PERFORMANCE AUDIT REPORT

CDDOs: Reviewing Issues Related To The Funding of Community Services

A Report to the Legislative Post Audit Committee
By the Legislative Division of Post Audit
State of Kansas
October 2003

04-02

Legislative Post Audit Committee
Legislative Division of Post Audit

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To: Members, Legislative Post Audit Committee

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This report contains the findings, conclusions, and recommendations from our completed performance audit, *CDDOs: Reviewing the Issues Related to the Funding of Community Services*.

The report also contains appendices showing how much county mill and discretionary State aid the CDDOs shared with their service providers, how CDDOs distributed targeted case management moneys, and information on CDDO Administration expenditures per client.

The report includes several recommendations for both SRS and the legislature. We would be happy to discuss these recommendations and the audit findings presented in this report with any legislative committees, individual legislators, or other State officials. These findings are supported by a wealth of data, not all of which could be included in this report because of space considerations. These data may allow us to answer additional questions about the audit findings or to further clarify the issues raised in the report.

Barbara J. Hinton
Legislative Post Auditor

EXECUTIVE SUMMARY

LEGISLATIVE DIVISION OF POST AUDIT

Overview of Kansas' System for Providing Services to People with Developmental Disabilities

In 1995, the Legislature reformed the developmental disability service system to emphasize providing services to clients in their communities, rather than in institutional settings. *By law, CDDOs may provide some or all services themselves, or they may contract with other community service providers. As "gatekeepers" of their region, CDDOs also are responsible for overseeing and monitoring the activities of service providers they contract with.*

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Developmental disability services are funded with federal, State, and local moneys. *In fiscal year 2003, Kansas spent more than $250 million in tax dollars to provide those services, with more than three-fourths of that from Medicaid Service funds. The Department has established a State-wide uniform rate structure to fund most community services for people with developmental disabilities; some services are reimbursed based on the client's level of disability, others are reimbursed on a flat rate.*

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Question 1: How Has Funding for CDDOs and Other Community Service Providers Changed in Recent Years, and Does the Amount a Provider Receives Generally Correspond with the Severity Level of its Clients?

Public funding for the State's Developmental Disabilities system has increased 15% over the last 4 years. *Funding went from almost $221 million to slightly more than $254 million, with most of this increase coming from Medicaid waiver funds and targeted case management. This funding, along with non-Medicaid service funds, pays a specific rate per service provided*.

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82% of the public funding is distributed based on client severity. Funding for the *Medicaid waiver and non-Medicaid services is distributed based on the number of clients and their severity level. In 2000, 84% of public funds were distributed by severity, but this proportion decreased slightly by 2003, largely because of the increase in funding for targeted case management. Community service providers serve more of the most difficult clients, but the reimbursement system generally pays more for such clients. CDDOs may be serving the less severe clients within some tiers based on their average behavior and functional ability, but they seem to serve clients with more health problems*.

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The proportion of funds going to CDDOs and community service providers has changed slightly. *Service providers' share of Medicaid waiver funds increased from 61% to 64% between 2000 and 2003. They also received a larger share of State Aid (from 25% to 35%) and county mill levy funds (from 20% to 26%). State Aid and county mill levy funds are known as discretionary funds because CDDOs get to decide how these funds will be used. Between 1999 and 2003, the number of CDDOs sharing discretionary funds doubled, although most of the additional money came from just 3 CDDOs. In 2003, $5.3 million out of the $19.2 million in discretionary funds was shared*. ..... page 11

Only 22% of new federal funds were distributed to providers in 2003 based on client severity. *The 2001 Legislature directed SRS to maximize State and local funds to bring in new federal funding. These new funds were to be used to supplement direct care services for clients on the developmental disability waiver. For fiscal year 2002, the temporary plan SRS developed for distributing the new federal funds was based on increasing federal funding for CDDO Administration. Under this plan, CDDOs received $6.8 million in new federal funds, 91% of which was distributed to direct service providers throughout the State based on the number and severity of clients they served.*

For fiscal year 2003, the more permanent plan SRS developed involved targeted case management services, and allowed CDDOs to decide how to distribute the new federal funds. Only $1.8 million of the $8 million in new federal funds drawn down in 2003 was distributed based on client severity. CDDOs received 50% of the new federal funding available in 2003 compared to 39% they received in 2002, in large part because of the distribution methods they selected were more favorable to them. ..... page 15

Question 1 Conclusion ..... page 19

Question 2: How Have Funding and Expenses for CDDO Administration Changed in Recent Years, and To What Extent Are the CDDOs Paying CDDO Administration Costs With Moneys that Otherwise Could Be Used for Purposes Such As Direct Service?

Over the last 4 years, CDDO Administration costs have increased by about 17%, and the majority of the funding is now federal. *State funding decreased by 20%, while CDDO funding and federal funding increased by 35% and 50%, respectively. The majority of funding for CDDO Administration has now shifted from State to federal sources: the proportion of CDDO Administration expenses paid with State funds decreased from 43% in 2000 to 30% in 2003, while expenditures paid with federal funds increased from 38% to 49%*. ..... page 20

Question 4: How Could CDDOs Be Organized To Maximize the Amount of Funding Available To Provide Services for the Disabled?

This audit was conducted by Katrin Osterhaus, Scott Frank, and LeAnn Schmitt. Cindy Lash was the audit manager. If you need any additional information about the audit's findings, please contact Ms. Osterhaus at the Division's offices. Our address is: Legislative Division of Post Audit, 800 SW Jackson Street, Suite 1200, Topeka, Kansas 66612. You also may call us at (785) 296-3792, or contact us via the Internet at LPA@lpa.state.ks.us.

CDDOs: Reviewing Issues Related to the Funding of Community Services

The Developmental Disabilities Reform Act of 1995 was designed to allow people with developmental disabilities to access appropriate services and supports in the community rather than in institutional settings.

The Act resulted in the closing of State mental retardation institutions, and establishment of a network of 28 community developmental disability organizations (CDDOs) which serve as a single point of application, eligibility determination, and referral for developmentally disabled people seeking services in the community. People with developmental disabilities can choose to receive services from the CDDO's own service provider or from other community service providers that operate within the CDDO's coverage area.

Recently, legislators have expressed a variety of concerns about equity issues related to the distribution of funding for community services for the developmentally disabled. Specifically, those concerns relate to whether the amount of money service providers receive corresponds with their clients' severity levels, whether the amount going to CDDOs' own service providers has increased more than the amount made available to other providers, what control CDDOs have over the amount going for administrative costs and for services, and what has happened to CDDO administration costs in recent years. Other concerns relate to whether there continue to be conflicts of interest for CDDOs, how to resolve those conflicts, and whether reducing the number of CDDOs would result in an overall higher level of funding for disability services.

Many of these concerns were addressed in 2 audits issued by Legislative Post Audit in November 1999. Those findings will be updated in this audit, which addresses the following questions:

1. How has funding for CDDOs and other community service providers changed in recent years, and does the amount an organization receives generally correspond with the severity level of its clients?

2. How have funding and expenses for CDDO Administration changed in recent years, and to what extent are the CDDOs paying CDDO Administration costs with moneys that otherwise could be used for purposes such as direct service?

3. Do CDDOs that provide services to clients have conflicts of interest related to the way they distribute funds or refer clients to other providers, and if so, how could those conflicts be resolved?

4. How could CDDOs be reorganized to maximize the amount of funding available to provide services for the disabled?

To answer these questions, we reviewed applicable State laws and regulations. We also reviewed and analyzed financial information from CDDOs, including revenues and expenditures for their administration and discretionary moneys.

In addition, we analyzed information from the Medicaid Management Information System for claims paid in fiscal year 2003, and from the BASIS database for information on services provided.

We also surveyed parents and guardians of people receiving State developmental disability services, service providers, and CDDO officials to get their opinions about various conflict of interest issues. We reviewed and analyzed the viability of the Alliance for Kansans with Developmental Disabilities' proposal for reorganizing CDDO areas to try to draw down more federal funding. Finally, we interviewed representatives of the CDDOs, community service providers, the Department of Social and Rehabilitation Services (SRS), Interhab, the Alliance, Kansas Advocacy and Protective Services (KAPS), and federal agencies, as needed.

A copy of the scope statement for this audit approved by the Legislative Post Audit Committee is included in Appendix A.

In conducting this audit, we followed all applicable government auditing standards, except we were unable to test all of the financial information we received from the CDDOs because of the time constraints of this audit. However, we did review supporting documentation that CDDOs sent to us along with their surveys, such as bank statements and unaudited financial statements from their computer systems. We have no reason to think the information submitted may be inaccurate to such an extent that it would affect our conclusions and recommendations.

Our findings begin on page 7, following a brief overview.

Overview of Kansas' System for Providing Services to People with Developmental Disabilities

In 1995, the Legislature Reformed the Developmental Disability Service Delivery System to Emphasize Providing Services To Clients in Their Communities, Rather Than in Institutional Settings

People with developmental disabilities include those who have low intellectual functioning and require special protection and services, as well as people with such disabilities as epilepsy, cerebral palsy, and autism.

Services to people with severe developmental disabilities traditionally were provided in institutions. However, over the last few decades the State has reduced its reliance on institutions and increased its use of community services. As part of that effort, the following things happened:

- Since 1988, Norton and Winfield State Hospitals have been closed, and Kansas Neurological Institute and Parsons State Hospital and Training Center have been significantly downsized, with the expectation that the clients formerly served by these institutions would receive services in their communities.

- When the 1995 Legislature passed the Developmental Disabilities Reform Act, it set up a new administrative structure for community services in which the Department of Social and Rehabilitation Services (SRS) would contract with the 28 former community mental retardation centers to serve as community developmental disability organizations (CDDOs).

Under the new system, CDDOs are the single point of entry, eligibility determination, and referral for anyone seeking developmental disability services. By law, each CDDO must administer and maintain an organized network of community-based services within its area.

Table OV-1
Major Types of Developmental Disability Services

Type of Service	Examples
Adult Day Services	Supported employment, job training, workshops, and recreational activities.
Adult and Child Residential Services	For adults, services include helping clients with daily living activities in a wide array of living arrangements–from group homes to individual homes to apartments. For children, services include providing funding for a licensed and trained foster family.
In-Home Support Services	Helping clients with daily activities like taking medication, bathing, and preparing meals. Can also include such things as providing temporary care or overnight assistance to provide relief for other family members, and installing ramps or wheelchair lifts in a home or van lifts in a vehicle.
Targeted Case Management	Assessing clients' needs, and helping them or their families or guardians select and obtain services and supports; acting as an advocate on behalf of the client.

Source: SRS staff

Table OV-1 summarizes the major types of services provided to individuals with developmental disabilities.

By law, CDDOs may provide some or all services themselves, or they may contract with other community service providers. Community service providers may actually contract with multiple CDDOs. As of September 2003, 23 CDDOs were providing one or more services, and CDDOs had contracts with about 200 service providers.

CDDOs inform clients or their guardians or families of all available service providers. If there is not a waiting list and funding is available, the client selects their provider of choice. The map on page 6 shows CDDO service regions and what role each CDDO plays in its area.

As "gatekeepers" of their region, CDDOs also are responsible for overseeing and monitoring the activities of service providers they contract with. CDDOs monitor the services provided to each client, and conduct quality assurance reviews to ensure that service providers are meeting the contract requirements.

Developmental Disability Services Are Funded With Federal, State, and Local Moneys

In May 2003, about 8,500 people were receiving community services through the State's developmental disability service system. That number is up 8% from the 7,900 disabled people who were receiving services in May 2000.

In fiscal year 2003, Kansas spent over $250 million in tax dollars to provide those services. As *Chart OV-1* shows, about 77% of that funding came through the federal Home and Community Based Services (HCBS) Medicaid "waiver." Those funds are available to all developmentally disabled clients who would have otherwise received services in an institutional setting, but who instead are receiving them in the community.

Other funds that flow through the State come primarily from the State General Fund and Social Service Block Grant to provide services for persons who are not eligible for the Medicaid waiver. State general funds, including State aid are also used to match federal Medicaid funds. In addition, CDDOs receive local mill levy taxes directly from counties in their region.

CDDOs and other community services providers also may receive additional local funds—such as earned interest, fees, or private donations—to help finance their operations. We didn't try to determine the amount of these non-tax revenues in this audit.

The Department has established a Statewide uniform rate structure to fund most community services for people with developmental disabilities. CDDOs that provide direct services and community service providers are paid either a variable rate based on the client's level of disability, or they are paid a flat rate for each service they provide. The 2 types of reimbursement are described below:

- Day and residential services are reimbursed based on the level of disability of the person receiving the service. This method of payment, which was implemented in 1992, is based on the premise that services are more costly to provide to people who are more

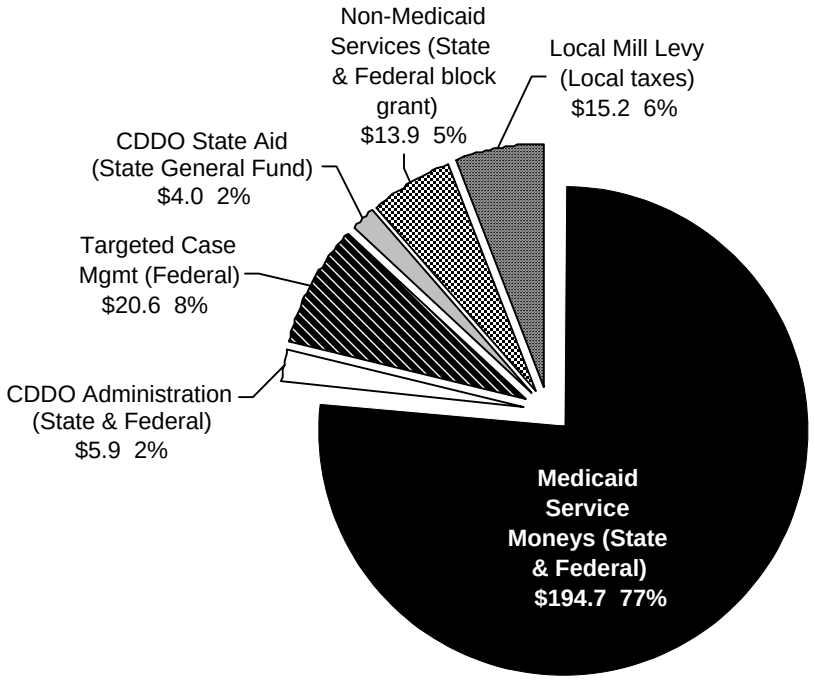
severely disabled. As an individual's level of disability increases, the reimbursement rate for providing services to that person also increases.

People who apply for day and residential services are assessed and placed into 1 of 6 "tiers." People in tier 1 are considered the most severely disabled, while those placed in tier 5 are considered the least severely disabled. The sixth tier, called tier 0, is for people whose disability is not so severe that they would be eligible for funding under the Medicaid waiver program, but who are eligible for State and federal Block Grant moneys outside the HCBS Medicaid waiver.

- Supportive home care services and targeted case management are reimbursed on a flat rate. For example, supportive home care services currently are reimbursed at $10.40 an hour, while the current rate for targeted case management is $395 per month.

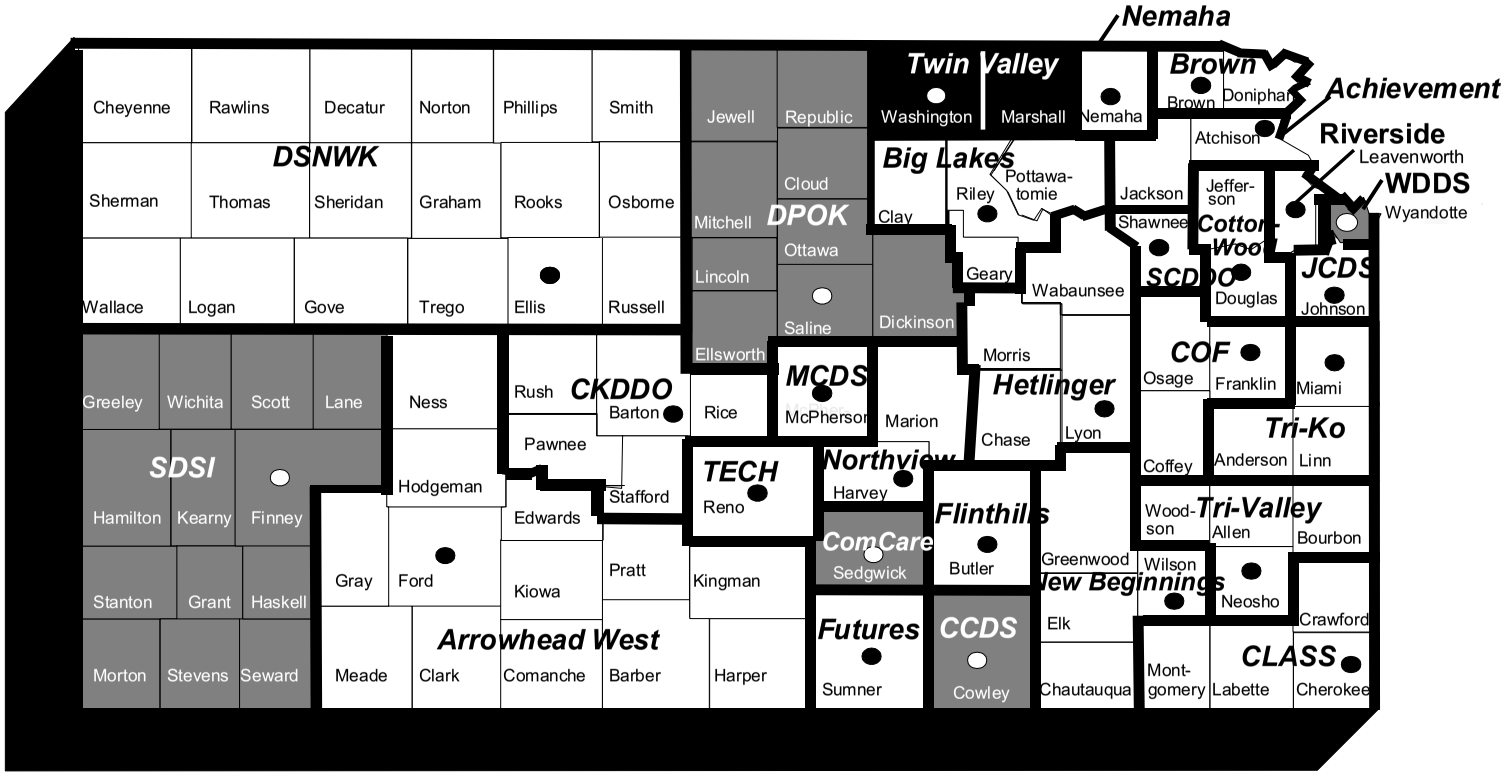
Rates for all services and tiers of clients may be adjusted slightly every year, depending on legislative appropriations.

Chart OV-1
Tax Dollars Used To Fund the State's Community-Based Developmental Disabilities System (in millions)
Fiscal Year 2003



Sources: Funding Allocation Spreadsheets prepared by SRS and MMIS database information.

CDDO Areas: What role does the CDDO play?



These 5 CDDOs don't provide any developmental disability services (a)

This CDDO is the only licensed service provider in their area

These 22 CDDOs provide services along with other community service providers in their areas.

(a) DPOK is legally separate from its associated service provider, OCCK, but because the 2 organizations share the same board of directors and executive director, we treated them as one for later analyses.

