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OFFICE OF PROGRAM POLICY ANALYSIS & GOVERNMENT ACCOUNTABILITY

March 2008 **Report No. 08-15**

APD Should Take Steps to Ensure New Needs Assessment and Individual Budget Process Is Timely and Effective

at a glance

The Agency for Persons with Disabilities (APD) administers the Developmental Disabilities Home and Community-Based Services Medicaid waiver to serve persons with developmental disabilities in community settings. Nineteen of the 26 states that we contacted place their waiver programs in a large, multi-program health or human services agency. Four states use the same model as Florida to administer their waiver programs in a stand-alone agency that serves persons with developmental disabilities, while three place the program in an agency that also administers mental health and substance abuse programs.

While all of the states we contacted conduct individual assessments to determine what waiver services clients need, 10 states establish spending limits for identified client needs. These states do this in one of three ways: assigning clients to levels of care that correspond to funding amounts, assigning clients to waivers that cap expenditures, or establishing individual client budgets.

APD is currently implementing a new client needs assessment process for developing client service plans. APD plans to assess all clients by July 2009 and subsequently develop individual client budgets. To effectively implement this system, APD needs to develop a plan that outlines major activities, milestones, and needed resources and establish an anticipated target date for completion within six months after it has finished assessing all clients using the new needs assessment process. This will also require the agency to ensure that its new needs assessment tool is valid and reliable.

Scope

Pursuant to a legislative request, OPPAGA reviewed the Developmental Disabilities Home and Community-Based Services (DD/HCBS) waiver program in Florida. As part of this review, we examined how 26 other states manage this program. [1] This report addresses four questions.

- What organizational placement do other states use for the DD/HCBS waiver program?
- How do states manage and control waiver services and costs?
- What is the status of waiver management in Florida?
- What experience have states had in requiring families to share in the cost of DD/HCBS waiver services?

[1] We selected these 26 states because they were among the states with the highest waiver enrollment, waiver expenditures, and/or total population, or were included because of specific program features. These states were Arizona, California, Colorado, Georgia, Illinois, Indiana, Iowa, Kansas, Kentucky, Maryland, Massachusetts, Michigan, Minnesota, Missouri, New Jersey, New York, North Carolina, Ohio, Oregon, Pennsylvania, Tennessee, Texas, Virginia, Washington, Wisconsin, and Wyoming.

Background

The Agency for Persons with Disabilities (APD), established in 2004, supports persons with developmental disabilities to ensure their safety, self-sufficiency, and well-being.[2] Persons with developmental disabilities include individuals who have or are at risk of having mental retardation, autism, cerebral palsy, spina bifida, or Prader-Willi syndrome.[3] APD administers the Developmental Disabilities Home and Community-Based Services (DD/HCBS) waiver, a 1915(c) Medicaid waiver, which allows Florida to serve persons with developmental disabilities in community settings, such as a client's home or a group home, instead of serving them in institutions. The waiver gives clients access to 29 services including personal care assistance, supported employment, respite care, skilled nursing, and residential habilitation. Also part of the DD/HCBS waiver program are the Family and Supported Living wavier and the Consumer Directed Care Plus waiver. The Family and Supported Living waiver provides a limited number of services to persons living in their own home and limits client spending to $14,792 a year. The Consumer Directed Care Plus waiver is offered as an alternative to the DD/HCBS waiver. It provides the same services provided by the DD/HCBS waiver and allows clients to direct their own care.

APD administers the waiver program through 14 area offices that are responsible for day-to-day operations and report to the central office in Tallahassee. In Fiscal Year 2006-07, the waivers served 31,257 clients, and expenditures totaled $897.1 million, of which 36% comprised general revenue ($322.3 million) and state trust funds ($47.6 million).[4] The remaining $527.2 million comes from federal Medicaid grants.

