Research

Sexual Health in the Community: Services for People with Intellectual and Developmental Disabilities

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Abstract

Background: Sexuality is a central dimension of overall health and well-being. People with intellectual and developmental disabilities (IDD) continue to experience disparities in healthcare, particularly regarding access to sexual health related services. Medicaid Home and Community-Based Services (HCBS) waivers are ideally situated to provide sexual and reproductive healthcare in accessible settings.

Objective: This preliminary study analyzed national Medicaid HCBS waivers to determine how they provide sexuality services for people with IDD.

Methods: 111 FY 2015 HCBS 1915(c) waivers for people with IDD from 46 states and the District of Columbia were analyzed to determine which waivers were providing services related to sexuality. Expenditure and utilization data were analyzed to determine service allotment.

Results: Currently, less than 12% of waivers include any kind of sexuality services, and those services provided are predominantly reactive, rather than proactive. Reactive services focused on interrupting sexually inappropriate behaviors through assessments and plans, intervention and therapy, and supervision. Meanwhile, proactive services promoted the healthy sexuality of people with IDD by providing sexuality education related to sexuality awareness, reproduction, and victimization avoidance.

Conclusions: The limited availability of Medicaid HCBS sexuality service provision not only hints at a lack of understanding of sexuality for people with IDD, but also presents an opportunity to perform increased evaluations on current service offerings in order to justify future expanded offerings in other states.

Keywords: Sexual health; intellectual and developmental disability; Medicaid Home and Community Based Services 1915(c) waivers; community living; behavioral services

Sexual Health in the Community: Services for People with Intellectual and Developmental Disabilities

In the past several decades, community-based service provision for people with intellectual and developmental disabilities (IDD) has improved in multiple domains [1]. A person-centered approach to service provision, operationalized by measurements of Quality of Life (QOL) have led to service offerings that emphasize a holistic sense of well-being [2]. One central dimension of overall health or well-being is sexuality. The World Health Organization (WHO) has described sexuality as “a central part of being human” [3], and has developed the concept of sexual health as a way to operationalize optimal outcomes for individuals related to sexuality [4]. In general populations, the centrality of sexuality is evidenced in the sexual health services provided, ranging from adolescent sexuality education to ongoing reproductive healthcare [5-7].

Not all sexual health services for the general population are created equal. The WHO’s insistence on sexuality as central to humanity is often obscured by the broader understanding of sexuality as risky or problematic [8]. In contrast, “sex-positive” approaches to education and human service provision promote and provide space for a variety of expressions of sexuality [9], Though sexuality education for the general population has not been standardized, which has led to disparities in access and approaches [10], the common denominator for most curriculums is that they communicate “sex-negative” messages [11]. Some sex-negative curriculums, particularly ones that emphasize abstinence, have been found to be ineffective, though more comprehensive programs have been more successful in raising condom use [12]. Even effective programs, however, have been associated with emphasizing inequalities related to race, class, and gender [13]. It has been suggested that taking a more sex-positive approach could increase effectiveness while also promoting equality through open communication about sexuality [9, 14].

The issues related to sexuality and reproductive health education in the general population are intensified in the case of people with IDD. People with IDD have only recently been perceived as being sexual beings. Sexuality in the context of IDD has only been recognized as danger or problem. Dark histories including North American sterilization policies in the nineteenth and twentieth centuries, and sex-segregated institutional settings served to reinforce the damaging and incorrect assumptions of people with IDD as sexual deviants [15, 16]. While both men and women with IDD were assumed to lack capacity for sexual relationship, women with IDD were often viewed as vulnerable victims while men with IDD were often viewed as aberrant predators [17].

Though attitudes and knowledge about the sexuality of people with IDD have expanded to acknowledge the sexual identities and experiences of people with IDD, much of the research on this topic has focused on controlling and categorizing people with IDD's sexuality [18]. Most recently, participatory research has focused on establishing the voices of people with IDD as sexual beings who practice agency and choice [19-21].

