

oppaga Progress Report



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Developmental Disabilities Program Takes Steps to Improve Medicaid Waiver Systems and Controls

at a glance

The Developmental Disabilities Program acted to correct its systems and controls for developmental services provided under the Home and Community-based Services Medicaid Waiver. The program is beginning to increase consumer involvement, improve monitoring systems, and make more cost-effective service decisions.

- Changes allow consumers and their families to review new policy initiatives and participate in new quality assurance efforts.
- A private contractor is providing additional monitoring of community providers.
- The program reviewed cost plans for high-cost clients and proposes to cap community-based services at current ICF/DD levels (\$75,925) as a means of ensuring cost-effective service decisions.

Purpose

In accordance with state law, this progress report informs the Legislature of actions taken by the Department of Children and Families (DCF) in response to a 2000 OPPAGA report.^{1,2} This report assesses the

extent to which the department has addressed the findings and recommendations included in our report.

Background

The primary purpose of the Developmental Disabilities Program is to ensure the safety and well-being of clients and provide opportunities for clients to work, socialize, and recreate as active members of their communities. Persons with developmental disabilities have or are at risk of having mental retardation, autism, cerebral palsy, spina bifida, or Prader-Willi syndrome. To be eligible for program services, a client must have a confirmed diagnosis of a developmental disability or be under the age of five and at high risk for having a developmental disability.

Because of the nature of their physical, behavioral and functional challenges, individuals with developmental disabilities need long-term support. Historically, the state provided this support in large institutions. Beginning in the early 1980s, federal and state governments began to change policies to serve the

¹ Section 11.45(7)(f), F.S.

² Performance Review: *The Home and Community-Based Services Waiver Systems, Controls Should Be Improved*, OPPAGA [Report No. 99-31](#), February 2000.

developmentally disabled in community settings where they can receive services such as personal care assistance, transportation, and supported employment. Community-based services offer two advantages over institutional care. First, many individuals with developmental disabilities and their families prefer community-based services to institutional care. Second, most clients can be served at a lower cost in community settings than in institutions.

Currently, the state operates a Home and Community-Based Services Medicaid Waiver for individuals with developmental disabilities. The waiver allows the department to receive Medicaid matching payments for services such as personal care, physical therapy, and training. The department enrolled 25,448 waiver clients as of June 30, 2001.

For Fiscal Year 2001-02, the Legislature authorized 301 positions and appropriated \$672.5 million for home and community-based services provided by the Developmental Disabilities Program.³ This amount consists of \$261 million in state funds and \$411.5 million in federal Medicaid funds.

Prior Findings —————

In our prior report, we examined whether the Department of Children and Families had established effective service delivery systems and controls to meet client needs in a timely manner, to ensure service quality, and to provide services in a cost-effective manner. We concluded that the department had taken initiatives to improve its responsiveness to changing client needs. However, we identified problems with the

department's systems and controls for developmental services provided under the Home and Community-Based Services Medicaid Waiver.

Systems for controlling costs limited responsiveness to changing client needs

To improve its responsiveness to changes in clients' needs, the department had developed initiatives that gave clients and their families more control over how to use the money allocated for their services. We identified two problems. First, not all clients may be willing or able to participate in these initiatives. Second, the department's responsiveness to the needs of those clients who remain on the Home and Community-Based Services Medicaid Waiver would remain limited.

We recommended that the department modify its processes for controlling service costs by giving clients and their support coordinators the flexibility to change cost plans without district approval as long as the proposed changes did not increase budgeted service costs. To accomplish this, the department needed to change its Allocation, Budget, and Contract Control System to change its control from individual services to total client costs. Thus, the system would reject invoices only if the total cost of all invoices for services provided during a certain time period exceeded the approved amount budgeted for that period. This would give clients and their support coordinators flexibility to modify services without district approval if the modifications did not increase the total cost of the services in the approved cost plan.

Monitoring systems and controls were ineffective to ensure quality service provision

At the time of our prior review, the department had developed a process to monitor the quality of services provided by

³ The funding for the Home and Community-Based Services Program includes approximately \$160 million in funding for private intermediate care facilities that provide 24-hour supervision and care.

waiver support coordinators. However, it had not implemented an effective system to monitor the quality of services from other providers.

As of December 1999, the department was continuing to revise plans to monitor provider performance. In its legislative budget request for Fiscal Year 2000-01, the department had requested \$2.5 million to fund 42 FTE positions. These positions would be used to create six monitoring and oversight teams that would monitor provider performance. The department's proposed plan sought to move away from a process-driven system to a more consumer-driven system. For example, one of the goals of the proposed monitoring plan was to create a system that relied more on the perceptions of clients and their families to determine the success of the service delivery system rather than on department process monitoring activities.