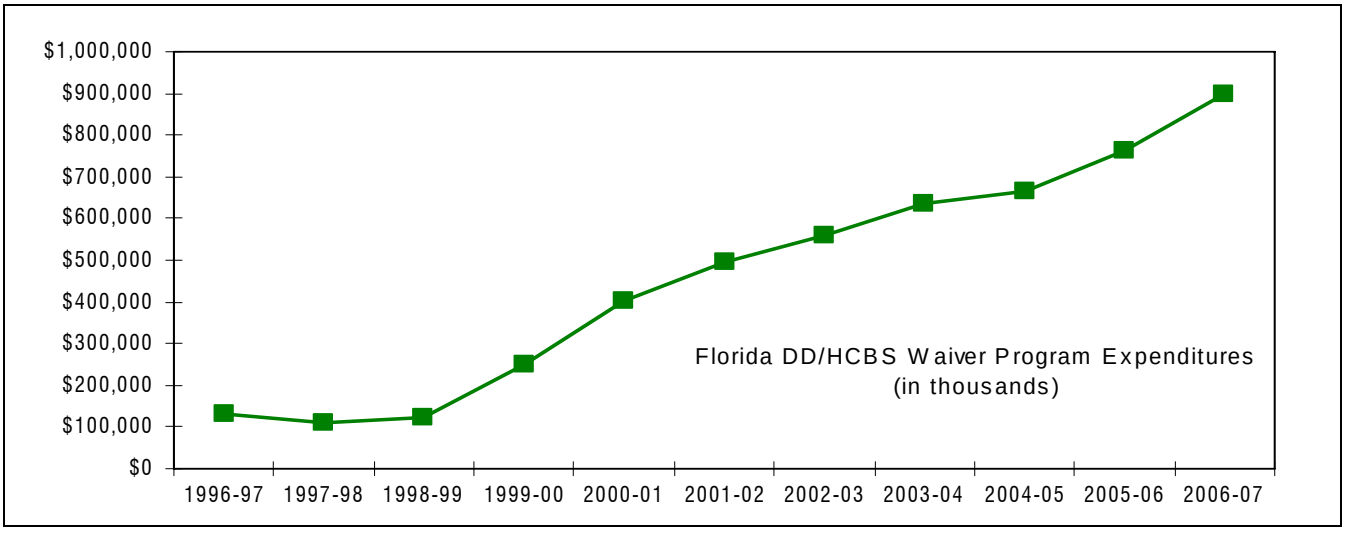
As shown in Exhibit 1, waiver program costs have substantially increased over time. Over the last seven years from Fiscal Year 1999-2000 to Fiscal Year 2006-07, costs for the DD/HCBS waiver program increased by 256.2%. This expenditure growth is due to increases in both the number of clients enrolled in the waivers and the amount of services provided to individuals. A 2002 OPPAGA report noted that the program lacked effective cost control mechanisms and identified several factors that contributed to rising program costs, including lawsuit settlements that resulted in serving more individuals and providing more services and an ineffective process for identifying

[2] Chapter 2004-267, *Laws of Florida.*

[3] Prader-Willi Syndrome is a rare disorder that causes poor muscle tone, low levels of sex hormones, and a constant feeling of hunger.

[4] The federal share for the waiver program constitutes 58.76% of the funding for the waiver while the state match is 41.24%.

Exhibit 1
DD/HCBS Waiver Expenditures in Florida Have Increased Substantially Over Time



Source: *Residential Services for Persons with Developmental Disabilities,* University of Minnesota Institute on Community Integration, August 2007.

client needs.[5] Agency staff and stakeholders report that these factors have continued to increase program costs.

To address the program's increasing expenditures and to better ensure that Florida is meeting the needs of persons with developmental disabilities, the 2007 Legislature directed APD to redesign the DD/HCBS waiver program.[6] It directed APD to establish a four-tier waiver system, capping client expenditures in three of the four tiers. The Legislature also directed APD to eliminate or limit certain services.

Questions and Answers—

What organizational placement do other states use for the DD/HCBS waiver program?

As shown in Exhibit 2, 19 of the 26 states that we contacted place their DD/HCBS waiver program in agencies that manage multiple health and human services programs. Four states use the same model as Florida and place their wavier programs in a separate agency established solely for the purpose of delivering developmental disability program services. Finally, three states administer their DD/HCBS waiver programs in agencies that also administer mental health and substance abuse programs.

Regardless of organizational placement used, officials in states we contacted emphasized the need to maintain an effective working relationship between a state's Medicaid office and the entity that administers its DD/HCBS waiver programs. State Medicaid offices are responsible for submitting and coordinating correspondence related to DD/HCBS waiver applications and amendments to the federal Centers for Medicare and Medicaid Services and for managing state Medicaid budget and caseload forecasting activities. Officials noted that it is important for the program officials administering DD/HCBS waivers to have input into these processes.

How do states manage and control waiver services and costs?

While all states that we contacted conduct client needs assessments, 10 states have established mechanisms to control program costs by linking identified client needs to the amount that clients can spend on waiver services. These states link needs assessment results to funding in one of three ways: assigning clients to levels of care that correspond to funding amounts, assigning clients to waiver programs that cap expenditures, and establishing individual client budgets. Two additional states manage and control DD/HCBS services and costs using capitated managed care systems.

[5] *Legislative Options to Control Rising Developmental Disabilities Costs,* OPPAGA Report No. 02-09, February 2002.