The literature emphasizing the voices of people with IDD represents an ongoing shift in how people with IDD's sexual identities are conceptualized, but people with IDD continue to experience disparities in healthcare, particularly regarding access to sexual health related services including sexuality education and services [22-24]. The general population typically receives sexuality education through K-12 educational programs and receives sexual and reproductive healthcare (SRH) through their primary care providers [25]. Unfortunately, people with disabilities do not often have equitable access to these pathways for a variety of reasons, including the use of equipment, discomfort with disability, false assumptions, and educational barriers [25, 26]. In addition, women with IDD are disproportionately affected by sexual violence [27],

making the need for increased sexuality education and SRH all the more urgent. Whereas the research and IDD communities have called for increased education and access around sexuality, little is known about how these services are provided in community settings. Among the interventions aimed at reducing incidence of sexual offenses by people with IDD, proactive, sex-positive services are rarely mentioned in the literature [28-31]. Such services could include social groups that encourage a variety of sexual expression and provide support for enacting those expressions. Because sexuality is an integral part of being human, sexuality services can and should be offered to people with IDD in a similar manner to the general population. Medicaid Home and Community-Based Services (HCBS), designed to provide long-term services and supports (LTSS) for people with disabilities in the United States, are ideally situated to provide sexuality education and SRH in an accessible setting. This is especially pertinent as many people with IDD do not receive adequate SRH in the K-12 education system, making HCBS waivers a timely and efficient method for delivering this education and support [25]. In order to better understand the current state of sexuality service provision for individuals with IDD in the United States, this preliminary study uses data from Medicaid HCBS waivers to demonstrate how sexuality services are provided and prioritized.

Medicaid Home and Community Based Services (HCBS) 1915(c) waivers permit states to provide community-based services tailored to particular populations, such as people with IDD, by ‘waiving’ the three main provisions of the Social Security Act [32]. In addition to expanding state plan services and providing services not typically covered in state plans, such as transportation, the HCBS waiver program allows states the “the authority to offer ‘other’ services that are not expressly authorized in the statute as long as it can be demonstrated that the service to be necessary to assist a waiver participant to avoid institutionalization and function in the

community" [33]. Because of the benefits of Medicaid HCBS waivers in terms of improved community outcomes and cost effectiveness, as well as because of the preferences of people with IDD, HCBS waivers have become one of the largest funding sources for LTSS for people with IDD in the United States [34-38].

While avoiding institutionalization was one of the original intents of the HCBS program, CMS has expanded on the rationale behind HCBS services and has been explicit in the aims of HCBS recipients gaining "full access to the benefits of community living"[39]. Because a central component of Medicaid HCBS regulations is that people receiving services should allow "the same degree of access as individuals not receiving Medicaid HCBS" [40], sexuality services can and should be universally offered through Medicaid HCBS. Moreover, a small percentage of people that leave institutional residential settings return to institutions. When this occurs, it is overwhelmingly because of behavioral issues, of which inappropriate sexual behaviors can be one[41]. Thus, the aim of this study is to examine how Medicaid HCBS 1915(c) waivers across the United States provide sexuality-related services for people with IDD. Fiscal year (FY) 2015 HCBS waivers for people with IDD were analyzed to determine how sexuality-related services were provided across the country. Sexuality-related services' definitions were compared to determine trends. Stand-alone sexuality services were then examined further to determine service provisions, including service utilization, projected expenditures, and reimbursement rates.

