REPORT TO THE

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A Performance Audit of the Division of Services for People with Disabilities

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State government in Utah provides services to its population who have disabilities through the Department of Human Services' Division of Services for People with Disabilities (DSPD or "the division"). Because resources are limited, not all needs communicated by people with disabilities can be met, so many potential clients must be placed on a waiting list to receive services and supports. Other state agencies, such as the Department of Health and the Utah State Office of Education, also provide services to people with disabilities, but this report focuses on DSPD.

We found that significant problems exist with the accuracy of DSPD's waiting list. We also found other areas where DSPD can improve, such as its effectiveness in utilizing federal matching funds and its effectiveness in making funding decisions. We examined these areas in response to the Legislature's audit question "Are we getting the funding to the people who need it the most?"

Chapter II: Significant Problems Exist With DSPD Waiting List

Our first area of review was the DSPD waiting list. This review, which included a detailed sample, revealed significant concerns that result in funding needs being overstated. Mainly, the three areas that make up the estimated cost of funding the waiting list—the number of individuals waiting for services, cost of services, and the percent of funding from the state—are unreliable.

But even if data were reliable, a complete representation of the cost to fund the waiting list may not be as helpful to the Legislature as presenting several funding scenarios based on different policy directions the Legislature could choose. For example, the Legislature could choose to fund only those waiting list clients who meet a certain critical needs assessment score or fund only those clients that are eligible for the Medicaid waiver, or both. Funding portions of the waiting list based on such specific policies could range from as little as $1.2 million to as much

as $7.5 million for the entire waiting list this audit revised. Chapter II presents some of these funding options.

Finally, because current waiting list information is not reliable, DSPD needs to consider changes to its current process of new client intake. For example, more detailed information on a client's eligibility and cost of service needs to be recorded so that better policy decisions can be made regarding waiting list funding.

Chapter III: Better Management of Medicaid Waiver Eligibility is Needed

Second, we reviewed some DSPD clients who receive services funded wholly with state dollars and found evidence that many of them could qualify for federal matching funds through one of the three Medicaid home and community-based service waivers administered by DSPD. Our review of a sample of clients who did not receive federal waiver funds revealed several concerns. Namely, some individuals qualify for waiver funds, but the state does not receive the funds because paperwork has not been completed. In addition, other individuals do not qualify for federal waiver funds because they do not have either the disability level of care need or the financial need to meet eligibility requirements. Given the limited resources available to provide services, serving these waiver ineligible clients raises important policy issues. Some possible ways for the state to better maximize federal Medicaid funds are discussed in connection with this review.

Chapter IV: Better Guidance Needed for DSPD Decision-Making Process

In our final area, we found that decisions about which clients get funded for services by DSPD are often inconsistent and confusing. Policy clarification about client funding practices as well as better information about available funds and the demands placed on those funds by different client groups can improve DSPD decision-making.

Chapter IV further discusses a number of issues related to how DSPD decides which clients receive funding for what services. We found that practices sometimes differ among regions and offices because of different policy interpretations and departures from using the Critical Needs Assessment (CNA) prioritization model. We also found that in some instances a lack of reliable information may affect decision making.

Chapter I
Introduction

State government in Utah provides many services to its population who have disabilities through the Department of Human Services' Division of Services for People with Disabilities (DSPD or "the division"). Because resources are limited, not all needs communicated by people with disabilities can be met, so many potential clients must be placed on DSPD's waiting list to receive services and supports. Other state agencies, such as the Department of Health and the Utah State Office of Education, also provide services to people with disabilities, but this report focuses on DSPD.

There is not enough funding to meet the needs of all persons with disabilities. So, a waiting list for services exists.

Utah's prioritized waiting list has grown to include almost 2,000 individuals who reportedly have immediate needs. Providing services to an increased number of individuals on the waiting list has been the focus of DSPD and the Legislature for the past several years. In fact, the waiting list has been the primary means for the division to communicate funding needs to the Legislature.

DSPD Manages Service Provision for People With Disabilities

The Division of Services for People with Disabilities is the state agency that provides services and supports for persons with disabilities.

According to ***Utah Code*** 62A-5-103, first in the list of responsibilities for the Division of Services for People with Disabilities is to "plan, develop, and manage an array of services and supports for persons with disabilities and their families throughout the state."

Statute Directs That the Most Severely Disabled Should Be Served. The Legislature has provided direction on the population of disabled people which should be served through definitions and policy set forth in statute. The statutory definition of "disability" is given in Figure 1.