[6] Chapter 2007-64, *Laws of Florida.*

Exhibit 2
Most States Administer DD/HCBS Waiver Programs in Multi-Program Health or Human Services Agencies

Separate Agency Similar to Florida	Developmental Disability / Mental Health /Substance Abuse Agency	Multi-Program Health or Human Services Agency	
California	Kentucky	Arizona	New Jersey
Massachusetts	Missouri	Colorado	North Carolina
New York	Virginia	Georgia	Oregon
Ohio		Illinois	Pennsylvania
		Indiana	Tennessee
		Iowa	Texas
		Kansas	Washington
		Maryland	Wisconsin
		Michigan	Wyoming
		Minnesota	

Source: OPPAGA interviews.

All states conduct needs assessments to identify the waiver services that clients need. In this process, states typically gather information from clients and their families, physicians, and others about individual clients' disabilities and service needs. States use varying approaches in conducting these needs assessments. Some states use decentralized systems in which regional or local levels establish their own process for identifying client needs. Other states use a standardized needs assessment process that assesses all clients the same way.

In addition, many states use or are in the process of adopting nationally recognized instruments that were developed and validated specifically to assess the needs of persons with disabilities. The most commonly used tools are the Supports Intensity Scale, the Inventory for Client and Agency Planning, and the Developmental Disabilities Profile. These instruments make the process of identifying client needs more standardized and objective and can help states be less vulnerable to legal challenges.

Ten states control costs by linking clients' assessed needs to the amount that they can spend. Six of these states (Illinois, Kansas, Maryland, Ohio, Tennessee, and Texas) assign clients to a level of care based on needs assessment results. For example, Kansas has established five levels of care and assigns clients to one of these levels based on their needs assessment score. A high-functioning client who needs only limited assistance would be assigned to the lowest funding level, while a client who needs 24-hour supervision and has a high needs assessment score would be assigned to the highest funding level that provides access to the highest level of services. Maryland, Illinois, Ohio, Tennessee, and Texas similarly assign clients to levels of care that link to client spending. Client spending is not capped in these states, and clients may move to the next level of care if need arises.

Two states, North Carolina and Washington, control DD/HCBS costs by creating multiple waiver programs and assigning clients to a specific program based on needs assessments. These states cap expenditures in the sense that the amount that clients can spend in a year cannot exceed the maximum dollar amount for that waiver program. Washington assigns clients to one of four waiver programs based on their identified needs and living situation. Once clients are assigned to a program, they cannot switch to another waiver program without a reassessment or major life change, such as losing a caregiver, and the amount that they spend on services cannot exceed the waiver cap. North Carolina is currently implementing a similar system that will place clients into one of three waivers based on their needs assessments.

Two states (Georgia and Wyoming) use individual client budgets as a way to control costs. These states establish individual client budgets by using funding algorithms that consider factors that impact costs such as the results of clients' needs assessments, current living arrangements, and expenditure and utilization data. The algorithms produce a dollar amount which clients may use to purchase waiver services but cannot exceed.

Each of these 10 states attempt to control costs by identifying client service needs using one of the nationally recognized and validated assessment tools that were developed specifically for persons with developmental disabilities and using this information to link client needs to funding.[7] States that use these tools to develop individual client budgets have noted improved ability to predict and control costs. For example, since implementing individual budgets, Wyoming has received fewer requests from clients for additional services and a decrease in the funding requested per client.

Two states, Arizona and Michigan, manage and control DD/HCBS services and costs through capitated managed care systems. Both of these states place waiver clients into capitated systems although they differ with respect to what services are covered by the capitated monthly fees. In Arizona, the monthly fee covers both DD/HCBS services and health care services, while in Michigan the fee covers only DD/HCBS services.

[7] However, while these states all require that individuals who assess needs and develop service plans have similar credentials, they vary as to whether they use state employees, county employees, or contracted providers to conduct needs assessments. Ohio uses county employees; Georgia and Washington use state employees; and Illinois, Maryland, North Carolina, Texas, and Wyoming use private providers. Kansas uses both county and private providers, and Tennessee uses both state employees and private providers.

In contrast with typical managed care programs that require services be provided by a managed care organization, both Arizona and Michigan use regional entities to administer DD/HCBS waiver services. Arizona uses district offices, while Michigan contracts with community organizations.

These regional entities receive an annual capitated payment allocation based on the number of DD/HCBS clients served in their region and are responsible for contracting with individual DD/HCBS providers to deliver services. The regional entities coordinate with clients' Medicaid managed care health plan companies to ensure that clients receive services from appropriate providers. Regional staff identify client needs and oversee the development of client service plans but do not use the needs assessment process to limit the amount that clients can spend.