Methods

Medicaid HCBS 1915(c) waivers were obtained from the Centers for Medicare and Medicaid (CMS) Medicaid.gov website over a period of 11 months (June 2015 to April 2016). First, all available waivers were collected (n = 498). All waivers that were not 1915(c) (i.e., 1115 and 1915(b) waivers) were then excluded (n = 158). Our next inclusion criteria required waivers

have a target population of people with IDD: intellectual disabilities (ID), developmental disabilities (DD), 'mental retardation[1]' (MR), and/or autism spectrum disorder (ASD). This resulted in the exclusion of waivers for all other populations (e.g., HIV/AIDs, physical disabilities, older adults, medically fragile, etc.); waivers that were pending or inactive were also excluded at this stage (n = 227). Finally, waivers for FYs other than 2015 were excluded (n = 2). To do so, the waiver year aligning closest with FY 2015 (July 1, 2014 to June 30, 2015) was used. Most often this was the state FY, however other states used the 2014 calendar year (January to December) or the federal FY (October 1, 2014 to September 30, 2015). We use the term FY for consistency. This resulted in the collection of 111 FY 2015 HCBS waivers for people with IDD from 46 states and the District of Columbia.

CMS requires all waiver applications describe: CMS assurances and requirements; levels of care; waiver administration and operation; participant access and eligibility; participant services, including limitations and restrictions; service planning and delivery; participant direction of services; participant rights; participant safeguards; quality improvement strategies; financial accountability; and cost-neutrality demonstrations [33]. We utilized this information to determine which HCBS IDD waivers were providing services related to sexuality in FY 2015. Sexuality-related service definitions were then analyzed to determine service trends.

Sexuality was generally provided in two different ways: 1) as a stand-alone service that exclusively provided sexuality services, that is a sexuality specific service; and, 2) embedded as part of another larger service, for example habilitation. While the service definitions of both types were qualitatively analyzed, expenditure and utilization data of embedded services could not be analyzed because we were not able to differentiate between what proportion of the service

[1] Although considered an outdated term, 'mental retardation' continues to be used in a number of HCBS waivers for people with IDD. For this reason, 'mental retardation' was a necessary search term.

went toward sexuality, and what proportion went toward the other features of the service. However, expenditure and utilization data from those sexuality-related services that were provided as stand-alone services were quantitatively analyzed to determine projected spending, projected number of users, reimbursement rates, and service allotment.

Conceptually, we then utilized the sex-negative/sex-positive distinction [8, 42] as the basis for our categories of "reactive" and "proactive" HCBS sexuality-related services. Reactive services contained elements of sex-negative ideas, including that sex is dangerous, should be avoided, or assuming sexual deviancy. Proactive services, while still attempting to solve sexuality-related issues, took a more sex-positive approach, assuming that people with IDD may want to be sexually active, and communicating openly about those possibilities. Proactive services were more in keeping with the WHO's definition of sexuality, with the overall goal of working towards best outcomes for individuals; in this case, individuals in an HCBS funded service system.

Findings

Sexuality Service Trends

Thirteen HCBS IDD waivers (11.71%) from seven states and the District of Columbia offered 37 sexuality-related services in FY 2015. Our findings revealed two major trends among sexuality-related services provided by HCBS waivers – they fell into two categories: reactive and proactive services. Ninety-two percent of services (n = 34) were reactive services aimed at preventing and stopping inappropriate behaviors, while 8% of services (n = 3) were more positively oriented, with purposes related to education and awareness. See table 1.

[Table 1 near here]

Reactive services

Reactive services (*n* = 34) portrayed sexuality more negatively by exclusively focusing on sexually inappropriate behaviors. Reactive services often (62% of reactive services; *n* = 21) included assessments and plans to stop current sexually inappropriate behaviors and prevent future behaviors.

Reactive services frequently (47% of reactive services; *n* = 16) also included intervention and therapy for sexually inappropriate behaviors. For example, Tennessee Statewide HCBS waiver's (TN.128.R05.00) 'Intensive Behavioral Residential Services' explained:

> Intensive Behavioral Residential Services is a home and community-based clinical treatment… for individuals who exhibit high risk behaviors that are dangerous or whose behaviors are so serious that when they occur, they present a potential danger to the person, staff, or the community. Examples of the behaviors that meet criteria are behaviors that have caused harm in the past (e.g., sexual predatory behavior) and have a probability of reoccurrence. These behaviors can be reasonably expected to occur in the absence of a highly structured therapeutic environment without support, supervision, and training in alternative behaviors. Specific examples include… sexually offensive behaviors with high frequency of occurrence or sexual behavior with any person who did not consent or is unable to consent to such behavior, or engaging in public displays of sexual behavior.