Figure 1. The Definition of "Disability" is Set Forth in *Utah Code* 62A-5-101.

(4)(a) "Disability" means a severe, chronic disability that:
- (i) is attributable to a mental or physical impairment or a combination of mental and physical impairments;
- (ii) is likely to continue indefinitely;
- (iii) results in a substantial functional limitation in three or more of the following areas of major life activity:
  - (A) self-care;
  - (B) receptive and expressive language;
  - (C) learning;
  - (D) mobility;
  - (E) self-direction;
  - (F) capacity for independent living; or
  - (G) economic self-sufficiency; and
- (iv) requires a combination or sequence of special interdisciplinary or generic care, treatment, or other services that may continue throughout life and must be individually planned and coordinated.

(4)(b) For purposes of this chapter mental illness alone does not constitute a "disability" (***Utah Code*** 62A-5-101(4)(a)(b)).

Typically, this definition of disability translates to services and supports for people with the following disabilities:

- mental retardation and/or developmental disabilities,
- brain injury, and
- physical disabilities.

Major DSPD services include:
- **residential services,**
- **day services,**
- **supported employment, and**
- **family support.**

The Division Offers Services and Supports in Several Areas. As shown, a broad range of people can apply for services with the division. Upon meeting specific eligibility requirements following guidelines just set forth in the ***Utah Code***, the division provides services and supports categorized into a few generalized areas:

- residential placement services—supported or supervised living in supervised apartments, professional parent homes or group homes,

- day services—site training services designed to promote ongoing development and self-help skill maintenance or senior supports for those over 55 with medical conditions,

- supported employment—job placement, development, coaching and on-the-job training in the community for adults with disabilities,

- family support—services and supports given to families supporting an individual with disabilities in the home; assistance includes respite services, cash assistance, family guidance/training, help with therapies and assistive devices, and

- transportation services—typically provided as a means for an adult with disabilities to transport to/from day programs, jobs and other activities.

In 2001, about 5,000 persons with disabilities were receiving services and supports from the division.

In fiscal year 2001, about 5,000 people received some level of services and supports through the division (1,100 of whom received one-time supports) with an additional 249 people residing in the Utah State Developmental Center. Figure 2 shows a current breakdown of service in the categories discussed most often throughout the audit report: residential services, day services, supported employment, family support and transportation.

Figure 2. Number of Home and Community Based Services Provided by DSPD in Fiscal Year 2001. The total exceeds 5,000 because many people receive more than one service. The unduplicated count of clients in service is 3,807. There are also 115 clients receiving services for physical disabilities.

Service Categories	Number of Services
Residential Services	2,069
Day Services	1,551
Supported Employment	985
Family Support	2,864
Transportation	1,493
TOTAL	**8,962**

Source: Division of Services for People With Disabilities, September 2001

The majority of DSPD clients are eligible for 70 percent of their services to be paid for by federal Medicaid waiver funds.

Most DSPD Clients Qualify for Federal Medicaid Funds. The majority of DSPD clients receive services funded by a combination of state funds and Medicaid funds by qualifying for one of three Medicaid Home and Community-Based Services (HCBS) waiver programs. These programs waive certain Medicaid requirements so that funding is available for individuals that are cared for in their homes and communities rather than in an institution. These individuals are funded by state dollars and a Medicaid match of approximately 70 percent. Existing HCBS waivers include services for individuals with

- mental retardation and other developmental disabilities,
- traumatic brain injuries, and
- physical disabilities.

As Utah's Medicaid Single State Agency, the Division of Health Care Financing in the Department of Health is responsible for managing Medicaid waivers. However, some administrative functions have been delegated to DSPD and are discussed in this report.

Many other individuals who do not qualify for the more stringent waiver standards are currently receiving services from the division funded wholly by state dollars.

DSPD Receives Significant State and Federal Funding

DSPD's fiscal year 2002 budget is $139 million, of which $94 million is federal funding.

To provide services to the clients discussed above, the division currently operates with a $139 million budget, which includes $94 million in federal funding. The division's budget for fiscal year 2002 is summarized in Figure 3.

Figure 3. Fiscal Year 2002 Budget for the Division of Services for People with Disabilities.

Schedule of Programs	
Administration	$ 2,983,000
Service Delivery	11,713,700
State Developmental Center	32,263,800
Residential Services	61,525,200
Day Training Services	15,346,300
Supported Employment	5,313,600
Family Support	7,131,300
Services for Individuals with Physical Disabilities	1,047,900
Transportation Services	1,889,300
Total of Programs	**$139,214,100**

Source: Appropriations Act (H.B. 1), 2001 General Session, Item 138.