To ensure that clients receive appropriate services, central office agency staff in these states monitor service quality. In Arizona, central office staff review and approve client service plans that exceed a certain dollar limit, review overall service use on a monthly basis, and meet with the regional offices on a quarterly basis to discuss clients with either high or low service utilization. Michigan central office staff review all client service plans to ensure appropriateness of care and conduct annual client file reviews to ensure that needed services have been provided.

What is the status of waiver management in Florida?

To better manage and control DD/HCBS waiver costs, APD began implementing a new needs assessment process in January 2008 and anticipates completing needs assessments on all current waiver clients by July 2009. To further manage and control costs, APD plans to also develop individual budgets for all clients. To ensure that this process is timely and effective, APD should develop an action plan that outlines major activities, milestones, and needed resources. It should submit this plan to the Legislature and should set an anticipated target date to have established individual client budgets within six months after completing needs assessments using the new process.

APD is implementing a new needs assessment process that should better ensure that clients receive appropriate waiver services. While APD previously had a client needs assessment process, this process did not effectively identify needed services and control costs. APD used private support coordinators to develop client service plans. While support coordinators could use various methods to assess clients, APD required them to use the Individual Cost Guidelines instrument as part of the assessment process. [8] This tool was developed by a private consultant in response to 2002 proviso. [9]

However, this process had two critical weaknesses. First, the assessment process did not adequately identify needed client services. Agency staff report that in Fiscal Year 2006-07, nearly two-thirds of client requests to modify services represented additional services not included in the service plans developed during the initial needs assessment. Second, the needs assessment process did not link client needs to their spending. Even though this was an intended goal of the Individual Cost Guidelines tool, APD did not use it for this purpose.

APD's new needs assessment process for developing service plans uses the Questionnaire for Situational Information, an instrument developed by a private consultant. This instrument collects information on client's physical, functional, and behavioral status. It also collects information on living situation, caregiver supports, and demographics. This instrument is web-based, which will enable central office staff to monitor the needs assessment process and record its results in an electronic database for planning and budgeting purposes. APD previously conducted needs assessments in a hard copy format and did not enter client needs information into a database, which hindered its ability to project costs and manage its budget.

[8] APD uses the same assessment process, including the Individual Cost Guidelines instrument, regardless of whether clients enroll in the DD waiver, the Family and Supported Living waiver, or the Consumer Directed Care Plus waiver.

[9] Proviso language specified that the new needs assessment instrument demonstrate validity and reliability. This new instrument was to replace the Florida Status Tracking Survey.

To ensure that the Questionnaire for Situational Information is consistently administered, APD is in the process of hiring and training OPS staff to administer the instrument.[10] This represents a change as APD previously used private providers to assess clients. APD expects that by having more control over personnel who conduct assessments and their training, the overall needs assessment process will be more reliable and objective. The OPS staff will be required to have four years of experience, an increase from the two years' experience previously required by private providers. APD is also requiring these staff to undergo a certification process which involves completing training in how to administer the instruments and then having initial needs assessments overseen and reviewed by supervisors.

Even though APD considered using the Supports Intensity Scale along with the Questionnaire for Situational Information to assess client needs, it decided to use only the latter instrument. The Supports Intensity Scale is a nationally recognized assessment tool developed in 2004 by the American Association of Mental Retardation. Its strength is that it was developed and validated as a needs assessment tool that identifies the frequency, intensity, and volume of specific services that clients need. Of the 26 states that we contacted, 9 states are either using or considering adopting the Supports Intensity Scale as its primary needs assessment tool.[11, 12]

APD officials assert that the Questionnaire for Situational Information will provide similar information to the Supports Intensity Scale and allow them to identify risk factors and client needs. The private consultant who developed the Questionnaire for Situational Information combined elements of two tools previously used as part of the needs assessment process for the waiver program—the Florida Status Tracking Survey and the Individual Cost Guidelines. Neither of these instruments was used to manage waiver services and control costs. Thus, it will be critical for APD to determine that the Questionnaire for Situational Information is a reliable and valid tool that will assist APD to accurately identify needed services and ensure appropriate utilization. While APD has conducted initial analyses of content validity and inter-rater reliability and consulted with national experts who agree that the new tool is likely to be valid and reliable, the agency will need to conduct further studies as it is implementing the new process.