- Achievement Services for Northeast Kansas, Atchison
- Arrowhead West, Inc., Dodge City
- Big Lakes Developmental Center, Inc., Manhattan
- BCDS, Brown County Developmental Services, Hiawatha
- CLASS, LTD, Columbus
- COF Training Services, Inc., Ottawa
- COMCARE of Sedgwick County, Wichita
- Cottonwood, Inc., Lawrence
- CCDS, Cowley County Developmental Services, Inc., Arkansas City
- CKDDO, Central Kansas Developmental Disability Organization, Great Bend
- DPOK, Disability Planning Organization of Kansas, Salina
- DSNWK, Developmental Services of Northwest Kansas, Inc., Hays
- Flinthills Services, Inc., El Dorado
- Futures Unlimited, Inc., Wellington
- Hetlinger Developmental Services, Inc., Emporia
- JCDS, Johnson County Developmental Supports, Lenexa
- MCDS, Multi Community Diversified Services, Inc., McPherson
- Nemaha County Training Center, Seneca
- New Beginnings Enterprises, Inc., Neodesha
- Northview Developmental Services, Inc., Newton
- Riverside Resources, Inc., Leavenworth
- SDSI, Southwest Developmental Services, Inc., Garden City
- SCDDO, Shawnee County Developmental Disability Organization, Topeka
- TECH, Training & Evaluation Center of Hutchinson, Inc, Hutchinson
- Tri-Ko., Inc., Osawatomie
- Tri-Valley Developmental Services, Inc., Chanute
- Twin Valley Developmental Services, Inc., Greenleaf
- WDDS, Wyandotte Developmental Disability Services, Kansas City

Question 1: How Has Funding for CDDOs and Other Community Service Providers Changed in Recent Years, and Does the Amount a Provider Receives Generally Correspond with the Severity Level of its Clients?

Public funding for the developmental disabilities system increased 15% from fiscal years 2000 to 2003. In all, 82% of that funding is distributed based on the severity of the clients' disabilities. Community service providers serve more of the most severely disabled clients, but the reimbursement system generally pays them more for those clients. Our analyses suggest CDDOs may serve the less severe clients within some tiers.

Over the last 4 years, community service providers have received an increasing share of both Medicaid waiver funding and CDDOs' "discretionary" funds. The 2001 Legislature directed SRS to maximize the amount of new federal funds that could be drawn down to help fund direct services. In fiscal year 2002, 91% of these new funds were distributed based on client severity. In fiscal year 2003, that figure was 22%. CDDOs also got a larger share of these new funds in 2003, mostly because the CDDOs were able to design distribution plans that were favorable to them. These and related findings are discussed in more detail in the sections that follow.

Public Funding for the State's Developmental Disabilities System Has Increased 15% Over the Last 4 Years

Public funding for services comes from a variety of sources, such as the Medicaid waiver, State aid to CDDOs, and county mill levies. ***Table I-1*** shows how funding from these sources has changed over the last 4 years.

Table I-1
Public Funding For Developmental Disabilities Services
Fiscal Year 2000 vs. Fiscal Year 2003
(In millions)

Funding Source	FY 2000	FY 2003	Change (FY 2000 to FY 2003) $	Change (FY 2000 to FY 2003) %
Medicaid Waiver	$ 170.5	$ 194.7	$ 24.2	14%
Non-Medicaid Services	15.4	13.9	(1.5)	(10)%
Targeted Case Management	10.7	20.6	9.9	93%
CDDO Administration	5.2	5.9	0.7	13%
State Aid	6.0	4.0	(2.0)	(33)%
County Mill Levy	13.2 (a)	15.2	2.0	15%
Statewide Total	**$ 220.9**	**$ 254.3**	**$ 33.4**	**15%**

(a) Fiscal year 1999 county mill levy funding
Source: LPA report 00-02; Analysis of SRS distribution spreadsheets and Medicaid claims data

As the table shows, overall public funding increased by 15%. Some other interesting points from the table:

- Most of the increase is for services where specific reimbursement rates are set for each unit of service provided. This includes the Medicaid waiver, targeted case management, and non-Medicaid services. With the exception of targeted case management, reimbursement rates weren't increased between 2000 and 2003. However, as we noted in the overview, the number of clients served in the community increased by 8% between 2000 and 2003–from 7,900 to 8,500.
- Targeted case management increased by more than 90%. That occurred because of a concerted effort to draw down more federal funding in response to a 2001 law passed by the Legislature. We discuss the changes to targeted case management in more detail later in this question.
- State aid decreased by 33%. SRS made cuts in fiscal year 2003 in response to State budget problems.

82% of the Public Funding for the System Is Distributed Based on Client Severity

Some types of funding—such as services through the Medicaid waiver—are distributed to providers based on the number of clients they serve and the severity of their disability. ***Table I-2*** shows how the different funding streams are distributed, and compares how the percent of funding has changed between fiscal years 2000 and 2003.

As the table shows, the proportion of funding that is distributed on the basis of client severity decreased slightly over the last 4 years—from 84% to 82%. That's largely because of the significant increase in targeted case management funding.

Community service providers serve more of the most difficult clients, but the reimbursement system generally pays more for such clients. In a survey response, one community service provider claimed that a CDDO was deliberately encouraging more disabled clients to get their services through a community service provider rather than the CDDO. We investigated similar concerns in our November 1999 audit of the CDDO system.

As described in the overview, developmentally disabled clients are assigned to 1 of 6 tier levels that corresponds to the severity of their disability. Tiers 1 (the most severe) through 5 (the least severe) are for clients who are eligible for the Medicaid waiver. Tier 0 is for less severely disabled clients who don't qualify for the waiver.

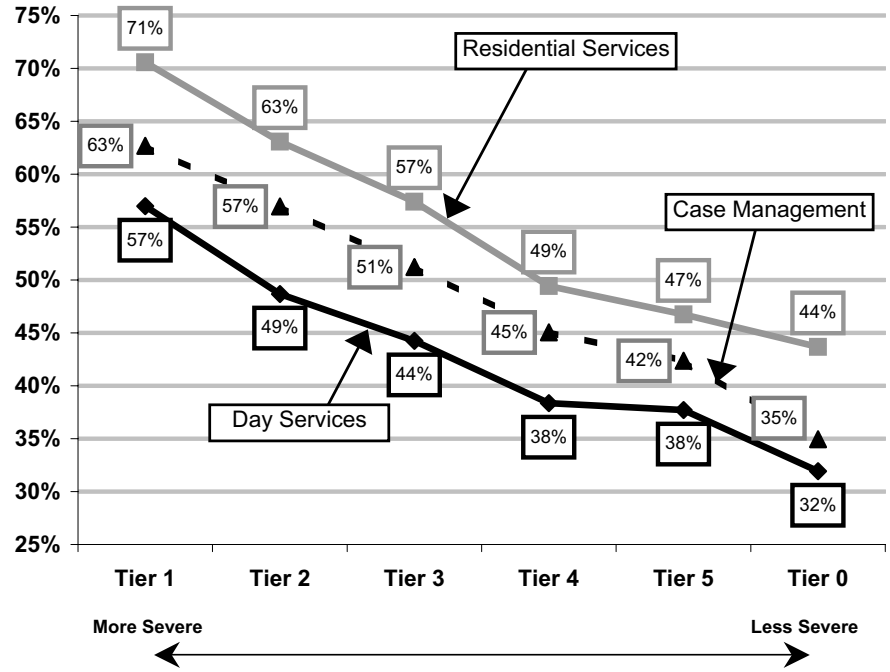
Chart I-1 shows that community service providers generally do serve more of the more severely disabled clients (those in tiers 1 and 2). For example, they provide residential services for 71% of all tier 1 and 63% of all tier 2 clients in the system. As we pointed out in our 1999 audit, however, a likely explanation for this pattern relates to the way the State's developmental disability system developed over time.

Table I-2
Basis for Distributing Funds For Developmental Disabilities Services
Fiscal Year 2000 vs. Fiscal Year 2003

Source of Funding	On what basis are the funds distributed?	Percent of Total Funding	
		FY 2000	FY 2003
Funds distributed based on how severe the client's disability is			
• Medicaid Waiver	Number of clients and their severity level	77%	77%
• Non-Medicaid Services	Number of clients and their severity level	7%	5%
Subtotal		**84%**	**82%**
Funds distributed based on other factors			
• Targeted Case Management	Monthly rate per client	5%	8%
• CDDO Administration	Number of clients served in the region	2%	2%
• State Aid	Number of clients served in the region	3%	2%
• County Mill Levy	Determined by county	6% (a)	6%
Subtotal		**16%**	**18%**
Statewide Total		**100%**	**100%**

(a) Fiscal year 1999 county mill levy funding
Source: LPA report 00-02; Analysis of SRS distribution spreadsheets and Medicaid claims data

Chart I-1
Percent of Clients Served by Community Service Providers
by Tier Level as of June 30, 2003



Source: LPA analysis of BASIS Database provided by SRS.

The 28 CDDOs originally were community mental retardation centers that provided community-based services for the more moderately disabled people living outside State institutions. Often those services included sheltered workshops, day care, and rehabilitation services. When the Developmental Disabilities Reform Act was passed, new community service providers that specialized in handling severely disabled clients emerged to fill the gap in services.

Because reimbursement rates for day and residential services are tied to the tier system and increase as the client's level of disability increases, providers who serve the more severely disabled clients receive a higher level of reimbursement. For example, a service provider is reimbursed $135 per day for providing residential services to a tier 1 client, but only $38 per day for providing those services to a tier 5 client.

On the other hand, the reimbursement rate for targeted case management isn't tied to the tier levels—that rate is the same regardless of the client's level of disability. In addition, in fiscal year 2003 SRS changed the way this service was paid from an hourly rate to a monthly rate.

Some stakeholders indicated that more severely disabled clients require more case management than less severely disabled, and that the monthly reimbursement rate financially disadvantages providers who serve more disabled clients. We looked at fiscal year 2002 Medicaid claims data for targeted case management clients to evaluate this claim. We found that, while more severely disabled clients did in fact receive slightly more case management services than less disabled clients, the financial impact of these differences was minimal.

Our analyses show that CDDOs may be serving the less severe clients within some tiers. Clients are assigned to tier levels based on the severity of their disabilities. This is done through annual assessments in which the clients are scored in 3 areas: health, behavior, and functional ability. Clients are assigned to a tier based on the area in which they are most severely disabled. Within each tier, clients may have a wide range of scores for the 3 areas.

If a provider were to consistently serve the less severely disabled clients within a tier, that provider might benefit financially. That's because the provider may have lower costs than providers who serve the more severely disabled clients within the same tier, even though both providers are paid the same amount.

To determine whether CDDOs or community service providers appeared to be consistently serving more or less severely disabled clients within tier groups, we analyzed the assessment scores for their clients that received day or residential services during fiscal years 2000 to 2003. We excluded clients from CDDOs that don't provide services from our analyses. The results of our analyses are shown in ***Chart I-2*** on the following page.

As the chart shows, overall we found a pattern of CDDOs serving the less disabled clients within many tier groups over the 4 years we reviewed. However, the results were mixed. We noted that the clients CDDOs served within various tier groups often had less severe functional and behavioral problems, but more severe health problems.

There could be any number of reasons for these patterns. For example, some of these patterns may relate back to the way in which community service providers developed to take care of the more severely disabled clients after Disability Reform. It may also be that clients who are fairly healthy but have severe functional or behavioral problems are more difficult to serve, and community service providers are better set up to serve them. SRS officials also speculated that CDDOs' clients may be getting older and their health is declining with age.

Because of the complexity of this issue and the types of data and analyses that would be involved, we weren't able to determine the cause of these patterns within the timeframe of this audit. But the questions providers have raised about whether CDDOs have intentionally steered clients to one type of provider or another can't be fully answered until such analyses are done.

The Proportion of Funds Going to CDDOs and Community Service Providers Has Changed Slightly

Medicaid waiver payments are given directly to service providers. Other funding—such as money for non-Medicaid services and targeted case management payments—passes through the CDDOs before it goes to providers. In addition, CDDOs receive State aid and county mill levy funds directly, and generally it's up to them to decide whether to share those funds with other service providers.

Table I-3 shows how the distribution of these various funds between CDDOs and community service providers has changed over the last 4 years. [As explained more fully in question 2, funding for CDDO Administration is for duties that are specific to the CDDO, and we wouldn't expect to see them share these funds with service providers.]

Community service providers received a slightly larger share of the Medicaid waiver in fiscal year 2003 than in fiscal year 2000. Table I-3 shows that community service providers' share of the Medicaid waiver increased from 61% to 64%. One likely reason is that

Chart I-2
Comparison of Assessment Scores For Clients Within Each Tier
CDDOs vs. Community Service Providers (CSPs)
Fiscal Years 2000 to 2003

Overall Score

Tier	Service	Fiscal Year			
		2000	2001	2002	2003
1	Day				
	Residential				
2	Day				
	Residential				
3	Day				
	Residential				
4	Day				
	Residential				
5	Day				
	Residential				

Functional Score

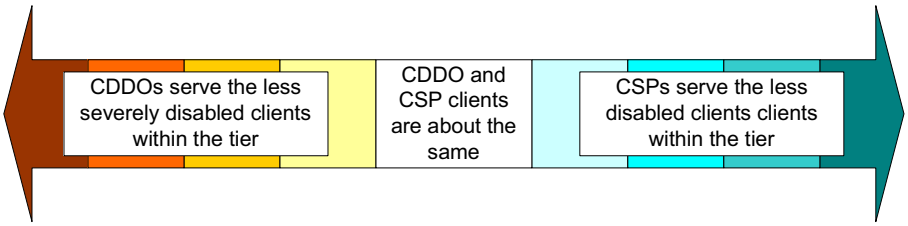
Tier	Service	Fiscal Year			
		2000	2001	2002	2003
1	Day				
	Residential				
2	Day				
	Residential				
3	Day				
	Residential				
4	Day				
	Residential				
5	Day				
	Residential				

Behavioral Score

Tier	Service	Fiscal Year			
		2000	2001	2002	2003
1	Day				
	Residential				
2	Day				
	Residential				
3	Day				
	Residential				
4	Day				
	Residential				
5	Day				
	Residential				

Health Score

Tier	Service	Fiscal Year			
		2000	2001	2002	2003
1	Day				
	Residential				
2	Day				
	Residential				
3	Day				
	Residential				
4	Day				
	Residential				
5	Day				
	Residential				



Source: LPA analysis of SRS' BASIS database

Table I-3
Comparison of Distribution of Funding Between CDDOs and CSPs
Fiscal Year 2000 vs. Fiscal Year 2003

Funding Source	Percent of funding source that went to:			
	CDDOs		*CSPs*	
	FY 2000	FY 2003	FY 2000	FY 2003
Medicaid Waiver • distributed directly to providers	39%	36%	61%	64%
Non-Medicaid Services • distributed to providers through CDDOs	*n/a*	*n/a*	*n/a*	*n/a*
Targeted Case Management • distributed directly to providers in 2000 • distributed to providers through CDDOs in 2003	54%	50%	46%	50%
CDDO Administration • distributed to CDDOs	100%	100%	0%	0%
State Aid • distributed to CDDOs	75% (a)	65%	25% (a)	35%
County Mill Levy • distributed to CDDOs	80% (a)	74%	20% (a)	26%

(a) Fiscal year 1999 State Aid and county mill levy funding
Source: LPA report 00-02; Analysis of SRS distribution spreadsheets and Medicaid claims data; Survey of 28 CDDOs

community service providers are serving a greater share of the clients in the system. For example, the CDDO in Cowley County stopped providing direct services in 2000, and all 280 clients in that area now are served by community service providers.

Community service providers also received a larger share of CDDOs' discretionary funds in fiscal year 2003 than in fiscal year 1999. State aid and county mill levies are referred to as "discretionary funds" because CDDOs get to decide how they will be used. ***Profile I-1*** provides more detail about the history of these funding streams.

Profile I-1
History of Discretionary State Aid and County Mill Levy Funds

The Legislature began giving State aid to community mental retardation centers (now CDDOs) in 1974 to support the services being provided to developmentally disabled people in the communities. In 1986, the Legislature specified that each center would receive at least the same amount of State aid it had received for fiscal year 1986. In 1987, this "hold harmless" amount was set in State regulation at $5,216,286 with specifics as to how moneys are to be distributed when annual appropriations exceed or are less than that hold harmless level. In 1999 and 2000, the Legislature appropriated an additional $750,000 in State aid. In 2003, the appropriation was reduced to $4 million. The allocation of discretionary State aid hasn't changed over the years to reflect who's actually providing services, or how many clients are being served.

Like discretionary State aid, county mill levy funds initially went to the community mental retardation centers to help support community-based services. Also, like State aid, there are no restrictions on how CDDOs can use those moneys. Although the State's system changed, this funding stream didn't. Unless State law were changed to redirect these funds, the use of county mill levy funds is basically a local issue.

Discretionary funds have been a source of contention for years. Many community service providers claim these funds should be shared with the providers of those services. In our November 1999 audit we looked at how much discretionary funding CDDOs were sharing with their service providers. ***Table I-4*** shows how the sharing of discretionary funds changed between fiscal year 1999 and fiscal year 2003.

Table I-4
State Aid and County Mill Levy Money Shared With CSPs
FY 1999 vs. FY 2003

	FY 1999	FY 2003	Change (1999 to 2003)
Total discretionary funds	$19.0 mil	$19.2 mil	$0.2 mil
Funds shared with CSPs	$4.1 mil	$5.3 mil	$1.2 mil
Percent shared with CSPs	*21%*	*28%*	—
Number of CDDOs that shared funds	*7*	*14*	*7*

Source: LPA report 00-02; Survey of 28 CDDOs

As the table shows, CDDOs shared $1.2 million more of their discretionary funds in 2003 than in 1999, even though the total amount of discretionary funds available to them remained almost the same. The table also shows that only 7 additional CDDOs began sharing these funds with their providers. Some additional highlights to point out:

- **A single CDDO, ComCare, was responsible for nearly 60% of all discretionary funds that were shared in fiscal year 2003.** ComCare in Sedgwick county, which doesn't provide direct services, shared virtually all its $3 million in discretionary funds. Excluding ComCare, the other 27 CDDOs shared about $2.3 million, or 14%, of all their discretionary funds.

- **The $1.2 million increase in shared discretionary funds can be attributed to just a few CDDOs.** Almost 90% of the additional funds shared in fiscal year 2003 came from just 3 CDDOs (Johnson County, Southwest Developmental Services, and Wyandotte Developmental Disability Services).

- **14 CDDOs received $4.7 million of discretionary funding in 2003, but didn't share any of this with service providers.** (1 CDDO, Twin Valley, doesn't have any providers in its region to share those funds with.)

Appendix B shows more detailed information about how much each of the CDDOs shared with their service providers in State aid and local mill levy funds.

Only 22% of New Federal Funds Were Distributed to Providers In 2003 Based On Client Severity

Because many CDDOs had significant amounts of "local" funding—State aid, county mill levy, and non-Medicaid services funding—that weren't being used to match federal funds, the 2001 Legislature amended the Developmental Disabilities Reform Act to require SRS to maximize the use of State and local funds to bring in additional federal funding. These new federal funds were to be used to supplement direct care services for clients on the developmental disabilities waiver or for other Medicaid reimbursable services.

For fiscal year 2002, the temporary plan SRS developed for distributing the new federal funds was based on the number and severity of clients served. Under this plan, CDDOs would use some of their unmatched local funds to match with federal funding for CDDO Administration expenses. The more local funding the CDDOs could match, the more federal dollars they could draw down.

By contract, SRS required the CDDOs to either distribute the new federal funds they received to direct service providers based on each provider's share of the developmental disabilities waiver payments in their CDDO region, or develop their own plan and have SRS approve it. Seven CDDOs created their own plans, 2 of which still distributed the funds based on the number and severity of clients served. The other 5 distributed the funds based on the number of clients without regard to the severity of their disabilities.

Under this plan, CDDOs received $6.8 million in new federal funds, 91% of which was distributed to direct service providers throughout the State based on the number and severity of clients they served. The Centers for Medicare and Medicaid Services (CMS) subsequently disallowed this funding because of the specific contract provisions SRS had included. This situation is described in more detail in ***Profile I-2.***

Profile I-2
New Federal Funds for Fiscal Year 2002 Were Recouped by CMS

In its plan to bring in new federal funds in fiscal year 2002, SRS had CDDOs use their unmatched local funds to bring in new federal funding for CDDO Administration. This plan brought in $6.8 million in new federal funds. SRS amended its contracts with the CDDOs, specifying that these new federal funds were for "residential, day, and in-home family support services provided to people with disabilities."