The Legislative Fiscal Analyst has analyzed the growth of appropriations to the division over the past several years and concluded that "budgets have grown faster than the number of people served."

DSPD Must Make Difficult Choices

Since DSPD does not have the resources to provide all the services desired to all individuals considered eligible for them, it must face difficult choices about who receives services and who does not. ***Utah Code*** provides criteria on which to base service decisions, and the division has developed a Critical Needs Assessment (CNA) instrument to decide which individuals have the greatest need for service.

Funding decisions for DSPD have been made more difficult because of waiting lists for services which have existed for over ten years.

Waiting lists for services have long been considered a major problem facing the division, and the Legislature has wrestled with the problem on many occasions. For example, a 1990 legislative task force reported that "a major problem facing persons with disabilities is waiting lists." Reported waiting list sizes at that time were 350 for residential, 140 for day treatment, and 250 for supported employment services. At that time, the Executive Director of the Department of Human Services cautioned that "there needs to be some balance between the needs of the individuals and what the state can afford." Since that time, as Figure 4 shows, the Legislature has greatly increased service appropriations. Despite funding increases, however, waiting lists have continued to grow.

Despite significant funding increases in the past decade, the waiting list for services continues to grow.

Figure 4. Comparison of 1992 and 2002 Appropriations for Home and Community Services. Despite large increases in service expenditures, waiting lists have continued to grow.

	FY1992 Appropriation	FY 2002 Appropriation	Total Percent Increase	Annual Percent Increase
Residential Services	$18,528,200	$61,525,200	232%	13%
Family Support	700,000	7,131,300	919	26
Day Services	6,409,000	15,346,300	139	9
Supported Employment	1,567,600	5,313,600	239	13

As will be discussed in Chapter II, eliminating the waiting list is not just a matter of funding; it will require that existing policies be reassessed, particularly in how the division prioritizes service delivery. Future state policy choices may also be driven in part by a recent United States Supreme Court decision. The *Olmstead* decision indicated that waiting lists are acceptable as long as they move at a reasonable pace.

DSPD Uses Critical Needs Assessment As Decision-making Model for Funding

DSPD prioritizes individuals for service using the Critical Needs Assessment (CNA) instrument which ranks individuals by severity of need on a 100-point scale.

DSPD's decision-making and prioritization model, the Critical Needs Assessment instrument (CNA), is used to identify those individuals who have the most critical need for services. The CNA, a 100-point scoring instrument, incorporates four statutory requirements for prioritization into eight weighted categories that ranks clients by severity of need. One hundred represents the most critical need. (See Appendix A for the CNA form with accompanying policies and guidelines.) Figure 5 illustrates how DSPD has taken the four prioritization requirements in ***Utah Code*** 62A-5-102(3) and implemented them into weighted categories in the CNA form.

Figure 5. CNA Derives Prioritization Criteria From Statute. DSPD's instrument for deciding which clients get funding incorporates prioritization guidelines from statute. The CNA ranks clients on a 100-point scale (100 being the greatest need) using eight different weighted categories.

Statutory Criteria for Providing Service [*Utah Code* 62A-5-102(3)]

1. Severity of disability;
2. Urgency of needs for service;
3. Length of time without services from the division regardless of whether that person has formally applied for services and support from the division; and
4. Ability of parents or guardians to provide them with appropriate care and supervision.

CNA Prioritization Categories	Points Possible
1. Ability to be Self Directing	13
2. Problem Behaviors	15
3. Family Dynamics	25
4. Special Medical Needs	10
5. Protective Service Issues	10
6. Resources Available / Supports Needed	10
7. Projected Deterioration Issues	10
8a. Accessibility to Supports	4
8b. Time on Waiting List	3
Total Points	**100**

A high CNA score (100 points possible) is intended to signify that an individual has critical needs.

A high CNA score is intended to identify the clients that have the greatest immediate needs. DSPD uses the CNA to illustrate an individual's greatest need by accounting for the wide range of conditions as listed in Figure 5. Identifying these multiple conditions enables DSPD to determine who has the greatest need, assuming that clients scoring high in each category should have the greatest need in multiple areas.

