PERFORMANCE AUDIT REPORT

Medicaid Waivers: Reviewing Differences in Rates and Hours of Service for Clients Receiving Self-Directed and Agency-Directed Care

Part II: The Department of Social and Rehabilitation Services' Physical Disability Waiver

A Report to the Legislative Post Audit Committee
By the Legislative Division of Post Audit
State of Kansas
May 2006

06PA04

Legislative Post Audit Committee
Legislative Division of Post Audit

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May 8, 2006

To: Members, Legislative Post Audit Committee

Senator Les Donovan, Chair	Representative John Edmonds, Vice-Chair
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This report contains the findings, conclusions, and recommendations from our completed performance audit, *Medicaid Waivers: Reviewing the Differences in Rates and Hours of Service for Clients Receiving Self-Directed and Agency-Directed Care, Part II: The Department of Social and Rehabilitation Services' Physical Disability Waiver.*

The report includes several recommendations to help ensure that clients with similar disability scores are treated consistently; to help control Medicaid spending on the physical disability waiver; and to help ensure accurate and complete waiver data.. We would be happy to discuss these recommendations or any other items in the 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

READER'S GUIDE

Get the Big Picture

Read these Sections and Features:

1. **Executive Summary** - an overview of the questions we asked and the answers we found.

2. **Conclusion** and **Recommendations -** are referenced in the Executive Summary and appear in a box after each question in the report.

3. **Agency Response** - also referenced in the Executive Summary and is the last Appendix.

Helpful Tools for Getting to the Detail

- In most cases, an "**At a Glance**" description of the agency or department appears within the first few pages of the main report.
- **Side Headings** point out key issues and findings.
- **Charts/Tables** may be found throughout the report, and help provide a picture of what we found.
- **Narrative text boxes** can highlight interesting information, or provide detailed examples of problems we found.
- **Appendices** may include additional supporting documentation, along with the audit **Scope Statement** and **Agency Response(s)**.

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EXECUTIVE SUMMARY

LEGISLATIVE DIVISION OF POST AUDIT

Overview of the Physical Disability Waiver Program

Medicaid waivers allow states to pay for long-term care in the community, rather than in institutional settings. *These community-based services are intended to prevent or delay placing people in an institutional setting. All service plans provided under the waiver must be developed by a center for independent living or a home health agency. The most common service provided under the waiver is attendant care–assistance with tasks such as bathing, dressing, shopping and cooking. Case managers develop "plans of care" at least once a year for physical disability waiver services*

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About 87% of the clients on the physical disability waiver have chosen to "self-direct" their care. *This means the client is responsible for hiring, training, and supervising his or her own attendants, and the client must sign up with a payroll agent to bill Medicaid. Alternatively, clients can choose to have a home health agency be in charge of providing services, hiring and supervising attendants, and paying them. There are few limits on the amount of service Medicaid will pay for.*

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What Are the Differences in the Cost and Hours of Service for Clients Receiving Self-Directed Versus Agency-Directed Services Under the Physical Disability Waiver, and What Is the Opportunity Cost to the State of Those Differences?

We didn't find the same magnitude of cost differences for the physical disability waiver as we did for the frail elderly waiver. *Information provided to the Legislature during budget hearings showed that frail elderly clients with self-directed care were receiving a disproportionate share of services. Legislators were concerned the same thing might be happening on the physical disability waiver, as well.*

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In Part I of this audit, we confirmed that frail elderly clients with self-directed care cost $272 per month more (41%) than frail elderly clients with agency-directed care. Here's why:

- *although frail elderly clients potentially received the same <u>total</u> hours of service per month, clients with self-directed care received 17 fewer hours of <u>volunteer</u> services. In other words, Medicaid had to pay for more of the services they received.*
- *they tended to use more of the services they'd been authorized (81%) than agency-directed clients used (76%).*

In this audit, we found that physically disabled clients with self-directed care also cost more than physically disabled clients with agency-

directed care, but the differences were much smaller. We estimate that self-directed clients cost $82 per month more (7%) than clients with agency-directed care.

We found that these clients:
- *are slightly more disabled*
- *are less able to contribute financially to the cost of their care*
- *are authorized and use more Medicaid-paid services*

Physically disabled clients with self-directed care also received an hour less of volunteer services per month. Had they received the same number of volunteer hours, we estimate the State would have saved about $128,000 in Medicaid costs. (For frail elderly clients, that savings was approximately $2 million.)

In both audits, we found that the number of hours of approved service varied widely for clients with the same assessed needs. *Case managers have broad discretion in deciding how many hours of service a client needs, which may result in clients being treated unequally. For example, we saw clients with the same assessed need for "hygiene and grooming" receive anywhere from 2.5 to 35 hours a month for this service. We saw the same variability when we audited the frail elderly waiver. Although agency officials said such differences could be due to clients being incontinent or having cognitive impairments, these factors don't explain all the differences we saw.*

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Complete, accurate information about clients on the physical disability waiver isn't readily available. *The Medicaid Management Information System (MMIS) contains payment information on a claim-by-claim basis and some service information for physically disabled clients, but it doesn't contain clients' needs assessment scores.*

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Some of the service data in MMIS aren't accurate and are of limited use. We noted the following:
- *data weren't recorded consistently or accurately. For example, some claims showed units of service were authorized, but there was no corresponding dollar amount.*
- *claims and payment data had limited information. Attendant care is supposed to be recorded as 1 unit per month (regardless of the amount of service to be provided) rather than in hours or 15-minute increments. Further, the rate of pay isn't recorded in the system. That limits anyone's ability to determine whether the correct rate was paid, or to verify the number of approved units of service.*
- *parts of the plan of care data were inaccurate. Attendant-care services recorded electronically in MMIS didn't always match the documentation.*

This audit was conducted by Chris Clarke, Molly Coplen, Brad Hoff, and Felany Opiso. Cindy Lash was the audit manager. If you need any additional information about the audit's findings, please contact Chris 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.

Medicaid Waivers: Reviewing Differences in Rates and Hours of Service for Clients Receiving Self-Directed and Agency-Directed Care

Part II: The Department of Social and Rehabilitation Services' Physical Disability Waiver

The Medicaid Program provides long-term care services to elderly and disabled people under waivers that allow them to receive services in their homes or community, rather than in an institution. After clients' needs are determined, they can either "self-direct" their care, or opt to have a home-health agency "direct" their care. Clients who self-direct their services choose their own service providers, and sign up with a "payroll agent" who bills Medicaid to pay for the services.

A Senate budget subcommittee reviewing the 2005 budget for the Department on Aging noted that certain populations appeared to be receiving proportionally more services than others. For example, they noted that in fiscal year 2003, clients on the frail elderly waiver with self-directed services accounted for only 41% of the people served, but accounted for 57% of the total costs.