The significant increase in federal funding for CDDO Administration caused officials from the federal Centers for Medicare and Medicaid (CMS) to question the claim and review SRS' contract with the CDDOs. CMS decided to recoup the entire $6.8 million, noting that the contract directed CDDOs to use CDDO Administration funding for non-administrative purposes (direct services), and that CMS was already paying for these services through the Medicaid waiver. Claiming them again would be a form of "double dipping."

According to SRS officials, providers weren't required to pay back any of the recouped funds, and SRS absorbed the cost.

For fiscal year 2003, the more permanent plan SRS developed involved targeted case management services, and allowed CDDOs to decide how to distribute the new federal funds. This plan was more complicated. First, it involved changing the case management reimbursement rate from $40 per hour to $395 per month, which was presumed to be a significant increase in the rate. In order to evaluate how many new federal dollars this rate would bring in, SRS estimated that the monthly equivalent of $40 per hour was $191 per month.

We found several flaws in the methodology SRS used to arrive at this figure, which made their base rate artificially low. The table below shows the difference in monthly rates.

Targeted Case Management Monthly Reimbursement Rates FY 2002 vs. FY 2003

Source of Funds	FY 2002 (Estimated Monthly Rate)		FY 2003
	SRS	LPA	
Local Match	$76	$96	$158
Federal Match	$115	$144	$237
Total	**$191**	**$240**	**$395**

Source: SRS distribution spreadsheets; LPA analysis of SRS' BASIS database

Using SRS' base rate of $191 per month overstated the amount of new federal funds generated. This rate also resulted in inaccurate guidance to CDDOs on the amount of new funding they were earning on case management. The numbers we report on the following pages are based on the base rate we calculated ($240 per month), however in developing their plans for using the new money, CDDOs were necessarily working from the numbers supplied by SRS.

Second, SRS redirected the billing and payment of these reimbursements from providers to CDDOs. SRS did this because it discovered that paying the providers directly didn't comply with Medicaid regulations. Targeted case management in Kansas is reimbursed differently than most other Medicaid services. For most services, the provider gets paid the full reimbursement and the State pays the local share. For case management, CDDOs "certify" that they have the local share and the providers only get the federal share. Since CDDOs have the local match, Medicaid requires that they get the federal payment as well.

This new process means community service providers now have to negotiate their reimbursement rate for case management services with CDDOs, rather than automatically receiving the full federal share. It also means that CDDOs now have to process and distribute all of the reimbursement payments to community service providers.

The increased reimbursement rate allows CDDOs to use more of their unmatched local funds to match against federal dollars. For every client who receives targeted case management services, CDDOs are now able to draw down an additional $93 in federal funding per month. This new plan brought in an additional $8 million for fiscal year 2003 rather than the $11.3 million projected by SRS.

Because the contract requirements in fiscal year 2002 led CMS to deny payment of those federal funds, SRS didn't put any language in its contracts with CDDOs regarding how these new case management funds were to be distributed. Instead, it left it up to each CDDO to develop its own local plan.

Most of the new federal money in 2003 wasn't distributed based on client severity. During this audit we looked at the distribution plans all 28 CDDOs developed for distributing the new federal funds in fiscal year 2003. Detailed information about each CDDO's plan is included in Appendix C.

In looking at these plans, we identified 3 major ways in which CDDOs planned to distribute the new funds (the various plans used a combination of these strategies):

- **Supplementing Direct Services**—16 CDDOs set aside some of the new federal funds to supplement direct service providers. This could be done in 2 ways:
  - by client severity—9 CDDOs distributed this money to providers based on their Medicaid waiver billings (similar to the fiscal year 2002 requirements imposed by SRS), which takes into account the severity level of the clients
  - by number of clients—7 CDDOs distributed the money to providers based on the number of clients served, which doesn't take into account clients' severity levels.

- **Supplementing Targeted Case Management**—15 of the 28 CDDOs used some amount of the new funds to increase the case management rate paid to providers. 10 CDDOs decided to pay all the new funds to the case management provider.

- **Charging Administrative Fees**—14 CDDOs decided to charge an administrative fee for handling case management payments and distributing the new federal funds. These fees ranged from 2% (CLASS) to 20% (Futures Unlimited) of each case management payment. The fees for 10 of the CDDOs were less than 7.5%.

Table I-5 shows how much new federal money was distributed by each method. As the table shows, only 22% of the new funds in 2003 were distributed to providers based how severe the disabilities were for their clients, compared with 91% in 2002.

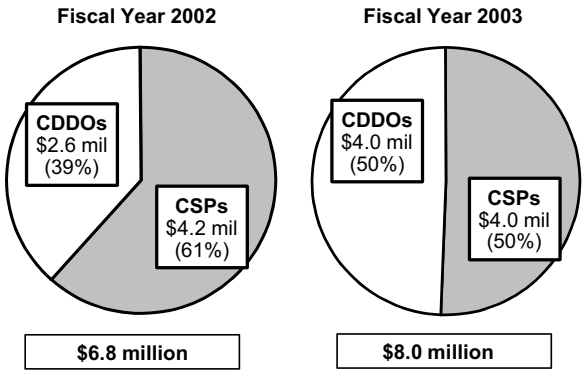
Table I-5
Basis for Distributing New Federal Funds
Fiscal Year 2003

Distribution Method	New Federal Funds			
	To CDDOs	To Service Providers	Total Dollars	Total Percent
Funds distributed based on how severe the client's disability is				
• **Supplement Direct Services** (By Client Severity)	$0.7 mil	$1.1 mil	**$1.8 mil**	**22%**
Funds distributed based on other factors				
• **Supplement Targeted Case Management**	$1.6 mil	$1.7 mil	**$3.3 mil**	**40%**
• **Supplement Direct Services** (By Number of Clients)	$0.9 mil	$1.3 mil	**$2.2 mil**	**27%**
• **Administrative Fees**	$0.7 mil	$0.0 mil	**$0.7 mil**	**8%**
• **Other** (a)	$0.2 mil	$0.0 mil	**$0.2 mil**	**3%**
Subtotal (Other Factors)	$3.4 mil	$3.0 mil	**$6.4 mil**	**78%**
Total (All New Federal Funds)	**$4.0 mil**	**$4.0 mil**	**$8.0 mil**	**100%**

(a) Includes funds that will be distributed at a later date, various reserve funds, and funds for case manager training

Source: Survey of 28 CDDOs; Local distribution plans obtained from CDDOs

Chart I-3
Comparison of Distribution of Federal Funds
To CDDOs and Community Service Providers (CSPs)
Fiscal Year 2002 vs. Fiscal Year 2003



Source: Survey of 28 CDDOs

CDDOs received a larger portion of the new federal funding available in 2003 than they did in 2002, in large part because many selected distribution methods that were more favorable to them. ***Chart I-3*** compares the proportion of new funds going to CDDOs and community service providers in fiscal years 2002 and 2003.

As the chart shows, CDDOs received 39% of the new federal funds in fiscal year 2002. In fiscal year 2003, when CDDOs were

allowed to create their own distribution plans, their share of the new funds increased to 50%.

We calculated that CDDOs received about $917,000 more in federal funds in 2003 than they would have if the new money had been distributed to providers in the same proportion as the federal funds were distributed to providers in fiscal year 2002.

Most of this gain occurred because funds were distributed to increase the case management fee paid to providers and pay administrative fees charged by the CDDO. Both of these distribution methods more heavily favor CDDOs than the distribution in fiscal year 2002.

Some CDDOs also developed plans that didn't appear biased on the surface, but that favored them significantly nonetheless. For example, in fiscal year 2002, Futures distributed about 15% of the new federal funds it received to its affiliated providers. Under the distribution plan it developed for 2003, Futures set aside most of the new federal funds to supplement day and residential services for adults. Because Futures is the only entity in the area that provides these services, it didn't have to share any of the new funds in fiscal year 2003.

Conclusion Community service providers are receiving an increasing share of the total public funding available to the State's developmental disability system, and most of those moneys are being distributed on the basis of clients' needs. However, legitimate questions persist about whether CDDOs are keeping more than their fair share of the available moneys. Under SRS' 2003 plan for maximizing federal funds by raising case management rates, CDDOs have been put in a position to control a fairly significant piece of the funding that's distributed to community service providers.

Some of their plans for distributing those moneys appeared to unfairly benefit CDDOs over other providers. And because CDDOs now get to decide how much case management providers will be paid per month, providers across the State are being paid anywhere from $110 to $237 for providing case management services. SRS has been hesitant to be more specific or provide greater guidance to CDDOs about how these new federal funds are distributed, but in our opinion it needs to take a stronger stand to ensure that all service providers are treated more equitably and fairly.

The recommendations for this report are presented at the end of question 4.

Question 2: How Have Funding and Expenses for CDDO Administration Changed in Recent Years, and To What Extent Are the CDDOs Paying CDDO Administration Costs with Moneys that Otherwise Could Be Used for Purposes Such as Direct Service?

CDDO Administration funding comes from federal, State, and local sources and is used to pay CDDOs' costs for administering the State's developmental disability system. Over the last 4 years, the majority of funding for CDDO Administration has shifted from State to federal sources because CDDOs are using more of their own funds to draw down federal dollars, and because the State's share has been cut. CDDO Administration expenditures have increased by 17%, in part because CDDOs are classifying more expenditures in that category. During that same period, federal and State spending on direct services increased by only 12%, in part because reimbursement rates for Medicaid services weren't increased. The amount of local moneys spent on direct services also isn't known. CDDO Administration expenditures per client vary widely, at least partly because of economies of scale. These and other findings are discussed in the sections that follow.

Over the Last 4 Years, CDDO Administration Costs Have Increased by About 17%, and the Majority of the Funding Is Now Federal

When the Developmental Disability Reform Act was passed, the 28 CDDOs became responsible for carrying out the administrative responsibilities for the new system. They became the single point of application, eligibility determination, and service referral for all developmentally disabled adults and children in the State. They also became responsible for contracting with other service providers in their areas, managing funds allocated by SRS for direct services, and monitoring the quality of services provided to clients.

Table II-1
Changes in CDDO Administration Funding and Expenditures
FY 2000 vs. FY 2003
(in millions)

Funding Sources	FY 2000 (actual)		FY 2003 (actual)		Change in Actual Expenditures (FY 2000 to FY 2003)		FY 2004 (est.)
	Certified/ Available	Actual Expenditures	Certified/ Available	Actual Expenditures	$	%	Certified/ Available
State (a)	$2.7	$2.7	$2.2	$2.2	($0.5)	(20)%	$2.2
CDDO (b)	$0.7	$1.2	$3.0	$1.6	$0.4	35%	$3.4
Federal (c)	$2.5	$2.5	$3.7	$3.7	$1.2	50%	$3.9
Total	**$5.9**	**$6.4**	**$8.9**	**$7.5**	**$1.1**	**17%**	**$9.5**

(a) Each year, SRS allocates State funds to CDDOs to help cover the costs for carrying out their CDDO responsibilities.
(b) To match federal dollars for CDDO Administration, CDDOs can "certify" some of their own local moneys that haven't been used to match other federal dollars. CDDOs aren't required to spend the moneys they "certify" to get these federal matching dollars. In fiscal year 2000 they spent more than they certified; in fiscal year 2003, they spent less.
(c) The federal match ends up being about 40 cents for every State and CDDO dollar that's available or "certified."

Source: Survey of 28 CDDOs; CDDO Funding Allocation Spreadsheets Prepared by SRS

To cover their CDDO Administration costs, CDDOs receive State and federal matching funds. Any CDDO Administration costs not covered by those funds must be paid for with other local sources of funds—

such as county mill levy moneys. [CDDO Administration costs should not be confused with the overhead and other administrative costs all community service providers incur as part of providing direct services.]

Table II-1 shows how the amounts available and spent on CDDO Administration have changed over time. The sources of funding for CDDO Administration expenditures changed over the 4-year period for the following reasons:

- **State funding decreased by 20%.** SRS significantly cut the State's share in 2003 to help address large budget shortfalls the State experienced that fiscal year.

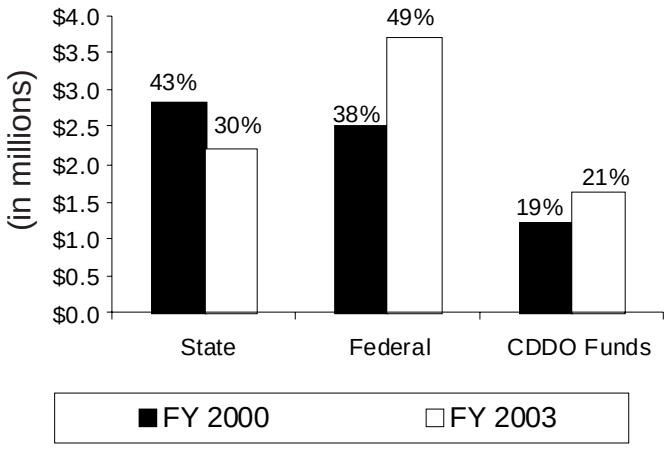
- **CDDO funding increased by 35%.** CDDOs are responsible for covering all CDDO Administration expenditures in excess of the State and federal funding. As described in more detail later, it appeared that some CDDOs had begun to categorize more expenditures as CDDO Administration, and some had added staff. There could be other reasons as well.

- **Federal funding increased by 50%.** These funds increased significantly despite the decrease in matching funds provided by the State. This was because CDDOs made a concerted effort to "certify" more of their local funds in order draw down more federal funding.

The majority of the funding for CDDO Administration has now shifted from State to federal sources. Because of the changes described above, the federal share of CDDO Administration costs has grown to 49%, while the State's share has dropped to 30%. ***Chart II-1*** illustrates this point.

The chart also shows that CDDOs' share has grown from 19% to 21%. When CDDOs spend more of their local resources on CDDO Administration, those funds are not available for services or other expenditures.

Chart II-1
Share of Funding for CDDO Administration, FY 2000 to FY 2003



Source: Survey of 28 CDDOs; CDDO Funding Allocation Spreadsheets Prepared by SRS.

CDDO Administration Expenditures Have Grown Faster Than Spending on Direct Services

As ***Table II-2*** shows, total CDDO Administration expenditures grew by 17% over the last 4 years, while State and federal spending on direct services grew by only 12%. We identified 2 likely reasons for these differences.

Table II-2
Comparison of CDDO Administration Expenditures to Spending on Direct Services and Number of Clients Served
FY 2000 to FY 2003

Category	FY 2000	FY 2001	FY 2002	FY 2003	% Change (00-03)
CDDO Administration (a)	**$6.4 mil**	**$6.4 mil**	**$7.1 mil**	**$7.5 mil**	**17%**
Direct Services (b)					
Medicaid	$170.5 mil	$176.6 mil	$189.7 mil	$194.7 mil	
Non-Medicaid	$15.4 mil	$15.4 mil	$13.6 mil	$13.9 mil	
Total Direct Services	**$185.9 mil**	**$192.0 mil**	**$203.3 mil**	**$208.6 mil**	**12%**

(a) Includes State funds, federal matching funds, and local discretionary moneys CDDOs used to fund CDDO Administration costs.
(b) Includes only State funds and federal matching funds.

Source: Survey of 28 CDDOs; CDDO Funding Allocation Spreadsheets Prepared by SRS

Some CDDOs have categorized more of their expenditures as CDDO Administration. As Table II-2 shows, the big increases in CDDO Administration expenditures occurred in fiscal years 2002 and 2003, when CDDOs were making a concerted effort to match more of their own local funds to draw down new federal dollars.

We explored the reasons for these increases with 5 of the 7 CDDOs that had the largest increases in CDDO Administration costs per client over that period—Developmental Services of Northwest Kansas (DSNWK), Futures, Hetlinger, Riverside, and Tri-Ko. Three of the 5 CDDOs said their expenditures increased because they changed the way they report existing expenditures; 2 CDDOs indicated their CDDO Administration function itself had grown. Here's what they told us:

- Officials from Futures and Hetlinger told us they did a better job of allocating costs to CDDO Administration and that earlier years were artificially low.
- An official from DSNWK said they moved a training program and a counseling program from their service provider division to their CDDO Administration division to help spend the additional federal funds they drew down. According to officials, the CDDO made these programs available to other community service providers.
- Officials from Riverside and Tri-Ko said they hired additional staff.

Reimbursement rates for Medicaid services weren't increased between 2000 and 2003. It's likely that the actual cost of providing direct services to clients increased, but service providers would have had to use other local funds available to them—such as shared county mill levy or State aid, donations, or grants—to cover those increased costs.

No one knows the total amount of local moneys service providers have available, or how much of it they spend on client services. However, we calculated that every $2 million CDDOs and community service providers spent of their own funds would have increased total expenditures for direct services by an additional 1%.

CDDO Administration Costs per Client Vary Widely, in Part Because of Economies of Scale

Because reimbursement rates weren't increased, the only factors that would impact expenditures for direct services are the number of clients served in the community (which increased 8% between 2000 and 2003) and the amount and type of services being provided to each client.

Table II-3 on the next page compares the CDDO Administration costs per client and the number of clients served for each CDDO in fiscal years 2000 and 2003. Appendix D provides more detailed information about each one.

As the table shows, the average cost per client in fiscal year 2003 was $852, and varied from about $480 at ComCare to more than $2,300 at Futures Unlimited. Some of this variation may be attributed to economies of scale: the 4 CDDOS with the most clients (ComCare, Johnson County Developmental Services, Shawnee County Developmental Disability Organization, and CLASS) had among the lowest average costs per client, while 2 of the 3 CDDOs with the fewest clients (Futures and New Beginnings) had some of the highest average costs per client.

In addition, because CDDOs aren't required to record administrative expenditures on a consistent basis, some of the variation in expenditures per client may result from inconsistent categorization and reporting of costs. Finally, other factors such as regional differences in salaries, differences in facility costs due to the age of facilities, and differences in the number of community providers a CDDO contracts with could all be contributing to variations in cost.

Identifying whether these costs and cost differences are reasonable would require a much more detailed review of each CDDO's accounting records and consideration of the types of factors mentioned above. That type of analysis was beyond the scope of this audit.

Table II-3
CDDO Administration
Expenditures Per Client and Clients Served
FY 2000 vs. FY 2003

CDDO	Expenditures Per Client			Number of Clients as of: (a)		
	FY 2000	FY 2003	*% Change (00 to 03)*	May 2000	May 2003	*% Change (00 to 03)*
COMCARE	$705	$483	*(31)%*	1,189	1,298	*9%*
Johnson County	$575	$551	*(4)%*	875	947	*8%*
Big Lakes	$639	$580	*(9)%*	220	217	*(1)%*
Northview	$520	$630	*21%*	142	159	*12%*
Arrowhead West	$887	$694	*(22)%*	303	276	*(9)%*
CLASS	$663	$697	*5%*	565	575	*2%*
Shawnee County	$616	$798	*29%*	680	698	*3%*
MCDS	$890	$814	*(9)%*	161	168	*4%*
TECH	$726	$843	*16%*	234	217	*(7)%*
COF	$597	$845	*42%*	238	253	*6%*
Achievement	$534	$902	*69%*	86	93	*8%*
Cottonwood	$1,022	$902	*(12)%*	382	478	*25%*
Cowley County	$721	$913	*27%*	285	284	*0%*
Tri-Valley	$1,094	$944	*(14)%*	195	230	*18%*
Sunflower	$822	$968	*18%*	221	245	*11%*
Hetlinger	$617	$1,027	*67%*	175	172	*(2)%*
DSNWK	$620	$1,043	*68%*	456	452	*(1)%*
DPOK	$730	$1,199	*64%*	438	472	*8%*
Wyandotte County	$948	$1,211	*28%*	327	342	*5%*
Riverside	$797	$1,247	*57%*	129	125	*(3)%*
Flinthills	$996	$1,256	*26%*	147	145	*(1)%*
TRI-KO	$788	$1,269	*61%*	200	198	*(1)%*
New Beginnings	$1,535	$1,294	*(16)%*	65	69	*6%*
SDSI	$1,375	$1,369	*(1)%*	349	413	*18%*
Futures	$1,105	$2,326	*111%*	77	72	*(7)%*
Brown County	n/a	n/a	*n/a*	73	77	*6%*
Nemaha County	n/a	n/a	*n/a*	76	66	*13%*
Twin Valley	n/a	n/a	*n/a*	103	95	*(8)%*
Statewide (b) (25 CDDOs)	$762	$852	***12%***	8,391	8,836	***5%*** (a)

(a) These counts include clients served in intermediate care facilities because CDDOs are responsible for these clients. As we noted in the overview, the growth of the "community-based" population over the same time period was 8%.
(b) 3 CDDOs (Brown County, Nemaha County, and Twin Valley) don't track CDDO Administration expenditures in their accounting systems

Source: Survey of 28 CDDOs, CDDO Funding Allocation Spreadsheets Prepared by SRS

Conclusion

CDDOs' costs for administering the State's developmental disability system have been the source of legislative concern for years. In both this audit and our 1999 audit, legislators have wondered how much was being spent on CDDO Administration, and whether CDDOs were using the State funds allocated to administer the system in an efficient manner. During this audit, we found that CDDO Administration accounts for only about 2% of the publicly funded expenditures for the system, but that individual CDDOs' costs range from about $480 to $2,300 per client. Some of those cost differences may be justifiable, but no one can really tell given the information that's currently available. SRS doesn't require CDDOs to compute their CDDO Administration costs on a uniform basis, or to report those expenditures back to SRS. Without such information, SRS is unable to analyze and assess the reasonableness of CDDO Administration costs, or to address the legitimate questions that persist.