Finally, a number of reactive services (38% of reactive services; *n* = 13) also provided supervision for inappropriate behaviors. For example, Colorado HCBS – Children's Habilitation Residential Program waiver's (CO.305.R04.00) 'Habilitation' service explained:

> supervision means the level of supervision necessary to keep the waiver participant safe in the home and in the community. Levels of supervision would

include line-of-sight, one-on-one, room-to-room, and within sight distance (yard). Behavioral needs would include, but not be limited to, the waiver participants physical and verbal aggressiveness, sexual inappropriateness, victimization, property destruction, self-harm, suicidal, stealing.

Proactive services

Unlike reactive services, proactive services (n = 3) promoted healthy sexuality education. All three proactive sexuality services provided education centered on sexuality awareness, reproduction, safe sex, and victimization avoidance. These include New Mexico Developmental Disabilities Waiver Program's (NM0173R0503) 'Socialization and Sexuality Education' services, which emphasizes social skills learning and sexuality learning, as both a class and individual service offering, and the District of Columbia Persons with IDD Renewal Waiver's (DC0307R0301) 'Sexuality Education,' offered as a wellness service.

Service Expenditures

Of the 37 sexuality-related services offered in FY 2015, 28 sexuality-related services (76%) were embedded within another service, such as habilitation, while nine services (24%) were provided as stand-alone services. These nine services had a total projected spending of $645,994 for 514 participants. However, this ranged greatly by service from $3,000 for Washington Children's Intensive In-Home Behavioral Support waiver's (WA.40669.R01.03) 'Sexual Deviancy Evaluation' service to $431,943 for NM.0173.R05.03's 'Socialization and Sexuality Classes' service, with the average stand-alone sexuality service projecting a total spending of $71,777. See table 2.

[Table 2 near here]

Proactive stand-alone sexuality services projected a greater total spending ($453,524) than reactive stand-alone services ($192,471), and had a larger average total projected spending per service ($151,175) than reactive services ($32,078). However, proactive stand-alone services also provided for a greater number of people with IDD, projecting a total of 361 participants, with an average of 120 participants per service, compared to a total of 153 for reactive services, with an average of 26 participants per service.

The average spending per participant also varied widely by service, and service type (i.e., reactive, proactive). While on average in FY 2015 stand-alone sexuality services projected spending $1,064 per participant this ranged from $475 per participant (DC.0307.R03.01's 'Sexuality education' service) to $1,500 per participant (WA.40669.R01.00's 'Sexual Deviancy Evaluation' service) (see figure 1). Moreover, reactive stand-alone sexuality services projected more spending per participant ($1,172) on average than proactive stand-alone sexuality services ($847).

[Figure 1 near here]

Stand-alone sexuality services were provided by a number of different reimbursement rates, including hourly (n = 3), each evaluation (n = 4), and series (n = 2). Those services reimbursed by 'each evaluation' had an average reimbursement rate of $1,143, ranging from $785 (Washington Basic Plus waiver's (WA.0409.R02.06) 'Sexual Deviancy Evaluation' service) to $1,5000 (WA40669R0103 'Sexual Deviancy Evaluation' service) an evaluation, with participants receiving one evaluation per year.

Those services reimbursed by hourly rate ranged from $75.96 (DC.307.R03.01's 'Sexuality education' service) to $106.48 (NM.0173.R05.03's 'Preliminary Risk Screening, Incentive (New)' service) an hour, having an average hourly reimbursement rate of $88.44. Of

those services reimbursed hourly, the average participant was projected to receive 10.75 hours of sexuality services per year, ranging from 6.25 hours (DC.307.R03.01's 'Sexuality education' service) to 13 hours (NM.0173.R05.03's 'Preliminary Risk Screening, Incentive (New)' and 'Preliminary Risk Screening, Standard (New)' services).