As shown in Figure 5, each category has a different weight attached to it based on policy judgements made by DSPD. For example, "Family Dynamics" is the greatest weight with 25 possible points while "Time on Waiting List" has the lowest weight with 3 possible points. The categories included in the CNA and their weighting can be debated, but they reflect what DSPD has determined to be the best state policy for prioritizing who will receive services first. Therefore, services should be

provided to those with high CNA scores while those with low scores have a lower priority for receiving services.

DSPD Updating Response to Waiting List

In both the 2000 and 2001 General Sessions, the Legislature wrote intent language that the division seek

> to maximize its ability to serve individuals on the waiting list through reviewing existing policies, budgets, and service allocations and pursuing any appropriate additional federal waivers or funding or other creative mechanisms.

DSPD's most recent response to funding the waiting list is to no longer have a waiting list. The division will attempt to fund individuals upon one year of intake.

In response, the division convened a task force in the Fall of 2000 and reported a goal to essentially provide services to all people on the waiting list by July 2002. In fact, the division's more recent goal is to eliminate the waiting list altogether, which would eliminate the need for prioritizing services. Instead, the division intends to move to a system where the immediate needs of persons applying for DSPD services will be addressed following their application and verification of eligibility.

This updated response also involves paring down the size of the existing waiting list through a more detailed review of the list by such means as

- removing the names of individuals who currently reside in Intermediate Care Facilities for the Mentally Retarded (ICFs/MR),
- removing the names of individuals who already receive some service and addressing their waiting list needs at an annual review and/or a requested utilization review,
- surveying the needs of all individuals on the waiting list who are seeking residential services to inquire whether they may need lesser services, and
- meeting the needs of all individuals on the waiting list who only need one-time or intermittent services.

The feasibility of achieving this new direction remains to be seen in coming months.

Audit Scope and Objectives

In light of the waiting list and other concerns about how funding decisions are made, the Office of the Legislative Auditor General was asked to conduct a performance audit of the Division of Services for People with Disabilities.

We were asked by the Health and Human Services Joint Appropriations Subcommittee to evaluate the appropriateness of the method by which DSPD allocates its funding to its clients. By unanimous motion, the committee asked

> . . . in terms of performance and funding, the audit to include a look at how the funding is prioritized, are we getting the funding to the people who need it the most, what is happening in terms of critical needs and how are we meeting those critical needs.

We were asked to review how DSPD makes funding decisions about which clients receive division services.

We found several areas where division decision-making, policy and practices can improve. Our findings are supported by budgetary analysis, policy review and samples of clients currently receiving services and waiting list clients.

Our audit objectives included:

- Evaluate the accuracy of DSPD's waiting list,
- Evaluate how effectively DSPD utilizes federal matching funds,
- Evaluate the effectiveness of DSPD's decision-making process.

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Chapter II
Significant Problems Exist With DSPD Waiting List

Problems exist with DSPD's cost estimate to fund the waiting list. Better information is needed in order to provide the Legislature with more policy options.

Our review of the full DSPD waiting list, which included a detailed sample review, revealed significant concerns. Mainly, the three areas that make up the estimated cost of funding the waiting list—the number of individuals waiting for services, cost of services, and the percent of funding from the state—are unreliable.

But, even if data were reliable, a complete representation of the cost to fund the waiting list may not be as helpful to the Legislature as presenting several funding scenarios based on different policy directions the Legislature could choose. For example, the Legislature could choose to fund only those waiting list clients that meet a certain critical needs assessment score or fund only those clients that are eligible for the Medicaid waiver, or both. Funding portions of the waiting list based on such specific policies could range from as little as $1.2 million to as much as $7.5 million for the entire waiting list revised by the audit. This chapter presents some of these funding options.

Finally, because current waiting list information is not reliable, DSPD needs to consider changes to its current process of new client intake. For example, more detailed information on a client's eligibility and cost of service needs to be recorded so that better policy decisions can be made regarding waiting list funding.

Future Funding Determined from Waiting List

For years, the waiting list has been DSPD's tool to communicate unmet needs to the Legislature.

For the past several years, the division has used the waiting list as a measure of unmet needs when seeking funding before the Legislature. In 2001, the division reported over 1,900 people were waiting for services with critical-immediate needs. The amount of state funds needed to provide services to those on the waiting list was estimated to be over $12 million. This information, as presented to the Health and Human Services Joint Appropriation Subcommittee, is summarized in Figure 6.

Figure 6. DSPD Service and Waiting List Information Presented to the 2001 Legislature.