Other information showed that frail elderly waiver clients who self-directed their care received an average of 68.4 hours of service per month, compared to just 37.5 hours for clients with agency-directed care.

The subcommittee requested an audit to review the discrepancies in service within the frail elderly waiver administered by the Department on Aging, and within the physical disability waiver administered by the Department of Social and Rehabilitation Services (SRS). The subcommittee also was interested in knowing whether there were ways money could be saved, and if so, how that could affect the waiver waiting lists.

Part I of this audit which focused on the frail elderly waiver administered by the Department on Aging, was issued in July 2005. Because of other work assigned by the Legislature, our review of the physical disability waiver administered by SRS had to be delayed. This report covers the physical disability waiver.

This performance audit answered the following question as it relates to the physical disability waiver:

What factors explain the differences in the cost and hours of service for clients receiving self-directed versus agency-directed services under the physical disability waiver, and what is the opportunity cost to the State of those differences?

To answer this question, we obtained Medicaid Management Information System (MMIS) records covering July 2002 through October 2005. We analyzed plans of care for 5,143 clients on the physical disability waiver, as of October 2005. We looked at the number of clients receiving services, the types and amounts of services they were authorized to receive, and their client obligations (the amount some clients pay toward the cost of their care).

We also looked at claims data in the aggregate for several years, and in-depth for a sample of clients, to assess the extent to which clients used services that were authorized for them. We obtained customer service worksheet data for about 600 clients from centers for independent living and home health agencies. We used that information to assess these clients' disability levels and estimate the hours of service provided by family or friends for free.

We reviewed SRS regulations and policies and interviewed Department staff as needed, and contacted officials from other states to gain comparable information about their physical disability waivers.

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

In conducting this audit, we followed all applicable government auditing standards set forth by the U.S. Government Accountability Office. We conducted reliability tests on the MMIS data on plans of care and on data from the centers for independent living. Because of time constraints, however, we didn't test the MMIS claims data. Because of inconsistencies in the MMIS plan-of-care data, we had to do additional work on the data before we could use it for our analysis. Thus, the information presented in this report should be viewed as an indicator and not as absolute fact. It is unlikely, however, that it would significantly affect our findings and conclusions. Our findings begin on page 7, following a brief overview of the physical disability waiver.

Medicaid Waivers Allow States To Pay for Long-Term Care in the Community, Rather Than In Institutional Settings

When first enacted, Medicaid paid for long-term care only in skilled nursing facilities. In the early 1980s, high costs and concerns about overly restrictive environments led the federal government to give states greater flexibility to use Medicaid for long-term care services in the community. These community-based services were intended to prevent or delay placing people in an institutional setting.

Medicaid community-based service programs often are referred to as "waiver programs." To offer them, states must apply to the federal government for a waiver of the requirement that services be provided in an institutional setting.

The physical disability waiver is one of six different waiver programs in Kansas. Established in 1984, this waiver provides services to people who are physically disabled and need help with everyday living. SRS manages this waiver program, plus four others. The Department on Aging manages the frail elderly waiver.

Medicaid Waiver Programs
AT A GLANCE

Authority: Created in 1965 by Title XIX of the federal Social Security Act, Medicaid provides health benefits coverage to low-income and medically needy individuals. In 1981, Congress authorized the waiver of certain Title XIX requirements to enable state to provide home and community based services to people who would otherwise require institutional care. The waivers are called 1915(c) waivers after the section of the Social Security Act that authorized them. In 1984, SRS established the first nursing facility waiver; the current physical disability waiver became effective January 1, 1997 when the original waiver was split into two; the frail elderly waiver and the physical disability waiver. The State has six Medicaid waivers.

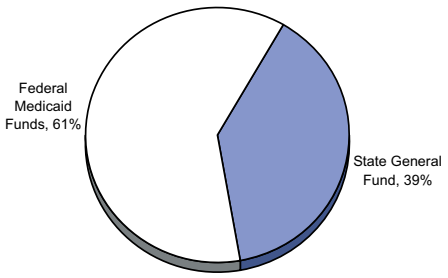
Staffing: The Department of Social Rehabilitation Services has two (about 1.25 FTE) central office employees for the physical disability waiver and 24 staff in the regional offices who conduct quality reviews for three of SRS' waivers.

Budget: A joint federal and State program, Medicaid's medical services are funded with State and federal moneys.

FY 2005 Waiver Expenditures

Type	Amount	% of Total
Developmental Disability Waiver	$217,142,480	61%
Physical Disability Waiver	$69,226,455	19%
Frail Elderly Waiver	$54,744,544	15%
Severe Emotional Disturbance Waiver	$10,576,062	3%
Traumatic Brain Injury Waiver	$5,621,164	2%
Technical Assistance Waiver	$182,471	0%
Total Expenses:	**$357,493,176**	**100%**

Sources of Funding for Expenditures



Total Funding: **$357,493,176**

Source: Medicaid MAR Report, FY 2005, and HCBS Physical Diability Waiver Policy and Procedure Manual, SRS

As shown in the At-a-Glance box, the physical disability waiver is the second largest of the six Medicaid waivers in Kansas.

The physical disability waiver is for individuals who qualify for Medicaid and who are:

- age 16-64
- defined as disabled by Social Security Disability Standards
- need assistance with activities of daily living
- eligible for nursing facility care

All Service Plans Under the Waiver Must Be Developed by a Center for Independent Living or a Home Health Agency

The basic types of services available through the physical disability waiver are described in ***Figure OV-1***.

Case managers develop "plans of care" for physical disability waiver services. The plan of care lists the following:

- services the client can receive under the physical disability waiver
- how much of each service the client can receive
- who is authorized to provide the services.

Plans of care are updated at least once a year. Currently, the State's 13 centers for independent living—as well as four home health agencies—can develop service plans under the physical disability waiver. These 17 agencies are shown on the map in ***Appendix C***.

Figure OV-1
Physical Disability Waiver Services

Service	Description	Maximum allowed
Attendant Care	(also known as personal services and assistive services)– clients get help completing daily tasks they'd do themselves if they didn't have a disability. These tasks can include bathing, dressing, shopping, cooking, and other everyday tasks. **This service is the most common one provided under the physical disability waiver; it accounted for about 96% of all service dollars in fiscal year 2005.**	**No limit.** Expenses over $2,312 per month must get special approval. "Cost cap" set at $8,000 per month, *although there are exceptions.*
Assistive Technology	Medical equipment, home modifications, and technology assistance devices such as ramps or lifts.	**$7,500 lifetime**
Case Management	Independent living counseling —clients get individual help and resources to maximize their ability to live independently; case managers also work with other agencies and programs to help clients become fully integrated and active in their communities.	**120 hours per year at $30/hr** ($3,600 yr)
Personal Emergency Response	24-hour a-day, on-call support for clients who have a medical or emergency need that could become critical at any time.	**$35 per month**
Sleep Cycle Support	Home-based, non-nursing help and/or supervision during the client's normal sleeping hours. These services can include physically helping the client use the bathroom, move from one place to another, and the like.	**$30 per night**

Source: information provided by SRS.

