of Virginia § 51.5-123, as amended by the 2014 legislature, directs the **Department for Aging and Rehabilitative Services (DARS)** to

*develop and implement a community rehabilitation case management system ... [for] ... coordination of medical, psychosocial, vocational, rehabilitative, long-term care, and family and community support services for persons with significant physical or sensory disabilities.*

The overarching goal of the **Community Rehabilitation Case Management (CRCM)** program, located within DARS's **Community-Based Services Division**, is to link individuals to the services that will improve quality of life as well as prevent, reduce, or eliminate economic and personal dependency.

### 1. Eligibility for and Types of CRCM Services

Community Rehabilitation Case Management (CRCM) staff links individuals who have severe, long-term physical or sensory disabilities with appropriate community rehabilitative services and supports. Program staff additionally provides outreach and support services to residents of nursing facilities and provides Support Coordination Services to recipients of Virginia's Individual and Family Developmental Disabilities Support Waiver (DD Waiver) under Medicaid. This section focuses only on non-Medicaid Waiver case management. (See the **Medicaid** chapter of this *Assessment* for information on case management under the Medicaid Waivers.)

CRCM rehabilitation specialists provide case management to Virginians who meet both disability and financial need criteria. As defined in Code of Virginia § 51.5-124, individuals eligible for this service include those who:

- have a developmental disability,
- are "disabled indefinitely" and require services for an extended or lifelong period, or
- have a disability that results in "substantive functional limitations" in three or more life activities, including economic self-sufficiency.



By statute, CRCM services cannot be provided to anyone who is eligible for Medicaid targeted case management or transition coordination or any other publicly funded case management program.

Due to limited resources, four Priority Levels for CRCM services exist. In all levels, preference is given to public safety officers and military veterans who were disabled in the line of duty. Descriptions of CRCM services, eligibility, and priority levels are found online at <http://www.vadrs.org/cbs/ltrcm.htm> or by contacting a local DARS office.

## 2. Access to and Delivery of CRCM Services

CRCM rehabilitation specialists work in the Richmond central office and in regional offices statewide: Abingdon, Christiansburg, Fishersville, Fredericksburg, Hampton, Lynchburg, Portsmouth, and Richmond. Locations and contact information are available online at <http://www.vadrs.org/formscabinet/documents/public/bids%20fund%20eligibility%20criteria%20cbs204.pdf> or by calling the CRCM manager at 1-800-552-5019. CRCM staff collaboratively works with each individual to identify needed services, assists with linkages to services, and coordinates and monitors service delivery to ensure that clients' evolving needs are met.

## 3. Availability of CRCM Services

The number of individuals who can receive CRCM services varies from year to year due to limited funding and staffing levels as well as variability in the level of individuals' service needs. When a staff vacancy occurs, services are reduced until the position is refilled. The CRCM division does not have a funded case manager position designated for Northern Virginia. **Table 53** identifies the number of individuals receiving CRCM services between SFYs 2008 and 2013.

| Table 53. Number receiving DARS Community Rehabilitation Case Management Services by SFY |      |      |      |      |      |      |
|--|------|------|------|------|------|------|
| State Fiscal Year  | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 |
| Number served  | 497  | 465  | 708  | 580  | 588  | 655  |

Source: Department for Aging and Rehabilitative Services

## 4. Cost and Payment for CRCM Services

CRCM services are, and have been, reliant on state General Funds. The DARS Community Based Services Division, of which CRCM is a part, however, regularly seeks grant funds, when available and appropriate, not only for CRCM but also other division programs to augment state funding. According to CRCM division staff, the annual budget appropriation for CRCM services has been flat since SFY 2005 with appropriations of \$507,643 each year through 2013. Additional state funds, however, may be transferred to CRCM services from other divisions or programs within DARS (e.g., BIDS Fund, BISC Unit, etc.) to address needs for specific populations or address waiting lists.

## 5. Monitoring and Evaluation of CRCM Services

Responsibility for oversight of CRCM Services rests with its program manager and the director of the Community Based Services (CBS) Division within the Department for Aging and Rehabilitative Services (DARS). Monitoring processes have remained constant over time. The CRCM program manager conducts record reviews and reviews results of customer satisfaction surveys conducted by regional offices. Based on findings, the manager identifies issues or problems to be addressed and updates policies and procedures as indicated. Concerns are forwarded to the appropriate rehabilitation specialist or assistant DARS commissioner as needed.

## F. Comprehensive Services Act for At-risk Youth and Families

Enacted in 1993, the Comprehensive Services Act (CSA) is a state law (Code of Virginia, 2.2-5200 et seq.) that established a single, state pool of funds comprised of monies from eight funding streams across four state agencies. This pool funds local services to youth and the state **Office of Comprehensive Services (OCS) for At-Risk Youth and Families** to administer and monitor both the services provided and their compliance with designated fund uses. The CSA charge is to

*create a collaborative system of services and funding that is child-centered, family focused, and community based when addressing the strengths and needs of troubled and at-risk youth and their families.*

CSA goals include the following:

- early identification of and intervention for at-risk youth,
- family preservation,
- more flexible use of available funds,
- reduced disparities in service access across localities, and
- the provision of services appropriate to individual needs “in the least restrictive environment while protecting the welfare of children and maintaining the safety of the public.”

Under CSA, local inter-agency collaboration and public/private partnerships are expected to promote community responsibility for developing and delivering needed services to youth in the area.

### 1. Eligibility for CSA Services

Because funding streams across four state agencies that have multiple federal mandates to meet, multiple eligibility criteria for services exist under the Act. Broad eligibility criteria are listed online at [http://www.csa.virginia.gov/html/for\\_parents/for\\_parents.cfm](http://www.csa.virginia.gov/html/for_parents/for_parents.cfm). To explore eligibility, agencies and parents should contact either a local CSA coordinator through the

online CSA coordinator roster at [http://www.csa.virginia.gov/rosters\\_reporting/coord3a.cfm](http://www.csa.virginia.gov/rosters_reporting/coord3a.cfm), or contact the state Office of Comprehensive Services at (804) 662-9815 or by email at [csa.office@csa.virginia.gov](mailto:csa.office@csa.virginia.gov).

Detailed descriptions of the CSA target populations are found in § 2.2-5212 of the Code of Virginia. At a minimum, to be eligible, the youth must meet one of these criteria:

- be in foster care or be eligible for foster care;
- require private placement for special education;
- be eligible for services through a Child-in-Need of Services Parental Agreement through agencies other than local departments of social services; or
- have significant emotional or behavior problems that are persistent over time and may require services either not available from an agency or require services from multiple agencies, or may be at risk of residential placement.

For the purposes of defining eligibility of youth for state pool funds, the age eligibility criteria for CSA mirrors the age criteria for foster care services and special education services. (See the **K–12 Screening and Eligibility for Part B Special Education** section in the **Education** chapter of this *Assessment*.)

Localities may choose to serve non-mandated youth with emotional or behavioral problems who meet CSA eligibility criteria, but there is no legal requirement that local governments provide the matching funds to do so. According to statewide data from the Office of Comprehensive Services, since state fiscal year (SFY) 2000, the program has predominately served youth in the mandated category. Statewide data on annual CSA utilization and expenditures is online at [http://www.csa.virginia.gov/publicstats/csa\\_pool.cfm](http://www.csa.virginia.gov/publicstats/csa_pool.cfm).

## 2. Access to and Use of CSA Services

Referrals to the CSA program can be made by family members, schools, or staff at human service, health, and public safety agencies. In accordance with local policies, the referring source should contact the local **Family Assessment and Planning Team (FAPT)** or the local CSA coordinator for an assessment. The CSA website provides a list of local FAPTs.

According to data from the state Office of Comprehensive Services, historically, referrals to CSA most frequently come from staff in local social services departments and school divisions because youth in foster care or with special education needs are mandated populations for CSA. These two referral sources consistently accounted for more than 80 percent of all referrals each year. The other main referral sources have been the juvenile justice system and the local Community Services Boards (CSBs). Over time, less than 4 percent of youth referrals came from interagency teams, families, health providers, or other sources. During SFY 2013, referrals came from the following sources:

- 59.4 percent referred by local social services departments;

- 24.2 percent referred by schools;
- 7.4 percent referred by juvenile justice; and
- 6.6 percent referred by Community Service Boards (CSBs).

Whether in a mandated or non-mandated category, all youth must be assessed by the local **FAPT**. Family members may contact the local CSA coordinator for information. User-friendly information for parents about access and delivery of CSA services, including the responsibilities of FAPTs, is provided online at [http://www.csa.virginia.gov/html/for\\_parents/for\\_parents.cfm](http://www.csa.virginia.gov/html/for_parents/for_parents.cfm). Access procedures vary by locality. Some localities allow parents to contact the FAPT team directly, while others require referral from a local agency. Additionally, some FAPTs require that one of its team's participating agencies serve as the point of contact for a family.

The FAPT is responsible for developing the appropriate service plans for each youth who is referred. With active participation by the youth and family members, the FAPT then must assess the strengths and needs of those youth and their families accepted for services. Since SFY 2009, all youth eligible to receive CSA services must be evaluated using the **Child and Adolescent Needs and Strengths (CANS)**, a standardized assessment instrument. After completing the assessment, the FAPT develops an **Individual Family Services Plan (IFSP)** that identifies the services required to meet their unique needs, and makes recommendations for funding to appropriate local services. If the family agrees with the plan, the FAPT assigns a case manager to work with the youth and family in implementing the service plan. The FAPT and the case manager are responsible for identifying service providers to address needs.

The FAPT may use CSA pool funds to purchase services if all of the following criteria are met:

- a family's needs cannot be met by the participating agencies;
- there are no other community resources available; and
- the youth meets CSA eligibility requirements.

If a family disagrees with the service plan, they may ask for a review in accordance with local policies by the local **Comprehensive Policy and Management Team (CPMT)**, which has management and administrative responsibilities for CSA activities. However, any necessary emergency services can proceed while this review occurs.

The **Office of Comprehensive Services (OCS) for At-Risk Youth and Families** (<http://www.csa.virginia.gov>), which administers the CSA program, reports that there has been a gradual decline in the number of youth served during each SFY since 2000. According to CSA data, the number served has declined by 20.3 percent, dropping from a peak of 18,458 youth served in SFY 2007; 16,567 youth served in SFY 2011; and 14,729 youth served in SFY 2013.

Since 2008, the CSA program has emphasized services to youth in their own communities in order to maintain natural supports and to reduce costs. That year, the legislature authorized

financial match incentives for that purpose. The State Executive Council for CSA established a hierarchy of service categories with an accompanying incentive rate match system. In addition, the Children’s Services Systems Transformation initiative was implemented statewide. (More information on this initiative is included in the **Available CSA Services** section of this chapter below.) The impact of these initiatives can be seen in **Table 54**, which depicts utilization data for admissions to various residential settings. The last row indicates the unduplicated number of youth served in residential settings. It is lower than the admission counts for each SFY because one youth may have had more than one residential admission during the year.

| <b>Table 54. CSA Admissions to Residential Settings by SFY</b> |             |             |             |             |                 |
|--|-------------|-------------|-------------|-------------|-----------------|
| <b>Type of Residence</b>                                       | <b>2010</b> | <b>2011</b> | <b>2012</b> | <b>2013</b> | <b>% Change</b> |
| Temporary care facility  | 93          | 190         | 187         | 145         | + 55.9 %        |
| Group Home   | 1,248       | 1,088       | 908         | 802         | - 35.7%         |
| Residential treatment  | 1,331       | 1,269       | 1,233       | 1,176       | - 11.6%         |
| Total admissions   | 2,672       | 2,547       | 2,328       | 2,123       | - 20.5%         |
| Total unduplicated youth served                                | 2,360       | 2,236       | 2,054       | 1,888       | - 20.0%         |

As defined by the CSA State Executive Council, a “temporary care facility” is defined as

*placement of youth outside their family homes in licensed facilities or emergency shelters that serve groups of youth and are specifically approved to provide a range of services as needed, on an individual basis not to exceed 90 days.*

Services provided while the youth is living in this facility include assessments, crisis stabilization, respite, or other outpatient services to the youth as well as services to the youth’s planned permanent caregiver, which are provided either in the facility or in the community. Excluded from the definition of temporary care facility are secure detention facilities.

The increased provision of CSA-funded services in communities additionally is evident in data on the proportion of youth served in various community settings, which are provided in **Table 55**. “Family-like settings” refer to family foster homes or therapeutic foster homes; and “licensed residential settings” refers to those such as intensive treatment services, group homes, or temporary shelter care. Data are the proportion of all youth who were served under CSA in a particular setting category. Percentages for each year may not total 100 percent due to rounding.

| <b>Table 55. Proportion of Youth Served under CSA by Setting Type and SFY</b> |                |                |                |
|---|----------------|----------------|----------------|
| <b>Type of Setting</b>  | <b>2008</b>    | <b>2010</b>    | <b>2013</b>    |
| <b>In the community or in schools</b>   | <b>34%</b>     | <b>42%</b>     | <b>43%</b>     |
| <b>Family-like settings</b>   | <b>47%</b>     | <b>39%</b>     | <b>40%</b>     |
| <b>Licensed residential settings</b>  | <b>17%</b>     | <b>19%</b>     | <b>16%</b>     |
| <b>Psychiatric hospitals</b>  | <b>&lt; 1%</b> | <b>&lt; 1%</b> | <b>&lt; 1%</b> |

Source: Office of Comprehensive Services, January, 2014.

Between SFYs 2008 and 2013, the proportion of youth served under CSA who received services in the community or in school increased by 9 percent, from 34 to 43 percent, respectively. During the same time period, those receiving CSA-funded services in family or therapeutic foster homes declined by 7 percent, from 47 percent to 40 percent.

### **3. Available CSA Services**

The Family Assessment and Planning Teams (FAPT) are responsible for identifying, planning, and coordinating services for CSA-eligible youth that are tailored to the unique needs of each child and his or her family. Within statutory and policy guidelines, a full range of services is possible, including comprehensive assessments, crisis stabilization and intervention, behavioral aides, respite care, mentoring, mental health services, substance abuse services, intensive in-home services, specialized “wrap-around” services, therapeutic day treatment, afterschool services, vocational services, independent living services, special education private day programs, or residential care. Since 2008, financial incentives and program policies have been in place for community-based services rather than residential placements under CSA (Code of Virginia 2.2-5211.1).

According to CSA utilization reports, eligible youth, a large proportion of whom have mental health challenges, generally receive more than one of the services available during any year. For the last several years, the following are the most frequently used services under CSA statewide:

- mentoring,
- intensive in-home services,
- intensive care coordination,
- out-patient therapy,
- parent education and skills training,
- treatment foster care, and
- private day special education.

For several years, the **Office of Comprehensive Services (OCS)** has worked closely with the Department of Social Services (DSS) to implement the **Children’s Services System Transformation** initiative. Its systemic goal has been to improve local services to youth and their families, to increase use of community services, and to ensure adoption of person-centered practices. As part of the initiative, clearer values and principles for CSA services were developed and disseminated, and implementation of a “Family Engagement Model” for youth in or at-risk of foster care was completed. This model promotes involvement of a child’s extended family and natural supports into the CSA decision-making processes. Ongoing training to members of local agencies, providers, and CSA teams has been provided to develop consistency across local programs. The *2013 Agency Executive Progress Report* from OCS notes that the initiative, now completed, achieved its goals.

In SFY 2013, the Department of Behavioral Health and Developmental Services was able to obtain federal grant funds to establish the **Virginia Wraparound Center of Excellence** within the **Office of Comprehensive Services (OCS)**. This four-year grant project, funded by the US Substance Abuse and Mental Health Services Administration (SAMHSA), is to implement the national **High Fidelity Wraparound (HFW) model of care** statewide. The Office of Comprehensive Services will be the project home and administrator. The project targets youth who have complex behavioral health needs and who are involved in one or more of these service systems:

- child welfare,
- juvenile justice,
- mental health, or
- special education.

The project goal is to integrate services to either (1) enable youth to return to their families and communities from various congregate and institutional settings or (2) enable youth at risk of out-of-home placements to stay with their families. This model of care requires extensive trainings to assist with skill development for members of each local FAPT and CPMT, local Community Services Boards (CSBs), and private providers.

In April of 2013, the CSA State Executive Council adopted a policy approving HFW as a model of care as well as the accepted practice for all **Intensive Care Coordination services** under CSA. Authorized in the 2009 Appropriations Act, Intensive Care Coordination (ICC) is a CSA service, wherein IC coordinators work to provide more comprehensive services around a family (“wrap”) that will support a child to stay or return home. More information is available at <http://www.csa.virginia.gov/>. Through this project, statewide monitoring of intensive care coordination will be improved. To maintain quality, annual training of the IC coordinators will be required.

#### 4. Cost and Payment for CSA Services

CSA is primarily funded through the state General Fund, as appropriated by the General Assembly, and through local match. State and local governments share funding for services under the CSA based on a formula, and some services are reimbursed under the Medicaid State Plan for enrolled youth. Except where prohibited by state or federal law and regulations, parents may be required to make co-payments for services according to a standard sliding-scale fee. **Table 56** provides the annual budget for CSA for state fiscal years (SFYs) 2011 through 2014, including the proportion of funding, by source.

| Table 56. Annual Budgets for CSA by Source and SFY |                       |                      |               |
|--|-----------------------|----------------------|---------------|
| State Fiscal Year                                  | State General Fund    | Non-General Funds    | Total Budget  |
| 2011   | \$271,234,333 (82.5%) | \$57,608,877 (17.5%) | \$328,843,210 |
| 2012   | \$270,060,815 (83.7%) | \$52,607,746 (16.3%) | \$322,668,561 |
| 2013   | \$225,423,724 (81.1%) | \$52,607,746 (18.9%) | \$278,031,470 |
| 2014   | \$217,197,736 (80.5%) | \$52,607,746 (19.5%) | \$269,805,482 |

Non-General Funds are comprised of federal monies from the national Social Services Block Grant and the Catalogue of Federal Domestic Assistance (CFDA #93667).

Between SFYs 2011 and 2014, the CSA annual budget decreased by 18 percent (\$59,037,728) with most of the decrease from the state General Fund. As noted in the 2013 CSA utilization report, the decrease in state appropriations in SFYs 2013 and 2014 was based on both the declining number of youth served and the declining use of residential services. The number of youth in foster care has been declining over time. For several years, the state Department of Social Services has had initiatives to promote family integrity and, as needed, more permanent placements for foster care youth. In addition, according to OCS staff, some of the decline in number served relates to technical guidance and assistance to local teams that clarified appropriate use of funds for foster care youth in special education.

The Office of Comprehensive Services (OCS) produces and posts online numerous studies on service utilization and expenditures each year. The OCS *2013 Strategic Plan Executive Progress Report* notes that the number of youth served in residential facilities has steadily declined since SFY 2009, falling by 33 percent between 2009 and 2012. During that same period, total net expenditures for residential care also declined.

**Table 57** below describes CSA service utilization and costs for SFYs 2010 and 2012 by population category (mandated vs. non-mandated). For financial reporting purposes, the category of “state funds” includes federal Social Services Block Grant monies for services under the CSA, which are provided through the Virginia Department of Social Services (DSS). Local



governments are the source of “other funds.” The “average cost” is a calculation of the total costs divided by number of youth served by category.

| <b>Table 57. CSA Expenditures by Funding Source and Populations Served for SFYs 2010 and 2013</b> |                      |                      |                      |                      |                     |
|---|----------------------|----------------------|----------------------|----------------------|---------------------|
| <b>Population</b>   | <b>Number Served</b> | <b>State Funds</b>   | <b>Other Funds</b>   | <b>Total Cost</b>    | <b>Average Cost</b> |
| <b>2010 Mandated</b>  | <b>16,193</b>        | <b>\$226,403,047</b> | <b>\$113,558,880</b> | <b>\$339,961,927</b> | <b>\$20,994</b>     |
| <b>2010 Non-Mandated</b>  | <b>1,375</b>         | <b>\$4,875,593</b>   | <b>\$2,064,484</b>   | <b>\$6,940,077</b>   | <b>\$5,047</b>      |
| <b>2010 Totals</b>  | <b>17,568</b>        | <b>\$231,278,640</b> | <b>\$115,623,364</b> | <b>\$346,902,004</b> | <b>\$19,746</b>     |
| <b>2013 Mandated</b>  | <b>13,495</b>        | <b>\$199,341,755</b> | <b>\$109,513,144</b> | <b>\$308,854,899</b> | <b>\$22,887</b>     |
| <b>2013 Non-Mandated</b>  | <b>1,234</b>         | <b>\$3,915,528</b>   | <b>\$1,443,641</b>   | <b>\$5,359,169</b>   | <b>\$4,343</b>      |
| <b>2013 Totals</b>  | <b>14,729</b>        | <b>\$203,257,283</b> | <b>\$110,956,785</b> | <b>\$314,214,068</b> | <b>\$21,833</b>     |

Source: Office of Comprehensive Services.

As the data indicate, both expenditures from state and other sources declined as did the total number of youth served under CSA. Between SFYs 2010 and 2013, the average cost per youth in a mandated-CSA category actually increased by 9 percent (\$1,893). By comparison, the average cost per non-mandated youth decreased by 14 percent (\$704).

## 5. Monitoring and Evaluation of CSA Services

The organizational structure and oversight provisions of the CSA are complex and cannot be fully detailed here, but basic features are described. State-level oversight consists of a two-tiered, multi-agency system. At the highest level, the **State Executive Council (SEC)** for the CSA is chaired by the Secretary of Health and Human Resources (or designee). Its other members, who are identified in the Code of Virginia, include the Special Advisor to the Governor on Children’s Services; representatives of the General Assembly, the Supreme Court of Virginia, a variety of state agencies, and local governments; public and private providers; and two parents. The SEC is responsible for:

- overseeing the interagency cooperation and collaboration necessary to implement CSA at both the state and local levels,
- appointing state and local advisory team (SLAT) members,
- establishing appropriate programmatic and fiscal policies,
- providing oversight of the use of CSA pool funds, and
- advising the Governor and Cabinet Secretaries on proposed policy and operational changes.

During the next biennium (SFYs 2015 and 2016), the SEC will be concentrating on three over-arching goals:

1. support implementation of a singular, unified system of care that enables equal access to needed services for at-risk youth;
2. support informed decision-making through data analysis to improve service outcomes for youth and their families; and
3. improve the operational effectiveness of CSA administration.

The **State and Local Advisory Team (SLAT)** comprises the second tier of the state CSA system, advising the State Executive Council on policy and related issues. SLAT membership includes staff members from relevant state agencies, parent and provider representatives, one judge, one local CSA coordinator, and five regional representatives who serve on a local Community Policy and Management Team (CPMT).

The **Office of Comprehensive Services (OCS) for At-Risk Youth and Families** is the administrative entity responsible for implementation of services as the CSA's administrative body. OCS works in partnership with other state agencies, localities, family organizations, and other stakeholders to improve CSA performance and ensure compliance with SEC and legislative policies. The OCS is responsible for policy development, fiscal management, data collection and management (including a database of authorized providers); and for technical assistance to and oversight of local CSA activities. For quality assurance, OCS coordinates resources, training, best practices dissemination, and management reports to support community CSA systems. When requested by localities, OCS provides utilization management for some residential programs.

The Office of Comprehensive Services (OCS) conducts both routine and special compliance/formal audits of local operations, which include on-site visits. The OCS audits are to ensure that CSA services are appropriate, cost effective, provide the best possible outcomes for at-risk youths and families, and are in compliance with CSA policies and procedures. Based on review findings, OCS identifies local training and technical assistance needs. If program specific concerns are found, staff from appropriate agencies may be called in to assist in the review process. Following any review, a summary is provided to the Chair of the local **Community Policy and Management Team (CPMT)** and shared with others as appropriate. The summary contains information collected during the review, requests for corrective plans for any areas needing remediation, and recommendations for training or technical assistance when appropriate.

In 2007, the Joint Legislative Audit and Review Commission (JLARC) published its research report, *The Evaluation of Children's Residential Services Delivered through the Comprehensive Services Act* (<http://jlarc.virginia.gov/reports/RPT346.PDF>). Since then, to strengthen CPMT and FAPT performance, the OCS has developed and provided training on service models for needs assessments, policy guidelines, assessment tools and skills training, and systems coordination,

among other topics. OCS staff is available to provide CMPTs and FAPTs with ongoing training and consultation. Over time, the OCS has modified CSA data collection to capture provider-specific information, results from the Child and Adolescent Needs and Strengths (CANS) standardized assessment instrument, and generally improve data analytics for service evaluation and improvement planning.

The Community Policy and Management Team (CPMT) has administrative and fiscal responsibility for managing the local and state pool of funds, developing local interagency policies and procedures for referral and assessment, planning long-range community services, conducting quality assurance and utilization reviews, and appointing members to the locality's Family Assessment and Program Management Team (FAPT).

While municipalities are required by Virginia law to establish their own two-tiered systems involving a CPMT and a FAPT, they are otherwise given considerable flexibility in designing and delivering CSA services that best fit their situations. To ensure CSA services are appropriate, cost effective, clinically effective, and in compliance with CSA policies, localities must have a system in place for review of extensive client data (including reasons for referral and planned services) as well as program data on service delivery, quality, and costs. Local reviews may also identify technical assistance and training needs and raise policy or procedural issues requiring attention.

The OCS develops an annual **Critical Services Gap Survey** regarding available community services, barriers to services, and service gaps at the local and regional levels. Local CPMTs meet, either by locality or regionally, to review and discuss data to determine needs as well as how to best address gaps. OCS staff sometimes facilitates meetings between the CPMTs and private providers regarding identified service gaps or to make connections that bring service providers to a locality or region. Although the top service gap for each CSA region may vary, since SFY 2004, annual surveys have found that: (1) **crisis intervention services for youth** are the most important critical service need statewide and (2) **intensive substance abuse services for youth** in the western, central, and northern regions of the State has been an ongoing, unfilled need.

Lack of local start-up funds to expand or develop needed critical services has been an ongoing barrier. In order to improve service development to address these gaps, the **CSA State Executive Council** adopted a **Carve Out Policy** at its April 2013 meeting. This policy allows a maximum of \$2 million dollars in state General Funds to be set aside from local CSA allocations in order to support one-time start up costs for new services. Availability of this fund is contingent upon future new state allocations.

## **G. Centers for Independent Living and Related Services**

Independent living services are defined broadly as training, education, and support services that promote self-determination, empowerment, self-advocacy, self reliance, independence and productivity for individuals with disabilities, including those with significant disabilities. The

ultimate goal of these services is **integration and inclusion** of individuals with disabilities in their communities. Although a variety of public and private entities offer these services, independent living services are provided through two state-administered and funded programs (1) Centers for Independent Living (CILs) under the Department for Aging and Rehabilitative Services (DARS) and (2) the Rehabilitation Teaching/Independent Living (RT/IL) Program offered by the Department for the Blind and Vision Impaired (DBVI).

The Commonwealth's **Centers for Independent Living (CILs)** are nonprofit, community, non-residential agencies operated by and for Virginians with disabilities. Authorized under the federal Rehabilitation Act of 1973 (29 US Code § 701 et seq.) and the Code of Virginia § 51.5-162, CILs help individuals with disabilities to develop or improve various skills for independent functioning in the family or community, or to gain or continue their employment. CILs additionally inform, advise, and work with local or regional political leadership and planning entities to make communities more accessible and to ensure equal opportunities for citizens with disabilities. Regulations require that CIL staff and management be individuals with disabilities who have been trained in independent living philosophy (<http://www.DARS.virginia.gov/cbs/cils.htm>).

## 1. Eligibility for and Available CIL Services

As required by federal legislation, CILs prioritize services to individuals who have a significant physical or mental impairment and have substantial limitations in the ability to function independently in the family or community or to obtain, maintain, or advance in employment. CILs are required to provide four **core services**:

1. information and referral,
2. peer counseling,
3. advocacy, and
4. independent living skills training.

Helping individuals develop **advocacy skills** for personal and systems change is a fundamental part of the CILs' mission.

Most CILs provide additional services beyond these core responsibilities, such as linkages to housing resources or Medicaid and efforts to expand employment opportunities for people with significant disabilities. Many CILs hold recreational events that bring together local residents with and without disabilities. Although adults with disabilities or parents of youth with disabilities are primarily served, some CILs provide peer counseling, mentoring, and skills training programs for youth in local schools. In recent years, the CILs have partnered with the state Department of Medical Assistance Services (DMAS) to create a statewide network of staff who serve as **Medicaid mentors**. These mentors, extensively trained by DMAS staff, provide

technical assistance to individuals and families to apply for and access needed Medicaid benefits and services.

## 2. Access to and Use of CIL Services

Individuals needing assistance should contact the CIL office in or closest to their locality. Directories of statewide CILs are online at <http://www.vasilc.org/cillist.htm> and <http://www.vadrs.org/cbs/cils.htm>. At the end of SFY 2013, there were 15 Centers for Independent Living (CILs) and 4 satellite centers spread across 20 of the State's 23 planning districts. Not all areas of the State are covered. As of January of 2014, these locations had CILs: Abingdon, Arlington, Big Stone Gap, Charlottesville, Christiansburg (satellite), the Eastern Shore, Fredericksburg, Grundy, Hampton, Harrisonburg, Loudon (satellite), Lynchburg, Manassas, Middle Peninsula (satellite), Norfolk, Petersburg (satellite), Richmond, Roanoke, and Winchester. A 16<sup>th</sup> CIL covering Planning District 12 (Martinsville/Danville) will open in September of 2014. The **satellite locations** require annual appropriations to be designated for them to become freestanding CILs. A map of the CILs can be found at <http://www.vadrs.org/cbs/cilsmap.htm>.

CIL staff works directly and collaboratively with individuals with disabilities to identify needs and to develop a plan for independent living services that best meets the individual's needs and preferences. Each individual's **CIL plan** records mutual agreements on what services will be provided and how and when they will be delivered. CIL staff assists both individuals and family members in finding and accessing local support services or resources that will enhance independence and community integration.

CILs typically are unable to provide an unduplicated count of individuals served. An individual may contact a CIL multiple times during a year for different services. According to Department for Aging and Rehabilitative Services (DARS) data, CILs estimate serving at least 9,000 individuals each year since state fiscal year (SFY) 2010. Each CIL tracks the number of hours during which staff provides key services. In SFY 2012 (the latest data available), statewide, CILs services to community members with significant disabilities amounted to:

- 19,709 hours for information/referral to services,
- 18,433 hours of collaboration and networking,
- 15,659 hours in community education,
- 12,881 hours in outreach, and
- 6,027 hours of technical assistance for service access.

## 3. Cost and Payment for CIL Services

CILs are nonprofit organizations that receive funding from the local, state, and federal government as well as private sources. General operations are supported by federal funds (approximately \$1.5 million per year) through Title VII of the federal Rehabilitation Act. Federal

funding has been relatively flat in recent years, and even reduced due to sequestration. The majority of CIL funding comes from the state General Fund. In addition, each CIL solicits local and private funds, and either individually or through the Virginia Association of CILs seeks funding through competitive grants for particular projects. The total **expenditures by CILs** for SFYs 2010 through 2013 are listed in **Table 58**.

| Table 58. CILs Expenditures for SFYs 2010 - 2013 |             |             |             |
|--|-------------|-------------|-------------|
| 2010   | 2011        | 2012        | 2013        |
| \$8,565,397                                      | \$7,795,932 | \$7,090,882 | \$7,071,694 |

Source: Department for Aging and Rehabilitative Services.

As the data indicate, expenditures have varied based on funding. Between SFYs 2011 and 2013, expenditures declined by nearly 10 percent.

#### 4. Monitoring and Evaluation of CIL Services

Under both state and federal statutes, responsibility for oversight of services provided by Centers for Independent Living (CILs) rests with their executive directors, individual governing boards, and the **Department of Rehabilitation Services (DARS)** through the Independent Living Services office of its Community Based Services Division. DARS oversight is accomplished through site visits and monitoring of CIL activities as well as review of quarterly and annual reports, financial audits, and evaluation of the outcomes of CIL services. Outcome measures track achievement of program activities planned by the CILs, local and statewide training for CIL staff and individuals with disabilities, and local efforts related to statewide systems change initiatives. CILs are actively engaged in statewide system change, such as increased access to Medicaid Home and Community Based Services (HCBS) Waivers and to transportation services, expanded housing options, and improved assistance to individuals who have transitioned from nursing facilities to community residences or who have needed services to avoid entering nursing facilities.

Since CIL core services are consumer-directed, feedback from the individuals with disabilities receiving services is a crucial part of service evaluation. All CILs collect this feedback through a variety of mechanisms. Many have a consumer advisory committee that designs, distributes, and collects responses to a consumer satisfaction survey in a process that is independent of the CIL staff. Results of these surveys are submitted to their respective executive directors and boards with recommendations for service improvements, changes, or additions.

## H. Independent Living Services for the Blind and Vision Impaired

Authorized under the 1973 Rehabilitation Act, as amended, and the Code of Virginia (Title 51.5, Chapter 12), the **Department for the Blind and Vision Impaired (DBVI)** is tasked to

provide vocational rehabilitation and other services to Virginians of all ages who are blind, deafblind or vision impaired, so they may become independent, contributing citizens. Although vocational rehabilitation is its primary goal, the DBVI programs have the equally important goal of fostering the personal independence of those with vision impairments. The DBVI's **Rehabilitation Teaching/Independent Living (RT/IL) Program** provides services to meet this goal (<http://www.vdbvi.org/RTILS.htm>).

### 1. Eligibility for and Available DBVI Independent Living Services

The **RT/IL Program** provides individualized needs assessments, adjustment counseling, information and referrals, and skills training. The DBVI RT/IL program specifically benefits individuals who are blind or have related visual or sensory impairments and provides services enabling those individuals to maximize their economic, social, and personal independence and participation in community life. Eligibility for RT/IL services requires verification of residence and medical documentation of the nature and scope of the vision impairment. Generally, an individual must have, in the better eye, visual acuity (with correction if needed) that is worse than 20/70 or a visual field that is less than 70 degrees across. Further information is available online at <http://www.vdbvi.org/services.htm>.

DBVI can provide intensive rehabilitation through its residential program, the **Rehabilitation Center for the Blind and Vision Impaired**, located in Richmond. Skills training programs cover self-advocacy and outreach, daily living, recreation, use of assistive technology, travel, vocational evaluation, home management, and forms of communication (including Braille). DBVI rehabilitation teachers, who are located across the State, generally also provide many services in an individual's home that promote independence. In addition to skills training and adjustment-to-blindness counseling to the individual, the rehabilitation center staff can educate and consult with family members, caregivers and others who wish to be of assistance to an individual with vision impairment. Staff also can arrange vision assessments and training with assistive technology.

The **Low Vision program**, which specifically serves persons who cannot see with conventional glasses, helps individuals maximize the vision that they have. Low Vision provides assistive technology, AT training and other specialized services, including visual examinations, optical aids, and follow-up services. DBVI **Orientation and Mobility training** teaches an individual to travel safely and independently as well as specific techniques to establish and maintain orientation to their surroundings. **Deafblind Services** provides additional specialized services for activities of daily living and especially for communication: skill assessments, adaptive equipment consultations, and technical assistance. RT/IL staff at DBVI additionally provides guidance, consultations and technical assistance to external public and private organizations, employers, and the general public regarding the unique needs of its target population.

## 2. Access to and Use of DBVI Independent Living Services

To request services, individuals or professionals should contact the regional Department for the Blind and Vision Impaired (DBVI) **Rehabilitation Teaching/Independent Living (RT/IL) Program** nearest them or the Department's central office. DBVI staff provides intake and makes referrals for the RT/IL program, which has six regional offices across the State (Bristol, Fairfax, Norfolk, Richmond, Roanoke, and Staunton). RT/IL staff works directly with individuals needing assistance to explain services, establish visual eligibility, educate them on available resources, and refer them to appropriate DBVI programs and other community services. Once basic visual eligibility has been determined, the individual receives a functional assessment by a DBVI Rehabilitation Teacher, who then creates an individualized service plan most appropriate to the individual's identified needs.

Essential to an individual's success in school, employment, and community living is **orientation and mobility training**. Many individuals receive this training either at the regional DBVI office or in their homes or communities. For some individuals, independent living and orientation-to-blindness skills training occurs at the Virginia Rehabilitation Center for the Blind and Vision Impaired, a short-term residential program in Richmond.

The service capacity for programs under DBVI has varied over time, largely due to both funding constraints and the related difficulty in filling staff vacancies. **Table 59** depicts the number of individuals under age 55 served by each DBVI program for independent living skills for state fiscal years (SFYs) 2010 through 2013. Rehabilitative Teaching and Independent Living (RT/IL) services provided to those ages 55 years and older are counted under the Older Blind Grant Program (included in the **Services for the Elderly Population** section of this chapter). Prior to SFY 2010, the number served included all age groups and some non-active cases and counts for these programs were duplicative with the Older Blind Grant Program data.

| <b>DBVI Program/Service</b>              | <b>2010</b>  | <b>2011</b>  | <b>2012</b>  | <b>2013</b>  | <b>Change<br/>(#/%)</b>  |
|--|--------------|--------------|--------------|--------------|--------------------------|
| <b>Orientation and Mobility Training</b> | <b>562</b>   | <b>487</b>   | <b>641</b>   | <b>411</b>   | <b>- 151<br/>- 26.9%</b> |
| <b>Independent Living (RT/IL)</b>        | <b>460</b>   | <b>472</b>   | <b>439</b>   | <b>423</b>   | <b>- 37<br/>- 8.0%</b>   |
| <b>Deafblind Services</b>                | <b>156</b>   | <b>170</b>   | <b>105</b>   | <b>125</b>   | <b>- 31<br/>- 19.9%</b>  |
| <b>Low Vision Services</b>               | <b>953</b>   | <b>1,129</b> | <b>1,082</b> | <b>1,013</b> | <b>+ 60<br/>+ 6.3%</b>   |
| <b>TOTAL</b>                             | <b>2,131</b> | <b>2,258</b> | <b>2,267</b> | <b>1,972</b> | <b>–</b>                 |

The most significant decline in the number served between SFYs 2010 and 2013 were for the Orientation and Mobility Training service, which decreased by 26.9 percent (151 individuals), and the Deafblind Services, which decreased by 19.9 percent (31 individuals). By



contrast, the Rehabilitation Teaching/Independent Living (RT/IL) Program had only an 8-percent decline in the number served over those SFYs, and participants in Low Vision Services actually increased by 6.3 percent. During SFYs 2010 and 2011, DBVI had additional monies from the federal stimulus fund awards as a result of the American Recovery and Reinvestment Act of 2009 (ARRA). DBVI notes that some variation in the numbers served occurs between years due to varying levels of service needed in the communities or schools of the individuals referred to a program. As noted in the DBVI *2013 Executive Progress Report*, the pool of credentialed professionals who can provide orientation and mobility training still is limited statewide, and vacancies are sometimes difficult to fill.

### 3. Cost and Payment for DBVI Independent Living Services

DBVI receives federal funding for its vocational rehabilitation programs through the US Department of Education's Rehabilitative Services Administration (RSA). It receives a separate federal grant for independent living services for older individuals who are blind under Title VII of The Rehabilitation Act. Federal funding has been flat in recent years, and in federal fiscal year (FFY) 2013, federal funds were cut by 5 percent due to sequestration. In SFY 2013, DBVI received \$6,301.368 in state General Funds. The appropriation was reduced to \$5,812,355 in SFY 2014, and, of the total DBVI budget for SFY 2014 (\$50.74 million), only 11.5 percent was from state General Funds.

DBVI additionally receives revenues each year from user fees, vending machine programs, and donations. Financial participation requirements, based on a formula intended to identify individuals with the greatest economic need, exist for the purchase of some equipment. While those meeting financial need guidelines can receive tangible goods and services at no cost, others may be required to pay some or all of the costs for certain goods and services. Financial need criteria are updated annually.

**Table 60** lists DBVI expenditures by independent living program and related services for SFYs 2010 through 2013. Expenditures for Deafblind Services are indirect; rather than a direct use of funds for these specific clients. Independent living service expenditures for the deafblind population are incurred by the RT/IL and vocational rehabilitation programs that also serve those with visual impairments who are not deafblind. Distinct expenditure data for the Orientation and Mobility Training service are not available.

| <b>Table 60. DBVI Expenditures for Independent Living and Related Services by SFY</b> |                  |                  |                  |                  |
|---|------------------|------------------|------------------|------------------|
| <b>DBVI Program/Service</b>   | <b>2010</b>      | <b>2011</b>      | <b>2012</b>      | <b>2013</b>      |
| <b>Rehabilitation Teaching/Independent Living</b>                                     | <b>N/A</b>       | <b>\$41,212</b>  | <b>\$99,574</b>  | <b>\$70,760</b>  |
| <b>Deafblind Services</b>   | <b>\$140,320</b> | <b>\$19,000</b>  | <b>\$26,000</b>  | <b>\$26,400</b>  |
| <b>Low Vision Services</b>  | <b>\$506,175</b> | <b>\$224,882</b> | <b>\$263,367</b> | <b>\$238,432</b> |

Source: Department for the Blind and Vision Impaired.

While expenditures for the Rehabilitation Teaching/Independently Living Program increased, expenditures for the other two programs decreased substantially.

#### **4. Monitoring and Evaluation of DBVI Independent Living Services**

Oversight for the **Rehabilitation Teaching/Independent Living Program** within the Department for the Blind and Vision Impaired (DBVI) is the responsibility of its director, who is assisted by 6 regional managers. Each regional manager supervises and evaluates the performance of 22 rehabilitation teachers who deliver RT/IL services. The RT/IL Program director and regional managers also review case records and accompany the rehabilitation teachers in the field to monitor their effectiveness. Quality assurance procedures for the Deafblind Services and Low Vision Services are similar. However, the program director for Low Vision Services has the additional responsibility for hiring, training, and monitoring the contracted examiners who provide direct services for the program's consumers. Periodic performance evaluations of these examiners are reviewed by the director for Low Vision Services and by regional leadership. If examiners are found to be non-compliant with DBVI policies and practices, their contracts may be cancelled.

The **DBVI central office** conducts annual case reviews for each of the regional offices and solicits feedback on services from DBVI's consumers and other stakeholders through periodic customer satisfaction surveys and other appropriate means. When problems are detected, corrective actions may result in additional staff training, casework corrections, or other personnel actions. The program directors may modify their policy manuals or arrange for general training to increase the effectiveness of a program. As a recipient of funding from the federal Rehabilitation Services Administration (RSA), DBVI is further required to submit an annual report to that agency. If RSA finds it to be non-compliant in any area, DBVI must submit a corrective plan indicating the actions to be taken and their projected completion dates.

The DBVI *2013 Strategic Plan Executive Progress Report*, as in the past, notes that attracting staff skilled in orientation and mobility training remains a challenge. DBVI anticipates greater demand for Low Vision and related services in the future as the number of Virginians who are elderly increases. Technology changes for accessibility increasingly "require a substantial investment of time and funding," which can impact funding available for direct services. DBVI established a **technology laboratory** through which staff can demonstrate cost-effective alternatives. DBVI also has worked to expand, and will continue to expand, partnerships with nonprofit and for-profit entities as well as public agencies to leverage its resources for direct services.

### **I. Intellectual Disability Services (Non-Medicaid Waiver)**

Individuals with an intellectual disability (ID) may need supports or services that are not covered by the Medicaid ID Waiver, and others who are on the ID Waiver Wait List may lack private insurance coverage or the financial resources for needed services. The Virginia **Department of Behavioral Health and Developmental Services (DBHDS)** is responsible for

planning, monitoring, and overseeing all publicly funded services for individuals with intellectual disabilities. To do so, it contracts with 37 independent, local **Community Services Boards** and three **Behavioral Health Authorities** (collectively referred to as **CSBs**) that are designated by the Code of Virginia (37.2-500 and 37.2-601) as the single point of entry into the State's mental health, intellectual disability, and substance abuse services system.

The **State Board for Behavioral Health and Developmental Services**, through State Board Policy 1038 (SYS) 06-1 (updated December 2013) affirms the responsibility of CSBs and DBHDS for assuring provision (either directly or through contracts) of a

*safety net of appropriate public services and supports to the greatest extent practicable in safe and suitable settings.*

This policy further states that this safety net responsibility covers those individuals who have a serious mental health or substance use disorder, intellectual disability, or co-occurring disorders and who

*are in crisis or have severe or complex conditions; cannot otherwise access needed services and supports because of their level of disability, their inability to care for themselves, or their need for a highly structured or secure environment; and are uninsured, under-insured, or otherwise economically unable to access appropriate service providers or alternatives.*

## **1. Eligibility for and Available (Non-Waiver) ID Services**

To receive services, an individual must have a current diagnosis of intellectual disability as determined by a formal evaluation by a qualified professional. Additional eligibility requirements for specific CSB services exist based on the purpose of the service, parameters set by federal or state legislation, and the availability of local government funding. CSB staff determines ID service eligibility and coordinates service delivery. CSBs either contract with private providers for ID services or provide the services themselves. CSBs are required to

*provide individualized, effective, flexible, and efficient treatment, habilitation, and prevention services in the most accessible and integrated setting possible.*

For all CSBs, the Code of Virginia (§§ 37.2-500 and -601) mandates only emergency services as a required service, and gives a limited mandate for case management services, subject to legislative appropriations.

As noted in the DBHDS annual *Overview of Community Services in Virginia*, any combination of 10 core service categories may be available through a CSB:

- emergency services,
- limited services,

- consumer-run services,
- local inpatient services,
- outpatient counseling,
- case management,
- day support services,
- employment services,
- residential services, and/or
- prevention services.

In addition, CSBs either provide or contract for early intervention services to infants and toddlers.

Each service category is defined in the DBHDS **Core Services Taxonomy**, which was developed and is periodically updated by DBHDS in partnership with the Virginia Association of Community Service Boards (VACSB). **Limited services** typically are services that are provided short-term (less than 30 days or 4 to 8 sessions), infrequently, or are of low-intensity. Limited services include: assessments and evaluations; consumer monitoring services (for those on waiting lists or those who only receive service coordination, intermittent emergency contacts, or outreach); early intervention services; and motivational treatment services for individuals with mental health (MH) or substance abuse (SA) disorders. **Consumer-run services** are

*self-help programs designed, governed and led by and for people in recovery.*

These are typically individuals with MH or SA disorders, and services typically are provided through peer drop-in centers.

## **2. Access to and Use of (Non-Waiver) ID Services**

Although legislatively accountable to local government, most CSBs operate as independent entities rather than as departments of city or county government. The service array at each CSB is unique, reflecting each CSB's own community priorities and available local resources. Each CSB determines its intake processes. To receive services from a CSB, an individual with an intellectual disability (ID) or his/her family member or caregiver must contact the local CSB serving the geographic area in which the individual lives. CSB staff then meets with the individual, and as appropriate, family members or caregivers, face-to-face. When eligibility for service is determined, the CSB "admits" or "enrolls" the individual, and opens a case record. This admission is for services in general, not for any particular program, and by enrolling, the individual expresses his or her willingness and intention to receive services through the CSB. Next, an assessment of the individual's needs is made and eligibility for specific services to address those needs is determined. Depending on the individual's specific needs, preferences and interests, an **Individual Support Plan (ISP)**, based on person-centered principles, is developed. This ISP guides the implementation of needed CSB services.

The biennial Performance Contract between each Community Service Board (CSB) and the Department of Behavioral and Developmental Services (DBHDS) identifies specific services that the CSB agrees to provide either directly or through contracts. Listed below are the unduplicated numbers of persons (children, adolescents, and adults) who received core ID [or developmental disability (DD)] services from CSBs for state fiscal years (SFYs) 2009 through 2013. Data are from the biennial DBHDS Comprehensive State Plans, the latest plan covering 2014 through 2020.

| <b>Table 61. Number receiving Non-Medicaid-Waiver ID or DD Services by SFY</b> |               |               |               |               |               |
|--|---------------|---------------|---------------|---------------|---------------|
| <b>State Fiscal Year</b>   | <b>2009</b>   | <b>2010</b>   | <b>2011</b>   | <b>2012</b>   | <b>2013</b>   |
| <b>Number Served</b>   | <b>27,172</b> | <b>19,374</b> | <b>20,387</b> | <b>20,562</b> | <b>20,248</b> |

DBHDS also reports the number of individuals who received specific ID/DD services. The number of individuals with ID who received **case management services** during the past four years was as follows:

- 17,530 individuals in SFY 2010
- 18,294 individuals in SFY 2011
- 18,376 individuals in SFY 2012
- 18,466 individuals in SFY 2013

The DBHDS Comprehensive State Plans also provide information on **unmet service needs** by disability area. The CSBs conduct a point-in-time survey (between January and April) to identify individuals who have sought any service and have been assessed by their CSB as needing a service that is not yet available. While the individual may be receiving one or more services through the CSB, he or she may still need another or additional services. CSB survey results are considered to be conservative estimates. Although more Medicaid Waiver slots have been funded annually in recent years, the number waiting for ID/DD services has grown over time:

- 5,216 individuals on waiting list in SFY 2005
- 5,992 individuals on waiting list in SFY 2007
- 6,458 individuals on waiting list in SFY 2009
- 6,415 individuals on waiting list in SFY 2011
- 7,806 individuals on waiting list in SFY 2013

In 2013, the most frequently identified ID/DD service needs for those on waiting lists were supportive services/day support and case management (especially for youth).

The Comprehensive State Plan additionally reports findings from the annual survey on the length of time individuals waited for a needed service. **Table 62** provides a comparison of survey data for SFYs 2009, 2011, and 2013. Until 2009, only the total number of individuals (youth and adults) was reported in the DBHDS Comprehensive State Plan. Beginning in 2011, separate totals were listed for youth and adults. The figures below are the totals calculated for both age groups.

| <b>Table 62. Length of Time on CSBs Waiting Lists for ID/DD Services by SFY</b> |              |              |  |
|---|--------------|--------------|--|
| <b>Wait Time</b>  | <b>2009</b>  | <b>2011</b>  | <b>2013</b>                              |
| <b>0 to 1 month</b>   | <b>57</b>    | <b>24</b>    | <b>(metric changed to 0 to 3 months)</b> |
| <b>1 to 3 months</b>  | <b>766</b>   | <b>546</b>   | <b>720</b>                               |
| <b>4 to 12 months</b>   | <b>1,048</b> | <b>832</b>   | <b>977</b>                               |
| <b>13 to 24 months</b>  | <b>1,112</b> | <b>956</b>   | <b>1,149</b>                             |
| <b>25 to 36 months</b>  | <b>709</b>   | <b>897</b>   | <b>867</b>                               |
| <b>37 to 48 months</b>  | <b>608</b>   | <b>722</b>   | <b>830</b>                               |
| <b>49 to 60 months</b>  | <b>500</b>   | <b>480</b>   | <b>756</b>                               |
| <b>61 to 72 months</b>  | <b>387</b>   | <b>431</b>   | <b>649</b>                               |
| <b>73 or more months</b>  | <b>1,209</b> | <b>1,473</b> | <b>1,979</b>                             |
| <b>Not reported</b>   | <b>62</b>    | <b>54</b>    | <b>N/A</b>                               |
| <b>TOTAL</b>  | <b>6,458</b> | <b>6,415</b> | <b>7,927</b>                             |

Source: Department of Behavioral Health and Developmental Services, *Comprehensive State Plans* for 2010–2016, for 2012–2018, and for 2014–2020.

The longest CSB wait times for individuals with ID/DD, according to the plan report, were for residential services (intensive and supervised) and employment services. For people with disabilities waiting for services provided under the Medicaid ID Waiver, the average wait time was at least 60 weeks for each of the following: personal emergency response systems (PERS), nursing services, assistive technology, and therapeutic consultations.

An additional measure of unmet service needs for individuals with ID is documented through the annual CSB survey and reported in the Comprehensive State Plan. The survey identifies the number of children and adults with an intellectual disability who are on a waiting list and who are not receiving *any* CSB services. Based on the point-in-time surveys, the number of these individuals on waiting lists was as follows:

- 938 individuals in SFY 2005
- 1,114 individuals in SFY 2007
- 1,342 individuals in SFY 2009
- 1,202 individuals in SFY 2011
- 945 individuals in SFY 2013

### **3. Cost and Payment for (Non-Waiver) ID Services**

According to the DBHDS *2014–2020 Comprehensive Plan*, the agency's total annual budget is funded by federal appropriations through various block grants and other programs as well as the Department's federal share of Medicaid and Medicare reimbursements and state General Funds. These funds support *all* DBHDS-operated facilities and all contracted CSB services for individuals with a mental illness, intellectual disability, or substance abuse disorder. System funding additionally comes from fees, state Medicaid funds, and local matches. Total DBHDS revenue system-wide (CSBs and state facilities) for SFY 2012 was \$2.397 billion dollars, of which only 23 percent was from state General Funds. The sources of DBHDS funds for SFY 2012 were proportioned as follows:

- 30 percent from state Medicaid match
- 30 percent from federal Medicaid funds
- 23 percent from state General Funds
- 10 percent from local match
- 4 percent from other fees
- 3 percent from federal grants

In SFY 2013, as reported to the legislative sub-committee for Health and Human Resources, DBHDS received \$1.639 billion in revenues for all system operations. CSB ID programs received a total of \$311.2 million dollars in revenue that year:

- 45 percent from fees, including Medicaid fees
- 24 percent was from state General Funds allocated through the CSB Performance Contracts
- 23 percent from localities
- 8 percent from other sources such as workshop sales, retained earnings, charitable donations, grants, and one-time funds

CSB services are also supported, to varying degrees, by annual appropriations from the localities that established them. CSB revenues for ID services include reimbursement for ID services from Medicaid, Medicare, and private insurance; individual co-payments; and other funds such as sheltered workshop sales, retained earnings, charitable donations, grants, and

one-time funds. Neither the number served nor expenditure data specific to CSBs' non-Waiver ID services was available for SFY 2013.

#### **4. Monitoring and Evaluation of (Non-Waiver) ID Services**

As the State's lead agency for intellectual disability services, the **Department of Behavioral Health and Developmental Services (DBHDS)** licenses public and private providers of ID services, offers technical assistance, and oversees protection of human rights. DBHDS additionally is responsible for operational and fiscal oversight, budgeting, allocation of state funds, and quality assurance—not only for the 40 local Community Services Boards (CSBs) but also for the 5 state-operated intermediate care facilities for individuals with intellectual and developmental disabilities (ICFs/IID), known in Virginia as Training Centers. (See the **Institutional Supports** chapter of this *Assessment* for more information on the regional Training Centers.)