We concluded that the department could use less costly alternative methods to obtain information about provider performance. For example, the department could obtain useful information about provider performance from waiver support coordinators and clients and their families because they deal with private providers on a daily basis. This would be sensible in light of department plans that call for more consumer participation in evaluating service delivery system success.

Due to continuing concerns about the performance of waiver support coordinators, we recommended that the department continue to seek ways to improve its monitoring process. We recommended that the department collect information about the number of waiver support coordinators who are decertified, the reasons for their de-certification, whether any coordinators previously decertified were re-certified, and if so, the reasons for re-certification.

We also recommended that the department establish a process to collect information about the performance of each provider. This process should involve feedback from the waiver support coordinators who deal with these other providers and the clients and their families who receive services from them.

Department could serve some clients more cost-effectively and redirect \$21.5 million for additional services

Home and community-based services are generally a cost-effective alternative to institutional placement. However, we identified instances in which waiver clients with high needs could be served more cost-effectively in an institutional setting. Conversely, we identified institutional clients with limited needs that could have been served more cost-effectively in the community. While Medicaid requirements limit the department's ability to divert clients from more costly institutional settings to less costly community settings, we concluded the department could do more to control institutional costs. Serving clients in the most cost-effective setting could have provided another \$21.5 million for additional services to clients.

Effective October 1, 1999, the department adopted a Waiver Cost Review Policy that required program staff to give more consideration to cost when deciding whether to enroll a client on the Home and Community-Based Services Medicaid Waiver. This policy required the department to annually review each client's support plan to determine whether clients are served in the most cost-effective manner. We recommended that the department gauge results by reporting the number of clients reviewed under the policy, and a list of the number, costs, and reasons for exceptions granted.

Because Medicaid rules entitle eligible clients to choose institutional care, clients with limited or minimal needs who are served in intermediate care facilities and institutions may remain in institutions. However, the department could still serve these clients more cost-effectively if it established a lower reimbursement rate for institutional clients who do not need the full range of institutional services. We therefore recommended that the department, in cooperation with the Agency for Health Care Administration, consider adopting lower reimbursement rates for institutional care reflecting the care required for clients with lower levels of need.

Current Status —————

Since our prior report, the Developmental Disabilities Program acted to correct deficiencies with its systems and controls for developmental services provided under the Home and Community-based Services Medicaid Waiver.

Department makes changes that allows more consumer involvement

Although the department did not implement our recommendation to allow consumers to change their cost plans, it has taken steps to make the current waiver more consumer-directed, including allowing consumers and their families to review new policy initiatives and to participate in the department's new quality assurance efforts. For example, the department created an official role for consumers and their families in their Interagency Quality Council that has worked to improve monitoring of community providers. Program officials believe that efforts to expand service providers should enhance consumer direction by providing increased consumer choice. Increasing the number of providers available enhances individual choice for

consumers. In other words, consumer-directed services means very little when consumer choice is limited because there is only one or only a few providers. Program officials also said that making service directories and choice counseling materials available through the Internet improves consumer access and choice.

Due to program officials' concerns about potential lawsuits, the department did not implement our recommendation to modify processes to allow support coordinators and clients greater flexibility in making changes to support plans. According to program officials, allowing consumers to change their services makes department decisions to deny or reduce services to other consumers more difficult to defend in court. The department currently must allow a fair hearing upon request whenever a consumer is denied services or has services reduced.

To address these concerns, and because of the need to defend its decisions to deny services to some clients, in July 2001 the department implemented strict medical necessity criteria for each service provided under the Medicaid Waiver. Medical necessity criteria limit the frequency, intensity, duration, and scope of services. For example, a service such as personal care assistance is limited to four hours per day except for consumers with uniquely complex needs. In November 2001, the department implemented prior authorization of all services. Maximus, under contract with the department, began reviewing consumer services to ensure that services are provided within medical necessity guidelines.

Department making improvements to monitoring systems and controls

As we recommended in our prior report, the department began making improvements to its monitoring systems and controls. In September 2001, the department and the

Agency for Health Care Administration contracted with a private firm, Delmarva, to implement a new quality assurance monitoring system. As part of this new system, Delmarva will do person-centered reviews of individual clients as well as performance reviews of community service providers. As of January 2002, the department reported that Delmarva had completed 286 person-centered reviews and 267 provider performance reviews. Over the four-year contract period, Delmarva expects to complete 10,292 person-centered reviews, 10,579 site/desk reviews, and 980 follow-up provider performance reviews. Program officials believe that the person-centered component of the new system that includes interviews with clients, their families and support coordinators will address the need for feedback from these key stakeholders.

In response to our recommendation to better monitor waiver support coordinators, the department tracks and reports the numbers of waiver support coordinators who have been de-certified. De-certifying a waiver support coordinator means that individual can no longer provide services. A decision to de-certify can be made based on a specific job performance reason or for no cause. For the period of July 1, 1999, to August 30, 2001, the department reported de-certification of 17 waiver support coordinators. The department explained that all de-certifications were without cause as allowed under Medicaid policy.