The recommendations for this report are presented at the end of question 4.

Question 3: Do CDDOs That Also Provide Services to Clients Have Conflicts of Interest Related to the Ways They Distribute Funds or Refer Clients to Other Providers, and if so, How Could Those Conflicts Be Resolved?

The Developmental Disabilities Reform Act created an inherent conflict of interest by making CDDOs the single point of entry for referring clients for services, while at the same time allowing CDDOs to continue providing services in competition with other providers. Potential conflicts can arise—and in some cases have arisen—in the areas of client referrals, contract terms, funding distribution, and quality assurance. Prohibiting CDDOs from providing direct servics would address most of the inherent conflict of interest issues in the State's developmental disability system. In addition, the discretionary State aid CDDOs receive could be distributed on a different basis, and CDDOs could be made sole providers of targeted case management services. All 3 areas likely would need further study. These and other findings are discussed in the sections that follow.

The Structure of the Current System Creates an Inherent Conflict of Interest For CDDOs That Provide Services

Before the Developmental Disability Reform Act was passed in 1995, services to people with severe developmental disabilities traditionally were provided in State institutions. For their part, the 28 community mental retardation centers received State and county funding to serve people with moderate disabilities who didn't need to be institutionalized.

Among other things, the Reform Act made CDDOs [the former mental retardation centers] the "gatekeepers" to the State's system for serving developmentally disabled clients by making them the single point of application, eligibility determination, and service referral. At the same time, the Act allowed CDDOs to continue providing services themselves, sometimes in direct competition with the other community service providers they contracted with.

Currently, 22 of the 28 CDDOs provide services themselves in competition with the community service providers they contract with. As a result, the inherent conflict of interest situation that was created when the Reform Act was passed still exists. However, the number of CDDOs that have the dual role of gatekeeper and service provider has dropped by 2 since our 1999 audit, as described below:

- Cowley County Developmental Services (CCDS), which had experienced a number of problems when it provided services itself, spun off its services component as a totally separate

organization in 2000. The CCDS director told us the separation had allowed CCDS to be a better administrator because it wasn't also concerned about being a service provider.

- Disability Planning Organization of Kansas (DPOK) in Salina created a legally separate service organization for liability reasons. However, the service organization and CDDO still share the same executive director and board members. As a result, we think the conflict of interest situation still exists for that CDDO.

Conflict of Interest Issues Can Arise in the Areas of Client Referrals, Contract Terms, Funding Distributions, and Quality Assurance

Table III-1 provides a quick overview of the various conflict of interest issues that could arise. The following sections discuss our findings related to each conflict of interest issue in more detail.

Table III-1
Conflict of Interest Issues Affecting CDDOs

Area	Potential for Conflict of Interest
Client referrals for services	Because of their gatekeeping role, CDDOs that provide services could steer clients to themselves or away from certain other providers.
Contract negotiations between SRS and CDDOs	CDDOs that provide services could negotiate contract terms that benefit them more than their competitors.
Contract negotiations between CDDOs and community service providers	CDDOs that provide services could negotiate terms that are more advantageous to their own service providers than to their competitors.
Funding	CDDOs control several funding streams—State aid, local tax moneys, and targeted case management fees—and have decision-making power over others (extraordinary funding for clients with extreme disabilities). CDDOs could make decisions about the way this money is distributed that benefits them over other community service providers.
Quality Assurance	By law, CDDOs have a quality assurance function for their CDDO region. For CDDOs that also provide services, this means they have quality assurance oversight of their competitors.

CLIENT REFERRALS FOR SERVICES

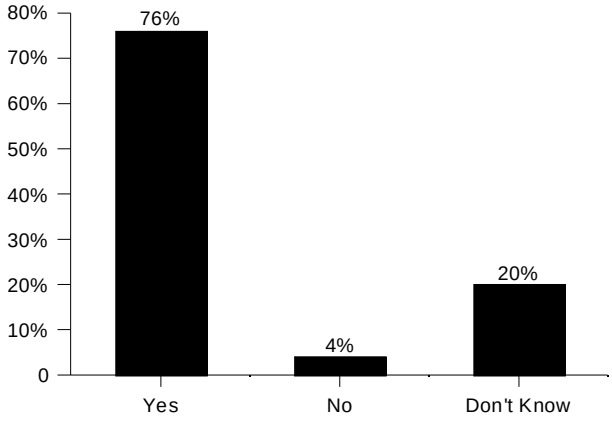
Because of their gatekeeping role, CDDOs are in a position to steer clients to or away from themselves. In fact, an ongoing concern providers have raised about CDDOs is that they deliberately encourage more disabled clients to get their services through a community service provider, so the CDDO can avoid having to serve costly clients.

The Legislature and SRS apparently recognized the risk in this area, and built in several statutory and regulatory requirements to help create a more "level playing field" for all providers. For example, they required CDDOs to:

- inform clients at least once a year about the availability of all service providers in their area who've asked that their names be furnished
- contract with any community service providers the client chose for services

Chart III-1

Percent of Parents and Guardians Responding to Question of Whether CDDOs Informed Them of All Available Service Providers



Source: LPA survey of parents and guardians of devlopmental disability clients.

Table III-2

Percent of Community Service Providers and CDDOs Responding to Question of Whether CDDOs Inform Parents and Guardians of All Available Service Providers

	Community Service Providers (26 responded to this question)	CDDOs (21 responded to this question)
Never or Almost Never	8%	0%
Sometimes	23%	5%
Always or Almost Always	46%	95%
Don't Know	23%	0%
Total:	**100%**	**100%**

Source: LPA survey of CDDOs and Community Service Providers.

Parents and guardians we surveyed generally thought they were being informed about service providers in their areas, but community service providers were less certain. In our 1999 audit, we recommended that SRS require all CDDOs to have parents or guardians sign a form indicating they'd been informed about all service options. The Departrment implemened this recommendation at the beginning of fiscal year 2002.

Most parents and guardians we surveyed thought they had been fully informed. ***Chart III-1*** summarizes the results of our survey on this issue. Also, nearly 94% of the parents and guardians who responded said the CDDO staff did not try to steer them to or away from a particular service provider.

We also asked community service providers and CDDOs if parents and guardians were being informed of all possible service providers. ***Table III-2*** shows how they responded. In addition, 15 of the 17 community service providers who currently contract with a CDDO that's a service provider, said they would prefer to affiliate with a CDDO that wasn't a service provider.

The box on page 30 presents a sample of survey comments we received from parents, guardians, CDDOs, and community service providers.

Finally, several of the issues we reported in question one about the types of clients CDDOs serve most often could come into play in this area. CDDOs do serve a larger share of the less severely disabled clients in the system (clients in tiers 3, 4, and 5), but that appears to be largely the result of the way the system developed over time. We also noted that, over the years, the clients CDDOs served within various tier groups often had less severe functional and behavioral problems, but more severe health problems. We weren't able to identify the reasons why during this audit.

CONTRACT NEGOTIATIONS

CDDOs that provide services are in a position where they could negotiate contract terms with either SRS or community service providers that benefit them or their own service providers more than their competitors. To help minimize this conflict of interest risk, SRS meets with advocates, community service providers, and other interested parties before beginning its contract negotiations with the CDDOs.

Regarding contracts between CDDOs and community service providers: CDDOs are required by law to contract with any community service providers that want to contract with them. Nearly all the CDDOs that responded to our survey told us they routinely communicate with their community service providers and supply them with information related to their contracts and the contract negotiation process.

SRS Is Currently Considering a Proposal for a 29th CDDO in Barton County

Barton County is currently part of the Central Kansas Developmental Disability Organization, which is located in Barton County [Great Bend] but which also serves clients from Rush, Pawnee, Stafford, and Rice Counties.

In November 2001, the Barton County Commission voted to approve the formation of a 29th CDDO that would also be located in Great Bend and would serve only Barton County.

The Commission submitted its proposal to SRS for approval on January 13, 2003. SRS officials told us they have been cautious in approving the proposal because of concerns with the fiscal viability of the new entity, and the impact on services funded by county mill levy moneys if one county pulled out of the existing CDDO area. In addition, they were hesitant to act because the proposal was submitted during the legislative session when SB 242 was under consideration. Senate Bill 242 would have consolidated the 28 current CDDO regions to 13, but didn't pass. SRS officials also told us they continue to receive additional information from interested parties such as Interhab (an organization representing 27 CDDOs and 18 community service providers) and the Alliance for Kansans with Developmental Disabilities (an organization representing 11 community service providers).

Survey Respondents Comments About Client Choice and Referral of Service Providers

Some parents and guardians who responded to our survey provided comments about their experience with the referral process at their CDDO. In addition, community service providers we surveyed provided comments about whether they thought CDDOs were informing parents and guardians of all service providers. Finally, some of the CDDOs who responded to our survey explained their referral process.

Parents

"The CDDO person told me about all the providers and offered to make appointments to tour and encouraged me to tour all the facilities. She talked highly of all the agencies."

"The staff was very helpful and informative of everything that was available. We feel that services meet our needs."

"There were a number of choices and it was very confusing to know what to choose, being new to all the info and the system."

"They (the CDDO) were helpful and continue to be, but are so limited by state funding that I don't believe I've received adequate services."

Service Providers

"We have never been asked to a provider fair, and get the impression that the intake coordinator recommends certain agencies to individuals based upon what they believe would be the best match. Most of our referrals in this area come from other provider that cannot provide the needed service."

"I believe the cases of . . . illustrate the difficulty of the CDDO giving parents information about all potential providers. Though these parents may have been informed of our existence, in their opinion they were discouraged from seeking an alternative service provider."

"Because the CDDO is also a service provider, the families are able to visit and ask questions of that provider agency as soon as they are informed of eligibility as they are in the same building. The CDDO does inform them about other providers and informs them of their right to interview and choose their provider."

"It APPEARS that the referrals we receive sometimes only involve "hard to serve," as they (the CDDO) never seem to have just the right opening when they have inquiries. This is perhaps the truth, but we find it hard to believe that we are able to shuffle/rearrange to meet individuals' needs, while they never seem to have that ability."

CDDOs

"CLASS LTD has developed a provider handbook that is given to all applicants for services. The provider handbook includes the list of all CSPs, their services and contact information. The information contained in the handbook is provided by each CSP. Annually, everyone in service is provided a current list of services and providers available in our CDDO area. We have developed several forms to document offering of choice of services and providers."

"In response to the potential conflict of interest in the intake/referral process, a procedure was established that provided for "Information Sessions," during which time an individual and their family applying for services could meet with each community service provider privately for an explanation of the services provided by that provider agency. They could also, at this same time, schedule a tour of the providers' services if they wished. This process allowed the community service provider to present itself, rather than relying on the explanation by the gatekeeper."

A Community Service Provider Has Sued a CDDO for Alleged Actions That Relate to Potential Conflict of Interest Issues

The Central Kansas Developmental Disabilities Organization (also known as Sunflower) located in Barton County is being sued by one of its community service providers, Rosewood Services Inc. One of the issues behind this case is that the CDDO "refinanced" its own consumers but not those served by other providers. Refinancing allows a client who is funded with State funds to obtain Medicaid funding when the client becomes eligible.

The lawsuit also alleges the CDDO provided funding for people on the waiting list who chose the CDDO's own service provider, but didn't fund the person on the waiting list if another community service provider was chosen. Some of the other actions Rosewood alleges Sunflower has taken include:

- Used their authority to harass consumers and their families who were seeking to change service providers from Sunflower to Rosewood
- Selectively and arbitrarily enforced statutes, rules, regulations, policies, and procedures against Rosewood, but not other providers.
- Initiated a new consumer transition policy when several consumers decided to leave Sunflower in favor of Rosewood. The new policy mandated a lengthy waiting period during which the person couldn't move, or if the individual did move, the new provider couldn't get paid for the services provided. Also, Sunflower denied funding for individuals who had selected Rosewood as their service provider, while other individuals wanting services from Sunflower were funded.

On September 8, the federal judge in the case denied Sunflower's motion to dismiss the case. The judge found there was sufficient credible evidence to allow the case to go to trial. The case will now either go to trial or be settled out of court.

Community service providers think they are disadvantaged in the contract process in several ways, and raised specific concerns about several contract provisions. In response to our survey, 10 community service providers (42%) indicated they didn't have adequate access to contract negotiations between CDDOs and SRS, and 8 providers (33%) thought they didn't have adequate access to CDDOs in their negotiations with them.

In addition, a total of 7 providers cited terms in their contracts with CDDOs, or in CDDOs' contracts with SRS, that they thought disadvantaged them. The issues they raised are as follows:

- Five providers cited issues with how SRS and the CDDOs handled targeted case management moneys. Some cited the same types of issues we reported in question 1—including SRS' decision to give CDDOs control over the distribution of these funds. They also complained that CDDOs set different rates for different providers of case management services, and that the reimbursement rates they set were less than the cost of providing the service. Some also noted that CDDOs didn't pay out targeted case management moneys for extended periods of time, and one indicated a CDDO had withheld payment until the provider agreed to the CDDO's terms.

- One community service provider objected to a contract clause that prohibited it from appearing before the county commission to ask for

county funding. The CDDO involved shares about 14% of the county mill levy it receives with its community providers. An official with the CDDO told us that, because getting multiple reports on county mill levy moneys can be confusing, most commissioners had asked that only the CDDO submit a report regarding the mill levy. The official indicated the contract does not prohibit providers from contacting commissioners on service issues not related to county funding.

- One service provider told us all 3 CDDOs it contracts with had included a "termination without cause" in its contracts with them. The service provider protested to one CDDO, and attorneys for both parties ultimately agreed on language stating that the CDDO could terminate the contract with advance notice if the State contract were cancelled or terminated, funding were no longer available, or the contract jeopardized the CDDO's ability to fulfill its responsibilities. The service provider also could terminate the contract at any time with 30 days written notice. The service provider is currently working with the 2 other CDDOs to have this provision removed from those contracts as well.

FUNDING ISSUES

As noted earlier, CDDOs have decision-making power over certain tax moneys community service providers can receive—including State aid and local tax moneys, targeted case management moneys, and "extraordinary" funds for clients with extreme disabilities. As the decision-maker over these funds, CDDOs are in a position to make decisions about the way they are distributed that benefit them over other community service providers.

Community service providers feel disadvantaged that they don't have access to the discretionary State aid and county tax moneys CDDOs receive. Under the current system, these moneys are distributed directly to the 28 CDDOs, and any decision to share them is voluntary. In 2003, 14 CDDOs shared $5.3 million in discretionary funds with other providers, which represented only 28% of the $19.2 million they received. As a result, many of the entities that provide services to developmentally disabled clients in Kansas have no access to these funds. Here are a few sample survey comments about this issue:

"Tech and Northview keep all county mill money for their own use as a provider and no accounting is provided to service providers of how this money is spent."

"I can tell you quite frankly that for a service provider to have the opportunity to keep all county mill levy and state discretionary funds under the guise of being a CDDO is totally bogus. I strongly disagree with the ability of CDDOs which are also service providers having the control over these funds without any accountability to its affiliates. Why should they prosper, and their clients prosper, at our clients' expense?"

"Flinthills keeps local and State discretionary aid. They do not or have ever asked for any input on how it is spent. We have specifically asked for an opportunity to request some of the funding and have been ignored. I believe it is unfair as both State discretionary aid and county mill were intended for all citizens living in the CDDO area, not just those served by Flinthills."

"The CDDO, because it is a county agency, has much higher salary and overhead costs. Much of the discretionary funds could be better spent on services than on these artificial costs. These funds have never been shared with service providers and that is an ongoing sore point."

When SRS made CDDOs responsible for distributing targeted case management moneys in 2003, many CDDOs developed distribution plans that benefitted them more than their service providers. As discussed more fully in question 1, the State received $8 million in new federal funding for targeted case management in fiscal year 2003. Under the distribution plans they developed, CDDOs received 50% of these new funds, or about $917,000 more than they would have if these new money had been distributed to providers in the same proportion as new federal funds were distributed to providers in fiscal year 2002.

Most of the CDDOs' gain occurred because their distribution methods favored them more heavily than other providers, whether intentionally or not. An example we cited earlier: one CDDO that developed a plan to distribute additional federal dollars based on adult clients was the only provider of day and residential services in its region.

Many community service providers we surveyed were upset with the way targeted case management moneys are being distributed. In question 1, we also noted that all reimbursements for case management services now flowed through CDDOs to the providers, and that providers now had to negotiate the rates they'd be paid for these services with CDDOs, rather than automatically receiving the full federal reimbursement rate.

Although SRS had legitimate reasons for taking such actions, this new process has put CDDOs in control of even more of the funding distributed to community service providers. Here are a sample of comments we received from providers on this issue:

"The CDDO only reimburses case management at $119 per client, and they keep the rest for what they consider administrative money to be distributed to full licenced agencies such as TARC and Sheltered Living. I do own my own agency and I do have

administrative expenses, as do the other independent agencies... we do not receive any portion of this money. ..."

Allowing CDDOs to decide if they can charge various fees ,and distributing the money on the encounter system, puts those who serve consumers with severe disabilities and severe behavioral issues at a financial disadvantage..."

When a CDDO is also a provider, it is only natural that they are going to negotiate a targeted case management rate that is more advantageous to them than to competitors. Less competitors equal more money to the CDDO. I feel that the State needs to make some fair guidelines on that and have input from others, not just CDDOs."

Another area of funding the CDDOs have authority over is extraordinary funding for extremely disabled clients. In October 2000, SRS delegated the authority to decide which clients receive extraordinary funding to the CDDOs. "Extraordinary" funding is an amount paid over and above regular reimbursement rates for extremely disabled clients whose needs far exceed ordinary funding levels. About 3% of all clients have such extreme needs and community service providers serve about 75% of those clients.

According to the contract between SRS and the CDDOs, CDDO Funding Committees (which may or may not include community service provider representatives, depending on how the CDDO has set them up) must make these funding decisions based on the financial ability of their CDDO. By having control over which clients receive this extra funding, CDDOs are in a position where they could approve such funding for their own clients, but not for the clients of other community service providers.

In March 2003, the Statewide Funding Committee, which is made up of SRS and CDDO representatives, approved a plan to curtail CDDOs' spending for fiscal year 2003, which at that time was projected to be $3.5 million over the Medicaid waiver allocation. One of the recommendations was for CDDOs to start reviewing the need for extraordinary funding in their areas. However, the 2003 Legislature wrote a proviso for fiscal year 2004 to prevent CDDOs from reducing or eliminating that funding unless clients' annual assessment scores improved to justify such a change.

QUALITY ASSURANCE ROLE OF CDDOS

State regulations require CDDOs to ensure that the services delivered by both the CDDO and other community service providers in their region are provided as called for in the client's service plan, and in a way that ensures all the client's rights are observed and protected.

Local committees made up of clients, their families, guardians, interested citizens, and providers are supposed to conduct on-site monitoring to make such determinations, as well as to assess whether services were provided and paid for, whether instances of suspicious abuse, neglect, or exploitation are being reported to the State, and whether providers have corrected any confirmed violations.