The key DBHDS accountability tool is the annual **Community Services Performance Contract**, signed by the DBHDS commissioner and CSB executive directors, which contains numerous data collection and accountability requirements to ensure state/federal regulatory compliance and a quality improvement approach. The **Central Office, State Facility, and CSB Partnership Agreement**, which is part of the contract, defines system values, delineates roles for each participant that establish a collaborative, operational partnership, and identifies processes for improving the quality of care throughout the DBHDS public service system. These documents are available online at <http://www.dbhds.virginia.gov/OCC-default.htm>. Locally, administration of each CSB is further guided by a board of directors consisting of 6 to 18 members appointed by the local governing bodies within their areas of jurisdiction.

The **DBHDS Office of Community Contracting (OCC)** is primarily responsible for negotiating and monitoring the performance contract, and OCC works with other DBHDS offices that conduct and document CSB-compliance activities pertaining to specific contract requirements. Onsite reviews of CSB client records and fiscal documents by DBHDS staff in each disability area are an important part of monitoring activities. However, DBHDS reports that limited staffing makes conducting them a challenge. When such reviews do occur and compliance issues or deficiencies are found, DBHDS attempts to resolve them initially through informal and then formal processes, which include discussion, negotiation, correspondence, or corrective action plans. If these efforts are not successful, the performance contract allows for other means of resolution that, as a rare and last resort, can include withdrawal of state funding from the applicable service or program.

The **DBHDS Office of Licensing (OL)** is responsible for development, oversight, and enforcement of DBHDS licensure standards, policies, and procedures for providers of treatment, training, and habilitation services for individuals with mental illness, intellectual disability, or substance abuse disorders statewide. These providers include day support, in-home residential, or crisis stabilization services under the Medicaid Home and Community Based Services (HCBS) Individual and Family Developmental Disabilities Support Waiver (DD



Waiver). Licensing staff investigates complaints against providers, which may operate multiple programs or services, and OL staff is required to make at least one unannounced inspection of each provider, each year. OL staff also develops electronic guidance and training materials for providers, which may be purchased; and the staff supplies technical assistance as indicated or requested when staffing allows.

**Table 63**, covering selected state fiscal years (SFY) between 2007 and 2013 provides a “big picture” regarding the total changes over time in the number of providers, services, and sites for mental health, intellectual disability, and substance abuse. For that period, the number of licensure staff is also listed. Between SFYs 2010 and 2013, Office of Licensure more than doubled its staff after being constant at 15 until SFY 2010. During the same time period, however, the number of providers and services nearly doubled, and the number of locations more than tripled.

| <b>Table 63. Number of DBHDS-licensed Providers, Services, and Sites by SFY</b> |              |              |              |
|---|--------------|--------------|--------------|
| <b>Available Resources</b>  | <b>2007</b>  | <b>2010</b>  | <b>2013</b>  |
| <b>Providers</b>  | <b>529</b>   | <b>697</b>   | <b>844</b>   |
| <b>Services</b>   | <b>1,257</b> | <b>1,662</b> | <b>2,038</b> |
| <b>Locations</b>  | <b>2,970</b> | <b>5,037</b> | <b>7,063</b> |
| <b>Office of Licensing staff</b>  | <b>15</b>    | <b>15</b>    | <b>31</b>    |

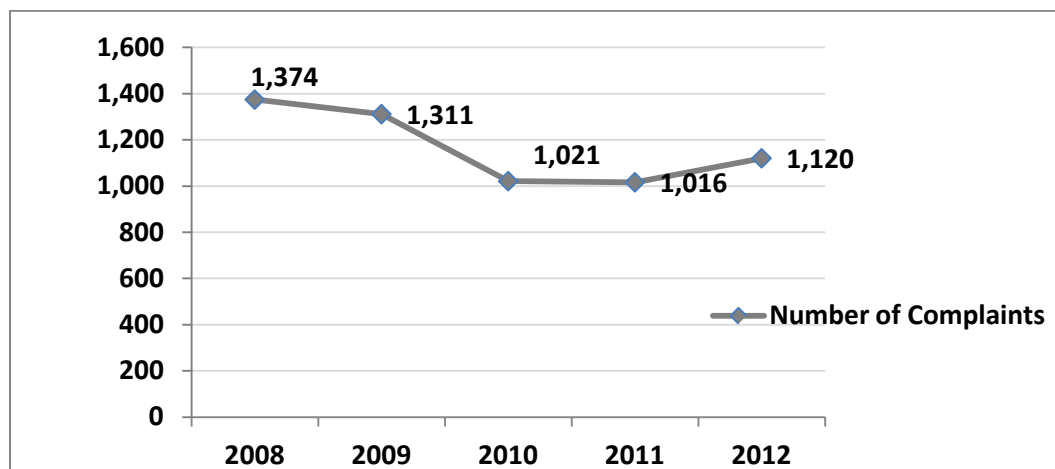
Source: Department of Behavioral Health and Developmental Services, Office of Licensing

Since the 2012 court approval of the DOJ Settlement Agreement, the Office of Licensure has engaged in revising standards and developing performance measures. The Code of Virginia (§ 37.2-418 and 419) was revised in 2012 to establish a range of OL sanctions for non-compliance by providers of residential behavioral health services to adults and youth. Other DBHDS staff concurrently developed a new training curriculum for CSB case managers, which has been implemented. DBHDS is working to strengthen oversight of providers through improved communication between case managers and OL staff.

The **DBHDS Office of Human Rights (OHR)** is responsible for protecting the legal and human rights of individuals receiving services either in state facilities or in the community-based programs operated, licensed, or funded by DBHDS (Code of Virginia, § 37.2-400). The OHR staff monitors provider compliance with relevant regulations, promotes the basic precepts of human dignity, receives and investigates allegations of client abuse and neglect, and provides training on human rights protection and abuse/neglect prevention to individuals with disabilities, family members, providers, and professionals. OHR additionally supports the work of Local Human Rights Committees across the State. OHR staffing has been relatively stable, but increased somewhat in the past 2 years: 19 HR staff in calendar years 2010 and 2011; 21 in 2012; and 22 in 2013.

The OHR posts information on how to make **human rights complaints** or allegations of abuse or neglect on the DBHDS web page at <http://www.dbhds.virginia.gov/OHR-default.htm>. This page includes various reports on the complaints and allegations made as well as OHR activities conducted each year. **Figure 22** depicts the total number of human rights complaints received from individuals in *all* public and private community settings licensed by DBHDS for the period of calendar years (CYs) 2008 through 2012. DBHDS licenses both settings and service providers for intellectual and related disabilities, mental illness, and substance abuse.

**Figure 22. DBHDS Human Rights Complaints in Community Settings for CYs 2008–2012**



Source: State Human Rights Committee, *2012 Annual Report on the Status of the Human Rights System*, <http://www.dbhds.virginia.gov/documents/reports/OHR-SHRC2012AnnualReport.pdf>.

The number of human rights complaints declined during this 5-year period with the sharpest drop occurring between CYs 2008 and 2010 (353, or 26.9 percent). Thereafter, the number of complaints has been relatively stable, although there was an increase (10.2 percent) between CYs 2011 and 2012.

In 2012, DBHDS contracted with the Social Science Research Center and Old Dominion University to conduct a statewide survey and focus groups of community stakeholders. The study's purpose was to obtain feedback for improvement on various issues related to the human rights complaint processes and local human rights committee (LHRC) role/functions, timeframes, and procedures for abuse/neglect allegations and human rights complaints, among others. The final report, issued in 2013, identified these main areas of consensus:

- The human rights complaint process needs to be simplified (strongest agreement).
- More training is needed on the definition of a complaint and on interpretation of human rights regulations (focus group feedback).
- The timeframe for completion of the initial provider investigation of an abuse/neglect allegation should be no more than 10 days (focus group feedback).

Consumer focus group participants and stakeholder feedback differed on many issues (sometimes substantially). Differences included acceptable reporting timeframes for allegations and the role and functions of the LHRC, among others. The researchers recommended that the Office of Human Rights (OHR) conduct additional dialogues with a wider range of stakeholders statewide to identify other areas of consensus for system and regulatory changes. The report is online at [http://www.dbhds.virginia.gov/documents/HumanRights/Compiled\\_final%20report.pdf](http://www.dbhds.virginia.gov/documents/HumanRights/Compiled_final%20report.pdf).

The OHR additionally reports the number of **abuse and neglect allegations** made and the number of those that are substantiated each year, both from the state Training Centers (detailed in the **Institutional Supports** chapter of this *Assessment*) and from community settings. “Substantiated” means that, after an investigation, the allegation was found to be valid. **Table 64** provides those numbers for calendar years (CYs) 2008 through 2012 for allegations made at all **public and privately operated community programs licensed by DBHDS**. The totals include allegations involving mental health, substance abuse, and ID/DD service providers statewide.

| <b>Table 64. Community Program Abuse/Neglect Allegations and Proportion Substantiated by CY</b> |              |              |              |              |              |
|---|--------------|--------------|--------------|--------------|--------------|
| <b>Calendar year</b>  | <b>2008</b>  | <b>2009</b>  | <b>2010</b>  | <b>2011</b>  | <b>2012</b>  |
| <b>Abuse/neglect allegations</b>  | <b>5,402</b> | <b>6,765</b> | <b>5,710</b> | <b>6,484</b> | <b>6,482</b> |
| <b>Abuse/neglect substantiated</b>  | <b>464</b>   | <b>658</b>   | <b>508</b>   | <b>534</b>   | <b>609</b>   |
| <b>Proportion substantiated</b>   | <b>8.6%</b>  | <b>9.7%</b>  | <b>8.9%</b>  | <b>8.4%</b>  | <b>9.4%</b>  |

Source: Department of Behavioral Health and Developmental Services.

Although the total annual number of abuse/neglect allegations may seem large, it must be remembered that Community Services Boards (CSBs) served a total of 213,902 unique individuals during SFY 2013. This number includes people who received mental health, developmental, substance abuse, emergency, ancillary, and consumer-run services.

The annual number of abuse/neglect allegations varied, sometimes significantly, between calendar years (CYs): A 25.2 percent increase occurred between CYs 2008 and 2009, followed by a 15.9 percent decline between 2009 and 2010. The number of allegations was relatively stable between CYs 2011 and 2012. A somewhat similar pattern occurred for the annual number of *substantiated* abuse/neglect cases: Between CYs 2008 and 2009, a dramatic increase of 41.8 percent, followed by a sharp decrease (22.8 percent) between CYs 2009 and 2010. Although the number of substantiated cases was stable between 2010 and 2011, another increase (12.2 percent) occurred between CYs 2011 and 2012. Of note, however, is that the proportion of annual abuse/ neglect allegations found to be substantiated since CY 2008 has been relatively stable, ranging from 8.4 percent to 9.7 percent.

Despite the substantial increase in the number of providers, services, and locations in recent years, legislative appropriations for OHR staffing has varied over time. In SFY 2007, OHR had 23.5 advocate positions. Due to state budget cuts during the Great Recession, OHR actually lost positions in 2008 and 2009, dropping down to 19 advocates for SFYs 2009 and 2011. However, the DBHDS and the Commonwealth made a commitment to expand funding for both the Office of Licensing and OHR as part of the Settlement Agreement with the US Department of Justice (DOJ). Three advocate positions were added in 2012, bringing the total to 21 advocates through SFY 2013.

Another oversight resource for all DBHDS services is the **State Office of the Inspector General (OSIG)**, which includes the **Inspector General for Behavioral Health and Developmental Services (IG-BHDS)**. The IG-BHDS monitors and investigates services delivered through all DBHDS-operated facilities, Community Service Boards, and contract providers as well as both mandated provider serious incident reports and citizen allegations of abuse, neglect, or inadequate care by these providers. The IG-BHDS additionally monitors activities and progress regarding implementation of the DOJ Settlement Agreement.

As of January of 2014, the IG-BHDS investigations and follow-up reports released prior to August 2012 are still available online at <http://www.oig.virginia.gov/>. During SFYs 2011 through 2013, new IG investigative reports focused more on mental health services. Specific issues regarding ID/DD community services have been monitored in the past by the Inspector General for DBHDS on an ongoing basis. These include but are not limited to:

- case management services for adults with an intellectual disability at Community Services Boards;
- progress by DBHDS in implementing the priority goals and objectives of the agency's *Creating Opportunities* strategic plan, especially development of a model for a person-centered service planning system and format;
- service gap identification and new service development for persons who have both an intellectual disability and either a concurrent diagnosis of mental illness or significantly challenging behaviors; and
- discharge planning for and community services to individuals who reside/have resided at state Training Centers.

One recent IG-BHDS study (*Report No. 208-12*), however, reviewed progress in the adoption of person-centered practices in community-based residential settings for individuals with an intellectual disability. For seven months, the IG staff examined services statewide in three types of residential settings: Medicaid Waiver group homes; sponsor family homes, and small, non-state Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). The IG found that adherence to the person-centered model varied significantly across settings. Various recommendations were made to make the model a standard of service delivery. (This study is described in more detail in the **Community Housing** chapter of this *Assessment*.)

## J. Interpreter and Other Services for the Deaf and Hard-of-Hearing

For individuals of any age who are deaf or hard-of-hearing, sign language interpreters are an invaluable resource in daily communication. Interpreter services (state regulation 22 VAC 20-30-10) is the specific process of facilitating communication using **American Sign Language (ASL)**, a form of manual communication of speech, based on English vocabulary and grammar. An interpreter, trained in ASL, accurately and objectively conveys both spoken and expressive communication between an individual who is deaf or hard-of-hearing and one or more other individuals.

### 1. Eligibility for VDDHH Interpreter Services

The **Department for the Deaf and Hard of Hearing (VDDHH)** operates two interpreter programs to enhance or ensure access to effective communication in state agencies, the Virginia courts, and in the private sector. The first of these, the **Interpreter Services Program (ISP)**, coordinates sign language interpreters in response to specific requests from state and local government agencies, Virginia courts, and in limited other circumstances. The second program is the **Virginia Quality Assurance Screening program (VQAS)**, which is a diagnostic assessment of the skill levels of sign language interpreters and Cued Speech Transliterators used in credentialing. Screening levels in interpreting and/or transliterating are awarded based on a strict rating process. Screening levels are valid for three years from the date of award.

The Code of Virginia (§ 51.5-113) authorizes VDDHH to coordinate the services of sign language interpreters and Computer Assisted Real-time Translation (CART) for all courts and state agencies, including state colleges and universities. However, VDDHH contracts do not cover interpreters for higher education. Through trained stenographers, CART provides computer or television captioning of spoken language at meetings, for presentations, or webinars. To accomplish that coordination, the VDDHH administers the **Interpreter Services Program** (<http://www.VDDHH.virginia.gov/IpAbout.htm>).

Various state laws mandate court appointment of interpreters for individuals who are deaf. In each of these instances, the cost for interpreters is borne by the State; however, the person who is deaf may waive his or her right to a court-appointed interpreter and provide one at his or her personal expense. Individuals who are deaf are entitled to a court-appointed interpreter by statute when they are

- alleged to have a mental illness or intellectual disability and facing commitment or certification (§ 37.2-802 and § 37.2-815);
- a party or a witness to a civil proceeding and request such assistance (§ 8.01-384.1);
- involved in a criminal case as either the victim of or witness to a crime (§ 19.2-164.1), or
- accused under trial in a criminal case (§ 19.2-164.1).

Individuals needing interpreter services to conduct certain Department of Motor Vehicle (DMV) business transactions or to attend 12-Step meetings or funerals may contact VDDHH directly for assistance. VDDHH uses state General Funds to pay for interpreter services at funerals and for one 12-Step meeting per week per person.

For situations in which VDDHH does not coordinate the service, individuals may locate a qualified interpreter through its **Directory of Qualified Interpreters**. This statewide directory, which is maintained by VDDHH, contains contact information for only those interpreters who meet state requirements. A copy of the directory is available on the VDDHH website at <http://www.vddhh.virginia.gov/ipdqi.htm> and also may be obtained by contacting a local VDDHH office.

## **2. Access to and Use of VDDHH Interpreter Services**

Requests for qualified interpreters for persons who are deaf or hearing impaired may be made directly to the Department for the Deaf and Hard of Hearing (VDDHH) by state courts, state agencies and institutions of higher education, local government agencies and legislative bodies, and other public and private organizations across the State. The **VDDHH Interpreter Services Program** directly coordinates the needs of state agencies and colleges, making referrals to contracted sign language interpreters. Agencies requesting services must provide VDDHH with: the name of the individual to be served (if known); the nature of the assignment (specific place, time, and predetermined number of hours); and their billing information. For general (non-court) interpreter requests, the agency pays for the interpreter. Interpreter requests and services for the courts or court-related activities are paid by the Supreme Court of Virginia.

Code of Virginia 51.5-113 requires use of “**qualified interpreters**” by all courts as well as by state and local government agencies. A qualified interpreter must hold one of the following credentials:

- certification from any national organization whose certification process has been recognized by the VDDHH; or
- current screening level awarded by the Virginia Quality Assurance Screening (VQAS) Program of VDDHH; or
- current screening level or recognized credential from another state that is valid, current, and meets the minimum requirements of the VQAS.

Through a Memorandum of Understanding (MOU) with the Supreme Court of Virginia, VDDHH only assigns interpreters who have full national certification for all court and court-related matters.

VDDHH tracks the number of interpreter service requests received from the courts and state or local agencies in each state fiscal year (SFY). In SFY 2010, the agency revised how interpreter requests are processed and counted. In previous years, VDDHH counted multi-date

assignments from a single agency (such as conferences or weekly 12-Step meetings) as separate requests. They now are processed as a single request. In SFY 2010, VDDHH received 2,258 requests for interpreter services; in SFY 2011, 2,474 requests; in SFY 2012, 2,800 requests; and in SFY 2013, 2,460 requests. VDDHH was able to arrange interpreter services for almost every request (at least 99.5 percent) annually.

One limitation, however, is the availability of a sufficient pool of qualified interpreters in the Commonwealth. The pool of available qualified interpreters depends on many factors, including professional mobility, reimbursement rates (which have been flat), and interest in being credentialed. The number of individuals who seek, apply for, or renew the credential of “qualified interpreter” varies by year.

### 3. Cost and Payment for VDDHH Interpreter Services

VDDHH funding for interpreter services comes primarily from state and federal sources. It receives an annual grant of \$100,000 from a federal special education grant through the state Department of Education to support interpreter services in public schools. State General Fund appropriations provide for interpreter services (including outreach), the Virginia Quality Assurance Screening (VQAS) program, and for agency program administration. VDDHH expenditures for the Interpreter Services Program alone have been as follows: In SFY 2011, \$172,643; in SFY 2012, \$177,112; and in SFY 2013, \$174,030.

The VQAS program receives approximately 47 percent of its annual budget from state General Fund appropriations. It also collects special revenue from fees through applications for interpreter training and for level screening assessments and re-assessments, which vary each year. In SFY 2011, the VQAS program received \$16,855 in Special Revenues; in SFY 2012, \$16,390; and in SFY 2013, \$18,665. Total expenditures for the VQAS program for the past 3 SFYs are listed in **Table 65**.

| Table 65. Expenditures for VQAS Interpreter Training and Assessments by SFY |           |           |           |
|---|-----------|-----------|-----------|
| State Fiscal Year   | 2011      | 2012      | 2013      |
| VQAS total program expenditures   | \$129,857 | \$131,754 | \$118,444 |

According to VDDHH, variation exists for both VQAS revenue and expenditures due to the number of contracted raters/diagnosticians (only 32 annually for SFYs 2011 through 2013) and the changing number of individuals seeking assessment or re-assessment each year.

### 4. Monitoring and Evaluation of VDDHH Interpreter Services

The commissioner and program directors of the Virginia Department for the Deaf and Hard of Hearing (VDDHH) administer and provide oversight of the **Interpreter Services Program**. The VDDHH commissioner must provide performance reports on all programs regularly to the Secretary of Health and Human Resources, the Governor and the General Assembly as required

by law and regulations. As a part of this oversight, VDDHH conducts customer satisfaction surveys and collects program statistics, which are reviewed routinely on an ongoing basis.

Since 1989, the Code of Virginia has charged VDDHH with the responsibility to administer the **Virginia Quality Assurance Screening (VQAS) Program**, which is an assessment and credentialing process for sign language interpreters. The VQAS Program establishes minimum standards and testing/proficiency procedures to be a “qualified interpreter,” which is the employment standard for interpreter services in public schools, courts, and state and local government agencies. Applicants are tested on professional ethics through written assessment and on performance as evaluated by a team of qualified raters. When assessment determines that an applicant meets a VQAS level, the level is awarded and is valid for three years from the date of award. Interpreters may re-test every six months.

The VDDHH VQAS program serves as one credential by which the public can determine the qualifications of a sign language interpreter in the Commonwealth. VDDHH uses the VQAS screening levels as one benchmark for inclusion in the Directory of Qualified Interpreters for participation in its contract for Sign Language Interpreter Services and for employment criterion as a sign language interpreter in Virginia Public Schools.

Sign Language Interpreting, however, is not a regulated profession in the Commonwealth. At the request of the VDDHH Advisory Board, the Department of Professional and Occupational Regulation (DPOR) conducted a study in 2007 to determine if there was need for regulation of the interpreter profession either by registration, certification or licensure. Based on their findings, the DPOR determined that there was not a need to regulate the profession. Because the profession is not regulated, VDDHH does not operate a formal disciplinary or complaint program regarding VQAS-screened interpreters. If the agency does receive a complaint about a VQAS-screened interpreter, VDDHH contacts the interpreter for an informal counseling session to review the Code of Professional Conduct and to discuss ways to address the concerns identified. Because the VQAS is a skills-based diagnostic assessment, VDDHH does not revoke or rescind VQAS screening levels, which are valid for three years from the date of award.

A variety of national certifications, all currently under the auspices of the **Registry of Interpreters for the Deaf, Inc. (RID)**, serve as important credentials for sign language interpreters. RID, the national certifying body has a formal complaint resolution and disciplinary process for RID-certified interpreters. VDDHH refers all callers who have a complaint about a nationally certified interpreter to RID to file a formal complaint. More information on the education and training requirements for RID certification is available online at <http://rid.org>.

## **K. Omnibus Budget Reconciliation Act Services**

The Omnibus Budget Reconciliation Act (OBRA) federal statute (PL 100-203), passed in 1987, is comprehensive legislation that sets legal mandates for the clinical and operational features of all long-term care facilities that seek Medicaid or Medicare certification for funding. At that time, the OBRA bill was the first major revision of federal standards for nursing facility



care since the 1965 creation of Medicare and Medicaid. OBRA requires states to pre-screen all individuals being considered for admission to a Medicaid/Medicare-certified nursing facility through a formal assessment to: (1) determine whether the individual requires that level of services and (2) identify needs, if any, for “specialized services,” whether needed in the community or in a nursing facility. In Virginia, “specialized services” have been defined as services to address a mental illness, an intellectual or related disability, or a substance abuse disorder. (See the **Institutional Supports** chapter for more information about assessments.)

## 1. Eligibility for OBRA Services

Individuals who receive OBRA assessments, known as the **Pre-Admission Screening and Resident Review (PASRR)**, include anyone being evaluated for eligibility for a potential nursing facility admission as part of long-term care planning. As part of the mandated assessment, a determination must be made of the specialized services needed to maximize the individual’s “highest practical physical, mental, and psychosocial well-being,” self-determination, and independence. After determining whether the individual can benefit from those services, the individual may choose to receive services in the community or in a nursing facility.

Typically, individuals eligible for services under OBRA have a significant disability arising from either a developmental or acquired disability, including but not limited to: intellectual disability, cerebral palsy, epilepsy, autism, brain or spinal cord injury, muscular dystrophy, multiple sclerosis, spina bifida, stroke, or other conditions of neurological origin. As required by federal law (Developmental Disabilities Act of 2000), a developmental disability is a severe, chronic disability (physical, cognitive or a combination of both) that manifests prior to age 22, is likely to persist indefinitely, and results in significant impairment in three or more activities of daily living.

All eligible individuals under OBRA can receive comprehensive assessment and evaluations for specialized services that are *not* covered by the Medicaid State Plan option. DBHDS contracts with a private vendor to conduct the assessments as well as with the Department for Aging and Rehabilitative Services (DARS) and local Community Services Boards (CSBs) for distribution of the funds covering the identified services.

DARS rehabilitation specialists in the Community Rehabilitation Case Management (CRCM) Services staff, who work out of DARS field offices or local CSBs, provide or coordinate these services. CRCM staff additionally works with residents of nursing facilities who wish to transition from the institution to a community setting. DARS Community rehabilitation specialists work with social workers, Centers for Independent Living (CILs), and other resources to ensure that those eligible for OBRA receive services appropriate to their individual needs as well as to their choices about where they will live. These decisions, however, are typically influenced by the availability of housing and community supports available through the Medicaid Home and Community Based Services (HCBS) Waivers or other sources.

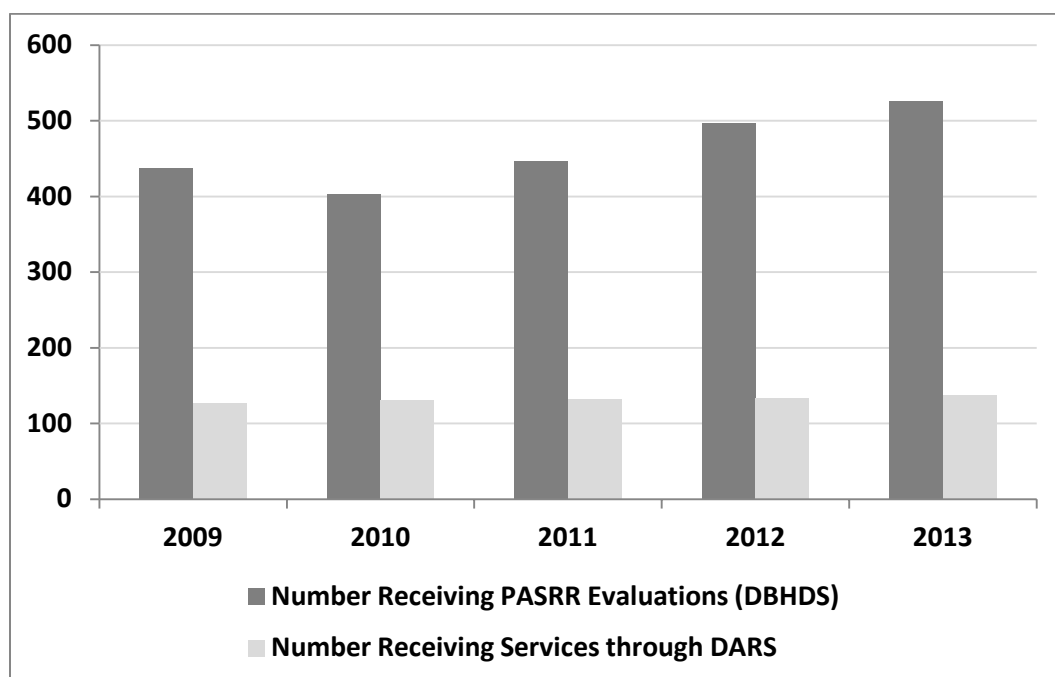
In most cases, support coordination by a CRCM rehabilitation specialist can be continued if an individual is not receiving case management through a Medicaid HCBS Waiver or other program, but OBRA funding for that support does not extend beyond the one-year transition period. In recent years, OBRA has increased transition assistance for individuals who leave a nursing facility on their own or with assistance from the Money Follows the Person (MFP) program. Transition assistance includes various supports such as home modifications, deposits for utilities, rehabilitation engineering, transportation to service providers, and assistive technology.

## **2. Access to and Use of OBRA Services**

In Virginia, OBRA requirements are collaboratively fulfilled by the Department of Medical Assistance Services (DMAS), the Department for Aging and Rehabilitative Services (DARS), and the Department of Behavioral Health and Developmental Services (DBHDS). DBHDS is administratively responsible for the Pre-Admission Screening and Resident Review (PASRR), and for determination of specialized service needs as well as provision or arrangement for delivery of those services. Once an individual qualifies for OBRA services, DBHDS staff conducts subsequent, targeted Resident Reviews at various time intervals, the frequency of which are determined by each individual's profile of needs. Both the PASRR and Resident Reviews include documentation of each individual's current capacity to transition to a less restrictive environment or to the community. (Information on OBRA is available on the DBHDS website at <http://www.dbhds.virginia.gov/omh-OBRA.htm>.)

The services most commonly requested and used by eligible individuals under OBRA who reside in nursing facilities or who are transitioning from nursing facilities to community settings have been support coordination (case management) and day support for socialization, communication, and community integration. Individuals generally also receive personal assistance services along with other services as needed and appropriate. **Figure 23** depicts the annual total number of individuals who received assessments through DBHDS or services from DARS under OBRA for the past five state fiscal years (SFYs). The DARS counts do not include individuals referred whose cases were closed because they left a facility, could not benefit from services, or died during the year.

**Figure 23. Number of Assessments and Individuals Served under OBRA by SFY**



Between SFYs 2009 and 2013, the number of individuals receiving PASRR evaluations through DBHDS increased by 16.9 percent (an additional 89 individuals). By contrast, the number of individuals receiving OBRA services through DARS has been relatively stable, declining by 7.3 percent (10 individuals).

### 3. Cost and Payment for OBRA Services

Funding for OBRA assessments and services is from federal and state monies. During the contract period of February of 2013 through January 31, 2014, the DBHDS paid its contractor \$418,994 to conduct nursing facility Pre-Admission Screening and Resident Reviews (PASRR). Of that amount, 75 percent was billed to and reimbursed by DMAS through a Memo of Understanding (MOU); and the remaining 25 percent (Virginia's "state match") was paid through state General Funds allocated to DBHDS. The annual amounts budgeted to DARS to provide services under OBRA for SFYs 2009 through 2013 are listed in **Table 66**.

| <b>Table 66. Annual Budget for Provision of DARS Services Under OBRA by SFY</b> |                  |                  |                  |                  |                  |
|---|------------------|------------------|------------------|------------------|------------------|
| <b>State Fiscal Year</b>  | <b>2009</b>      | <b>2010</b>      | <b>2011</b>      | <b>2012</b>      | <b>2013</b>      |
| <b>Budget for DARS OBRA Services</b>  | <b>\$509,509</b> | <b>\$388,731</b> | <b>\$416,989</b> | <b>\$486,700</b> | <b>\$404,000</b> |

According to DARS staff, the average per person expenditure varies, sometimes significantly, based on the particular services needed by the individuals who are eligible that year. One-time expenditures for specialized equipment such as motorized wheelchairs or

communication devices can be as high as \$15,000 to \$25,000. From SFY 2009 through 2013, the average OBRA expenditure ranged from \$3,000 to \$4,000 per person.

#### **4. Monitoring and Evaluation of OBRA Services**

The Virginia **Department of Behavioral Health and Developmental Services (DBHDS)** monitors and provides oversight for assessments conducted by its contracted vendor. DBHDS contracts with the **Department for Aging and Rehabilitative Services (DARS)** to monitor and provide oversight of compliance with federal regulations by providers of OBRA services to eligible individuals. DARS consults with its DBHDS liaison on an ongoing basis about its findings. Customer comments are routinely documented and concerns by DARS staff are forwarded to the appropriate rehabilitation specialist, program coordinator, and division director as needed. All activities and expenditures must comply with guidelines set forth by the federal Centers for Medicare and Medicaid (CMS); DBHDS annually provides reports on OBRA activities and expenditures to CMS.

#### **L. Personal Assistance Services (Non-Medicaid Waiver)**

Under Virginia Administrative Code 22 VAC 30-20-10, **personal assistance services (PAS)** are a range of *non-medical* supports provided by one or more persons who assist an individual with a disability in performing **activities of daily living (ADLs)** that they themselves cannot do because of their impairment either “on or off the job.” ADLs are bathing, dressing, toileting, eating, and bowel or bladder control (12 VAC 5-381-10). PAS may include training to assist the individual with a disability in “managing, supervising, and directing” such services. Personal assistance services (PAS) must be (1) designed to increase autonomy and self-determination, (2) necessary to the achievement of an employment outcome, and (3) may be provided only while the individual is receiving other vocational rehabilitation services. Individuals with such limitations who receive vocational rehabilitation services may also receive personal assistance services (known as **VR-PAS**) through the **Department for Aging and Rehabilitative Services (DARS)**.

In addition, through DARS policy and the annual state appropriations bill, PAS are made available through two programs to additional groups when no other source of personal assistance services is a viable option: the **State-funded PAS program** (non-Medicaid PAS for individuals with significant disabilities) and the **PAS for Individuals with Brain Injury (PAS-BI) program**.

##### **1. Eligibility for (Non-Waiver) PAS**

General eligibility requirements for the State-funded (but non-Medicaid) PAS program are that an individual (1) has a significant physical disability (regardless of cause), and, (2) based on a formal determination, does not have financial resources above a set limit, and (3) does not qualify for PAS under public insurance (Medicare, Medicaid, or a Medicaid Waiver), private insurance, or any other public program. For PAS-BI, eligibility also requires (1) an assessment of

the brain injury made by a qualified professional, and (2) that the individual have a representative who will manage the services.

For each of the three PAS programs (VR, non-VR, and Brain Injury PAS), an individual must submit an application, which is available online or upon request by phone. For more information on eligibility, individuals can contact PAS staff within the DARS Division of Community Based Services by calling the following numbers toll-free 800-552-5019 or (TTY) 800-464-9950, or by going online to <http://www.vadrs.org/cbs/pas.htm>.

## **2. Access to and Use of (Non-Waiver) PAS**

After the individual has submitted an application for personal assistance services, DARS staff in the Division of Community Based Services conducts an assessment of both the individual's service needs and of his or her eligibility for comparable services from any other source. If the individual is found eligible for services under vocational rehabilitation (VR-PAS), DARS staff provides information and referral to help an individual obtain those services. Based on an individual's ability or choice, the VR-PAS may be provided either as a consumer-directed option (whereby the client is the "employer of record" for IRS and management purposes) or as an agency-directed option.

Being solely reliant on state General Funds, the State-funded PAS and the PAS-BI are available to a limited number of individuals each year. Additional funding is available when either the state legislature increases the annual appropriation or an individual discontinues PAS because alternative funding was obtained. When funds become available, DARS staff conducts assessments for each applicant, and selection of individuals for services is based on severity of need.

Both **State-funded PAS and PAS-BI programs** are only available as **consumer-directed services**. As with consumer-directed PAS offered through the Medicaid Home and Community Based Services (HCBS) Waivers described in the **Medicaid** chapter, the individual with a disability recruits and hires a **personal assistant (PA)**, provides training to the PA, establishes work schedules and duties, directs the PA's work, authorizes timesheets for payment, and terminates the PA if necessary. Those eligible for PAS-BI must have a designated representative to either assist with or perform these responsibilities. To learn more about handling these responsibilities effectively, the individual with a disability must participate in PAS orientation training.

At this time, Virginia does not have a credential or certification program for personal assistance providers. Through grant funding, the **Virginia Association of Centers for Independent Living (VACIL)** established a directory that allows both those looking for a personal assistant and individuals seeking such employment to self-identify themselves. As a result of this project and collaboration with the Department of Medical Assistance Services (DMAS), in 2011 the Public Partnership Limited (PPL), a fiscal agent of DMAS, assumed the maintenance for the online directory. The lists (available at

<https://connect.publicpartnerships.com/LoginASD.aspx>) are generated by individuals. As noted on the website, PPL does not conduct any background or reference checks on individuals seeking employment. PPL is not responsible for verifying or examining the accuracy of any information provided online. Consumers and family members have expressed concern regarding the utility of the directory and indicate that it is not user friendly.

DARS staff review PAS applications, conduct initial eligibility screenings, and authorize related activities by the Centers for Independent Living (CILs), which are responsible for conducting needs assessments, orientation for persons with disabilities, and reassessments as well as providing other support services. DARS also reviews personal assistant (PA) hiring packets for completeness and accuracy, calculates and approves the number of PAS hours that the individual may receive, and determines final eligibility. Following DARS review and approval of timesheets, verification of employment and earnings, and payroll preparation, a contract payroll provider handles payments, taxes, and earnings reports.

The numbers of persons either receiving PAS through DARS or on the waiting list for PAS at the end of each state fiscal year (June 30) for 2007 through 2013 are listed in **Table 67**. Of the three PAS programs, only the VR-PAS does not have a wait list because it is mandated through federal vocational regulations and funding.

| <b>Table 67. Number Served and Number on Waiting Lists for DARS Personal Assistance Services by SFY</b> |                               |             |             |             |             |             |             |
|---|-------------------------------|-------------|-------------|-------------|-------------|-------------|-------------|
| <b>PAS Program</b>  | <b>2007</b>                   | <b>2008</b> | <b>2009</b> | <b>2010</b> | <b>2011</b> | <b>2012</b> | <b>2013</b> |
| <b>PAS/Brain Injury</b>   | <b>Number served</b>          | 6           | 6           | 5           | 5           | 5           | 7           |
|   | <b>Number on waiting list</b> | 2           | 2           | 3           | 3           | 3           | 2           |
| <b>State-funded PAS</b>   | <b>Number served</b>          | 168         | 155         | 155         | 122         | 163         | 177         |
|   | <b>Number on waiting list</b> | 54          | 40          | 40          | 94          | 82          | 69          |
| <b>VR-PAS</b>   | <b>Number served</b>          | 62          | 31          | 35          | 45          | 22          | 22          |

Source: Department for Aging and Rehabilitative Services, Division of Community Based Services.

Over this time period, the number of individuals served under PAS-BI and State-funded PAS has been relatively stable, which reflects each program's capacity resulting from individual needs and available state funds. Between SFYs 2009 and 2010, however, the number waiting for State-funded PAS increased dramatically and remained high until SFY 2013. The State-funded PAS program served 9 more individuals in SFY 2013 than in SFY 2007, an increase of 5.4 percent. The number served under VR-PAS fell by 50 percent between SFYs 2007 and 2008, and has remained low as compared to SFY 2007 due to the recession and weak job growth.

### 3. Cost and Payment for (Non-Waiver) PAS

While the VR-PAS program is federally funded through Title 1 of the Rehabilitation Act, both the PAS-BI and State-funded PAS are solely reliant on legislative appropriations of state General Funds. **Table 68** lists the total annual expenditures for each PAS program through the Department for Aging and Rehabilitative Services (DARS). As the expenditure data indicate, the level of funding has declined for each PAS program, in part due to the slow economic recovery, which impacts state revenues (PAS-BI and State-funded PAS) and available federal funds (VR-PAS).

| <b>Table 68. Expenditures for DARS Personal Assistance Service Programs by SFY</b> |                    |                    |                    |                    |                    |
|--|--------------------|--------------------|--------------------|--------------------|--------------------|
| <b>DARS PAS Program</b>  | <b>SFY 2009</b>    | <b>SFY 2010</b>    | <b>SFY 2011</b>    | <b>SFY 2012</b>    | <b>SFY 2013</b>    |
| <b>PAS/Brain Injury</b>  | <b>N/A</b>         | <b>\$77,659</b>    | <b>\$52,217</b>    | <b>\$64,569</b>    | <b>\$69,673</b>    |
| <b>State-funded PAS</b>  | <b>\$2,145,345</b> | <b>\$2,276,131</b> | <b>\$1,950,952</b> | <b>\$1,984,803</b> | <b>\$1,965,819</b> |
| <b>VR-PAS</b>  | <b>\$604,547</b>   | <b>\$511,417</b>   | <b>\$547,466</b>   | <b>\$436,364</b>   | <b>\$307,840</b>   |

### 4. Monitoring and Evaluation of (Non-Waiver) PAS

The State-funded PAS and PAS for Individuals with Brain Injury (PAS-BI) are overseen by both a program manager and the director of the Community Based Services Division of the Department for Aging and Rehabilitative Services (DARS). DARS staff conducts internal record reviews and program audits to identify areas for improvement such as program policy updates or operational issues. A PAS Advisory Committee—comprised of individuals with disabilities, representatives from Centers for Independent Living (CILs), and agency staff—meets quarterly to review each program and make additional recommendations for improvements. Feedback is also obtained through consumer satisfaction surveys and contacts with individuals served, their families and personal assistants, and the local Centers for Independent Living (CILs).

The same oversight is provided by DARS for the VR-PAS program. However, federal law requires that DARS additionally prepare and submit an annual report to its federal funding source, the Rehabilitation Services Administration.

## M. Services for the Elderly Population

While many state agencies provide disability services across the lifespan, three programs specifically serve Virginians who are elderly:

1. The **Public Guardian and Conservatorship Program** is administered by the Virginia Division for the Aging (VDA), within the Department for Aging and Rehabilitative Services (DARS). VDA is responsible for oversight of state programs or services specifically funded through the federal Older Americans Act (as amended PL 109-365) and through certain related appropriations by the Virginia General Assembly. Although

an independent state agency until July of 2012, VDA now, as in the past, coordinates and administers services to the elderly through contractual partnerships with local Area Agencies on Aging (AAAs).

2. The **Older Blind Grant Program** is administered by the Department for the Blind and Vision Impaired (DBVI).
3. The **Program of All-inclusive Care for the Elderly (PACE)**, an optional Medicaid State Plan service, is funded and administered by the Department of Medical Assistance Services (DMAS).

Each of these programs has somewhat different eligibility criteria, access procedures, and services due to the purposes and functions established under its funding authorization. Services are organized here by state agency with information on eligibility, types of services, service access and availability, costs and funding for services, and how they are monitored and evaluated.

### **1. DARS' Virginia Division for the Aging**

Within the Department for Aging and Rehabilitative Services (DARS), the Virginia Division for the Aging (VDA) contracts with 25 **Area Agencies on Aging (AAA)** to provide services to the elderly. The AAAs may be any one of the following entities, and this list includes the number of each in 2013:

- 14 were private or nonprofit organizations;
- 5 were joint exercise-of-powers agency;
- 5 were part of a government unit; and
- 1 was a Community Services Board (CSB).

Each AAA is required to develop and provide services that address the needs of the target populations in its geographic service area(s). In addition, VDA administers funds through contracts for the **Virginia Public Guardian and Conservatorship Program**, which is a resource “of last resort” for legal guardians for those with a documented need for such assistance.

#### ***a. Eligibility for and Available VDA Contracted Services***

Through contracts with VDA, each Area Agency on Aging (AAA) offer information, referrals, and technical assistance to locate and obtain available services to anyone in their service area who is either (1) age 60 or over, or (2) has a serious disability and is 18 through 59 years old. The same services are available to family members, caregivers, and/or guardians of these individuals at AAA offices statewide.

To receive any **direct service** from an AAA, individuals must be **age 60 or over**. Priority for AAA services is given to older individuals who are in the greatest socio-economic need and to those who are at risk for institutional placement. Preference is also given to older individuals



who are part of a low-income minority population, have limited English proficiency, or live in rural areas.

Two exceptions for age eligibility are services provided through the **National Family Caregiver Support Program (NFCSP)** and the **Title V Senior Community Service Employment Program**, which are both open to those who are **age 55 or over**. The employment program is available only from a few AAAs. Family members themselves are eligible for services under the **NFCSP** if they are (1) adult caregivers of individuals who either are elderly or are under age 50 with early onset dementia, or (2) are themselves age 55 or over and are caring for a child or adult up through age 59 who has a severe disability.

Although the scope and type of services may vary depending on area needs, the following are common services provided by the AAAs:

- information and referral, communication, and assistance;
- service coordination;
- meals and nutrition services (delivered in homes or at program sites);
- transportation;
- in-home (chore or homemaker services) and caregiver support services;
- health and wellness information and screenings;
- options counseling (to help determine how and where to meet long-term care needs); and
- elder abuse prevention.

Some AAAs also operate senior centers, which offer recreation and social activities as well as assistance in completing applications for services or tax filing, and/or adult day centers to provide daily supervision and activities for older adults who cannot stay at home alone safely all day. A few AAAs administer housing programs for older residents, operate comprehensive transportation systems, or operate a Program of All-inclusive Care for the Elderly (PACE) center. Many AAAs provide benefit counseling for Medicare beneficiaries and others through the Virginia Insurance Counseling and Assistance Program (VICAP). In addition, many AAAs operate the local **Long Term Care Ombudsman program**, which provides advocacy for older persons who receive long-term care services (whether in nursing facilities, licensed adult homes, or community-based settings) as well as investigates and resolves complaints made by (or on behalf of) these older persons.

Administered under contract with the VDA, the Virginia **Public Guardian and Conservator Program** was established under § 51.5-149 et seq. of the Code of Virginia. This program funds local human service agencies to provide guardianship services for any person aged 18 and over (not just the elderly) for whom all three of the following apply:

1. have been legally determined to be unable to care for themselves or to make decisions about their care or finances (are “incapacitated”);
2. are found to be financially indigent; and
3. do not have a suitable person willing or able to serve as their decision-maker.

Information on this program and guardianship procedures is online at <http://www.vda.virginia.gov/guardboard.asp>.

#### ***b. Access to and Use of VDA Services***

The **Virginia Division for the Aging (VDA)** is responsible for coordination of services provided by the independent **Area Agencies on Aging (AAAs)** and other contractual partners. VDA serves as both an educational and outreach resource on aging issues and acts as a central referral agency for direct services provided by the 25 AAAs and 19 other community-based organizations.

For several years, the VDA has been active in the federal initiative, Aging and Disability Resource Connections (ADRC). Its purpose is to help all individuals who are looking for services—either for themselves or a family member—to locate them more easily through a “virtual” single point of entry. Virginia’s initiative, called **No Wrong Door**, has developed statewide partnerships with other state agencies, professional associations, disability advocacy groups, local governments, and private and nonprofit community organizations that provide services to citizens who are elderly or have a disability.

The local No Wrong Door network of public and private agencies can access a database to locate needed services for individuals as well as eliminate duplicative application forms and streamline eligibility determinations. The network can also share up-to-date client information to make referrals between agencies faster and easier, to better coordinate services, and to improve tracking of outcomes. The No Wrong Door website is at <http://www.vda.virginia.gov/nowrongdoor.asp>.

This evolving model relies heavily on interagency cooperation and coordination among the participating service providers. In partnership with **SeniorNavigator**, a 501c(3) nonprofit organization, leadership within the VDA and the Department for Aging and Rehabilitative Services coordinate and provide technical assistance to all participating organizations and establishes the protocols to ensure that providers’ and their clients’ privacy is protected and that information is shared only with their consent. The AAAs, with assistance from Advisory Councils, coordinate No Wrong Door with community partners in their localities.

VDA also manages an online information service that includes information on services and topics for adults who are elderly or have a disability. Created to be user-friendly and available 24/7, **Virginia Easy Access** is a search engine for locating services anywhere in the State. It is a virtual gateway to **VirginiaNavigator**, which lists over 21,000 programs and services statewide, and to the 2-1-1 Virginia Call Center, which provides referral assistance by phone. Each of these

resources is free to use, confidential, and available to the general public. **Virginia Easy Access** is at <http://www.easyaccess.virginia.gov>.

Although “walk-ins” may occur, the Area Agencies on Aging (AAAs) typically receive requests for information or for services by phone and then follow-up with a person-to-person assessment, as indicated. Services vary by region or locality, since AAAs develop and deliver services based on the needs of the geographic area that each serves. Through its **No Wrong Door** initiative, and with individual consent, AAAs can enter an applicant’s information into a shared, confidential electronic database to expedite their application for and receipt of services as well as to coordinate services.

Since state fiscal year (SFY) 2010, when participation reached a peak, the number of individuals receiving services through the AAAs has been declining. **Table 69** lists the number served from SFYs 2008 through 2013.

| Table 69. Number Served by Area Agencies on Aging by SFY |        |        |        |        |        |        |
|--|--------|--------|--------|--------|--------|--------|
| State Fiscal Year  | 2008   | 2009   | 2010   | 2011   | 2012   | 2013   |
| Number served  | 57,835 | 59,045 | 63,303 | 58,487 | 54,283 | 53,831 |

Source: Department for Aging and Rehabilitative Services, Division for the Aging

The total number served through the AAAs peaked in SFY 2010 and declined thereafter annually. Between SFYs 2011 and 2013, the number of elderly served by AAAs declined by 8.9 percent (5,186 individuals). According to the Virginia Division for the Aging (VDA) staff, local funding for AAAs decreased during the recession (SFYs 2008 through 2010); and federal American Recovery and Reinvestment Act of 2009 (ARRA) “stimulus funds” were available in SFYs 2010 and 2011, enabling more people to receive services. Some local and federal funds were decreased as a result of budget cuts under the sequestration bill in SFY 2013. Waiting lists have been maintained by some local programs where the number of service requests exceeded the number of people for which the AAA was contracted to serve.

With respect to the **Virginia Public Guardian and Conservator Program**, initial identification of individuals who need assistance, regardless of age, is made by staff at local adult care facilities, the Adult Protective Services divisions of local social services departments, hospitals, and other service organizations that serve persons who are elderly, have a disability, and/or are indigent. The referring agency forwards relevant information about the individual’s functioning to a multi-disciplinary panel of the local guardianship program, which determines eligibility. Once an individual is determined to be eligible, the referring agency, either independently or with the assistance of a city or county attorney or volunteer counsel, requests a guardianship or conservatorship hearing by the Circuit Court. The Circuit Court judge may require specialized evaluations of the individual to obtain additional medical, psychiatric, psychological, or social information.

If the court finds the person to be incapacitated, the judge has flexibility in establishing the type of guardianship or conservatorship to preserve as much of the individual's independence as possible. A time-limited guardian or conservatorship may be established by the court on an emergency or temporary basis while decisions that correct the conditions causing the emergency are implemented or made to address specific issues that place an individual at-risk, such as medical or monetary matters. A standby guardian can also be designated by the court to assume that role after the death of a person who was responsible for the care of someone determined to be incapacitated.

When court approval is given, the local guardianship program takes responsibility for the person who is incapacitated and acts on his or her behalf consistent with the specific tenets set forth by the court and state law. An individual who was determined "incapacitated" may petition the court at a later date to end the guardianship, and a judge may terminate the guardianship if the individual is able to show that he or she can care for and manage his or her own affairs. In some circumstances, upon formal request, the judge may appoint another person or entity to be guardian or conservator.

Other legal alternatives to guardianship and conservatorship available in Virginia include power of attorney, advanced medical directives (commonly called "living wills"), representative payees, and various types of trusts. The details of these alternatives are beyond the scope of this *Assessment*, and appropriate legal and administrative authorities should be consulted for more information.

The **Virginia Public Guardian and Conservator Program**, which relies on state appropriations, historically has had limited service capacity. This program is not available in all areas of the State: programs do not exist at all in Southwest and Southside Virginia. Based on available funds and cost projections, the Virginia Division for the Aging (VDA), which administers the program, designates a maximum number of individuals who can be served annually by each local guardianship program. Since SFY 2008, this program served up to a maximum of 601 individuals each year. Of those served annually, services to 307 individuals are funded through state General Funds; and services to another 294 individuals who have a mental health or intellectual disability are funded through the Department of Behavioral Health and Developmental Services (DBHDS). All local programs stay at or near capacity, and some have maintained waiting lists.

The *2014 Biennial Report on the Virginia Public Guardian and Conservator Program* noted that there were 891 individuals documented on program waiting lists statewide who need Public Guardian services. Of that number, 580 individuals could be served immediately if state funds were allocated to do so. A 2007 study by the Virginia Tech Center for Gerontology projected that over 1,200 individuals statewide have unmet needs for guardian services.

**c. Cost and Payment for VDA Coordinated/Contracted Services**

The Virginia Division for the Aging receives over 60 percent its annual budget from the **US Administration on Community Living** in support of the Older Americans Act (OAA); additional federal funds come through the US Department of Labor (employment services), the federal Centers for Medicare and Medicaid (CMS), or competitive federal and other grant programs. Legislatively appropriated state General Funds must be provided as “match” for any OAA funds or federal grant awards, which primarily apply to the following:

- community-based services;
- transportation services;
- home-delivered meals;
- care coordination services;
- the No Wrong Door initiative, including SeniorNavigator; and
- VDA administration.

The VDA annually distributes funding to the Area Agencies on Aging based on a formula that was jointly developed by the Division and the AAAs. Funding details on services to the elderly by source are provided in the VDA five-year plan, *Virginia’s State Plan for Aging Services, October 1, 2011–September 30, 2015*, which is posted on its website at <http://vda.virginia.gov/pdfdocs/StatePlanForAging2011-2015.pdf>. The Public Guardian and Conservator Program is solely funded by state General Funds.

The VDA 2011–2015 state plan points out that federal funding, with the exception of the one-time federal ARRA stimulus funds in 2009 and 2010, has not kept up with inflation. Rising fuel costs have negatively impacted in-home meal delivery and transportation services to the elderly, in particular. With the first “baby boomers” turning 65 years old in 2011, the demand for public services is likely to continue to increase along with the growing number of elderly “boomers.” While many AAA services, such as information and referral, are offered free of charge, some in-home and other services are provided on a sliding fee scale based on an individual’s ability to pay.

**Table 70** lists the expenditures for each VDA program for SFYs 2009 through 2013.

| <b>Table 70. VDA Expenditures for Services to the Elderly by SFY</b> |                     |                     |                     |                     |                     |
|--|---------------------|---------------------|---------------------|---------------------|---------------------|
| <b>Program/Service</b>   | <b>2009</b>         | <b>2010</b>         | <b>2011</b>         | <b>2012</b>         | <b>2013</b>         |
| <b>AAA Contracts</b>   | <b>\$52,709,018</b> | <b>\$53,570,233</b> | <b>\$51,951,039</b> | <b>\$52,948,655</b> | <b>\$49,747,106</b> |
| <b>Public Guardianship</b>   | <b>\$1,869,645</b>  | <b>\$2,040,600</b>  | <b>\$1,954,950</b>  | <b>\$1,993,332</b>  | <b>\$1,993,550</b>  |

Expenditures for contract services with the AAAs have varied somewhat. In SFY 2013, expenditures dropped to their lowest level of the five-year period. Expenditures for the Public Guardian and Conservatorship Program, with the exception of 2010, were relatively flat over these years.