Finally, those services provided by series ranged from $423.15 (NM.0173.R05.03's 'Socialization and Sexuality Individual' service) to $708.00 (NM.0173.R05.03's 'Socialization and Sexuality Classes' service) a series, having an average reimbursement rate of $565.58 per series. Of series rate services, the average participant projected to receive 2.11 series per year, ranging from 1.00 (NM.0173.R05.03's 'Socialization and Sexuality Individual' service) to 3.21 series (NM.0173.R05.03's 'Socialization and Sexuality Classes' service).

Rates cannot be directly compared across reactive and proactive services because reactive stand-alone services were provided by hourly and each evaluation rates, while proactive services were provided by hourly and series reimbursement rates.

Discussion

Of the 111 Medicaid HBCS waivers for people with IDD offered in FY 2015, less than 12% provided any type of sexuality-related service. Two types of sexuality-related services were offered to people with IDD: reactive and proactive services. Reactive sexuality services focused on interrupting sexually inappropriate behaviors through assessments and plans, intervention and therapy, and supervision. Meanwhile, proactive sexuality services promoted the healthy sexuality of people with IDD by providing sexuality education related to sexuality awareness, reproduction, and victimization avoidance. That less than 12% of HCBS waivers offer any sexuality-related services reveals the overall lack of recognition of sexuality as an integral part of life for HCBS waiver participants. While greater reforms are needed surrounding the healthcare

provision for people with IDD, HCBS has the potential to provide sexuality-related services in settings that are community-based and acknowledge the important role that sexuality plays for most individuals. While the majority of current HCBS-funded sexuality services are reactive, and respond to currently existing sexually problematic behaviors, a small minority of services take more proactive approaches, recognizing "the need for a continuum of sexuality services to address the gaps in socialization and sexuality education that existed for individuals with developmental disabilities" (NM173R0503 'Socialization and Sexuality Education service'). While these services have not been formally evaluated they represent a novel approach that honors the value of full community inclusion for people with IDD.

The majority of HCBS sexuality-related services were embedded within another service, such as habilitation. Meanwhile, stand-alone sexuality services projected approximately $646,000 of funding in FY 2015 – less than .01% of total HCBS IDD waiver projected spending[43]. While proactive stand-alone sexuality services had a higher total projected spending and average projected spending in FY 2015 than reactive stand-alone sexuality services we believe this is because it was more common for reactive sexuality-related services to be embedded in bulk services. Direct expenditure comparisons between these bulk services were not possible because there is no way to differentiate the sexuality-related services from other service provisions**.** However, as HCBS waiver requirements become more focused on maximizing community-based and person-centered service options, providing proactive sexuality services, either as standalone services or within habilitation services, offers a way to ensure high-quality services while also providing cost-effective services [9, 14, 44]. More longitudinal research is needed in order to measure such an initiative's effects, but the changing paradigm of service provision, including increased usage of demonstration waivers within an

1115 plan, makes this an ideal moment in which to increase waiver coverage of proactive sexuality services.

The State of New Mexico's current HCBS waiver offerings provide an example for other states of how proactive sexuality services may be offered. New Mexico's Socialization and Sexuality Education service (NM173R0503) offers a series of classes that recognize "the need for a continuum of sexuality services to address the gaps in socialization and sexuality education that existed for individuals with developmental disabilities that were being integrated in the community, as well as those who had always lived in the community." Using a train-the-trainer approach, and administered by the Office of Behavioral Support within the State Health Department's Developmental Disabilities Support Division, the "Friends and Relationships" class discusses how relationships change over time and how sexuality may play a role in some of those relationships [45]. Currently, participants in the waiver may take this class up to six times [45].