As of February 2008, APD had conducted 1,028 needs assessments using the Questionnaire for Situational Information and expects to have assessed all DD/HCBS waiver clients by July 2009. Based on the results of the needs assessments, APD will assign clients to one of the four tiers established by the 2007 Legislature.[13] The legislation specifies criteria and spending caps for tiers two, three, and four, and defines tier one as reserved for clients whose needs cannot be met in the other tiers. (See Exhibit 3.) APD will assign a client to a tier for a three-year period, at which time it will conduct another needs assessment. If during this three-year period a client experiences a significant life change, such as the death of a caregiver, APD will conduct another needs assessment to determine if the client needs additional services or needs to be placed in a higher tier.

Once APD has implemented the new needs assessment process, it should no longer need to continue its contracts for prior service authorization. The agency currently contracts with two vendors to ensure that client service plans and additional service requests are

[10] The Legislature appropriated 75 OPS positions during the 2007 Special Session C to APD to conduct needs assessments. As of February 2008, APD had filled 51 of these positions.

[11] Nine of the other 26 states use one of the other two nationally recognized instruments, the Inventory for Client and Agency Planning and the Developmental Disabilities Profile; eight states use state-developed instruments.

[12] The American Association on Intellectual and Developmental Disabilities (AAIDD), formerly known as the American Association of Mental Retardation, has developed a children's version, for ages 5 – 15, of the Supports Intensity Scale and is ready to field test and norm the tool. AAIDD is currently looking for states to participate in this effort.

[13] The Agency for Health Care Administration (AHCA) and APD modified both the DD and Family and Supported Living (FSL) HCBS waivers and applied for two new waivers. The FSL waiver represents tier four, and the DD waiver represents tier one. The two new waivers will represent tiers two and three. When the federal Centers for Medicare and Medicaid Services approves the waivers, APD will use a client's most recent assessment to make a tier assignment. APD will reevaluate tier placement of those clients that it places into tiers based on the old assessment process upon administering the Questionnaire for Situational Information.

Exhibit 3
The 2007 Legislature Directed APD to Assign Waiver Clients to One of Four Tiers

Tier	Annual Expenditure Limit	Criteria for Tier Placement
One	None	Service needs cannot be met in the other tiers and are essential for avoiding institutionalization, or behavioral problems are exceptional in intensity, duration, or frequency and present risk of harm to self or others.
Two	$55,000	Service needs include a licensed residential facility and greater than five hours per day in residential habilitation or greater than six hours a day of in-home support services.
Three	$35,000	Shall include, but is not limited to, clients requiring residential placements, clients in independent or supported living situations, and clients who live in their family home.
Four	$14,792	Shall include, but is not limited to, clients in independent or supported living situations and clients who live in their family home.

Source: Section 393.0661(3)(a-e), *Florida Statutes*.

necessary for meeting client needs. However, APD staff assert that the Questionnaire for Situational Information should better identify the amount, duration, and scope of client needs, which should then allow APD to eliminate these contracts. Many states that we contacted do not use prior service authorization vendors. Eliminating these contracts would save $4.7 million annually. [14]

In conjunction with assigning clients to a tier, APD plans to set individual client budgets but needs to develop a plan for doing so. In addition to implementing the new needs assessment process, APD plans to establish individual budgets for persons receiving waiver services. If done properly, developing individual budgets should enable APD to better project its expenditures by determining the specific amount that clients may spend within their assigned service tier and holds the promise of ensuring appropriate utilization and strengthening APD's ability to accurately project resource needs.

To help ensure that this process is successful, APD should develop a detailed action plan for the initiative. The plan should detail major planned activities, milestones, and needed resources. APD should set an anticipated target date to have established individual client budgets within six months after it completes assessing DD/HCBS clients using the new assessment instrument. The plan also should detail the steps APD will need to take to link needs assessment results to individual client budgets. To do so, APD will need to create a database that includes individual client information collected by its needs assessment instrument and develop an algorithm that is a good predictor of client costs.

This will require APD to use needs assessment information as well as other factors that correlate with costs such as living situation, family supports, and demographics (age, gender, area of state, etc.) together with actual expenditure and utilization data. [15] This will also require the agency to ensure that the Questionnaire for Situational Information is a valid and reliable needs assessment instrument that will assist APD to accurately identify the services that clients need, assign clients to tiers, and develop an algorithm that predicts costs and individual budgets. Savings from eliminating the prior service authorization contracts could be used to support these activities.

APD should provide this plan to the Legislature as well as quarterly progress reports. In addition, the Legislature may wish to have OPPAGA monitor APD progress in completing needs assessments and developing a model for establishing individual client budgets.

[14] This represents approximately $1 million of general revenue. The remaining is federal trust funds.