**d. Monitoring and Evaluation of VDA Contracted Services**

The **Virginia Division for the Aging (VDA) within DARS** is legally designated as the State's "unit on aging" by the federal Office of Administration on Aging. This designation charges the VDA to provide funding, planning, coordination, technical support, and oversight of all programs funded through the federal Older Americans Act. Federal law requires VDA to conduct periodic needs assessment of older Virginians to determine the extent to which public and private programs meet those needs. Programs for the elderly under VDA oversight are those operated by the local Area Agencies on Aging (AAAs) and other contractual partners. Under Code of Virginia § 51.5-135, VDA is charged to

*act as lead state agency ... for research, policy analysis, long-range planning, and education on aging issues.*

VDA develops and monitors quality standards of services to the elderly provided through the AAAs or other contractors. Service standards, which are posted on the VDA website, cover recordkeeping, appeals processes, federal and state legal requirements, use of the Uniform Assessment Instrument (UAI), and other program-specific matters. VDA conducts fiscal and program reviews of the AAAs and other contractors; and provides onsite technical assistance when needed. When deficiencies are noted, program providers may be required to prepare and implement corrective action plans.

VDA also provides staff support for three state advisory boards/councils on issues faced by the elderly population and on the programs that it administers:

1. The **Commonwealth Council on Aging** is a statewide citizens group that promotes efficient, coordinated planning and services by state government to meet the needs of older Virginians. (See Code of Virginia §§ 51.5-127 and-128 for full duties.)
2. The **Alzheimer's Disease and Related Disorders Commission** is an advisory group that makes recommendations for funding, statutory or regulatory changes, and other issues to the state Secretary of Health and Human Services. (See Code of Virginia § 51.5-154 for full duties.)
3. The **Virginia Public Guardian and Conservator Advisory Board**, as authorized by Code of Virginia § 2.2-2411, provides technical assistance and advises VDA staff in the coordination, management, and oversight of local guardianship programs. It also advises the VDA commissioner on policies and issues. Members of each board/commission are appointed by the Governor and General Assembly.

During 2014, as it has done previously, the **Commonwealth Council on Aging** will hold a series of “listening” sessions, called Community Conversations on Aging, to gather information on the availability and quality of services in various regions. The discussions have been used to inform the development of policy recommendations. The 2014 listening session will be held at: Charlottesville, Newport News, Richmond, Roanoke, and Woodbridge (Prince William area). A report of these meetings will be published.

In SFYs 2010 and 2011, VDA conducted extensive monitoring of all local **public guardianship programs**, reviewing at least 80 percent of client records at each local program. The reviews were made to ensure compliance with state law and Circuit Court orders as well as to establish baseline performance measures. VDA now annually conducts on-site monitoring of all programs, which includes client record reviews of a randomly selected sample.

The **Virginia Department for Aging and Rehabilitative Services (DARS)** has statutory responsibility (Code of Virginia, 51.5-135) for either providing or contracting for the administration of Virginia’s **Long-Term Care Ombudsman Program**. DARS administers and operates this program but contracts with local **Area Agencies on Aging (AAAs)** to provide Ombudsman services. The ombudsman program receives, investigates, and works to resolve complaints made by or on behalf of older Virginians regarding long-term care services provided by state or local public agencies, contractual providers, or private nonprofit or for-profit entities. Long-term services may be located in institutions (nursing facilities, assisted living facilities, long-term care hospitals) or community-based outpatient programs. However, only a small percentage of cases (1 to 2 percent) annually have been based in community programs through SFY 2013. To ensure coordinated statewide access, the DARS operates a toll-free hotline for information and referrals. As part of its quality assurance, VDA requires Ombudsman program staff to complete a certification curriculum. (More information on this program is included in the **Institutional Supports** chapter of this *Assessment*.)

## **2. DBVI’s Older Blind Grant Program**

### ***a. Eligibility for and Available OBG Program Services***

The Department for the Blind and Vision Impaired (DBVI) administers the federally funded Older Blind Grant (OBG) Program for Virginia residents **ages 55 and over** who have documented blindness or a severe visual impairment that significantly interferes with normal life activities. Many of the seniors referred to the OBG program have either become blind or experienced a significant vision loss late in life, which threatens their personal independence. DBVI program staff provides free assessments, one-on-one training, and instructional services for all individuals; however, financial need criteria must be met for coverage of costs associated with services such as the provision of adaptive equipment for individuals who are blind or vision impaired. The program web page is at <http://www.afb.org/info/programs-and-services/professional-development/experts-guide/older-blind-grant-program/1235>.

The OBG program offers a wide variety of essential supportive services for independent functioning in the home and community:

- outreach,
- information and referral,
- advocacy,
- visual screening,
- eyeglasses and low vision aids,
- assistance with housing relocation,
- adaptive equipment,
- guide and orientation services to improve mobility and self-sufficiency,
- transportation,
- peer counseling,
- volunteer reader services, and
- adaptive skills training for daily living activities.

Program staff additionally conducts local independent living training workshops, as needed, for consumers and their family members.

***b. Access to and Use of OBG Program Services***

To obtain information or services from the Older Blind Grant (OBG) Program, older Virginians or their family members can contact any one of the agency's six regional offices or call its toll free number: 800-622-2155. Regional offices are located in Bristol, Fairfax, Norfolk, Richmond, Roanoke, and Staunton. Staff will explain the available services and the visual and financial need eligibility requirements, assist with service applications, and make referrals to specific DBVI programs or other community resources, as appropriate.

**Table 71** lists the number of seniors (ages 55 and older) served through the DBVI's OBG program for state fiscal years (SFYs) 2010 through 2013. Data prior to SFY 2010, which were based on broader guidelines, are not comparable because of changes to the reporting requirements made by the US Rehabilitative Services Administration beginning that year.

| <b>Table 71. Number Served by the Older Blind Grant Program by SFY</b> |              |              |              |              |
|--|--------------|--------------|--------------|--------------|
| <b>State Fiscal Year</b>   | <b>2010</b>  | <b>2011</b>  | <b>2012</b>  | <b>2013</b>  |
| <b>Number served</b>   | <b>1,602</b> | <b>1,890</b> | <b>1,756</b> | <b>1,694</b> |

Source: Department for the Blind and Vision Impaired.



Program capacity has varied over time, largely due to funding levels and the service needs of the individuals referred to the OBG program. Budget cuts (both state and federal) have occurred since 2008—with the brief exception of added federal ARRA stimulus funds in 2010 and 2011. The SFY 2014 budget also had a 5-percent cut as a result of the 2013 federal sequestration. According to DBVI, since SFY 2007 the number of private providers available to serve individuals with significant vision impairments increased, thereby reducing the number of referrals to the OBG program. Between SFYs 2010 and 2013, the number served under the Older Blind Grant program increased by 5.7 percent (92 seniors). However, compared to the peak in SFY 2011, the number of seniors served in SFY 2013 declined 12.2 percent (196 seniors). DBVI has implemented various outreach strategies to better inform optometrists, ophthalmologists, and other eye care professionals about services available through this program.

### ***c. Cost and Payment for OBG Program Services***

The Older Blind Grant program receives funding for services to seniors through a federal grant program called Independent Living Services for Older Individuals who are Blind, which is administered by the US Office of Special Education and Rehabilitative Services. A grant “match” must be provided annually through state General Fund appropriations. Salaries for rehabilitation teachers serving seniors in the OBG program are funded through both federal and state funds. Annual expenditures for the Older Blind Grant program over the past three SFYs have been as follows:

- \$388,792 for SFY 2011;
- \$279,476 for SFY 2012; and
- \$295,255 for SFY 2013.

The increase in OBG program expenditures in SFY 2011 was attributed to added federal stimulus funds provided by the ARRA.

### ***d. Monitoring and Evaluation of OBG Program Services***

The DBVI commissioner and program director are responsible for program administration and oversight. The regional DBVI offices send data collected on services provided, number served, outcome measures, and expenditures to the administrators for review. Outcomes include customer and family feedback on service impact from satisfaction surveys as well as federal measures of improved independent functioning. As required by statute, the DBVI commissioner reports performance indicators on this and all other programs to the Secretary of Health and Human Services, the Governor, and the legislature. Reports are posted on the Virginia Performs website at <http://www.vaperforms.virginia.gov>.

On a quarterly and annual basis, the DBVI commissioner additionally is required by federal mandate to provide performance reports to two other entities. One entity is the **DBVI State Rehabilitation Council (SRC)**, a federally mandated advisory group focused primarily on services

to those who are either employed or in the DBVI vocational rehabilitation program. SRC members are appointed by the Governor, and a majority of members are individuals who are blind or visually impaired. DBVI also must file an annual programmatic and fiscal report regarding the Older Blind Grant Program to its funding source, the **US Rehabilitative Services Administration (RSA)** under the Office of Special Education and Rehabilitative Services. Both SRC meeting minutes and the annual federal program reports can be found on the DBVI website at <http://www.vdbvi.org>.

### **3. DMAS' Program of All-inclusive Care for the Elderly (PACE)**

The **Program of All inclusive Care for the Elderly (PACE)** is an optional Medicaid State Plan service that specifically targets Virginians who are elderly and Medicaid eligible. PACE is funded through and administered by the state **Department of Medical Assistance Services (DMAS)**.

#### ***a. Eligibility for and Available PACE Services***

**PACE** provides care coordination of the entire continuum of medical care and supportive services needed by Virginians ages 55 and over in order to: remain in their own or family homes, and

*maintain self-sufficiency and preserve the highest level of physical, social and cognitive function, and independence.*

To be eligible for PACE, state regulations (12 VAC 30-120-63) specify that an individual at the time of application must meet all of the following requirements:

1. be 55 years or older;
2. be eligible for or enrolled in the Medicaid and/or Medicare insurance programs;
3. meet level of care criteria for a nursing facility or, if an individual with an intellectual disability, meet the level of care of an intermediate care facility for persons with an intellectual disability (ICF/IID);
4. reside in the geographic service area of a PACE organization;
5. have his or her health, safety, and welfare "assured in the community;" and
6. meet any other criteria used by the local program.

To determine eligibility, a preadmission screening team under contract with DMAS conducts a formal evaluation of an individual using the **Uniform Assessment Instrument (UAI)**, a standardized questionnaire (see Code of Virginia § 32.1-330 for full description). Screenings must be conducted by staff from (1) the local Department of Social Services together with the local Department of Health or (2) a hospital from which the individual is being discharged.

Generally, individuals who are eligible for Medicaid or Medicare are eligible to enroll in PACE. Individual income must be equal to or less than 300 percent of the current year's

Supplemental Security Income (SSI) payment standard for one person, and their financial resources must be equal to or less than the resource allowance established in the current Medicaid State Plan. PACE also accepts otherwise eligible individuals who desire to participate and will pay for the services out of private funds.

***b. Access to and Use of PACE Services***

Referrals to a PACE provider may be from the individual, a family member, caregiver, or a human service professional or agency on behalf of the individual. Services are provided by designated agencies under contract with the **Department of Medical Assistance Services (DMAS)**. Begun in November 2007, PACE has gradually expanded from 6 to 14 locations across the State. DMAS provides a current list of PACE providers, locations, and contact information online at [http://dmasva.dmas.virginia.gov/Content\\_pgs/ltc-pace.aspx](http://dmasva.dmas.virginia.gov/Content_pgs/ltc-pace.aspx). During 2013, 8 PACE providers offered services in the 14 locations listed by region below.

- Tidewater
  - Sentara Senior Community Care (SSCC) has two sites; one serves the Portsmouth area, and the other serves the Virginia Beach area.
  - Riverside PACE has two sites; one serves the Newport News area, including parts of York County, and the other serves Hampton Roads, including Poquoson.
- Capitol Area
  - Riverside PACE has three sites; two sites serve the greater Richmond metro area and one serves the Petersburg area for coverage that includes the counties of Chesterfield, Dinwiddie, Goochland, Hanover, Henrico, New Kent, Powhatan, and Sussex.
- Southwest
  - Mountain Empire PACE in Big Stone Gap serves the counties of Lee, Norton, Scott, and Wise.
  - AllCare for Seniors PACE in Cedar Bluff serves the counties of Buchanan, Dickerson, Russell, and Tazewell.
- Roanoke Valley
  - Kissito PACE in the city of Roanoke serves the Roanoke Valley as well as Blacksburg and surrounding counties.
  - Centra Health PACE in Lynchburg serves the city the counties of Amherst, Appomatox, Bedford, Campbell, and Nelson.
  - Blue Ridge PACE in Charlottesville serves the city and surrounding counties.
- Southside
  - Centra PACE in Farmville serves the city and surrounding counties.

➤ Northern Virginia

- InovaCares for Seniors in Fairfax County serves that area.

Each PACE location provides the full scope of services under the Medicaid State Plan (described in the **Medicaid** chapter of this *Assessment*). Each PACE participant receives comprehensive assessment and treatment planning from an Interdisciplinary Team (IDT) of professionals who are specialists with at least one year of paid experience working with the elderly population. The IDT directly provides or arranges for individualized, comprehensive supports and services, and additionally coordinates medical and other services needed or requested by a participating individual. PACE service delivery is guided by state and federal regulations.

Locations for PACE services are determined by the state **Department for Medical Assistance Services (DMAS)**, based on analysis of Medicaid enrollee data and on exploration of interest by local or regional service providers resulting from outreach efforts. Typically, PACE locations are planned where higher concentrations of enrollees (who are 55 or older and qualify for both Medicaid and Medicare) reside. PACE operations began with 1 program location in SFY 2007. DMAS expanded PACE to 6 programs in SFY 2010, and, in SFY 2013, PACE had 14 program locations. As PACE coverage has expanded, so have the number of individuals served by the program. **Table 72** lists the number served through PACE in SFY 2007, the initial year of operation, as well as participation in the past four SFYs.

| Table 72. Number Receiving PACE Services by SFY |      |      |      |      |       |
|---|------|------|------|------|-------|
| State Fiscal Year                               | 2007 | 2010 | 2011 | 2012 | 2013  |
| Number served                                   | 123  | 626  | 810  | 901  | 1,090 |

Source: Department of Medical Assistance Services.

At the time of this assessment, DMAS was considering PACE expansion requests from several areas of the State. Implementation of new PACE operations is expected after July 1, 2014 (in SFY 2015).

Each PACE program submits an annual report directly to DMAS that includes (in aggregate) demographic and related information on the individuals served. One sub-population identified in the annual report is the number of its participants who are elderly and who have a documented diagnosis of **intellectual disability (ID)**. At the end of SFY 2013 (June 30), only 3 percent (or 33 individuals) of total PACE participants statewide were elderly individuals who had an ID diagnosis. These individuals were served primarily by PACE operations in the Richmond metropolitan area and in the Tidewater area. This percentage is dramatically different from percentages reported by DMAS for June 21, 2010 (36.3 percent or 185 individuals) for the *2011 Assessment of the Disability Services System*, which may have been inaccurate.

**c. Cost and Payment for PACE Services**

PACE is a federal program available to states through the **US Department of Health and Human Services**. PACE is a dual-capitated, single-payment benefit program that is funded through the Medicaid and, as applicable, Medicare health insurance programs. DMAS annually identifies the *average cost* of services per PACE participant in order to demonstrate the cost effectiveness of PACE over alternative institutional settings. DMAS data indicate that the annual average cost per PACE participant was \$25,620 during SFY 2010, and was \$31,219 per participant in SFY 2013.

Total **expenditures** for PACE have increased as the number of programs and individuals served has expanded. Cost variation occurs based on the evolving service needs of those served in each program and in each region. Total PACE expenditures for the past four SFYs are provided in **Table 73**.

| <b>Table 73. PACE Expenditures by SFY</b> |                   |                     |                     |
|---|-------------------|---------------------|---------------------|
| <b>SFY 2010</b>                           | <b>SFY 2011</b>   | <b>SFY 2012</b>     | <b>SFY 2013</b>     |
| <b>\$16,038,014</b>                       | <b>23,388,039</b> | <b>\$28,906,686</b> | <b>\$34,029,185</b> |

Source: Department of Medical Assistance Services

**d. Monitoring and Evaluation of PACE Services**

Federal PACE regulations and state regulation (12 VAC 30-120-62) assign responsibility for oversight of the Program of All-inclusive Care for the Elderly (PACE) to the **Virginia Department of Medical Assistance Services (DMAS)**. Under regulation 12 VAC 30-120-1060, DMAS has the specific responsibility for determining whether to extend PACE coverage to another area of the State, the schedule for doing so, and implementation of a competitive Request for Application (RFA) process. When an entity is selected in response to an RFA, DMAS conducts a feasibility study to determine whether that entity has the ability and resources necessary to effectively operate a PACE in compliance with federal guidelines; and DMAS can only contract with those providers who receive a positive determination.

Each PACE provider must meet all conditions of participation required by federal **Centers for Medicare and Medicaid (CMS)** regulations (42 CFR, Part 460) and relevant state statutes (Code of Virginia, 32.1-330.2 and -330.3 et seq.), and comply with DMAS regulations, policies, and procedures. Prior to initiation of a PACE location, DMAS conducts an onsite **State Readiness Review** and provides training on services and referral processes to all pre-admission screeners in localities covered by the new PACE. CMS staff, or its contracted staff, in collaboration with DMAS, also conducts an onsite review and evaluation of each new PACE.

DMAS conducts quarterly **Quality Management Reviews** of each PACE in operation to ensure that the health, safety, and welfare of all participants are protected and that each program's services are in compliance with both federal and state regulations. All reviews

include a thorough examination of all PACE processes and procedures, care plans, and participants' medical records. DMAS also conducts participant and family satisfaction surveys for each PACE to gather their perceptions about enrollment procedures, information sharing, quality of services, and other program features. If a review finds a provider's non-compliance to be significant enough to warrant such action, DMAS can retract Medicaid payments, terminate the provider agreement, or do both.

As with its Medicaid program, DMAS is accountable to the federal Centers for Medicare and Medicaid Services (CMS) for compliance with PACE service and programmatic requirements as well as expenditures. (Details about reporting of Medicaid expenditures and CMS oversight are provided in the **Medicaid** chapter of this *Assessment*.)

## N. 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

#### **ATLFA Fund**

<http://www.atlfa.org/>

#### **Brain Injury Association of Virginia (BIAV)**

<http://www.biav.net>

#### **Disability Law Center of Virginia (formerly Virginia Office for Protection and Advocacy, VOPA)**

<http://disabilitylawva.org/>

#### **SeniorNavigator**

<http://www.seniornavigator.org>

#### **Statewide Independent Living Council (SILC)**

<http://www.vasilc.org/statewideindependentlivingcouncil.htm>

#### **US Administration on Aging (AOA)**

<http://www.aoa.gov>

#### **Community Living Program**

[http://www.aoa.gov/AoARoot/AoA\\_Programs/HCLTC/NHD/index.aspx](http://www.aoa.gov/AoARoot/AoA_Programs/HCLTC/NHD/index.aspx)

#### **Virginia Association of Area Agencies on Aging (VAAAA)**

<http://vaaaa.org>

**Virginia Association of Centers for Independent Living (VACIL)**

<http://vacil.org/>

**Virginia Association of Community Services Boards**

<http://www.vacsb.org>

**Weldon Cooper Center, University of Virginia**

<http://www.coopercenter.org/demographics/publications/>

## **2. State Websites Referenced**

**Auditor of Public Accounts (APA)**

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

**Division of State Internal Audit**

[http://www.doa.virginia.gov/DSIA/Annual\\_Survey.cfm](http://www.doa.virginia.gov/DSIA/Annual_Survey.cfm)

**Comprehensive Services Act (CSA) for At-Risk Youth and Families**

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

**Child and Adolescent Needs and Strengths (CANS) Assessment**

<http://www.csa.virginia.gov/html/cans/cans.cfm>

**CSA Statewide Statistics and Reports**

<http://www.csa.virginia.gov/publicstats/index.cfm>

**Reports and Publications**

[http://www.csa.virginia.gov/html/manual\\_pubs/csa\\_reports\\_publications.cfm](http://www.csa.virginia.gov/html/manual_pubs/csa_reports_publications.cfm)

**State Executive Council**

[http://www.csa.virginia.gov/html/sec\\_slat/sec.cfm](http://www.csa.virginia.gov/html/sec_slat/sec.cfm)

**Systems of Care**

[http://www.csa.virginia.gov/html/systems\\_of\\_care/systems\\_of\\_care.cfm](http://www.csa.virginia.gov/html/systems_of_care/systems_of_care.cfm)

**Wraparound Center of Excellence**

<http://www.csa.virginia.gov/COE/coe.cfm>

**Department for Aging and Rehabilitative Services (DARS)**

<http://www.vadars.org>

## **Division for the Aging**

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

### **Area Agencies on Aging**

<http://www.vda.virginia.gov/aaalist.asp>

### **No Wrong Door Initiative**

<http://www.vda.virginia.gov/nowrongdoor.asp>

### **Public Guardianship and Conservatorship Program**

<http://www.vda.virginia.gov/vapublicguardpgm.asp>

### **Community Based Services Division**

<http://vadars.org/community.htm>

### **Brain Injury Services Coordination (BISC)**

<http://vadars.org/cbs/biscis.htm>

### **Centers for Independent Living (CILs)**

<http://vadars.org/cbs/cils.htm>

### **Community Rehabilitation Case Management (CRCM)**

<http://vadars.org/cbs/ltrcm.htm>

### **Personal Assistance Services (PAS)**

<http://vadars.org/cbs/pas.htm>

### **Virginia Assistive Technology System (VATS)**

<http://www.vats.org>

### **Virginia Reuse Network**

<http://www.vats.org/atrecycling.htm>

### **Virginia Brain Injury Council**

<http://www.DARS.virginia.gov/vbic.asp>

### **Woodrow Wilson Rehabilitation Center**

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

### **Assistive Technology**

<http://www.wwrc.virginia.gov/AssistiveTechnology.htm>



**Brain Injury Services**

<http://www.wwrc.virginia.gov/BrainInjury.htm>

**Spinal Cord Injury Program**

<http://www.wwrc.virginia.gov/SpinalCordInjury.htm>

**Department for the Blind and Vision Impaired (DBVI)**

<http://www.vdbvi.org>

**Rehabilitation Teaching/Independent Living**

[http://www.vdbvi.org/independent\\_living.htm](http://www.vdbvi.org/independent_living.htm)

**Older Blind Grant Program Annual Reports**

<http://www.afb.org/info/programs-and-services/professional-development/experts-guide/older-blind-grant-program/1235>

**Department for the Deaf and Hard-of-Hearing (VDDHH)**

<http://www.VDDHH.org>

**Interpreter Services**

<http://www.VDDHH.org/IpAbout.htm>

**Outreach Services**

<http://www.VDDHH.org/OrAbout.htm>

**Technology Services**

<http://www.VDDHH.org/TechIntro.htm>

**Technology Assistance Program**

<http://www.VDDHH.org/tapabout.htm>

**Virginia Relay**

<http://www.varelay.org>

**Virginia Quality Assurance Screening**

<http://www.VDDHH.org/IpVqas.htm>

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

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

**Core Services Taxonomy 7.2**

<http://www.dbhds.virginia.gov/documents/reports/OCC-2010-CoreServicesTaxonomy7-2v2.pdf>

**Office of Community Contracting**

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

**Office of Developmental Services**

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

**Individual and Family Support Fund**

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

**Person-Centered Practices**

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

**Reports and Survey Results**

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

**Waivers**

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

**Waiver Wait Lists**

<http://www.dbhds.virginia.gov/ODS-UsefulInformation.htm#waitlists.htm>

**Office of Human Rights**

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

**Office of Licensing**

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

**Office of Planning and Development**

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

**Omnibus Budget and Reconciliation Act (OBRA)**

<http://www.dbhds.virginia.gov/omh-OBRA.htm>

**Settlement Agreement with US Department of Justice**

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

**START program**

<http://www.dbhds.virginia.gov/settlement/121022START.pdf>

**State Board for Behavioral Health and Developmental Services**

<http://www.dbhds.virginia.gov/adm-StateBoardDefault.htm>

**Department of Health (VDH)**

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

**Division of Long Term Care**

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

**Office of Family Health Services**

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

**Office of Licensure and Certification**

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

**Department of Health Professions**

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

**Department of Medical Assistance (DMAS)**

<http://dmasva.dmas.virginia.gov/default.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 initiative**

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

**Children's Mental Health Demonstration Waiver**

[http://dmasva.dmas.virginia.gov/Content\\_atchs/mch/mch-cmh1.pdf](http://dmasva.dmas.virginia.gov/Content_atchs/mch/mch-cmh1.pdf)

**Long-Term Care**

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

**Information for Medicaid Clients**

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

**Department of Planning and Budget (DPB)**

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

**General Assembly of Virginia**

<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/>

**Joint Commission on Health Care**

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

**Senate Finance Committee**

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

**State Budget Information**

<http://viriniageneralassembly.gov/virginiaStateBudget.php?secid=22&activesec=4#!hb=1&mainContentTabs=0>

**Joint Legislative Audit and Review Commission (JLARC)**

<http://jlarc.virginia.gov/reports.shtml>

**Office of the Attorney General of Virginia**

<http://www.oag.state.va.us/>

**Official Opinions**

<http://www.oag.state.va.us/Opinions%20and%20Legal%20Resources/Opinions/index.html>

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

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

**Office of the State Inspector General (SOIG)**

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

**IG for Behavioral Health and Developmental Services**

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

**Semi-Annual Reports**

<http://www.oig.virginia.gov/rpt-AnnualSemiAnnual.htm>

**Special Studies**

<http://www.oig.virginia.gov/rpt-specialstudies.htm>

**Virginia Administrative Code**

<http://leg1.state.va.us/000/reg/TOC.HTM>

**Virginia Easy Access**

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

**Virginia Performs**

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

**Health and Human Resources Secretariat**

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

**State Agency Strategic Plans**

<http://www.vaperforms.virginia.gov/agencylevel/index.cfm>

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## VII. Institutional Supports

### A. Introduction to Institutional Services

This chapter focuses on two types of institutions in Virginia that serve individuals with intellectual (ID) or other developmental disabilities (DD): (1) state- and non-state-operated facilities certified as **Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID)**, and (2) **nursing facilities** licensed by the State but operated by local public agencies and private nonprofit or for-profit organizations. Note that in this *Assessment*, all references to the term “mental retardation” (MR) have been changed to “intellectual disability.” Not all statutory or regulatory language has caught up to this change, and an ICF/IID is the equivalent of what was termed an “ICF/MR.”

The State’s **Training Centers**, non-state-operated ICFs/IID, and nursing facilities are certified for Medicaid or Medicare reimbursement for services and monitored by state agencies on a regular basis. While each category of institution has unique characteristics based on its function, all provide daily room and board as well as varying levels of health care and other services that are defined by state and federal regulation. Throughout this chapter, in keeping with national reports, references to “**large institutions**” apply to those having a building or unit with a capacity for 16 or more residents.

With its first Training Center closing by June of 2014, Virginia will join 39 states that have closed one or more of its state-operated institutions. Three other state-operated Training Centers are scheduled to close by 2020, leaving the Southeastern Virginia Training Center open with a bed capacity of 75. Nationally, a substantial shift to small, community-based, non-state-operated residential services has occurred. During the past decade, several states have significantly decreased their number of community, intermediate care facilities for individuals with intellectual disabilities (ICFs/IID). They have done so by converting them to small residences of 6 or fewer residents who receive services and supports through increased funding of **Medicaid Home and Community Based Services (HCBS) Waivers**. Alaska no longer has any ICFs/IID, and 20 states have fewer than 10 each.

In 2008, under the authority of the national Civil Rights of Institutionalized Persons Act (CRIPA, 42 USC 1997 et seq.) the **US Department of Justice (DOJ)** began an investigation of services at Central Virginia Training Center (CVTC). Among other findings, the DOJ found that CVTC failed to provide for “reasonable care and safety” as evidenced by

*repeated accidents and injuries, inadequate behavioral and psychiatric interventions, and inadequate physical and nutritional management supports ... CVTC’s failure to identify root causes of bad outcomes and respond to prevent their recurrence.*

The investigation was later expanded to include examination of whether individuals at that facility as well as those already discharged from it were being served in **the most integrated settings appropriate to their needs** and examined state policies, procedures, and practices regarding admissions and discharges by all Training Centers. The DOJ concluded that Virginia had failed systematically to

*provide services to individuals with intellectual and developmental disabilities in the most integrated setting appropriate to their needs in violation of the ADA [Americans with Disabilities Act, 42 USC. 12101 et seq.]*

and that these deficiencies

*have resulted in needless and prolonged institutionalization of, and other harms to, individuals in CVTC and other segregated Training Centers*

in violation of their civil rights.

Specifically, the DOJ found that the Commonwealth:

- failed to develop a sufficient quantity of community-based alternatives for individuals now served at all Training Centers, especially those with complex needs;
- failed to use resources already available, such as the Money Follows the Person (MFP) project and Medicaid Home and Community Based Services (HCBS) Waivers to expand community-based services; and
- placed individuals with intellectual and developmental disabilities now in the community at risk of unnecessary institutionalization at state Training Centers by (1) failing to develop a sufficient quantity of community services, including respite and crisis services to prevent admission when they experience crises; and (2) failing to develop a sufficient quantity of community services, especially Medicaid HCBS Waiver slots, to maintain community life and prevent admission to state Training Centers.

The Commonwealth negotiated a **Settlement Agreement** rather than litigate against the findings as some states have done. In August of 2012, a federal judge entered the Settlement Agreement and appointed an Independent Reviewer. The target population for the Agreement is individuals who (1) currently reside at any Training Center, (2) meet the criteria for the Medicaid ID or DD Waiver Waiting Lists, or (3) currently reside in a nursing facility (NF) or intermediate care facility (ICF). With respect to individuals residing in the Training Centers, the Department of Behavioral Health and Developmental Services (the lead agency for implementation of the Agreement) has and continues to put forth extensive efforts to ensure quality discharges to the community.

The General Assembly approved \$30 million for state fiscal year (SFY) 2012 and an additional \$30 million for SFY 2013 to meet the requirements of the DOJ Settlement Agreement. These were called “Trust Fund dollars,” and they were intended to

*enhance and ensure for the coming years the quality of care and treatment provided to individuals receiving public mental health, developmental, and substance abuse services.*

The \$30 million appropriated in SFYs 2012 and 2013 was directly deposited to (1) provide or improve community-based services, including new Medicaid Home and Community Based Services (HCBS) Waivers to transition individuals from state Training Centers to community settings, and (2) expand the capacity of community-based providers to serve the DOJ target population. That Trust Fund has subsequently been expended. All new General Fund dollars are being appropriated as General Funds and included in the DBHDS budget.

The Budget Act and Code of Virginia § 37.2-318 established the **Behavioral Health and Developmental Services Trust Fund (BHDS Trust Fund)** as a special, nonreverting fund for the deposit of all proceeds from the sale of surplus DBHDS land (mental health or Training Center property) as well as other moneys appropriated by the General Assembly and any private donations. Net proceeds from the sale of surplus property at the Southeastern Virginia Training Center (SEVTC) in Chesapeake was approximately \$300,000 as of June 30, 2014. The final deposit of \$4 million plus was scheduled to occur in January of 2015. However, when the General Assembly passed the budget in June of 2014, it eliminated \$5.4 million from the BHDS Trust Fund with the rationale that at least that much in General Funds had been provided for in community services. This depleted all the money currently in the Trust Fund and all of the remaining proceeds that would have been received from the sale of the SEVTC.

On February 13, 2012, the Secretary of Health and Human Resources submitted a plan to transition individuals from state Training Centers to community-based settings to the Governor and the Chairs of the House Appropriations and Senate Finance Committees. This plan was submitted pursuant to the amended 37.2-310 of the Code of Virginia, which relates to the administration of the BHDS Trust Fund and is available at [http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/RD862012/\\$file/RD86.pdf](http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/RD862012/$file/RD86.pdf). The plan was based on a number of factors, including the following:

- the declining Training Center census (down 42 percent since SFY 2000) and, therefore, less need for Training Center beds;
- the advanced age of the centers (more than 35 years old) and their significant infrastructure needs;
- the 10-year, court-enforced Settlement Agreement with the Department of Justice; and
- Virginia being 4<sup>th</sup> among the states in the number of individuals with ID living in large settings like Training Centers (37 percent) and ranking 48<sup>th</sup> in the number of people served in community-based settings of less than 15 people (63.4 percent).

Among other provisions, the plan requires that long-term admissions to Training Centers end. According to DBHDS projections presented to the DOJ Stakeholder Advisory Committee in April of 2013, the total cost of Settlement Agreement implementation over 10 years is

estimated to be \$2.4 billion. Virginia's General Fund share of the cost is estimated at \$1.2 billion. With projected savings and offsets of \$867.1 million from facility closures and appropriations in place before the \$60 million allotted to the Trust Fund, projected additional General Fund dollars required are estimated at \$340.4 million. The presentation is available at <http://www.dbhds.virginia.gov/settlement/IX%20Budget%20Update%2004-17-13.pdf>.

In January of 2014, the DBHD submitted a required update to its Training Center Closure Plan to the Governor and the Chairs of the Senate Finance and House Appropriations Committee. The update continues to recommend the closure of four training centers on the same timetable as originally proposed. It provides an update on census reduction goals and discharge targets. The report also addresses community capacity development, critical incidents and deaths, regional information, and budget updates. More information is included in the **Access to and Delivery of ICF/IID Services** section of this chapter, in relevant sections of other chapters, and the update is available online at <http://www.dbhds.virginia.gov/settlement/Item%20314.O.%20Quarterly%20Report%201-10-14.pdf>.

The Settlement Agreement is complex and contains provisions related to the Training Centers, community services and supports, housing, employment, case management, and quality assurance. DBHDS has dedicated a web page to the Settlement Agreement that houses all documents, including the DOJ Findings Letter, the Settlement Agreement, reports of the Independent Reviewer, and implementation updates by the DBHDS. Other documents and resources are also available on the page, which can be found at <http://www.dbhds.virginia.gov/settlement.htm>.

The situation at Virginia's Training Centers is extremely fluid. The population continues to decline, and initiatives related to the DOJ Settlement Agreement are ongoing. Because this *Assessment* is based primarily on state and federal fiscal year data, by the time this *Assessment* is released, some data, particularly data related to Training Center census, will be out of date. DBHDS has available a multitude of reports and data on its website at <http://www.dbhds.virginia.gov> for those seeking more detailed and comprehensive information that is beyond the scope of this *Assessment*.

## **B. Intermediate Care Facilities for Individuals with Intellectual Disabilities**

Federal regulations (CFR 440.150), based on the Social Security Act (42 USC 1396 et seq.), define an **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICFs/IID)** as an institution or a distinct part of a facility other than an ICF/IID, that:

1. has the primary purpose of providing "health or rehabilitative services to persons with intellectual disability or persons with related conditions,"

2. meets certain standards specified by federal regulations (42 CFR 483.400, subpart I et seq.),
3. has been certified to meet additional requirements (42 CFR 442.100, subpart C) as evidenced by a valid agreement between the state Medicaid agency and the facility,
4. fully meets the requirements for a state license to provide services that are above the level of room and board, and
5. provides “active treatment” to all individuals served and for whom payment is requested (42 CFR 483.440).

**Active treatment** is federally defined as

*aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services*

Its goals must be to help the individual (1) acquire the essential skills or behaviors that enable him or her to function as independently as possible and (2) prevent or slow the loss of current “optimal functional status.” For complete information, refer to

<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Institutional-Care/Intermediate-Care-Facilities-for-Individuals-with-Mental-Retardation-ICFMR.html>.

The majority of ICFs/IID statewide are owned and operated by public agencies such as Community Services Boards or by private, nonprofit or for-profit organizations. These facilities, referenced in this *Assessment* as **non-state-operated ICFs/IID**, are defined by state regulations (12 VAC 35-105-20) as a service that:

1. is licensed by DBHDS to provide care to individuals diagnosed with intellectual disability or a developmental disability due to brain injury who do not need “...nursing care, but require more intensive training and supervision than may be available in an assisted living facility or group home,”
2. complies with standards established in Title XIX of the Social Security Act and related federal regulations,
3. provides health or rehabilitation services, and
4. provides active treatment to individuals to achieve more independence in functioning and improved quality of life.

**Non-state-operated ICFs/IID** are subject to the same minimum federal requirements as the State’s large Training Center ICFs/IID. Either directly or by contract, they are required to provide their residents with an array of medical, health, and rehabilitative therapies as required by those residents’ individual, comprehensive functional assessments.

The **Centers for Medicare and Medicaid Services (CMS)**, an agency of the US Department of Health and Human Services, is authorized to certify ICFs/IID, to establish the detailed minimal requirements under which they operate, to monitor their compliance with those requirements, and to set penalties for noncompliance. Federal regulations require that, once a state has chosen to fund ICF/IID services or any other allowable service as an optional service under Medicaid, the state must continue to cover that service until it has been removed from the state's annual **Medicaid State Plan**.

An annual **directory** of ICFs/IID, nursing facilities, hospital long-term units, and mental health facilities statewide is produced by the Office of Licensure and Certification at the Virginia Department of Health (VDH). It is available online at <http://www.vdh.virginia.gov/OLC/Facilities/> or on the DBHDS website at <http://www.dbhds.virginia.gov/OL-default.htm>.

## 1. Eligibility for ICF/IID Services

As federally required, an **applicant for entry into an ICF/IID**, whether state- or non-state-operated, must have a primary diagnosis of intellectual disability (ID), as determined by a formal assessment by a licensed, qualified professional, and must meet the level-of-functioning requirements for an ICF/IID. The Virginia Administrative Code (12 VAC-34-190-10) defines the diagnosis criteria as:

1. onset prior to age 18 of significantly sub-average intellectual function, as demonstrated by performance on a standardized measure of intellectual functioning administered in conformity with accepted practice, and
2. concurrent, significant limitations in adaptive behavior, as expressed in conceptual, social, and practical adaptive skills.

Individuals served in non-state-operated ICFs/IID must have Medicaid or Medicare public insurance, private insurance, or the ability to pay for care directly.

As required by the Code of Virginia § 37.2-505, referral for potential admission to one of the State's five Training Centers (ICFs/IID) is the responsibility of local **Community Services Boards or Behavioral Health Authorities** (jointly referred to as **CSBs**). Most of the individuals still remaining in Virginia's Training Centers are either individuals diagnosed with severe or profound intellectual disability and co-occurring complex medical or physical conditions, such as cerebral palsy, or "dually diagnosed" individuals with an intellectual disability and co-occurring mental illness who have challenging behaviors.

## 2. Access to and Delivery of ICF/IID Services

All ICFs/IID, whether they be state- or non-state-operated, are covered by the same state and federal regulations. Individuals must receive "all necessary services" appropriate to their individual needs based on an individual assessment. An **Individualized Support Plan (ISP)** must be developed, and active treatment must be provided according to that plan. Assessments



must be conducted regularly to determine and update the individual's service and support needs, and reassess whether the individual continues to need the ICF/IID level of care. Involvement by the individual (or his or her parents, guardian, or authorized representative, as appropriate) in treatment planning is required, and involvement by a CSB support coordinator is requested. Individuals served in ICFs/IID must be certified annually to ensure that they are receiving the appropriate level of care. Any transition to another residential or service setting must be planned to ensure continuity of needed services and supports.

***a. State-operated Training Centers (ICFs/IID)***

Virginia's Medicaid State Plan has included ICF/IID services for over 30 years, and the State directly owns and operates five, large ICFs/IID, known as **Training Centers**, through its **Department of Behavioral Health and Developmental Services (DBHDS)**. These are

- Central Virginia Training Center (CVTC) in Amherst County,
- Southside Virginia Training Center (SVTC) in Petersburg,
- Southeastern Virginia Training Center (SEVTC) in Chesapeake,
- Southwestern Virginia Training Center (SWVTC) in Hillsville, and
- Northern Virginia Training Center (NVTC) in Fairfax.

In July of 2012, DBHDS presented a plan that was approved by the General Assembly to cease residential operations at 4 of the 5 Training Centers. The plan was presented as part of implementation of the Settlement Agreement with the Department of Justice. Although facility closure is not required under the Agreement, the Commonwealth determined that it could not continue to operate a dual-system of services (institution and community) and meet the tenets of the Agreement. The plan notes that it conservatively estimates that there will be fewer than 600 individuals residing in Training Centers in SFY 2015 and fewer than 300 by SFY 2019. As of March 14, 2014, there were 661 individuals residing in the State's Training Centers ([http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/RD862012/\\$file/RD86.pdf](http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/RD862012/$file/RD86.pdf)). The Settlement Agreement calls for a minimum of 805 Medicaid Home and Community Based Services (HCBS) Waiver slots from SFY 2012 to SFY 2020 to transition individuals from Training Centers into the community. A total of 380 waiver slots were available to Training Center residents in SFYs 2012 through 2014.

The first Training Center to close will be Southside Virginia Training Center (SVTC) no later than June of 2014 (prior to publication of this *Assessment*). The final closure in 2020 will be Central Virginia Training Center (CVTC), which also houses a skilled nursing unit. The Southeast Virginia Training Center (SEVTC) is the only Training Center that will remain open after 2020. It has an operational capacity of 75 beds.

In SFY 2012, 15 new, 5-bed homes were developed on the SEVTC campus to serve the individuals remaining at that downsized facility. Construction of 11 residences in Region 5 (Tidewater) was also completed to serve individuals leaving SEVTC. Of the 11 buildings, 6 were

waiver homes and 5 were small ICFs/IID. Renovations of 2 buildings at CVTC were completed, as was construction of two ICFs. Commitments were made to fund an additional 11 residences near the CVTC.

Three types of **admission to state-operated Training Centers** are authorized by state Code and regulation.

1. Respite admission: residential supports provided to an individual with mental retardation [intellectual disability] on a short-term basis because of the emergency absence of or need to provide routine or periodic relief of the primary caregiver for the individual (12 VAC 35-200-10). Both emergency and respite care temporary admissions are intended to be of short duration, and neither involves a judicial certification of eligibility unless the individual's stay extends past the limits set by state law of 21 consecutive days or a total of 75 days in any calendar year.
2. Emergency admission: the temporary acceptance of an individual with mental retardation [intellectual disability] into a Training Center when immediate supports are necessary and no other community alternatives are available (12 VAC 35-200-10).
3. Regular admission: the acceptance of an individual with intellectual disability to a Training Center for a period typically longer than 21 consecutive days. A regular admission is based on consideration of the preliminary evaluation and requires a judicial certification in accordance with § 37.2-806 of the Code of Virginia. Judicial certification is not an involuntary admission, and the individual has the right to appeal the admission order to the Circuit Court.

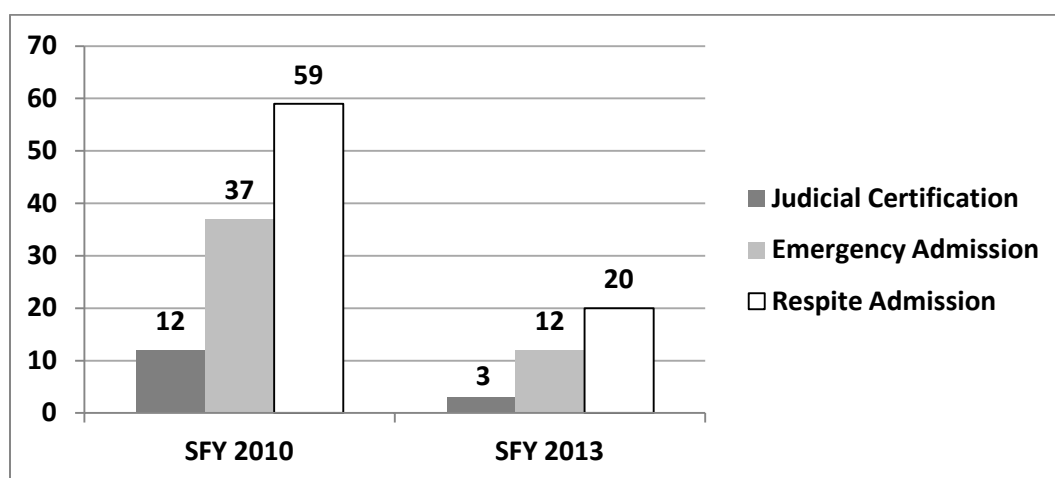
In the past, **admission and discharge protocols** were combined in the DBHDS *Admission and Discharge Protocols for Individuals with Intellectual Disabilities*. The most recent protocols took effect March 1, 2011. They are online at <http://www.dbhds.virginia.gov/documents/ODS/ods-Admission-Discharge-Protocol.pdf>. However, in light of the Settlement Agreement with the Department of Justice, these protocols are now being separated. New discharge protocols have been developed and admission protocols were updated in January of 2014. Admissions to **Southside Virginia Training Center** are closed. All admission requests will be funneled by the appropriate community services board (CSB) to either **Central Virginia Training Center** or **Southwestern Virginia Training Center**, depending on which CSB is requesting admission on behalf of the individual. Southeastern Virginia Training Center is still over its established capacity of 75 and is not taking admissions at this time.

Admission to a Training Center can be initiated only after a community services board (CSB) representative has explored and exhausted all community options. Individuals and their families or authorized representatives must be fully informed about community services and supports that are available to meet the individual's needs. Once fully informed of options, the individuals (or their parents, guardians, or authorized representatives, if appropriate) must sign a written declaration of their "choice of services," including, but not limited to, placement in a Training Center. They must also be informed that if the individual has a Medicaid Home and

Community Based Waiver, they will lose their waiver slot. (See the **Medicaid** chapter for more information on waivers and available slots.)

**Figure 24** shows the decline in Training Center admissions from SFY 2010 to SFY 2013. The Trust Fund Plan noted that since 2007, there were an average of 12.6 long-term, regular admissions per year for all 5 Training Centers, 42 emergency admissions, and 66 respite admissions. Admissions have decreased significantly from those numbers not only as a result of the DOJ Settlement Agreement but due to concerted efforts by the DBHDS and local community services boards to ensure, consistent with state regulations, that all community alternatives have been exhausted prior to making a request for a regular admission. Judicial certifications in SFY 2013 were down 75 percent from 2010; respite admissions were down 66 percent; and emergency admissions were down 68 percent over the same 7 years.

**Figure 24. Training Center Admissions by Type**



Source: Department of Behavioral Health and Developmental Services: *Update on Implementation of DOJ Settlement Agreement to Joint Committee on Training Center Closures*, July 18, 2013.

An **admission appeal** is possible when any admission request is denied. A Training Center's director must provide a written statement of the reason for the denial and may also provide recommendations for alternative services. If the parent, guardian, or authorized representative for the individual denied admission disagrees with this decision, that person or the CSB representative may submit a written request for reconsideration. The request must be submitted within 10 days of receiving the decision notice.

The Code of Virginia (37.2-505) requires that a discharge plan be developed at the initial meeting of an individual's interdisciplinary team in consultation with Training Center staff and the individual's CSB support coordinator. The plan must include the following information:

1. the anticipated date of discharge from the Training Center;

2. a description of all the services and supports needed for the individual's successful return to life in the community (such as psychiatric, social, educational, medical, housing, employment, legal, advocacy, transportation, and others); and
3. the specific public and private providers who agree to supply these needed services, consistent with the right of the individual (or his or her parents, guardian, or authorized representative, if applicable) to choose his or her own providers.

As a result of the DOJ Settlement Agreement, DBHDS implemented new guidelines and processes at Training Centers to improve the discharge process for transitioning Training Center residents to the community. In its July 1, 2012 **Training Center Community Integration Project Update**, DBHDS reported establishing five community integration managers (CIM) positions, one at each Training Center. The role of the CIMs is to coordinate the internal Training Center discharge process and ensure that discharges occur in a timely manner and in compliance with the Settlement Agreement. Detailed information on the transition decision-making process, the moving process, team member roles and responsibilities, and post-move monitoring are described in the update, which is available at <http://www.dbhds.virginia.gov/settlement/121022CommIntegrationProject.pdf>.

New discharge protocols are in effect. The DBHDS **Training Center to Community Discharge Workflow Process and Activities** can be found at <http://www.dbhds.virginia.gov/documents/ODS/TC%20to%20Community%20Move%20Workflow%20process%20and%20Activities.pdf>. In these protocols, DBHDS establishes procedures to ensure that the training centers

*use person-centered principles and practices to help individuals living in training centers and those who support them to identify and make informed choices regarding specific protections, supports, and services necessary to live successfully in a more integrated setting and to define requirements for discharge planning, transition, pre-move activities, and post-move monitoring.*

According to the protocols, the discharge process typically takes about 12 weeks to complete and includes the following activities:

1. an initial pre-move meeting,
2. individual/authorized representative and CSB reviews of providers,
3. provider tours,
4. provider information requests,
5. day visits,
6. evening visits,
7. provider training and overnight visits,
8. final pre-move meeting,

9. preparation for moving,
10. moving, and
11. post-move monitoring.

More information on the requirements for post-move monitoring are covered in the **Monitoring and Evaluation of ICF/IID Services** section of this chapter below.

In its April 17, 2013 update of the Training Center **Community Integration Project** (<http://www.dbhds.virginia.gov/settlement/121022CommIntegrationProject.pdf>), DBHDS discusses the role of **Regional Support Teams (RSTs)**. The RSTs established under the Settlement Agreement

*provide recommendations and assistance in resolving barriers to the most integrated community setting consistent with an individual's needs and informed choice.*

Informally referred to as “barrier-busting teams,” there is an RST in each region coordinated by Community Integration Managers (CIM) and Community Resource Consultants. The teams include individuals with a diversity of experience in ID/DD services and complex medical and behavioral supports. The RSTs receive their referrals from the CIMs under the following circumstances:

- A **Personal Support Team (PST)** working with the individual to develop his or her discharge plan recommends that the individual move to a nursing facility or congregate setting (ICF/IID or group home) with more than 5 beds. (PSTs were established to resolve barriers and gaps in services and ensure that individuals are informed of choices.)
- There is difficulty in identifying or locating supports at various, specified timeframes.
- The PST cannot agree on a discharge plan outcome within 15 days of the annual meeting or within 30 days of admission to the Training Center.
- The individual or their **authorized representative (AR)** opposes moving or does not wish to participate in the discharge planning process.
- The individual has not moved within 3 months of locating a provider.
- It is recommended that the individual remain at the Training Center (requires reassessment every 90 days).

Almost all of the individuals residing in the State’s Training Centers are adults. Southeastern and Southwestern Virginia Training Centers (SEVTC and SWVTC) have a children’s residential services license from DBHDS to serve small numbers of youth, ages 8 through 17 at SEVTC and ages 12 through 21 at SWVTC. Youth admitted to these two facilities typically have a dual diagnosis of intellectual disability and behavioral challenges, and these facilities are considered to be “providers of last resort” for these age groups.

In addition to its certified ICF/IID units for adults with intellectual disability, Central Virginia Training Center (CVTC) has a certified, skilled nursing unit that can accommodate up to a total of 104 residents. In its Fiscal Year 2013 *Annual Report, Item 314.K*, DBHDS reported that in SFY 2013, 83 individuals received skilled nursing services. This was down 12 percent from the previous year when 94 individuals received skilled nursing services, according to the 2012 *Annual Report, Item 314.K*.

**Table 74** compares the **age distribution** of Training Center residents at the end of selected state fiscal years (SFYs), including both residents of the certified nursing units at CVTC and residents of the ICF/IID-certified units at all of the Training Centers. Counts reflect all individuals “on books” at the end of each state fiscal year, June 30, and the amount and percent of change is for the entire period shown. On-books refers to all persons admitted to a facility, but not yet discharged, and includes any who were off-campus on a pass or on leave. There are few individuals in the Training Centers below the age of 21. It is likely that the two, additional individuals on-books in SFY 2012 in this age category were respite or emergency admissions. The largest decrease in census has been in the 22-to-54 age group. This is not unexpected as individuals over 55 are likely to have more significant health needs, which may require a longer planning period prior to discharge.

| <b>Table 74. Ages of State Training Center Residents by SFY</b> |              |              |             |             |                               |
|---|--------------|--------------|-------------|-------------|-------------------------------|
| <b>Age Category</b>   | <b>2010</b>  | <b>2011</b>  | <b>2012</b> | <b>2013</b> | <b>% Change<br/>2010–2013</b> |
| Birth to 5 years  | 0            | 0            | 0           | 0           | 0.00                          |
| 6 to 15 years   | 1            | 1            | 1           | 1           | 0.00                          |
| 16 to 21 years  | 6            | 6            | 8           | 5           | - 17.0%                       |
| 22 to 54 years  | 722          | 565          | 480         | 387         | - 46.0%                       |
| 55 to 64 years  | 295          | 279          | 315         | 300         | + 1.70%                       |
| 65 years or older   | 136          | 235          | 174         | 123         | + 9.60%                       |
| <b>Total</b>  | <b>1,160</b> | <b>1,086</b> | <b>978</b>  | <b>816</b>  | <b>- 29.70%</b>               |

Source: Department of Behavioral Health and Developmental Services.

**Average Daily Census (ADC)** reflects the *average* number of residents on-books (including those on pass or leave) at a facility over a period of time, usually the state fiscal year. **Table 75** shows the ADC at selected points in time from March 2010 through July 2013. The total Training Center census has declined by a third just in the last 4 years. As a further comparison, the July 2013 census was down 56 percent from the census in 2000, which was 1,746 ([http://hac.virginia.gov/subcommittee/Training\\_Centers\\_Closure\\_Joint\\_Sub/07-18-13/DBHDS%20-%20DOJSpecialSubcommittee%2007-18-13.pdf](http://hac.virginia.gov/subcommittee/Training_Centers_Closure_Joint_Sub/07-18-13/DBHDS%20-%20DOJSpecialSubcommittee%2007-18-13.pdf)).

| Table 75. Average Daily Census at State Training Centers |              |              |            |            |                |
|--|--------------|--------------|------------|------------|----------------|
| Training Centers   | March 2010   | June 2011    | June 2012  | July 2013  | % Change       |
| Central (CVTC)   | 426          | 381          | 342        | 300        | - 29.6%        |
| Northern (NVTC)  | 170          | 157          | 153        | 135        | - 20.6%        |
| Southeastern (SEVTC)                                     | 143          | 124          | 104        | 84         | - 41.2%        |
| Southside (SVTC)   | 267          | 243          | 197        | 113        | - 57.7%        |
| Southwestern (SWVTC)                                     | 192          | 181          | 173        | 156        | - 18.8%        |
| <b>Total</b>   | <b>1,198</b> | <b>1,086</b> | <b>969</b> | <b>788</b> | <b>- 34.2%</b> |

Source: Department of Behavioral Health and Developmental Services. *Update on Implementation of the DOJ Settlement Agreement to Joint Committee on Training Center Closures*, July 18, 2013.

As **Table 75** shows, all of the Training Centers experienced a decline, with the largest percentage decreases at SVTC (as the first facility scheduled to close), at SEVTC (due to the downsizing of that facility to 75 beds), and at CVTC, the largest training center in the State and the last scheduled to close. Southside Virginia Training Center closed on June 30, 2014.