New Mexico's Friends and Relationships curriculum has much in common with other training material cited in the literature, including a focus on relationships [46, 47], safety [48], and skill-building [49-51]. It was also designed to be delivered in conjunction with another service offered as a stand-alone waiver service in New Mexico: the 'Preliminary Risk Screening & Consultation Service.' The Preliminary Risk Screening program is uniquely community-based and seeks to identify and manage risk for behavior associated with sexual offenses. Participants receive treatment in community-based settings, which may allow them greater control over their own behavior in addition to fuller participation in employment, leisure, and educational settings (NM173R0503).

One of the ongoing issues with getting comprehensive sexuality education and intervention services included in more states' waivers is the overall lack of evaluation on training

curriculums and outcomes for adults with IDD [52]. Even when trainings and curriculum are evaluated, methodological issues frequently arise, due in part to time and monetary restrictions [53]. New Mexico's Friends and Relationships curriculum, however, utilizes a train-the-trainer approach. Train-the-trainer models have been found to be effective in training professional in health and social work contexts [54], and have also been found efficacious when training adults with IDD about healthy lifestyles [55]. In addition, the companion service provided through 'Preliminary Risk Screening & Consultation' utilizes lessons learned from other community-based interventions focused on risk factor management for adults with IDD [56]. By following trends located within the most current evidence base for providing effective services to adults with IDD, New Mexico demonstrates that its HCBS waiver proactive sexuality service offerings may represent an effective model for other states to follow.

As our study was preliminary and resulted in a small sample size, it does have limitations. The method used in this study lead to a sample size that is also part of the results; the finding that less than 12% of all HCBS IDD waivers offered sexuality-related services in FY 2015 is significant. While this small proportion as well as the variation across the HCBS waivers providing sexuality services may appear extreme, this variability is the hallmark of the HCBS waiver program[43]. CMS does not require states to detail why they make the decisions they do regarding expenditures and utilization. Moreover, the HCBS program by its very nature allows states flexibility in terms of how they provide services. Therefore, this variability may relate to both contextual state differences as well as state priorities. According to waivers alone there is no way to determine the causes of these differences, making it a valuable direction for future study.

Another limitation of our study is Medicaid HCBS 1915(c) waivers are not utilization data but instead state projections made to the federal government. However, HCBS waivers are

an accurate proxy of utilization because they are based on previous years' actual waiver utilization[57]. Moreover, research by Rizzolo et al.[57] found HCBS waiver projections

> congruent with spending patterns identified by researchers at Mathematica who used 2008 Medicaid Statistical Information Systems claims data from 44 states and Washington, DC, to determine trends in waiver expenditures across the states. (pp. 19-20)

It should also be noted that the availability of service provision alone is not necessarily a good metric of success of the sexuality-service provision. We suggest future research evaluate how successful these sexuality services are at fulfilling the sexuality needs of people with IDD.

In order to move towards universal coverage of proactive sexuality education and other intervention services, such as the use of positive behavioral supports, the efficacy of current Medicaid HCBS waiver sexuality services must be measured. However, the increased inclusion of sexuality services within HCBS would also signal at a broader shift in how people with IDD are understood as sexual beings. Viewing sexuality as a natural part of life for most people can and should necessitate increased service provision around sexuality. While localized sexuality education programs have existed since the 1980s, the time has come for sexuality services to be endorsed and funded at the Federal and State levels through HCBS waivers.

Conclusion

This paper has explored, through an analysis of HCBS waiver service offerings, the current state of sexuality service provision funded through Medicaid HCBS. Currently, less than 12% of waivers include any kind of sexuality services, and of that 12%, the services provided are predominantly reactive, rather than proactive. This reveals an understanding of people with IDD's sexuality as mostly deviant, rather than viewing sexuality as a natural part of all people's

experiences. Three proactive services in New Mexico and the District of Columbia were identified and discussed as models for other states creation of and inclusion in HCBS waiver service offerings. The limited availability of Medicaid HCBS sexuality service provision not only hints at a lack of understanding of sexuality for people with IDD, but also presents an opportunity to perform increased evaluations on current service offerings in order to justify future expanded offerings in other States. Understanding how and why these programs operate is the next step in providing optimal HCBS service provision that ensures maximum quality of life.