In developing the plan of care, the case managers assess each client in terms of the level of help needed for each of 13 identified everyday activities. Based on the code assigned, the relative weighting of the activity, and other factors such as whether the client is incontinent, the case manager determines the client's long-term-care score.

These scores can range from 26 to more than 100. Higher numbers generally mean clients need more help with the various activities. The case manager also determines the number of hours of service the client needs. More information about this process is contained in Question 1.

About 87% of the Clients On the Physical Disability Waiver Have Chosen To "Self-Direct" Their Care

Any home health agency that is licensed by the Department of Health and Environment is authorized to provide attendant-care services. Currently, there are 308 licensed home health agencies in the State.

Clients can choose to have one of these agencies provide the services on their plan of care, or they can choose to "self-direct" those services. Self-directing means the client is responsible for hiring, training, and supervising his or her own attendants, and the client must sign up with a payroll agent to bill Medicaid. In fiscal year 2005, about 87% of the physical disability waiver clients chose to self-direct their care.

A center for independent living, a home health agency, or another entity that's certified to bill Medicaid can serve as a payroll agent. To avoid conflicts of interest, agencies that develop service plans (act as a case manager for a client) aren't allowed to provide those services. Conversely, agencies that provide services aren't allowed to develop the service plans. This information is summarized in ***Figure OV-2:***

Figure OV-2
Summary of the Types of Physical Disability Waiver Services That Can Be Provided by Independent Living Centers and Home Health Agencies

Type of Agency	Can Provide the Following Services		
	Case Management	Attendant Care	Payroll Agent
Agencies that Authorize Services: Independent Living Centers (13) Home Health Agencies (4)	YES	No	YES
Agencies that Don't Authorize Services Home Health Agencies (304)	No	YES	YES

Source: SRS; Kansas Department of Health and Environment licensing data

The payroll agent bills Medicaid for the services that were provided, uses the Medicaid reimbursement to pay the attendants and all applicable employer taxes, and keeps any remaining money. The billing rates for attendant-care services differ for agency-directed care and self-directed care, as follows:

Agency-directed	= $12.82 per hour
Self-directed	= $11.94 per hour

There are few limits on the amount of service Medicaid will pay for. As ***Figure OV-1*** showed, these limits per client are as follows:

- 120 hours of case management (independent living counseling) per year
- $7,500 lifetime maximum on home modification expenditures
- special approval is needed if the plan of care is Level II ($2,313-$3,677 per month) or Level III ($3,678 or more per month)

To gauge the cost-effectiveness of the program, SRS analyzes whether, as a group, clients' waiver expenses are less than what it would cost to serve the same number of people in a nursing home. Using this type of analysis, some individuals can be served in the community even if it would be less expensive to serve them in a nursing home.

What Are the Differences in the Cost and Hours of Service for Clients Receiving Self-Directed Versus Agency-Directed Services Under the Physical Disability Waiver, and What Is the Opportunity Cost To the State of Those Differences?

ANSWER IN BRIEF: *Physically disabled clients with self-directed care cost about $82 per month more (7%) than their counterparts with agency-directed care. That difference is significantly less than what we saw in Part I for frail elderly clients. In that audit, frail elderly clients with self-directed care cost $272 per month more (41%) than similar clients with agency-directed care. Physically disabled clients who self-direct their care tend to be slightly more disabled and poorer, and use more of the services they are authorized than clients with agency-directed service. However, the differences between these two groups aren't great, and likely aren't anything the State can control for. The opportunity costs we saw for the physical disability waiver were much smaller than for the frail elderly waiver—about $128,000 compared with approximately $2 million. We also saw the same variability in authorized hours of care for clients with the same assessed need for service as we did in the frail elderly waiver. Finally, we found some existing data are inaccurate and incomplete. These and other findings are discussed in the sections that follow.*

We Didn't Find the Same Magnitude of Cost Differences for the Physical Disability Waiver As We Did for the Frail Elderly Waiver

This audit was authorized because of concerns and information relating to clients on the frail elderly waiver. A Senate subcommittee reviewing the 2005 budget for the Department on Aging noted that, in fiscal year 2003, clients on the frail elderly waiver with self-directed services appeared to account for only 41% of the people served but 57% of the waiver costs.

Subcommittee members didn't have any information on the physical disability waiver, but they were concerned that clients with self-directed care might be getting a disproportionate share of services on that waiver, as well. If so, the impact could be significant, because nearly all clients on the physical disability waiver self-direct their care. Because of this possibility, the audit was designed to address both waivers.

To recap, Part I of this audit confirmed that frail elderly clients with self-directed care cost considerably more than frail elderly clients with agency-directed care. Frail elderly clients with self-directed care cost Medicaid about $272 more per month than their counterparts with agency-directed care, a difference of about 41%. The audit also found that frail elderly clients with self-directed care made up about 42% of the population but accounted for 51% of the costs, as of February 2005.

Although both groups of clients potentially received about the same total hours of services each month, the frail elderly waiver audit found that their costs were very different because:

- Clients with self-directed care received about 17 hours less of volunteer (unpaid) services each month. As a result, Medicaid paid for attendants to provide these services. [In developing plans of care, case managers try to determine whether volunteers—including friends or relatives—can provide any of the needed services for free, including housework, laundry, or shopping.]
- Clients with self-directed care tended to use more of the services they'd been authorized (81%) than agency-directed clients used (76%).

Appendix B compares clients with self-directed care to those with agency-directed care for both the frail elderly and physical disability waivers, and highlights the differences between the populations.

In Part II of this audit, we also found that physically disabled clients with self-directed care cost more than physically disabled clients with agency-directed care, but the differences were much smaller. We estimate the cost difference between these two groups to be about $82 per month per person, or only a 7% difference. Further, we found there was a closer match-up between these groups' numbers and their costs. For example, physically disabled clients who self-direct their care made up about 87% of the population, and accounted for 89% of total costs, in fiscal year 2005.

The main differences between clients on the physical disability waiver who self-direct their care and those who use agency-directed care are summarized in ***Figures I-1 (Population Differences) and I-2 (Service Differences)***.