[15] Georgia developed its individual budget algorithm by identifying the factors that predict client spending. To do so, it created two databases, one that captured information from needs assessments on 600 clients and one that contained actual utilization and expenditure data for those 600 clients.

What experience have states had in requiring families to share in the cost of DD/HCBS waiver services?

Three of the states that we contacted (Kansas, Minnesota, and Wisconsin) have established systems that require families to pay part of the cost of services provided to their children. [16] These states require parents to pay a monthly fee based on adjusted gross income and family size, and fees are assessed to families with incomes at or above a specified percentage of the federal poverty level. [17] While Kansas and Minnesota were unable to provide data on the amount of fees collected through their systems, Wisconsin officials reported collecting $104,058 in Fiscal Year 2006 and $298,047 in Fiscal Year 2007. [18]

Officials in each of the three states reported that the primary rationale for establishing these cost sharing systems was a philosophy that parents should contribute toward their children's care if they can afford to do so. Thus, achieving costs savings thus was not a primary goal of these efforts. Officials noted that monies collected from parents were at least partially offset by administrative costs to assess, track, and collect fees. Also, because federal regulations prohibit states from denying services to children whose parents refuse to pay such fees, collections can be less than anticipated.

Recommendations

APD is in the process of implementing a new process to assess client needs and establish individual budgets. APD is making these changes to enable it to better manage and control its costs and better predict its budget for waiver services. In accomplishing this objective, it will be critical for APD to use a valid and reliable assessment tool that accurately identifies client needs and ensures appropriate utilization of services.

To ensure APD's success in this effort, we recommend the Legislature direct APD to take the two actions described below.

- Develop an action plan for establishing individual client budgets. The plan should outline major activities, milestones, and needed resources, and establish a target date to begin developing individual budgets within six months after all waiver clients are assessed using the new needs assessment instrument. The plan should also lay out key steps and deadlines for creating a database that contains individual client information collected by the needs assessment instrument, and developing a funding algorithm that uses results from client needs assessments together with actual expenditure and utilization data. APD should provide this plan to the Legislature as well as quarterly progress reports. The Legislature may wish to have OPPAGA monitor APD's progress in implementing the needs assessment process, assessing the reliability and validity of the Questionnaire for Situational Information as soon as possible, and developing a model for establishing individual client budgets.

  The Legislature may also wish to direct APD to use a nationally recognized and validated instrument, such as the Supports Intensity Scale, as its major assessment tool for identifying client needs. This would require APD to train staff in administering the tool which could then affect its ability to meet the July 2009 date for completing assessments of all waiver clients.
- Eliminate current contracts for prior service authorization for an annual savings of $4.7 million. Since 2001, APD has contracted with vendors to ensure that client service plans and additional service requests are necessary for meeting client needs. These contracts should be unnecessary once the new client needs assessment and budget process is established.

[16] North Carolina and Illinois plan to implement cost-sharing systems in 2008.

[17] Wisconsin also bases the monthly fee on the total cost of services that a client receives.

[18] This represents fees collected from multiple medical assistance programs for children in Wisconsin, one of which is the DD/HCBS waiver program.

Agency Response

In accordance with the provisions of s. 11.51(5), *Florida Statutes,* a draft of our report was submitted to the director of the Agency for Persons with Disabilities for her review and response.

The director's written response is reproduced in its entirety in Appendix A. Where necessary and appropriate, OPPAGA comments have been inserted into the response.

Appendix A

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Dear Mr. VanLandingham:

This is the Agency's response to the OPPAGA report "APD Should Take Steps to Ensure New Needs Assessment and Individual Budget Process Is Timely and Effective." We appreciate the opportunity to respond and we have addressed the report recommendations, as well as the information within the body of the report.

Report Information

Organizational Placement: The Agency for Persons with Disabilities (Agency) became a separate agency from the Department of Children and Families (DCF) in October 2004 (HB 1823). Prior to that time, it was the Developmental Disabilities Program within DCF. Section 11.905, Florida Statutes, requires that the Agency undergo Legislative Sunset Review by July 1, 2014. Since the Agency is newly created and has undergone substantial redesign by the Florida Legislature to address the budget deficit, we believe that more time is needed to allow the Agency to mature and comply with legislative direction.

The OPPAGA report notes that three of the four largest states in the country have determined that Developmental Disability Programs are best served by stand-alone agencies. This validates the Legislature's decision to create the Agency for Persons with Disabilities in Florida.