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Table 1

Sexuality-related Services in HCBS IDD waivers in FY 2015

State	Waiver	Service	Embedded in service[1]	Reactive service[2]
Colorado	CO0305R0400	Habilitation (foster home level 1)	X	X
Colorado	CO0305R0400	Habilitation (foster home level 2)	X	X
Colorado	CO0305R0400	Habilitation (foster home level 3)	X	X
Colorado	CO0305R0400	Habilitation (foster home level 4)	X	X
Colorado	CO0305R0400	Habilitation (foster home level 5)	X	X
Colorado	CO0305R0400	Habilitation (foster home level 6)	X	X
Colorado	CO0305R0400	Habilitation (group home level 1)	X	X
Colorado	CO0305R0400	Habilitation (group home level 2)	X	X
Colorado	CO0305R0400	Habilitation (group home level 3)	X	X
Colorado	CO0305R0400	Habilitation (group home level 4)	X	X
Colorado	CO0305R0400	Habilitation (group home level 5)	X	X
Colorado	CO0305R0400	Habilitation (group home level 6)	X	X
Colorado	CO0305R0400	Supported Community Connections	X	X
District of Columbia	DC0307R0301	Sexuality education (wellness services)		
New Mexico	NM0173R0503	Preliminary Risk Screening and Consultation Related To Inappropriate Sexual Behavior, Incentive		X
New Mexico	NM0173R0503	Preliminary Risk Screening and Consultation Related To Inappropriate Sexual Behavior, Standard		X
New Mexico	NM0173R0503	Socialization and Sexuality Education, Individual		
New Mexico	NM0173R0503	Socialization and Sexuality Education, Classes		
Pennsylvania	PA0147R0504	Behavioral Support	X	X
Pennsylvania	PA0354R0304	Behavioral Support	X	X
Tennessee	TN0128R0500	Intensive Behavioral Residential Services	X	X
Tennessee	TN0357R0300	Intensive Behavioral Residential Services	X	X
Utah	UT0158R0504	Residential habilitation	X	X
Virginia	VA0372R0302	Residential Support Services	X	X
Virginia	VA0372R0302	Residential Support Services	X	X
Washington	WA0409R0206	Behavior Support and Consultation	X	X
Washington	WA0409R0206	Behavioral Health Stabilization Services-Behavior Support and Consultation	X	X
Washington	WA0409R0206	Sexual Deviancy Evaluation		X
Washington	WA0410R0206	Behavior Support and Consultation	X	X
Washington	WA0410R0206	Behavioral Health Stabilization Services-Behavior Support and Consultation	X	X

Washington	WA0410R0206	Sexual Deviancy Evaluation		X
Washington	WA0411R0204	Behavior Support and Consultation	X	X
Washington	WA0411R0204	Behavioral Health Stabilization Services-Behavior Support and Consultation	X	X
Washington	WA0411R0204	Sexual Deviancy Evaluation		X
Washington	WA40669R0103	Behavior Support and Consultation	X	X
Washington	WA40669R0103	Behavioral Health Stabilization Services-Behavior Support and Consultation	X	X
Washington	WA40669R0103	Sexual Deviancy Evaluation		X

[1] Alternative: Stand-alone service.

[2] Alternative: Proactive service.