Figure I-1
Differences in Physical Disability Waiver Client Populations, October 2005 (unless otherwise noted)

Population Differences	Self-Directed Care	Agency-Directed Care	How much more/less Medicaid pays for self-directed clients because of this factor
Average number of clients served per month in fiscal year 2005	4,030	624	n/a
Clients as a % of total	87%	13%	n/a
Growth in number of clients, FY2003 to FY2005	23%	49%	n/a
Average long-term-care score (measure of disability)	46	45	$32
Financial ability: % of clients who were required to contribute financially to their care	16%	21%	$11
Average amount those clients contributed	$189	$197	

Source: MMIS and data from centers for independent living and home health agencies

As ***Figure I-1*** shows, most clients on the physical disability waiver (87%) have chosen to self-direct their care. Those clients:

- have slightly higher long-term-care scores compared to clients with agency-directed care
- are somewhat poorer than clients with agency-directed care (i.e., they are less able to pay part of the cost of their own care, and those that can pay for part of their care can't pay as much)

Service differences between clients who self-direct their care and those who use agency-directed care are summarized in ***Figure I-2***.

Figure I-2
Differences in Physical Disability Waiver Client Services, October 2005 (unless otherwise noted)

Service Differences	Self-Directed Care	Agency-Directed Care	How much more/less Medicaid pays for self-directed clients because of this factor
Hours of Medicaid-paid, attendant-care services authorized per client, per month (a)	120	111	n/a
% and # of those hours actually used	81% 97 hrs	77% 85 hrs	$67
Estimated number of volunteer (unpaid) hours per client, per month	13	14	$6
Paid and estimated unpaid hours of service used per client, per month	110	99	n/a
Hourly Medicaid payment rate for attendant care	$11.94	$12.82	-$75
Cost of services other than attendant care	$92	$97	-$3
Other cost differences between the client groups that we couldn't account for	n/a	n/a	$44
Total Average Medicaid payments per client, per month for all services	**$1,203**	**$1,121**	**$82**

(a) Until fiscal year 2005, physically disabled clients who self-directed their care were authorized many more hours of Medicaid-paid service than were their counterparts who used agency-directed care. However, for the time period we analyzed, October 2005, the differences had gotten much smaller.

Source: MMIS, data from centers for independent living and home health agencies

As ***Figure I-2*** shows, physically disabled clients who self-direct their care:

- are authorized and use somewhat more Medicaid-paid services than clients with agency-directed care. In part, this could be because they are somewhat more disabled and less able to contribute financially to their care
- receive an estimated one hour less of volunteer (unpaid) services per month. Had they received the same number of volunteer hours, we estimate the State would have saved about $128,000 in Medicaid costs. Our findings in this area were much less significant than our findings for clients on the frail elderly waiver (Part I of the audit). In that audit, we found that frail elderly clients with self-directed care

received 17 fewer volunteer hours of service per month, and estimated that the difference cost the State about $2 million per year.

- have their Medicaid-paid services reimbursed at a lower hourly rate. The same was true for the frail elderly waiver. Those lower rates helped offset some of the cost differences between the two types of clients.

Under the "other factors," we analyzed living arrangements (alone or with others) and urban-rural differences between the two client groups, but these factors had minimal impact on Medicaid costs. We also analyzed special services such as sleep-cycle support (an attendant is present during the nighttime sleeping hours), and found that had an impact of only $3 per client per month. The remaining difference could be caused by factors we didn't analyze, but may include availability of services in client locations.

In Both Audits, We Found That the Number of Hours of Approved Service Varied Widely For Clients With the Same Assessed Needs

As part of our review of a sample of 600 client files from October 2005, we looked at the number of hours authorized for each client, and the assessed need that had been determined for each client. We then compared the number of hours authorized for clients with similar assessed needs.

As part of each client's annual assessment, the case manager evaluates his or her need for help with everyday activities by assigning a code of 1 to 4 for each activity, as follows:

1 = the client doesn't need any help
2 = the client needs supervision while performing the activity
3 = the client needs hands-on physical assistance with the activity
4 = the client can't complete the activity at all

Case managers have broad discretion in deciding how many hours of service a client needs, which may result in clients being treated unequally. As ***Figure I-3*** shows, the hours of service that case managers approved varied widely for clients with the same level of assessed need. For example, some clients with an assessment code of "2" for hygiene and grooming were approved to receive 2.5 hours of assistance each month, while others with the same assessment code were approved for 35 hours a month.

Figure I-3
Examples of How the Number of Approved Attendant-Care Hours Varied

Individual clients with an assessment code "2" were authorized to receive these hours per month:				Clients with code "3"
Activity	**Minimum**	**Maximum**	**Median**	**Median**
Hygiene and Grooming	2.5	35	8.75	17.5
Dressing	5	35	5	10
Transfer	2.5	35	8.75	10

Source: LPA Analysis of a sample of clients' October 2005 attendant-care worksheets.

Such variability suggests that case managers' opinions about the number of hours needed aren't highly standardized, and that clients may benefit unequally depending

on who the case manager is. We found this same level of variability when we audited the frail elderly waiver, which is administered by the Department on Aging.

The Department on Aging has commissioned the University of Kansas to complete a study of the uniform assessment instrument and to make recommendations for changes. As this audit was being completed, the study had been completed but the report hadn't been released yet.

Officials from SRS and the centers for independent living told us this wide variation could occur for several reasons. For example, they said, it may take more time to work with clients who are incontinent or have cognitive impairments. Also, clients with unpaid support (volunteers) need fewer authorized Medicaid-paid hours.

We reviewed the annual assessments for the three clients with the highest number of hours for the three activities listed above. Based on information in the file, we noted that one client was incontinent and had impaired vision, one was cognitively impaired, and the third had seizures and hearing and vision impairments. Such conditions certainly could justify a higher number of hours. However, the hours still varied widely even when we excluded these clients from our analysis.

Examples of the different levels of Medicaid-paid service provided to clients with similar long-term-care scores are shown on the next page.

Complete, Accurate Information About Clients on the Physical Disability Waiver Isn't Readily Available

Case managers employed by the centers for independent living and home health agencies enter data about clients on the physical disability waiver into the State's Medicaid Management Information System (MMIS). These data include authorized services from the plan of care, effective dates of service, and the like. In addition, agencies serving as payroll agents enter information into the MMIS claims system regarding services actually provided.

SRS doesn't have detailed individual data for analysis about clients, but does have basic information and is developing a database. MMIS is a huge data system that tracks Medicaid spending for all programs and is operated by the Medicaid fiscal agent, EDS. The system has payment information on a claim-by-claim basis and some service information for the physical disability waiver clients. SRS has basic management information such as total and average expenditures per client, and the number of clients. SRS doesn't have information about each client's disability such as the long-term-care score.