OPPAGA Comment

The OPPAGA report shows that four states (California, Massachusetts, New York, and Ohio) have stand-alone agencies similar to Florida but does not provide information or make conclusions as to how organizational placement relates to state population or why these states decided on this organizational placement. Our report also shows that some large states have other organizational arrangements. For example Texas, Illinois, and Pennsylvania (the second, fifth, and sixth most populous states, respectively) place their DD/HCBS waiver programs in large multi-program agencies.

The primary issues that have challenged APD since its creation are not organizational in nature. Rather, they result from the structure of the waiver program and the Agency's lack of critical infrastructure.

The Agency has repeatedly advised the Legislature over the past several months about the structural issues that hinder effective management of the waiver. The Legislature listened and should be commended for allowing the Agency to hire 75 staff to conduct needs assessments. This is a very subtle, yet important step in laying the foundation for responsible management of the waiver program.

The Agency was created without being provided resources for critical support infrastructure. The Agency is developing capacity as it can from within its existing budget. In addition, the Agency's primary information technology support system is antiquated and does not provide the functionality and flexibility of a modern system. The Agency has requested funding for a new information system that, if approved, will allow it to significantly upgrade internal business processes.

Changing the organizational placement of the program does not ensure improvement. In fact, Florida's experience with the Developmental Disabilities program as a unit of a larger, multi-faceted organization suggests the opposite. The program did not receive full attention from upper management of that multi-faceted organization. Many of the problems that are coming to the forefront now were simply never identified in the past.

Changing organizational placement of the Agency now will simply add turmoil to a program that is undergoing the most extensive changes in its history. It will divert valuable staff time, attention and resources away from the individuals served by the Agency. We think that Florida's size and diversity justify a separate Agency.

Managed Care: It is interesting that the two states identified by OPPAGA have implemented managed care concepts without using a traditional managed care organization. The Agency feels that a move to individual budgets will allow the benefits of managed care to be realized without the bureaucracy and administrative costs associated with traditional managed care arrangements.

Family Cost Sharing: The Agency contacted the Agency for Health Care Administration several months ago to determine the feasibility and impact of personal responsibility or means testing to assist with the cost of care. Both agencies determined the financial impact would be minimal. The Agency concurs with the OPPAGA report that efforts to require families to participate in the cost of services for children will yield results similar to that of the other states OPPAGA contacted.

OPPAGA Comment

The OPPAGA report does not conclude that establishing cost-sharing requirements in Florida would yield results similar to the states that we contacted. Rather, the report presents information about the experiences of three states that currently require cost-sharing.

The Agency, however, realizes the symbolic and philosophical importance of requiring family participation. The Agency will defer to the Legislature to make this decision. The Agency asks that the Legislature recognize the administrative resources necessary to implement such a system if it chooses to adopt this requirement.

OPPAGA Recommendations

Prior Service Authorizations (PSA): Clearly the current means of cost control mandated by the Legislature, the prior service authorization (PSA) contracts, has failed to yield results that many stakeholders find acceptable. For this reason, the Agency is proposing the use of individual budgets. This will shift cost control and financial planning to the front-end of the needs assessments process rather than after-the-fact review by an outside entity.

Thus, the Agency concurs with the suggestion that the PSA contracts can eventually be eliminated. The only caution is that such review is necessary during the transition and that there may be a legitimate role for utilization management assistance from outside experts. If a peer review organization is engaged, the state retains the 75/25 enhanced Medicaid match from the Federal government to cover the costs of the contract.

The Agency is in the process of developing a Request for Proposals to re-bid the PSA contracts that targets one contractor and significantly reduces the current expenditure. Once the system for individual budgets is implemented, the Agency will once again re-evaluate the role of a third party contractor to perform this function.

Change Assessment Tool: **APD is very concerned** about the practical implications and additional costs associated with OPPAGA's suggestion that "the Legislature may also wish to direct APD to use a nationally recognized and valid instrument, such as the Supports Intensity Scale (SIS), as its major assessment tool for identifying client needs."

OPPAGA Comment

In considering the agency's response, it is important to note that OPPAGA did not recommend that APD change its assessment tool. Rather, OPPAGA recommended that the Legislature direct APD to "develop an action plan for establishing individual client budgets." This plan should outline major activities, milestones, and needed resources to ensure that APD is in a position to begin developing individual budgets within six months after it has assessed all waiver clients using its new needs assessment instrument, the Questionnaire for Situational Information (QSI). The QSI contains elements from two tools previously used by APD (the Florida Status Tracking Survey and the Individual cost Guidelines). Some items from these tools have been modified. As such, APD needs to conduct further studies demonstrating that the QSI is a valid and reliable tool for determining waiver services for DD/HCBS clients. Our recommendation also specifies that APD's plan include key steps and deadlines for developing a funding algorithm that accurately predicts client budgets. APD should provide its plan as well as quarterly progress reports to the Legislature. In addition, we note that the Legislature may wish to direct OPPAGA to monitor APD's progress in implementing its new needs assessment process, assessing reliability and validity of the QSI, and developing an algorithm for establishing individual budgets. While OPPAGA suggested that the Legislature may wish to direct APD to use a nationally recognized and validated instrument as its major assessment tool for identifying client needs, OPPAGA did not recommend that the agency change its assessment tool.