In our view, it's an inherent conflict of interest for CDDOs to be given regulatory responsibility to perform quality assurance over their own providers. In addition, CDDOs that also provide services are in a position to oversee their competitors. They also could make decisions that benefit their own service providers more than other community service providers.

In at least one situation, there was confusion and concern about the actions one CDDO took against a community service provider as a result of a quality assurance review. Johnson County Developmental Supports (JCDS) placed 8 of its service providers on corrective action plans for issues such as not submitting required documentation to the CDDO on time, and not properly designing the client service plans.

One of these providers—Community Living Opportunities (CLO)—later found out that JCDS had stamped "Not Available" over its name on the service provider list that JCDS gives to new clients. JCDS officials told us they hadn't told anyone that CLO had been placed on a plan of correction.

JCDS' policy states that, when a provider has been placed on a corrective action plan, the provider can't take new clients without JCDS' prior authorization. In this case, the senior administrator of CLO argued she didn't know the provider wouldn't be getting any referrals. JCDS officials contend they made this point clear to the staff person who signed the plan of correction, but admit they should have informed the administrator as well. JCDS officials also told us the 7 other providers didn't take issue with the corrective action plans and some of them were also marked "Not Available" on the provider list.

The 2 parties went to mediation to resolve this issue, and JCDS revised its list of providers to show that CLO was available for client referrals again. Furthermore, JCDS and CLO staff had a follow-up meeting on the corrective action plan, and the necessary changes were made.

Prohibiting CDDOs from Providing Direct Services Would Address Most of the Inherent Conflict of Interest Issues in the State's Developmental Disability System

Many of the problems we've pointed out in this question are caused by CDDOs' dual roles as gatekeepers and service providers. That inherent conflict of interest has existed since the Reform Act was passed. Most of these issues would be eliminated if CDDOs were limited in their roles and not allowed to provide direct services.

Senate Bill 242, which was introduced but not passed during the 2003 legislative session, would have prohibited CDDOs from providing services themselves. (The bill also would have reduced the number of CDDOs from 28 to 13, an issue discussed in question 4.)

Because the law makes CDDOs responsible for ensuring that services are available to all clients in their region, critics claim that gaps in services would develop if CDDOs weren't allowed to provide services and community service providers declined to serve certain clients or to provide certain services. And in one region, a CDDO is the only licensed service provider in their area.

Although that concern may be legitimate, we don't think it's insurmountable. In such cases, other community services might develop to fill the needs that exist, or the CDDOs' own providers could split off completely from their parent organizations—just as Cowley County Developmental Services (CCDS) did in 2000.

Other changes would be needed to address the real or perceived conflicts of interest that we identified, or that community service providers have expressed concerns about. These are described below:

The discretionary State aid CDDOs receive also could be distributed on a totally different basis. The State's system for providing developmental disability services has changed drastically over time, but the allocation of discretionary State aid hasn't changed to reflect who's actually providing those services. Consider the following:

- When the Legislature authorized State aid in 1974 to support the services being provided to developmentally disabled people in the communities, the community mental retardation centers (now CDDOs) that received it provided essentially all of those community-based services.

- Today, other community service providers are providing services to many of the clients in the State's developmental disability system—yet the CDDOs still receive all the discretionary State aid. CDDOs have total

flexibility in how these funds are spent—including the decision to share any of these moneys with other service providers.

If the stated purpose of State aid is to help support community-based services, it's difficult to justify allocating these funds solely to CDDOs, rather than among all participating providers. One way to address this situation would be to eliminate State aid payments to CDDOs, and put those same funds into the Medicaid waiver—either to increase reimbursement rates for the direct services that are provided (residential, day, and in-home), or to serve additional clients. If that were to happen, funding would go directly to the CDDOs and other providers who actually provide the services.

Although CDDOs would have less "unmatched" tax moneys available to match federal dollars for CDDO Administration or targeted case management, all these new Medicaid waiver moneys automatically would be matched 60-40 with federal Medicaid dollars for the additional residential, day, and in-home support services that were provided. With additional funding, other providers also could be in a better position to provide some of these services.

CDDO officials have told us they use about 57% of the discretionary funds they retain (State aid and county mill levy funds) for client services and transportation. CDDOs would continue to get about $14 million they now receive in State and federal block grant funds for providing services to non-Medicaid-eligible clients.

A similar situation exists for the county mill levy funds CDDOs now receive. Like State aid, these local tax moneys initially went to the community mental retardation centers to help support community-based services, and now go almost exclusively to the CDDOs. However, unless State laws were changed to redirect these funds, how they are used—and how much is raised—are local issues that are up to the county commissioners.

CDDOs also could be made sole providers of targeted case management services. Case management includes such things as planning, coordinating, and monitoring of direct services for the clients. If CDDOs' roles were limited to "gatekeeper" activities, it also could make sense for them to become the sole providers of case management as well. That's how the Area Agencies on Aging—who are the gatekeepers for the elderly services system—handle case management.

Without this change, entities that provide case management services in the community would be in a position to refer their clients to their own affiliated direct service providers—a charge that community service providers now level against CDDOs.

One potentially significant drawback: as long as SRS uses the targeted case management reimbursement rate as the mechanism for maximizing federal funds, CDDOs would be the only entities eligible to receive these new funds.

Conclusion An inherent conflict of interest arose within the State's developmental disability system when CDDOs were given responsibility for determining clients' eligibility and referring them for services, while still being allowed to provide services in competition with other service providers. This conflict of interest can be managed somewhat to minimize the problems it creates, but recent decisions that gave CDDOs more control over the funds distributed to service providers—and the ways in which some CDDOs chose to distribute those funds—clearly demonstrate this conflict of interest will never be eliminated under the current structure. As we pointed out in our 1999 audit, the only way to accomplish that is to separate client intake and referral from client treatment and care services.

The recommendations for this report are presented at the end of question 4.

Reorganizing and consolidating CDDOs, as the Alliance for Kansans with Disabilities has proposed, isn't likely to help CDDOs draw down as much new federal funding for services as claimed. That's because SRS isn't likely to be able to significantly increase the reimbursement rate for targeted case management, counties might not maintain their current level of mill levy funding to support consolidated CDDOs, and the Alliance's funding projections have a serious flaw.

However, consolidating CDDO regions could result in other savings and non-financial advantages, such as reducing CDDO Administration costs, lowering SRS' overhead costs, and making the delivery of services more uniform. While many stakeholders cited disadvantages to consolidating CDDO regions—such as incurring costs during the consolidation, forcing clients to travel further for services, and reducing local control of services—most of these concerns didn't appear to be significant problems. These and other findings are discussed in more detail in the sections that follow.

Reorganizing and Consolidating CDDOs Isn't Likely To Significantly Increase Federal Funding for Services

At the beginning of fiscal year 2003, the Alliance for Kansans with Developmental Disabilities, a group representing 11 community service providers in Kansas, proposed reducing the number of CDDOs from 28 to 13, and changing the system so CDDOs could no longer act as direct service providers. The purpose of the proposal was to:

- eliminate the inherent conflict of interest in the system
- reduce inefficiencies and duplication of effort
- reconfigure the CDDO regions in a way that would maximize the amount of federal funding CDDOs could draw down

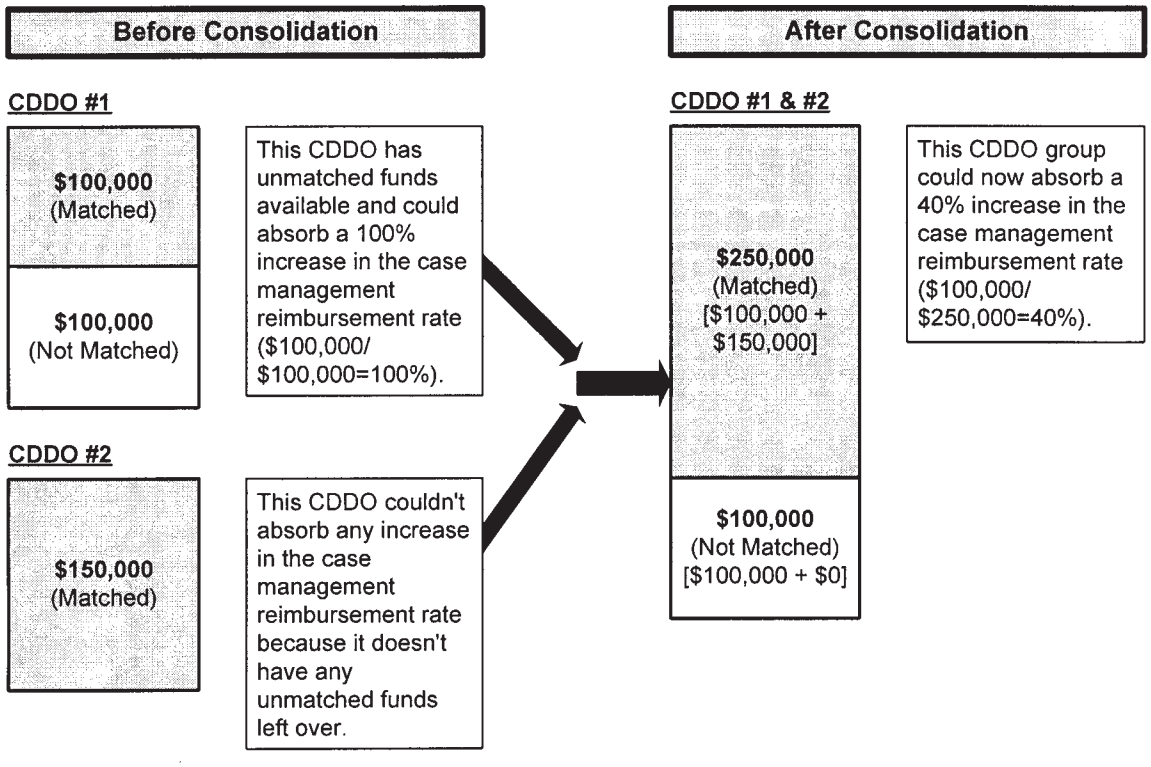
According to the Alliance, the consolidation proposal would have brought in an additional $10.7 million in federal funds in fiscal year 2003. We already discussed issues relating to conflict of interest in Question 3. In this question, we focused solely on the viability of the proposal.

The Alliance's proposal attempts to bring in additional federal funds by helping CDDOs pool their unmatched local funds. While the Alliance doesn't explicitly mention case management in its proposal, bringing in new federal funds is based on SRS raising the reimbursement rate for targeted case management. As discussed in question 1, SRS significantly increased the targeted case management rate in fiscal year 2003 in an effort to help CDDOs

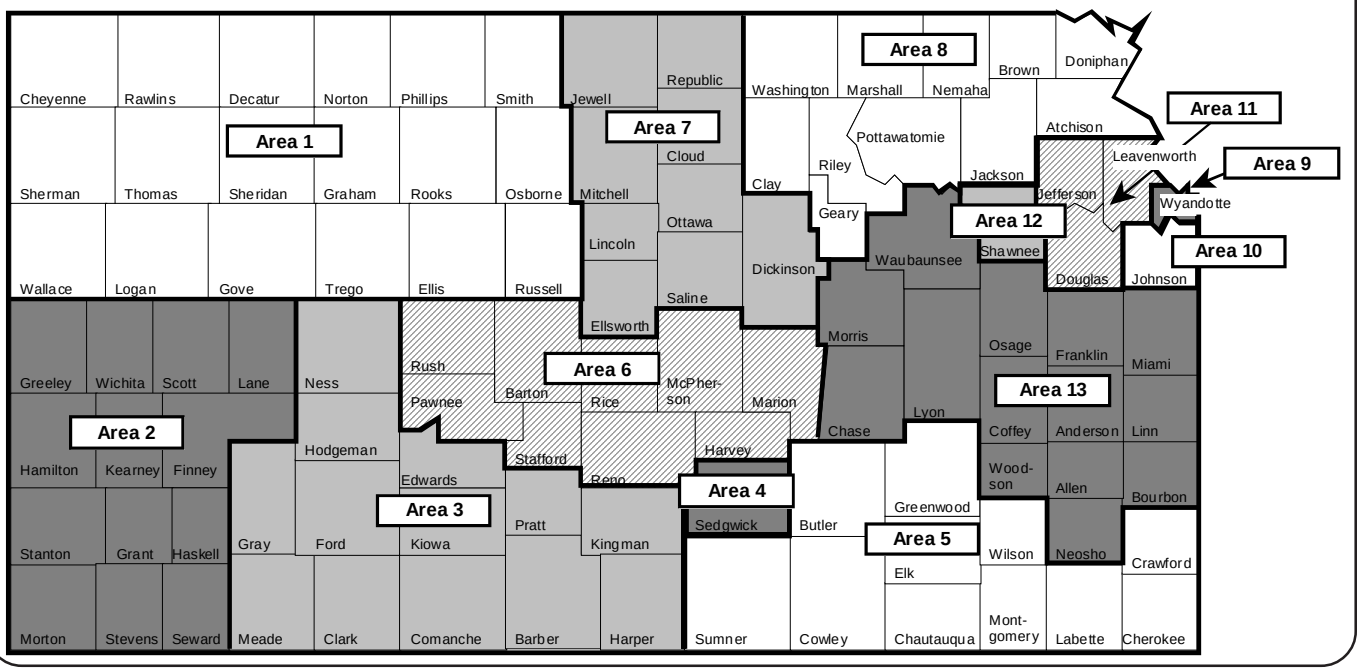
maximize the amount of local funds they could match with federal dollars. SRS set the new rate at $395 per month. At that rate, 2 small CDDOs (New Beginnings and Cowley County) were able to match all their available local funds, and couldn't absorb a larger rate increase. Even with the increased rate, the other 26 CDDOs still had about $10 million of unmatched State and local funds in fiscal year 2003.

According to the Alliance, its proposal would have allowed CDDOs to match $7.2 million of these funds, bringing in $10.7 million more in federal dollars. By folding 20 of the existing CDDOs—including the 2 that had already matched all their local funds—into 5 larger CDDOs, each new CDDO would have at least $550,000 in unmatched local funds. The map on page 41 shows the Alliance's proposal of 13 CDDOs regions. SRS could then increase the targeted case management rate further, allowing CDDOs to draw down additional federal funds. ***Chart IV-1*** illustrates this concept.

Chart IV-1
Illustrating How Combining CDDO Regions Could Increase Federal Funding



Map of the Alliance's Proposed CDDO Areas



The Alliance's assumption that SRS will be able to further increase the targeted case management reimbursement rate may not be feasible. SRS raised the reimbursement rate to $395 per month in fiscal year 2003. To bring in $10.7 million in additional federal funding, the Alliance's proposal would have required SRS to increase the monthly rate by another 49%. However, Medicaid reimbursement rates for all services recently have come under increased scrutiny from the Centers for Medicare and Medicaid Services (CMS). SRS officials told us they are concerned they may have difficulty justifying the current rate to CMS, let alone further increases.

When the 2001 reimbursement rate study was completed, (the most recent available) it showed that Kansas' case management rate already exceeded providers' cost of providing the service. That was before the rate was increased in fiscal year 2003. There's no uniform benchmark for a reasonable rate because definitions and methods for establishing payment rates vary from state to state. We did find that the case management rate in Iowa was only $250 per month.

The Alliance's proposal also assumes that counties would continue to provide their current mill levy funding to consolidated CDDOs. This may not be the case. A number of CDDOs and community service providers who responded to our survey questioned this assumption. We asked county commissioners from 2 counties that would be affected by the Alliance's proposal whether they thought their counties would continue to fund a consolidated CDDO. Their responses were mixed:

- A commissioner from Labette County said his county probably would fund a consolidated CDDO at the same level, as long as the new CDDO remained responsive to the commission.

- A commissioner from Lyon County said his county probably wouldn't continue to fund a consolidated CDDO because the commission wouldn't be as familiar with the new organization.

There's no way to know what actions county officials across Kansas actually would take. Alliance officials think that, once county commissions are educated about the value of consolidating CDDOs, they would maintain their mill levy funding at the current level. ***Table IV-1*** shows, for 2 large CDDO regions, the mill levy rate and amounts that counties contributed to their CDDO.

Table IV-1
County Funding for Developmental Disability Services
Fiscal Year 2003

Counties w/n CDDO region	Mill Levy Total	Mill Levy For CDDO	County Funding for CDDO
Developmental Services for Northwest Kansas (DSNWK)			
Ellis (a)	38.285	1.477	$331,000
Thomas	34.597	0.995	$78,290
Russell	73.595	1.208	$73,228
Norton	71.302	1.436	$56,000
Gove	57.870	1.246	$46,200
Graham	93.186	1.518	$43,670
Rawlins	67.658	1.321	$45,941
Sheridan	67.911	1.174	$40,000
Rooks	76.485	0.930	$36,239
Phillips	75.960	0.697	$33,152
Decatur	51.955	0.781	$27,500
Smith	81.878	0.679	$27,000
Logan	67.078	0.771	$24,000
Trego	65.816	0.572	$20,000
Osborne	66.767	0.354	$13,020
Wallace	52.463	0.423	$12,100
Cheyenne	47.762	0.216	$7,840
Sherman	51.503	na	$32,783
TOTAL DSNWK			**$947,963**
Arrowhead West			
Ford (a)	39.895	0.695	$140,000
Pratt	52.515	0.945	$79,560
Kingman	46.309	0.890	$68,119
Barber	53.217	0.985	$60,000
Harper	80.308	1.051	$52,500
Meade	42.177	0.367	$34,664
Edwards	64.148	0.858	$33,735
Gray	63.790	0.407	$31,329
Ness	54.634	0.443	$16,500
Clark	72.873	0.479	$15,000
Comanche	76.047	0.403	$13,694
Hodgeman	101.384	0.425	$9,925
Kiowa	56.767	0.096	$5,000
TOTAL Arrowhead West			**$560,026**

(a) County where the CDDO is located.

Source: County budget documents from the Kansas Association of Counties

County mill levies account for about half the funds CDDOs use to match with federal funds. The 20 CDDOs that would be consolidated under the Alliance's plan received about 28% of those county funds. If some of the affected counties didn't fund consolidated CDDOs at their current levels, fewer local dollars would be available to match federal dollars.

Even if all the Alliance's assumptions held true, its proposal would bring in only about $6 million in new federal funds, not $10.7 million. The Alliance's proposal calculated that each consolidated CDDO would have $550,000 in unmatched local funds (the "lowest common denominator") to use as a match for an additional $10.7 million in federal funding.

We noted, however, that those calculations didn't take into account the fact that some CDDOs serve fewer clients than others, and that changing the reimbursement rate would have a smaller impact on these CDDOs. For example, here's how a 25% increase in the case management rate would affect 3 different CDDOs of varying sizes:

CDDO	Number of clients in case mgt	At the current reimbursement rate of $395 per month		If the rate is raised by 25% to $494 per month	
		the CDDO can match these local funds	with this much in Federal funds.	the CDDO will be able to match this much more in local funds	with this much more in Federal funds.
CDDO A	100	$190,000	$285,000	$47,500	$71,250
CDDO B	500	$950,000	$1,425,000	$237,500	$356,250
CDDO C	1,000	$1,900,000	$2,850,000	$475,000	$712,500

As the above example shows, the amount of local matching funds that each CDDO will be able to use to draw down federal funds varies significantly. As a result, the new federal funds that each will receive also varies.

Again, the Alliance's proposal assumed that all the newly configured CDDOs would be able to match an equal amount of additional unmatched moneys, regardless of their number of clients. We reworked the Alliance's projections to correct for this oversight. Those figures are shown in ***Appendix E***. Alliance officials agreed that our approach was a more appropriate method for estimating the potential increase in federal funds.

The corrected calculations showed that the maximum amount of additional federal funds that could be drawn down under the Alliance's proposal was $6.1 million. To accomplish that, SRS would have to increase the targeted case management rate by 28%, to about $504 per month.

Consolidating CDDO Regions Could Result in Other Savings And Non-Financial Advantages

Although consolidating CDDOs might not bring in significantly more federal dollars, our survey of CDDOs and community providers indicated there may be other monetary and non-monetary advantages.