Comparisons of Physical Disability Waiver Clients with the Same Long-Term-Care Scores And Widely Different Number of Authorized Hours

In our review of 600 client files for October 2005, we saw wide variations in the number of paid hours authorized for clients who had the same long-term-care score. Factors that affect paid service hours include such things as availability of volunteers, health status and availability of transportation. The comparisons below illustrate some of these variations.

Two clients with a long-term-care score of 30:

A 65-year old female client with kidney failure is authorized 10 hours of paid services per month. She lives alone, is at-risk of falling, is unsteady, and has impaired vision. Her daughter assists her in performing several activities, and she has Medicaid-paid attendant care to help her complete laundry and housekeeping duties.

A 46-year old female client with circulation problems and asthma is authorized 67.5 hours of paid services per month. She doesn't live alone, is at-risk of falling, is unsteady, and has impaired vision. She is independent in several activities, but needs help in activities such as meal preparation, laundry/housekeeping, shopping, medications, and transportation. She has no informal supports (relatives or friends who provide care for free).

Two clients with a long-term-care score of 40:

A 57-year old male client with a head injury, only one kidney, and a history of seizures is authorized 40 hours of paid services per month. He doesn't live alone, is at-risk of falling, is unsteady, has impaired vision, and impaired hearing. He is independent and has informal support in several activities, but receives paid assistance to help prepare his meals and manage his medication.

A 49-year old female client with a heart ailment and breathing problems is authorized 80 hours of paid services per month. She lives alone, is at-risk of falling, and is unsteady. She is independent in several activities, but needs help in activities such as toileting, preparing meals, laundry/housekeeping, and shopping. She has no informal supports.

Two clients with a long-term-care score of 50:

A 66-year old female client with ataxia, an inability to coordinate muscular movements, is authorized 78.8 hours of paid services per month. She lives alone, is at-risk of falling, is unsteady, and has impaired hearing. She has few informal supports.

A 40-year-old male client whose left arm was amputated and who is paralyzed from the waist down is authorized 290 hours of paid services per month. He lives alone and is independent in a few activities. He receives informal support for transportation activities, but has paid support for a majority of his daily activities.

Most Areas of Kansas' Physical Disability Waiver Are Comparable to Waivers in Other States

We compared Kansas' waiver to similar waivers in other states to see if there were differences in terms of rates, the self-directed option, limits on hours, and the like. While each state's waiver was unique, Kansas' waiver seems to be in-line with the others in most areas. The main difference we noted was in the limit on home modifications/assistive technology. Kansas' limit of $7,500 per lifetime was the lowest of the comparison states, which ranged from $10,000 per lifetime to no limit. This and other comparisons are shown in the table below.

Comparison of the Kansas Physical Disability Waiver to Other States

		Kansas	Oklahoma	Colorado	Missouri	Iowa	Nebraska
Attendant-care rates	Agency - Directed	$ 12.82	$ 7.18	$ 12.80	$ 14.60	$ 19.04	Not available
	Self - Directed	$ 11.94	$ 7.18	$ 12.80	$ 12.40	$ 12.70	Not available
Number of people on the wait list		Negligible	None	None	could not provide	1,500 +	None
Number of people on the waiver		4,500	13,000 [a]	15,000 [a]	650	2,500 (two waivers)	4,000 [a]
Client can chose to self-direct care		Yes	Yes	Yes	No	Yes	Yes
Allowance for Home Modifications and Assistive Technology		$7,500 lifetime	Unlimited	$10,000 lifetime	Unlimited	$6,000/ year	$5,000/ year [e]
Limitations for attendant-care services		Unlimited	Unlimited	$53,290/yr [b] $61,320/yr [c]	Cost of putting that person in a nursing facility	$7,452/ year for one waiver, $36,228/ year for the other	Unlimited
Limitations on paying family members [d]		None	Family members are not paid	444 hours/ year	Family members are not paid	None	Paid at 75% of the regular rate

Source: Program officials from other states; SRS
a Physically Disabled and Frail Elderly clients on the same waiver.
b Agency-directed clients
c Self-directed clients
d Per Medicaid regulations, spouses of clients and parents of minor children (where the child is the client) are not paid.
e $5,000/year for Home Modifications and $5,000/year for Assistive Technology

For the Department on Aging's frail elderly waiver program, the Department maintains this sort of basic operational data, and has a separate database with disability information that can be merged with the claims data from MMIS to provide a full picture, when needed. Aging staff can run their own queries. SRS officials say they are developing a database with information on each individual served by the waiver.

Some service data in MMIS aren't accurate and are of limited use. SRS has a number of policies in place to try to make sure the data in MMIS are accurate. For example, to help ensure that only authorized users can enter data into the system, case managers have to obtain security access, a user ID, and a password. Because SRS is required by Medicaid to "approve" all plans of care, SRS staff review

each electronic plan of care. Among other things, staff check to see if the hours of services meet the consumers needs, and check that the math is correct (hours of service times rate) since the plan is based on a month. Despite these policies, we found the following problems with the MMIS data:

- **Data weren't recorded consistently or accurately**. For a sample of 7,982 electronic plan-of-care records (clients can have more than one record if they are receiving more than one type of service) for October 2005, 27% show some amount of authorized units of service, but $0 authorized dollars. Another 49% show an amount for authorized dollars, but zero units of authorized service.

- **The claims and payment data had limited information**. MMIS is set up to record attendant care in units of one month rather than one hour. SRS officials say the unit of one month is necessary to allow flexibility of attendant care, some of which is either not on an hourly basis, or not provided by the paid attendant, such as lawn care. This means there's no way to track the hours of attendant care performed by the paid attendant. Because the rate of pay isn't stored in the system and the number of units wasn't meaningful, we weren't able to determine whether the correct rate was paid, or to feel confident about the number of approved units of service. (To get an estimate of the number of authorized hours of service, we divided the amount paid by the maximum hourly rate.)

  Given that attendant care is in units of one month, we expected to see that in the data. However, 75% of the claims for attendant care had a unit value of something other than one month and ranged from 0.01 to 992 units per claim. To make the data more meaningful and allow for a way to track attendant care hours, SRS could change the units from one month to one hour and have a separate code for non-hourly services such as lawn care and Meals on Wheels.

- **Parts of the electronic plan-of-care data were inaccurate**. For attendant-care, which is based on an hourly rate, we expected to see the same number of attendant-care hours recorded in MMIS as on the plan-of-care worksheet for each client. The worksheets record the hours of attendant care authorized for each month. However,16% of the plans-of-care we tested had a discrepancy of more than 20 hours per month between the paper worksheet and our calculation of hours based on the electronic data.