The Agency, along with outside experts and other stakeholders evaluated several different tools, including the SIS and we concluded that the Questionnaire for Situational Information (QSI) was the best choice. The QSI is a more robust instrument that provides more in-depth data than any other available instrument.

The OPPAGA report offers no evidence that the SIS or another instrument would perform better at helping to predict resource needs than the QSI. In fact, there is no research that indicates that the SIS as compared to the QSI is a more valid needs assessment tool. Therefore, it would be premature to make a decision to not use the QSI or to use the SIS as the primary needs assessment tool in addition to the QSI. No formal survey instrument, whether SIS, QSI or any other available product, predicts resource needs. Most experts in the field agree that the needs assessment, while a vital piece of the information required to establish resource need, provides only about 30% of the necessary information. The process of using the various data produced during the needs assessment process must be validated regardless of the formal instrument and other data elements chosen.

The Agency strongly disagrees with any suggestion that the QSI is not valid. Content validity has been established. Predictive validity was established for the QSI's predecessor here in the state of Florida. The portions of the instrument that were found to be useful in predicting level of service need were left intact. Improvements were specifically designed to address deficiencies identified during validity testing of the previous instrument. The APD has submitted a plan that describes the concurrent validity study that is planned this year to compare the QSI to other validated tools. Upon completion of this study there will be more definitive information from which the state could determine any necessary changes that should be made to the QSI or to the entire process of establishing individual budgets.

The SIS includes scales that allow the assessor to identify the number of hours of support an individual might need. This type of information can be subjective and may not be congruent with the current rate system and waiver program policies.

It is important to note that the SIS has significant limitations that would require the Agency to develop and invest in companion tools to address the critical shortcomings of the SIS. The SIS is not yet valid for children aged 5-15 years. Field testing of the SIS for this age cohort is currently being conducted; however, until the testing is competed, APD would have

to employ another assessment instrument for children. Even for those over the age of 16, APD has identified gaps in the data provided by the SIS. Every state contacted by the Agency that uses the SIS has established a companion tool that is administered to better gather information on "risk" areas, such as more intense medical and behavioral needs as the SIS does not adequately provide such information.

The Legislature should also consider the substantial, ongoing investment from the state, its workforce and its citizens in the QSI. The Legislature provided $4.5 million during the 2007 special session to allow APD to hire and train OPS staff to conduct assessments using the QSI tool. In addition, the Agency has invested significant time and expertise into the development of an automated application to support use of the QSI instrument within three months. Staff to conduct the assessments have been hired, trained and certified to meet inter-rater reliability standards. The Agency has imposed stringent requirements on these professionals; minimum requirements for education and experience and inter-rater reliability exceed those for support coordinators who formerly conducted needs assessments. Much of this work mentioned above would have to be redone as APD moves to a new instrument.

More importantly, however, are the countless hours that have already been spent by consumers, family members and the professionals that serve them. (As of March 3, 2008, approximately 1,200 QSI assessments had been completed.) Putting these people through another round of assessments will mean additional expenditure of their money, time and energy on an effort that is unlikely to yield any significant result.

The ongoing research that OPPAGA correctly notes to be necessary must be done regardless of the formal survey instrument used. Any notion that the state could bypass any part of this process because of experiences in other states ignores accepted best practice for effective use of assessment tools. APD has provided OPPAGA with its preliminary plans to conduct the necessary research. Further details, such as specific target dates, will be negotiated with the vendors who the state engages to assist in this effort.

The OPPAGA report offers no finding or even a suggestion that a better outcome would result from using another needs assessment instrument.

In the absence of such a finding, the Agency questions whether the additional investment of taxpayers' money and our citizens' time and effort to introduce a new instrument is advisable.

Thank you for your thoughtful consideration of APD's comments. If further information concerning our response is needed, please contact Karen Laiche, Director of Auditing.

Sincerely,

Jane E. Johnson
Agency Director

cc: Charles Faircloth, Inspector General
Karen Laiche, Director of Auditing

The Florida Legislature

Office of Program Policy Analysis and Government Accountability

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