In its quarterly *Update to the Training Center Closure Plan* to the Governor and Chairs of the Senate Finance and House Appropriations Committee, DBHDS reported on revised census reduction targets as shown in **Table 76**.

| Table 76. Revised Census Reduction Targets for State Training Centers for SFYs 2013–2020 |            |            |            |           |           |           |           |           |
|--|------------|------------|------------|-----------|-----------|-----------|-----------|-----------|
| Admissions   | 2013       | 2014       | 2015       | 2016      | 2017      | 2018      | 2019      | 2020      |
| SVTC *   | 80         | 118        | N/A        | N/A       | N/A       | N/A       | N/A       | N/A       |
| NVTC *   | 14         | 60         | 74         | N/A       | N/A       | N/A       | N/A       | N/A       |
| SWVTC  | 15         | 20         | 20         | 40        | 40        | 36        | N/A       | N/A       |
| CVTC   | 26         | 35         | 50         | 56        | 50        | 50        | 35        | 23        |
| <b>Total</b>   | <b>135</b> | <b>248</b> | <b>144</b> | <b>96</b> | <b>90</b> | <b>86</b> | <b>35</b> | <b>23</b> |

\* SVTC is scheduled to close in SFY 2014, NVTC in SFY 2015.

Source: DBHDS Update to Training Center Closure Plan, January 10, 2014.

These updated targets have some significant differences from those presented in the DBHDS *Update on the Implementation of the Settlement Agreement* provided to the Joint Committee on Training Center Closures. At that time, it was anticipated that 51 individuals would transition out of NVTC in SFYs 2013 and 2014, but that target was revised downward to

14 in SFY 2013 and upward from 51 to 74 in SFY 2015, which is the projected date of closure for that facility. Both family resistance to the closure and lack of community capacity in Northern Virginia are the likely reasons for these revisions. Southwestern Virginia Training Center's original discharge targets were set to begin in SFY 2016, but as of the January 2014 revisions, it now has discharge targets for each year through SFY 2018. The targets at CVTC remain fairly close to the original, although more individuals (48) are targeted for discharge in the final year, compared to 23 in the original targets.

**b. Non-state-operated ICFs/IID**

Individuals seeking admission to a non-state-operated, community, intermediate care facility for individuals with intellectual disability (ICF/IID) apply directly to the provider organization responsible for the institution's operation. Currently, a number of the ICFs/IID are operated by local Community Services Boards (CSBs), and others are operated by private nonprofit and for-profit entities. Their geographic service areas vary, and each determines its own application and admissions processes. Most ICFs/IID operated by CSBs serve individuals within their own local jurisdictions first, but they can serve individuals from outside of their localities if they choose to do so. Private providers may accept referrals from anywhere. **Table 77** below contains data provided by the Department of Medical Assistance Services (DMAS) showing the number of individuals served in non-state-operated ICFs/IID for state fiscal years (SFYs) 2010 and 2013 by age groups.

| <b>Table 77. Persons Served in Non-state-operated ICFs/IID<br/>by Age for SFYs 2010 and 2013</b> |                 |                 |
|--|-----------------|-----------------|
| <b>Age Groups</b>  | <b>SFY 2010</b> | <b>SFY 2013</b> |
| <b>Under 1 year</b>  | <b>0</b>        | <b>2</b>        |
| <b>1 to 5 years</b>  | <b>9</b>        | <b>8</b>        |
| <b>6 to 14 years</b>   | <b>44</b>       | <b>44</b>       |
| <b>15 to 20 years</b>  | <b>52</b>       | <b>55</b>       |
| <b>Subtotal for Ages 0 to 20</b>   | <b>105</b>      | <b>109</b>      |
| <b>21 to 44 years</b>  | <b>132</b>      | <b>157</b>      |
| <b>45 to 64 years</b>  | <b>137</b>      | <b>176</b>      |
| <b>Subtotal for Ages 21 to 64</b>  | <b>269</b>      | <b>333</b>      |
| <b>65 to 74 years</b>  | <b>17</b>       | <b>29</b>       |
| <b>75 to 84 years</b>  | <b>0</b>        | <b>3</b>        |
| <b>85 and older</b>  | <b>0</b>        | <b>0</b>        |



| <b>Table 77. Persons Served in Non-state-operated ICFs/IID<br/>by Age for SFYs 2010 and 2013</b> |                 |                 |
|--|-----------------|-----------------|
| <b>Age Groups</b>  | <b>SFY 2010</b> | <b>SFY 2013</b> |
| <b>Subtotal for Ages 65 and Older</b>  | <b>17</b>       | <b>32</b>       |
| <b>Total for All Ages</b>  | <b>391</b>      | <b>474</b>      |

In SFY 2010, children and youth ages one through 20 comprised 26.9 percent of all individuals served by non-state-operated ICFs/IID. In SFY 2013, the number of children and youth increased to 109, but children and youth comprised a smaller percentage (22.9 percent) of an otherwise growing number of individuals served in non-state-operated ICFs/IID. The SFY 2013 total population in non-state-operated ICFs/IID rose 21.2 percent from SFY 2010. The most significant growth was in the population of individuals ages 45 to 64. It is possible that the overall increase is due at least in part to the transition of some Training Center residents to non-state-operated ICFs/IID, including homes that have been developed by the State near Southeastern and Central Virginia Training Centers.

The state has experienced growth in the number of non-state-operated ICFs/IID. A single provider may be licensed for and operate more than one community ICF/IID at different locations. Therefore, the number of providers does not increase at the same rate as the number of beds. DMAS maintains data on “enrolled ICF/IID providers,” meaning those approved for Medicaid reimbursement. Such approval first requires licensing by the Department of Behavioral Health and Developmental Services (DBHDS), which is further contingent on a determination by the Virginia Department of Health that the facility meets federal regulations.

**Table 78** shows a 15.6-percent increase in total bed capacity and a 19-percent increase in the number of facilities since 2010. The number of ICFs/IID has more than doubled since SFY 2007 when there were only 21 non-state-operated ICFs/IID. Of the current 48 ICFs/IID, 25 percent (12) have a bed capacity of 10 or more. Only 10 (20.8 percent) have 4 beds or less. St. Mary’s Home for Disabled Children, with 92 beds, has 20.3 percent of all non-state-operated ICF/IID beds.

| <b>Table 78. Non-state-operated ICFs/IID Bed Capacity by SFY</b> |                 |                 |                  |                 |
|--|-----------------|-----------------|------------------|-----------------|
| <b>Capacity</b>  | <b>SFY 2007</b> | <b>SFY 2010</b> | <b>SFY 2013*</b> | <b>% Change</b> |
| <b>Total Beds</b>  | <b>340</b>      | <b>391</b>      | <b>452</b>       | <b>+ 32.9%</b>  |
| <b># of ICFs/IID</b>   | <b>21</b>       | <b>36</b>       | <b>48</b>        | <b>+ 129.0%</b> |

\* Report dated April 2013.

Source: DBHDS Office of Licensing website.

### 3. Available ICF/IID Services

ICFs/IID, whether state- or non-state-operated, are required by federal and state regulations to provide or to obtain a full range of appropriate medical, health, and rehabilitative services to meet the needs identified by formal assessment of the individuals whom they serve. Core services, which may be provided either directly or by contract, include physical, occupational, and recreational therapy; speech pathology; and nutritional, medical, dental, pharmaceutical, psychological, and social services. Intermediate care facilities for individuals with intellectual disabilities (ICFs/IID) may also provide vocational training, as appropriate. The Central Virginia Training Center (CVTC) operates certified skilled nursing units. And, as noted in the **Access to and Delivery of ICF/IID Services** section of this chapter, the Training Centers also provide short-term respite and emergency stays for behavioral management and intervention.

#### a. State-operated Training Centers (ICFs/IID)

Training centers provide highly structured, intensive services in a large facility setting. The Department of Behavioral Health and Developmental Services (DBHDS) website addresses the changing role of state facilities, stating:

*In the evolutionary movement towards a single, integrated system of care, increased emphasis has been placed on the establishment of community services and on the more effective and efficient use of state facilities. This emphasis has defined the role of state facilities as one of several resources in an overall continuum of care.*

Procedural variations exist in **treatment and discharge planning** by type of admission. For regular admissions, the Code of Virginia § 37.2-806 specifies that an individual must receive active treatment throughout his or her stay at a Training Center and that the treatment be based on an “individualized habilitation plan” describing the services that will be provided to meet the individual’s needs as identified by assessment. Within 30 days of admission, an interdisciplinary team must collaborate with CSB staff to develop this plan, referred to by DBHDS as an **Individualized Support Plan (ISP)**. The ISP must include supports toward a discharge plan as well as input from the individual, and/or his or her family members, guardian, or authorized representative, if applicable, and the CSB. To facilitate the participation of external participants, meetings may be conducted using teleconferencing or video-conferencing if necessary.

All Training Centers conduct the **Supports Intensity Scale (SIS)** as part of the ISP process. Developed by the American Association on Intellectual and Developmental Disabilities (AAIDD), this standardized assessment purports to measure the level and types of supports needed by persons with intellectual and developmental disabilities to be successful (as opposed to measuring the individual’s deficits.) It is administered every three years for each resident of Training Centers. However, there have been continuing concerns in other states and more recently in Virginia with respect to the validity and reliability of the SIS and how SIS results are used to make decisions regarding the services and supports needed by the individual. DBHDS is

now reviewing the usage of the SIS and processes for its usage are anticipated to undergo significant modification.

As of the time of this report, using information from the SIS and other assessments, an individual's interdisciplinary team reviews his or her progress at 30, 60, 90, and 180 days following regular admission to a Training Center. Thereafter, team reviews are conducted annually or whenever circumstances warrant, such as when the interdisciplinary team (IDT) identifies a major change in the individual's needs. A Qualified Intellectual Disability Professional (QIDP), or service coordinator, who works with the individual, must also conduct quarterly reviews. Whenever an annual or special review identifies a change in an individual's status that would significantly affect that individual's discharge potential (such as medical issues), statutes require that Training Center staff collaborates with the Community Services Board (CSB) to ensure that the individual's CSB support coordinator (case manager) is informed of any changes in the services or supports needed for the individual's discharge plan.

Over the past decade, in addition to the core services mentioned above, each of the State's Training Centers has been tasked to directly provide or contract with private clinicians to provide some services and specialized supports on an outpatient basis through **Regional Community Support Centers (RCSC)**. For more information on the RCSCs, see the **Health Care** chapter of this *Assessment*.

#### ***b. Non-state-operated ICFs/IID***

As with the state-operated Training Centers, the Centers for Medicare and Medicaid Services (CMS) regulations require that non-state-operated ICFs/IID provide the core services listed above either directly or by contract and that the services be tailored to meet each individual's unique needs. This requirement applies to all ICFs/IID be they public or private, nonprofit or for-profit.

### **4. Cost and Payment for ICF/IID Services**

Services at state- and non-state-operated ICFs/IID are funded by private and public sources. The national public health insurance programs, Medicare and Medicaid, are a significant source of funding. Other sources of payment include personal, out-of-pocket expenditures as well as various types of purchased, private insurance such as long-term care insurance, Medicare Supplemental Insurance ("Medigap"), or managed care health insurance.

To receive reimbursement through Medicare or Medicaid, facilities must conform to specific federal **Centers for Medicare and Medicaid Services (CMS)** standards in eight operational areas: management, client rights, facility staffing, active treatment services, behavior and facility practices, health care services, physical environment, and dietetic services. To be "CMS certified" and thus eligible for reimbursement, a facility must be found to meet those standards based on an inspection by the designated state agency. Note that Central Virginia Training Center operates a skilled nursing unit. Beds at a facility may be CMS certified for Medicare, Medicaid, or both under the following categories.

- **Skilled Nursing Facility (SNF):** Any long-term care bed specifically certified for *Medicare* reimbursement.
- **Nursing Facility (NF):** Any long-term care bed specifically certified for *Medicaid* reimbursement.
- **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID):** Any long-term care bed specifically certified for a *Medicaid* reimbursement program designated to provide care or supervision for residents who have a primary diagnosis of intellectual disability (ID) or a developmental disability (DD).

**Table 79** and **Table 80** compare the number of individuals served, total operational expenditures, and the annual, per capita cost for the State's Training Centers and non-state-operated ICFs/IID for SFYs 2010, 2011, and 2012. Detailed budget and expenditure information for the State's Training Centers were provided by the **Department of Behavioral Health and Developmental Services (DBHDS)**. The **Department of Medical Assistance Services** provided details on Medicaid expenditures related to non-state-operated ICFs/IID. Information on persons and services covered by private payments is not available.

| <b>Table 79. Expenditures for State-operated ICFs/IID (Training Centers) by SFY</b> |                      |                    |                      |                    |                    |                        |
|---|----------------------|--------------------|----------------------|--------------------|--------------------|------------------------|
| <b>State Fiscal Year</b>  | <b>Number Served</b> | <b>State Funds</b> | <b>Federal Funds</b> | <b>Other Funds</b> | <b>Total Funds</b> | <b>Per Capita Cost</b> |
| 2010  | 1,197                | \$97,978,045       | \$122,380,664        | \$463,164          | \$220,821,883      | \$184,479              |
| 2011  | 1,105                | \$97,750,264       | \$127,182,881        | \$3,483,248        | \$225,416,393      | \$203,997              |
| 2012  | 1,013                | \$117,841,792      | \$109,041,285        | \$497,974          | \$227,381,051      | \$224,463              |
| 2013  | 868                  | \$114,403,187      | \$112,598,189        | \$627,782          | \$227,629,158      | \$262,246              |

Source: Department of Behavioral Health and Developmental Services.

| <b>Table 80. Expenditures for Non-state-operated ICFs/IDD by SFY</b> |                      |                    |                      |                    |                    |                        |
|--|----------------------|--------------------|----------------------|--------------------|--------------------|------------------------|
| <b>State Fiscal Year</b>   | <b>Number Served</b> | <b>State Funds</b> | <b>Federal Funds</b> | <b>Other Funds</b> | <b>Total Funds</b> | <b>Per Capita Cost</b> |
| 2010   | 391                  | \$20,657,952       | \$33,124,793         | \$0                | \$53,782,745       | \$137,552              |
| 2011   | 422                  | \$23,902,815       | \$35,424,102         | \$0                | \$59,326,917       | \$140,585              |
| 2012   | 427                  | \$33,003,452       | \$33,003,452         | \$0                | \$66,006,904       | \$154,583              |
| 2013   | 475                  | \$38,719,065       | \$38,719,065         | \$0                | \$77,438,130       | \$163,028              |

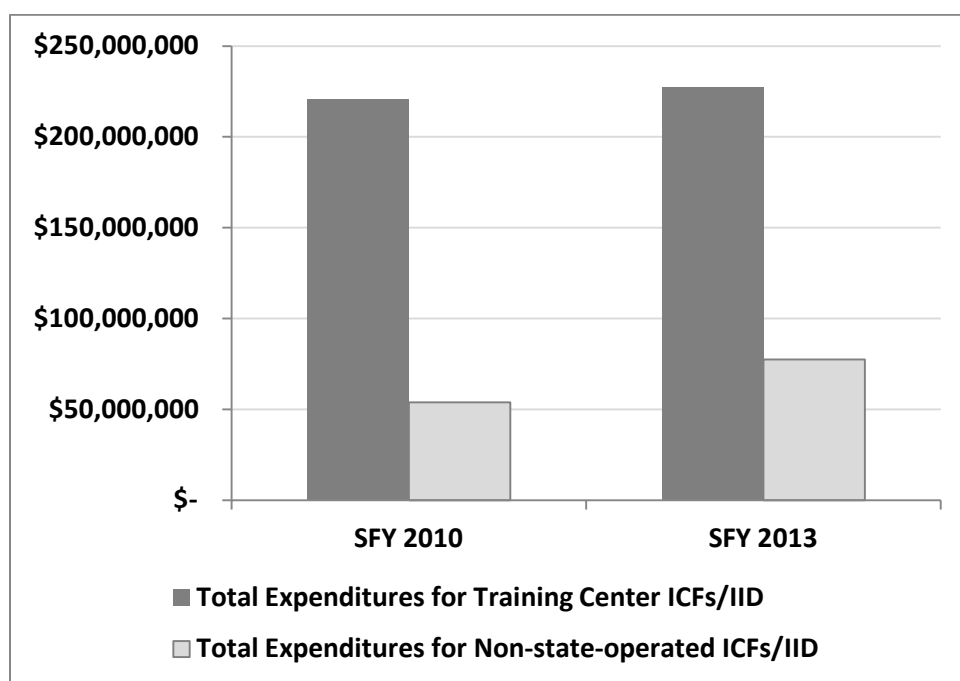
Source: Department of Medical Assistance Services.

**Table 79** and **Table 80** show the rising **costs of providing ICF/IID services** in both training centers and ICFs/IID. But the two types of placements paint a different picture more easily

visualized in **Figure 25** and **Figure 26** below. Despite the significant census reductions, the overall cost of providing Training Center services has remained about the same, up 3.08 percent since SFY 2010. However, the per capita cost of providing these services has increased 42.1 percent between SFYs 2010 and 2013. This is because buildings still need to be maintained and services provided at certain levels to meet standards of care, regardless of the number of individuals residing in the Training Centers.

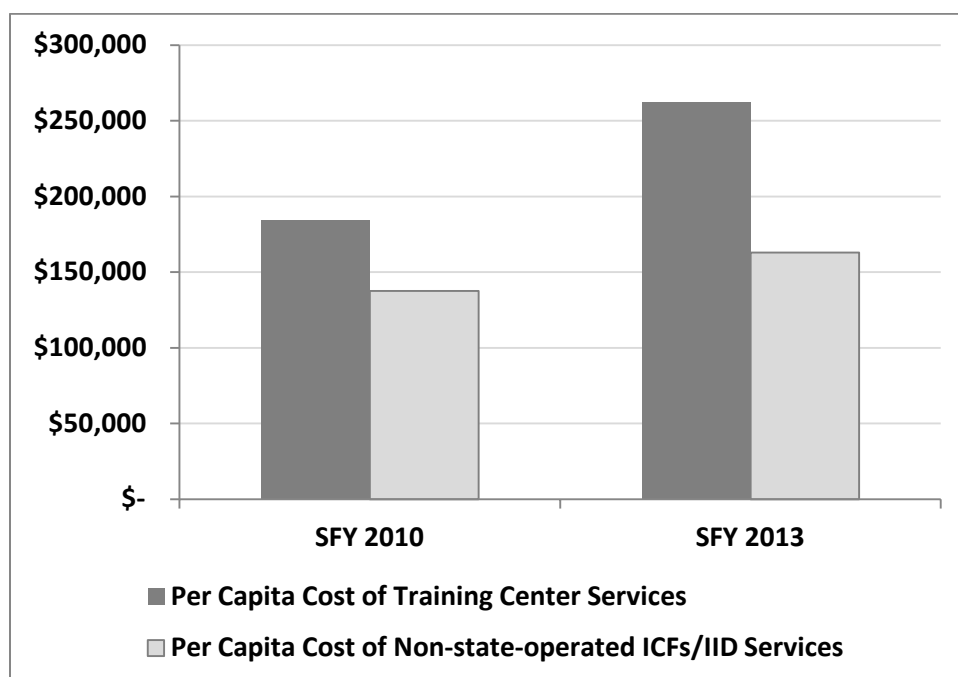
As the census continues to decrease, the per capita cost will continue to increase although it will be mitigated somewhat when buildings and Centers close. As a result of the census reduction and closed units/buildings, actual savings in SFY 2013 was \$5.6 million; **projected savings** for SFY 2014 is \$19.4 million, down from an earlier projection of 23.4 million. Projected savings for SFY 2015 is \$42.1 million and for SFY 2016, \$58.4 million.

**Figure 25. Total Expenditures for Training Centers vs. Non-state-operated ICFs/IID by SFY**



On the other hand, the total expenditures for non-state-operated ICFs/IID services have risen about 44 percent since SFY 2010. This rise is likely due funds provided for the development of new ICFs by the General Assembly prior to the Settlement Agreement as well funds for ICF/IID beds that are being developed as a result of the Agreement. The per capita cost for non-state-operated ICFs/IID has also increased but at a far lower level than the increase in per capita Training Center cost at 18.5 percent.

**Figure 26. Per Capita Cost of Training Center Services vs. Non-state-operated ICFs/IID Services by SFY**



In addition to the operating expenditures detailed above, there have been ongoing, significant costs for Training Center maintenance and renovation, including modifications to meet federal life and safety, and other physical plant standards. As noted earlier, all of the Training Centers have buildings in use that are at least 35 years old, and 2 have even older buildings. SEVTC's 15 residential cottages are new but will, of course, require ongoing maintenance dollars. There will be a continuing need to invest dollars at the remaining 3 Training Centers (following the closure of SVTC) to ensure that the buildings in use meet life and safety codes.

The DBHDS' *2014–2020 Comprehensive State Plan* notes that the Department will implement closure plans that maintain existing property while expending minimum funds. As units and Centers close, significant savings should be realized. In addition, the *2014–2020 Comprehensive State Plan* notes that as Centers close, every effort will be made to sell those properties at market value with those dollars then reinvested into community services and supports. Funding for building maintenance and repair at the Training Centers comes from state General Funds and state Capital Outlay Funds that are appropriated by the General Assembly or obtained, with its approval, through the sale of bonds. **Table 81** lists capital improvement expenditures for renovation and upgrading of residential areas and the physical plant at each of the State's Training Centers in SFYs 2010 through 2013.

| Table 81. Capital Improvement Expenditures at Training Centers by SFY |             |              |              |             |
|---|-------------|--------------|--------------|-------------|
| Training Center   | 2010        | 2011         | 2012         | 2013        |
| Central (CVTC)  | \$1,985,554 | \$4,231,489  | \$6,808,699  | \$3,609,115 |
| Northern (NVTC)   | \$0         | \$2,539,312  | \$1,862,544  | \$629,671   |
| Southeastern (SEVTC)  | \$170,726   | \$7,576,015  | \$14,216,493 | \$139,653   |
| Southside (SVTC)  | \$0         | \$2,463,532  | \$574,091    | \$1,020,229 |
| Southwestern (SWVTC)  | \$1,727,456 | \$1,111,826  | \$332,661    | \$1,075,429 |
| Total   | \$3,883,736 | \$17,922,174 | \$23,794,488 | \$6,474,097 |

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

The amounts shown above for Central Virginia Training Center (CVTC) and Southeastern Virginia Training Center (SEVTC) in SFY 2010 are the expenditures from the General Assembly's 2009 appropriation of \$24.5 million for extensive renovations to CVTC and \$23 million for building a replacement, 75-bed facility for SEVTC. A total of \$7,492,518 in SFY 2011 and \$14,064,128 in SFY 2012 were related to the construction of the new SEVTC. All of the remaining expenditures were for capital maintenance.

In addition to funding for their residential services and capital outlays, the Training Centers receive designated funds to operate their outpatient **Regional Community Support Centers (RSCS)**. Funding for the RSCS at Northern Virginia Training was first established in January of 1996 as \$350,000 per year. Each of the 4 remaining Training Centers listed above was appropriated \$200,000 per year from SFYs 2009 through 2012. As noted earlier, the model of locating the community medical services at the Training Centers is being phased out. For more information on the RCSCs, see the **Health Care** chapter of this *Assessment*.

## 5. Monitoring and Evaluation of ICF/IID Services

Regulations and processes involving monitoring and certification of ICFs/IID and nursing facilities follow the same processes. To avoid duplication, information regarding these processes, including Virginia Department of Health certification and monitoring is included only once, in the **Monitoring and Evaluation of ICFs/IID and Nursing Facilities** section of this chapter. This section focuses on the specific responsibilities related to ICFs/IID by the **Department of Behavioral Health and Developmental Services (DBHDS)**, the **Office of the Inspector General for BHDS (OIG-BHDS)**, and the **Independent Reviewer** for the Department of Justice Settlement Agreement. The role of the protection and advocacy system, the **disAbility Law Center of Virginia**, formerly the Virginia Office for Protection and Advocacy (VOPA), is also briefly discussed.

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

Pursuant to Code of Virginia § 37.2-405, DBHDS is responsible for licensing community intermediate care facilities for individuals with intellectual disabilities (ICFs/IID) and has oversight responsibilities for the programmatic, financial, and administrative activities of the State's five Training Centers. It also licenses private providers of community behavioral health, intellectual disability, and substance abuse services. The State's **Training Centers** are certified by the Virginia Department of Health (VDH) for Medicare and Medicaid but are not licensed by VDH or DBHDS. (See the **Monitoring and Evaluation of ICFs/IID and Nursing Facilities** section of this chapter below.)

The **DBHDS Office of Licensing** ensures that new, non-state-operated ICFs/IID comply with licensing regulations, policies, and procedures; that existing ICFs/IID maintain compliance; and that child protective services reference checks, as well as criminal and central registry background checks, are conducted for all staff of all providers licensed by DBHDS. Office of Licensing staff processes license renewals as well as written Service Modification Applications that must be submitted 30 to 60 days before a provider adds or changes either a service within a program or a program location. As of January 2013, information provided on the DBHDS licensure page of its website did not indicate that any non-state-operated ICF/IID had a provisional license. Information on revoked licenses and/or licensing violations was not available.

The Code of Virginia (§ 37.2-400) also charges DBHDS with ensuring the protection of human and civil rights and the provision of care consistent with human dignity for every person served by the Training Centers, non-state-operated ICFs/IID, and community programs that it operates, funds, or licenses, excluding those operated by the Department of Corrections. The **DBHDS Office of Human Rights** develops and monitors compliance with the human rights regulations (12 VAC 34-115-10) adopted and implemented by the State Board for Behavioral Health and Developmental Services.

Provisions addressed by the human rights regulations include, but are not limited to: protection from neglect, abuse, and exploitation; a nutritionally adequate diet; safe and sanitary housing; participation in non-therapeutic labor; attendance or nonattendance at religious services; use of telephones; the availability of suitable clothing; and possession of money and valuables. Most importantly, the regulations address an individual's right to participate in decisions about his or her treatment and the due process procedures to be followed when an individual with a disability may not be able to make an informed decision without support.

Complaints about human rights violations are reviewed by **Local Human Rights Committees (LHRCs)** that serve specific regions of the state, and appeals are reviewed by the **State Human Rights Committee**. LHRCs also review and approve plans for human rights protections by license applicants and by institutions or programs renewing their licenses. For more information on human rights processes, including how to file a complaint, see <http://www.dbhds.virginia.gov/OHR-default.htm>.



As one of its responsibilities, the State **Board for Behavioral Health and Developmental Services** (BHDS) adopts and implements regulations that require the public and private facilities and programs licensed or funded by DBHDS to supply non-privileged information and statistical data to designated offices in the Department. This data is specific to:

- the results of investigations of abuse or neglect,
- deaths and serious injuries,
- instances of seclusion and restraint, including the duration, type, and rationale for use per person, and
- findings by the DBHDS Office of Human Rights or by State or Local Human Rights Committees of any human rights violations or abuse or neglect of individuals with disabilities.

For more information on the responsibilities of the State Board, see <http://www.dbhds.virginia.gov/adm-StateBoardDefault.htm>.

The State Human Rights Committee's *2012 Annual Report on the Status of the Human Rights System* (<http://www.dbhds.virginia.gov/documents/reports/OHR-SHRC2012AnnualReport.pdf>) was presented in July of 2013. **Table 82** shows the number of abuse and neglect allegations and those that were substantiated from calendar years 2008 through 2012.

| <b>Table 82. Abuse and Neglect Allegations at Training Centers and Number Substantiated by SFY</b> |                |               |                |                |               |
|--|----------------|---------------|----------------|----------------|---------------|
| <b>Training Centers</b>  | <b>2008</b>    | <b>2009</b>   | <b>2010</b>    | <b>2011</b>    | <b>2012</b>   |
| CVTC   | 98/36          | 87/21         | 46/15          | 56/18          | 51/21         |
| NVTC   | 12/3           | 19/11         | 19/11          | 24/16          | 11/5          |
| SEVTC  | 19/10          | 14/7          | 13/5           | 25/13          | 6/5           |
| SVTC   | 75/34          | 60/36         | 92/57          | 123/110        | 58/25         |
| SWVTC  | 72/19          | 57/11         | 38/17          | 56/22          | 36/10         |
| <b>Total</b>   | <b>276/102</b> | <b>237/86</b> | <b>208/105</b> | <b>284/179</b> | <b>162/66</b> |
| <b>Percent Substantiated</b>   | <b>37%</b>     | <b>36.3%</b>  | <b>50.5%</b>   | <b>63%</b>     | <b>40.7%</b>  |

Source: The State Human Rights Committee *2012 Annual Report on the Status of the Human Rights System*.

As the figures show, the number of abuse and neglect allegations reached a high in 2011—the year that also had the highest level of substantiated allegations at about two-thirds. It is important not to draw too many conclusions with respect to the decrease in allegations in 2012 as this coincides with significant census reduction efforts due to the DOJ Settlement

Agreement. The report also notes that in 2011, SVTC had multiple findings of neglect due to staff sleeping, lack of care, and exploitations. It further noted that these problems had been resolved. In general, the rate of founded allegations in the Training Centers is much higher than the founded rate for complaints in all state-operated facilities (Training Centers, state mental health facilities, and the Virginia Center for Behavioral Rehabilitation, which houses individuals who have been civilly convicted for sexual offenses). Substantiated allegations for all facilities reached a high of 34 percent in 2011.

The *2013 Annual Report of the Status of the Human Rights System* had not yet been published at the time of this report. The DBHDS *Fiscal Year 2013 Annual Report (Item 314.K)* noted that there were 473 allegations of abuse, neglect, or exploitation filed in state facilities and that 139 were determined to be founded. However, the report did not separate out the Training Centers from mental health facilities.

**Table 83** shows the number of human rights complaints processed formally and informally from calendar years 2008 through 2012. The *2012 Annual Report on the Human Rights System* notes that the vast majority of the complaints are resolved at the facility director's level or below. There were 7 human rights complaints heard on appeal at the local level and 5 on the state level, but it is not known whether these were complaints filed about Training Centers.

| Table 83. Human Rights Complaints at Training Centers by SFY |      |      |      |      |      |
|--|------|------|------|------|------|
| Training Centers   | 2008 | 2009 | 2010 | 2011 | 2012 |
| CVTC   | 3    | 4    | 60   | 12   | 7    |
| NVTC   | 4    | 0    | 1    | 9    | 1    |
| SEVTC  | 2    | 7    | 2    | 3    | 4    |
| SVTC   | 12   | 16   | 2    | 3    | 1    |
| SWVTC  | 22   | 7    | 11   | 3    | 20   |
| Total  | 43   | 34   | 76   | 30   | 33   |

Source: The State Human Rights Committee, *2012 Annual Report on the Status of the Human Rights System*.

As part of work being undertaken as a result of the **DOJ Settlement Agreement**, significant improvements to oversight and accountability are underway, but much work remains. According to the DBHDS March 2012 *Creating Opportunities Implementation Report*, all Training Centers (as well as community services boards and other community providers) are required to implement risk management and quality improvement processes, including establishing uniform risk triggers and thresholds. **Regional Quality Councils (RQC)** meet quarterly and assess relevant data, identify trends, and recommend responsive action. Advocacy organizations are not included on the RQCs, although there are reportedly parent representatives.

Discharge process standardization began prior to Court approval of the Settlement Agreement. As noted earlier, five community integration managers were hired to assist with the discharge process at each Training Center. In its *Fiscal Year 2012 Annual Report to the Governor and Chairs of the Senate Finance and House Appropriations Committees, Item 314K* (<http://www.dbhds.virginia.gov/documents/RD360.pdf>) and the July 31, 2013 *DOJ Implementation Update to the Governor and Chairs of Senate Finance and House Appropriations Committee*, DBHDS reported that all Training Center residents had discharge plans and that pre-move and post-discharge monitoring processes had been established. These processes include the following:

- **Training Center:** Visits at 3, 10, and 17 days after discharge; contact with the individual's authorized representative (AR) to determine satisfaction; 2 visits in the home and 1 at day services.
- **Licensing:** Enhanced licensing visit guidelines (within 2 months of move). The enhanced licensing protocol can be found at <http://www.dbhds.virginia.gov/documents/Enhanced%20Licensing%20Visit%20Protocol%20-%20website%20version.pdf>.
- **Human rights:** Visit within 1 month of move.
- **CSB case manager:** Visits on day 7 and monthly visits for 12 months following enhanced case management guidelines.
- **Community resource consultant:** Visits within 7-90 days of move to meet with individual in their home setting, review the Individual Support Plan (ISP) and provide technical assistance if needed.

An education and training plan was developed and implemented on **Person-Centered Thinking**, terms of the Settlement Agreement, the discharge process, and community options. Training is provided to all new Training Center employees and is required for all employees each January. The July 31, 2013 *DOJ Implementation Update* notes that all discharge plans are updated within 30 days of discharge, and the DBHDS Central Office receives monthly reports regarding individuals who have moved and the types of placements.

The January 2014 *DOJ Implementation Plan Update, Item 314.V.I.* to the Governor and Chairs of the Senate Finance and House Appropriations Committee, (<http://www.dbhds.virginia.gov/settlement/Item%20314.O.%20Quarterly%20Report%201-10-14.pdf>) further described the discharge process and the work done with individuals, families, and providers to ensure that "each essential support need" is met prior to the individual's transition from a Training Center into the community. DBHDS regularly contacts families and authorized representatives (ARs) to assess receptivity to long-term placement in the community. A community integration preference score is assigned and, as of November 18, 2013, it was reported that:

- 19 percent of individuals were in the process of moving, actively considering community options, or will be seeking options in the future;
- 27 percent were willing to participate in the discharge process but wanted more information;
- 30 percent were not reachable or non-responsive; and
- 25 percent were not willing to participate in the discharge process at the current time.

DBHDS noted that some of those saying “no” were not saying no to the discharge process but were indicating “not yet.” These numbers are fluid and updated quarterly.

DBHDS has examined **provider capacity** across all regions. According to the January 2014 *DOJ Implementation Update* and the *2014 Update to the Training Center Closure Plan*, the areas that have the most limited capacity are the southwestern region, which lacks capacity in the area of licensed congregate care and other key services, such as behavioral supports, that will slow downsizing progress at SWVTC. Northern Virginia is the principal area in which there is limited capacity for residential, day support, and employment services due to limitations of the Medicaid Home and Community Based Waivers, inadequate waiver rates, the high cost of delivering services, and high developmental costs. The factors, according to DBHDS, are keeping providers from expanding services to individuals at NVTC who want to move into the community and will hamper progress in meeting discharge targets without intervention.

To help with this situation, the Department of Medical Assistance Services’ (DMAS’) SFY 2014 budget includes \$7.8 million for **exceptional** Medicaid ID Waiver rates. This will fund a 25-percent increase for ID Waiver congregate residential services to meet the needs of individuals with significant medical or behavioral challenges. The rates, approved by the 2013 General Assembly, will enable Training Center residents with complex needs to move to quality community settings. It also will enable individuals with complex needs who are already living in the community to receive services from providers with more expertise. The rates are required to be approved by the Centers for Medicare and Medicaid Services (CMS) and by DBHDS. Approval was initially expected in December of 2013 but has been delayed. Once approved, emergency regulations will need to be issued to implement the rates.

**Bridge funding** is now available to pay the providers that serve individuals with complex needs who are transitioning from SVTC and NVTC (the first two Training Centers slated to close). This is a repurposing of state General Funds to provide the necessary additional support dollars. In October of 2013, Virginia approved limited funding to support discharge planning and the moving process to relocate these individuals to their own homes or to a provider home licensed by the DBHDS. While approved in October of 2013, the funds were not available until 2014 but are retroactive.

According to the DBHDS *Bridge Fund Guidelines*, bridge funding cannot be used to purchase goods or services that can be funded through Medicaid or any other means at the time that funding is provided. It also cannot be used to supplement transitional services that are

currently available through the Money Follows the Person (MFP) Program or the Intellectual Disability Waiver. Bridge funding cannot be used for ICFs/IID. Providers who receive bridge funding must agree to support the individual for whom the funding is sought for a minimum of 12 months unless the individual chooses another provider or the provider is unable to meet the individual's needs. The guidelines are at <http://www.dbhds.virginia.gov/documents/ODS/Bridge%20Funding%20Final%20Guidelines%202-6-14.pdf>.

Examples of possible use of **bridge funding pre-discharge** include the following:

- home and vehicle modifications, assistive technology, and durable medical equipment; and
- specialized staff training to address the unique needs of the transitioning individual.

Acceptable **post-discharge bridge funding** examples include the following:

- Room and board subsidies for verified room and board costs that exceed the amount available through other sources [such as Supplemental Security Income (SSI), other social security programs, etc.] for individuals living in DBHDS-licensed provider homes or the individual's own home. Room and board cannot be covered by Medicaid according to federal rules; the use of state bridge funding for room and board subsidy will continue only until the rate study being conducted by the Human Services Research Institute (HSRI) for DBHDS is complete and new rates are approved.

According to DBHDS, the process is as follows: A provider who is serving individuals transitioning from NVTC and/or SVTC will provide DBHDS with verification of their monthly mortgage and/or rent. They will subtract from that monthly cost, the amount of money that is paid by the residents (i.e., the portion of each resident's SSI payments or other available funds that can be charged to them.) The rate subsidy the providers receive is the verified difference. The intent of using bridge funding for room and board subsidies is to increase residential service capacity, particularly for individuals with ID in northern Virginia.

- General/overnight supervision for individuals receiving congregate residential supports (currently not allowable under state Medicaid regulations).
- Off-site supervision to support individuals who receive congregate residential supports and may require out-of-home care such as hospitalizations.
- Necessary nutritional supplements and special foods that do not meet the criteria for sole source of nutrition as required under state Medicaid rules.
- Infrastructure grants to help DBHDS-licensed residential providers strengthen their internal processes and programs to avoid or mitigate the risk of harm to individuals.

- Extended medical supports that can be used for private-duty nursing for continuous nursing needs (not currently an ID Waiver service) and for Applied Behavioral Analysis (ABA) for individuals whose behavioral needs require direct therapy or intervention. ABA is not currently an ID Waiver service nor a component of the crisis stabilization services covered by ID Waivers.
- Infrastructure grants for employment, prevocational and day support programs. These funds would be used to (1) deliver or enhance training provided to direct support professionals (DSP); (2) create continuous quality improvement plans; and (3) develop community integration initiatives to implement new federal Home and Community Based Waiver requirements; and (4) establish mentoring teams to support DSPs in identifying and addressing risk of harm; and (5) upgrade assistive technologies used and needed by multiple individuals.

It will be critical to closely monitor the use of bridge funding, particularly with respect to room and board subsidies, and to evaluate its impacts, both on provider service capacity and on the individuals served using bridge funds pre- and/or post-discharge. Appropriate usage and the ability to prevent and identify fraud will be essential.

In SFY 2012, the DBHDS began developing a new **quality improvement process** that focused on the state facilities and community programs. At that time, it deferred implementation of quality measures for developmental services in light of the DOJ Settlement Agreement as the Agreement itself contains extensive data reporting and quality improvement requirements. Data are required to be collected in the areas of:

- safety/freedom from harm;
- physical, behavioral health and well being;
- avoiding crises, stability;
- choice and self-determination;
- community inclusion;
- access to services; and
- provider capacity.

Activities undertaken to address quality improvements include work done by project teams that address the following areas: case management, provider risk management, incident reporting, mortality review, licensing, and quality service reviews. For more detail, refer to the *DOJ Stakeholders Group—Quality Management Project Team Updates*, from April 17, 2013 at <http://www.dbhds.virginia.gov/settlement/VII%20Quality-RM%204-17-13.pdf>.

The initial focus for developmental services has been case management services and information collected by case managers as well as provider risk management. This has included the development of “risk triggers” for facility, CSB, and community private providers and the

process for reviewing the trigger and threshold data. The review process will be executed by the Regional Quality Councils established under the Settlement Agreement.

### **Independent Reviewer on Compliance with the DOJ Settlement Agreement**

Since the 2011 edition of this *Assessment*, the **Independent Reviewer** (referred to hereafter as the Reviewer) has begun working to verify and report on Virginia's implementation of the Department of Justice (DOJ) Settlement Agreement. The Reviewer is responsible for factual investigation and verification of data and documentation provided by DBHDS. The Reviewer submits reports to the DOJ every six months. At the time of this assessment, all of the Reviewer's reports indicate that the Commonwealth has made a good faith effort to implement the Agreement and to be "substantially in compliance" with a number of provisions and "not in compliance" with a lesser number of requirements. There are also requirements for which the Reviewer has not yet made a determination on compliance. These reports can be found at <http://www.dbhds.virginia.gov/settlement.htm>.

Each of the Reviewer's reports is an update on progress made in various areas. The third report, *Report of the Independent Reviewer on Compliance with the Settlement Agreement in United States v. Commonwealth of Virginia* was issued in December of 2013 and included a number of items related to ICFs/IID and nursing facilities. (See the **Nursing Facilities** section of this chapter below for the latter.) Other chapters of this *Assessment* include Reviewer comments on those respective areas (e.g., **Community Living Supports**, **Community Housing**, **Employment**, etc.). The report is lengthy, so only specific highlights are included below. The complete report can be found at <http://www.dbhds.virginia.gov/settlement/131206%20Report%20of%20the%20Independent%20Reviewer%203.12CV059.pdf>.

The Reviewer and his expert consultants used a monitoring questionnaire to obtain information on **48 individuals** who had moved from Southside Virginia Training Center and Northern Virginia Training Center in the last two quarters of state fiscal year (SFY) 2013. Two-person teams then reviewed a random sample (noted to be statistically significant) of 28 individuals, 22 from Southside Virginia Training Center (SVTC) and 6 from Northern Virginia Training Center (NVTC). These facilities were chosen because they are the first 2 scheduled to close with SVTC transitions well underway. In addition to noting that the Commonwealth has created and implemented a detailed **discharge planning and transition process** for Training Center residents, the Reviewer found a number of **positive outcomes** related to the individuals who had transitioned. These included but were not limited to:

- Individuals who had transitioned had improved behavior and health.
- They had adjusted to their new homes and lived in homes that were attractive, in appealing neighborhoods, and close to resources.
- Individuals were clean, well kempt, and had properly fitted clothing.

- Authorized representatives (ARs) who had been reluctant to move their loved one had visited frequently, were satisfied with the placements, and noted positive changes.
- The Commonwealth has made available some increased resources to assist individuals with complex needs who are moving from SVTC and NVTC. As noted above, approval on the exceptional rate is pending with the federal Centers for Medicare and Medicaid. At the time of the Reviewer's report, bridge funding was noted as an additional resource but was not available yet. Those funds did become available in early 2014 as noted previously.

A representative of the Virginia Network of Private Providers (VNPP), in testifying before a subcommittee of the 2014 General Assembly, provided her organization's perspective that the exceptional rates and bridge funding were inadequate to resolve capacity issues critical to Settlement Agreement implementation. Other advocacy organization representatives also testified with respect to the need for rate increases and significant, additional resources in the community.

The Independent Reviewer also had less positive findings, noted to be "**areas of concern**" with respect to the sample of individuals who had left the Training Centers. He found that the range of **integrated housing options** available to individuals had not changed, although it was noted that the Commonwealth was taking important steps to build capacity in the future. He noted that in his judgment,

*the greatest barrier to the Commonwealth achieving the goals of the Agreement is providing a sufficient number and variety of integrated programs that promote skill development and community participation with the following specific areas of concern:*

- **Program options** (including employment options) that offered "most integrated settings" were not available to many individuals. The Reviewer found that the Personal Support Teams (PSTs) described some community options to individuals and their authorized representatives (ARs) but did not describe supports and services that met needs and offered the most integrated setting. The Reviewer notes that this was reportedly because such services and supports were not available. He further noted that documentation did not indicate that steps were undertaken to resolve barriers.
- The individual's support plans and daily routines did not support **skill development** to increase independence or participation in the community. The Reviewer noted that Individual Services Plans (ISPs) did not usually include a description of the individual's skills or what skills or community involvement were being taught or supported, reflecting a "lack of adequate attention to habilitation." The Reviewer reported that there did not appear to be a "core program expectation" to help individuals learn skills and increase their ability to participate in community life. It was also noted that community trips did not appear to be skill development oriented. In addition, ISPs did



not reflect the supports needed for individuals to work, even when the individual had previously worked at the Training Center or expressed a desire to work.

- The Reviewer found that the community residential and day services offered to individuals in the sample he studied were **limited to congregate options** (group homes and day support centers). He found that Personal Support Teams (PSTs) had not consistently described available and appropriate program options in the most integrated setting that would meet the needs of the individuals. An example provided by the reviewer was that residential options with four or fewer beds, subsidized independent housing options, supported employment, and integrated day opportunities were not described or offered and were almost always unavailable. The reviewer further found that **barriers were often not identified**, and when they were, steps were not taken to address the barriers.
- Community activities were primarily group based, and none of the individuals sampled had **daily, integrated activities**.
- The Independent Reviewer also addressed the requirement in the DOJ Settlement Agreement for the **transition of youths** (under age 22) who are in nursing facilities and large ICFs/IID. As noted in an earlier, 25 children were expected to transition in SFY 2013, but only 11 did so. All of the children who transitioned had intellectual disability (ID), and it was noted that they did not leave as a result of the Commonwealth's initiative. The Reviewer deferred a determination on whether the Commonwealth was in compliance with the requirements of the Agreement.

Other positive findings and areas of concern as set forth by the Reviewer can be found in these reports. The fourth report of the Independent Reviewer was released on June 6, 2014. That report focuses how the Commonwealth is addressing services to individuals who have transitioned or are in the process of transitioning from institutional settings into the community, including but not limited to: crisis services, licensing community living options, integrated employment and day activities, and services for individuals with behavioral challenges. It can be found at <http://www.dbhds.virginia.gov/settlement/ODS-140606IRReport.pdf>.

### **Office of the State Inspector General (OSIG)**

On April 12, 2011, then Governor Bob McDonnell signed **government reform legislation** that included the establishment of a State Inspector General to investigate waste and inefficiencies in state government. The code change (2.2-307 et seq.) was a result of recommendations from the Governor's Commission on Government Reform (<http://www.reform.virginia.gov/>). The law established the **OSIG** to be headed by a State Inspector General to:

- investigate complaints alleging fraud, waste, abuse, or corruption by a state agency or non-state agency or the officers and employees thereof, and

- examine the management and operation of state agencies.

In addition to other provisions, the code change consolidated the Offices of Inspector General of the Departments of Behavioral Health and Developmental Services, Corrections, Juvenile Justice, and Transportation, and the Department of the State Internal Auditor into this new office.

Prior to and since the consolidation, the purpose of the **OIG for Behavioral Health and Developmental Services** (OIG-BHDS) is to provide additional oversight and monitoring for facilities or programs licensed or operated by DBHDS, primarily involving quality and standards of care issues. The **OIG-BHDS** resigned from his position in March of 2014. Originally authorized under Code of Virginia § 37.2-424, the mandates for the **OIG-BHDS** were moved to the new code section at § 2.2-309.1. As noted by the former state **OIG** in his *SFY 2013 Annual Report to the Governor and General Assembly of Virginia* ([http://osig.virginia.gov/media/2408/annualreport2013\\_20130829.pdf](http://osig.virginia.gov/media/2408/annualreport2013_20130829.pdf)), the BHDS division is exclusively responsible for:

- conducting annual, unannounced inspections of the 16 state facilities operated by DBHDS;
- inspecting, monitoring and reviewing the quality of services at the state-operated facilities and the 814 providers of behavioral health and developmental services;
- assuring that the General Assembly and Joint Commission on Health Care are fully and currently informed of significant problems; and
- investigating specific complaints of abuse, neglect, or inadequate care.

Reports on each **OIG** onsite visit, study, or investigation are published on the **OSIG** website. Reports from the **OIG-BHDS** published prior to 2013 can be found at <http://www.oig.virginia.gov>. Those published in and after 2013 are located at <http://www.osig.virginia.gov>. Reports include findings and recommendations for service or system improvements along with responses from the facilities or programs identifying the actions that they have taken or will be taking to address each **OIG** finding.

In its September 2010 semi-annual report, the **OIG-BHDS** recommended that **DBHDS** complete work in the areas of emergency services, critical incident reporting, determining readiness for discharge, and educating family members and authorized representatives of individuals residing in state Training Centers about community options. See <http://www.oig.virginia.gov/documents/SAR-4-1-10-9-30-10.pdf>). This report also provided the first summary of **findings related to the US Department of Justice (DOJ) investigation** that resulted in the Settlement Agreement. The **OIG-BHDS** has been monitoring **DBHDS** activities to implement the Settlement Agreement. (More information is included in the **Community Living Supports** chapter of this *Assessment*.)

The *SFY 2013 Annual Report to the Governor and General Assembly of Virginia* by the state OIG ([http://osig.virginia.gov/reports/docs/AnnualReport2013\\_20130829.pdf](http://osig.virginia.gov/reports/docs/AnnualReport2013_20130829.pdf)) reported on the former OIG-BHDS activities during SFY 2013. During that year, the OIG reviewed 680 critical incidents, 11 abuse/neglect cases, and 74 deaths. The report included information on deficiencies of the behavioral health and developmental disabilities system that remain outstanding from previous reports published by the OIG-BHDS. Recommendations were made with respect to a number of areas. Those related, at least in part, to individuals with ID/DD are noted below.

Recommendations include the need for:

- improved performance measures and accountability, including integration into the DBHDS strategic planning process;
- development of quarterly updates (that are compliant with the Health Insurance Portability and Accountability Act) summarizing the number of individuals and issues related to the Extraordinary Barriers List (EBL) at each state facility to document the number and type of issues related to the ability of residents to successfully transition from facility to community; and
- evaluation of supported housing requirements needed for each region to reduce the Extraordinary Barriers List with a report of findings to the commissioner and OIG by January of 2013.

#### **disAbility Law Center of Virginia (dLCV)**

As the Commonwealth's protection and advocacy system, **dLCV**, formerly the Virginia Office for Protection and Advocacy (VOPA) serves as an additional oversight entity for the State's facilities and programs for individuals with disabilities. Authorization for its activities is provided by various federal statutes and by the Code of Virginia (51.5-39.2) as

*[T]he agency to protect and advocate for the rights of persons with mental, cognitive, sensory, physical, or other disabilities and to receive federal funds on behalf of the Commonwealth of Virginia to implement the federal Protection and Advocacy for Individuals with Mental Illness Act, the federal Developmental Disabilities Assistance and Bill of Rights Act, the federal Rehabilitation Act, the Virginians with Disabilities Act and such other related programs as may be established by state and federal law.*

In carrying out its responsibilities to support and defend the rights of individuals with disabilities, the Code of Virginia § 51.5-39.4 gives it the authority to:

- Resolve complaints concerning violations of individuals' rights when related to their disabilities, and
- Access facilities, institutions, providers, and records of these facilities, institutions, and providers consistent with various sections of the Code of Virginia.

With regards to the latter, dLCV is specifically authorized to access records of an individual with a disability

*who by reason of his mental or physical condition is unable to authorize the Office to have such access; (2) who does not have a legal guardian or for whom the Commonwealth, or designee of the Commonwealth, is the legal guardian; and (3) with respect to whom a complaint has been received by the Office or with respect to whom there is probable cause to believe that such person has been subjected to abuse or neglect.*

Directors of all state facilities operated by the Department of Behavioral Health and Developmental Services (DBHDS) are required by the Code of Virginia § 37.2-709 to send information about critical incidents or deaths of clients to dLCV in writing within 48 hours of their occurrence. A critical incident is defined as being “serious bodily injury or loss of consciousness requiring medical treatment.” dLCV staff reviews these reports to identify data trends as well as possible instances of abuse and neglect and conducts follow-up investigations as the office deems appropriate. dLCV also regularly monitors facility conditions and follows up on injuries to individuals served at the state’s Training Centers and other institutions. When violations are found, dLCV first attempts to resolve complaints through administrative remedies but has the authority to pursue legal or other alternative remedies to protect individuals’ rights.

dLCV posts its investigation reports on its website. The most recent report posted related to care and conditions in Training Centers was under the auspices of VOPA, dLCV’s predecessor, and addressed **dental care** in the Training Centers. VOPA had the following findings described in detail in their report, which also referenced an investigation by the Virginia Department of Health Professions:

- The Training Centers failed to comply with the accepted standard of care for the provision of daily dental care.
- The Training Centers failed to comply with the accepted standard of care applying to the practice of dentistry.

A number of specific recommendations were included in the report. For more information on the findings and recommendations, see <http://disabilitylawva.org/wp-content/uploads/2013/06/dental-care-investigation-report-March-2012.pdf>.

## C. Nursing Facilities

Referred to as a “nursing facility” in this *Assessment*, the Code of Virginia (§ 32.1-123) defines a **nursing home** as

*any facility or any identifiable component of any facility licensed pursuant to this article in which the primary function is the provision, on a continuing basis, of nursing services and health-related services for the treatment and inpatient care*

*of two or more nonrelated individuals, including facilities known by varying nomenclature or designation such as convalescent homes, skilled nursing facilities or skilled care facilities, intermediate care facilities, extended care facilities and nursing or nursing care facilities.*

It further defines a **certified nursing facility** as

*any skilled nursing facility, skilled care facility, intermediate care facility, nursing or nursing care facility, or nursing home, whether freestanding or a portion of a freestanding medical care facility, that is certified as a Medicare or Medicaid provider, or both*

under Title XVIII of the national Social Security Act (42 USC 1395). Entities exempted from this definition and subsequent provisions of the Code of Virginia (§ 32.1-124 through 136) include institutions licensed by DBHDS, institutions or portions thereof licensed by the State Board of Social Services, nursing facilities owned or operated by the federal government, and nursing facilities owned or operated by the State unless it is certified as a nursing facility.

As of October 1, 2010, to ensure that individuals reside in the “least restrictive environment,” CMS required new elements in the comprehensive assessment of each potential or current nursing facility resident that occurs at admission, annually, and whenever there is a significant change in a resident’s status. This **Return to Community Referral Assessment** requirement is described in more detail in the **Eligibility for Nursing Facilities** section of this chapter below.

In a federally initiated effort to have states shift the balance of their systems from institutional to community-based services, the Commonwealth received \$28 million in federal funding beginning in July of 2008 for a **Money Follows the Person (MFP)** demonstration project. With these funds, Virginia planned to facilitate the transition of 1,041 individuals back to community settings of their choice during state fiscal years 2009 through 2011. These individuals are elderly (325) or have intellectual or other developmental disabilities (358 each) and are currently receiving services in institutions, such as nursing facilities, ICFs/IID, and long-stay hospitals. To do so, the State’s MFP project enriched services provided under several of the Medicaid Home and Community Based Services (HCBS) Waivers. Through trained staff at Transition Coordination agencies, MFP developed and implemented transition plans that supported individuals’ housing and transportation needs.