Over the past two years the department continued to monitor waiver support coordinators on an annual basis. However, the department could not provide us with sufficient documentation to determine the percentage of the 907 individual support coordinators who were monitored. Some waiver support coordinators work independently while others work for agencies that employ a number of support

coordinators. The department's monitoring and reporting combines individual and agency providers and these aggregate figures do not provide the level of detail needed to determine whether monitoring increased or decreased over time. However, the department reports monitoring 284 providers in Fiscal Year 2000-01, a slight increase from 280 in the previous fiscal year.

Department reviews high-cost clients, takes additional steps to ensure cost-effective service decisions

From October 1999, when the department implemented its new Waiver Cost Review policy through June 2001, the department reported reviewing the cost plans of 368 "high-cost" clients. Cost plans for these clients exceed the average ICF/DD reimbursement rate, currently \$75,925, and must be reviewed by the Secretary of Children and Families.⁴ Support coordinators must request an exception to exceed the cost cap and to justify the additional service costs. They must document the client's needs as well as plans to reduce costs over a three-year period. Of the 368 consumers whose high cost plans were reviewed, the department rejected requests from 5 clients (1%) and modified plans for 51 clients (14%).⁵ Modified plans reduced costs in some instances or approved services for a shorter time period, less than one year. Program officials stated that the high-cost review process produced a number of valuable outcomes including cost sharing with other programs, reductions in services in some cases, and competitive bidding to provide services.

The 2000 Legislature appropriated \$600,000 for a choice counseling program to increase

⁴ ICF/DD is an intermediate care facility for the developmentally disabled. ICF/DDs are institutions, usually privately operated, that provide continuous 24-hour care for their clients.

⁵ According to the department's policy, a consumer whose request is denied will be offered an ICF/DD placement.

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awareness of community-based services, which are generally more cost-effective than institutional care. While the department has not formally evaluated the choice counseling program's success, in January 2002 it reported that 137 individuals had moved from private ICF/DDs to less restrictive community-based settings. The department also indicated that in the 18 months prior to January 2002, 54 people had moved from state institutions to private or community-based settings.

From its fall 2000 inception through June 30, 2001, the choice-counseling program provided counseling to 8,413 waiver funded clients, 366 people in residential habilitation centers, and 1,913 clients in private ICF/DDs. For Fiscal Year 2001-02, the department provided written materials and made video materials on choice counseling available to approximately 24,000 Medicaid waiver clients. In addition, one-half of the 24,000 waiver clients also had an opportunity to attend a group session on choice counseling, although only 280 persons attended those sessions. Program staff expressed concern about low turnout and speculated that consumers may have felt that meetings were not necessary because written materials were sufficient, or they may be confusing the disabilities choice counseling program with the Medicaid choice counseling program.

Clients residing in the state's four public institutions have not received choice counseling services. However, during August and September 2001 the department provided choice counseling training for staff at these facilities and has made choice counseling materials available for residents who express an interest in community-based services. The department plans to provide choice counseling sessions during March and April 2002 at the Miami-based Landmark Learning Center that is scheduled for closure by June 2005.

To improve cost-effective service delivery, the department has proposed in its 2002-03 Legislative Budget Request to cap community-based services at the current ICF/DD rate. The Legislative Budget Request estimates that this proposal would result in a cost savings of \$5.7 million if fully implemented.⁶ However, cost savings may not be fully realized because services for clients who are party to department litigation and settlement agreements may not be reduced. The proposal to cap costs, if approved by the Legislature, would require an amendment to the current waiver. In addition, each high-cost client affected by the new policy would require an alternative placement if they cannot be safely served in the community at the lower rate.

The department's prior authorization reviews will provide an additional review of high-cost clients and their cost plans. Maximus, the private contractor for prior authorization reviews, will examine whether current services are within acceptable ranges in terms of the frequency, scope, and cost for units of service.

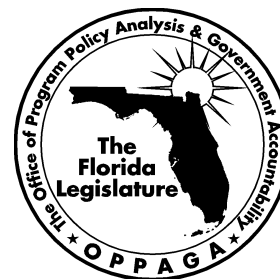
The 2001 Legislature directed OPPAGA to examine the rapidly rising costs to serve Florida's developmentally disabled, the steps the program is taking to reduce costs, and alternative Legislative strategies for managing growth and controlling costs. We published this report in February 2002.⁷

⁶ Costs to serve high cost clients exceed \$30 million annually, an average of \$103,377 per client.

⁷ *Program Review: Legislative Options to Control Rising Developmental Disabilities Costs*, OPPAGA [Report No. 02-09](#), February 2002.

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