Individuals with "critical-immediate" needs	1,931
Individuals with "future" needs	814
Total individuals on the DSPD waiting list	2,745
Total needed to fund the waiting list, fiscal year 2002	$12,400,603
DSPD's FY 2002 request for waiting list funding	$2,350,000
Number of individuals on the waiting list anticipated to be funded	365

Audit Evaluated August 2001 Waiting List

DSPD analysis of the waiting list sets the cost of providing service in the four major areas plus support coordination at $10.5 million.

We reviewed the waiting list data as of August 2001. DSPD analysis showed that the cost—in state general funds—of providing the four major services plus support coordination is about $10.5 million, as shown in Figure 7.

Figure 7. DSPD Cost Information for August 2001 Immediate Waiting list. According to DSPD, the cost of eliminating all immediate needs in four major service areas plus support coordination was about $10.5 million in state general funds.

Service	Number Waiting	Average Cost	Percent State	State Cost
Community Living	663	25,900	31%	$5,323,227
Day Training	214	12,493	34	908,991
Supported Employment	349	7,270	31	786,541
Family Support	996	5,632	38	2,131,599
Support Coordination				1,311,096
Total Individuals	**1,869***			**$10,461,454**

** Some individuals are listed as waiting for more than one service.*

In order to focus on major service areas, some of the lesser cost areas of the waiting list were not reviewed.

Note that the $10.5 million in Figure 7 is less than the $12 million DSPD reported earlier to the Legislature for a couple of reasons. First,

there is a time difference; we reviewed the August 2001 waiting list, while the information provided to the Legislature was based on an earlier list. Second, the waiting list we reviewed did not have any information about two categories

- the costs of housing assistance that DSPD may provide solely with state funds to subsidize some individual's housing costs, and

- the cost of funding the physical disabilities waiting list because our timeliness in learning that it was a separate list administered by the state office, not the regions, did not allow adequate time for analysis. (Nonetheless, this waiting list—despite being much smaller—likely needs to be scrutinized in the same manner as the main waiting list we review in this chapter.)

We included support coordination in our cost estimates based on information from DSPD. We found that 84 percent of those on the waiting list did not currently receive DSPD services. If many new clients are provided services, additional staff will be needed to coordinate their supports. DSPD has determined that cost of a support coordinator is about $50,000 and that 30 clients is a full workload. We estimated additional support coordination costs on that basis.

Waiting List Information Is Not Reliable

Although we have a revised cost of funding the waiting list, our concerns will still exist with the new figures. Concerns exist in the following three major categories:

Concerns exist with DSPD's waiting list estimates of the
- **number of people included,**
- **costs of services, and**
- **percent of state funding used.**

- the number waiting for immediate services is overstated,
- the cost of service estimates are not reliable, and
- the percent of state costs appears underestimated.

The criteria for being on the waiting list is that the individual be eligible for services and that they would accept the services immediately if they were offered. DSPD determines eligibility for its services by completing an evaluation form for each individual. This form (Form 19) assesses whether the individual has functional limitations in at least three of seven areas (see Appendix C for DSPD Form 19). Individuals who are

eligible may choose the services they desire. If the person would accept the service now, he or she is placed on the immediate need list; otherwise, the person is placed on the future need list.

Number Waiting for Immediate Services Is Overstated

Our initial review suggested 172 individuals could be removed from the list of 1,869 people.

We found that the DSPD waiting list includes many individuals who do not belong on the list. On our initial review of the list, we found that about 9 percent of the individuals could be removed because they already received services. Then, based on a detailed review of a random sample of the other cases on the list, we found about an additional 24 percent of those individuals could be dropped.

Initial Review Removes Some Individuals from Waiting List. Our initial review of the waiting list identified 172 individuals (9 percent) who should be removed from the waiting list. We discussed the following two categories of individuals with DSPD staff who agreed that these people did not belong on the waiting list.

Reasons for initial removal were that
- **135 individuals were already in ICFs/MR, and**
- **37 individuals were receiving the same service they were waiting for.**

- 135 individuals residing in ICFs/MR (Intermediate Care Facilities for the Mentally Retarded). These people have access to a full range of services in the institutional setting. If they seek a community placement, there is a portability option they would follow. (Portability allows funding for individuals to move from an ICF/MR to a community setting, if they desire.)

- 37 individuals who are receiving the same or a similar service from DSPD as was shown on the waiting list.

After removing these individuals, the immediate needs waiting list included 1,697 individuals.

Our audit sample showed that about 24 percent of those on the waiting list could be removed.