  One reason for this, as mentioned above, may be programs paid for by the physical disability waiver (such as Meals on Wheels) that have been recorded as "attendant-care" in MMIS, but that aren't recorded as such on the plan-of-care worksheet. Other mis-coding could be due to the fact that several services were bundled together under the "attendant-care" code until June 2005. After that time, personal emergency response was assigned its own code, for example, but providers still may be using the "attendant-care" code by mistake.

Conclusion:	For the period we reviewed, we didn't find significant differences in terms of hours or costs on a per-person basis between physically disabled clients who self-direct their care, and physically disabled clients who have chosen to agency-direct their care. Most of the differences we saw were because clients with self-directed care were slightly more disabled, poorer, and somewhat more likely to use the services for which they'd been approved.

Recommendations:

1. To help ensure that clients with similar disability scores are treated equally when case managers determine the number of hours of service needed, the Department of Social and Rehabilitation Services (SRS) should do the following:

   a. provide additional training or guidance to case managers on how to determine the appropriate amount of service for a client
   b. when it becomes available, review the study the University of Kansas recently conducted for the Department on Aging on the reliability of assessment scores, and implement any recommendations of the study that are applicable to the physical disability waiver.

2. To help control the amount Medicaid is spending for clients on the physical disability waiver, SRS should do the following:

   a. work with centers for independent living to more actively tap volunteers and volunteer organizations to increase volunteer services available to clients
   b. develop a method for quantifying and electronically recording the service hours provided by unpaid volunteers.
   c. work with the Department on Aging to evaluate options for reducing costs associated with services provided by family members, and report the results of that evaluation to the Legislative Post Audit Committee and the appropriate legislative budget committees by the start of the 2007 legislative session.

3. To help ensure it has accurate, valid, and complete data to effectively manage the physical disability waiver, SRS should do the following:

   a. change the "unit' of measurement for attendant-care services in MMIS from 1 month to something more meaningful, such as 1 hour, or 15 minutes. Two other SRS waivers use 15 minutes as the "unit" of measurement for

attendant-care services. A more specific unit amount would allow for better accountability and data checking.

b. conduct periodic checks of the waiver database in MMIS, looking at all data fields to ensure that the data in them are reliable. In particular, plan of care units, amounts, dates, the agency-directed or self-directed designation, and other data should be accurate and updated.

c. establish a separate way to track services covered by the waiver, but not performed by the paid attendant, such as home-delivered meals and lawn care so they can be better accounted for.

d. review and match electronic plans of care to paper plans-of-care (separate from the approval process) to ensure that the electronic data are accurate and updated

APPENDIX A
Scope Statement

This appendix contains the scope statement approved by the Legislative Post Audit Committee for this audit on December 14, 2004. The audit was requested by the 2004 Senate Ways and Means Subcommittee on Aging.

This report presents the results of our findings related to the physical disability waiver. Results relating to the frail elderly waiver were reported in July 2005.

Medicaid Waivers: Reviewing Differences in Rates and Hours of Service for Self-Directed and Agency-Directed Care

The Medicaid program provides long-term care services to elderly and disabled individuals under waivers that allow clients to receive services in the community rather than in an institution. After assessments are conducted to determine the type and amount of services needed, clients can either self-direct their care or can opt to have a home-health agency direct the care. Clients who self-direct their services select their own service providers and sign up with a payroll agent who will bill Medicaid to pay for the services.

A Senate budget subcommittee reviewing the 2005 budget for the Department on Aging noted that certain populations appeared to be receiving proportionally more services than others. For example, they noted that in FY03, clients on the Frail Elderly waiver with self-directed services accounted for only 42% of the people served, but accounted for 61% of the total costs. Similarly, other information showed that clients who self-directed their care received an average of 68.4 hours of service per month, compared to 37.5 hours for clients with agency-directed care.

Based on this information, the subcommittee requested an audit to review the discrepancies between rates and hours of service for self-directed and agency-directed clients under the Home and Community Based Services Frail Elderly and Physical Disability Waivers. The subcommittee also was interested in whether there were ways money could be saved, and if so, how that could affect the waiver waiting lists. Finally, the subcommittee recommended that, after completion of the report, the Department on Aging and Long-Term Care Services Task Force review the audit findings and report any findings to the 2005 Legislature.

A performance audit of this topic would answer the following questions:

1. What factors explain the differences in the cost and hours of service for clients receiving self-directed versus agency-directed services under the HCBS Frail Elderly or Physical Disability waivers, and what is the opportunity cost to the State of those differences? To answer this question, we would become familiar with the regulations related to self-directed and agency-directed care. We would review statistics on the number of clients, hours of service, and costs for the last several years, and would explore how those statistics are developed to ensure that comparisons on those measures between self-directed and agency-directed clients are valid. We would review a sample of files for self-directed and agency-directed clients and compare their plans of care for the type and amount of services approved, controlled for level of disability. We would investigate whether there are certain types, times, or location of service that seem to be primarily self-directed. We would discuss any significant differences with the Department on Aging (for the Frail Elderly Waiver) and SRS (for the Physical Disability Waiver). If our analyses suggest that clients who self-direct are receiving a disproportionate level of service relative to their needs, we would estimate the savings that could be generated if they received the same level of service, relative to their assessed needs, as agency-directed clients, and would calculate how redirecting those funds would affect waiting lists for the HCBS waivers.

Estimated time to complete: 10 - 12 weeks

APPENDIX B

Comparison of the Frail Elderly Waiver and the Physical Disability Waiver

This appendix contains information comparing the frail elderly waiver administered by the Department on Aging, with the physical disability waiver administered by SRS. Areas of comparison include the number of clients on each waiver, hours of services authorized and used, waiver expenditures, and other categories.

Comparison Between the Frail Elderly Waiver and the Physical Disability Waiver, And the Client Groups Within the Waivers Fiscal Year 2005 (unless otherwise noted)

	Frail Elderly Waiver		Physical Disability Waiver	
Areas of Comparison	Self direct	Agency direct	Self direct	Agency direct
Number of Clients Average number of clients served per month, fiscal year 2005	2,870	4,038	4,030	624
Clients as a % of total	42%	58%	87%	13%
Growth in # of clients from FY 2003-2005	4%	3%	23%	49%
Hours of Service (a) Average # hours of service in plan of care, per month	88	85	133	125
Hours of Medicaid-paid services	75	55	120	111
Volunteer hours	13	30	13	14
% of Medicaid-paid services used	81%	76%	81%	77%
Waiver Expenditures Average payments per client, per month, fiscal year 2005 (all services)	$810	$553	$1,219	$1,013
% of total payment per client group	51%	49%	89%	11%
Total waiver expenditures, fiscal year 2005	$54.7 million		$69.2 million	
Other Average long-term-care score (a)	55	51	46	45
Attendant-care payment rate	$11.96	$13.92	$11.94	$12.82
% of clients who contribute financially to their own care (a)	26%	34%	16%	21%
Average amount contributed, per month	$157	$231	$189	$197
Age group waiver applies to	65 years and older		16-64 years	
Limits on attendant care	8 hours per day		No limit	
Waiver overseen by	Dept. on Aging		SRS	

Source: Frail elderly waiver data from LPA audit 05-12; Physical disability waiver data from SRS, MMIS, centers for independent living and home health agencies
a) Frail elderly data is based on January 2005. Physical disability data is based on October 2005.