Table 2
Stand-alone Sexuality Services

State	Waiver	Service	Projected Users	Projected Total Spending
District of Columbia	DC0307R0301	Sexuality education (wellness services)	38	$18,041
New Mexico	NM0173R0503	Preliminary Risk Screening, Incentive (New)	96	$132,887
New Mexico	NM0173R0503	Preliminary Risk Screening, Standard (New)	5	$5,387
New Mexico	NM0173R0503	Socialization and Sexuality Individual	5	$3,540
New Mexico	NM0173R0503	Socialization and Sexuality Classes	318	$431,943
Washington	WA0409R0206	Sexual Deviancy Evaluation	6	$4,710
Washington	WA0410R0206	Sexual Deviancy Evaluation	14	$19,326
Washington	WA0411R0204	Sexual Deviancy Evaluation	30	$27,160
Washington	WA40669R0103	Sexual Deviancy Evaluation	2	$3,000

Note. Stand-alone services are those services that specifically provide sexuality service as opposed to embedded services that provide sexuality as part of a larger service category.

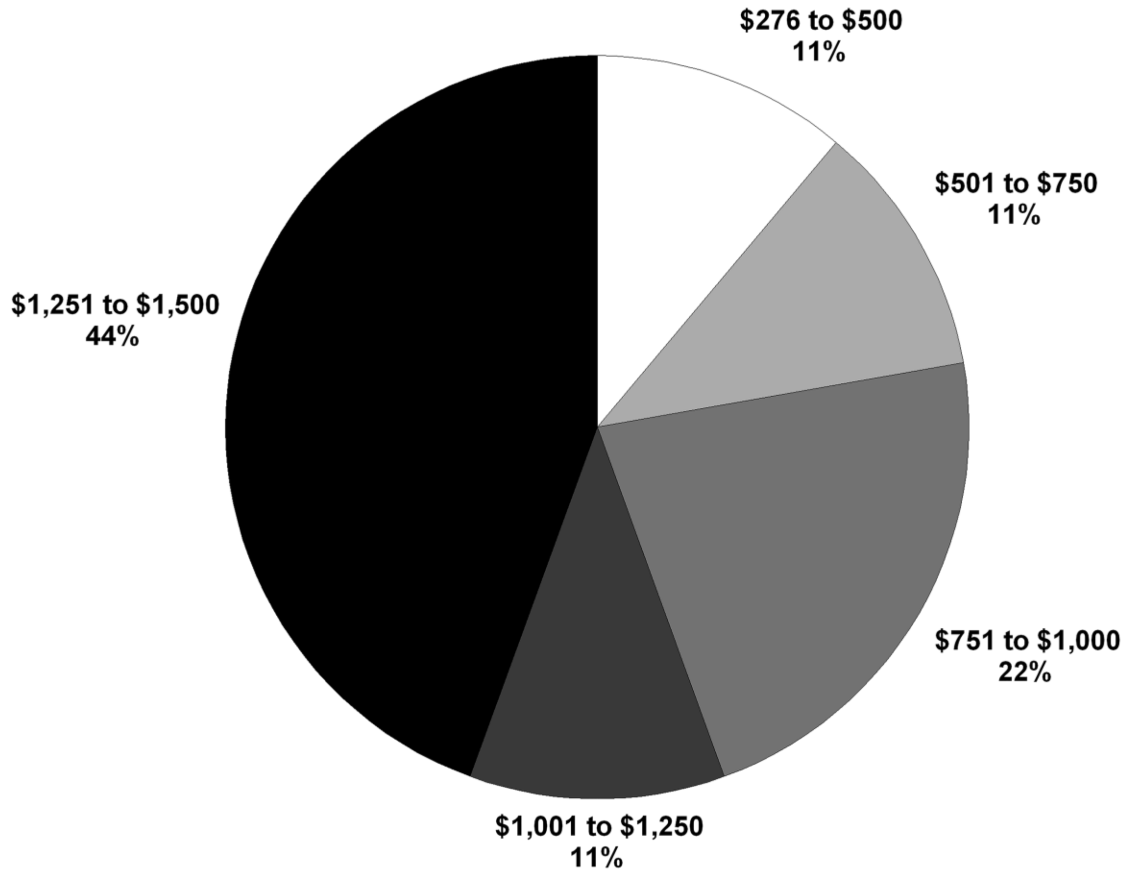

Figure 1. Average spending per participant for stand-alone sexuality services.