Consolidating CDDOs may reduce their CDDO Administration costs. As we noted in Question 2, CDDOs with the largest number of clients in their regions tended to have the lowest CDDO Administration costs per client. Because of such economies of scale, the Alliance's proposal to consolidate CDDOs potentially could result in lower CDDO Administration costs.

In fiscal year 2003, the 28 CDDOs served an average of 316 clients each, ranging from a low of 66 clients in Nemaha County to a high of almost 1,300 in Sedgwick County. The 13 consolidated CDDOs in the Alliance's proposal would serve an average of 680 clients, ranging from a low of 276 clients to a high of 1,300 clients.

Consolidation may reduce SRS' administrative overhead expenses. Reducing the number of CDDOs would mean SRS would

have fewer CDDOs to oversee and negotiate contracts with, and fewer reports, forms, and electronic data transfers to deal with. In addition, fewer CDDOs could mean reduced travel costs for SRS staff for quality assurance activities.

Consolidating CDDOs may make the delivery of services more uniform across the State. Reducing the number of CDDOs would reduce the number of potential ways that services are provided. SRS officials noted this benefit in their testimony to the Legislative Budget Committee in August 2003. This sentiment was echoed by several of our survey respondents. For example, 2 service providers commented:

> "I like the idea of reducing the number of CDDOs if they are all independent CDDOs and not service providers. I feel that things would be more consistent with fewer CDDOs"
>
> "One would hope that it would lead to more consistency in how regulations are implemented across the State. Providers would have fewer affiliate agreements if they serve more than one CDDO area."

Many Stakeholders Also Cited Disadvantages To Consolidating CDDO Regions

During this audit we spoke with officials from SRS, Interhab, and the Alliance for Kansans With Disabilities, and surveyed officials from CDDOs and community service providers about any disadvantages they would expect from consolidating CDDOs. They cited several, although most didn't appear to us to be very significant. These disadvantages—and our assessment of their significance—are summarized in ***Table IV-2*** on the next page**.**

Conclusion

The Alliance's proposal didn't specify how new federal funds could be drawn down by consolidating CDDOs, but its assumptions are based on significantly increasing the targeted case management rate again. That proposal could bring in significantly less new money than originally estimated, largely because of a calculation error, but also because of very real concerns that SRS couldn't justify another large increase in these rates, and that the counties which would lose CDDOs may not be willing to provide the same level of funding.

Collapsing the number of CDDO regions to gain other efficiencies, or to create a more uniform way of delivering services across the State, is a policy decision the Legislature should consider regardless of additional federal funding streams. While significant changes in the structure might be disruptive at first, in the long run they could result in more efficient administration of the system and a more effective provision of services.

Table IV-2
Concerns About CDDO Consolidation

Problem or Concern	Is it a significant problem?
Loss of Local Control. Many stakeholders point out that the current system was built on the foundation of local Community Mental Retardation Centers and that the Reform Act emphasizes local control.	**Maybe.** Currently, counties have the ability to choose who will serve as their CDDO and to decide how much funding to provide them. This helps make the CDDOs responsive to the needs of the county. While counties won't have the ability to change CDDOs, they will retain control over how much money to contribute to their CDDO.
Weakens the Connection Between the CDDO and Other Organizations in the Area. Some stakeholders had concerns that larger CDDOs would be spread too thin and be less responsive to the needs of service providers throughout their area.	**Maybe.** However, several CDDOs that currently represent large geographic areas appear to have managed to make multi-county regions work.
Problems with Transportation. Many stakeholders were concerned that clients would have to travel farther for services or not be able to reach services at all.	**No.** Regarding CDDO intake and evaluation services, we spoke with officials from 2 of the larger CDDO regions in Western Kansas and asked if transportation was a problem. Officials from both CDDOs indicated they travel to the clients to make such services available. Regarding direct care services, as long as the CDDOs that lose their "CDDO status" through consolidation continue to provide direct care services, there's no reason to think that consolidation would affect the clients' access to service providers.
Quality and Quantity of Services Would Suffer. Stakeholders were concerned larger CDDOs would be less able to give personal attention to their clients and the quality of services would suffer.	**No.** None of the new CDDO regions would serve more clients than the largest current CDDO. For administrative services, the consolidated CDDOs would get more administrative funding from SRS to handle the larger caseload. For direct care services, we noted above that the number of direct care providers is unlikely to change.
Services to Non-Medicaid Clients Would Be Eliminated. Some stakeholders are concerned that consolidating CDDOs would lead to an "all Medicaid" system.	**No.** Nothing in the Alliance's proposal seeks to eliminate services to non-Medicaid clients. Under the plan, clients currently served with State money would still receive their services.
Cost of Consolidation Would Take Money Away From Services.	**Maybe.** While there may be some realignment costs associated with consolidating CDDOs, it seems unlikely these costs would be permanent.

Recommendations *Recommendations for the Legislature*

1. To eliminate the inherent conflict of interest that exists in the current developmental disabilities system, and to ensure that State funding is allocated in a more fair and equitable manner that follows the client, the Legislative Budget Committee or other appropriate legislative committees should amend State law to:

   a. separate the functions of client intake and service referral from client treatment and care services in the State's developmental disability system.

b. allow all service providers in the State's system—including CDDOs and other community service providers—to receive discretionary State aid funds. This could be accomplished in a number of ways. Putting all current State aid funds into the Medicaid waiver would ensure that this funding goes directly to the entity who's actually providing the service, and that all those funds would be matched with federal dollars. Another option could include distributing those funds through the CDDOs to all service providers based on the number and severity of clients they serve.

2. As part of its deliberations during the 2003 interim, the Legislative Budget Committee should receive testimony on the feasibility and desirability of making CDDOs the sole providers of case management services—much as the Area Agencies on Aging handle case management for the elderly services system. Because of the potential ramifications of this decision on drawing down federal funds, this issue may require significant study before legislation is introduced.

3. To determine the financial and non-financial benefits of consolidating CDDO regions, the Legislative Budget Committee or other appropriate legislative committees should do the following:

   a. receive testimony from SRS and from representatives of CDDOs and the community service providers as to the one-time and recurring additional costs and cost savings such a change would bring.
   b. receive estimates from SRS officials of any cost savings that would result at the Department level.
   c. consider the effect of 2 other key statutes that would be affected by such a change: KSA 19-1001 et seq, which makes county governments responsible for designating community mental retardation facilities and setting the county mill levy to help fund them, and KSA 65-4411, which allocates State aid to CDDOs.

Recommendations for SRS

4. To better understand the reasons why CDDOs appear to be serving more of the less severely disabled clients within some tiers, SRS should analyze the reasons for the patterns we saw, and should assess whether CDDOs are benefitting financially.

5. To ensure that reimbursements for targeted case management services are distributed equitably and fairly among all providers, and that CDDOs aren't able to develop plans that benefit them unfairly compared with other community providers, SRS should develop contract language that accomplishes the following:

    a. limits the amount of administrative fees that CDDOs can charge to cover the cost of distributing targeted case management funds to service providers.
    b. either requires CDDOs to provide the remainder of the funds to the provider of case management services, or requires each CDDO to develop a formal plan for how the remaining funds will be distributed and submit that plan to SRS for approval. SRS should develop guidelines for the types of distribution plans that are acceptable.

    If CDDOs were to become the sole provider of targeted case management services, that would have significant ramifications on the State's current approach to maximizing federal funds. SRS should assess the potential impact of this issue and provide that information to the Legislative Budget Committee.

6. To improve the State's ability to monitor the reasonableness of CDDO Administration costs, SRS should identify the types of costs that are allowable under this category, and should require CDDOs to compute and report their expenditures on a consistent, uniform basis. That information can then be reviewed and analyzed to help explain reasons for significant variations in expenditures per client, to help identify any changes that might be needed to ensure those costs are more reasonable, and to assess the potential cost implications of changing the way the State's developmental disability system is administered.

7. If CDDOs are allowed to continue providing services to clients in competition with other service providers, SRS should take the following actions to help minimize the conflicts that arise:

    a. To help minimize the contractual problems that can arise between CDDOs and community service providers, SRS should inform all CDDOs of the types of contract provisions that have caused problems, and should provide them with guidance on how to avoid such provisions. This could be done through updating an affiliate contract

template SRS created in the first years after the Reform Act was passed.

b. To provide some controls over CDDOs' ability to decide which clients receive extraordinary funding, SRS should amend its contracts with the CDDOs to allow them to reduce or eliminate that funding only if clients' annual assessment scores improved to justify such a change. Such a change would be in keeping with the proviso passed by the 2003 Legislature. Further, SRS should require that the CDDO funding committees include staff from community service providers.

c. To eliminate the conflict of interest that exists by requiring CDDOs to perform quality assurance over their own providers, SRS should amend its regulations to require SRS staff to take the lead role in performing such reviews of CDDOs' service providers.

APPENDIX A

Revised Scope Statement

This audit was originally approved by the Legislative Post Audit Committee on June 17, 2003. Revisions were made to the scope and the revised scope statement below was approved by the Legislative Post Audit Committee on September 3, 2003. The audit was requested by Senator Steve Morris.

CDDOs: Reviewing Issues Related To The Funding of Community Services

The Developmental Disabilities Reform Act of 1995 was designed to allow people with developmental disabilities to access appropriate services and supports in the community rather than having to get those services in institutional settings.

The Act resulted in the closing of State mental retardation institutions, and establishment of a network of 28 community developmental disability organizations (CDDOs) which serve as a single point of application, eligibility determination, and referral for developmentally disabled people wanting to access services in the community. People with developmental disabilities can choose to receive services from the CDDO or affiliated service providers that operate within the CDDO's coverage area.

Recently, legislators have expressed a variety of concerns about equity issues related to the distribution of funding for community services for the developmentally disabled. Specifically, those concerns relate to whether the amount of money service providers receive corresponds with the their clients' severity levels, whether the amount going to CDDOs' own provider organizations has increased more than the amount made available to other providers, what control CDDOs have over the amount going for administrative costs and for services, and what has happened to administrative costs since the implementation of the Reform Act. Other concerns relate to whether there continue to be conflicts of interest for CDDOs, how to resolve those conflicts, and whether reducing the number of CDDOs would result in an overall higher level of funding for disability services.

Many of these concerns were addressed in 2 audits issued by Legislative Post Audit in November 1999. Those findings would be updated in this audit which addresses the following questions:

1. **How has funding for CDDOs and their affiliate organizations changed in recent years, and does the amount an organization receives generally correspond with the severity level of its clients?** To answer this question, we would review information about the overall funding made available for services to the disabled for the past 3 fiscal years, and look at the relative proportions going to CDDOs and to affiliated provider organizations. We would determine the reasons for any significant changes in the overall funding patterns. In addition, we

would review available information about the clients served by each type of organization and determine whether there is a relationship between the disability levels of these clients and the amount of money each organization receives.

2. **How have funding and expenses for CDDO Administration changed in recent years, and to what extent are the CDDOs paying CDDO Administration costs with moneys that could otherwise be used for purposes such as direct service?** To answer this question, we would look at funding and expenditures for CDDO Administration for the last 4 years (2000-03). We would compare the State and federal moneys provided for CDDO Administration to the CDDOs' reported expenditures. We would interview staff of CDDOs where expenses significantly exceed revenues, or where there's been significant growth in expenses for CDDO Administration, to see what moneys the CDDO is using to pay those expenses. We also would look at how these expenses have changed on a per client basis over the 4-year period.

3. **Do CDDOs that also provide services to clients have conflicts of interest related to administering funding and client referrals, and if so, how could those conflicts be resolved?** To answer this question, we would review the overall system for administering funding and referring clients to service providers. We also would survey or contact a sample of affiliated service providers to determine whether they think their interests have been adequately represented by their CDDO in aspects related to funding and client referrals. We also would gather available data about legal actions, formal grievances, or mediation involving CDDOs and other providers in their areas to look for potential problems with conflicts of interest. In addition, we would review available records on a sample basis to determine whether there appeared to be any clear patterns of bias. Finally, we would survey a sample of clients or their guardians who have gone through the intake process to determine whether they received information about all the available service providers in their area, and whether they felt they were steered to a particular provider of services. If conflicts remain, we would make recommendations for how they might be minimized or eliminated.

4. **How could CDDOs be reorganized to maximize the amount of funding available to provide services for the disabled?** We would review the funding structures for CDDOs to determine how changing the number of CDDOs in Kansas could potentially affect the amount of money available from various sources. We would look in detail at proposals made by the Alliance for Kansans with Developmental Disabilities or other proposals that may have been made, and discuss the advantages and drawbacks of such proposals with officials from the CDDOs and affiliated service providers. If we see flaws in the cost savings generated by those proposals, we would recalculate the proposed benefits. Also, if we see opportunities to modify those proposals to make them more cost-beneficial or more acceptable to CDDOs and affiliated service providers, we would do so.

Estimated time to Complete: 10 weeks

Appendix B
Legislative Post Audit Survey
Expenditure of Discretionary Funds
FY 1999 vs. FY 2003

	FY 1999			FY 2003		
	Received	Shared		Received	Shared	
CDDO	$	$	%	$	$	%
Achievement						
State Aid	$ 32,085	$ -	0.0%	$ 20,752	$ -	0.0%
County Mill	$ 76,890	$ 31,890	41.5%	$ 74,345	$ 29,875	40.2%
Total	**$ 108,975**	**$ 31,890**	**29.3%**	**$ 95,097**	**$ 29,875**	**31.4%**
Arrowhead						
State Aid	$ 322,193	$ -	0.0%	$ 226,193	$ -	0.0%
County Mill	$ 546,290	$ -	0.0%	$ 570,222	$ -	0.0%
Total	**$ 868,483**	**$ -**	**0.0%**	**$ 796,415**	**$ -**	**0.0%**
Big Lakes						
State Aid	$ 258,621	$ -	0.0%	$ 181,211	$ -	0.0%
County Mill	$ 402,544	$ -	0.0%	$ 411,600	$ -	0.0%
Total	**$ 661,165**	**$ -**	**0.0%**	**$ 592,811**	**$ -**	**0.0%**
Brown						
State Aid	$ 28,900	$ -	0.0%	$ 15,536	$ -	0.0%
County Mill	$ 28,400	$ -	0.0%	$ 58,606	$ 30,723	52.4%
Total	**$ 57,300**	**$ -**	**0.0%**	**$ 74,142**	**$ 30,723**	**41.4%**
CLASS						
State Aid	$ 199,985	$ -	0.0%	$ 123,565	$ -	0.0%
County Mill	$ 513,485	$ -	0.0%	$ 542,604	$ -	0.0%
Total	**$ 713,470**	**$ -**	**0.0%**	**$ 666,169**	**$ -**	**0.0%**
COF						
State Aid	$ 136,073	$ -	0.0%	$ 81,876	$ -	0.0%
County Mill	$ 239,372	$ -	0.0%	$ 281,752	$ 9,000	3.2%
Total	**$ 375,445**	**$ -**	**0.0%**	**$ 363,628**	**$ 9,000**	**2.5%**
COMCARE						
State Aid	$ 1,260,173	$ 1,260,173	100.0%	$ 888,497	$ 888,497	100.0%
County Mill	$ 2,115,819	$ 1,766,840	83.5%	$ 2,129,595	$ 2,127,182	99.9%
Total	**$ 3,375,992**	**$ 3,027,013**	**89.7%**	**$ 3,018,092**	**$ 3,015,679**	**99.9%**
Cottonwood						
State Aid	$ 157,717	$ -	0.0%	$ 94,784	$ -	0.0%
County Mill	$ 564,600	$ -	0.0%	$ 621,320	$ 31,250	5.0%
Total	**$ 722,317**	**$ -**	**0.0%**	**$ 716,104**	**$ 31,250**	**4.4%**
Cowley County						
State Aid	$ 83,704	$ -	0.0%	$ 39,941	$ 35,611	89.2%
County Mill	$ 144,159	$ 139,906	97.0%	$ 163,335	$ 159,193	97.5%
Total	**$ 227,863**	**$ 139,906**	**61.4%**	**$ 203,276**	**$ 194,804**	**95.8%**
Disability Planning Organization of Kansas (DPOK) (a)						
State Aid	$ 243,838	$ -	0.0%	$ 160,945	$ -	0.0%
County Mill	$ 600,335	$ -	0.0%	$ 119,900	$ -	0.0%
Total	**$ 844,173**	**$ -**	**0.0%**	**$ 280,845**	**$ -**	**0.0%**
Developmental Services of Northwest Kansas (DSNWK)						
State Aid	$ 449,541	$ 46,396	10.3%	$ 313,050	$ 35,281	11.3%
County Mill	$ 936,564	$ 129,193	13.8%	$ 1,018,818	$ 148,592	14.6%
Total	**$ 1,386,105**	**$ 175,589**	**12.7%**	**$ 1,331,868**	**$ 183,873**	**13.8%**
Flinthills						
State Aid	$ 125,180	$ -	0.0%	$ 80,312	$ -	0.0%
County Mill	$ 190,824	$ -	0.0%	$ 185,736	$ -	0.0%
Total	**$ 316,004**	**$ -**	**0.0%**	**$ 266,048**	**$ -**	**0.0%**
Futures						
State Aid	$ 64,970	$ -	0.0%	$ 42,494	$ -	0.0%
County Mill	$ 139,676	$ -	0.0%	$ 162,114	$ -	0.0%
Total	**$ 204,646**	**$ -**	**0.0%**	**$ 204,608**	**$ -**	**0.0%**
Hetlinger						
State Aid	$ 62,612	$ -	0.0%	$ 44,061	$ -	0.0%
County Mill	$ 31,835	$ -	0.0%	$ 39,492	$ -	0.0%
Total	**$ 94,447**	**$ -**	**0.0%**	**$ 83,553**	**$ -**	**0.0%**

(a) DPOK gives all of its discretionary funding to OCCK, a community service provider we determined wasn't independent because it has the same executive leadership and membership on its board of directors as DPOK.