As the table shows, there are several similarities between clients who self-direct their care and clients who chose agency-directed care under the two waivers. For example, under both waivers, clients who self-direct their care tend to:

- be more disabled, as reflected in the average long-term-care score
- use more of the services authorized
- cost more, on average
- be poorer, as reflected in the percentage who contribute to their own care costs
- have slightly more hours of service in their plans of care

However, there are also many significant differences between clients who self-direct their care and clients who chose agency-directed care under the two waivers. These are summarized in the following table:

Areas of Differences	Frail Elderly Waiver	Physical Disability Waiver
Clients Majority of the waiver clients are...	Agency-directed (58%)	Self-directed (87%)
Age of clients	65 years +	16-64 years (a)
Services Average hours of service reflected in plan of care, per month	86	131
How many more hours of volunteer/unpaid services clients with agency-directed care receive...	17 hours more per month	1 hour more per month
Limits on attendant-care hours...	8 hours per day	No limit
Services offered in addition to attendant care, personal emergency response, sleep support, and home modifications/technology...	Adult day care Medication reminder Nursing visit/eval. Wellness monitoring	None
Expenditures On average, how much more Medicaid pays for services for clients with self-directed care...	$272	$82
Average cost per client per month, all services	$660	$1,192
(a) clients who are on the physical disability waiver can choose to remain on that waiver when they turn 65.		

As the table shows, physical disability waiver clients tend to:

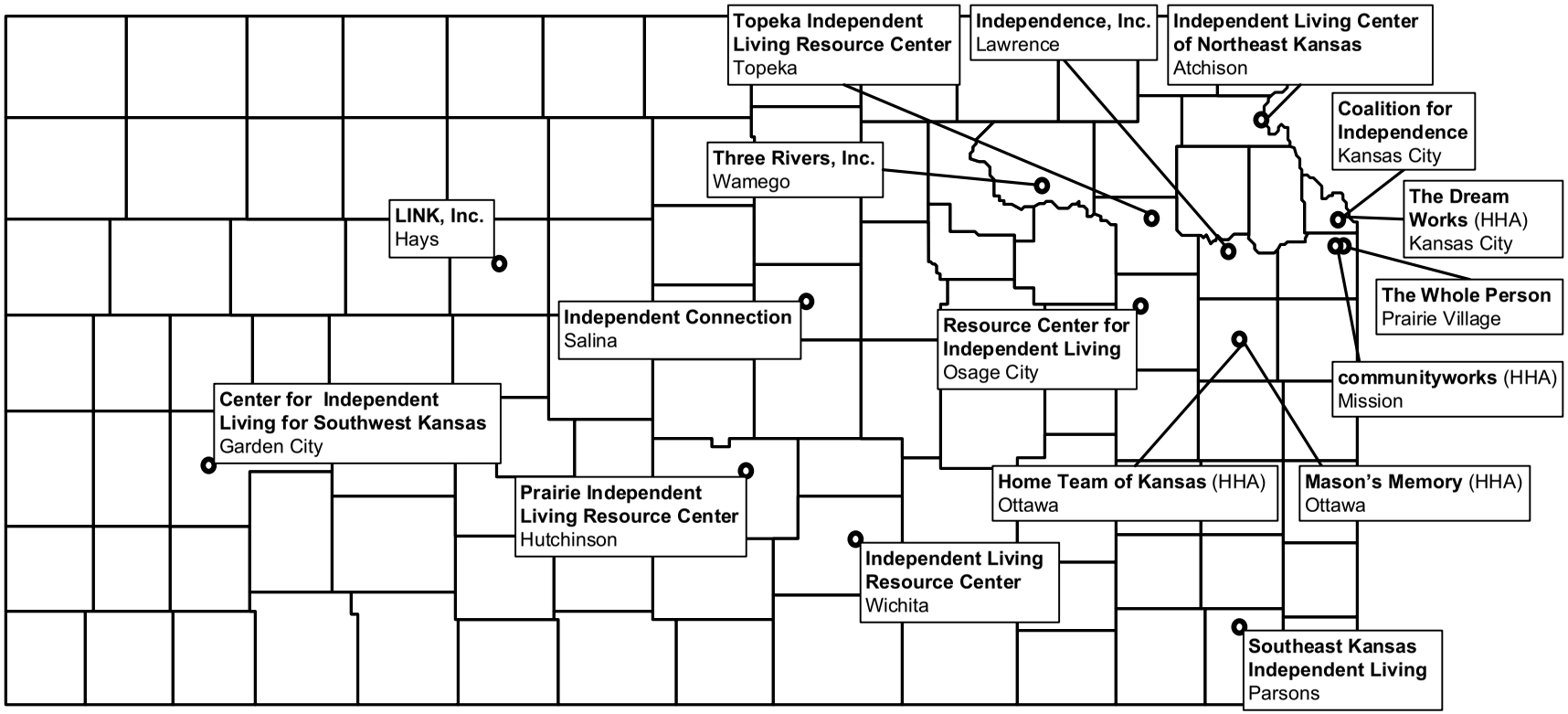
- be younger,
- have lower disability scores
- get many more service hours than the frail elderly population. That may be because these clients are younger and more active.
- chose to self-direct their care. This is likely due in part to the fact that SRS supports clients' independence, and clients who choose their attendants feel more in control of their services.

APPENDIX C

State Map Showing Location of Centers for Independent Living

The map on the following page shows the location of the State's 17 centers for independent living that authorize attendant care services and provide payroll services. In addition, Kansas has more than 300 home health agencies which can provide attendant care services and payroll agent services.

Centers for Independent Living and Home Health Agencies That Authorize Physical Disability Waiver Services in Kansas



The centers for independent living and home health agencies listed above are able to authorize plans of care. In addition, there are about 300 home health agencies across the state that provide the attendant care services.

APPENDIX D

Agency Response

On April 24, 2006 we provided copies of the draft report to SRS. Its response is included as this Appendix.