The Kaiser Family Foundation’s Kaiser Commission on Medicaid and the Uninsured issued its most recent MFP Snapshot in February of 2013. According to its report, *Money Follows the Person: A 2012 Survey of Transitions and Costs*, 25,000 individuals nationwide have transitioned back to the community as of August of 2012, and 6,400 transitions were in progress at that time. Three states, Ohio, Texas, and Washington, made up nearly half (43 percent) of all transitions. As noted in the Kaiser Commission’s MFP: Snapshots for 2010, 2011, and 2012, start-ups under the program were slow, but states have increased transitions significantly since

2010. The report is available at  
<http://kaiserfamilyfoundation.files.wordpress.com/2013/02/8142-03.pdf>.

Originally a 4-year initiative, MFP was extended until 2016 under the Affordable Care Act (ACA). To strengthen the program and address the issues being faced by Virginia and other states, CMS made program changes and approved additional funding effective June of 2011 through 2016. All MFP participants must still meet eligibility criteria for Medicaid HCBS Waivers at the time of discharge; however, the original MFP eligibility requirement that an individual be a resident in an institution for 6 consecutive months was reduced to 3 months. Additional administrative funding received by Virginia was used to add several new positions at DMAS and the Department of Behavioral Health and Developmental Services (DBHDS) to focus on discharge planning, housing, and transitions.

Virginia was much like other states in its slow start up and its number of overall transitions. According to the Department of Medical Assistance Services (DMAS), there have been 696 MFP transition program enrollments and 539 actual transitions between 2008 and 2013<sup>469</sup> individuals made the transition between 2008 and 2012, and an additional 70 people transitioned between January and May of 2013. These individuals moved using the Medicaid Home and Community Based Waiver supports shown in **Table 84**.

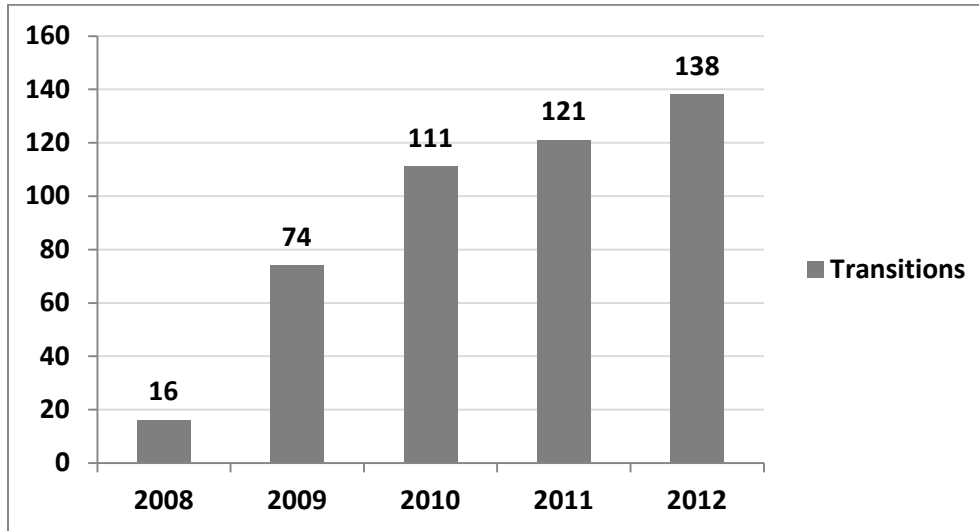
| Table 84. Money Follows the Person Transitions for CYs 2008–2013 |             |           |           |             |             |              |
|--|-------------|-----------|-----------|-------------|-------------|--------------|
| Medicaid Waiver  | EDCD Waiver | ID Waiver | DD Waiver | Tech Waiver | AIDS Waiver | PACE Program |
| Number Transitioning   | 197         | 329       | 7         | 2           | 3           | 1            |

Causes of slow progress included delays in the development and approval of operational protocols, outreach to institutions, and the recruitment and training of transition coordinators. Continuing problems cited by DMAS include the resistance of nursing facilities and other institutions to MFP outreach, a lack of affordable, accessible housing, stressed State resources for necessary activities, and the amount of time needed to arrange appropriate community services. Since the beginning of the program, there also has been a **barrier to securing environmental modifications or assistive technology** that individuals need in order to transition. This has yet to be resolved: *The waiver cannot pay for services until the individual has left the institution; yet, the individual cannot leave the institution until they have the needed modifications*. Funding from the Department of Housing and Community Development for this purpose has been exhausted. A number of interagency meetings have been held to discuss possible solutions, but as of the time of this assessment, no resolution has been achieved. It is unclear how many individuals this affects.

As **Figure 27** shows, transitions have increased slowly but steadily since 2010. Standing at 70 transitions between January and May of 2013, the total for the year should reach or exceed the number of transitions completed in 2012. MFP transitions must be made to a setting of 4 beds or less. The vast majority of MFP transitions (over 75 percent) under the ID Waiver have

been to group homes with a smaller number moving to apartments. For those exiting through the EDCD waiver, the majority have gone to an apartment with slightly fewer moving back to their own homes. The DD Waiver does not allow for transition to a congregate facility.

**Figure 27. Annual MFP Transitions for CYs 2008–2012**



Source: Department of Medical Assistance Services, *Data Updates: Money Follows the Person Program*. Note that this chart represents 460 transitions, not the 469 figure discussed above, which represents an updated figure in a more recent report. A further breakdown to determine in what years the additional 9 transitions took place is not available.

Between 2008 and 2012, the highest number of transitions (111) was in the Central Virginia region, and the majority of these individuals were between 45 and 65 years old. This is consistent with the national average age of 56 years as noted in the Kaiser Commission report referenced above. Most of the Virginians who transitioned during that time period (over 80) had been in an institution for less than 1 year. About 50 individuals were in an institution for 1 to 2 years, and about 25 were in an institution for 6 to 10 years. The range of time spent in an institution prior to discharge was less than 1 year to over 50 years. The 2013 figures (not final at the time of this assessment) provide a different age range. As of May 2013, 55 of 70 individuals who transitioned were between the ages of 22 and 64. Five were under the age of 22, and 10 were over 65. It is positive that there is more participation and transitions are now increasing. However the numbers remain quite low, and the Money Follows the Person program has not met expectations.

The target population of the **Department of Justice Settlement Agreement** sets forth particular requirements for children in NFs and ICFs. The Agreement requires DBHDS and the Department of Medical Assistance Services (DMAS) to target waiver slots for children younger than 22 who reside in NFs and ICFs and want to transition to the community. The Settlement Agreement required 25 children to transition using the Intellectual Disability (ID) waiver, and 15 children using the Developmental Disability (DD) Waiver in SFY 2013. That did not happen. As of

the July 31, 2013 DBHDS, *DOJ Implementation Update to the Governor and Chairs of the Senate Finance and House Appropriations Committee* (Item 315.V.I. of the 2012 Appropriations Act) only 11 children had transitioned. DBHDS and DMAS have been meeting with NFs and ICFs to discuss how to work directly with families. A workgroup that includes The Arc of Virginia, the Virginia Board for People with Disabilities, and Centers for Independent Living was established to assist, but there has not been significant progress. The DOJ Independent Reviewer, in his December 6, 2013 *Report on Compliance with the Settlement Agreement*, found the Commonwealth to be out of compliance with respect to this requirement. For more information, see [http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/RD1612013/\\$file/RD161.pdf](http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/RD1612013/$file/RD161.pdf) and the **Monitoring and Evaluation of ICF/IID Services** section of this *Assessment*.

Around the time that the report was issued, DBHDS staff requested technical assistance from PASRR Technical Assistance Consultants (PTAC) to formulate a new plan to increase the number of children transitioning from NFs and ICFs/IID. A draft implementation plan was submitted in March of 2013. Comment on the plan was solicited and more work has been done on the plan. In his fourth report, the Independent Reviewer notes that the revised plan will

*reportedly include initiatives to prevent the further unnecessary institutionalization of children.*

The Reviewer states that the

*success of the plan will be increased if the range of supports available to individuals transferring from Training Centers is available for children transitioning from nursing facilities. These include Bridge Funds, enhanced rates, 24-hour nursing, customized community programs ... and housing supports.*

See <http://www.dbhds.virginia.gov/settlement/ODS-140606IRReport.pdf>.

## **1. Eligibility for Nursing Facilities**

As detailed in *A Guide for Long-Term Care Services in Virginia* by the Department of Medical Assistance Services (DMAS), admissions to one of these facilities may occur when an individual:

- cannot care for personal needs and requires more care than his or her family or loved ones can or is willing to provide;
- has extensive or complex medical conditions that may be unstable or has the potential for instability;
- has been recommended for nursing facility placement by his or her physician;
- has a medical condition that requires observation and assessment to assure evaluation of needs due to an inability for self-observation or self-evaluation; or
- lacks adequate supports and resources, including environmental adaptation for functional needs, to ensure his or her health and safety.



The guide is available at [http://dmasva.dmas.virginia.gov/Content\\_attachments/ltc/ltc-guide\\_srvcs.pdf](http://dmasva.dmas.virginia.gov/Content_attachments/ltc/ltc-guide_srvcs.pdf).

The federal Centers for Medicare and Medicaid Services (CMS) requires a **Return to Community Referral Assessment** (also referred to as MDS Section Q) that includes a specific question about whether the individual is interested in speaking with someone about the possibility of moving out of the nursing facility and back into the community. If the individual requests such information, CMS guidelines require the nursing facility to initiate care planning to provide it. This does not commit the individual to a move but guarantees that he or she will receive information about the options and process for making a transition. More information about these guidelines is at <http://www.vdh.virginia.gov/OLC/LongTermCare/returntocommunity.htm>. If the individual does want to move to the community and has transition needs that the facility cannot plan for or provide, the facility must make a referral to an appropriate community resource. The community agency then serves as the initial point of contact to provide the resident with introductory information about community resources and collaborate with the nursing facility to make arrangements for the individual's transition to community living. In either instance, the nursing facility remains responsible for discharge planning and development of a post-discharge plan with the resident and his or her family, as appropriate.

Based on CMS guidance, Virginia has designated Area Agencies on Aging (AAAs) to serve as the local contact agency (LCA) with the primary, but not exclusive, role of providing information and technical assistance for nursing facility transition. The LCA's role is to contact individuals referred to them by nursing facilities through the MDS Section Q processes in a timely manner, provide information about choices of community services and supports appropriate to the person's needs, and collaborate with the nursing facility to effect the transition. The LCA referrals go to the State's Centers for Independent Living (CILs) if the interested individual is not eligible for the Money Follows the Person (MFP) initiative described above. If the individual has an intellectual disability, the LCA referral goes to the local CSB. If the individual is MFP eligible, the LCA refers the individual to the MFP transition coordinator that the individual chooses for transitioning to the EDCD or Tech Waiver. They may also refer to the local screening clinic or the DD case management organization of the individual's choice. Each state determines the extent of the LCA's contact and roles. Other public or private entities, including Centers for Independent Living (CILs), also can and do provide this information and assistance.

## **2. Access to and Use of Nursing Facilities**

Admission to a nursing facility is required to be based on a formal, face-to-face assessment by a trained, qualified professional. Individuals may be screened while at home or in another community setting or during a treatment stay at an inpatient hospital. Individuals may also be screened in the nursing facility if the screening is not done prior to admission or when the individual needs Medicaid long-term care support (e.g., Medicaid Waiver or PACE) at the time of transition from the facility to the community. Community-based assessments are conducted by a social worker from the local social services department and a nurse from the local health

department. Results of their assessments are forwarded to the director of the local health department for a decision on whether nursing care is necessary.

A screener conducts the assessment using the **Uniform Assessment Instrument (UAI)**, a standardized, multi-dimensional questionnaire that addresses an individual's social functioning, physical and mental health, medical and nursing needs, and functional abilities. Federal regulations (§ 483.20 Resident Assessment) require that the individual be reassessed every three months. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed, direct care staff members on all shifts.

Although the requirements are clear, throughout the implementation of the **Money Follows the Person (MFP) Program**, reports have been made by transition coordinators and peer mentors that there have been numerous instances in which it has been found that a person in a nursing facility did not have a UAI in their file. In some instances, individuals could not transition from nursing facilities with Medicaid-funded community supports such as the EDCD Waiver or PACE because they did not have a UAI that indicated that they required nursing facility care (although they were in the nursing facility). Data on the number of individuals to whom this applies is not kept; however, the reports over several years at MFP and other meetings have been so widespread that even if anecdotal, they bear examination.

Further, there is an acknowledged significant backlog in local departments of social services, health departments, and hospitals for completing UAI screenings. This led to the passage of HB 702 by the Virginia General Assembly. HB 702 amends § 32.1-330 of the Code of Virginia, adding § 32.1-330.4. The new code section requires that the Department of Medical Assistance Services (DMAS) contract with other public or private entities to conduct the required community-based and institutional screenings in addition to or in lieu of the screening teams described in the Code in jurisdictions in which that team has been unable to complete a screening within 30 days of the individual's application. This should eliminate the backlog and lead to identification of all individuals who are required to have—but do not have—a UAI. However, it does not resolve concerns expressed by advocates over a number of years that the UAI represents a medical model of assessment and is not person centered.

Medical or nursing needs include such things as wound care and assistance in medication administration. Functional ability refers to the degree of assistance that an individual requires to complete daily living activities such as bathing, toileting, or dressing. Based on the information gathered using the UAI, the screener determines the person's care needs, whether he or she meets the criteria for nursing facility care, and whether or not he or she will be at risk of nursing facility placement if additional assistance is not received. When UAI screening indicates that an individual may have or does have a diagnosis of an intellectual or other developmental disability (ID/DD) or a serious mental illness, federal regulations require an additional "Level II" evaluation, the **Pre-Admission Screening and Resident Review (PASRR)**.

The PASRR determines whether a nursing facility is the most appropriate setting to meet both the individual's medical and physical needs and his or her behavioral or psychiatric needs. In Virginia, when ID/DD or a serious mental illness is suspected or known based on the Uniform Assessment Instrument (UAI), the local pre-screener sends a report to DMAS and the Department of Behavioral Health and Developmental Services (DBHDS). Staff members from the two agencies consult on the findings as indicated and, if a PASRR has not been completed recently, DMAS (as the purchasing agency) will typically request a PASRR evaluation through its contract with Dual Diagnosis Management Ascend (DDM Ascend), a private provider. This evaluation must be completed within 5 to 7 working days of receipt of the UAI assessment. Based on the PASRR findings, DBHDS conducts a Quality Assurance review and advises DMAS on appropriate placement and specialized services needed by the individual. DMAS then determines whether or not a nursing facility is appropriate.

Nursing facility residents with ID/DD, as well as those eligible for the Money Follows the Person demonstration project described above, are part of the target population in the Commonwealth's Settlement Agreement with the Department of Justice. Therefore, helping individuals who want to move out of nursing facilities make the transition and diverting individuals who could be supported in the community from moving into nursing facilities is an increasing priority.

If an individual needs to be assessed during a hospital stay, a hospital social worker or discharge planner typically conducts the UAI evaluation and explains its results. When support needs are identified, the staff person must describe the long-term care options available, both institutional and community-based. State and federal regulations also require that hospital staff ask the individual about their preference for receiving services. If after receiving this information, an individual chooses to stay in the community, the hospital must make a referral to appropriate community resources.

If an individual chooses institutional care, hospital staff provides him or her with a list of nursing facilities in the area that have available beds, and in all cases, a nursing facility selected by an individual must provide that individual with a written description of services, charges, and fees *before* the individual moves to that facility. Lists of nursing facilities are also available from SeniorNavigator (<http://www.seniornavigator.com>) using a search for key words such as nursing facility, skilled nursing facility, or nursing facility in a specific geographic area. The information provided will include the number and type of certified beds based on the latest available information from the Virginia Department of Health (VDH).

The *Guide to Choosing a Nursing Home*, a booklet available online from CMS (<http://www.medicare.gov/Publications/Pubs/pdf/02174.pdf>), encourages individuals interested in nursing facility care to contact or meet with local AAAs, CILs, or other appropriate community resources to identify all available long-term care options. Quality-of-care information for making a more informed choice also can be obtained using the Medicare Nursing Home Compare online tool (<http://www.medicare.gov/NHCompare/Home.asp>) or by contacting VDH, DMAS, the Virginia Department for Aging and Rehabilitative Services (DARS)

Division of Aging Long-Term Care Ombudsman program, or local consumer affairs offices. Comparative site visits to various facilities being considered are also recommended.

Once an individual has entered a nursing facility, a comprehensive plan of care must be developed based on a formal assessment of his or her needs for supervision, assistance with daily living activities, therapy, nursing care, and other related services. This plan includes assessments of the resident's clinical and psychosocial needs, appropriate interventions to meet them, treatment goals, and measures to identify progress in achieving the goals. If the individual received a PASRR evaluation as a part of his/her assessment, the plan must also incorporate its recommendations. A written discharge plan is also required as part of the individual's clinical record and must include the services to be delivered, goals to be achieved, and the post-discharge services needed or final disposition at the time of discharge.

In 2010, DMAS developed and implemented **Virginia Gold** in collaboration with other state agencies, long-term care providers, and stakeholders to improve the quality of care in nursing facilities by increasing retention of Certified Nursing Assistants (CNAs) through better employee benefits, workforce models, and organizational practices. The Virginia Gold pilot projects involved five nursing facility grantees and ended on August 2011. It focused on enhanced staff orientations, peer mentoring, coaching supervision, staff rewards and recognition, and training. Each grantee had a work plan with objectives; tracked the monthly number of CNAs employed, the number terminated, and the reasons for termination, such as retirement, resignation, or dismissal for cause; and submitted mandatory reports on project activities, their results, and progress toward meeting program objectives.

In July 2012, DMAS published a *Review of the Virginia Gold Quality Improvement Program* ([http://www.dmas.virginia.gov/Content\\_attachments/lrc/vagold-rpt3.pdf](http://www.dmas.virginia.gov/Content_attachments/lrc/vagold-rpt3.pdf)). The agency found that the program achieved its intended goal of improving quality of care by developing a supportive work environment for CNAs and that the program may represent a good investment for states and other interested organizations.

In interviews with participants, peer mentoring was noted to be an effective strategy for improving retention. Other strengths reported from the CNA focus groups included greater recognition, professional and relational skills training, and supportive relationships among staff. Weaknesses reported by the focus groups included inconsistent or insufficient peer mentoring, inadequate reward incentives for CNAs, limited combined relationship skills training for CNAs, nursing and supervisory staff, and strained relationships among some CNAs, nursing and supervisory staff. Overall it was reported by the small group of individuals involved in the pilots (a study limitation) that retention was improved and residents received a better quality of care.

According to the Virginia Department of Health, in 2013, there were more than 279 nursing facilities containing 31,927 beds located throughout Virginia. All but 15 nursing facilities are certified for federal reimbursement under Medicare and Medicaid (<https://www.vdh.virginia.gov/OLC/LongTermCare/>). During state fiscal year (SFY) 2010, the number of nursing facilities was the same. The facilities are each unique in their day-to-day

operation. Because of staff availability, especially psychiatrists or psychologists, they vary in their capacity to serve individuals with complex needs such as serious mental illness, intellectual disability, or behavioral problems and, as a result, variation exists in the populations that they accept for services. According to DMAS data, most nursing facilities primarily serve individuals ages 65 and over. The information in **Table 85** shows the number of individuals served in nursing facilities in SFYs 2010 and 2013.

| <b>Table 85. Ages of Nursing Facility Residents by SFY</b> |               |               |                 |
|--|---------------|---------------|-----------------|
| <b>Age Groups</b>  | <b>2010</b>   | <b>2013</b>   | <b>% Change</b> |
| <b>Under 1 year</b>  | <b>1</b>      | <b>1</b>      | <b>0%</b>       |
| <b>1–5 years</b>   | <b>21</b>     | <b>21</b>     | <b>0%</b>       |
| <b>6–14 years</b>  | <b>38</b>     | <b>31</b>     | <b>- 18.4%</b>  |
| <b>15–20 years</b>   | <b>29</b>     | <b>29</b>     | <b>0%</b>       |
| <b>Subtotal for Ages 1–20</b>                              | <b>89</b>     | <b>82</b>     | <b>- 7.9%</b>   |
| <b>21–44 years</b>   | <b>622</b>    | <b>584</b>    | <b>- 6.1%</b>   |
| <b>45–64 years</b>   | <b>4,251</b>  | <b>4,607</b>  | <b>8.4%</b>     |
| <b>Subtotal for Ages 21–64</b>                             | <b>4,873</b>  | <b>5,191</b>  | <b>6.5%</b>     |
| <b>Ages 65 and older</b>                                   | <b>22,588</b> | <b>22,668</b> | <b>0.35%</b>    |
| <b>Total for All Ages</b>                                  | <b>27,550</b> | <b>27,941</b> | <b>1.4%</b>     |

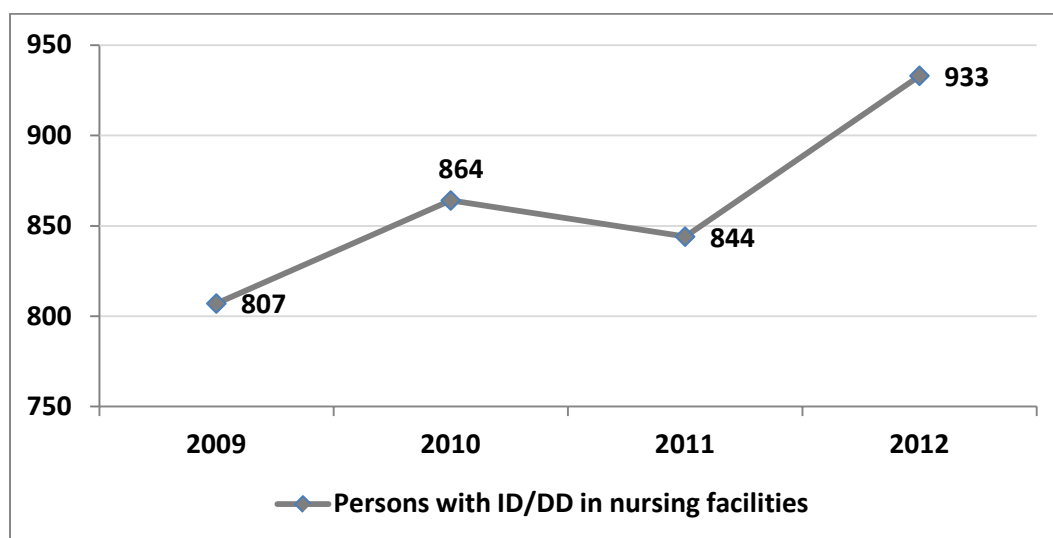
Source: Department of Medical Assistance Services, Long-Term Care Division.

Overall the number of individuals in nursing facilities remains stable. The population of those between 6 and 14 years old has gone down over 18 percent, which is positive. However, there are still 82 children under age 21 living in nursing facilities. These children are part of the target population for the Commonwealth’s Settlement Agreement with the Department of Justice. A potentially concerning trend is the increase in the number of people between the ages of 45 and 64 entering nursing facilities, particularly with the Commonwealth’s focus on aging in place. In SFY 2014, there were 27,708 individuals in nursing facilities. The number of children under a year old has decreased from 11 in SFY 2004 to 1 in SFY 2013, while those between the ages of 1 and 14 has remained about the same.

Individuals with intellectual or developmental disabilities (ID/DD) are a sub-population served at nursing facilities, and preliminary data from the 2013 edition of the *State of the States in Developmental Disabilities* (<http://www.stateofthestates.org/>) reports Virginia as being one of 26 states with nursing facility census reductions between FFYs 2009 and 2011. However, Virginia’s nursing facility census remains higher than the national average utilization rate. That

rate was 10.1 out of 100,000 of general population; Virginia's rate was 13.4 per 100,000. **Figure 28** shows a steady increase in the number of individuals with ID/DD residing in nursing facilities with the exception of SFY 2011 when there was a decrease. SFY 2012 shows a sharp uptick in the reported number of residents with ID/DD residing in nursing facilities. Upon inquiry, the Department of Behavioral Health and Developmental Services (DBHDS) did not have an explanation for the increase.

**Figure 28. Reported Number of Nursing Facility Residents with ID/DD in Virginia**



Sources: Department of Behavioral Health and Developmental Services and University of Minnesota, *Residential Services and Trends for Persons with Intellectual and Developmental Disabilities: Status and Trends through Fiscal Year 2011*, National Residential Information Systems Project (2013).

In addition to the issues above among the reports that provide data on the placement of people with ID/DD in nursing facilities, methodologies and disability definitions or categories vary, making it difficult to identify trends. The *State of the States in Developmental Disabilities* (the national report mentioned above) analyzes data collected from both state ID/DD agencies and from the CMS Online Survey, Certification, and Reporting (OSCAR) system. The University of Minnesota Institute on Community Living publishes another report, *Residential Services for Persons with Intellectual and Developmental Disabilities: Status and Trends through Fiscal Year 2011—National Residential Information Systems Project (RISP)* (<http://rtc.umn.edu/risp/docs/risp2011.pdf>). This report provides information from state survey data regarding residential settings for people with ID/DD, including average daily census, facility depopulation, expenditures, utilization rates, facility closures for state- and non-state-operated residential settings, as well as information on status and changes in Medicaid-funded residential and related services.

While this comparative information can be useful, the information is only as good as the data provided by the states. In **Figure 28** above, the Virginia Board for People with Disabilities chose to leave 2008 data out because, according to the Department of Behavioral Health and

Developmental Services (DBHDS), during that year (and all previous years), the number reported by to the national RISP report included nursing facilities at ICFs/IIDs as well as generic nursing facilities, thus inflating the total. DBHDS provided corrections to the University of Minnesota's RISP report SFYs 2009 and 2010 after the 2011 edition of this *Assessment* was published. For SFY 2013, DBHDS reported that certain diagnosis categories were added based on Department of Medical Assistance Services (DMAS) diagnostic codes for payment to facilities. These include multiple sclerosis, muscular dystrophy, spina bifida, and some categories of brain injury. This is problematic since some, but not everyone, in these categories would meet the definition of developmental disability, and it also indicates that individuals who did meet the definition in years past were not included in the figures that denoted the number of individuals with ID/DD. At this point it is clear that the Commonwealth is not meeting its obligation under the Settlement Agreement to identify individuals in nursing facilities with ID/DD, and that the data provided over the course of many years are unreliable.

### **3. Available Nursing Facility Services**

The nursing facilities (NFs) covered below are required by federal and state regulations to provide or to obtain a full range of appropriate medical, health, and rehabilitative services to meet the needs identified by formal assessment of the individuals they serve with:

- room and board,
- 24-hour-a-day nursing care,
- personal care,
- supervision, and
- various therapies and rehabilitation.

They may be operated by local public agencies or by private nonprofit and for-profit organizations.

**Core services**, which may be provided either directly or by contract, include physical, occupational, and recreational therapy; speech pathology; and nutritional, medical, dental, pharmaceutical, psychological, and social services. Based on their residents' needs, nursing facility services may include assistance with and supervision of daily living, recreation, and social activities. Room and board, some medical equipment and supplies, and laundry services are included in the daily rate. Skilled nursing care, as well as physical, occupational, and speech therapies and medical, dental, and pharmaceutical services, are usually provided on premises. Additional equipment and other services, including adult day care or respite care, may also be provided.

### **4. Cost and Payment for Nursing Facility Services**

Nursing facilities are funded from both private and public sources. Medicare and Medicaid are significant sources of funding. However, to be covered by Medicare, medical conditions

apply, and an individual must receive the services from a Medicare-certified, skilled nursing facility immediately following a qualifying hospital stay of at least 3 days. Other sources of payment include personal, out-of-pocket expenditures as well as various types of purchased private insurance such as long-term care insurance, Medicare Supplemental Insurance (“Medigap”), or managed care health insurance. Managed care will only pay for nursing facility services if the facility has a contract with the plan. Medigap insurance is sold by private companies and can help pay some of the health care costs not covered by Medicare such as copayments, coinsurance, and deductibles. For more information, go to <http://www.medicare.gov/nursing/Payment.asp>.

Skilled nursing facilities (SNFs) and nursing facilities (NFs) are required to comply with the requirements in 42 CFR Part 483, Subpart B, to receive payment under the Medicare or Medicaid programs (<http://www.law.cornell.edu/cfr/text/42/part-483/subpart-B>). To receive reimbursement through Medicare or Medicaid, facilities must conform to specific federal **Centers for Medicare and Medicaid Services (CMS)** standards. Nursing facilities may be CMS certified for Medicare, Medicaid, or both under the following categories.

- **Skilled Nursing Facility (SNF):** Any long-term care bed specifically certified for **Medicare** reimbursement.
- **Nursing Facility (NF):** Any long-term bed specifically certified for **Medicaid** reimbursement.

Almost all nursing facilities in the State are certified for either Medicaid or Medicare according to the Virginia Department of Health (VDH), Division of Long Term Care’s website (<http://www.vdh.virginia.gov/OLC/LongTermCare>). However, **public insurance** coverage for these facilities varies. **Medicaid** will pay most costs incurred in a CMS-certified nursing facility for persons with income and assets meeting eligibility limits. Others, including about half of all nursing facility residents, pay costs out of their own savings, as noted in the CMS nursing home guide referenced earlier. Many individuals who move into nursing facilities initially do not qualify financially for Medicaid but eventually exhaust their savings and other resources, enabling them to become eligible for Medicaid. More detailed information on these eligibility requirements can be found in the **Medicaid** chapter of this assessment.

Most nursing facility care is not covered by the basic **Medicare** plan, but under limited conditions, it will pay for up to 90 days of certified skilled nursing facility care when an individual has had at least a 3-day inpatient hospital stay immediately prior to the nursing facility admission and the care has been determined to be medically necessary to recover from an illness or injury.

**Medicare Supplemental Insurance**, often called “**Medigap**,” helps pay for items not covered by Medicare such as deductibles and copayments. Most Medigap plans will help pay for skilled nursing care, but only when that care is covered by Medicare. Some employer group health insurance plans and long-term care insurance plans can help cover nursing facility costs, but a managed care insurance plan will help pay for care only if it has a contract with a



particular nursing facility. Costs and benefits for all of these types of plans vary widely, but many nursing facility residents who pay for care out of their own private funds receive some assistance from these plans.

Annual nursing facility costs are substantial. The *Genworth 2013 Cost of Care Survey* (<https://www.genworth.com/corporate/about-genworth/industry-expertise/cost-of-care.html>) reports that the median annual cost of nursing facility care in Virginia was \$74,460 for a semi-private room, an increase of over 13 percent from the 2010 survey figure of \$65,700. For a private room, the cost went from \$73,000 in 2010 to \$83,950 in 2013, a 15-percent increase.

According to the Virginia Department of Medical Assistance Services (DMAS), a total of \$836.9 million in Medicaid funds were spent on **nursing facility care** in state fiscal year (SFY) 2013. It accounted for 11 percent of total Medicaid expenditures for the year. In SFY 2010, \$793.4 million in Medicaid funds were expended on **nursing facility care**, 12 percent of all Medicaid expenditures. In 2010, the Virginia General Assembly reduced Medicaid reimbursement rates for nursing facilities by 3 percent effective in SFY 2012; however, the 2011 General Assembly voted to reverse that decision, eliminating the planned SFY 2010 rate reduction. The 2011 budget amendment also restored full funding to continue an incentive payment for long-stay rehabilitation hospitals in SFY 2012 that had been eliminated by the legislature in 2010. The amendment provided a total of \$50.6 million in General Funds to cover both of these reauthorized expenditures.

## 5. Monitoring and Evaluation of ICFs/IID and Nursing Facilities

The Virginia Department of Health (VDH) and the Virginia Department of Behavioral Health and Developmental Services (DBHDS) have responsibilities for oversight and monitoring of all nursing facilities and public or private intermediate care facilities for individuals with intellectual disability (ICFs/IID). The jurisdictions and activities of each agency are different. The responsibilities of DBHDS with respect to ICFs/IID were covered in the **Monitoring and Evaluation of ICF/IID Services** section of this chapter. This section addresses VDH responsibilities.

Titles XVIII and XIX of the national Social Security Act (42 USC 1395 and 1396, respectively) require that each state designate an official “**survey and certification agency**” for Medicare and Medicaid to monitor and certify facilities’ compliance with national standards of care on behalf of the federal **Centers for Medicare and Medicaid Services (CMS)**. The Code of Virginia (32.1-137) assigns this responsibility to **Virginia Department of Health (VDH)**, where it is carried out by the **Office of Licensure and Certification (OLC)**. VDH-OLC certifies the State’s Training Centers and public or private non-state-operated ICFs/IID, and it licenses or certifies all nursing facilities statewide. State statutes specify these oversight duties for VDH-OLC:

- providing regulatory oversight of medical care service providers licensed by VDH through routine onsite investigations and by enforcing state licensure regulations;

- receiving and investigating complaints by individuals regarding the quality of care for services provided by hospitals, nursing facilities, home care providers, hospice organizations, and the quality of care provided through managed care health insurance plans;
- inspecting health care facilities, programs, and services for compliance with federal regulations, including Medicare, Medicaid, and clinical laboratory improvement programs; and
- certifying the quality of care standards governing managed care health insurance plan providers and maintaining a registry of private review agencies.

VDH-OLC is required to conduct initial Medicare and Medicaid **certification surveys** for all new facilities and recertification surveys for each facility no later than 15 months after the last day of its previous survey. Unannounced onsite inspections to determine ongoing compliance with federal standards for health, safety, and quality of care are also required as part of the recertification process. Surveys are also required to investigate complaints, and “revisit” surveys” determine if facilities have corrected previously cited deficiencies. Its surveyors are health care professionals such as physicians, registered nurses, dietitians, social workers, and laboratory medical technologists. To ensure uniform, consistent interpretation and application of federal standards, they receive extensive training in federal standards, survey techniques, and procedures and methods for assessing direct services and treatment plans. Assessments of facility compliance with federal life and safety code requirements are provided by the Office of the Fire Marshall within the Virginia Department of Fire Programs under contract with VDH.

During each facility survey, VDH-OLC surveyors formally review clinical records as well as interview employees and individuals receiving services or their family members or guardians. Federal regulations require surveyors to directly observe the actual provision of services and care to individuals and, based on those systematic observations, assess the outcomes of care for individuals served as well as whether the services meet those individuals’ current needs. Quality of care is further examined by reviewing facility data on outcome indicators for medical, nursing, and rehabilitative care; dietary and nutritional services; activities and social participation; sanitation and infection control; and physical plant conditions. The survey also includes a review of the facility’s compliance with federal requirements for clients’ rights.

If no deficiencies are found, surveyors deem the ICF/IID or nursing facility to be in compliance with standards. A finding of **noncompliance** results when deficiencies exist that have the potential to either result in more than a minimal impact on the individual served or compromise the individual’s ability to

*maintain and/or reach his/her highest physical, mental and/or psychological well-being as defined by an accurate and comprehensive resident assessment, plan of care and provision of services.*

Noncompliant findings initiate a 6-month enforcement period for correction. For both types of facilities, the most serious finding on noncompliance is **immediate jeopardy**, which means that noncompliance with standards either has caused or is likely to cause “serious injury, harm, impairment or death,” and immediate corrective action is necessary. When this finding is made, the facility must immediately take all actions necessary to come into compliance with standards and to ensure processes that will prevent future reoccurrence, and these actions must be approved by the surveyors as being sufficient to resolve the citation.

Federal regulations establish several categories for citations of noncompliance with standards that apply to nursing and skilled nursing facilities, but not to ICFs/IID. Surveyors of these facilities must cite the seriousness of deficiencies based on their “severity,” the degree of actual harm or potential for harm to individuals, and their “scope,” whether they are isolated occurrences, constitute a pattern of care, or are widespread. **“Substandard quality of care” (SQC)** is a very serious citation of deficiency for nursing facilities that refers to either any deficiency in facility practices, resident quality of life, or quality of care that constitutes immediate jeopardy or a “pattern of widespread potential for or actual harm” that does not reach the level of immediate jeopardy (42 CFR 483.13 et seq.). As with immediate jeopardy, a nursing facility must immediately take corrective action.

After completing an inspection, VDH-OLC surveyors discuss their findings with the facility’s administrator or designee. When a deficiency in meeting one or more standards is found, the facility administrator must submit a plan of correction that addresses each identified deficiency citation within a specified timeframe. VDH-OLC reviews the plan of correction and either accepts it or notifies the facility of any plan of correction item that it does not accept as adequately resolving a deficiency. When the latter occurs, the facility must revise the plan until accepted. The facility administrator is then responsible for ensuring that the plan of correction is implemented and monitored so that compliance is maintained. A provider is expected to take the actions necessary to achieve compliance within 45 days of the findings notification.

VDH forwards each survey’s findings to the US Centers for Medicare and Medicaid Services (CMS) and the **Virginia Department of Medical Assistance Services (DMAS)**, the State’s designated Medicare and Medicaid administrative agency. Based on these findings, either CMS or DMAS may impose enforcement remedies for noncompliance with standards of care and, in the case of ICFs/IID, for noncompliance with their required “Conditions of Participation.” Remedies may range from mandatory staff in-service training, to civil monetary penalties and denial of payment for new admissions. Termination of Medicaid or Medicare certification may be imposed on an ICF/IID that no longer meets the Conditions of Participation or when the facility’s deficiencies pose immediate jeopardy to their residents’ health and safety.

State and federal regulations authorize **termination of the provider agreement** for a nursing facility licensed by VDH if it still fails to comply with federal standards 6 months after a finding of noncompliance. Immediate imposition of administrative sanctions or civil penalties can also be imposed by the VDH commissioner for noncompliant facilities when:

- the health and safety of residents are deemed at risk;
- quality of care has been severely compromised;
- illegal acts in the facility were permitted, aided or abetted; or
- the facility's program or services deviated significantly from those for which the license was issued without prior written approval from VDH-OLC or the facility failed to correct such deviation within a specified time.

Upon receipt of VDH's notice of intent to impose sanctions and its rationale for doing so, a facility licensed by VDH has the right to appeal under the State's Administrative Process Act (Code of Virginia 2.24000 et seq.). Possible sanctions that VDH may impose include the following:

- restricting or prohibiting new admissions to the facility;
- petitioning the court to impose a civil penalty (such as a fine), to appoint a receiver, or both; or
- revoking or suspending the facility's license.

The **VDH-OLC Complaint Unit** has the responsibility for receiving and processing allegations of violations of the standards of care and of abuse, neglect, or exploitation of individuals served by nursing facilities and other providers that VDH licenses. Complaints may be made anonymously by phone (toll-free, 800-955-1819) or in writing using a Consumer Complaint Report form that is posted online along with a copy of the confidentiality policy at <http://www.vdh.virginia.gov/OLC/Complaint/index.htm>.

Complaints pertaining to the provision of health care that may seriously jeopardize patient health or safety or that relate directly to other state and federal regulatory requirements are referred to a VDH-OLC surveyor for investigation. When the investigation is complete, the licensee and the complainant, if known, are notified of its findings. When violations are found, the same procedures for resolution and monitoring described above for certification surveys applies. Whenever VDH-OLC finds that there has been abuse or neglect, it notifies the **Adult Protective Services Division** of the **Virginia Department of Social Services (DSS)**. If the facility is not found to be in violation of applicable state or federal regulations, the complainant, if known, is notified and informed other available options for addressing the complaint, including referral to the State Office of the Long Term Care Ombudsman or another appropriate state regulatory agency. All investigative survey reports for nursing and skilled nursing facilities are also forwarded to the **State Office of the Long Term Care Ombudsman**, and that office is alerted of any findings of substandard quality of care (SQC).

The **State Office of the Long Term Care Ombudsman** was established nationally under the federal Older Americans Act in 1972 (42 USC. § 3001 et seq.). The program is mandated to receive, investigate, and resolve complaints made by or on behalf of persons in nursing facilities and assisted living facilities. In Virginia, the General Assembly expanded the program's scope in

1983 to include community-based, long-term care services provided by state and private agencies. The **Virginia Association of Area Agencies on Aging (V4A)**, which is a private nonprofit organization, manages and operates the program under contract with the Virginia Department for Aging and Rehabilitative Services (DARS). It receives federal, state, local and charitable contributions.

The Long-Term Care Ombudsman Program consists of the Office of the State Long-Term Care Ombudsman at V4A and 20 local offices located in area agencies on aging throughout the State to provide direct service in their communities. Pursuant to the provisions of the Older Americans Act and Virginia Code (§ 51.5-140), the Office of the State Long-Term Care Ombudsman has **statutory access** (with consent and within specific code provisions) to resident, facility, and patient records in assisted living facilities, adult care programs, certified nursing facilities and nursing facilities, and state hospitals operated by the Department of Behavioral Health and Developmental Services. The 2014 General Assembly passed HB 240, which modifies § 51-5-40 to expand access to records for the purpose of investigating complaints to

*providers of services by an area agency on aging or any private nonprofit or proprietary agency whenever the entity has the consent of the client, patient, or individual receiving services or his legal representative.*

It also stipulates that

*a client, patient, or individual receiving services is unable to consent to the review of his medical and social records and has no legal representative and access to the records is necessary to investigate a complaint, access shall be granted to the extent necessary to conduct the investigation. Access is also granted to the entity if a legal representative of the client, patient, or individual receiving services refuses to give consent and the entity has reasonable cause to believe that the legal representative is not acting in the best interests of the client, patient, or individual receiving services.*

In addition to the training and oversight of the local Ombudsman offices, duties of the Office of the State Long-Term Care Ombudsman include the following:

- addressing **systemic care problems** through participation in committees, task forces, and advisory boards working on issues such as staffing, workforce development, survey and enforcements processes, long-term care financing, and quality standards; and
- analyzing and monitoring the development and implementation of laws, regulations, and policies that relate to the **health, safety, welfare, and rights** of long-term care recipients; and **program data, trends and issues** in long-term care.

For more information on the Ombudsman program including how to access Ombudsman services or policies and procedures relating to the program, go to

<http://www.elderrightsva.org/aboutlongtermcare.aspx> or  
<http://www.vda.virginia.gov/ombudsman.asp>). For information on the top 10 long-term care deficiencies nationally and in Virginia for 2010–2012, see the Department of Health website at <https://www.vdh.virginia.gov/OLC/LongTermCare/documents/deficiency/Top%2010%20Health%20Deficiencies%202012.pdf>.

## **D. 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. Websites Referenced**

#### **Code of Federal Regulations (CFR): 42 CFR Part 43**

<http://www.law.cornell.edu/cfr/text/42/part-483/subpart-B>

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

#### **Code of Virginia**

<http://lis.virginia.gov/cgi-bin/legp604.exe?000+cod+37.2-505>

<http://lis.virginia.gov/cgi-bin/legp604.exe?111+ful+CHAP0871>

#### **Kaiser Family Foundation**

<http://www.kff.org>

#### **Office of the Inspector General for Behavioral Health and Developmental Services**

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

#### **Office of the State Inspector General**

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

#### **SeniorNavigator**

<http://www.seniornavigator.org>

#### **State of the States in Developmental Disabilities (2013)**

<http://www.stateofthestates.org>

#### **US Department of Health and Human Services (HHS)**

<http://www.hhs.gov>

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

<http://www.cms.gov>

### **Intermediate Care Facilities for Individuals with Mental Retardation**

<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-topics/Delivery-Systems/Institutional-Care/Intermediate-Care-Facilities-for-Individuals-with-Mental-Retardation-ICFMR.html>

### **Nursing facilities**

<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Institutional-Care/Nursing-Facilities-NF.html>

### **CMS Community Living Initiative**

<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Community-Living/Community-Living-Initiative.html>

### **My Medicare**

<http://www.medicare.gov/default.aspx>

### **Medicaid Nursing Home Compare**

<http://www.medicare.gov/NHCompare/Home.asp>

### **Medigap**

<http://www.medicare.gov/supplement-other-insurance/medigap/whats-medigap.html>

### **Paying for Nursing Home Care**

<http://www.medicare.gov/nursing/Payment.asp>

### **Office of Certification and Compliance**

<http://www.cms.gov/CertificationandCompliance>

### **Preadmission Screening and Resident Review (PASRR)**

<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Institutional-Care/Preadmission-Screening-and-Resident-Review-PASRR.html>

## **National Clearinghouse for Long-Term Care Information**

<http://www.longtermcare.gov/>

## **US Social Security Act (42 USC 1496)**

[http://www.ssa.gov/OP\\_Home/ssact/title19/1905.htm](http://www.ssa.gov/OP_Home/ssact/title19/1905.htm)

**Virginia Department for Aging and Rehabilitative Services**

**Office of the State Long-Term Care Ombudsman Program**

<http://www.vda.virginia.gov/ombudsman.asp>

**Virginia Department of Behavioral Health and Developmental Services**

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

**Enhanced Licensing Protocol**

<http://www.dbhds.virginia.gov/documents/Enhanced%20Licensing%20Visit%20Protocol%20-%20website%20version.pdf>

**Executive Progress Report**

[https://solutions.virginia.gov/pbreports/rdPage.aspx?rdReport=vp\\_AgencyExecutiveProgressReport&Agency=720&selAgency=720&selBiennium=2&selSPVersion=2&Run=Run](https://solutions.virginia.gov/pbreports/rdPage.aspx?rdReport=vp_AgencyExecutiveProgressReport&Agency=720&selAgency=720&selBiennium=2&selSPVersion=2&Run=Run)

**Regional Support Teams**

<http://www.dbhds.virginia.gov/settlement/Regional%20Support%20Team%20Description.pdf>

**Settlement Agreement**

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

**Stakeholder Group Meetings: Minutes and Supporting Materials. (January 2014, November 2013, July 2013, April 2013)**

<http://www.dbhds.virginia.gov/Settlement.htm#Meetings>

**DBHDS Training Center to Community Discharge Work Flow Process and Activities**

<https://www.dbhds.virginia.gov/documents/ODS/TC%20to%20Community%20Move%20Workflow%20process%20and%20Activities.pdf>

**Virginia Department of Health**

<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>

**Return to Community Assessment**

<https://www.vdh.virginia.gov/OLC/LongTermCare/returntocommunity.htm>

**Virginia Department of Medical Assistance**

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

**Money Follows the Person demonstration project**

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

**MDS 3.0 Section Q Implementation**

<http://www.olmsteadva.com/mfp/MDS3SectionQ.htm>

**Virginia Office of the Long Term Care Ombudsman**

<http://www.elderrightsva.org>

**2014 State Budget proposals**

<http://leg2.state.va.us/MoneyWeb.NSF/sb2014>

**2013 State Budget**

<http://leg2.state.va.us/MoneyWeb.NSF/sb2013>

**2011 State Budget**

<http://leg2.state.va.us/MoneyWeb.NSF/sb2011>

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## VIII. Community Housing

### A. Introduction to Accessible Housing

Access to suitable, safe, affordable, and accessible housing with opportunities for education, employment, relationships, and active participation is the foundation of inclusive communities. In Virginia and nationally, individuals with disabilities receiving Supplemental Security Income (SSI) benefits or whose income is otherwise limited continue to be priced out of the housing market. Many people with disabilities can and would choose to live independently, with or without support services, if they had access to affordable, accessible housing options. This chapter emphasizes the availability and sources of affordable, accessible housing for people with disabilities, particularly those with low to moderate incomes.

To create real and meaningful opportunities for individuals with disabilities to live inclusively in communities, it is necessary to acknowledge the community housing challenges associated with the deep poverty that affects the majority of people with disabilities. Most government housing programs have eligibility requirements related to median income. Under current federal guidelines, housing is considered to be affordable for low-income households when the cost of monthly rent, including tenant-paid utilities, does not exceed 30 percent of monthly household income.

Data reported in the **Technical Assistance Collaborative's** report, *Priced Out in 2012: The Housing Crisis for People with Disabilities*, and by the **National Low Income Housing Coalition's** *Out of Reach 2012* rank Virginia as the ninth most unaffordable state in the nation to rent a two-bedroom housing unit. In Virginia, the 2012 Fair Market Rent for a two-bedroom apartment was \$1,054. In order to afford this level of rent and utilities without paying more than 30 percent of income on housing, earned household income must be \$3,512 monthly or \$42,143 annually. The annual income of a single individual in Virginia receiving an SSI payment of \$698 equaled only 15.6 percent of median income. This is almost 30 percent below the 2012 federal poverty guidelines of \$11,170 for an individual, and as a result, the **housing affordability gap** for people with disabilities in the Commonwealth is significant.

Together, these two national reports confirm that individuals with disabilities who rely on SSI payments as their source of income continue to be some of the poorest people in the nation. These reports provide a vivid picture of the housing challenges faced by Virginians, with and without disabilities, who have low to moderate incomes. National findings, according to *Priced Out in 2012*, report the following:

*The **average annual income** of a single individual receiving SSI payments was **\$8,714**, equal to only 19.2 percent of the national median income for a one-person household and almost 22 percent below the 2012 federal poverty level.*



*The **national average rent** for a modest, one-bedroom apartment was **\$758**, equal to 104 percent of the national average monthly income of a one-person SSI household.*

These findings confirm that in 2012, it was virtually impossible for a single adult receiving SSI to afford rental housing in the community unless they had some type of permanent rental subsidy.

Based on federal guidelines, a SSI recipient receiving \$698 per month, the unreduced benefit amount in Virginia for 2012, could afford monthly rent of no more than \$191 at 30 percent of that monthly SSI benefit—well below the Average Fair Market Rent of \$818 for a one-bedroom unit. That year, in Virginia, 82,629 non-elderly adults (ages 18 to 64) with disabilities received SSI benefits. For individuals, regardless of age, who rely on SSI benefits as their major or only source of income, the cost of housing makes it virtually impossible to afford decent, safe housing in their local community. Virginians receiving SSI benefits are at extreme levels of poverty and facing a housing crisis.

Nationwide, since the release of the reports mentioned above, SSI benefit increases have not kept up with rising housing costs. The unreduced SSI benefit as of January 1, 2013, is \$710 for an individual and \$1,066 for a couple. As noted above, people with disabilities receiving SSI can only afford to pay 30 percent of their income in housing costs, which as of January 1, 2013 is \$213 per month or \$2,556 per year. Additionally, the annual cost of operating one unit of affordable housing ranges from \$3,000 to \$5,000 per unit, before factoring in mortgage debt service payments. Consequently, even housing that is funded debt-free with a capital grant must still charge rents that exceed what a person dependent on SSI can afford. This leaves most people with disabilities dependent on federal rent subsidy assistance to obtain quality, accessible housing that they can afford.

Virginia continues to rank among the 10 lowest states in average income for a person with a disability receiving SSI, and the situation is more severe in rapidly growing urban areas than in the State as a whole. Affordability is at the core of providing meaningful opportunity for accessible community housing for individuals with disabilities and a wide range of options, including such things as ongoing rent subsidies, must be considered. Since the 1999 US Supreme Court decision in *Olmstead v. L.C.* (<http://www.law.cornell.edu/supct/html/98-536.ZS.html>) requiring that individuals with disabilities be served in the most integrated setting appropriate to their needs, the development of affordable, accessible community housing for people with disabilities has been identified as a needed priority nationwide. In Virginia and across the country, the federal **Money Follows the Person (MFP)** demonstration and other initiatives aimed at moving individuals from institutions to the community have been hampered by the lack of affordable, accessible housing.

Published in the Federal Register on January 16, 2014 was the CMS 2249-F and 2296-F Final Rule. The intent of the **final rule** is to



*ensure that individuals receiving long-term services and supports through home and community based services (HCBS) programs under the 1915(c), 1915(i) and 1915(k) Medicaid authorities have full access to benefits of community living and the opportunity to receive services in the most integrated setting appropriate.*

The final rule requirements for **home and community-based settings** establish an outcome-oriented definition that focuses on the nature and quality of individuals' experiences. The requirements maximize opportunities for individuals to have access to the benefits of community living and the opportunity to receive services in **the most integrated setting**.

The final regulation provides for a transition process that will allow states to implement this rule in a manner that supports continuity of services for Medicaid Home and Community Based Services participants and minimizes disruptions in service systems during implementation. Per the final rule, the home and community-based setting:

1. is integrated in and supports access to the greater community.
2. provides opportunities to seek employment and work in competitive, integrated settings, engage in community life, and control personal resources.
3. ensures the individual receives services in the community with the same degree of access as individuals not receiving Medicaid Home and Community Based Services.
4. is selected by the individual from among setting options, including non-disability specific settings and an option for a private unit in a residential setting.
5. ensures an individual's rights of privacy, dignity, respect, and freedom from coercion and restraint.
6. optimizes individual initiative, autonomy, and independence in making life choices.
7. facilitates individual choice regarding services and supports, and who provides them.

Additional requirements:

8. The Specific unit/dwelling is owned, rented, or occupied under a legally enforceable agreement.
9. The individual has the same responsibilities/protections from eviction as all tenants under landlord/tenant laws of the state, county, city or other designated entity.
10. If tenant laws do not apply, the State ensures the lease, residency agreement, or other written agreement is in place providing protections to address eviction processes and appeals comparable to those provided under the jurisdiction's landlord/tenant laws.
11. Each individual has privacy in his or her sleeping or living unit.
12. Units have lockable entrance doors with the individual and appropriate staff having keys to doors as needed.

13. Individuals sharing units have a choice of roommates.
14. Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.
15. Individuals have freedom and support to control their schedules and activities and have access to food any time.
16. Individuals may have visitors at any time.
17. The setting is physically accessible to the individual.

The final rule further describes settings that are **not** home and community based:

- nursing facilities;
- institutions for mental disease (IMD);
- intermediate care facilities for individuals with intellectual disabilities (ICFs/IID);
- hospitals.

Settings presumed **not** to be home and community-based:

- setting in a publicly or privately owned facility providing inpatient treatment;
- setting on grounds of, or adjacent to, a public institution; or a
- setting with the effect of isolating individuals from the broader community of individuals not receiving Medicaid HCBS.

The rule went into effect on March 17, 2014. Additional Information about the final rule can be found at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Home-and-Community-Based-Services/Home-and-Community-Based-Services.html>.