CDDO	FY 1999 Received $	FY 1999 Shared $	FY 1999 Shared %	FY 2003 Received $	FY 2003 Shared $	FY 2003 Shared %
Johnson County						
State Aid	$ 468,180	$ -	0.0%	$ 304,461	$ 180,000	59.1%
County Mill	$ 2,777,192	$ -	0.0%	$ 4,707,993	$ -	0.0%
Total	**$ 3,245,372**	**$ -**	**0.0%**	**$ 5,012,454**	**$ 180,000**	**3.6%**
Multi Community Diversified Services (MCDS)						
State Aid	$ 151,184	$ -	0.0%	$ 103,062	$ 11,183	10.9%
County Mill	$ 113,500	$ -	0.0%	$ 99,735	$ 10,530	10.6%
Total	**$ 264,684**	**$ -**	**0.0%**	**$ 202,797**	**$ 21,713**	**10.7%**
Nemaha County						
State Aid	$ 35,833	$ -	0.0%	$ 23,575	$ -	0.0%
County Mill	$ 60,517	$ -	0.0%	$ 72,017	$ -	0.0%
Total	**$ 96,350**	**$ -**	**0.0%**	**$ 95,592**	**$ -**	**0.0%**
New Beginnings						
State Aid	$ 21,142	$ -	0.0%	$ 12,718	$ -	0.0%
County Mill	$ 77,000	$ -	0.0%	$ 76,445	$ -	0.0%
Total	**$ 98,142**	**$ -**	**0.0%**	**$ 89,163**	**$ -**	**0.0%**
Northview						
State Aid	$ 187,979	$ -	0.0%	$ 128,936	$ 15,878	12.3%
County Mill	$ 140,966	$ -	0.0%	$ 154,500	$ -	0.0%
Total	**$ 328,945**	**$ -**	**0.0%**	**$ 283,436**	**$ 15,878**	**5.6%**
Riverside						
State Aid	$ 147,648	$ -	0.0%	$ 108,437	$ -	0.0%
County Mill	$ 71,319	$ -	0.0%	$ 71,885	$ -	0.0%
Total	**$ 218,967**	**$ -**	**0.0%**	**$ 180,322**	**$ -**	**0.0%**
Shawnee County						
State Aid	$ 333,488	$ 117,674	35.3%	$ 205,599	$ 72,763	35.4%
County Mill	$ 820,942	$ 157,195	19.1%	$ 939,021	$ 191,186	20.4%
Total	**$ 1,154,430**	**$ 274,869**	**23.8%**	**$ 1,144,620**	**$ 263,949**	**23.1%**
Southwest Developmental Services (SDSI)						
State Aid	$ 146,698	$ -	0.0%	$ 190,975	$ 52,447	27.5%
County Mill	$ 880,460	$ 354,479	40.3%	$ 927,042	$ 752,490	81.2%
Total	**$ 1,027,158**	**$ 354,479**	**34.5%**	**$ 1,118,017**	**$ 804,937**	**72.0%**
Sunflower						
State Aid	$ 139,690	$ -	0.0%	$ 87,529	$ -	0.0%
County Mill	$ 334,779	$ -	0.0%	$ 250,023	$ -	0.0%
Total	**$ 474,469**	**$ -**	**0.0%**	**$ 337,552**	**$ -**	**0.0%**
Training and Evaluation Center of Hutchinson (TECH)						
State Aid	$ 204,117	$ -	0.0%	$ 138,803	$ -	0.0%
County Mill	$ 407,500	$ -	0.0%	$ 543,392	$ -	0.0%
Total	**$ 611,617**	**$ -**	**0.0%**	**$ 682,195**	**$ -**	**0.0%**
TRI-KO						
State Aid	$ 150,150	$ 25,979	17.3%	$ 92,712	$ -	0.0%
County Mill	$ 193,484	$ 48,830	25.2%	$ 214,957	$ 55,287	25.7%
Total	**$ 343,634**	**$ 74,809**	**21.8%**	**$ 307,669**	**$ 55,287**	**18.0%**
Tri-Valley						
State Aid	$ 131,500	$ -	0.0%	$ 81,566	$ -	0.0%
County Mill	$ 164,131	$ -	0.0%	$ 179,447	$ -	0.0%
Total	**$ 295,631**	**$ -**	**0.0%**	**$ 261,013**	**$ -**	**0.0%**
Twin Valley						
State Aid	$ 81,946	$ -	0.0%	$ 51,947	$ -	0.0%
County Mill	$ 105,120	$ -	0.0%	$ 96,000	$ -	0.0%
Total	**$ 187,066**	**$ -**	**0.0%**	**$ 147,947**	**$ -**	**0.0%**
Wyandotte						
State Aid	$ 183,263	$ -	0.0%	$ 123,137	$ 84,600	68.7%
County Mill	$ 560,253	$ -	0.0%	$ 525,505	$ 371,007	70.6%
Total	**$ 743,516**	**$ -**	**0.0%**	**$ 648,642**	**$ 455,607**	**70.2%**
STATEWIDE						
State Aid	$ 5,808,410	$ 1,450,222	25.0%	$ 3,966,674	$ 1,376,260	34.7%
County Mill	$ 13,237,956	$ 2,628,333	19.9%	$ 15,237,401	$ 3,916,315	25.7%
Total	**$ 19,046,366**	**$ 4,078,555**	**21.4%**	**$ 19,204,075**	**$ 5,292,575**	**27.6%**

Source: LPA report 00-02; Survey of 28 CDDOs

Appendix C
CDDO Targeted Case Management Distribution Plans for Fiscal Year 2003

CDDO	Administrative Fee	$ for Case Management	$ for Direct Services				
					Distribution Method		
	Amount CDDO Charges	Amount	Set Aside?	Amount	Basis	Description	Who's Eligible For Funds
Achievement	$23.71 (10%)	$142.31	**Yes**	$71.48	By Client	Proportional to the number of services provided (i.e., 1 client in day services = 1 service).	**Clients Served** • Adults **Services** • Day • Residential
Arrowhead	$35.58 (15%)	$135.00	**Yes**	$66.61	By Client	The funds are used to serve clients on the waiting list. Day and residential rates are based on Tier 0 rates	**Clients Served** • Waiting List **Services** • Day • Residential
Big Lakes	n/a	$237.19	No	n/a	n/a	n/a	n/a
Brown County	n/a	$237.19	No	n/a	n/a	n/a	n/a
CLASS, LTD	$5.70 (2.4%)	$175.00	**Yes**	$56.49	By Client and Severity	$47.93 is distributed based on HCBS and Tier 0 payments for day and residential services. $4.28 per unit is paid to a "crisis management" program. $4.28 per unit is held in reserve in case of recoupments.	**Clients Served** • Adults • Children **Services** • Day • Residential • Supp Home Care • Case Management
COF	n/a	$237.19	No	n/a	n/a	n/a	n/a
ComCare	n/a	$170.00	**Yes**	67.19	By Client	$100 per residential client $75 per day client	**Clients Served** • Adults • Children **Services** • Day • Residential

Appendix C (cont.)
CDDO Targeted Case Management Distribution Plans for Fiscal Year 2003

CDDO	Administrative Fee		Case Management	Direct Services				
						Distribution Method		
	Charges Fee?	Amount	Amount	Set Aside?	Amount	Basis	Description	Who's Eligible For Funds
Cottonwood	**Yes**	$16.60 (7%)	$125	**Yes**	$95.59	By Client	$70 per residential client $50 per day client	**Clients Served** • Adults • Children **Services** • Day • Residential
Cowley County	No	n/a	$237.19	No	n/a	n/a	n/a	n/a
Disability Planning Organization of Kansas (DPOK)	**Yes**	$15.00 (6.3%)	$124.18	**Yes**	$97.82	By Client and Severity	Based on HCBS payments for day, residential, and supportive home care services.	**Clients Served** • Adults • Children **Services** • Day • Residential • Supp Home Care
Developmental Services of Northwest Kansas (DSNWK)	No	n/a	$115.40	**Yes**	$121.79	By Client	Case mgt providers that also participate in the CDDOs capacity plan get the full reimbursement. TCM only providers only get $115.40 (currently, there aren't any of these).	See Description
Flinthills	No	n/a	$237.54	No	n/a	n/a	n/a	n/a
Futures	**Yes**	$47.44 (20%)	$110.00	**Yes**	$79.75	By Client and Severity	Based on HCBS payments for adult day and residential services.	**Clients Served** • Adults **Services** • Day • Residential
Hetlinger	No	n/a	$237.19	No	n/a	n/a	n/a	n/a
Johnson County	**Yes**	$17.19 (7.2%)	$220.00	No	n/a	n/a	n/a	n/a

Appendix C (cont.)
CDDO Targeted Case Management Distribution Plans for Fiscal Year 2003

CDDO	Administrative Fee		Case Management	Direct Services				
						Distribution Method		
	Charges Fee?	Amount	Amount	Set Aside?	Amount	Basis	Description	Who's Eligible For Funds
Multi Community Diversified Services (MCDS)	**Yes**	$11.53 (4.9%)	$123.00	**Yes**	$102.66	By Client and Severity	Based on HCBS payments for day, residential, and supportive home care services.	**Clients Served** • Adults • Children **Services** • Residential • Supp Home Care
Nemaha County	**Yes**	$7.50 (3.2%)	$120.00	**Yes**	$110.04	By Client	Proportional to the number of services provided.	**Clients Served** • Adults • Children **Services** • Day • Residential
New Beginnings	No	n/a	$237.19	No	n/a	n/a	n/a	n/a
Northview	**Yes**	$7.11 (3.0%)	$137.00	**Yes**	$93.08	By Client and Severity	Based on HCBS payments for day, residential, and supportive home care services.	**Clients Served** • Adults • Children **Services** • Day • Residential • Supp Home Care
Riverside	**Yes**	$11.87 (5.0%)	$225.67	No	n/a	n/a	n/a	n/a
Shawnee County	**Yes**	$17.00 (7.2%)	$119.00	**Yes**	$101.19	By Client and Severity	Based on HCBS and Tier 0 payments for day and residential services. 15% of the pool is held in reserve, to be distributed the following quarter.	**Clients Served** • Adults **Services** • Day • Residential

Appendix C (cont.)
CDDO Targeted Case Management Distribution Plans for Fiscal Year 2003

CDDO	Administrative Fee		Case Management	Direct Services				
						Distribution Method		
	Charges Fee?	Amount	Amount	Set Aside?	Amount	Basis	Description	Who's Eligible For Funds
Southwest Developmental Services (SDSI)	No	n/a	$185.00	**Yes**	$52.19	By Client and Severity	$47.10 is distributed based on HCBS payments for day and residential services. $5.00 is used for case manager training.	**Clients Served** • Adults **Services** • Day • Residential
Sunflower	No	n/a	$115.00	**Yes**	$122.35	By Client	Case mgt providers that also participate in the CDDOs capacity plan get the full reimbursement. TCM only providers only get $115.40 (currently, there aren't any of these).	See Description
Training and Evaluation Center of Hutchinson (TECH)	**Yes**	$12.04 (5.1%)	$127.00	**Yes**	$98.15	By Client and Severity	Based on HCBS payments for day, residential, and supportive home care services.	**Clients Served** • Adults **Services** • Day • Residential • Supp Home Care
Tri-Ko	**Yes**	$25.00 (10.5%)	$125.00	**Yes**	$87.35	By Client and Severity	Based on HCBS and Tier 0 payments for day and residential services.	**Clients Served** • Adults • Children **Services** • Day • Residential • Supp Home Care
Tri-Valley	No	n/a	$237.19	No	n/a	n/a	n/a	n/a
Twin Valley	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Wyandotte County	No	n/a	$237.19	No	n/a	n/a	n/a	n/a

Appendix D
CDDO Administration Expenditures Per Client
FY 2000 vs. FY 2003

	FY 2000			FY 2003			% Change (FY 2000 to FY 2003)		
	CDDO Admin Expenditures	Number of Clients as of May 2000 (a)	Expenditures Per Client	CDDO Admin Expenditures	Number of Clients as of May 2003 (a)	Expenditures Per Client	CDDO Admin Expenditures	Number of Clients (a)	Expenditures Per Client
CDDO									
Achievement	$ 45,886	86	**$ 534**	$ 83,911	93	**$ 902**	82.9%	8.1%	**69.1%**
Arrowhead West	$ 268,893	303	**$ 887**	$ 191,452	276	**$ 694**	(28.8%)	(8.9%)	**(21.8%)**
Big Lakes	$ 140,552	220	**$ 639**	$ 125,759	217	**$ 580**	(10.5%)	(1.4%)	**(9.3%)**
Brown County (b)	n/a	73	**n/a**	n/a	77	**n/a**	n/a	5.5%	**n/a**
CLASS	$ 374,408	565	**$ 663**	$ 400,915	575	**$ 697**	7.1%	1.8%	**5.2%**
COF	$ 142,062	238	**$ 597**	$ 213,747	253	**$ 845**	50.5%	6.3%	**41.5%**
COMCARE	$ 837,852	1,189	**$ 705**	$ 627,115	1,298	**$ 483**	(25.2%)	9.2%	**(31.4%)**
Cottonwood	$ 390,336	382	**$ 1,022**	$ 431,381	478	**$ 902**	10.5%	25.1%	**(11.7%)**
Cowley County	$ 205,403	285	**$ 721**	$ 259,389	284	**$ 913**	26.3%	(0.4%)	**26.7%**
Devel. Serv. of NW Ks. (DSNWK)	$ 282,701	456	**$ 620**	$ 471,628	452	**$ 1,043**	66.8%	(0.9%)	**68.3%**
Disab. Planning Org. of Ks. (DPOK)	$ 319,601	438	**$ 730**	$ 565,754	472	**$ 1,199**	77.0%	7.8%	**64.3%**
Flinthills	$ 146,459	147	**$ 996**	$ 182,096	145	**$ 1,256**	24.3%	(1.4%)	**26.0%**
Futures	$ 85,075	77	**$ 1,105**	$ 167,455	72	**$ 2,326**	96.8%	(6.5%)	**110.5%**
Hetlinger	$ 107,926	175	**$ 617**	$ 176,639	172	**$ 1,027**	63.7%	(1.7%)	**66.5%**
Johnson County	$ 503,410	875	**$ 575**	$ 522,087	947	**$ 551**	3.7%	8.2%	**(4.2%)**
Multi Comm. Div. Serv. (MCDS)	$ 143,319	161	**$ 890**	$ 136,780	168	**$ 814**	(4.6%)	4.3%	**(8.5%)**
Nemaha County (b)	n/a	76	**n/a**	n/a	66	**n/a**	n/a	(13.2%)	**n/a**
New Beginnings	$ 99,744	65	**$ 1,535**	$ 89,281	69	**$ 1,294**	(10.5%)	6.2%	**(15.7%)**
Northview	$ 73,835	142	**$ 520**	$ 100,109	159	**$ 630**	35.6%	12.0%	**21.1%**
Riverside	$ 102,761	129	**$ 797**	$ 155,905	125	**$ 1,247**	51.7%	(3.1%)	**56.6%**
Shawnee County	$ 419,122	680	**$ 616**	$ 556,903	698	**$ 798**	32.9%	2.6%	**29.4%**
Southwest Dev. Serv. (SDSI)	$ 479,980	349	**$ 1,375**	$ 565,325	413	**$ 1,369**	17.8%	18.3%	**(0.5%)**
Sunflower	$ 181,623	221	**$ 822**	$ 237,052	245	**$ 968**	30.5%	10.9%	**17.7%**
Train. & Eval. Ctr. of Hutch. (TECH)	$ 169,990	234	**$ 726**	$ 182,940	217	**$ 843**	7.6%	(7.3%)	**16.0%**
TRI-KO	$ 157,541	200	**$ 788**	$ 251,246	198	**$ 1,269**	59.5%	(1.0%)	**61.1%**
Tri-Valley	$ 213,302	195	**$ 1,094**	$ 217,186	230	**$ 944**	1.8%	17.9%	**(13.7%)**
Twin Valley	n/a	103	**n/a**	n/a	95	**n/a**	n/a	(7.8%)	**n/a**
Wyandotte County	$ 310,106	327	**$ 948**	$ 414,191	342	**$ 1,211**	33.6%	4.6%	**27.7%**
Statewide	**$ 6,201,887**	**8,391**	**$ 762** (c)	**$ 7,326,246**	**8,836**	**$ 852** (c)	**18.1%**	**5.3%** (a)	**11.8%** (c)

(a) These counts include clients served in intermediate care facilities because CDDOs are responsible for these clients. As we noted in the overview, the growth of the "community-based" population over the same time period was 8%.

(b) Brown County, Nemaha County, and Twin Valley don't track CDDO Administration expenditures in their accounting systems.

(c) Based on the 25 CDDOs that track CDDO Administration expenditures.

Source: Survey of 28 CDDOs, CDDO Funding Allocation Spreadsheets Prepared by SRS

Appendix E
Projected Impact of the Alliance Consolidation Proposal On Fiscal Year 2003 Federal Funds Drawn Down By CDDOs As Adjusted by Legislative Post Audit
(in millions)

CDDO Area	Total Local Funds Available	FY 2003 (Before Rate Increase)			Max Increase to Case Mgt Rate Each CDDO Can Absorb	FY 2003 (After Rate Increase)			Increase in Federal Funds After Consolidation
		Local Funds (Matched)	Local Funds (Un-matched)	Federal Funds		Local Funds (Matched)	Local Funds (Un-matched)	Federal Funds	
Area 1 (DSNWK)	$1.8	$0.8	$1.0	$1.2	127%	$1.0	$0.8	$1.5	$0.3
Area 2 (SDSI)	$1.6	$0.6	$1.0	$0.9	178%	$0.7	$0.9	$1.1	$0.2
Area 3 (Arrowhead)	$1.5	$0.4	$1.1	$0.6	279%	$0.5	$1.0	$0.8	$0.2
Area 4 (ComCare)	$5.6	$2.4	$3.2	$3.6	134%	$3.1	$2.5	$4.6	$1.0
Area 5 (CLASS, Cowley Co., Flinthills, Futures, New Beginnings)	$2.5	$2.0	$0.6	$3.0	**28%**	$2.5	$0.0	$3.8	$0.8
Area 6 (MCDS, Northview, Sunflower, TECH)	$2.3	$1.4	$0.9	$2.1	67%	$1.7	$0.5	$2.6	$0.6
Area 7 (DPOK)	$1.5	$0.8	$0.7	$1.2	89%	$1.0	$0.5	$1.5	$0.3
Area 8 (Achievement, Big Lakes, Brown Co., Nemaha Co., Twin Valley)	$2.1	$0.8	$1.2	$1.2	152%	$1.0	$1.0	$1.6	$0.3
Area 9 (Wyandotte Co.)	$1.3	$0.7	$0.6	$1.0	94%	$0.8	$0.4	$1.3	$0.3
Area 10 (Johnson Co.)	$5.5	$1.5	$4.1	$2.2	279%	$1.9	$3.7	$2.8	$0.6
Area 11 (Cottonwood, Riverside)	$1.7	$0.9	$0.8	$1.4	91%	$1.2	$0.6	$1.8	$0.4
Area 12 (Shawnee Co.)	$2.0	$1.2	$0.8	$1.7	73%	$1.5	$0.5	$2.2	$0.5
Area 13 (COF, Hetlinger, Tri-Ko, Tri-Valley)	$2.9	$1.4	$1.5	$2.1	103%	$1.8	$1.1	$2.7	$0.6
STATEWIDE	**$32.1** (a)	**$14.7**	**$17.5**	**$22.1**	**28%**	**$18.7**	**$13.4** (a)	**$28.2**	**$6.1**

(a) Includes $7.5 million in federal funds that can't be used as matching funds.

Source: Fiscal Year 2003 Consolidation Proposal from the Alliance for Kansans With Disabilities, adjusted by Legislative Post Audit

Because Area 5 is least able to absorb an increase in the case management rate, it limits the increase that SRS can make for the whole system to 28%.

APPENDIX F

Agency Responses

On October 8, we provided copies of the draft audit report to the Department of Social and Rehabilitation Services and to the 28 CDDOS. The Department's response and a consolidated response submitted on behalf of 24 CDDOs are included as this appendix. In addition, 24 CDDOs also submitted individual responses, which have been bound separately because of volume. These responses will be made available upon request.

After carefully reviewing the responses we made some clarifications, as well as minor corrections and changes, to the draft audit. In addition, we modified one conclusion and recommendation after learning SRS had already taken appropriate action.

JANET SCHALANSKY, SECRETARY

KANSAS

SOCIAL AND REHABILITATION SERVICES

KATHLEEN SEBELIUS, GOVERNOR

October 16, 2003

Ms. Barbara J. Hinton
Legislative Division of Post Audit
800 SW Jackson Street, Suite, 1200
Topeka, Kansas 66612-3792

Dear Ms. Hinton,

Thank you for the opportunity to review the completed performance audit, **CDDOs: Reviewing the Issues Related to the Funding of Community Services**. Below, you will find the SRS responses to the recommendations that begin on page 46 of the report. In addition, several technical recommendations are attached.

Recommendation, Pg. 46:

4. To better understand the reasons why CDDOs appear to be serving more of the less severely disabled clients within some tiers, SRS should analyze the reasons for the patterns we saw, and should assess whether CDDOs are benefitting financially.

Response:
The Developmental Disabilities Reform Act requires SRS to contract with an entity on a bi-annual basis, to perform a review of the reimbursement rates provided by the State. We are currently in the midst of such a review and anticipate having the results by the end of October, 2003. Information contained in the rate study should assist us in an effort to analyze the patterns discovered in this Post Audit report and assess whether CDDOs are benefitting financially.

Recommendation, Pg. 46-47

5. To ensure that reimbursements for targeted case management services are distributed equitably and fairly among all providers, and that CDDOs aren't able to develop plans that benefit them unfairly compared with other community providers, SRS should develop contract language that accomplishes the following:

a. limits the amount of administrative fees that CDDOs can charge to cover the cost of distributing targeted case management funds to service providers.

b. Either requires CDDOs to provide the remainder of the funds to the provider of case management services requires each CDDO to develop a formal plan for how the remaining funds will be distributed and submit that plan to SRS for approval. SRS should develop guidelines for the types of distribution plans that are acceptable.