After reviewing SRS' response, we made some changes in wording to clarify the report, and changed a recommendation. In their response to the draft report, SRS officials stated that they run basic management reports monthly. However, it's important to note SRS doesn't have a list of clients, information about which clients choose to self-direct their care, or their long-term-care score. SRS officials are working on a new database to capture this information.

We also provided a copy of the draft report to the Department of Administration, Division of Health Policy and Finance, as that division is the single State Medicaid agency for federal purposes. Agency officials chose not to submit a response.

KANSAS
SOCIAL AND REHABILITATION SERVICES
GARY J. DANIELS, SECRETARY

April 28, 2006

Ms. Barbara J. Hinton
Legislative Post Audit
800 SW Jackson, Suite 1200
Topeka, KS 66612-2212

Dear Ms. Hinton:

Thank you for the opportunity to comment on the performance audit, "Medicaid Waivers: Reviewing Differences in Rates and Hours of Services for Self-Directed and Agency-Directed Care". I understand this was Part II of an audit and this review was of the Home and Community Based Services Waiver for individuals with physical disabilities. I would like to thank you and your staff for the work that was completed. It was a pleasure working with you and your staff.

Before I respond to the recommendations, I would like to address the use of two (2) terms utilized throughout the report. The first is the use of the word "rate" in referencing the scoring system utilized to determine the long term care score, and the use of the assessment process in the development of a consumer's plan of care. We do not consider it a rating system, it is an assessment process. Independent Living Counselors (ILC) use an assessment tool that asks questions regarding a persons ability to perform the activities of daily living. A person's ability to perform the activity is what determines the score that is given for that activity. The total of the scores is then utilized to determine if an individual is eligible for waiver services. If a consumer has a score of 26 or greater, the ILC will complete the remaining sections of the assessment tool. The ILC uses the completed tool to assist in determining the services that are needed. Factors that affect the hours of service include where the individual lives, how accessible the home is, availability of transportation services in the area of residence, availability of unpaid supports, the health status of the individual, etc. A plan of care is not developed based on the long term care score alone. Many factors affect the number of hours of service needed, paid or unpaid.

The second term is "authorize". The report utilizes this term in report when referencing the agencies that "authorize" services. The Centers for Independent Living and Home Health Agencies that provide Independent Living Counseling do not "authorize" services. They work with a consumer to develop a plan of care, enter the plan into the MMIS, and then submit the plan to SRS for approval. SRS does rely on the ILCs to determine a consumer's eligibility for services and to determine the number of service hours needed by the consumer, SRS authorizes the plan, thereby allowing payment for services provided.

The audit made three (3) recommendations. Please find SRS's response to each recommendation below.

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1. To ensure that consumers with similar long term care scores are treated equally in the process of determining the number of hours of services, the audit recommended that additional training or guidance be provided to Independent Living Counselors(ILC). SRS/Health Care Policy will be providing training to all ILCs beginning in May 2006. As part of this training there will be a review of the assessment process and the development of plans of care. There will be a discussion about consumer needs and how to determine the number of service hours that are necessary to meet health and welfare needs. As stated above, there are many factors that are evaluated when determining the services necessary to met a consumers health and welfare needs.

   The recommendation was made that SRS review the study completed by the University of Kansas for the Kansas Department on Aging (KDOA) regarding the reliability of assessment scores. SRS will contact KDOA to obtain a copy of the report. We will review the recommendations that may have been made. If the findings are applicable to the physical disability waiver, we will evaluate the possible implementation of the recommendations.

2. The second recommendation was related to the amount of Medicaid spending for consumers receiving services through the physical disability waiver and how to control the costs. The report recommends SRS work with the IL Counseling agencies to more actively tap volunteer services that might be available to consumers. As you stated in your report, individuals who self-direct their services are currently utilizing 13 hours of volunteer services per month. This appears to be a good rate over all for the use of unpaid supports. SRS will review the use of unpaid supports in our upcoming training, reminding ILCs unpaid supports should be used whenever possible.

   In regards to volunteer supports, the recommendation was made that a method be developed to quantify and electronically record the service hours provided by unpaid supports. SRS will consider this and determine what options may be available to develop such a system.

   The last section of this recommendation asked that SRS work with KDOA to evaluate options for reducing costs associated with services provided by family members and report the results of that evaluation to the Legislative Post Audit Committee by the start of the 2007 legislative session. Within three years ago SRS implemented a policy that states if a consumer receiving services lives with another person with whom they have a significant relationship, attendant care hours will not be reimbursed for activities the person would normally be doing for the individuals living in the home. Examples might include laundry, lawn care, meal preparation and house keeping. We feel this is one way to control the costs to the waiver while requiring family members to assist in the everyday lives of consumers. Family members are a primary source of care for individuals with disabilities. Many times the consumer prefers someone they know, as opposed to someone they have no relationship with preforming personal care tasks.

   Federal regulations that control the use of waiver services allows for family members to provide service as long as they are not a spouse or parent of a minor child. In many cases, family members are the only persons available to provide services as well as it is the choice of the consumer. SRS will continue to monitor the use of family members as care givers to assure only the necessary services are being reimbursed.

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3. The final recommendation related to accurate, valid, and complete data. SRS is in the process of writing a request for proposal that would allow us to contract for the development of a data base system that would provide information about the individuals served by the waiver. The work should begin on the data base in late May.

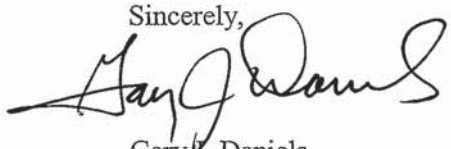
The recommendation was made that the "unit" of measurement for attendant care services in the MMIS be changed. The development and continued use of 1 unit equals 1 month was done to allow for flexibility in the use of attendant care hours as well as the inclusion of activities necessary for an individual with disabilities to remain in their home, i.e. lawn care, transportation, and money management. The use of the monthly unit allows for increased flexibility in a consumers use of their hours of service. At this time there are no plans to change this unit of service. With this, the recommendation was made to establish a specific sub-code for home delivered meals within attendant-care. SRS will review this recommendation.

The report made recommendations regarding the MMIS plan of care system and the accuracy of the data. SRS will look into this further and make any necessary changes.

It was recommended SRS request EDS run basic management reports regarding the number of waiver consumers, total expenditures, etc. SRS currently receives that information from our Operations Management unit. The information is drawn from the MMIS. The information is shared on a regular basis with the Department of Administration, Division of Budget. The information is shared with shakeholders and is used by program managers on a continuous basis.

Again, thank you for the opportunity to respond to the report. If you have any questions regarding the responses, please contact Margaret Zillinger at 296-3561.

Sincerely,



Gary J. Daniels
Secretary

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