Conversations taking place today, in Virginia and nationally, emphasize the decoupling of housing and services in favor of a “**supportive housing**” model. The goal of this movement is to help people with disabilities control their own lives, become socially and economically productive, and have the opportunity to live in permanent, independent, affordable, and accessible housing. There are various iterations of the supportive housing model. All emphasize consumer choice and control over both housing and services in contrast to the “placement” approach in which professional assessments constitute the main basis for housing selection. The supportive housing approach leads to separation of housing from services, and emphasizes conventional, integrated, scattered-site housing to reduce stigma, and rights of tenancy under landlord/tenant laws.

The Virginia Housing Trust Fund Structure and Use Plan was released in November of 2012. It is available at [http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/RD2882012/\\$file/RD288.pdf](http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/RD2882012/$file/RD288.pdf) and states:

*An important subset of the lower-income population—persons with disabilities—faces even greater difficulty in obtaining appropriate, affordable housing options.*

With respect to the mismatch between housing cost and SSI income, the Plan further states that this mismatch

*represents a problem for the current recipients of SSI support, [and] it is also a potentially serious impediment to the State's efforts to lower its reliance on institutional settings for persons with a variety of mental, intellectual, sensory or physically limiting conditions. The provisions of the State's recent settlement with the Department of Justice with respect to persons with intellectual disabilities underscored the importance of having appropriate housing resources available for this population.*

The income barriers identified above and a lack of comprehensive coordination of resources on the federal, state, and local level have perpetuated a long-standing disconnect between housing and disability services agencies. In Virginia, coordinated and aligned efforts and activities have been taken to bridge this disconnect. With this in mind, a discussion of steps being taken, and other related issues and barriers in Virginia follows.

## **B. Coordinated State and Local Housing Activities**

On April 10, 2010, Governor Bob McDonnell issued Executive Order No. 10 calling for a ***Housing Policy Framework for the Commonwealth of Virginia*** to

*establish broad goals and policy direction related to housing policy and to coordinate a comprehensive and effective housing policy with other public policy areas and initiatives across multiple secretariats within the executive branch.*

Executive Order No. 10 was the first executive branch effort to craft a comprehensive, state-level housing policy framework for Virginia.

An interim report (<http://www.virginiahousingpolicy.com>) published on November 18, 2010 included policy recommendations that solidify a continued commitment to cross-secretariat coordination. Specific recommendations of note are the need for (1) better linkage of housing, transportation, and land-use planning and use of the **Transportation and Housing Alliance Toolkit** (<http://www.tjpd.org/housing/thatookit.asp>) by localities as a best practice; (2) the need to maintain and enhance administrative structures that support inter-agency and inter-secretariat collaboration in addressing special housing needs; (3) a continuum of quality housing options for special needs populations consistent with the US Supreme Court's 1999 *Olmstead* decision; and (4) establishment and promotion of state policy priorities for the incorporation of “**visitability**” and “**universal design**” elements in private housing development. Universal design refers to items or home features that are usable by most people regardless of their level of ability or disability. On the latter, the report further recommends that

*once voluntary standards are adopted, charge state agencies with identifying specific means for promoting their use through development of voluntary program incentives, provision of technical assistance, and public-private partnerships.*

In late February 2011, the **US Department of Justice (DOJ)** issued findings from its investigation of the Central Virginia Training Center, which was expanded to all five of the State's Training Centers. In that report, discussed in greater detail in the **Institutional Supports** chapter of this *Assessment*, the DOJ found that the Commonwealth was not in compliance with the *Olmstead* decision or the mandate under the Americans with Disabilities Act to provide services for individuals with disabilities in the most integrated setting. The following requirements, excerpted from the Community Living section (section D) of the **Settlement Agreement** between Virginia and the DOJ, are intended to increase opportunity and access to affordable, accessible housing for the Agreement's target population.

1. *The Commonwealth shall serve individuals in the target population in the most integrated setting consistent with their informed choice and needs.*
2. *The Commonwealth shall facilitate individuals receiving Medicaid Home and Community Based Services (HCBS) Waivers under this Agreement to live in their own home, leased apartment, or family's home, when such a placement is their informed choice and the most integrated setting appropriate to their needs. To facilitate individuals living independently in their own home or apartment, the Commonwealth shall provide information about and make appropriate referrals for individuals to apply for rental or housing assistance and bridge funding through all existing sources, including local, state, or federal affordable housing or rental assistance programs (tenant-based or project-based) and the fund described in Section III.D.4 below.*
3. *Within 365 days of this Agreement, the Commonwealth shall develop a plan to increase access to independent living options such as individuals' own homes or apartments. The Commonwealth undertakes this initiative recognizing that comparatively modest housing supports often can enable individuals to live successfully in the most integrated settings appropriate to their needs.*
  - a. *The plan will be developed under the direct supervision of a dedicated housing service coordinator for the Department of Behavioral Health and Developmental Services (DBHDS) and in coordination with representatives from the Department of Medical Assistance Services (DMAS), Virginia Board for People with Disabilities, Virginia Housing Development Authority, Virginia Department of Housing and Community Development, and other organizations as determined appropriate by DBHDS.*
  - b. *The plan will establish, for individuals receiving or eligible to receive services through the Medicaid HCBS Waivers under this Agreement: (1) baseline information regarding the number of individuals who would choose the independent living*

*options described above, if available; and (2) recommendations to provide access to these settings during each year of this Agreement.*

4. *Within 365 days of this Agreement, the Commonwealth shall establish and begin distributing, from a one-time fund of \$800,000 to provide and administer rental assistance in accordance with the recommendations described above in Section III.D.3.b.ii, to as many individuals as possible who receive HCBS Waivers under this Agreement, express a desire for living in their own home or apartment, and for whom such a placement is the most integrated setting appropriate to their needs.*
5. *Individuals in the target population shall not be served in a sponsored home or any congregate setting unless such placement is consistent with the individual's choice after receiving options for community placements, services, and supports consistent with the terms of Section IV.B.9 of the Settlement Agreement.*
6. *No individual in the target population shall be placed in a nursing facility or congregate setting with five or more individuals unless such placement is consistent with the individual's needs and informed choice and has been reviewed by the Region's Community Resource Consultant and, under circumstances described in Section III.E below, by the Regional Support Team.*
7. *The Commonwealth shall include a term in the annual performance contract with the CSBs to require case managers to continue to offer education about less restrictive community options on at least an annual basis to any individuals living outside their own home or family's home (and, if relevant, to their authorized representative or guardian).*

In May of 2012, an interagency housing committee comprised of stakeholder organizations and agency representatives (required per the Settlement Agreement) was formed to create a plan that addresses the above requirements and to increase independent living options. The workgroup developed Virginia's Plan to Increase Independent Living Options, which provides action items and policy considerations required under the Settlement Agreement between the Commonwealth of Virginia and the US Department of Justice. The plan acknowledges that:

*Public perception is shifting toward greater understanding and acknowledgement that people with disabilities want to remain in their homes and communities. Inclusion of individuals with disabilities into all aspects of our society—work, school, recreation, and government—offers the Commonwealth the opportunity to benefit from our diversity, share our experiences, and be collectively strengthened.*

The Plan further identifies the following Guiding Principles and the Commonwealth's intentions:

*The Commonwealth of Virginia supports efforts to make housing options available to individuals with intellectual and developmental disabilities. For the*

*purposes of this plan, the housing options being developed have the following characteristics.*

*De-coupled housing and services so that (1) service provision and housing decisions are separate and distinct, (2) the housing is not subject to licensing, (3) individual leases are executed, and (4) there is consumer-driven choice in relationship to where an individual lives and who provides services.*

*Through this plan, the Commonwealth is leading an effort to develop clear and proactive housing and service strategies to better meet the housing needs and preferences of individuals in the Settlement Agreement's target population.*

*The Commonwealth acknowledges that the need for affordable, integrated housing options by individuals with a disability who do not meet the target population criteria is significant. The Commonwealth further acknowledges that housing options created through federal, state and local resources should not create disability-specific housing silos. Therefore, housing initiatives and strategies developed and implemented may include and benefit a larger population of individuals with disabilities than the Settlement Agreement's target population.*

The Plan addresses the Settlement Agreement with specific program, policy, and outreach activities. The complete *Housing Plan to Increase Independent Living Options* can be found at [http://www.dbhds.virginia.gov/settlement/FINAL\\_DOJ\\_Housing\\_Plan\\_3\\_6\\_13.pdf](http://www.dbhds.virginia.gov/settlement/FINAL_DOJ_Housing_Plan_3_6_13.pdf). More information is included in **Community Living Supports** chapter of this *Assessment*.

On August 20, 2013 the Department of Behavioral Health and Developmental Services, Department of Housing and Community Development, Department of Medical Assistance Services, and the Virginia Housing Development Authority entered into a **Memorandum of Understanding (MOU)**. The MOU, developed in response to Virginia's Housing Plan to Increase Independent Living Options, delineates respective duties and responsibilities of the parties implementing activities related to the Plan. Per the MOU, each party agrees to commit staff, time and resources, as set forth in the Plan. Virginia's **Community Integration Advisory Commission** and the associated **Community Integration Implementation Team** have been involved in a wide variety of interagency activities in support of the coordination of housing resources on the federal, state, and local level. Virginia's **Olmstead Strategic Plan**, approved by the Community Integration Advisory Commission on July 2013, complimentary to the DOJ Housing Plan activities above, states the following:

*For many individuals, access to and choice of housing is the missing link for a successful transition from an institution or for those already living in the community, life in a more independent and integrated setting. For years, room and board were covered with services in institutions. As the Commonwealth moves away from a predominately institutional model to one that embraces*

*community inclusion, the availability of affordable, safe, and accessible housing is crucial. Even with the most robust package of support services, shelter is a basic human need that must still be met for an individual to live and thrive in their community.*

Listed below are **housing barriers** identified by the Community Integration Advisory Commission and its recommendations:

1. Need to decouple funding for housing and support services to support choice and options.
  - a. Reallocate room and board costs used to support congregate care to fund community-based housing programs such as rental assistance and gap funding.
  - b. Coordinate housing and community integration efforts around housing, Medicaid, and disability service agencies to achieve desired outcomes.
  - c. Prioritize housing waiting lists.
  - d. Educate state and local governments, individuals, families, and communities about available options.
2. Lack of coordinated housing planning, including transportation access.
  - a. Educate localities on the need for coordinated planning and potential opportunities for funding, collaboration, best practices, and transportation alignment.
  - b. Allocate housing resources efficiently and effectively to support individual choice.
3. Shortage of housing options fed by a growing demand and a lack of affordability and accessibility.
  - a. Encourage the use of nontraditional housing and other options such as microboards. A microboard, as defined by the Tennessee Microboard Association and as trademarked by the Vela Microboard Association in Canada, is formed when a small group of committed family and friends join together with a person with a disability to create a nonprofit organization (usually 5 to 7 members. Together, this small group of people addresses the person's planning and support needs in an empowering fashion that supports the person-centered planning philosophy. Members develop a deep knowledge of the individual's needs, desires, and wishes. The Microboard:
    - i. manages services such as home supervision, transportation, medical care, job search, etc.;
    - ii. builds bridges between the individual, family, and community;
    - iii. affords individuals flexibility, self-determination, and carries out the dreams of the individual; and

- iv. members develop a deep knowledge of the individual's needs, desires and wishes.
  - b. Reinvest profits from state institution land sales into community housing options and other community supports.
- 4. Inadequate compliance with fair housing practices.
  - a. Provide training to property managers and individuals while developing strategies for reaching the broader public.
  - b. Create and support partnerships between state agencies such as the Department of Professional and Occupational Regulation and local entities such as Centers for Independent Living, Community Services Boards, and Area Agencies on Aging.
- 5. Continued local community resistance.
  - a. Educate localities, homeowners associations, and others regarding federal and state law.
  - b. Address common misperceptions.

The federal Quality Housing and Work Responsibilities Act of 1998 (QHWRA) established a requirement that public housing agencies maintain a comprehensive planning document known as a **Public Housing Agency (PHA) Plan**. The *Priced Out in 2012* report cited earlier notes that, in addition to new requirements for the PHAs such as the creation of these plans, this statute

*gave PHAs more flexibility and control over how federal public housing and Section 8 Housing Choice Voucher programs are used in their communities.*

**Centers for Independent Living (CILs)** have been successful in developing relationships locally and statewide with staff of **public housing agencies (PHAs)** and other housing officials, educating them on the housing needs and preferences of people with disabilities.

A PHA plan, produced in consultation with a Resident Advisory Board, describes the overall mission for serving low and very-low income families and includes the strategies that the public housing agency will implement in order to meet local housing needs. It should also be consistent with the local jurisdiction's **Consolidated Plan (ConPlan)**, described in greater detail below. Both plans include a statement of the housing needs of families with low and very low incomes and describe how the PHA's resources, specifically federal public housing funds and the Housing Choice Voucher program, will be used to meet those needs. For example, through its PHA Plan, local housing officials could decide to direct more Housing Choice Vouchers to people with disabilities receiving Supplemental Security Income (SSI) benefits. Centers for Independent Living (CILs) have been successful in facilitating such dialogues to identify opportunities at the local and state levels to better integrate housing planning for people with disabilities into other planning processes. CILs recognize that local government involvement in statewide planning efforts is critical if housing capacity for Virginians with disabilities is to be increased.



## C. US Department of Housing and Urban Development

Every year, the **US Department of Housing and Urban Development (HUD)** offers community and faith-based organizations, local governments, and housing authorities across the nation the opportunity to compete for direct grants for housing-related projects. HUD awards grants to entitlement community grantees to carry out a wide range of community development activities directed toward revitalizing neighborhoods, economic development, and providing improved community facilities and services.

**Entitlement communities** develop their own programs and funding priorities. However, grantees must give maximum feasible priority to activities that benefit low- and moderate-income persons. A grantee may also carry out activities that aid in the prevention or elimination of slums or blight. Additionally, grantees may fund activities that meet other community development needs when existing conditions pose a serious and immediate threat to the health or welfare of the community. Virginia's eligible entitlement communities are as follows:

**Cities:** City of Alexandria; City of Bristol; City of Charlottesville; City of Chesapeake; City of Colonial Heights; City of Danville; City of Fredericksburg; City of Hampton; City of Harrisonburg; City of Hopewell; City of Lynchburg; City of Newport News; City of Norfolk; City of Petersburg; City of Portsmouth; City of Radford; City of Richmond; City of Roanoke; City of Suffolk; City of Virginia Beach; City of Winchester.

**Counties:** County of Arlington; County of Chesterfield; County of Fairfax; County of Henrico; County of Loudoun; County of Prince William.

**Towns:** Town of Blacksburg; Town of Christiansburg.

For the 51 localities that make up Virginia's Balance of State (i.e., the localities that are non-entitlement communities) the **Virginia Department of Housing and Community Development (DHCD)** receives and administers HUD funds. HUD describes non-entitlement communities as

*all units of general local government that do not meet the definition and qualifications for an entitlement community. This includes all cities, counties, towns, townships, etc., that do not qualify to receive CDBG entitlement funds; and any incorporated units of general local government located in urban counties who have opted not to participate in the urban county's entitlement CDBG program.*

HUD determines the amount of each entitlement grant by a statutory dual formula that uses several objective measures of community needs, including the extent of poverty, population, housing overcrowding, age of housing and population growth lag in relationship to other metropolitan areas.

To receive HUD entitlement grants, a grantee must develop and submit to HUD its Consolidated Plan (ConPlan). The ConPlan is a jurisdiction's comprehensive planning document and application for funding under the following HUD formula grant programs:

- Community Development Block Grant (CDBG),
- HOME Investment Partnerships,
- Housing Opportunities for Persons with AIDS (HOPWA), and
- Emergency Shelter Grants (ESG).

In its ConPlan, the jurisdiction must identify its goals for these programs as well as for housing programs. The goals serve as the criteria against which HUD will evaluate a jurisdiction's plan and its performance under the plan. HUD provides the following guidance to grantees:

*A grantee must develop and follow a detailed plan which provides for, and encourages, citizen participation and which emphasizes participation by persons of low- or moderate-income, particularly residents of predominantly low- and moderate-income neighborhoods, slum or blighted areas, and areas in which the grantee proposes to use CDBG funds. The plan must:*

- 1. provide citizens with reasonable and timely access to local meetings, information, and records related to the grantee's proposed and actual use of funds;*
- 2. provide for public hearings to obtain citizen views and to respond to proposals and questions at all stages of the community development program, including at least the development of needs, the review of proposed activities, and review of program performance;*
- 3. provide for timely written answers to written complaints and grievances; and*
- 4. identify how the needs of non-English speaking residents will be met in the case of public hearings where a significant number of non-English speaking residents can be reasonably expected to participate.*

HUD is prioritizing initiatives that develop more livable and sustainable communities and build economic competitiveness by connecting housing with employment, quality schools, and transportation. This direction demonstrates a commitment to interagency collaboration in policy development, programs, and funding to ensure better results for communities and better use of tax dollars. However, continued and strengthened engagement of the disability community is needed to ensure that people with disabilities are fully included and immersed in integrated community life.

In Virginia, multiple governmental and private nonprofit and for-profit entities, including but not limited to the **Virginia Housing Development Authority (VHDA)** and the **Virginia Department of Housing and Community Development (DHCD)**, are involved in funding, developing, and providing community housing and related services. Together, DHCD and VHDA, along with entitlement communities mentioned above, provide the “bricks and mortar” of access to affordable housing. They administer a range of federal grant funding and tax incentives for housing and community development projects and programs. Brief introductions to several key agencies and initiatives appear below.

## **D. Virginia Department of Housing and Community Development**

The Virginia Department of Housing and Community Development (DHCD) works in partnership with local governments, state and federal agencies, nonprofit groups, and others to make Virginia’s communities safe, affordable, and prosperous places in which to live, work, and do business. Each year, DHCD invests more than \$100 million in housing and community development projects throughout Virginia. The majority of these projects are designed to help persons with low to moderate incomes through an array of housing and community development projects and programs. In addition, DHCD works to ensure safe buildings and homes by administering Virginia’s building and fire codes as well as by training and certifying the State’s building officials. It also administers the Livable Home Tax Credit discussed in more detail later in this chapter.

Individual programs address **preservation of housing stock** as well as **housing for targeted groups** such as people who are homeless, people diagnosed with HIV/AIDS, first-time homebuyers, and others. Eligibility requirements are complex and vary among projects and programs, making it impossible to cover them adequately within the limited framework of this *Assessment*. Detailed information can be obtained at the DHCD website at <http://www.dhcd.virginia.gov> or by contacting the Department directly.

Funding and services provided by DHCD are channeled through state and local governmental agencies, nonprofits, and other intermediaries who provide direct services for consumers. DHCD is not a direct service provider to individuals with disabilities. For access to DHCD funding, organizations respond to Requests for Proposals or submit grant applications in accordance with program requirements and established deadlines. Depending on the funding opportunity, awards are made either competitively or on a first-come, first-served basis. Eligibility and application details for funding opportunities may be obtained from the DHCD website or by contacting the agency directly.

DHCD does not provide funds for services. For state fiscal year (SFY) 2014, DHCD had \$5.4 million available in federal funding for affordable and special needs housing and general affordable housing development and preservation activities. DHCD also allocated approximately \$5.4 million in Virginia Housing Trust Funds for low-interest loans to develop

affordable housing. The majority of these funds went to projects targeting persons with disabilities.

The following programs target Virginians with low to moderate incomes in general and, in some cases, individuals with disabilities. Regardless of their emphasis, collectively these programs play a significant role in making safe, affordable, accessible housing available to persons with disabilities.

Federal **Community Development Block Grants (CDBGs)** provide funding to eligible local governments for crucial community needs such as housing, infrastructure, and economic development. Each project that utilizes CDBG funding must meet one or more national objectives. Funding through the **HOME Investment Partnership** is used to develop and rehabilitate transitional and permanent housing that serves low-income and special needs households and is available to government, nonprofit, and for-profit organizations.

The **Down Payment Assistance (DPA)** program makes purchasing a home more affordable for individuals and families with low to moderate incomes. The program provides flexible gap financing for first-time homebuyers at, or below, 80 percent of the Area Median Income (AMI) to purchase homes that are safe, decent and accessible. The long-term goal is sustainable housing and growth in personal wealth and equity for low- and moderate-income Virginians. Homebuyers access funds through local DPA provider agencies selected by the State through a competitive application process. Eligible costs associated with purchasing a home may include a down payment of up to 10 percent of the purchase price. (This percentage is based on need and may be up to 20 percent in certain high-cost or economically depressed communities.) Up to \$2,500 for closing costs may be included in certain circumstances. The buyer must agree to complete a homebuyer education counseling course. Eligible homebuyers can access DPA assistance through local DPA provider agencies.

The **Emergency Home and Accessibility Repair Program (EHARP)** provides funds to remove urgent, emergency health and safety hazards. It also addresses physical accessibility barriers for low-income Virginians. The program provides funding to local administrators to undertake physical repairs that improve housing conditions. Eligible repairs can include plumbing, structural, electrical, and roofing as well as installation of wheelchair ramps and other accessibility modifications. Applications for local agencies to participate as EHARP local administrators are announced and accepted periodically. Assistance from local administrators is available to occupants based on income on a first-come, first-served basis. Homeowners and tenants (with homeowner written approval) are eligible to apply. The maximum assistance is \$4,000.

The **Homeless Prevention Program (HPP)** is a state-funded program for the prevention of homelessness in Virginia. The program goal is to provide effective and efficient assistance to prevent new cases of homelessness. The program is intended to be administered as a community-based resource that maximizes mainstream resources.

The **Homeless Solutions Grant (HSG)** is a state-funded program to assist households experiencing homelessness to obtain and maintain housing stability. This program replaces the State Shelter Grant (SSG). HSG is designed to assist households experiencing homelessness to quickly regain stability in permanent housing. It is intended to be administered as a community-based resource that maximizes mainstream resources. Eligible applicants include units of local governments, nonprofits, planning district commissions (PDCs), and public housing authorities (PHAs). Eligible activities for the HSG program include shelter operations, rapid re-housing, housing relocation and stabilization services, and Homeless Management Information System (HMIS) cost and administration.

The **Housing Opportunities for Persons with AIDS (HOPWA)** program supports housing and other services for low-income persons with AIDS or HIV and their families within non-eligible metropolitan statistical areas within Virginia. The program provides funding for rental and mortgage assistance, utility payments, resource identification, technical assistance, and other supportive services. Applicants must be nonprofits, including faith-based organizations, or governmental housing agency currently receiving HOPWA funding through DHCD and/or Ryan White funding. Applicants must be targeting services to individuals living within Virginia's non-eligible metropolitan statistical areas.

The **Livable Home Tax Credit** is administered by DHCD. To be eligible for the tax credit, new homes must meet three key requirements:

1. have at least one zero-step entrance approached by an accessible route on a firm surface no steeper than a 1:12 slope proceeding from a driveway or public walkway;
2. have an accessible bathroom (can be a half-bath/powder room) on the same floor as the zero-step entrance; and
3. have doors with at least 32 inches of clear width and hallways/passageways of at least 36 inches of clear width to the accessible bathroom and eating area.

The tax credit also applies to retrofitting existing residential units to make them more accessible. Owners or residents do not have to have a disability requiring these visitability features; income is not a consideration. For new construction, the tax credit can be used by either the homebuilder or the home purchaser. For more information, go to <http://www.dhcd.virginia.gov/index.php/housing-programs-and-assistance/tax-credit-programs/livable-homes-tax-credit.html>.

Individuals lacking both the financial literacy skills and assets to achieve their goals of homeownership can obtain assistance through the **Virginia Individual Development Account (VIDA) Program**. This special savings program, typically offered through local governmental and nonprofit agencies, provides financial skills training, which includes assistance with the application process by local administrators. In addition, the VIDA program matches each dollar saved by the participant with two dollars. The combined savings can be used to purchase a home, start a business, or pursue postsecondary education. VIDA receives funding from the

Virginia Department of Social Services, Virginia Housing Development Authority, and the US Department of Health and Human Services, Office of Community Services Assets for Independence Grant.

The DHCD **Weatherization Assistance** program provides funds to install measures that reduce residential heating and cooling costs for low-income families and enhance the health and safety of residents. The program provides repairs and improvements to home heating and cooling systems and provides for the installation of energy-saving measures in the house such as insulation and air sealing. This program does not offer assistance with paying utility bills. Services are delivered through a statewide network of community-based organizations that screen for eligibility, conduct energy audits, and install energy efficient measures in the home.

DHCD publishes a handbook containing the current **Virginia Residential and Landlord Tenant Act** that specifies the rights and responsibilities of tenants under a rental agreement. It also provides information on sources of legal assistance specializing in landlord and tenant issues. The handbook is online at [http://www.dhcd.virginia.gov/HomelessnessToHomeownership/PDFs/Landlord\\_Tenant\\_Handbook.pdf](http://www.dhcd.virginia.gov/HomelessnessToHomeownership/PDFs/Landlord_Tenant_Handbook.pdf). The **Virginia Office of Consumer Affairs** can also provide assistance on matters covered by this statute.

## E. Virginia Housing Development Authority

The **Virginia Housing Development Authority (VHDA)** is the State's mortgage finance agency. Created in 1972 by the Virginia General Assembly, the VHDA's mission is to "help low- and moderate-income Virginians attain quality, affordable housing." As an independent public authority, VHDA receives no state appropriations for its operations and is fully self-supporting from revenues generated by its programs. For complete information on the programs introduced below, go to <http://www.vhda.com>.

As an independent state public authority, VHDA is subject to oversight by the Governor and the General Assembly. The Governor appoints its eleven-member governing **Board of Commissioners**, which is required to submit an annual report to the Governor on its operating and financial status. VHDA annual financial statements are subject to review by the state **Auditor of Public Accounts** and are available online at <http://www.vhda.com/about/InvestorRelations/Pages/FinancialStatements.aspx>.

Like those of the Department of Housing and Community Development (DHCD) described above, VHDA's activities target individuals and families with **low to moderate incomes**; however, VHDA may provide services for them both directly and through intermediaries. This includes outreach and training for developers and builders on Americans with Disabilities Act (ADA) **accessibility requirements** and the concepts of universal design.

**Funding** for VHDA lending programs comes from agency sales of bonds and mortgage securities, mortgage loan securitization, and net revenues from its operations. VHDA also

administers federal rental assistance programs under contract with HUD, and federal Low-Income Housing Tax Credits on behalf of the State. The administrative costs of federal programs are funded through federally authorized, administrative-fee income. VHDA receives no state budget support.

VHDA provides **mortgage financing** to developers of affordable, accessible, and safe housing options and flexible mortgage financing for the purchase of homes by first-time buyers with low and moderate incomes. These programs increase the inventory of accessible, affordable housing and expand opportunities and choices for persons with disabilities to live independently.

VHDA's investor-funded, multifamily mortgage programs are frequently used in conjunction with federal Low-Income Housing Tax Credits and VHDA REACH program subsidies funded from agency net revenues in order to achieve a financing structure that enables rents to be affordable to lower income renters.

VHDA administers the federal **Low-Income Housing Tax Credit (LIHTC)** program on behalf of Virginia. Currently, the LIHTC program is the federal government's primary program for writing down the cost of developing affordable rental housing units for low-income households. The program is administered through the states, which receive annual, per-capita, formula-based amounts of credits for allocation to eligible rental housing developments. VHDA annually allocates Virginia's credits on a competitive basis to proposed affordable rental housing developments. The tax credits provide developer equity, which substantially reduces development debt service costs and enables rents that are affordable to low income people. VHDA has set aside a portion of Virginia's annual allocation of tax credits in a non-competitive pool exclusively for providing housing services to people with disabilities. In addition, VHDA's competitive allocation of federal tax credits includes incentives for building accessible apartments and incorporating universal design features.

Despite the depth of capital subsidies provided through VHDA mortgage programs and federal Low-Income Housing Tax Credits, renters with extremely low incomes still require additional rent subsidy assistance in order to afford rental housing. To assist with this need, VHDA administers federal Section 8 "project-based rent subsidies" in housing developments it finances and federal "tenant-based" Housing Choice Vouchers in localities without an ability or willingness to directly administer those federal funds.

Previously known as "Certificates," "Section 8," or "Section 8 Existing," the **Housing Choice Voucher** is the latest name for the federal program that assists low income families, the elderly, and individuals with disabilities with rental expenses. Recipients of Housing Choice Vouchers typically pay no more than 30 percent of their monthly income for rent and utilities. Federal funds distributed through VHDA and local Public Housing Agencies (PHAs) are paid to landlords directly to cover the balance of the contracted monthly rent.

The voucher program provides **“tenant-based” assistance** that is tied directly to the tenant and not to the property or structure. Forty-one local PHAs and 32 other local agencies overseen by VHDA receive funds from the US Department of Housing and Urban Development (HUD) to administer the voucher program. Together, these agencies serve 112 Virginia counties and cities. As of December 2013, there were 49,931 vouchers authorized for use statewide. VHDA administers approximately 19 percent (9,655) of the vouchers, and the remaining 81 percent are administered by local PHAs. A complete listing of agencies that administer vouchers and eligibility for voucher assistance based on family size and annual gross income is available on the VHDA website.

When a voucher becomes available and is issued to an individual or family, the voucher holder must find a rental unit and a willing landlord. The unit must be inspected by the agency administering the voucher, and the rent requested must be reasonable for the market area. The housing assistance payment authorized by the voucher is paid by VHDA directly to the landlord, and the voucher holder pays the difference between the actual rent charged by the landlord and the amount subsidized by the voucher. Sometimes people with disabilities—who are able to find housing through a Housing Choice Voucher but need and are eligible for other services and supports to live in the community—can work with their service provider to develop the “wrap-around services” they need to stay in the community.

VHDA also administers **“project-based” Section 8 subsidies** in rental developments it has financed. Federal project-based rental assistance contracts were provided to a significant share of the private, affordable rental housing developments financed from the mid-1970s through the mid-1980s. While new subsidy contracts have been limited since that time, the inventory of older HUD and Rural Housing units continues to comprise approximately 36 percent of rental assistance units in Virginia. Public Housing units comprise 19 percent of rent subsidy units, while the Housing Choice Voucher program makes up the remaining 45 percent of rental assistance units. Preserving the existing stock of affordable rental units with federal project-based rent subsidies is a high federal and state priority, and a significant share of federal and state capital subsidies is devoted to this purpose.

Rent subsidy assistance is not a federal entitlement, and funding is insufficient to provide rental assistance for all who request it. Currently, only about one quarter of eligible households receive federal rental subsidies. As a result, housing agencies maintain waiting lists of eligible applicants. As of December 2013, VHDA reported 9,749 applicants on waiting lists for agencies that it oversees through the Housing Choice Voucher program. VHDA has not opened any agency waiting list since February of 2013 due to the March of 2013 sequestration. Local PHAs have similarly long wait lists for their rent subsidy programs.

**Educational programs** and **financial services** offered by VHDA target individual homebuyers or renters as well as developers and builders of a wide range of housing options. As with DHCD above, programs addressing the needs of individuals with low to moderate incomes, such as the Housing Choice Voucher and home loans, have income and affordability restrictions. Programs for developers and builders may require the building of a certain number of



affordable housing units for funded projects. Complete information on current eligibility requirements for each of these programs can best be obtained on the VHDA website at <http://www.vhda.com> or by contacting the Authority directly.

The Virginia Housing Development Authority (VHDA) created **Housing Search Virginia** (<http://www.virginiahousingsearch.org>), a website with a comprehensive collection of information for locating accessible apartments and learning more about accessibility requirements and universal design principles. This website, originally developed as **Access Virginia** (<http://www.accessva.org/index.html>) through a VBPD grant, is helping Virginians investigate and obtain affordable, accessible housing. To keep content current, VHDA partnered with Socialserv.com, a nonprofit organization dedicated to helping people access affordable housing and supportive services by developing solutions that utilize leading edge technology. Socialserv.com's staff ensures that listings at this site are up-to-date and accurate, conducts housing searches for tenants, and helps owners and landlords input listings and update property information. Socialserv.com staff also fields toll-free and TTD/TTY calls from people without access to the Internet who are seeking rental housing information.

VHDA's **Homeownership Loan Programs** meet the changing needs of persons with low to moderate incomes by removing barriers to purchasing a home. VHDA home mortgage loans, usually originated by private lenders, are available for both first time and repeat homeowners. Two traveling vans serve as **Mobile Mortgage Offices** to process and approve loans in the Southwest, Southside, and Eastern Shore regions of Virginia, areas not adequately served by traditional lenders. Since 1993, VHDA has also offered **Homeownership Education Classes** throughout the State to help Virginians learn the process of buying a home and maintaining it over the long-term. Classes are conducted in English, Spanish, and American Sign Language (ASL) and can also be accessed online.

VHDA's net revenues enable the **REACH Virginia** program to subsidize an array of targeted homeownership and rental funding programs serving priority housing needs, including those of people with disabilities.

Funds from VHDA's **Rental Unit Accessibility Modification** program are available to persons earning 80 percent or less of an area's median income. Grant funds are available on a first-come, first-served basis, up to \$2,000 per dwelling unit, and can be used for any work needed to make the unit accessible for an individual with a disability. The application form for these funds is available on the VHDA website.

The following sections of this chapter cover additional options for persons with disabilities to live in the community provided through **assisted living facilities (ALFs)** licensed by the **Department of Social Services (DSS)**, **adult foster care (AFC)**, an optional service provided in coordination with local departments of social services, and group homes and sponsored residential placements licensed by the **Department of Behavioral Health and Developmental Services (DBHDS)**.

## F. Auxiliary Grant for Housing and Support Services

Virginia's **SSI Supplement**, called the **Auxiliary Grant (AG)**, is currently provided to every

*needy aged, blind, and disabled person who lives in an assisted living facility or in an approved adult foster care home and who is eligible for SSI benefits or would be eligible except for excess income.*

The **Virginia Department for Aging and Rehabilitative Services (DARS)** administers the AG to ensure that recipients of Supplemental Security Income (SSI) benefits, residing in a Virginia **assisted living facility (ALF)** that is licensed by the Department of Social Services (DSS) or an approved **adult foster care (AFC) home**, are able to maintain a standard of living that meets a basic level of care. Nursing facilities and other institutional settings are covered in the **Institutional Supports** chapter of this *Assessment*.

### 1. Eligibility for the AG Program

Eligibility for Auxiliary Grant (AG) benefits is determined by the department of social services in the Virginia city or county where the individual last lived outside of an institution or an adult foster care home. The AG regulations, (22 VAC 30-80) were revised to include a **residency requirement** for all individuals applying for the AG. Individuals must be a resident of Virginia for at least 90 days or have relocated to Virginia to be closer to a relative who has been a resident for at least 90 days. To be eligible, an individual also must:

1. be blind, have a disability, or be age 65 or older;
2. reside in a licensed assisted living facility (ALF) or approved adult foster care (AFC) home;
3. be a citizen of the United States or an alien who meets specified criteria;
4. have a countable income less than the total of the Auxiliary Grant rate approved for the ALF plus the personal needs allowance;
5. have non-exempted resources of less than \$2,000 for one person or \$3,000 for a couple; and
6. have been assessed and determined to need ALF or AFC placement.

Following determination of eligibility and the level of care needed, an individual typically works with the qualified assessor or his or her case manager to select a licensed ALF. Then, at admission, the individual receives a service agreement and a preliminary service plan based on results determined through an assessment using the **Uniform Assessment Instrument (UAI)** and other relevant information. The admissions director or another appropriate employee of the ALF reviews the UAI with the individual and explains how the facility can meet his or her needs through the service plan. Standards allow up to 45 days for completion of a final service plan so that the facility can obtain a more accurate picture of the needs and capabilities of the

resident. This is helpful for individuals who may be in some degree of crisis at entry or need time to adjust to the new residence.

## 2. Access to AG Funds and Services

The Department of Social Services (DSS) is state supervised and locally administered. DSS provides oversight and guidance to 120 local offices across the State that deliver a wide variety of services and benefits to over 1.6 million Virginians each year. Virginia regulations specify procedures for assisted living facility (ALF) licensure and standards of care (22 VAC 40-72-10), the Auxiliary Grant Program (22 VAC 30-80-10), and the assessment of individuals who seek admission to ALFs (22 VAC 30-110-10). There are two main services covered by Auxiliary Grants:

- **Room and board** includes a furnished room in a building that meets all required fire safety codes; housekeeping services appropriate for the resident's needs; complete meals, snacks, and special diets, if necessary; and clean linens and towels as needed and at least once a week.
- **Maintenance and care services** include minimal assistance with personal hygiene and grooming, including provision of personal supplies; administration of medications as required by licensing regulations; minimal assistance with the care of personal possessions and personal funds, if requested by the recipient and allowed by the facility; minimal assistance with telephones and correspondence; securing health care and transportation when needed; making appointments and arranging transportation; provision of social and recreational activities as required by licensing regulations; and general supervision for safety.

In addition to these basic services provided by an ALF or AFC home, Auxiliary Grants provide a **personal needs allowance**, mentioned above, to the recipient. This allowance is used to cover medical expenditures such as copayments, prescriptions not covered by Medicaid, dental care, eyeglasses, and nonprescription over-the-counter medications; local and long-distance telephone service; personal transportation, clothing, toiletries, and other personal expenditures; and other needs outside of what are offered by the ALF or adult foster care provider. Regulations prohibit use of the allowance funds for recreational activities, administration of accounts, debts owed to the ALF for basic services, or laundry charges of more than \$10 per month.

Although persons with intellectual disabilities or other developmental disabilities may reside in ALFs, persons with mental illness are typically their primary residents. Pursuant to DARS regulations, individuals seeking admission to an ALF must be assessed at least annually to determine their level of care. Local departments of social services or other qualified assessors use the Uniform Assessment Instrument (UAI) to conduct the assessment. The UAI gathers information to assess an individual's care needs and eligibility for various services to accommodate care planning and monitoring across multiple agencies. In addition to its use by local departments of social services, it has been used by local departments of health, Area Agencies on Aging (AAAs), Medicaid-funded, long-term care service providers, and Medicaid

nursing facility preadmission screening teams since July 1994. The form is available online at <http://www.cdaaa.org/images/UAI.pdf>.

**Adult foster care (AFC)** is a community-based contractual arrangement, authorized by the Code of Virginia (63.2-1601, 51.5-146 and 51.5-160), and involving DARS, the local department of social services, an approved service provider, and an individual intending to utilize AFC services. No more than three individuals may receive AFC services at one time in the home of an approved provider, regardless of whether those services are funded privately or through an Auxiliary Grant. To provide care for more than three individuals requires licensure by DSS as an assisted living facility. Room, board, supervision, personal care, and other special services are provided to individuals in approved adult foster care homes. Policies relating to service delivery can be found in the 2010 Department of Social Services' *Manual for the Provision of Adult Foster Care Services*. Currently, the information in this manual is being incorporated into another document. Once this process is complete, the manual will be obsolete. At the time of this assessment, it remains available online at [http://www.dss.virginia.gov/files/division/dfs/as/as\\_intro\\_page/manuals/adult\\_fc/adultfostercareguide\\_1\\_2010.pdf](http://www.dss.virginia.gov/files/division/dfs/as/as_intro_page/manuals/adult_fc/adultfostercareguide_1_2010.pdf).

Currently, about 15 percent of assisted living facility (ALF) residents are receiving the AG each month. According to the Department of Social Services' *Fiscal Year 2013 Adult Protective Services Division Report*, which summarizes data from the Adult Services and Adult Protective Services (ASAPS) case management system, Auxiliary Grants were received by a total of 5,766 unduplicated individuals in state fiscal year (SFY) 2013. The average monthly ALF caseload in SFY 2013 was 4,669. Of these, 1,655 were classified as aged; 6 were blind; and 3,008 had a disability. The average monthly adult foster care (AFC) caseload was 35. Of these, 8 were classified as aged; 1 was blind; and 26 had a disability.

According to the Joint Legislative Audit and Review Commission's report summary *Funding Options for Low-Income Residents of Assisted Living Facilities*, there were 561 licensed ALFs with a licensed bed capacity of 32,000 in Virginia as of 2011. These counts, however, are fluid and can change monthly. The number of ALFs has declined by 118 from 679 in 2001 to 561 in 2011. Not all ALF's accept AG recipients, and the number of ALFs that do accept them declined from 375 in 1997 to 349 in 2005 to 312 in 2011. The number of localities with no ALFs accepting AG recipients increased from 41 in 2006 to 48 in 2011.

In 2009, 75 percent of the 78 local departments of social services (DSS) with declines in their caseloads during SFYs 2007 and 2008 responded to a survey that identified the top three reasons for this decline:

1. ALF providers are unable to accept Auxiliary Grant recipients because the grant rate is insufficient for them to provide for recipients' required needs.
2. The needs of Auxiliary Grant recipients exceed ALF levels of care.

3. Individuals choose to remain at home and utilize home-based services, Medicaid Home and Community Based Services (HCBS) Waivers, or case management by Community Services Boards (CSBs).

In addition, due to current DSS licensure requirements and Medicaid HCBS Waiver regulations, few people with intellectual or developmental disabilities (ID/DD) are being served in assisted living settings. Those facilities face the same challenges as group homes in providing small, quality residential settings and will likewise require higher provider rates or supplemental funding assistance to become a viable, community housing alternative for that population.

Virginia state agencies, auxiliary grant recipients, and advocates have expressed a desire to pursue **portability of the Auxiliary Grant** and additional funding structures that could efficiently and effectively support an array of quality, supportive housing alternatives. Progress has been stymied by concerns related to Maintenance of Effort (MOE) requirements, which ensure that federal cost-of-living adjustments are passed along to individuals receiving Supplemental Security Income (SSI) benefits. Efforts to test the feasibility of various alternatives to current SSI program design, including establishing and funding a separate but similar “state supplement” program that is independent of Social Security Administration (SSA) and AG regulations, are worthy of continued exploration.

In addition to Virginia, 44 other states provide recipients of federal Supplemental Security Income (SSI) benefits with a variety of monetary supplements tied to various types of residential settings that may serve persons with disabilities. Unlike some other states, Virginia’s Auxiliary Grants are only available to residents of ALFs or adult foster care and do not provide supplemental funds for individuals living independently. As a result, the use of Auxiliary Grants, the only state-guaranteed housing assistance available to most Virginians with disabilities, is restricted to residential settings that are congregate and more institutional in nature.

A complaint was filed against the Commonwealth of Virginia by the Quality Trust for Individuals with Disabilities and the National Alliance on Mental Illness of Virginia. The complaint alleges that Virginia is violating the Americans with Disabilities Act (ADA) by requiring people with disabilities to live in segregated group homes in order to receive benefits under the AG. In a notice dated July 30, 2013, the Office for Civil Rights at the US Department of Health and Human Services announced that it had “determined that it will pursue action” on the complaint. Specifically, the complaint states that the regulations issued by the Virginia Department of Social Service (DSS) require people to live in group homes or adult foster care in order to receive any benefits from the program. The complaint contends that such a requirement violates the letter and spirit of the ADA and Virginia law. The complainants ask that AG fund recipients be permitted to live in housing of their choice versus facilities that are segregated, isolated in relatively few areas of the Commonwealth, and those that DSS refers to as “institutions.” The full complaint and the decision from the Office for Civil Rights can be accessed online at <http://namivirginia.org/advocacy/legislative-issues/>.

### 3. Funding for the State AG Program

State General Funds constitute 80 percent of the funding for Auxiliary Grants (AGs). Localities must provide matching funds to make up the remaining 20 percent. Not all assisted living facilities accept AG payments. The General Assembly sets the maximum rate for Auxiliary Grants and adjusts it periodically.

Following is a general example that does not apply uniformly since an individual's AG or personal allowance amounts may be different, but using sample figures helps to explain how the AG program typically works. Let us say that an individual with a disability receives SSI in the amount of \$710 per month (the unreduced SSI benefit as of January 1, 2013) and lives in a DSS-licensed ALF or AFC placement. The AG would increase the monthly SSI payment to \$1,278 (\$1,457 in planning district 8 due to a 15-percent differential). In other words, a supplement of \$486, plus the \$82 personal needs allowance, provides a total of \$568 that is added to the SSI payment for a total payment of \$1,278. The individual residing in the ALF/AFC is entitled to a personal needs allowance of \$82 per month. Once that \$82 is given to the individual (or his or her representative), the remaining \$1,196 is paid to assisted living facility or adult foster care home provider for room, board and services mentioned below.

As of July 1, 2012, ALF and AFC providers can accept third-party payment on behalf of an AG individual. These payments are not counted as income when determining eligibility for AG. The payments must be made directly to the provider by the third party (on behalf of the individual receiving AG) after the goods or services have been provided. The payment needs to be voluntary by the third party and not a condition of admission, stay, or provision of proper care and services to the individual receiving the AG. The payments must be made for goods and services that are provided to the individual who receives the AG but cannot be for food, shelter, or specific goods and services that the ALF or AFC provider is required provide. Third-party payments cannot be used for a private-room upgrade.

### 4. Monitoring of AG Programs

The Department of Social Services' **Division of Licensing Programs** has responsibility for protecting children and vulnerable adults in some residential, daycare, and other settings. It licenses assisted living facilities (ALFs) and adult daycare centers and has regulatory responsibilities covering family day homes, independent foster homes, child-placement agencies, and children's residential facilities. It also voluntarily registers family day homes that are not required to be licensed.

Local department of social services **Adult Protective Services (APS) units** investigate reports of abuse, neglect, and exploitation of incapacitated adults ages 18 and over and all adults ages 60 and over. Protective measures are initiated when warranted by the results of their investigations and the individual who is the subject of the report agrees to accept services. DARS Adult Protective Services Division provides state oversight for local APS. DSS **Child Protective Services (CPS)** has equivalent responsibilities for children under age 18. Reports of abuse, neglect, and exploitation are directed to local departments of social services. Local DSS

staff conducts the investigations and initiates protective measures as warranted. The goal of CPS is to identify, assess, and provide services to children and families in an effort to protect children and preserve families.

The Code of Virginia (63.2-1728) specifically requires DSS to establish a toll-free telephone line (800-543-7545), for complaints. DSS investigates all complaints received regarding the operations of assisted living facilities, adult daycare centers, and child welfare agencies, regardless of whether the program is subject to licensure. The Code of Virginia (51.5-148) requires the establishment of a toll-free APS hotline (call 888-832-3858); and a Child Protective Services hotline, 800-552-7096.

Investigations of complaints about licensed facilities and homes may include onsite visits by the DSS licensing division to inspect activities, services, records, and facilities as well as interviews with a facility's employees, agents, and anyone within its custody or control. If a facility is found to be noncompliant, DSS must provide notice to the operator and may then take appropriate action as provided by law to ensure corrective action. The Code of Virginia (63.2-1808) details the rights of residents of assisted living facilities, the responsibilities of their operators, and requirements for an annual review of residents' rights.

The Code of Virginia (51.5-148) also details the responsibility and authority of Adult Protective Services (APS). APS investigations are confidential, and reports may be made anonymously. The investigation must include an in-person meeting with the alleged victim, unless the APS worker documents why the interview cannot occur and makes contact with others who have knowledge of the individual or the circumstances, such as relatives, personal representatives, caregivers, and facility staff. A disposition must be made within 45 days of the report unless the APS worker documents in the case file why a disposition has not been made. APS will only investigate if the individual is deemed to be "at-risk of or experiencing abuse, neglect or exploitation."

An investigation that has started may cease if the individual dies, if the individual is removed from the abusive situation, or if the alleged perpetrator no longer has access to the individual.

## **G. Department of Behavioral Health and Developmental Residential Services**

Additional options for persons with disabilities to live in the community are provided through **group homes** (sometimes called **waiver homes**) and **sponsored residential homes** licensed by the **Department of Behavioral Health and Developmental Services (DBHDS)**. The DOJ Settlement Agreement requires the Commonwealth to

*facilitate individuals receiving HCBS waivers under this Agreement to live in their own home, leased apartment, or family's home when such a placement is their informed choice and the most integrated setting appropriate to their needs.*

Virginia's current Medicaid Intellectual Disability Waiver structure favors (and ID Waiver service providers predominately provide) services in **congregate residential facilities** as opposed to **individualized supports** that can be used in any type of housing, regardless of the level of care or its intensity. This programmatic approach toward the ID Waiver links housing and services in ways that inhibit individual choice and flexibility. For example, in DBHDS-licensed group homes and supervised living programs, individuals can select a provider that makes both the housing and the services available. However, if an individual decided to change service providers, he/she might have to move to another living situation. Likewise, if an individual wanted to live in another area or a different type of housing (e.g., an apartment or mobile home), he or she may have to find a different service provider who will work in that setting.

Medicaid law prohibits the use of Medicaid funds to pay for rent, utilities or food (room and board) outside of an institution (i.e., nursing facility, Training Center, long-stay hospital, ICF/IID). Consequently, this means that Medicaid Waiver funds cannot be used to support the monthly operating costs (room and board) of community-based congregate housing (group homes) or for an individual's own home or apartment. Other financial sources, including client fees, must be used to cover these costs (See the **Funding for Residential Services** section of this chapter.) This can make it more difficult for providers of community-based housing to cover their monthly operating costs and it incentivizes the use of institutional settings (For more information, see the **Medicaid** and **Institutional Supports** chapters of this *Assessment*.)

The demand for **integrated housing** is expected to rise as people become more knowledgeable about the ability to select integrated living settings. The apparent preference of people served with the ID Waiver to use congregate housing may be the result of a lack of information or availability of services in integrated housing. Their options may be limited to congregate housing if they cannot otherwise afford market-rate housing or if they do not have a Housing Choice Voucher or other housing subsidies. However, the pace of that progress has been and will continue to be hampered by limitations in locating affordable, accessible housing.

## **1. Eligibility for Residential Services**

As described in earlier chapters of this assessment, local **Community Services Boards (CSBs)** are the single point of entry in Virginia for all publicly funded services for persons with intellectual disability (ID), including **residential services** such as those provided in a DBHDS-licensed group home. Within the Medicaid Home and Community Based Services Waivers, the Medicaid **Intellectual Disability Waiver (ID Waiver)** is the primary source of funding for residential placement of people with intellectual disability in DBHDS-licensed group homes.



Eligibility for residential supports requires that a person have a diagnosis of intellectual disability. The CSB then determines and documents that the person's functional needs can be met by, and are appropriate for, a **group home** and that the individual chooses to receive services through the ID Waiver rather than receive institutional services. The appropriate level of residential supports is based on each person's needs and his or her natural supports. Under the ID Waiver, there is also an option for in-home residential supports, and services are provided to an individual in his or her **private home**, rather than in a group home.

It is important to note that an option for congregate (group home) residential services is not available through the **Medicaid Individual and Family Developmental Disabilities Support Waiver (DD Waiver)**; however, the DD Waiver does provide in-home residential support services for individuals residing in their own home or apartment and does allow for shared residences that are not considered congregate, i.e., a DBHDS-licensed group home. Therefore, when an individual receiving DD Waiver services wants to change providers, he or she can do so without fear of losing their housing. More information on Home and Community Based Waivers can be found in the **Medicaid** chapter of this *Assessment*.

## 2. Access to and Use of Residential Services

After an individual has been determined to be eligible for the Medicaid Home and Community Based Services ID Waiver and has selected **community residential services** rather than an institutional residential services option, his or her Community Services Board (CSB) case manager submits the required enrollment information to the DBHDS Division of Developmental Services (DDS). If no ID Waiver "slot" is available to the CSB, the individual's name is placed on a waiting list until a slot becomes available. The CSB case manager is responsible for notifying the individual or family of placement on the **ID Waiver Waiting List** in writing within 10 days of placement on the statewide waiting list and must also provide notification of appeal rights and processes. Once an ID Waiver slot is available to the individual, he or she can choose a residential services provider if one is needed. Detailed information on ID Waiver Waiting List policies and procedures are found in the **Medicaid** chapter of this *Assessment*.

DBHDS regulations (12 VAC 35-105-20) describe **residential services** as a category of service providing 24-hour support in conjunction with care and treatment or a training program in a setting other than a hospital or a state-operated Training Center. Residential services are provided to people in a range of living arrangements from highly structured and intensively supervised to relatively independent, requiring a modest amount of staff support and monitoring. Current residential support services include the following:

- residential treatment, group or community homes,
- supervised living,
- residential crisis stabilization,
- community gero-psychiatric residential services,
- community intermediate care facilities for individuals with ID (ICF/IID),

- sponsored residential homes,
- medical and social detoxification,
- neurobehavioral services, and
- substance abuse residential treatment for women and children.

Among the housing options for individuals with intellectual disabilities or developmental disabilities are the following, as described in the report of a housing study mandated by the General Assembly through the 2009 Appropriations Act, Item 315.Z.

- **Group Homes:** In 2009, 62 percent of the recipients of Medicaid Home and Community Based Services (HCBS) Intellectual Disability Waiver services resided in DBHDS-licensed group homes. There are a few state and federal programs available to help finance the development of new group homes. In particular, the federal Section 811 program provides both capital grants and ongoing operating subsidies to support group home development. The challenge is that small homes with four or fewer residents that conform to Virginia's and other states' model of community integration lack sufficient economies of scale to support ongoing feasibility at established provider rates. Consequently, there continues to be a predominance of larger homes. Resolution of this problem requires higher provider rates or supplemental funding assistance.
- **Sponsored Residential Homes:** Called "host homes" in other states, this is a model of residential services in which a licensed provider contracts with a family that lives in its own private residence to share the family residence with up to two individuals with disabilities. In this setting, family members provide all of the supports that are prescribed in the individual's service plan (ISP) and are subject to all of the regulations that apply to group homes. Because sponsored residential homes are licensed as a congregate service, they are not provided under the DD waiver as it is currently structured.
- **Supervised Apartments:** Also called supportive in-home services, supervised apartments are not licensed congregate settings. Supervised apartments enable people with ID or DD to reside independently in mainstream housing while receiving the in-home services and supports they need through the Medicaid HCBS Waivers. There is no mechanism to provide assistance with shelter costs (i.e., rent) for a supervised apartment. Therefore, housing providers are reliant on their ability to access scarce federal rent or operating subsidies in order to create new, affordable supervised apartments.

More specific information on services covered under the Medicaid ID and DD Waivers can be found in the **Medicaid** chapter of this *Assessment*. Detailed information on public and private ICFs/IID can be found in the **Institutional Supports** chapter.

### 3. Funding for Residential Services

Virginia began utilizing **Medicaid funding** for community-based services for persons with intellectual disability (ID), including residentially based supports, in 1991 via the then-termed the “Medicaid Mental Retardation Waiver.” This was followed in 2000 by the current Individual and Family Developmental Disabilities Services Waiver (DD Waiver) to provide supports to persons with other, non-ID developmental disabilities (DD). Both waivers include residentially based services and supports. The ID Waiver funds supports for those who live in group homes, host homes, family homes, and supported living apartment settings. The DD Waiver funds supports for those with developmental disabilities residing in family homes and supported living apartment settings. As noted above, the Medicaid Waivers do not cover the costs of room and board.