Response:
From information contained in the report, it appears that 21 CDDOs are currently distributing funds in some equitable manner. SRS will work with all CDDOs, through it's contracting process, to further address equitable distribution of these funds

Recommendation, Pg. 47

6. To improve the State's ability to monitor the reasonableness of CDDO Administration costs, SRS should identify the types of costs that are allowable under this category, and should require CDDOs to compute and report their expenditures on a consistent, uniform basis. That information can then be reviewed and analyzed to help explain reasons for significant variations in expenditures per client to help identify any changes that might be needed to ensure those costs are more reasonable, and to assess the potential cost implications of changing the way the State's developmental disability system is administered.

Response:
SRS will work with CDDOs to develop a more consistent manner to review expenditures related to CDDO Administration. It should be noted that over the past two Fiscal Years, the State contribution to CDDO Administration has been reduced and there has been a greater reliance placed on using local dollars to provide the necessary match funding to draw down federal administrative match funding.

Recommendation, Pg. 47-48

7. If CDDOs are allowed to continue providing services to clients in competition with other service providers, SRS should take the following actions to help minimize the conflicts that arise:

a. To ensure that parents and guardians are being given adequate information about services and providers in the area, SRS should require all CDDOs to document that such information was made available by having parents or guardians sign a form annually, indicating they'd been informed of available services and service providers in the area.

Response:
Currently, the SRS Quality Enhancement Coordinators review CDDO areas on a regular basis to ensure that parents and guardians are provided information annually regarding the choices of available service providers in their areas. SRS will look to add language to the FY05 contract between SRS and the CDDO's that will require the CDDOs to demonstrate that they are assuring all families and guardians receive information regarding the array of service providers available in the CDDO area.

During September of 2003, the Centers for Medicare and Medicaid Services (CMS) completed their five year review of the HCBS-MR/DD waiver. A part of their visit included reviewing consumer files. It should be noted that CMS found signed documentation for 100% of the consumer files reviewed indicating that consumers/guardians had been given information regarding the array of service providers in their CDDO area and that the consumer had been given the opportunity to choose his/her preferred provider.

b. To help minimize the contractual problems that can arise between CDDOs and community service providers, SRS should inform all CDDOs of the types of contract provisions that have caused problems, and should provide them with guidance on how to avoid such provisions. This could be done through updating an affiliate contract template SRS created the first years after the Reform Act was passed.

Response:
SRS will convene a work group during this Fiscal Year to review the current affiliate contract template and make necessary revisions. As a part of their work, the group will identify which provisions of the agreement have caused problems in the local areas and brainstorm suggestions regarding how to eliminate or reduce the problems. This process will be completed in a manner that allows the products of the work group to be available before the beginning of contract negotiations for FY05.

c. **To provide some controls over CDDOs' ability to decide which clients receive extraordinary funding, SRS should amend its contracts with the CDDOs to allow them to reduce or eliminate that funding only if clients' annual assessment scores improved to justify such a change. Such a change would be keeping with the proviso passed by the 2003 Legislature. Further, SRS should require that the CDDO funding committees include staff from community service providers.**

Response:
Beginning on October 21, 2003, as specified in this year's FY04 contract between SRS and the CDDOs, SRS will convene a work group comprised of SRS staff, CDDO representatives and community service providers. The task of the workgroup is to make a recommendation to SRS on the type of assessment tool that will be implemented statewide to evaluate any person applying for extraordinary funding. The tool chosen for state wide implementation must yield valid and reliable measurements and/or indices that will be consistent with the following:

1. Any/all settings (HCBS, State Mental Retardation Hospitals, and Private Intermediate Care Facilities for Persons with Mental Retardation)
2. All locations (urban and rural)
3. All providers (large and/or small), and
4. Clearly defines and targets 'extraordinary' need.

The work group will review six tools and assess each tool for validity and reliability. The benchmark against which all tools will be measured is BASIS, the current statewide assessment tool, which has been determined to be valid and reliable and is used in many states. As a part of this process, criteria will be established regarding circumstances in which funding can be reduced or eliminated.

As the extraordinary funding work group progresses, a second group or subcommittee will be developed to create policy recommendations. Inclusion of community service providers on CDDO funding committees will be addressed by this policy.

d. **To eliminate the conflict of interest that exists by requiring CDDOs to perform quality assurance over their own providers, SRS should amend its regulations to require SRS staff to take the lead role in performing such reviews of CDDOs' service providers.**

Response:
Each recognized CDDO is required to establish a quality assurance (QA) committee. These committees are typically either part of the Council of Community Members or report to the Council of Community Members. The State takes the lead responsibility for the CDDO QA committees, by requiring each CDDO to submit a specific policy regarding the fulfillment of Article 30-64-27. The policies are approved and monitored by SRS. State staff (QEC) locally meet regularly with CDDO QA Committees to review monitoring activities, trend findings, and review CAP responses. The CDDO QA committee requirement is designed to augment to the Quality Enhancement responsibilities of the state staff persons. The CDDO QA responsibilities are specifically responsible for monitoring to ensure that the services paid for are delivered and that the delivered service meets the quality expectations of the person and the family or guardian.

The state staff have an integral role in the CDDO QA process. The CDDO QA committee review all findings with the state staff persons (Quality Enhancement Coordinators) to ensure that both the CDDO and the state (SRS) are observing similar types of issues in their separate monitoring activities.

Sincerely,

Janet Schalansky
Secretary

Attachment

Additional SRS Comments and Recommendations for Inclusion in the LPA regarding CDDOs

General Comments

Page 30 – SRS is currently considering a proposal for a 29th CDDO in Barton County.

Response:

SRS is considering the proposal for a 29th CDDO at this time. The Barton County Commission submitted it's proposal to SRS for approval on January 13, 2003 for consideration. Since that time we have requested further information from them. In addition, we met with Barton County representatives from Barton county regarding their additional responses and have requested further information as a result of that meeting.

Technical Recommendations:

- Page 1/Paragraph 1: The stated policy of the Developmental Disability Reform Act is to assist persons who have a developmental disability to receive services and supports that increase their integration and inclusion in the community. There is nothing that states, "rather than in institutional settings."

- The Act did not result in closing state mental retardation institutions. Norton State Hospital and Winfield State Hospital were closed because of the successful placement of large numbers of persons into individually developed community settings. These placements were a result of the Community Integration Project (CIP) which began long before the passage of the Act. The Act, however, did codify the concepts used by the CIP in developing community services for these people.
- Page 3/Paragraph 3: "Since 1988, Norton and Winfield State Hospitals have been closed and Kansas Neurological Institute **and Parsons State Hospital and Training Center have** been significantly downsized...."

- Page 3/Paragraph 4: "When the 1995 Legislature passed the Developmental Disabilities Reform Act, it set up a new **administrative structure for community services**....." Service delivery did not significantly change

- Page 4/Paragraph 4: ".....eligible for the **HCBS Medicaid waiver** if they **were eligible to receive** services in an institutional setting....."

- Page 4/Paragraph 5: "Other funds that flow through the State come primarily from State General Fund and Social Services Block Grant **provide supports and services for persons who are not eligible for the HCBS Medicaid waiver. State General Funds, including State Aid, are also used to match federal Medicaid funds."**

- Page 5/Paragraph 1: "...but who **are** eligible for State and Federal Block Grant moneys outside **the HCBS Medicaid waiver."**

- Page 23/Table: SRS believes it may be somewhat misleading to compare CDDO Administration expenditures with direct service payments. It is not know, and it is very likely, CDDOs and CSPs expended more funds for services than SRS paid. Therefore, it might be more useful to compare administration expenditures with service expenditures. However, SRS realizes in the absence of the rate study, this data may not be available. So SRS suggestions another comparison that compares the amount paid for CDDO administration with the amount paid for services might be useful. That comparison is shown in the table below:

Comparison of Payments Made for CDDO and Direct Services				
Category	FY 2000	FY 2001	FY 2002	FY 2003
CDDO Administration*	$5.2	$5.3	$5.7	$5.9
Direct Services				
HCBS Waiver	$170.5	$176.6	$189.7	$194.7
Non-Waiver	$15.4	$15.4	$13.6	$13.9
Total Administration & Services	$191.1	$197.3	$209.0	$214.5
Per Cent Administration	2.7%	2.7%	2.7%	2.8%
* Includes state funds and federal matching funds paid to the CDDOs.				

Comprehensive CDDO Response to LPA Draft Report

October 15, 2003

The following thoughts were received from as many as 24 CDDOs that indicated they had concerns about some of the findings in the draft Legislative Post Audit Report; *CDDOs: Reviewing the Issues Related to the Funding of Community Services.* While many CDDOs may choose to offer individual feedback about the contents of the draft report, we believe it is helpful to gather something approaching a statewide perspective in a single response.

Please be advised that the process utilized to provide this feedback causes some CDDOs to question how it will be received. We understand that there are legal requirements concerning who receives a draft copy and with whom that copy can be shared, and we believe those requirements are problematic. Because of them, there is no capability for CDDOs to consult with other service providers within the system concerning the validity of views expressed in the report. We believe it is very likely that many non-CDDO service providers would have identified the same shortcomings in the LPA report that CDDOs did, however your office can only report that feedback was received exclusively from CDDOs. Disallowing other community service providers from participating in this feedback process eliminates the opportunity for a well-rounded, system-wide view of the issues being examined.

While we understand that the performance audit was completed to satisfy the scope statement, which was created at the request of Senator Morris, much of the specific focus and flavor of the report appears to have come from system stakeholders. In several instances it appears the focus of study on a particular issue probably stemmed from suggestions of service providers that are not also CDDOs. The reorganization plan created by The Alliance is one area of study that was identified in the scope statement. However, many of the assertions and points of view within the report seem to also reflect opinions of The Alliance or its members that were not expressed in the reorganization report. Those familiar with The Alliance's advocacy issues could draw the conclusion that The Alliance or its members were given extraordinary input into the creation of this report that was not also afforded to any participating CDDO.

On a general note, the portrayal of InterHab as a "lobbyist organization representing CDDOs" and The Alliance for Kansans with Developmental Disabilities as an agency "which represents community service providers" is misleading. While InterHab counts 27 of the existing 28 CDDOs amongst its membership, it also has a large membership base of non-CDDO community service providers, far more than The Alliance can claim. Additionally, The Alliance contracts with a lobbyist and should therefore also be categorized as a "lobbyist organization." Clarification of these points in your final report should help eliminate confusion about the roles of both organizations.

We certainly hope that the attached comments will be considered as they are offered; not to be argumentative, but rather to suggest that the report lacks balance and complete factual content in some areas.

Consumer Severity Issues

There were recurring references to the fact that non-CDDOs seemed more inclined to serve clients with greater needs and also that CDDOs seemed to serve the clients with lesser support needs within tiers. While there is likely some numerical evaluation that went into these conclusions, two very important considerations did not appear to have been taken into account:

- There are CDDOs that provide no services and depend entirely on CSPs to serve clients. The largest CDDO in the state presently must refer all clients to CSPs for service, thus that area would obviously have an entirely disproportionate amount of referrals of higher-needs clients to other providers. There was no indication that the numbers were adjusted for areas where this system configuration is utilized.

- Dealing with more severe needs is still a fairly recent development. Some CDDO/CSPs have been providing services for decades, but have only been tasked with meeting the needs of clients with exceptional support needs during the past 10 years. At the same time the general level of support needs increased, the system was reformed and new providers entered the system. CMRCs became CDDOs, but continued to serve the same clients they had served for years. To effectively evaluate whether clients with higher needs are being inappropriately directed to CSPs rather than CDDOs, the study would need to look at the following factors only:
    - Provider selections made since the adoption of DD Reform by tier,
    - Number of CSPs that choose to serve higher-needs, or Medicaid-eligible clients only,
    - Number of CDDOs that are the only source of services for individuals who are not Medicaid eligible.

- Annual assessment scores do not necessarily correlate with the amount of support that will be required to meet the needs of the individual. If an assumption of the audit is that a higher score is always more difficult to serve than a lower score, that is simply not the case. While the study looked at scores within tiers, the assessment tool is designed in such a way that an individual could be classified in a tier with lower reimbursement rates and require more support and staff assistance than individuals in tiers with higher reimbursement rates.

- The first paragraph on page 1 is inaccurate or misleading in various different ways. The intent of the paragraph seems to be that most funding is distributed to waiver-eligible people who receive different reimbursement rates through tiers. Assumptions included about severity of clients' disabilities, CSPs serving more of the most severely disabled individuals and CDDOs serving less severe clients within tiers are nothing more than assumptions or opinions that would be difficult to substantiate through a cursory examination of BASIS scores.

- The draft report includes a statement that indicates CDDOs were not capable of meeting higher-needs clients leaving state hospitals. While it is obvious that this assertion is almost always not correct, we would further question the origin of this statement that was inserted as fact. We doubt that any CDDOs indicated they were not capable of meeting the needs of individuals leaving state hospitals.

- Indicating that CDDOs serve grant-funded individuals and CSPs serve those who are waiver-funded is misleading. While there may be numbers to indicate that CDDOs are more likely to serve those who are not Medicaid-eligible, both CDDOs and non-CDDOs serve clients with both funding sources across the state.

- The only true way to distribute funding according to severity as the report seems to support is to improve the ability of the DDP to determine the relative level of support required by each individual and then take appropriate steps to increase the reimbursement rates for each need level. Increasing CDDO administration, case management rates, or adjusting state aid funding will not accomplish this goal.

Funding Issues

Assertions that CDDOs receive discretionary funding and then only use those funds to further the CDDO's financial position are not accurate.

- As the entity that contracts with the State, CDDOs are expected to meet the needs of people who are eligible for the service system even if they are not eligible for Medicaid. If all discretionary funding is distributed to enhance funding for those who are Medicaid eligible, the considerable population of individuals who are not Medicaid eligible cannot be supported.

- At least two CDDOs that were listed as not sharing discretionary funding indeed do share that funding. It may make good sense to double check which CDDOs share discretionary funding before drawing conclusions that the number who share is not acceptable.

- Was enough information requested and provided to determine HOW discretionary dollars are utilized by CDDOs? The underlying assumption of the report is that the funding is used to better the financial position of the CDDO, however we would contend that it is routinely used to make programs available that would otherwise not be available.

- Profile I-2 concerning the new federal funding for FY02 does a good job of explaining why the funding was not allowed by CMS, but does not explain that the funds had already been distributed to providers of services across the state. If all a reader took into consideration were this bold profile, it would appear CDDOs received $6.8 million in funding without strings attached from SRS. This is simply not accurate.

Targeted Case Management (TCM) Issues

Case management is always a source of confusion for those who are not generally involved in the service system. This report is another example of how the system may be difficult to understand for those who don't regularly work in it.

- As previously indicated, there is no process by which funding – including TCM funding – can be distributed based on severity. CDDOs utilized the new funding made available through TCM based on a local interpretation of legislative intent because SRS was not willing to clarify legislative intent. Because of the reasons given for recoupment of the first maximization funds, CDDOs were not uniformly comfortable that the new funding could be used specifically to increase reimbursement for individuals who were already Medicaid funded. Some CDDOs paid the entire rate out to TCM providers and others used varying percentages of the rate for "capacity building" as specified in statute.

- The chart on page 16 and other references inaccurately give the impression that there was a rate increase for case management. In actuality, the system changed from an hourly rate to a monthly encounter rate. Because of this, some providers that were apt to bill more hours per client may not have seen an increase in TCM reimbursement. The suggestion from SRS when the system change was implemented was that the CDDOs become the sole Medicaid providers for TCM, pay a locally negotiated rate to performing providers and use any remaining funds for local system building.

- Did CDDOs create TCM distribution plans that were more beneficial to them as indicated in the report, or that were beneficial to other types of services being provided? As the entity receiving the TCM funds, the unwritten expectation from SRS was to utilize funding received to benefit both TCM and other types of services if possible. If the CDDO is the largest provider of other services, retaining a larger share of any remaining TCM funds would seem to comply with the suggestions of SRS and statutory language that speaks to capacity building.

- We believe that CDDOs are paid the same TCM rates as non-CDDOs in each area. The report was not clear on this point.

CDDO Administration Issues

The information presented under question #2 gives the impression that any growth in CDDO administrative funding is inappropriate. No information is presented to indicate that CDDO admin was not prioritized over other funding, it was instead one of the limited areas where available funding could be increased without scrutiny from Medicaid. Additionally, information presented in this area seems incomplete or misleading:

- Growth in CDDO administrative costs is natural as the costs of salaries and benefits commonly go up in subsequent years. Additionally SRS routinely

changes the expectations for CDDOs, which may increase the duties of CDDOs and increase costs.

- Overall, CDDO administrative expenditures still seem to be a very acceptable percentage of expenditures for the service system.

- The need to fund system functions under the CDDO administrative funding was mentioned, but not fully explained. Because there has been so much difficultly in maximizing other types of funding, some CDDOs have found ways to appropriately charge system support functions to CDDO administration. In doing this, other resources are made available to fund client services.

Conflict of Interest Issues

Due to the recurring theme of "inherent conflict of interest" in this section, the reader is caused to assume the current system is generally not functioning well without adequate information or analysis to make their own conclusion.

- Two examples of substantial CDDO/CSP conflict were cited in the report (Cowley and Barton counties) following 8 years of business relationships in 28 CDDO areas. Is there some evidence to suggest that there would be fewer instances of conflict between CDDOs and CSPs if CDDOs were separate from service providers for a similar length of time?

- Ninety-four percent of families surveyed indicated they believe they were made aware of their service choices, which seems very good. The report ignores its own statistic and then fails to uncover an existing SRS policy that requires CDDOs to document that individuals have been made aware of their choices. Both of these oversights give the impression that the report's opinion concerning service choices was made without consideration of the facts.

- The reference to competition between CDDOs and CSPs seems to assume that both parties are vying to be selected by new clients. Were those parties that were surveyed asked whether they were actively trying to increase the number of clients they serve or build new programs?

- There is an assertion that CDDOs inappropriately govern the use of special tiers. While this is commonly not accurate, the data indicates that CSPs do utilize a significantly higher number of special tiers than CDDO providers.

- There seems to be judgment concerning whether CDDOs are using funding appropriately to benefit all providers, but that really isn't the role of a CDDO. As designed, the role of a CDDO is to create a local service system that benefits individuals who need services. Unfortunately that may not always look like the best use of available funding to providers that are not similarly responsible for maintaining a diverse and accessible local service system.

Reorganization for Maximization of Funding

- Simply assuming that fewer CDDOs is a cheaper and more efficient way of doing business is only an assumption. There are presently efficiencies experienced because CDDO can utilize common positions to benefit both the CDDO and CSP. If the positions must be separate, the same efficiencies may not be possible.

- As regards the mischaracterization of the Alliance representing service providers and InterHab being only a lobbying organization for CDDOs, can we have an attachment that shows the memberships of both organizations? We believe it would illustrate that InterHab is an organization where CDDOs and non-CDDOs work together to serve a substantially larger number of people with disabilities in Kansas. If the report was based on an assumption that the Alliance speaks for the majority of clients in the state who are not served by CDDO/CSPs, we believe that is simply not correct.

- There is no correlation between the number of CDDOs and oversight role of SRS. Any hope that the number of positions at SRS would decrease with fewer CDDOs is simply not accurate.

- The report was not clear that maximization of remaining funding can ONLY take place by affecting services to those who are not Medicaid eligible. While The Alliance has indicated its plan was not intended to harm services for this population, the inability to further maximize case management funding only leaves the non-Medicaid funding as a target for further maximization.

- The report indicates that additional transportation costs are not a real concern. This would not be accurate if discretionary funding that presently supplements transportation costs of the CDDO in some areas is redistributed. Additionally, there needs to be more information about the cost of CDDO transportation to help people access the system versus the cost of transportation so that people who are in the system can actually get to the service site.

In closing, we would again indicate that the thoughts expressed above do not necessarily represent the views of all 28 CDDOs. Each CDDO that offered input during discussion was not asked to cast a vote on each point presented here. In general we believe all comments are supported by the vast majority of CDDOs in the state. Further, we have recommended that each CDDO that submits an individual response take the time to indicate its level of support for this consolidated response.

Thank you for providing the opportunity to gather this feedback and make it available to you prior to finalizing the audit report.