Providers of services covered by Medicaid's Home and Community Based Services (HCBS) Intellectual Disability (ID) Waiver are licensed by DBHDS and are reimbursed by Medicaid for **residential services** [provided that the services are consistent with an individual's approved Individual Support Plan (ISP)]. Reimbursement rates are set by the Virginia Department of Medical Assistance Services (DMAS) with the approval of the Virginia General Assembly and are based on an hourly rate for an approved number of hours of service per month. As mentioned earlier in this chapter, Medicaid does not pay for room and board as part of its community-based residential services. It reimburses only for actual services provided by residential staff according to the individual's ISP. Group home residents are typically assessed a fee for room, board, and general supervision (not funded by Medicaid) by their service provider. The fee is a large percentage of the individual's income, which, in the majority of cases, is limited to Supplemental Security Income (SSI) benefits.

### 4. Monitoring of Residential Services

The regulatory and oversight of responsibilities of DBHDS for public and private residential facilities and services that it licenses or funds are covered in the monitoring and evaluation section of the **Community Living Supports** and **Institutional Supports** chapters of this *Assessment*. These chapters also include information on the **Office of the Inspector General (OIG) for Behavioral Health and Developmental Services** and the **Office of Human Rights**. The **Medicaid** chapter discusses the monitoring requirements of the State's Medicaid agency.

## H. Virginia Fair Housing Office

Public awareness and enforcement of the State's fair housing law is the responsibility of the **Department of Professional and Occupational Regulations' (DPOR) Virginia Fair Housing Office (VFHO)**, which serves as the investigative arm of Virginia's **Fair Housing Board (FHB)** and **Real Estate Board (REB)**. The FHB administers and enforces the fair housing law for most individuals and businesses, while the REB retains jurisdiction over real-estate licensees, their employees, and a property owner (or owner's agent or principal) who has engaged a real-estate licensee to perform real-estate activities. The FHB is also charged with establishing a fair housing certification program applying to non-licensed property managers, leasing consultants,

and homeowners who are involved in selling or renting dwellings. Both boards meet at the DPOR offices in Richmond, and the public is welcome to attend their meetings.

The State's **first fair housing law**, enacted by the General Assembly in 1972, was initially similar to the fair housing provisions of the national Fair Housing Act of 1968; however, amendments over time have extended its coverage to protect an additional class of individuals, making it broader than the federal law. Virginia's fair housing law **prohibits discrimination** on the basis of race, color, religion, national origin, sex, familial status, "handicap," and "elderliness." Elderliness, which refers to anyone who is age 55 or older, is not a covered protected class under the federal law.

Individuals who feel they have been discriminated against or that fair housing laws have been violated report their **complaints** directly to the VFHO. Staff investigates the allegations by conducting interviews with the complainants, respondents, and relevant witnesses and by reviewing appropriate records and other documents.

Once the investigation is complete, a final report is completed that summarizes the evidence obtained. That report and the evidence are presented to the FHB or REB, whichever is appropriate, at its next regularly scheduled meeting. Following the FHB or REB's review of the evidence, it can issue a "no reasonable cause" finding or a "reasonable cause" finding. If it finds no reasonable cause, both parties are notified in writing, and no further action is taken. If there is a finding of reasonable cause, the parties have 30 days to engage in conciliation attempts.

**Conciliation** is a voluntary process in which the parties attempt to come to a mutually acceptable agreement. If conciliation is successful and approved by the FHB or REB, the investigation is suspended. If one or both parties reject conciliation or they are unable to resolve the complaint through the conciliation process, a charge is issued and immediately referred to the state Office of the Attorney General for further action. Both parties involved are notified accordingly, in writing. In fiscal year 2013, the VFHO investigated and closed 58 cases. Conciliation was successful in approximately 25 percent of these cases, resulting in awards to complainants of approximately \$37,000.

In addition to investigating and settling complaints, the VFHO conducts outreach and training on fair housing laws. These activities range from distribution of handouts to sophisticated interactive presentations by the VFHO staff to state and local officials, housing providers, and consumers. This training is offered free and is tailored to meet the specific needs of its recipients.

Virginia and other states across the nation are pursuing a variety of cost-effective investment models to expand choice in community housing for people with disabilities. A key element in successful efforts has been targeting state funds to fill critical funding gaps, stimulating investment of private capital to develop affordable housing. The size and nature of these funding gaps vary with the type of housing being developed; therefore, diverse funding strategies are needed to support different housing choices. These strategies were recognized in

the report of the housing study recently called for by the General Assembly (2009 Appropriations Act, Item 315.Z):

*First, a number of states have appropriated funding for rent or operating assistance tied to specific newly created rental housing units—often a set-aside of units in rental housing receiving development subsidies through the federal Low-Income Housing Tax Credit (LIHTC) program. This has enabled state LIHTC administrative agencies to mandate set-asides of units in their LIHTC programs. Absent such state funded assistance, many states, including Virginia, have provided incentives to developers in the competitive tax credit allocation process to encourage set-aside units for people with disabilities, but have not made such set-asides mandatory.*

*Second, some states have created state rental voucher assistance programs for people with disabilities. Often assistance is targeted to Medicaid Waiver recipients to enable them to access affordable community housing without the multi-year wait time frequently necessary to participate in over-subscribed local Section 8 Housing Choice Voucher programs. State voucher assistance has expedited the use of Medicaid Waivers and facilitated the success of state Money Follows the Person initiatives. Absent such state funded assistance, it has been nearly impossible for Virginia to coordinate locally managed federal Housing Choice Voucher waiting lists with state Medicaid Waiver waiting lists, thus making it extremely difficult to transition people from state institutions to community housing in a timely manner.*

As values shift toward community inclusion and full citizenship for people with disabilities, the focus on needed community housing grows. Individuals with disabilities desire control over decisions about where, how, and with whom they will live. They want decent, safe, affordable, and accessible housing as well as access to the services and supports that they need to live as independently as possible. Best practice models of housing choice and community integration for people with disabilities do not couple the two within a particular residential setting.

As noted above, **universal design** refers to items or home features that are usable by most people regardless of their level of ability or disability. For example, round doorknobs are not usable by people with limited use of their hands, but lever handles are usable by almost everyone, including people who have no hands. Universal design addresses the scope of accessibility and promotes making all elements and spaces accessible to and usable by all people to the greatest extent possible.

Two additional key initiatives have influenced the availability of accessible housing. During its 2011 session, the Virginia General Assembly voted to increase the **Livable Home Tax Credit** from \$2,000 to \$5,000 for new homes and for the retrofitting of current homes that meet specific visitability and universal design requirements. Additional information on this tax credit

program appears in the **Virginia Department of Housing and Community Development** section of this chapter.

Complementing the tax credit, the Virginia **EasyLiving Home** certification program, established through the work of a coalition of public and private organizations, encourages the inclusion of key features that make a home cost effective, accessible, and convenient for everyone. This voluntary certification specifies criteria in everyday construction that builders can incorporate into new homes to make them welcoming to residents and their friends, family, and visitors, regardless of age, size, or physical ability. More information on the certification program is available at <http://www.elhomes.org>.

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#### **National Low Income Housing Coalition**

<http://www.nlihc.org>

#### **Transportation and Housing Alliance Toolkit**

<http://www.tjpdc.org/housing/thatookit.asp>

#### **US Department of Housing and Urban Development**

<http://portal.hud.gov/portal/page/portal/HUD>

#### **US Social Security Administration**

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#### **Virginia Department for Aging and Rehabilitative Services, Division for the Aging**

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

#### **Virginia Department of Behavioral Health and Developmental Services**

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

#### **Virginia Department of Housing and Community Development**

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

**Virginia Department of Medical Assistance Services**

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

**Virginia Department of Professional and Occupational Regulation, Fair Housing Office**

<http://www.dpor.virginia.gov/FairHousing/>

**Virginia Department of Social Services**

[http://www.dss.virginia.gov/family/adult\\_care.html](http://www.dss.virginia.gov/family/adult_care.html)

**Virginia Housing Development Authority**

<http://www.vhda.com>

**Virginia Olmstead Initiative**

<http://www.olmsteadva.com>

**Virginia Statewide Independent Living Council**

<http://www.vasilc.org>

**Virginia Uniform Assessment Instrument**

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## IX. Transportation

### A. Introduction to Accessible Transportation Services

The Americans with Disabilities Act (ADA, 42 USC 12101) and the Virginians with Disabilities Act (51.5-44) stipulate that people with disabilities have the same rights as other persons to the full, free use of the streets, highways, sidewalks, and all other parts of the transportation system. For people with disabilities, the Code of Virginia (54.1-44[B]) further requires

*full and equal accommodations, advantages, facilities, and privileges of all common carriers, airplanes, motor vehicles, railroad trains, motorbuses, streetcars, subways, boats, or any other public conveyances or modes of transportation.*

In addition to being guaranteed access to basic transportation systems, as required by law, Virginians with disabilities are served by the following specialized transportation systems:

- regularly scheduled accessible transit services,
- “paratransit” or “demand-response” services, and
- emergency and nonemergency human service transportation available through publicly funded insurance programs or from disability services providers.

Since the passage of the Americans with Disabilities Act (ADA) in 1990, **paratransit service** has grown rapidly as a mode of public transit across the nation, and continued growth can be expected due to the aging of baby boomers. Some estimates suggest paratransit ridership could double during the next 10 years. In its mode of service definitions, the American Public Transportation Association (<http://www.apta.com>) defines paratransit as:

*a mode of transit service [also called demand response or dial-a-ride] characterized by the use of passenger automobiles, vans or small buses operating in response to calls from passengers or their agents to the transit operator, who then dispatches a vehicle to pick up the passengers and transport them to their destinations. The vehicles do not operate over a fixed route or on a fixed schedule. The vehicle may be dispatched to pick up several passengers at different pick up points before taking them to their respective destinations and may even be interrupted en route to these destinations to pick up other passengers.*

A variety of state entities are involved with providing transportation services for Virginians with disabilities. The **Virginia Department of Transportation (VDOT)** is the Commonwealth’s chief agency for transportation planning and for the construction, maintenance, and operation of its highway systems and related infrastructure; however, while extremely important, VDOT’s

role in providing service to people with disabilities is largely indirect. VDOT's mission is to "plan, deliver, operate, and maintain a transportation system that is safe, enables easy movement of people and goods, enhances the economy, and improves our quality of life." It is responsible for ensuring that Virginia's state-maintained highway system is compliant with the federal Americans with Disabilities Act (ADA), but it has no programs, projects, or initiatives specifically targeted to serving the transportation needs of people with disabilities. More can be read about VDOT and its array of activities and programs at the VDOT website: [http://www.virginiadot.org/default\\_noflash.asp](http://www.virginiadot.org/default_noflash.asp).

An important priority for the Commonwealth for the past 5 years has been the coordination of human service transportation. On November 6, 2013, the **Government Accountability Office (GAO)** released its publication, *Transportation Disadvantaged Populations, Coordination Efforts Underway, but Challenges Remain*. This *Statement for the Record* report indicates that people in need of transportation benefit more often and experience a higher quality of service when transportation providers coordinate their operations. In 2012, the GAO reported that 80 federal programs in 8 different agencies fund a variety of transportation services for transportation-disadvantaged populations. Within the Department of Transportation, the **Federal Transit Administration (FTA)** is a key source of federal transportation funding. FTA funds assist state and local grantees in helping transportation-disadvantaged populations, including older adults and individuals with disabilities. For example, FTA's Enhanced Mobility for Seniors and Individuals with Disabilities program provides formula funding to states to service the unique needs of transit-dependent populations beyond traditional public transportation services. This program requires grantees to **coordinate transportation services**.

One key barrier identified by the GAO to increased coordination efforts is the lack of federal guidance on how to **share costs across programs**. The GAO further states that

*limited financial resources and growing unmet needs are also challenges for state and local providers and their ongoing coordination efforts—both now and in the future. State and local officials nationally express concern about their ability to adequately address expected growth in elderly, disabled, low-income, and rural populations.*

Public transportation, and in particular paratransit services, explained in greater detail later in this chapter, are heavily subsidized. The GAO estimates that the cost of ADA paratransit services can be three-and-a-half times more expensive than the average cost of fixed-route trips. This increased expense creates a dilemma: As the need for and use of paratransit service grows, so does the cost and need for increased funding to subsidize the service.

At the Federal level, the total funding for transportation services for the transportation disadvantaged remains unknown because, in many cases, federal departments do not separately track spending for these services. Of the 80 programs that the GEO identified in 2012, roughly two-thirds of the programs were unable to provide spending information for eligible transportation services offered in federal fiscal year (FFY) 2010.

The **Virginia Department of Rail and Public Transportation (DRPT)** receives funding from the FTA and plays a key role in meeting transportation needs for Virginians both with and without disabilities. It provides financial and technical assistance to more than 160 public transportation operators, health and human service providers, commuter assistance agencies, and railroad operators in the State. Three of the 75 largest transit agencies in the country operate in Virginia. Metrorail is the nation's second most heavily used rail transit system, with more than 700,000 average weekday passenger trips. The Virginia Railway Express (VRE) commuter rail system is one of the fastest-growing commuter rail services in America.

## **B. Department of Rail and Public Transportation**

In accordance with state law, the mission of the Virginia Department of Rail and Public Transportation (DRPT) is

*to improve the mobility of people and goods while expanding transportation choices in the Commonwealth.*

The Code of Virginia (33.1-391.1-391.5) identifies 164 specific responsibilities for DRPT, under the categories of

*economic and financial analysis capabilities, accountability, planning and programming, and coordination.*

The DRPT director reports to the Secretary of Transportation, and the Commonwealth Transportation Board provides guidance and oversight for the agency. The Governor appoints the Board's 17 members with the Secretary of Transportation as chair, and the Commonwealth Transportation Commissioner as vice chair. The DRPT director is a non-voting member. DRPT works with VDOT and other state agencies to plan and administer a wide range of transportation activities in Virginia and has specific responsibility for oversight, evaluation, and technical assistance for certain federal grant programs.

The *2012–2014 Strategic Plan for the Commonwealth's Department of Rail and Public Transportation* (DRPT) states that:

*In FY 2005, the DRPT budget totaled \$248.5 million as compared to \$459.3 million in FY 2013. This represents an increase of over 84% during the past eight years despite the recent recession.*

It further states that:

*Ridership on transit systems in Virginia totaled 196,371,408 for FY 2012. Additionally, there were 1,292,436 passenger trips provided for transit dependent Virginians to ensure access to basic human services such as employment, medical care, shopping, and social activities.*

In its strategic plan, DRPT notes that:

*As Virginia's population ages, services such as human service transportation will be in higher demand. As such, the number of organizations providing these services must increase as well as the coordination among operators to share best practices and create a seamless network of services.*

For a number of years, Virginia has emphasized development of coordinated human service transportation models that include a broad range of services designed to meet the needs of populations who need transportation options beyond a personal automobile, particularly older adults, people with disabilities, and people with lower incomes. Depending on their abilities, their environment, and the transportation services available in their communities, these individuals may require a variety of mobility options. Examples include transportation services provided by human service agencies for people participating in their programs, "dial-a-ride" paratransit services, taxi voucher programs, and transportation services provided through volunteer drivers.

DRPT has taken the lead in statewide efforts on human service transportation coordination. Many of these initiatives emanated from federal directives and incentives. DRPT's strategic plan for 2012 through 2014 cited earlier, describes human service transportation programs in the Commonwealth as

*operated by local government social service agencies or private nonprofit human service agencies for the benefit of their clients. These clients are elderly or disabled individuals and economically disadvantaged children who are enrolled to receive publicly funded social services. Human service transportation differs from public transportation in that it is designed to serve the very specific needs of human service agency clients and in most cases, service is restricted to the clients of those agencies who often have no other transportation service available to them. It is not open to the general public.*

An example of DRPT's leadership on statewide and regional efforts to improve human service transportation coordination is its establishment of the **State Agencies Coordinating Transportation (SACT) Work Group**. The goal of the SACT, established in 2003, was to promote interagency cooperation at the state level. (The SACT Work Group last met in 2011.) This Work Group was instrumental in the development of a *Memorandum of Understanding Related to Coordinated Human Service Transportation in Public and Nonpublic Transit Systems*. Additionally, the SACT drafted the *State Coordination Model for Human Service Transportation*, which provided recommendations focusing on state-level and regional structure, the role of Planning District Commissions, and the ongoing funding structure.

The vision and guidance provided by SACT also informed DRPT's approach to the development of regional **Coordinated Human Service Mobility (CHSM) Plans**. A total of 21 regional plans, conforming to Planning District Commission boundaries, were initially developed

in 2008. These plans were revised and updated in 2013 through a series of 26 regional meetings. Additional information about the development and content of the CHSM Plans is provided later in this chapter.

DRPT's **Rail and Transit Division** administers and manages state and federal grant programs, including state operating-assistance grants, capital assistance grants, and special projects grants. It conducts performance evaluations, provides technical assistance, and works to support ride-sharing operations and alternate commuting options. The advice, technical support, and funds that DRPT provides for operators of passenger rail and public buses, including paratransit service operators, are of particular importance to transportation services for people with disabilities. Public transportation staff within the Division also manages rural and specialized grant funds provided by the Federal Transit Administration (FTA).

### 1. Eligibility for Public Transportation Services

With the passage of the Americans with Disabilities Act (ADA) in 1990 and its subsequent amendment in 2008, **all activities of state and local government are required to be accessible to people with disabilities**. Accessibility is not limited to programs receiving federal funds, as required by Section 504 of the Rehabilitation Act (29 USC 794). Under ADA, public transit services, regardless of how they are funded or managed, must be accessible. Transit providers may meet accessibility requirements through the use of paratransit services, either on existing **fixed routes** or on a **demand-response** basis. Eligibility for paratransit service typically requires verification of a disability under the Americans with Disabilities Act. Different localities may have different processes for establishing eligibility.

### 2. Access to Public Transportation Services

Buses, trains, and other means of public conveyance usually operate on fixed routes with stops at specified times or time intervals. As indicated in the eligibility section above, when individuals with disabilities are not able to use these services, the Americans with Disabilities Act (ADA) requires that they be served by **paratransit** or **demand-response services**. Those services may be provided directly by the transit system itself or through a separate operator. As of June of 2014, there were 72 public transit providers listed in the Department of Rail and Public Transportation (DRPT) statewide database. This list is available at <http://www.drpt.virginia.gov/locator/allproviders.aspx?type=0>.

For paratransit and demand-response systems, the rider or someone acting on his or her behalf typically calls a reservation agent to schedule a pickup day and time. The caller must inform the agent of any special circumstances such as the need for a wheelchair accessible van or an attendant accompanying the rider. Times of operation and requirements for advance notice of a pickup vary widely among localities. Most services require notice at least 24 hours in advance, and some providers have penalties for late notice or frequent trip cancellations. Transportation service providers in a rider's locality should be contacted directly for details. Local transportation information and resources can also be found at the Virginia Easy Access website at <http://www.easyaccess.virginia.gov/transportation.shtml>.

### 3. Available Public Transportation Services

The vast majority of scheduled, fixed-route transit services use buses or trolley buses on public streets and highways. **Paratransit services** are required by law for persons with disabilities who are not able to use fixed-route services. Paratransit services generally use smaller, specially equipped vehicles such as vans or minibuses and have specially trained operators. Paratransit must operate in the same areas and during the same hours as fixed-route services, and their fares can be no more than twice the fixed-route fares.

**Demand-response services**, which operate outside of a locality's public transit system hours or in areas where public transportation is not available, are not legally mandated and are not subject to either the route and schedule requirements or fare restrictions for paratransit services. Vehicles may be dispatched to pick up several different passengers at several different points before taking them to their respective destinations, and they may even be diverted en route to these destinations to pick up additional passengers. Services may be limited to certain target populations, areas, or times. Some localities use demand-response services during latenight and weekend hours in place of fixed-route services.

**"User-side subsidy" services**, which are partially subsidized by a transit agency, provide reduced fares to riders (users). A typical user-side subsidy program uses taxicab services and operators or a brokerage system that may charge a per-ride fee for handling the rider's transportation arrangements.

### 4. Public Transportation Program Monitoring

Individual operators of local public transportation programs determine how best to monitor and evaluate their performance and quality of service. Virginia does not have a statewide system for coordinating or monitoring their activities. Paratransit services, on the other hand, are now highly regulated and closely monitored for compliance with Federal Transit Administration (FTA) standards. Local providers should be contacted directly for information on their quality assurance practices.

### 5. Public and Human Service Transportation Grant Programs and MAP-21

In addition to Human Service Transportation Capital Grants, DRPT manages Public Transportation Paratransit Capital Grants that use state funds to support procurement of vans and small buses for demand-response transport services for individuals who are elderly, have a disability, or are economically disadvantaged. It also funds and provides training, expert advice, and technical assistance for human service transportation operators regarding defensive driving, wheelchair lift operations and wheelchair securement, vehicle and lift preventive maintenance, and working with people with disabilities.

On July 6, 2012, President Obama signed into law the **Moving Ahead for Progress in the 21<sup>st</sup> Century Act (MAP-21)**, which went into effect on October 1, 2012. The program changes in this legislation included the repeal of the Federal Transit Administration's (FTA) Section 5316 (Job Access and Reverse Commute—JARC Program) and Section 5317 (New Freedom Program) and



the establishment of an enhanced Section 5310 program that serves as a single-formula program to support the mobility of seniors and individuals with disabilities. This legislation continued the coordinated transportation planning requirements established in previous law.

In 2008, DRPT worked with rural and small urban areas around the Commonwealth to develop **Coordinated Human Service Mobility (CHSM) Plans** that met the coordinated transportation planning requirements, and DRPT supported the development of such plans in large urban areas. The CHSM Plans are organized geographically around 21 Planning District Commissions (PDC's) throughout the Commonwealth. The PDC's have been chartered by the local governments of each planning district under the Regional Cooperation Act to conduct planning activities on a regional basis.

With the enactment of the MAP-21 legislation, DRPT began a process of consultation with local stakeholders to update the CHSM Plans for their respective regions. This process included extensive discussion of MAP-21 changes to human service transportation funding and careful review and updating of local and regional transportation needs and issues.

Through a series of initial, regional meetings held from September through November of 2012 and series of a follow up meetings conducted in June and July of 2013 to review plan revisions and gather additional input, Virginia's CHSM planning effort provided a structure and process intended to:

- provide a forum to gain consensus on the transportation priorities in the region and facilitate input from seniors, individuals with disabilities, representatives of public, private, and nonprofit transportation and human services providers, and others;
- take into account previous transportation planning efforts;
- foster local partnerships and provide an opportunity for the development of new ones;
- identify examples of projects and programs initiated since issuance of 2008 plans that demonstrate human service transportation enhancements and coordination efforts, i.e., mobility management efforts and new services;
- continue an ongoing structure to support coordination efforts or help establish new coordination structures; and
- serve as a tool for educating local decision makers, elected officials, and other stakeholders on unmet transportation needs in the region.

The planning process also drove the development of updated CHSM Plans to meet the federal coordinated transportation planning requirements and facilitate access to critical FTA monies. As of September of 2013, 19 of 21 regional plans have been updated and finalized and can be accessed at [http://kfhgroupp.com/DRPT\\_CHSM/VACoordinatedPlans.html](http://kfhgroupp.com/DRPT_CHSM/VACoordinatedPlans.html).

As noted above, the MAP-21 legislation established a modified FTA Section 5310 Program that consolidated the previous New Freedom and Elderly and Disabled Programs. The purpose

of the new **Section 5310 Program** is to enhance mobility for seniors and persons with disabilities by providing funds to serve the special needs of transit-dependent populations with programs that go beyond traditional public transportation services and the Americans with Disabilities Act's complementary paratransit services required by the. Section 5310 Program recipients must continue to certify that the funded projects are included in a locally developed, coordinated, public transit/human services transportation plan.

Funds through the Section 5310 Program are apportioned for urbanized and rural areas based on the number of seniors and individuals with disabilities. Sixty percent of the funds are apportioned to designated recipients in urbanized areas with populations larger than 200,000; 20 percent goes to states for use in urbanized areas of fewer than 200,000 persons; and 20 percent goes to states for use in rural areas. The federal share is 80 percent for capital projects and 50 percent for operating grants. (Note that designated recipients in large urban areas can include the state. By mutual agreement, DRPT will serve as the designated recipient for Hampton Roads, Richmond/ Petersburg, and Roanoke).

By mutual agreement, DRPT will serve as the designated recipient for Hampton Roads, Richmond/Petersburg, and Roanoke. Under the MAP-21 legislation, eligible sub-recipients for the Section 5310 Program include state or local government authorities, private nonprofit organizations, or operators of public transportation services that receive a grant indirectly through a designated or sub-recipient.

The **local funding share** for Section 5310 Program projects can be derived from other federal, non-Department of Transportation (DOT) sources. Examples of programs that are potential sources of local match funds include employment training, aging, community services, vocational rehabilitation services, and Temporary Assistance for Needy Families (TANF).

MAP-21 also modified eligible activities under the Section 5310 Program:

- At least 55 percent of program funds must be used on capital projects for public transportation projects that are planned, designed, and carried out to meet the special needs of seniors and individuals with disabilities when public transportation is insufficient, inappropriate, or unavailable.
- The remaining 45 percent of funds may be used for
  - public transportation projects that exceed ADA requirements;
  - public transportation projects that improve access to fixed-route service and decrease reliance by individuals with disabilities on complementary paratransit; and/or
  - alternatives to public transportation that assist seniors and individuals with disabilities.

DRPT is responsible for ensuring that local applicants for Section 5310 funds and their projects are eligible for the funds and in compliance with federal requirements, that private nonprofit transportation providers have an opportunity to participate as feasible, and that the program provides for as much coordination of federally assisted transportation services as possible. Section 5310 funds are obligated based on an annual program of projects included in a grant application submitted to the Federal Transit Administration (FTA) by DRPT.

DRPT's Public Transportation staff also manages FTA Section 5311 grants for public transportation in areas with fewer than 50,000 residents. Section 5311 funds are used for capital expenditures and may also be used to cover administrative and operating costs. Eligible entities include state and local governments, transportation district commissions, nonprofit organizations, and public service corporations. They can be used to pay up to 90 percent of the cost of projects that meet the requirements of the Americans with Disabilities Act (ADA), the Clean Air Act, or address bicycle access.

## 6. Funding for Transportation Programs

As shown in **Table 86**, DRPT reports in its *Six Year Improvement Plans for FYs 2009–2013* that it has received \$14.8 million in Section 5310 funding for vehicles purchased in state fiscal years (SFYs) 2009 through 2013.

| Table 86. Vehicles Purchased with Section 5310 Funds by SFY |                              |                            |                              |
|---|------------------------------|----------------------------|------------------------------|
| State Fiscal Year   | Amount of Section 5310 Funds | Number of Grant Recipients | Number of Vehicles Purchased |
| 2009  | \$2,832,364                  | 39                         | 66                           |
| 2010  | \$3,037,891                  | 36                         | 76                           |
| 2011  | \$2,992,765                  | 36                         | 76                           |
| 2012  | \$2,979,350                  | 36                         | 76                           |
| 2013  | \$2,969,518                  | 37                         | 81                           |

All vehicles purchased using DRPT's Section 5310 funds in SFY 2010 forward were fully accessible for persons with disabilities, and DRPT continues to require all organizations to purchase accessible vehicles with removable, regular seating that helps to maximize space to meet the needs of their riders.

DRPT funds only a portion of rail and public transportation project costs; a large portion of the cost is borne by localities. It is essential that projects meet local needs and have local support. Transportation Authorities play the lead role in defining the rail and public transportation initiatives for their areas. Citizens and businesses interested in advancing rail and public transportation initiatives in their localities may share their ideas or propose new initiatives to their local or regional transportation authority.

## C. Medicaid-funded Transportation Services

The **Virginia Department of Medical Assistance Services (DMAS)** is the State's designated agency for administration of Medicaid. As such, it has the responsibility under Title XIX of the Social Security Act (42 USC 1396 et seq.) to assure that necessary emergency and nonemergency transportation is available, when necessary, to approved providers of services covered by Medicaid.

### 1. Eligibility for Medicaid-Funded Transportation Services

According to information provided by DMAS, a monthly average of 249,838 Virginians were eligible for nonemergency transportation services in 2013. Of these, typically 21,000 individuals actually use these services each month, and about 50,000 unduplicated individuals use them in the course of a year. In SFY 2012, approximately 4.2 million one-way, nonemergency transportation trips were made throughout the Commonwealth.

When individuals who are eligible for Medicaid do not have other access to transportation, their transportation to and from approved providers of medically necessary services are covered under Virginia's **Medicaid State Plan** and **State Children's Health Insurance Program (CHIP)**. Additional information on Medicaid and CHIP eligibility can be found in the **Medicaid** chapter of this *Assessment* or obtained from the Department of Medical Assistance Services (DMAS). The DMAS website is at <http://dmasva.dmas.virginia.gov/default.aspx>.

In addition to its other eligibility requirements, the Virginia Administrative Code section 12 VAC 30-50-530 stipulates specific requirements. Two such requirements are that (1) Medicaid provided transportation shall only be used when recipients have no other means of transportation available; and (2) recipients shall be furnished with the transportation services that are most economical to adequately meet their medical needs. If the Medicaid recipient either does not own an operable automobile or cannot operate one safely and has no other transportation available from a spouse or, in the case of a minor, a custodial parent, Medicaid transportation can be used. Exceptions to the "no-other-transportation-available" provision must be made for individuals going to:

- dialysis treatment, chemotherapy, or radiation therapy;
- recipients of foster care; or
- enrollees in a **Medicaid Home and Community Based Services (HCBS) Waiver**.

An additional exception is possible when the length or frequency of a trip, or trips, would impose a financial burden on the recipient or the recipient's family.

Under the "**eligible purpose**" guideline, transportation is provided so that services covered by Medicaid can be received. If the service requires preauthorization by DMAS or its agent, the recipient must obtain that preauthorization before requesting transportation to travel to the service or to any follow-up visits. Chapter IV of the *DMAS Transportation Manual* contains

detailed information on coverage and eligibility for transportation services and is available at <https://www.viriniamedicaid.dmas.virginia.gov/wps/portal/ProviderManual>.

## 2. Access to and Availability of Medicaid-funded Transportation

Medicaid recipients' access to health care is highly dependent on a reliable network of transportation providers. In Virginia, the **Department of Medical Assistance Services (DMAS)** is responsible for creating and managing this network. DMAS solicits and contracts with a **Medicaid transportation broker** that subcontracts with individual community agencies or private providers to transport people with disabilities. The transportation broker is responsible for establishing and maintaining a safe, sufficient, and reliable network of providers of nonemergency Medicaid-funded transportation. In addition, the broker determines a rider's eligibility in compliance with DMAS guidelines, verifies his or her need for transportation services, determines the most appropriate mode of transportation to meet the rider's needs, authorizes the transportation service, and arranges trips with the subcontracted transportation providers.

To receive reimbursement for nonemergency Medicaid trips, transportation providers must have a contract with the Medicaid transportation broker. The broker is encouraged by DMAS to contract with Community Services Boards (CSBs), private providers of intellectual and developmental disabilities services, Area Agencies on Aging (AAAs), and other community-based organizations that provide disability-related transportation services. DMAS requires all transportation providers to comply with the Americans with Disabilities Act (ADA) and the Rehabilitation Act of 1973, as amended (29 USC 791 et seq.), and requires the broker to ensure, to the greatest extent possible, that service recipients have stable and consistent transportation services with regular drivers. With prior approval from DMAS, these community-based providers may restrict their transportation services to the specific populations that they serve.

Unless it is an urgent trip, to arrange for Medicaid-funded transportation, an eligible individual, relative, caregiver, or medical facility staff member must call the **broker reservation line at least 5 days in advance**. The broker obtains information about the rider's health condition and physical limitations, and then determines the appropriate pickup time, based on that information as well as the expected travel time, in order to arrive at the scheduled service on time. Verifiable **urgent trips**, such as sudden illness or hospital discharges, may be accepted with less than 5 days notice. For recurring appointments, such as dialysis or day supports funded through a Medicaid Home and Community Based Services Waiver (HCBS Waiver), the transportation is scheduled in advance and continues until the broker is instructed to cancel it. The broker refers to such appointments as "standing orders" or "prescheduled trips."

Individuals who are deaf, hard of hearing, deafblind, or speech disabled can access a free public service, **Virginia Relay**, with a standard telephone to schedule transportation. Relay services are available 24 hours a day, 365 days a year, with no limit on the number or length of calls a user may make. Anyone can initiate a Virginia Relay call by dialing 7-1-1. After reaching

Virginia Relay, callers give the Virginia Relay Communications Assistant the phone number of the person or business that they wish to contact. Once a connection has been made, the Communications Assistant helps the caller arrange transportation by relaying the conversation between the two parties. More information on Virginia Relay appears in the **Community Living Supports** chapter of this *Assessment* or can be found at <http://www.varelay.org>.

DMAS has been promoting alternative means of nonemergency transportation to augment existing Medicaid transportation options and to better support the needs and circumstances of individual service recipients. When possible and feasible, fixed route (not paratransit) public transit is the most desirable alternative because it can increase passenger mobility significantly. If a member lives near a bus line, the broker can send them bus tickets or tokens, so they can use public transportation to get to their Medicaid-covered services.

Two other alternatives available in Virginia have been successful in increasing transportation capacity, especially in rural or isolated areas. In the **Volunteer Driver Program**, trained volunteers are assigned by the transportation broker to transport eligible recipients to Medicaid-funded services in their own, approved vehicles and are reimbursed for mileage. Information on this service, including becoming a driver, is available by telephone from the nonemergency transportation broker at 866-810-8305, extension 625 (toll-free). In the **Mileage Reimbursement Program**, a family member or friend of the individual needing to go to a medical appointment or other Medicaid-funded service can obtain advanced approval from the broker to drive that individual and be reimbursed for mileage. Information on this program is available at 866-386-8331 (toll-free).

### 3. Available Medicaid-funded Transportation Services

Transportation services covered by Virginia's Medicaid programs are categorized as "emergency ambulance" and "nonemergency." **Emergency ambulance transportation** covers situations such as heart attacks and life-threatening injuries. It does not include service for minor abrasions, lacerations, bruises, fever, normal labor pains, headaches, intoxication, or other conditions that are not lifethreatening and are categorized as nonemergency.

**Nonemergency transportation services** are provided through the brokerage system introduced earlier in this chapter and described in more detail below. DMAS is responsible for administering Virginia Medicaid's Fee For Service (FFS) Emergency Ambulance and Non-Emergency Medicaid Transportation (NEMT) services. DMAS FFS transportation services include Emergency Air, Emergency Ground, Neonatal Ambulance, and NEMT services.

The **Fee-For-Service Non-Emergency Medicaid Transportation** service is managed and operated by Virginia's statewide contracted transportation broker, **LogistiCare**. LogistiCare is responsible for managing every aspect of transportation on behalf of DMAS. LogistiCare is not a transportation company and does not own or operate vehicles. LogistiCare takes transportation eligible member's reservations, assigns trips to providers, and pays providers for all non-emergency transportation services. Non-Emergency Medicaid Transportation (NEMT) services

include ambulatory, wheelchair, stretcher van, and non-emergency ambulance. NEMT also provides alternative means of transportation that include the use of volunteer drivers, mileage reimbursement, and bus tickets.

In non-emergency situations, the Medicaid transportation broker determines the appropriate level of service needed for a safe pickup and delivery of the recipient to his or her destination. **Curb-to-curb service** is provided for individuals who need little, if any, assistance from the door of the pickup point or destination to the vehicle. **Door-to-door service** is provided to passengers who need assistance to safely move between the door of the vehicle and the door of the passenger's pickup point or destination. The driver exits the vehicle and assists the passenger from the door of the pickup point (e.g., residence), escorts the passenger to the door of the vehicle and assists the passenger in entering the vehicle. The driver is responsible for assisting the passenger throughout the trip and to the door of the destination. It does not include the lifting of any passenger. Drivers, except for ambulance or stretcher van personnel, should not enter a residence. In some cases, transportation service recipients are transported **hand-to-hand**, meaning a person at the pickup point passes the recipient into the hands of the driver who will transfer the recipient into the hands of a facility staff member, family member, or other responsible party at the destination. Examples of individuals who may require this level of service include those with dementia or significant cognitive disabilities.

Ambulatory recipients may be transported by cars or minivans, including taxis, arranged by the broker. Wheelchair users are transported in lift-equipped vehicles, and those who must remain prone are transported by nonemergency ambulance or by stretcher van transportation. **Travel training** services, which help recipients get the information and develop the skills they need to travel safely and independently, may also be provided for recipients who require it.

In some cases, Medicaid may also cover transportation-associated costs such as meals, overnight lodging, and an attendant. With prior approval by the DMAS Medical Support Unit, out-of-state transportation is also provided when a medically necessary service cannot be provided in Virginia. As mentioned earlier, for Medicaid recipients living in areas with transit systems, the transportation broker can provide tickets or passes for use on fixed-route public transportation. If a recipient does not own a car or cannot drive, the broker may reimburse preapproved mileage expenses to a spouse or to a parent, guardian, or foster parent of a minor child for driving the recipient to an appointment.

#### 4. Cost and Payment for Medicaid-funded Transportation

The Medicaid transportation broker is responsible for all nonemergency transportation services provided to Medicaid recipients, whether they are served by a traditional, fee-for-service program or enrolled in a capitated managed care organization. The broker pays transportation providers at negotiated rates, and providers are prohibited from obtaining additional reimbursements from the transportation recipient or the recipient's family. For state fiscal year (SFY) 2013, the Department of Medical Assistance Services (DMAS) reported that there were 4,104,492 total trips provided at a cost of \$70,102,002.

## 5. Medicaid-funded Transportation Monitoring

The Department of Medical Assistance Services (DMAS) is responsible for monitoring the performance of its contracted Medicaid transportation broker. The broker is responsible for receiving and responding to all verbal or written **complaints** about nonemergency transportation services from service recipients, providers, DMAS, or other sources. Individuals wishing to report a problem or file a complaint should contact the **Ride Assist Call Center** through its toll-free customer service telephone number, 866-246-9979. A complaint number will be assigned and provided at the time of the call. If a complaint is ongoing or unresolved, an individual can complete a written complaint form. Updated in September 2013, the form can be accessed at [http://dmasva.dmas.virginia.gov/Content\\_atchs/trn/trn-info3.pdf](http://dmasva.dmas.virginia.gov/Content_atchs/trn/trn-info3.pdf). The completed form should be faxed to 866-660-4372.

The broker is also responsible for monitoring its network of transportation operators to ensure compliance with the terms of their subcontractors and with all state and federal laws and regulations, including a number of DMAS safety and performance requirements. Operators must meet driver and vehicle requirements, resolve complaints, and deliver courteous, safe, timely, and efficient services.

Specifically, the broker is required to regularly review drivers' licenses, driving records, criminal records, and training requirements of its subcontracted operators. The broker tracks safety equipment carried on vehicles, makes semiannual vehicle inspections, and verifies maintenance records. Operators must provide accident and incident reports to both the transportation broker and DMAS. The safety of service recipients, the assistance provided to them, and driver courtesy are monitored by DMAS and the broker through on-street observations, analysis of complaints, and a semi-annual customer service survey. DMAS staff members and its broker can also conduct unannounced, onsite monitoring of drivers' performance as well as detailed inspections of vehicles. For major safety violations, authorized DMAS employees or the broker may immediately remove any driver or vehicle from service until the deficiencies have been corrected. Deficiencies and corrective actions are documented and become a part of the driver's or a vehicle's permanent record.

In addition to these monitoring activities, DMAS conducts quality assurance reviews of services. These DMAS **Utilization Reviews** may be conducted anonymously and without advance notice. DMAS is also responsible for conducting fraud investigations in cooperation with state and federal law enforcement agencies. DMAS reports that in November of 2013 there were 249,690 fee-for-service members. In SFY 2013 DMAS reports 4,176,261 Medicaid non-emergency transportation trips and 50,000 unique riders. Of those trips, DMAS reports 28,640 complaints: 24,373 provider late complaints; 2,652 provider no-show complaints; and 1,615 identified as "other."

In 2013, a national research organization, GreatBlue Research, Inc. of Cromwell, Connecticut, conducted a **Client Satisfaction Study** on behalf of LogistiCare, the State's current Medicaid transportation broker, LogistiCare. Using a random sample generated by LogistiCare



of Medicaid-funded transportation clients living in Virginia at the time, GreatBlue conducted 402 interviews between December 7 and 22 of that year to determine those clients' level of satisfaction with the transportation services they had received. GreatBlue Research determined that a random sample of this size has a maximum statistical error of plus or minus 5 percentage points, a 95-percent level of confidence. In theory, a sample survey of 402 LogistiCare clients would differ no more than plus or minus 5 percent from a survey in which all clients were interviewed.

All respondents interviewed reported to researchers they had traveled recently to a Medicaid-covered appointment and used LogistiCare (Virginia's current transportation broker) services. Each respondent was asked a series of questions in each of the following areas of investigation and was asked to use a scale of 1 to 4 where 1 represented "very good" and 4 represented "very poor." The study report, which is not available online, indicated the following levels of satisfaction.

- Call Center Satisfaction: 96.1 percent average positive rating
- Ride Assist Satisfaction: 85.5 percent average positive rating
- Driver Assessment: 93 percent average positive rating
- Vehicle Assessment: 98.1 percent average positive rating
- Service Assessment: 92 percent average positive rating
- Needs Met: 88.8 percent needs met "always" or "most of the time"

The DMAS contract with LogistiCare expires on September 30, 2014. If DMAS chooses, it could add another 12 months to the contract up to 3 times, extending the contract by 3 years. If this occurs, LogistiCare will remain the broker until September 30, 2017. Prior to end of the contract, DMAS will issue a Request for Proposals (RFP) for selection of a future contracted Medicaid transportation broker or brokers. Answers to frequently asked questions are available at <https://facilityinfo.logisticare.com/vafacility/FAQ.aspx>.

## D. Human Service Agency Transportation Services

Other state agencies play significant roles in providing and monitoring human service transportation. Brief descriptions of the human service transportation services provided by other agencies, some at least in part through DRPT resources or the Medicaid brokerage system, are listed in **Table 87**.

| Table 87. Human Service Agency Roles in Transportation  |   |
|---|---|
| State Agency  | Role in Human Service Transportation  |
| Department for Aging and Rehabilitative Services (DARS) | Provides funding for transportation services operated by local Area Agencies on Aging (AAAs). |

| Table 87. Human Service Agency Roles in Transportation             |   |
|--|---|
| State Agency   | Role in Human Service Transportation  |
|  | Purchases transportation for individuals to participate in vocational rehabilitation services.  |
| Department for the Blind and Vision Impaired (DBVI)                | Purchases transportation for individuals to participate in vocational rehabilitation services.  |
| Department of Behavioral Health and Developmental Services (DBHDS) | Has authority for mental health, intellectual disability, and substance abuse transportation services.<br>Oversees Community Services Boards (CSBs) that may use funding for transportation in association with allowable services. |
| Department of Social Services (DSS)                                | Oversees local departments of social services, including programs that can fund transportation services.  |

Eligibility for these transportation services varies based on the service being provided, the agency providing the service, and the source of funding. Local Area Agencies on Aging (AAAs) and Community Services Boards (CSBs) often provide transportation as a Medicaid-reimbursed provider. Eligibility is based on the specific program or local requirements. Similarly, the Department for Aging and Rehabilitative Services (DARS) and the Department for the Blind and Vision Impaired (DBVI) can purchase transportation if it is needed for an individual participating in their vocational rehabilitation programs to access agreed upon services. Eligibility for DARS and DBVI vocational rehabilitation programs is covered in the **Employment** chapter of this *Assessment*.

As noted above, individuals who receive services under a Medicaid Home and Community Based Services (HCBS) Waiver are eligible for human service transportation services subject to the rules of their particular waiver. For example, under the Individual and Family Developmental Disabilities Support Waiver (DD Waiver), transportation may be provided to and from any service authorized under the DD Waiver, such as to and from an individual's place of residence or other designated location and an enrolled waiver services provider of supported employment or day support. Each waiver has specific eligibility requirements and criteria for services that are detailed in the **Medicaid** chapter of this *Assessment*.

**Table 88** shows agency funding for human service transportation for (SFY) 2013.

| Table 88. Funding for Human Service Transportation by Agency for SFY 2013 |                |
|---|----------------|
| State Agency  | SFY 2013 Funds |
| Department of Rail and Public Transportation (DRPT)                       |                |
| Section 5310  | \$3,589,000    |
| Section 5316  | \$3,515,797    |

| Table 88. Funding for Human Service Transportation by Agency for SFY 2013 |                            |
|---|----------------------------|
| State Agency  | SFY 2013 Funds             |
| Section 5317  | \$2,462,182                |
| Senior Transportation   | \$140,016                  |
| <b>DRPT Total</b>   | <b>\$9,706,995</b>         |
| Department of Medical Assistance Services (DMAS)                          | \$70,102,002               |
| Department for Aging and Rehabilitative Services (DARS)                   |                            |
| Division of Aging   | \$5,876,527                |
| Division of Rehabilitative Services (DRS)                                 | \$1,065,591                |
| Department for the Blind and Vision Impaired (DBVI)                       | \$128,195                  |
| Department of Social Services (DSS)                                       | \$6,443,267                |
| <b><u>TOTAL</u></b>   | <b><u>\$93,322,577</u></b> |

More user-friendly information on human service transportation can be found at the **Virginia EasyAccess** website at <http://www.easyaccess.virginia.gov/transportation.shtml>.

Additionally, Senate Bill 58, identical to House Bill 296, was introduced and passed in the 2014 session of the General Assembly. This bill requires the **alignment of transportation services with accessible housing and other community services** in a locality's Comprehensive Plan. Beginning in July of 2014 localities, when developing their Comprehensive Plan, will be required to

*take into consideration how to align transportation infrastructure and facilities with affordable, accessible housing and community services that are located within the territory in order to facilitate community integration of the elderly and persons with disabilities.*

This change should positively impact local coordination of land use and services and is consistent with the anticipated outcomes of Virginia's Settlement Agreement with the US Department of Justice.

## E. Vehicle Modification, Adaptive Driving, Accessible Parking, Other Resources

**Adaptive driving** and **vehicle modifications** are an important transportation option for many individuals with disabilities. Adaptive driving allows an individual with a disability to drive

as well as an individual who does not have disabilities, and the organization Infinite Potential Through Assistive Technology (<http://www.infinitec.org>) notes that

*almost any car can be modified, but the types of vehicles and modifications appropriate for each driver are based completely on individual need and preference.*

The first step to vehicle modification for adaptive driving is to obtain a reliable assessment by a driving rehabilitation specialist. This assessment determines whether the individual, with appropriate adaptive aids, can drive safely. A list of local vehicle modification dealers is available from the National Mobility Equipment Dealers Association (NMEDA). They can be reached by phone at 866-948-8341 or online at <http://www.nmeda.com/>. An online brochure detailing the process of selecting and installing assistive devices for drivers with disabilities is available at <http://www.nhtsa.gov/cars/rules/adaptive/brochure/brochure.html>.

In Virginia, **Woodrow Wilson Rehabilitation Center** provides comprehensive driving services that are managed and provided through its Occupational Therapy (OT) Department. This state-certified program is comprised of certified driving instructors (CDI) and certified driver rehabilitation specialists (CDRS). Several vehicles with a variety of adapted driving equipment are available for assessment and training purposes. More information about this service can be found at <http://wwrc.virginia.gov/DrivingServices.htm>.

The **Assistive Technology Loan Fund Authority (ATLFA)** offers creative and flexible services to help individuals with disabilities who might not otherwise be eligible for borrowing to procure loans. Any Virginian with a disability can apply for a loan, regardless of income and no matter how small a loan they might need. Credit history, current income, and existing debt will determine if an application is approved. ATLFA makes many loans for modified vehicles, hearing aids, and more. ATLFA also provides telework loans for individuals with disabilities who want to work from their homes, at telework centers (if available), or to remove barriers in an existing employment situation.

In years past, there were no rules or regulations requiring public facilities to provide special parking spots for people with disabilities. This meant that some people were unable to patronize these facilities. Since the enactment of the Americans with Disabilities Act of 1990, public facilities, including schools, businesses, libraries, hospitals, and government buildings, are required to have designated parking spaces for people with disabilities. Also, the Fair Housing Act requires landlords to provide accessible parking for individuals with a disability at their homes. As shown in **Table 89**, as of September of 2013, there were a total of 622,950 active accessible parking placards and license plates in Virginia.

| <b>Table 89. Accessible Parking Permits Active in September of 2013</b> |                |                   |
|---|----------------|-------------------|
| <b>Permit Type</b>  | <b>Count</b>   | <b>% of Total</b> |
| Permanent placard   | 462,624        | 93.83%            |
| Institutional placard   | 5,605          | 1.14%             |
| Temporary placard   | 24,776         | 5.03%             |
| <b>Total placards</b>   | <b>493,005</b> | <b>100.00%</b>    |
| Accessible parking license plates                                       | 129,945        | n/a               |
| <b>Total plates and placards</b>  | <b>622,950</b> | <b>n/a</b>        |

In support of state and local efforts and in response to extensive public comment in this area, the Virginia Board for People with Disabilities (VBPD), author of this *Assessment*, has had a long-standing focus on improving transportation options for individuals with disabilities. The Board believes that self-determination, independent living, and full community inclusion can only be accomplished when planners and managers at the local and statewide levels develop a system of mutual responsibility for communication, coordination, and collaboration that integrates housing and transportation in ways that meet the unique needs and overlapping interests of people with disabilities.

## F. 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. Websites Referenced

**American Public Transportation Association**

<http://www.apta.com/resources/statistics/Pages/glossary.aspx>

**Infinite Potential for Assistive Technology**

<http://www.infinitec.org>

**National Mobility Equipment Dealers Association (NMEDA)**

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

**United We Ride (Federal Inter-agency Coordinating Council on Access and Mobility)**

<http://www.unitedweride.gov>

**US Department of Justice, Civil Rights Division**

<http://www.ada.gov>

**Virginia Department of Medical Assistance Services**

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

**Virginia Department of Rail and Public Transportation**

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

**Virginia Department of Social Services**

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

**Virginia Department of Transportation**

<http://www.virginiadot.org>

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Virginia Department of Rail and Public Transportation. (2012). *2012–2014 Strategic Plan*. Retrieved from [https://solutions.virginia.gov/pbreports/rdPage.aspx?rdReport=vp\\_StratPlan102&Agency=505&Run=Run&selAgency=505](https://solutions.virginia.gov/pbreports/rdPage.aspx?rdReport=vp_StratPlan102&Agency=505&Run=Run&selAgency=505)

Virginia Department of Rail and Public Transportation. (April 2010). *State Coordination Model for Human Service Transportation*. Retrieved from [http://www.drpt.virginia.gov/activities/files/State\\_Coordination\\_Model\\_for\\_Human\\_Service\\_Transportation.pdf](http://www.drpt.virginia.gov/activities/files/State_Coordination_Model_for_Human_Service_Transportation.pdf)

Virginia Transportation Board. (November 2009) *VTrans2035. A Statewide Multimodal Long-Range Transportation Plan*. Retrieved from <http://www.vtrans.org/vtrans2035.asp>





## Appendix A. Statewide Information and Advocacy Resources

Virginia's disability information services and advocacy programs are diverse and multilayered. They may operate independently or as a part of a larger agency or organization. Some of these resources and initiatives have been described in the most appropriate chapters of this *Assessment*. Others with statewide reach are included here.

Most government agencies and nongovernmental organizations have information on their websites that contain lists of helpful documents and web links to sources of further assistance. Many agencies and organizations also provide printed copies of documents in response to written, telephone, or e-mail requests. Some, but not all, provide their materials in foreign languages. Organizations receiving state and federal funding are required to provide information in alternate formats for individuals with disabilities who require reasonable accommodations to access the material.

The information below is not all-inclusive. Only organizations that have a statewide office or presence are listed, and the focus is on organizations that work with or provide information to people with developmental disabilities and their families. Website addresses and phone numbers were current as of June of 2014. For further information on these agencies or organizations and their programs, readers are encouraged to contact them directly.

### **2-1-1 VIRGINIA**

<https://211.getcare.com/211provider/consumer/index211.do>

Standard phone: dial 211

Relay users: dial 711, then 211

Videophone users: 1 (800) 230-6977

By dialing 211 or visiting 2-1-1 Virginia's interactive website, anyone can use this free information and referral service. Trained professionals respond to calls and e-mail inquiries submitted via the website with information on available services and suggested resources from a large database of health and human services in Virginia. Referrals are confidential, and the website includes a link to information on eligibility for benefits available through the Virginia Department of Social Services. Government agencies, community-based nonprofit organizations, and businesses that provide health and human services for the citizens of Virginia are encouraged to list their services on this site.

### **American Civil Liberties Union of Virginia (ACLU)**

<http://www.acluva.org>

(804) 644-8022

This private, nonprofit affiliate of the national ACLU promotes the civil liberties and civil rights of all residents through litigation, public education, and other activities. Issues relevant to individuals with disabilities include, but are not limited to, free speech, religious rights, access to government, due process and criminal justice, privacy rights, and students' rights.

### **The Arc of Virginia**

<http://www.thearcova.org>

(804) 649-8481

This nonprofit organization advocates on behalf of individuals with intellectual and developmental disabilities and their families for changes in state policies. It promotes the creation of individualized, community-based supports that enable people with disabilities to lead productive lives. The Arc of Virginia's 26 chapters across the State each provide a variety of services and supports for individuals with disabilities and their families appropriate to their communities' needs. Together with the statewide organization, they offer service providers training and technical assistance regarding strategies that enhance family involvement and share families' perspectives with Virginia's policymakers. The Arc of Virginia has launched a program called New Path (<http://new-path.thearcova.org/>) that helps families navigate through the early intervention services system when their children are newly diagnosed as having a disability. The program provides linkages to other families, services, and supports.

### **Assistive Technology Loan Fund**

<http://www.atlfa.org>

1 (866) 835-5976

Voice/TTY: (804) 662-9000

This quasi-state agency offers financial services to assist individuals who might not otherwise be eligible to borrow funds for assistive technology they need. Their mission is to provide alternative funding resources for Virginians with disabilities to help them obtain the needed assistive technology. Any Virginian with a disability can apply for a loan with this organization, regardless of income and no matter how small a loan he or she might need. Credit history, current income, and existing debt will determine if an application can be approved. This organization makes many loans for modified vehicles, hearing aids, and more.

### **Autism Society of America (ASA)**

Central Virginia chapter: <http://www.asacv.org>

(804) 257-0192

Northern Virginia chapter: <http://www.asanv.org>

(703)-495-8444

Tidewater chapter: <http://www.tidewaterasa.org>

(757) 461-4474

The Autism Society of America has several chapters in Virginia. While there is no state chapter, local chapters have a strong, statewide presence. All three chapters share information with individuals, families, and professionals on treatment, education, research, and advocacy. They hold support meetings, training, and other events, and they undertake legislative advocacy.

### **Brain Injury Association of Virginia (BIAV)**

<http://www.biav.net>

1 (800) 444-6443

This nonprofit organization works to support individuals with brain injuries and their families and to prevent brain injuries in Virginia. The BIAV also works with service providers and advocates and provides outreach to those affected by brain injuries. This organization maintains an extensive clearinghouse of brain injury information and makes referrals for information and services. Further, they offer training and recreation programs for individuals with brain injury and their families and provide a toll-free Family Help Line through the number listed above.

### **Centers for Independent Living (CILs)**

<http://www.vadrs.org/cbs/cilslisting.htm>

(804) 662-7000

The federal Rehabilitation Act of 1973, as amended, authorizes CILs to provide services and advocacy that promote the leadership, independence, and productivity of people with significant disabilities. CILs are nonprofit, non-residential places of action and coalition building where persons with disabilities develop the skills necessary to make decisions and choices about their own lives. CIL staff members work with individuals and local communities to remove barriers to independence and to ensure equal opportunities for persons with disabilities. All CILs provide the core services of advocacy for individuals and for system change, information and referrals, peer counseling, and training in independent living. Other services offered by CILs vary and may include, but are not limited to: disability awareness outreach, information on accessibility, educational and housing advocacy, nursing facility transition services, and general disability information and referrals. Additional information on CILs appears in the **Centers for Independent Living and Related Services** section of the **Community Living Supports** chapter of this *Assessment*. To contact a CIL in a specific location, call the Department of Aging and Rehabilitative Services at the number listed above or use the local phone numbers provided on its CILs website.

### **Cerebral Palsy of Virginia**

<http://www.cerebralpalsyofvirginia.org>

(757) 497-7474

This nonprofit organization serves children and adults with cerebral palsy and other developmental disabilities such as Down's syndrome, intellectual disabilities, autism, muscular dystrophy, and learning disabilities, as well as those who have vision, hearing, or speech impairments. It advocates on behalf of individuals and their families and provides programs and services to help them attain maximum independence and inclusion in their communities. Guidance is provided on the availability of adaptive toys, assistive technology, computer software, books, and other resources that are available for loan, allowing individuals to test and use these items in their home to ensure their effectiveness before making a purchase.

### **Commonwealth Autism Service (CAS)**

<http://www.autismva.org>

1 (800) 649-8481

This organization provides leadership and a statewide system of services to maximize the potential of Virginians with autism spectrum disorders (ASD) through regional service networks. It provides services to children with ASD and their families, and to adults and older Virginians with ASD. CAS promotes best practices for treatment and for state policy changes that improve service access and availability. CAS provides ongoing support for families as well as technical assistance and training, including an annual conference. It has developed and implemented a model of instructional support for students with ASD in classrooms across the State and, most recently, created a model for transitioning graduating seniors with ASD to higher education.

### **The disAbility Law Center of Virginia (dLCV)**

<http://disabilitylawva.org>

1 (800) 552-3962

The dLCV is Virginia's Protection and Advocacy System and also operates the Client Assistance Program in Virginia. Formerly the Virginia Office for Protection and Advocacy, the dLCV became an independent nonprofit in October of 2013. The dLCV operates a variety of federally funded and administered programs, including those authorized by the federal Developmental Disabilities and Bill of Rights Act of 2000 (DD Act). Its mission is to

*protect and advance the legal, human, and civil rights of persons with disabilities;  
combat and prevent abuse, neglect, and discrimination; and promote  
independence, choice, and self-determination by persons with disabilities.*

Because dLCV has limited resources, priorities and goals for its activities are set annually by its governing board. All individuals who contact dLCV requesting assistance receive information or referrals. However, only individuals with problems targeted by the Center's goals and priorities may be eligible for advocacy or legal assistance.

### **Housing Opportunities Made Equal (HOME) of Virginia**

<http://www.phonehome.org>

(804) 354-0641

Located in Richmond, HOME is certified by both the Virginia Real Estate Board and the Virginia Fair Housing Board to provide fair housing classes covering topics such as money management, tenant's rights, purchasing a home, fair housing reasonable accommodations, and home modifications. Courses are offered to the general public periodically throughout the year and can also be arranged for a company or other group on request. HOME also helps income-eligible Virginians afford home purchases by providing financial assistance to cover closing costs and down payments.

### **Learning Disabilities Association of Virginia (LDAV)**

<http://www.ldavirginia.org/>

e-mail: [info@ldavirginia.org](mailto:info@ldavirginia.org)

This statewide organization seeks to support and encourage individuals with learning disabilities, family members of individuals with learning disabilities, and the professionals who serve them to improve public awareness and promote lifelong career options. LDAV supports research on prevention and early detection to ensure educators adequately accommodate those with learning disabilities. The LDAV also encourages families to be rigorously involved in the education of their loved ones to improve life success. This organization does not have a phone but can be contacted at the email address above.

**The Legal Aid Justice Center**

<http://www.justice4all.org>

1 (800) 763-7323 (clients only)

(434) 977-0553

This legal aid center is based in Charlottesville and performs significant work in the area of disability. Its Civil Advocacy Program addresses legal issues in housing, public benefits, employment, consumer protection, and the rights of the elderly, new immigrants to Virginia, and individuals with disabilities. Its JustChildren program works to ensure that young people have access to the services and supports necessary for them to live successfully in their communities. The Center provides direct legal services for families with children from birth to age 18 through its offices in Charlottesville, Richmond, and Petersburg. Legal representation is provided in matters concerning appropriate education services for children with disabilities, necessary treatment services for children with psychiatric concerns, and services and supports required for children involved with the juvenile courts to remain in their communities. The JustChildren program also engages in community education and works with other statewide advocacy efforts that involve foster care, and/or the juvenile justice system. Telephone numbers for the regional offices and program contact names and numbers are listed on the website.

**Long-Term Care Ombudsman Program**

<http://www.elderrightsva.org>

1 (800) 552-3402

The national Older Americans Act requires all states to provide advocacy services for older persons receiving long-term care. The Virginia Department for Aging and Rehabilitative Services (DARS) contracts with 25 local Area Agencies on Aging (AAA) to provide these services through the Long-Term Care Ombudsman Program. The State ombudsman, who has expertise in both long-term care and advocacy, coordinates and supports designated local ombudsmen who complete a certification curriculum and then identify, investigate, and resolve complaints made by or on behalf of older persons.

**March of Dimes**

<http://www.marchofdimes.com>

(804) 968-4120

This nonprofit organization's Virginia chapter has five offices in Virginia with two located in Glen Allen and one each in Chesapeake, Harrisonburg, and Roanoke. It conducts research, community outreach, education, and advocacy to improve the lives of babies by preventing birth defects, premature birth, and infant mortality through education and outreach to families of young children.

**Medicaid Waiver Technical Assistance Center (MWTAC)**

<http://www.endependence.org> (Click on "Services," then "Medicaid Advocacy.")

1 (866) 323-1088

This center provides materials and workshops for individuals with disabilities and their families, including detailed information about accessing Virginia's Medicaid Home and Community Based Services (HCBS) Waivers. This independent, voluntary network of individuals and representatives of organizations across the State have expertise and training in Medicaid HCBS Waivers.

**Medical Home Plus**

<http://www.medhomeplus.org>

(804) 330-5030

This nonprofit organization facilitates family, professional, and community partnerships to support a more transparent service delivery system. It works with individuals with special health care needs and their family members to help individuals with disabilities remain in their own homes. Its website includes information for medical professionals and offers a family resource center that details laws related to children with disabilities and provides information on financing a child's needs and planning for a child's education and future needs. The organization also offers referral resources, preventative services, and information regarding diagnosis-specific conditions such as autism.

**Mental Health America of Virginia (MHAV)**

<http://www.mhav.org>

1 (866) 400-6428

This nonprofit organization promotes mental health, develops services to prevent mental illness, and works to ensure that children and adults with mental illness receive proper care and treatment. It advocates for public and private sector policies, services, and financing to ensure adequate and appropriate detection, treatment, and rehabilitation for those with mental illness as well as for housing and other supports. It raises public awareness of mental illness in order to eliminate the stigma that deters some individuals from seeking help when they need it.

**Muscular Dystrophy Association (MDA)**

<http://www.mda.org>

(804) 285-2961

This association focuses on research to find cures and effective treatments for neuromuscular diseases that affect more than a million Americans. Its national website

contains information and educational resources for families, including a zip-code-based locator to find local offices that can direct Virginians to other community and governmental organizations for assistance. Service providers listed on their website include state agencies and organizations especially for parents and other disability-related resources specific to Virginia. To contact the Virginia headquarters, call the number above.

**National Alliance on Mental Illness (NAMI) of Virginia**

<http://www.namivirginia.org>

Informational HelpLine (not a crisis line): 1 (888) 486-8264

Main office: (804) 285-8264

This organization provides information and support for those with mental illness, including youth and their family members, adults, veterans, and seniors. It maintains a help line for information on mental illness and makes referrals to local self-help groups that provide support, share additional information on community services, and advocate on behalf of individuals with mental illness and their families. NAMI of Virginia's Richmond office is responsible for state-level policy and legislative advocacy.

**Office of the Attorney General of Virginia, Division of Human Rights**

[http://www.ag.virginia.gov/Programs%20and%20Resources/Human\\_Rights/index.html](http://www.ag.virginia.gov/Programs%20and%20Resources/Human_Rights/index.html)

(804) 786-2071

This Division was formerly a separate agency called the Human Rights Council of Virginia. Effective July 1, 2012, its functions transferred to the Office of Attorney General's Division of Human Rights, pursuant to HB 1291 and SB 678. In addition to promoting public awareness of human rights for all citizens of the Commonwealth, the Division has authority to investigate complaints under state statute as well as under Title VII of the federal Human Rights Act of 1964 (as amended), the Americans with Disabilities Act (ADA), and the Age Discrimination in Employment Act. It has jurisdiction in specified matters relating to public accommodations, including educational institutions, real estate transactions, and employment. The Division also investigates certain computer crimes, bullying, gang prevention, elder abuse and neglect, and Medicaid fraud. It receives and reviews discrimination complaints in these areas and uses mediation, conducts investigations, and renders determinations.

**Parent Education Advocacy Training Center (PEATC)**

<http://www.peatc.org>

1 (800) 869-6782

Voice or TTY: (703) 923-0010

Funded by a grant from the US Department of Education, PEATC is Virginia's parent education, support, training, and information center. PEATC works collaboratively with families, schools, and service professionals to increase opportunities to improve education as well as personal success in school and community life. It offers disability information development and training curricula for families and professionals that are experience based, and research tested.



The Center also provides information on Virginia's Comprehensive Services Act (for at-risk youth and families), foster care, transition services, and other areas of interest to families.

### **Parents of Autistic Children (POAC)**

<http://www.poac-nova.org>

(703) 391-2251

This organization became statewide in 2007. It serves as a clearinghouse for research-based instructional materials and methodologies for students with autism spectrum disorders (ASD). POAC also advocates for the use of certain methodologies in public and private schools and provides training to enable successful implementation of programs that support students with ASD.

### **Partnership for People with Disabilities (PPD)**

<http://www.vcu.edu/partnership>

TTY: 1 (800) 828-1120

(804)-828-3876

The Partnership, as it is commonly known, is located at Virginia Commonwealth University and is Virginia's University Center for Excellence in Developmental Disabilities (UCED). As the UCED, it is authorized by the federal Developmental Disabilities and Bill of Rights Act of 2000 (DD Act). It operates more than 30 state- and federally funded programs that are staffed by more than 100 professionals and students who provide support for children with disabilities and their families as well as adults with intellectual or developmental disabilities (ID/DD). Its activities are diverse and include but are not limited to: advocacy on issues affecting individuals with disabilities and their families; promotion of changes to related state policies; training; and development of resources for families and professionals. Early intervention, education, health, and self-advocacy are among the many topics that those activities address. The Partnership maintains an interdisciplinary approach in all its activities. Its collaborators include disability service providers, elementary and secondary schools and school divisions, higher education, state and local agencies, and professional organizations. The Partnership operates a number of programs. The two listed below may be of particular interest.

### **SeniorNavigator**

<http://www.SeniorNavigator.org>

1 (866) 393-0957

(804) 525-7728

This nonprofit organization focuses on information dissemination and service referrals for elderly individuals and those with disabilities, helping people to "navigate" the services system. Over the last several years, SeniorNavigator has located physical sites throughout Virginia and expanded content through the disAbilityNavigator and VirginiaNavigator links on its website. Individuals seeking assistance can access more than 27,000 health and community support resources for seniors and adults with disabilities and for their families and caregivers. Access to this information is available online or in person through a statewide network of over 750



community-based SeniorNavigator and VirginiaNavigator Centers. These Centers throughout Virginia are operated in partnership with local and regional governmental and nongovernmental organizations. Services can be located by zip code.

**Virginia Assistive Technology System (VATS)**

<http://www.vats.org>

(757) 309-1079

This statewide program, authorized and funded by the federal Assistive Technology Act of 2004 (as amended), is administered by the Virginia Department for Aging and Rehabilitative Services (DARS). VATS promotes public awareness and provides training and technical assistance regarding the availability and use of assistive technology for people with disabilities. Staff at its central and three regional offices demonstrates or assists with training on specific devices, provides information on equipment sources, and coordinates an equipment exchange program and statewide network of recycling programs. Staff members also provide information on low-interest loans that make devices more affordable.

**Virginia Association of Area Agencies on Aging (VAAAA)**

<http://www.vaaaa.org>

(804) 644-2804

This nonprofit organization supports information sharing, training, and other educational activities for and by the State's 25 Area Agencies on Aging (AAAs) in their work on behalf of older Virginians and their families. It also serves as the AAAs' liaison with the Virginia Department for Aging and Rehabilitative Services (DARS) and other state and national public and private organizations working on aging issues.

**The Virginia Association of Centers for Independent Living (VACIL)**

<http://www.vacil.org>

Voice or TTY: (540) 342-1231

This association provides guidance and policy support for the Commonwealth's CILs, and represents them before the General Assembly on issues of importance. VACIL advocates for the inclusion and integration of individuals with disabilities in communities. VACIL also supports the improvement and expansion of the number of community-based, consumer-controlled CILs. VACIL posts a map on its website with the locations of 21 independent living centers in Virginia and the municipalities they support.

**Virginia Association of Community Rehabilitation Programs (vaACCSES)**

<http://www.vaACCSES.org>

1 (877) 877-2777

(571) 339-1305

Organizational members of this association provide employment, day support, training, and other support services for people with disabilities. vaACCSES advocates on public policy areas of interest to its members and provides educational resources and training for them, other service

providers, individuals with disabilities, and their families. Training topics include work incentives for Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) beneficiaries. vaACCSES is also a Work Incentives Planning and Assistance (WIPA) project under the federal Ticket to Work and Work Incentives Improvement Act, providing benefits counseling to individuals who wish to work but need to maintain public benefits such as Medicaid.

**Virginia Association of Community Services Boards (VACSB)**

<http://www.vacsb.org>

(804) 330-3141

As the statewide organization for Virginia's network of 39 local Community Services Boards (CSBs) and one Behavioral Health Authority (BHA), the VACSB represents those local service providers on matters of state and federal public policy. VACSB advocates for legislation, seeks funding, and advocates for policy change. It provides public education and promotes the improvement and expansion of an accessible, affordable, statewide public system for providing prevention, treatment, and rehabilitation services for individuals with mental illness, intellectual disabilities, developmental disabilities and/or substance abuse disorders. The VACSB website offers e-learning opportunities, conference information, legislative updates, and links to other resources and services for individuals with disabilities and their families.

**Virginia Association for Parents of Children with Visual impairments (VAAPVi)**

<http://www.vaapvi.org/>

(804) 938-1624

This association is a statewide organization that supports families, professionals, and the community to meet the needs of children who are blind or visually impaired. Often the children VAAPVi serves have multiple disabilities. VAAPVi is a state affiliate of VAAPVi, the National Association for Parents of Children with Visual impairments.

**Virginia Commonwealth University Autism Center for Excellence (VCU-ACE)**

<http://www.vcuautismcenter.org>

1 (855) 711-6987

TTY: (804) 828-2494

This is a university-based, professional development, and technical assistance and educational research center for autism spectrum disorders (ASDs) in the Commonwealth of Virginia. The VCU-ACE provides services to individuals with autism spectrum disorders and promotes the use of evidence-based practices in schools and the community. The Center is a collaborative effort of the Virginia Commonwealth University (VCU) Rehabilitation and Research Training Center (RRTC), the VCU School of Education, and the Virginia Department of Education (VDOE). It brings together experts and practitioners from a variety of fields to support its multidisciplinary approach. One of its first major initiatives has been to assist with the VDOE's work to improve the responsiveness and quality of programming provided for students with ASD by selected local school divisions across the Commonwealth. The Autism Center for Excellence provides online course registration related to ASD coursework, paraprofessional

training opportunities, a calendar of trainings available, newsletters that are archived online, and web links to research that supports individuals with ASD.

**Virginia Department of Behavioral Health and Developmental Services (DBHDS) Office of Human Rights (OHR)**

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

(804) 786-2008

This office fulfills the Code of Virginia (§ 37.1-84.1) requirement for protection of the legal and human rights of individuals with mental illness, intellectual disabilities, and substance abuse disorders who receive services in facilities or programs operated, licensed, or funded by that agency. OHR is charged with monitoring compliance with state human rights regulations, promoting the basic precepts of human dignity, advocating for the rights of persons with disabilities, and managing the human rights dispute resolution program, including local human rights committees.

**Virginia Department of Education (VDOE)**

<http://wp.vcu.edu/vcucfi/files/2012/09/PRC-Guidebook-Jan2011.pdf>

(703) 923-0010

Parent Resource Centers (PRCs) are located in most but not all school divisions. Drawing on a variety of state and community resources, they are local sources of referral and assistance. The PRCs provide workshops on special education issues for parents and educators. Out of 134 school divisions in Virginia, 49 operate PRCs for parents and families of children receiving special education services. Virginia's PRCs vary significantly in the way they are staffed and in their hours and months of operation. The PRC model promoted by the VDOE includes both a parent and a teacher working as a team throughout the school year to help parents access resources, understand service options, navigate the services system for their children, and to act as a link between families and schools. A *Guidebook for Parent Resource Centers* is available through the Virginia Commonwealth University's website using the above link.

**The Center for Family Involvement**

<http://www.centerforfamilyinvolvement.org/>

1 (877) 567-1122

TTY: 1 (800) 828-1120

The Center for Family Involvement partners with the Virginia departments of Education and Health, the federal Maternal and Child Health Bureau, the Administration on Intellectual and Developmental Disabilities, and others in supporting a variety of activities to strengthen family involvement. The Center works with families to increase their skills as advocates, mentors, and leaders so that families, children, and young adults with disabilities can lead the lives they want.

**Virginia Leadership Excellence in Neurodevelopment Disabilities (Va-Lend)**

<http://www.vcu.edu/partnership/valend/>

(804) 828-0073

Va-LEND is an interdisciplinary leadership-training program funded through a grant from the US Maternal and Child Health Bureau, Health Resources and Services Administration. The grant supports an interdisciplinary training program to prepare health professionals and related disciplines in the field of childhood disabilities for leadership and advocacy roles. Va-LEND also provides continuing education, community training, and consultation/technical assistance.

**Virginia Department of Education (VDOE) Ombudsman Program**

[http://www.doe.virginia.gov/special\\_ed/resolving\\_disputes/ombudsman/index.shtml](http://www.doe.virginia.gov/special_ed/resolving_disputes/ombudsman/index.shtml)

1 (800) 422-2083

The VDOE ombudsman acts as a source of information and referral, answers individuals' questions, and assists in the resolution of concerns and issues. The program serves as a resource for parents in non-legal special education matters and does not provide direct advocacy. No formal complaint forms or documentation are involved. The interests and rights of all parties involved are taken into account in considering any given instance or concern. The ombudsman's role is neutral as an independent advocate for a fair process, encouraging all parties to resolve differences at the lowest organizational level possible. Through appropriate informal or formal dispute resolution processes, there is a focus on listening and providing information, discussing issues and options, and making referrals to other services, including mediation.

**Virginia Easy Access**

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

1 (800) 552-3402

(804) 662-9333

This website is an interactive, online gateway to information on public and private long-term services and supports for older adults and adults with disabilities. It was developed by the Commonwealth of Virginia, VirginiaNavigator, and 2-1-1 Virginia as a part of the State's "No Wrong Door" initiative. The program is administered by the Virginia Department for Aging and Rehabilitative Services. The website provides three different search functions that allow users to access the extensive VirginiaNavigator database of service providers and other resources. The resources include those related to community supports, emergency preparedness, finances, housing, transportation, legal rights, veterans' issues, and other topics. Telephone and e-mail support for the website is provided by 2-1-1 Virginia. VirginiaNavigator and 2-1-1 Virginia are two interrelated and complementary resources described as in their respective listings in this appendix.

**Virginia Fair Housing Office**

<http://www.dpor.virginia.gov/FairHousing/>

1 (888) 551-3247

(804) 367-8530

Details on discrimination prohibited by fair housing laws and of the processes for investigating and resolving complaints under those laws may be found in the **Community**

**Housing** chapter of this *Assessment*. In addition to its role in these processes, the Fair Housing Office provides free training for state and local officials, housing providers, and individuals.

### **Virginia Housing Search**

<http://www.virginiahousingsearch.com>

1 (877) 428-8844

(704) 334-8722

This housing locator service, launched by the Virginia Housing Development Authority (VHDA) in 2009, provides detailed information about rental properties and home ownership opportunities and helps people find housing that best fits their needs. It can be accessed at no cost, 24-hours-per-day online or by calling its bilingual call center Monday through Friday, 9:00 a.m. to 8:00 p.m. Eastern Time, using the toll-free (877) number above. Individuals can search for rental housing using a wide variety of criteria and special, accessible mapping features. The listings provide detailed information on each available unit. The service also provides links to housing resources and helpful tools for renters such as an affordability calculator, rental checklist, and information on renters' rights and responsibilities.

### **Virginia Legal Aid**

<http://www.valegalaid.org>

1 (866) 534-5243

Free or low-cost legal services are provided for individuals with low incomes on matters such as immigration, health care, family and domestic violence, elder law, debt and consumer issues, criminal defense, employment, education, benefits, and housing. In addition, the website offers educational materials and referrals on topics including but not limited to debtor's rights, elder law, and eligibility for social and other services. Legal aid programs are located in nine offices in the state of Virginia. The website contains an electronic listing of all offices in Virginia, though not all services are available at all offices.

### **Virginia Organization of Consumers Asserting Leadership (VOCAL)**

<http://www.vocalvirginia.org>

(804) 343-1777

Initially formed to address mental health and mental illness concerns, VOCAL is increasingly involved in providing services for individuals with multiple disabilities, including intellectual disabilities. The VOCAL Network is a statewide coalition of individuals with disabilities and their families united to provide a voice for individual empowerment and to foster a mental health system driven by individuals with disabilities themselves. Coalition partners act as peer mentors and work with other advocacy organizations to protect individual rights and to fight discrimination, encourage the exchange of information, build service system capacity, improve state mental health policies, and increase the well-being of individuals with mental illness, developmental and/or intellectual disabilities, or substance abuse problems.

### **Voices for Virginia's Children**

<http://www.vakids.org>

(804) 649-0184

This statewide research and advocacy organization works on behalf of Virginia's children. It conducts policy analyses and distributes reports on multiple issues. In part, it addresses federal spending trends and tax policies, and information about children living in poverty. VaKids also provides information on domestic and international adoptions, raises awareness of issues, forms coalitions, and organizes grassroots advocacy efforts. Its areas of focus have included improvements to permanent planning for youth in foster care, supports for immigrant families, and improved access to quality preschool education for all children.

## Appendix B. Emergency Preparedness

The US Department of Homeland Security's Federal Emergency Management Agency (FEMA) is the primary response agency in the event of a disaster. Updated in May of 2013, FEMA's *National Response Framework* (<http://www.fema.gov/national-response-framework>) defines an emergency as

*an event that causes, or threatens to cause, loss of life, human suffering, public and private property damage, and economic and social disruption. Disasters and emergencies require resources that are beyond the scope of local agencies in routine responses to day-to-day emergencies and accidents, and may be of such magnitude or unusual circumstances as to require response by several or all levels of government—federal, state and local.*

Emergency planning and preparedness is critical for all citizens. For individuals with disabilities who often have more complex support needs, emergency planning is even more important to ensure individualized supports will be available. As more individuals with all types and levels of disabilities are living in the community and the Commonwealth's aging population increases, it is critical that individuals and their families be prepared for emergencies. It is equally critical that those charged with emergency preparedness planning ensure that there are adequate provisions in place to support persons with disabilities both in shelters and in place. This includes considering such factors as the accessibility of shelter sites, transportation needs, and medical and other support needs for a diverse population.

### Disaster Planning

The **Virginia Department of Emergency Management (VDEM)** continues to be the lead disaster-planning agency in the Commonwealth. The VDEM website, <http://www.vaemergency.gov/>, provides information on multiple types of preparedness planning and updates for citizens regarding current threats, whether they be natural disasters, inclement weather, hurricanes, violent storms, or a manmade disaster such as terrorism, an active shooter, or bio hazards related to chemical spills or nuclear disasters. VDEM also has a course catalogue that contains options for preparing professionals to include individuals with disabilities and aging populations in planning processes. It is available at <http://www.vaemergency.gov/em-community/training/course-catalogue>.

VDEM's website provides important information and resources to help individuals with and without disabilities make a plan to prepare for an emergency. This includes information related to specific types of emergencies (like a tornado), how to decide whether to evacuate or shelter in place, how to plan for pets, and other relevant factors. The planning pages begin at <http://www.vaemergency.gov/readyvirginia/makeaplan>. The VDEM also maintains Listo VA, which contains all relevant information in Spanish and is available at <http://www.vaemergency.gov/listoVirginia>.



The **Ready Virginia** link on VDEM's website gives specific information on how to make a plan, get a kit, stay informed, and get access to resources for special needs populations. According to VDEM, emergency kits should contain supplies such as food that won't spoil, water, a working battery-operated radio, extra batteries, and a written emergency plan. Some grocery and department stores and the Red Cross may offer kits to citizens for a charge. VDEM recommends that after obtaining essentials, an individual should add flashlights; a first aid kit; extra contact lenses or glasses; a written list of medications and prescriptions; sanitation supplies such as toilet paper, soap, a change of clothing, and sturdy shoes; and a blanket or sleeping bag.

Special items for pets, infants, and elderly family members or individuals with disabilities are also recommended. VDEM recommends a plan that includes an agreed on family meeting place in case family members are unable to return home, an out-of-town friend or relative as a point of contact, and to be sure every family member has such information. Evacuation orders and shelter locations may be broadcast on local media along with information such as where to find medical help during an event. For more information, visit <http://www.vaemergency.gov/readyvirginia>.

For older Virginia residents and individuals with disabilities, VDEM has additional recommendations and posts a list of important considerations for each of these populations. For example, for older Virginians, VDEM specifically warns that, following a disaster or emergency, there may be people who try to take advantage of those affected by the disaster. They advise that if seniors suspect someone is trying to take advantage of them, to report it to the Federal Trade Commission at 1-877-382-4357 or to the Better Business Bureau in Virginia at <http://www.usa.gov/directory/bbb/virginia.shtml>.

For individuals with disabilities and those who rely on care providers, VDEM recommends creating a support network to ensure there is help to operate special equipment during an emergency. Further, they recommend that there be a trusted friend who has a house key, and a person who knows what evacuation plans are in place. For individuals who may need special, accessible transportation, plans need to be made in advance and include communications regarding where to locate emergency supplies for the individual with disabilities.

There is also specific information for individuals who have pets. Foremost, some shelters do not allow pets, except for service animals. VDEM advises individuals to contact a local veterinarian, pet shelter, or pet hotel to find out if they are prepared to assist during an emergency. Furthermore, VDEM recommends families plan for their pet's needs and have on hand a kit for their pet's own needs. There may be a relative or friend who needs to be contacted to care for the specific needs of the pet in the local or broader community.

Virginians with and without disabilities and their families are largely responsible for educating themselves about emergency and disaster preparedness, resources, and training in their communities. Local police, fire, and other emergency services, as well as the Virginia Citizen Corps (<http://www.vaemergency.gov/volunteer/va-cit-corps-councils>) are sources of



information and training, typically provided at no cost. **Volunteer opportunities** are provided to ensure individuals can learn and practice implementing the plan, its response strategies, and recovery plans. Organizations that provide these opportunities include Citizen Corps, Neighborhood Watch, Citizen Emergency Response Training, Fire Corps, and Volunteers in Public Service.

Planning processes vary throughout the Commonwealth. For more information on emergency preparedness plans in a particular jurisdiction, individuals should contact their local agencies and organizations directly. The VDEM website contains a list of local emergency planners at <https://lemd.vdem.virginia.gov/Public/Default.aspx>. This list includes local contacts, where shelters are located, and more information regarding local emergency planning.

## Additional State and Local Resources

Individuals who are deaf or hard of hearing and their family members can visit **the Virginia Department for the Deaf and Hard Hearing (DDHH)** online at <http://www.vddhh.org/video.htm>. The site features several emergency and disaster planning videos with closed-captions and a sign language interpreter. It provides information on why it is important to be prepared, how to make a plan, where to find training, how to build an emergency kit, where to go to volunteer, how to locate a shelter, and also includes a video that specifically addresses planning for people with disabilities, and what to do in the event of an evacuation.

The **Department of Behavioral Health and Developmental Services (DBHDS)** is a key agency involved with emergency preparedness for individuals with intellectual, behavioral health, and substance abuse disabilities. DBHDS Policy 1043 (SYS) 08-1 states

*The Department, state facilities, and CSBs [Community Services Boards] shall, to the greatest extent possible, assure that emergency preparedness, response, recovery, and post disaster planning is undertaken by state agencies, local governments, and other organizations to integrate mental health into physical health and medical support functions.*

The DBHDS policy manual covers specific action steps for educating policy makers, establishing liaisons between service staff, ensuring participation in state and local emergency services planning, and advocating for more funding and human resources to respond to and recover from emergencies/disasters.

DBHDS is responsible for ensuring that the **state-operated institutions** (behavioral health facilities and Training Centers) have up-to-date emergency plans. DBHDS is also responsible for ensuring that its licensed providers comply with state and federal laws, and regulations and policies with respect to emergency preparedness. Agencies that license other types of facilities (e.g., assisted living facilities) are also responsible for ensuring that their licensees comply with federal and state mandates regarding emergency preparedness. DBHDS developed a **family**

**preparedness guide** that is intended to help families prepare, respond, and recover from a disaster. It is located at <http://www.dbhds.virginia.gov/CWD-HelpingToHeal.htm>.

**The Virginia Department of Health (VDH)** provides educational materials to help individuals and families prepare to take specific actions related to various scenarios such as bioterrorism or quickly spreading viruses at <http://www.vdh.state.va.us/OEP/>. They also provide information on how to talk to children about disasters. VDH offers a separate resource page on what to do in the event of natural disasters at <http://www.vdh.state.va.us/oep/disasters.htm>. It includes tips on how to prepare your family and pets should a natural disaster take place.

**Centers for Independent Living (CILs)** provides information and resources to individuals on how to become involved in emergency preparedness planning and learn more about what to expect during and after an emergency. To find the list of Centers for Independent Living, go to <http://www.vadrs.org/cbs/cilslisting.htm>. Other helpful agencies include the Area Agencies on Aging (AAAs) and faith-based organizations. The listings of AAAs in Virginia are located at <http://www.vaaaa.org/agencies/>.

## Emergency Response

Often an emergency will require the use of shelters. If local shelters are full following an emergency/disaster, the Virginia Department of Social Services (DSS) is responsible for oversight of the **State Managed Shelter (SMS) Program**. This program is administered and operated by the State to support mass evacuations across jurisdictional boundaries when ordered by the Governor. SMS facilities are open only when they provide an appropriate response to catastrophic events. Messages regarding those sites are communicated by various media to the public. They are designed to keep family units together by providing rapid registration, tracking, and reunification of individuals and families and by co-locating persons with special medical needs, seniors, or individuals with disabilities within general population shelters. If your local shelter is overwhelmed and SMS sites are activated, citizens can monitor the VDEM website to determine where state shelters are activated.

SMS sites are at 19 locations across the Commonwealth. Most are located in campuses of higher education; however, a few are on private, nonprofit properties. Sites are assessed by a multi-disciplinary team with representatives from the SMS facility itself, local government, State Police, VDSS, VDH, the Department for the Aging and Rehabilitative Services (DARS), the Virginia Department of Agricultural Services, (VDACS), and the Red Cross. DARS assesses the site for compliance with the Americans with Disabilities Act (ADA), and those areas needing modification are addressed. VDACS acts as the lead agency for sheltering pets in an emergency. Plans are being developed to shelter pets and service animals in close proximity to certain State Managed Shelters.

If an emergency evacuation is ordered, the Virginia Department of Transportation (VDOT) offers several methods to access information on the conditions of traffic and roads. This includes their website (<http://www.511virginia.org/>), which includes information on travel congestion and alternate routes. VDOT updates road conditions and traffic via its 24-hour

telephone service, available by dialing 511 and through its mobile telephone app, which can be downloaded at <http://www.virginiadot.org/travel/511.asp>. Staying informed about road accessibility and driving time is important should an evacuation being necessary.

Following an emergency declaration by the President of the United States, federally funded assistance is typically distributed through state and local agencies to affected individuals and businesses within specifically designated areas. For all families in Virginia seeking emergency relief in the form of a disaster related to the loss of their home, the **Virginia Department of Social Services (DSS)** is the state agency to contact. Once the Governor has requested, and the President has approved, a federal disaster declaration for Virginia, DSS and the Federal Emergency Management Agency (FEMA) jointly administer the Individuals and Households Program (IHP). Individuals and households within the disaster area can access IHP's two components, **Housing Assistance** and **Other Needs Assistance**, for necessary disaster-related expenses and serious needs that cannot be met through other means. IHP funds are not intended to cover disaster losses or to purchase items or services that may be considered nonessential, luxury, decorative, or improvements. The current maximum for all forms of assistance under IHP is \$27,200. This program and two other programs, Other Housing Assistance Grants and Other Needs Assistance Grants, are detailed on the DSS website at <http://www.dss.virginia.gov/benefit/disasterasst.html>.

**FEMA Housing Assistance** is 100 percent federally funded and is available to applicants displaced from their primary residences. It can be used to cover the cost of temporary housing or for permanent housing construction, repair, or replacement in situations where pre-disaster housing has been deemed uninhabitable and no insurance is available to cover those expenses. To explore the many disaster-assistance programs available through FEMA and find out how to access such services, go to <http://www.fema.gov/grants-assistance-programs-individuals>. Though FEMA does respond once local and State resources have been activated and a declaration has been made, for all citizens of the Commonwealth, it is also important to be familiar with several state and local agencies and nonprofit organizations. In this way, a person may better understand the interrelationship between agencies and how to access the service most appropriate to their needs during an event.



## Appendix C. Acronyms

**Table 90. Disability Service Acronyms**

| Abbreviation | Full Expression   |
|--------------|---|
| AAA          | Area Agencies on Aging  |
| AAC          | Alternative/Augmentative Communication (devices)                        |
| AAID         | American Association on Intellectual Disabilities                       |
| AAL          | Alzheimer's Assisted Living   |
| ABA          | Applied Behavioral Analysis   |
| ACA          | Affordable Care Act   |
| ACE          | Autism Center for Excellence (of Virginia Commonwealth University)      |
| ACF          | Administration for Children and Families                                |
| ACHC         | Accreditation Commission for Health Care                                |
| ADA          | Americans with Disabilities Act   |
| ADAP         | AIDS Drug Assistance Program  |
| ADC          | Average Daily Census  |
| ADLs         | Activities of Daily Living  |
| ADM          | Average Daily Membership  |
| ADRC         | Aging and Disability Resource Connectors                                |
| AFC          | Adult Foster Care   |
| AG           | Auxiliary Grant   |
| AHEC         | Area Health Education Centers   |
| AIM          | Accessible Instructional Materials                                      |
| ALF          | Assisted Living Facility  |
| AMI          | Area Median Income  |
| AMOs         | Annual Measurable Objectives  |
| APA          | Auditor of Public Accounts  |
| APR          | Annual Performance Report   |
| APS          | Adult Protective Services   |
| AR           | Authorized Representative   |
| ARRA         | American Recovery and Reinvestment Act                                  |
| ASAPS        | Adult Services and Adult Protective Services                            |
| ASD          | Autism Spectrum Disorders   |
| ASL          | American Sign Language  |
| ASOL         | Aligned Standards of Learning   |
| AT           | Assistive Technology  |
| ATLFA        | Assistive Technology Loan Fund Authority                                |
| AYP          | Adequate Yearly Progress  |
| BCCED        | Breast and Cervical Cancer Early Detection (see EWL)                    |
| BEP          | Business Enterprise Program (also called the Randolph Sheppard program) |
| BHSA         | Behavioral Health Services Administrator                                |
| BI           | Brain Injury  |
| BIAV         | Brain Injury Association of Virginia                                    |
| BIDS         | Brain Injury Direct Services  |
| BIS          | Brain Injury Services   |
| BISC         | Brain Injury Services Coordination                                      |

| Abbreviation | Full Expression   |
|--------------|---|
| BLS          | Bureau of Labor Statistics  |
| BPQY         | Benefits Planning Query   |
| BRFSS        | Behavioral Risk Factor Surveillance System  |
| CANS         | Child and Adolescent Needs and Strengths  |
| CARF         | Commission on Accreditation of Rehabilitation Facilities                          |
| CART         | Computer Assisted Real-time Translation   |
| CAS          | Commonwealth Autism Service   |
| CBIR         | Crossroads to Brain Injury Recovery   |
| CBO          | Congressional Budget Office   |
| CCC          | Care Connection for Children  |
| CCC          | Commonwealth Coordinated Care (Virginia's FAD)                                    |
| C-D          | Consumer-directed   |
| CDBG         | Community Development Block Grant   |
| CDC          | US Centers for Disease Control  |
| CDI          | Certified Driving Instructor  |
| CDRI         | Certified Driver Rehabilitation Specialist  |
| CFR          | Code of Federal Regulations   |
| CHIP         | Children's Health Insurance Program   |
| CHSM         | Coordinated Human Service Mobility  |
| CIL          | Center for Independent Living   |
| CIM          | Community Integration Manager   |
| CMS          | Centers for Medicare and Medicaid Services  |
| CNA          | Certified Nursing Assistant   |
| ConPlan      | Consolidated Plan   |
| CoPAs        | Communities of Practice in Autism   |
| CORF         | Commission of the Council of Occupational Education                               |
| CPMT         | Comprehensive Policy and Management Team  |
| CPS          | Current Population Survey   |
| CPS          | Child Protective Services   |
| CRCM         | Community Rehabilitation Case Management  |
| CRIPA        | Civil Rights of Institutionalized Persons Act                                     |
| CRP          | Community Rehabilitation Program  |
| CSA          | Comprehensive Services Act  |
| CSB          | Community Services Board  |
| CTI          | Center for Transitions Innovations  |
| CVTC         | Central Virginia Training Center  |
| CWIC         | Community Work Incentive Coordinator  |
| CY           | Calendar Year   |
| CYSHCN       | Children and Youth with Special Health Care Needs                                 |
| DARS         | Department for Aging and Rehabilitative Services                                  |
| DBHDS        | Department of Behavioral Health and Developmental Services                        |
| DBVI         | Department for the Blind and Vision Impaired                                      |
| DD           | Developmental Disability  |
| DD Waiver    | Individual and Family Developmental Disabilities Support Waiver (Medicaid Waiver) |
| DDHH         | Department for the Deaf and Hard of Hearing                                       |
| DDM          | Dual Diagnosis Management   |
| DHCD         | Department of Housing and Community Development                                   |

| Abbreviation | Full Expression   |
|--------------|---|
| DHHS         | Department of Health and Human Services                                       |
| DHP          | Department of Health Professionals  |
| dLCV         | disability Law Center of Virginia   |
| DLM          | Dynamic Learning Maps   |
| DMAS         | Department of Medical Assistance Services                                     |
| DME          | Durable Medical Equipment   |
| DMV          | Department of Motor Vehicles  |
| DOA          | Department of Accounts  |
| DOJ          | Department of Justice   |
| DOT          | Department of Transportation  |
| DPA          | Down Payment Assistance   |
| DPB          | Department of Planning and Budget   |
| DPOR         | Department of Professional and Occupational Regulation                        |
| DRC          | Disability Resource Coordinator   |
| DRPT         | Department of Rail and Public Transportation                                  |
| DRS          | Department of Rehabilitative Services   |
| DS Waiver    | Day Support Waiver (Medicaid)   |
| DSH          | Disproportionate Share Hospital   |
| DSP          | Disabilities Service Plan   |
| DSS          | Department of Social Services   |
| EBL          | Extraordinary Barriers List   |
| EDCD Waiver  | Elderly and Disabled with Consumer Direction Medicaid Waiver                  |
| EES          | Extended Employment Services (also LTESS)                                     |
| EHARP        | Emergency Home and Accessibility Repair Program                               |
| EHS          | Early Head Start  |
| EI           | Early Intervention  |
| EN           | Employment Network  |
| EO           | Executive Order   |
| EPSDT        | Early and Periodic Screening, Diagnosis, and Treatment                        |
| ESEA         | Elementary and Secondary Education Act (also called No Child Left Behind Act) |
| ESG          | Emergency Shelter Grants  |
| ESI          | Employment Support Institute (of Virginia Commonwealth University)            |
| ESO          | Employment Support Organization   |
| ETA          | Employment Training Administration  |
| ETC          | Empowerment Through Communication   |
| EWL          | Every Woman's Life (see BCCED)  |
| F.R.E.E.     | Foundation for Rehabilitation Equipment and Endowment                         |
| FAD          | Financial Alignment Model Demonstration Grant for Medicare/Medicaid Enrollees |
| FAMIS        | Family Access to Medical Insurance Security                                   |
| FAPE         | [right to a] Free, Appropriate Public Education                               |
| FAPT         | Family Assessment and Planning Team   |
| FCC          | Federal Communications Commission   |
| FFS          | Fee For Service   |
| FFY          | Federal Fiscal Year   |
| FHB          | Fair Housing Board  |
| FPL          | Federal Poverty Level   |

| <b>Abbreviation</b> | <b>Full Expression</b>  |
|---------------------|---|
| FPP                 | Federal Financial Participation   |
| FTA                 | Federal Transit Administration  |
| FTA                 | Federal Transit Authority   |
| GAO                 | Government Accountability Office  |
| GED                 | General Educational Development (certificate)                             |
| GF                  | General Funds (state)   |
| HB                  | House Bill  |
| HBE                 | Health Benefit Exchange   |
| HCBS Waiver         | Home and Community Based Services Medicaid Waiver                         |
| HFW                 | High Fidelity Wraparound (model of care)                                  |
| HHR                 | Health and Human Resources  |
| HMIS                | Homeless Management Information System                                    |
| HOPWA               | Housing Opportunities for Persons with AIDS                               |
| HPP                 | Homeless Prevention Program   |
| HRSA                | Health Resources and Services Administration                              |
| HSG                 | Homeless Solutions Grant  |
| HSRI                | Human Services Research Institute   |
| HSSCO               | Head Start State Collaboration Office                                     |
| HUD                 | Department of Housing and Urban Development                               |
| ICC                 | Intensive Care Coordination   |
| ICF                 | Intermediate Care Facility  |
| ICF/IID             | Intermediate Care Facility for Individuals with Intellectual Disabilities |
| ID                  | Intellectual disability   |
| ID Waiver           | Intellectual Disability (Medicaid) Waiver                                 |
| ID/DD               | Intellectual Disability and/or Developmental Disability                   |
| IDEA                | Individuals with Disabilities Education Improvement Act                   |
| IDT                 | Interdisciplinary Team  |
| IEE                 | Independent Educational Evaluation  |
| IEP                 | Individualized Education Program  |
| IFSP                | Individualized Family Services Plan                                       |
| IFSP                | Individual and Family Support Program                                     |
| IG                  | Inspector General   |
| IG-BDHS             | Inspector General for Behavioral and Developmental Health Services        |
| IMD                 | Institutions for Mental Disease   |
| IPE                 | Individualized Plan for Employment  |
| IRS                 | Internal Revenue Service  |
| IRWE                | Impairment Related Work Expense   |
| ISP                 | Individual Services Plan  |
| ISP                 | Interpreter Services Program  |
| ITOTS               | Infant and Toddler Online Tracking System                                 |
| JARC                | Job Access and Reverse Commute  |
| JCHC                | Joint Commission on Health Care   |
| JLARC               | Joint Legislative Audit and Review Commission                             |
| L2O                 | Loan-To-Own (assistive technology program)                                |
| LACs                | Local State Special Education Advisory Committees                         |
| LCA                 | Local Contact Agency  |
| LDSS                | Local Departments of Social Services                                      |



| Abbreviation | Full Expression   |
|--------------|---|
| LEAS         | Local education agencies (school divisions)                       |
| LHRC         | Local Human Rights Committee                                      |
| LICC         | Local Interagency Coordinating Council                            |
| LIHTC        | Low Income Housing Tax Credit                                     |
| LRE          | Least Restrictive Environment                                     |
| LTC          | Long Term Care  |
| LTESS        | Long Term Employment Support Services                             |
| MAP-21       | Moving Ahead for Progress in the 21st Century Act                 |
| MCO          | Managed Care Organization   |
| MFCU         | Medicaid Fraud Control Unit                                       |
| MFP          | Money Follows the Person  |
| MH           | Mental Health   |
| MIRC         | Medicaid Innovation and Reform Commission                         |
| MOE          | Maintenance of Effort   |
| MOU          | Memorandum of Understanding                                       |
| NEMT         | Non-emergency Medicaid Transportation                             |
| NF           | Nursing Facility  |
| NFCSP        | National Family Caregiver Support Program                         |
| NGF          | Non-General Funds   |
| NMEDA        | National Mobility Equipment Dealers Association                   |
| NVTC         | Northern Virginia Training Center                                 |
| OAA          | Older Americans Act   |
| OBG          | Older Blind Grant   |
| OBRA         | Omnibus Budget Reconciliation Act                                 |
| OCC          | Office of Community Contracting                                   |
| OCS          | Office of Comprehensive Services                                  |
| ODRAS        | Office of Dispute Resolution and Administrative Services          |
| OHR          | Office of Human Rights  |
| OL           | Office of Licensing   |
| OLC          | Office of Licensure and Certification                             |
| OPI          | Office of Program Integrity                                       |
| OSCAR        | Online Survey, Certification, and Reporting System                |
| OSEP         | Office of Special Education Programs (US Department of Education) |
| OSIG         | Office of the State Inspector General                             |
| OT           | Occupational Therapy  |
| PA           | Personal Assistant  |
| PACE         | Program of All-inclusive Care for the Elderly                     |
| PALS         | Phonological Awareness Literacy Screening                         |
| PAS          | Personal Assistance Services                                      |
| PAS-BI       | Personal Assistance Services [for individuals with] Brain Injury  |
| PASRR        | Pre-Admission Screening and Resident Review                       |
| PASS         | Plan for Achieving Self-support                                   |
| PD           | Planning District   |
| PDC          | Planning District Commissions                                     |
| PEATC        | Parent Education Advocacy Training Center                         |
| PERS         | Personal Emergency Response System                                |
| PERT         | Post-secondary Education/Rehabilitation Transition                |

| Abbreviation | Full Expression   |
|--------------|---|
| PHAs         | Public Housing Agencies   |
| PHA          | Public Housing Authority  |
| PIR          | Performance Improvement Report  |
| PL           | Public Law  |
| PPD          | Partnership for People with Disabilities  |
| PST          | Personal Support Team   |
| PTAC         | PASRR (Pre-Admission Screening and Resident Review) Technology Assistance Consultants |
| QHWRA        | Quality Housing and Work Responsibilities Act   |
| QIDP         | Qualified Intellectual Disability Professional  |
| QMR          | Quality Management Review   |
| QRI          | Qualitative Reading Inventory   |
| RCSC         | Regional Community Support Center   |
| REACH        | Regional Educational Assessment Crisis Response and Habilitation                      |
| REB          | Real Estate Board   |
| RFA          | Request for Applications  |
| RFP          | Request for Proposal  |
| RID          | Registry of Interpreters for the Deaf   |
| RISP         | Residential Information Systems Project   |
| RQC          | Regional Quality Councils   |
| RSA          | Rehabilitation Services Administration  |
| RST          | Regional Support Team   |
| RT/IL        | Rehabilitation Teaching/Independent Living  |
| RTI          | Response To Intervention  |
| SA           | Substance Abuse   |
| SACT         | State Agencies Coordinating Transportation Workgroup                                  |
| SAMHSA       | Substance Abuse and Services Administration   |
| SB           | Senate Bill   |
| SCI          | Spinal Cord Injury  |
| SEC          | State Executive Council   |
| SFY          | State Fiscal Year   |
| SGA          | Substantial Gainful Activity  |
| SIS          | Supports Intensity Scale  |
| SLAT         | State and Local Advisory Team   |
| SNAP         | Supplemental Nutrition Assistance Program   |
| SNF          | Skilled Nursing Facility  |
| SOL          | Standards of Learning   |
| SOP          | State-operated Program  |
| SOQ          | Standards of Quality  |
| SPP          | State Performance Plan  |
| SQC          | Substandard Quality of Care   |
| SRC          | State Rehabilitation Council  |
| SSA          | Social Security Administration  |
| SSDI         | Social Security Disability Insurance  |
| SSEAC        | State Special Education Advisory Committee  |
| SSG          | State Shelter Grant   |
| SSI          | Supplemental Security Income  |

| Abbreviation | Full Expression  |
|--------------|--|
| START        | Systematic, Therapeutic Assessment, Respite and Treatment                      |
| SVTC         | Southside Virginia Training Center   |
| SWVTC        | Southwestern Virginia Training Center  |
| TANF         | Temporary Assistance to Needy Families   |
| TAP          | Technology Assistance Program  |
| TPR          | Timely Progress Review   |
| Tech Waiver  | Assistive Technology Medicaid Waiver   |
| TTW          | Ticket to Work   |
| TTY          | Teletype   |
| UAI          | Uniform Assessment Instrument  |
| USC          | US Code  |
| USDOE        | US Department of Education   |
| V4A          | Virginia Association of Area Agencies on Aging                                 |
| vaACCSES     | Virginia Association of Community Rehabilitation Programs                      |
| VAAP         | Virginia Alternative Assessment Program  |
| VAC          | Virginia Administrative Code   |
| VAC          | Virginia Autism Council  |
| VaCares      | Virginia Congenital Anomalies Reporting and Education System                   |
| VACIL        | Virginia Association of Centers for Independent Living                         |
| VACSB        | Virginia Association of Community Services Boards                              |
| VATS         | Virginia Assistive Technology System   |
| VBOE         | Virginia Board of Education  |
| VBPD         | Virginia Board for People with Disabilities                                    |
| VCCS         | Virginia Community College System  |
| VCU-ACE      | Virginia Commonwealth University Autism Center for Excellence                  |
| VCU-RRTC     | Virginia Commonwealth University's Rehabilitation and Research Training Center |
| VDA          | Virginia Department of Aging   |
| VDH          | Virginia Department of Health  |
| VDOE         | Virginia Department of Education   |
| VDOT         | Virginia Department of Transportation  |
| VEC          | Virginia Employment Commission   |
| VEHDIP       | Virginia Early Hearing Detection and Intervention Program                      |
| VFHO         | Virginia Fair Housing Office   |
| VGLA         | Virginia Grade Level Alternative   |
| VHDA         | Virginia Housing Development Authority   |
| VHRI         | Virginia Health Reform Initiative  |
| VIB          | Virginia Industries for the Blind  |
| VICAP        | Virginia Insurance Counseling and Assistance Program                           |
| VICC         | Virginia Interagency Coordinating Council                                      |
| VIDA         | Virginia Individual Account  |
| VITA         | Virginia Information Technology Agency   |
| VMAST        | Virginia Modified Achievement Standards  |
| VNPP         | Virginia Network of Private Providers  |
| VOPA         | Virginia Office for Protection and Advocacy                                    |
| VPI          | Virginia Preschool Initiative  |
| VQAS         | Virginia Quality Assurance Screening   |
| VR           | Vocational Rehabilitation  |

| Abbreviation | Full Expression  |
|--------------|--|
| VRCVBI       | Virginia Rehabilitation Center for the Blind and Vision Impaired |
| VRE          | Virginia Railway Express   |
| VRN          | Virginia Reuse Network   |
| VR-PAS       | Vocational Rehabilitation Personal Assistance Services           |
| VRS          | Video Relay Service  |
| VSBD         | Virginia School for the Blind and Deaf                           |
| VSEP         | Virginia Substitute Evaluation Program                           |
| VSH          | Virginia Supportive Housing                                      |
| VTSS         | Virginia Tiered System of Supports                               |
| VWC          | Virginia Workforce Council                                       |
| VWC          | Virginia Workforce Center  |
| WCQA         | National Committee for Quality Assurance                         |
| WDAC         | Waiver Design Advisory Committee                                 |
| WIA          | Workforce Investment Act   |
| WIB          | Workforce Investment Board                                       |
| WIC          | Special Supplemental Nutrition for Women, Infants, and Children  |
| WIN          | Work Incentive (WIN bank account for MEDICAID WORKS program)     |
| WIPA         | Work Incentive Planning and Assistance                           |
| WISA         | Work Incentive Specialist Advocate                               |
| WWRC         | Woodrow Wilson Rehabilitation Center                             |

# Board Membership and Staff Contacts

## VIRGINIA BOARD FOR PEOPLE WITH DISABILITIES

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