Audit Sample Identifies Waiting List Deletions. Of the 1,697 individuals remaining on the waiting list following our initial review, we believe about one-fourth do not meet the criteria to be on the list and should be removed for several reasons including

- they no longer desired the service for which they were listed,
- they had moved or passed-away, or

- they had already come into services, but the waiting list data was not updated.

In addition, a few individuals who belong on the waiting list have fewer service needs than listed.

Our random sample included follow-up with DSPD Support Coordinators in all four regions.

We randomly selected 132 waiting list individuals for a detailed review. According to the list, the 132 individuals were waiting for 158 total services. Auditors examined case files at DSPD region offices and discussed any discrepancies with division staff. While most files showed why a person had been placed on the waiting list, often there was no evidence of any recent contact to verify current needs. Therefore, if there was any question about current needs, we sent a survey to the responsible DSPD workers asking them whether or not the individual or his/her family would accept the listed service if offered. Based on the files and the survey responses, we determined whether each individual met the criteria to be listed. Figure 8 has our results.

Of 132 in our audit sample of waiting list individuals, we removed 32, or 24 percent, from the list.

Figure 8. Summary of Sample Results. Audit staff performed a detailed review on 132 random waiting list individuals and determined that 32 (or 24 percent) should be removed.

	Individuals	Percent	Services	Percent
Removed	32	24.2%	45*	28.5%
Kept	100	75.8	113	71.5
Total	**132**	**100.0%**	**158**	**100.0%**

** Of the services removed, 37 come from the 32 individuals removed and 8 come from individuals kept on the list, but for fewer services.*

It is interesting to note that when we followed up with DSPD staff about whether some of the clients in our sample still had "immediate" needs, some of the staff reported that clients' needs actually changed. Thus, we further questioned the reliability of the service data on the waiting list.

We estimate that there are 1,290 individuals waiting for services compared to DSPD's count of 1,869.

Audit Revisions Show 1,290 on DSPD Waiting List. After applying the sample exception rate of 24 percent to our initial review waiting list number of 1,697, we determined the adjusted number of

individuals on the waiting list to be 1,290 rather than the DSPD number of 1,869. This analysis is shown in Figure 9.

Figure 9. Summary of Audit Adjustments to the DSPD Waiting List. Audit revisions put the waiting list at 1,290 compared to DSPD's count of 1,869.

Individuals on DSPD's waiting list (see Figure 7)	1,869
Removed ICF/MR clients from waiting list	135
Removed clients receiving same or similar services	37
Subtotal	1,697
Removed 24 percent of clients (audit sample exception rate)	407
Revised Waiting List Total	**1,290**

Cost of Service Estimates Not Reliable

We believe that DSPD's cost of service estimates are not reliable.

The second factor in estimating the funding needs (the number of individuals waiting being the first) is the average cost of services provided. DSPD reports it uses actual costs of providing services to individuals already receiving services to estimate waiting list costs. We do not feel the cost figures used by DSPD are reliable for two reasons:

- First, cost figures used by DSPD have not been updated for years and are not accurate.
- Second, the average cost of serving individuals on the waiting list may be different from those now in service.

DSPD reports that it estimates service costs on a full program equivalent (FPE) basis. The FPE determination is based on the amount of services provided individuals (usually on a per hour or per day basis) and the cost of those services. In general, we feel this approach makes sense. When individuals are brought off the waiting list, they must be funded on an ongoing basis for the number of service units DSPD will provide annually.

Initial figures used by DSPD to cost-out the waiting list in 2001 had not been updated since 1998.

The first concern with DSPD's cost figures is accuracy. Figures used to cost out the waiting list have not been updated for three years and do not reflect current costs. Once we learned that old cost figures had been

used, we did not try to determine how they were initially established. Instead, we compared the old cost figures to recent FPE costs and found significant differences. For example, the fiscal year 2001 FPE cost for day training service was $9,080. However, DSPD has used a higher amount of $12,493 since August, 1998. DSPD reports that transportation costs should be included in day services, which may account for some, but not all of the difference.

The average cost of services for those on the waiting list may differ from average costs of those already in service.

Our second concern is that DSPD has not considered whether the average cost of individuals on the waiting list would be the same as those currently receiving services. Since DSPD has tried to serve those with the greatest needs, those on the waiting list may have lower and less costly needs than those in service. If those on the waiting list tend to cost less than those now in service, then using an FPE cost based on current clients would overstate waiting list funding needs.

For our cost analyses which follow, we used the fiscal year 2001 total costs per program divided by the total clients per program to obtain the average costs. Our cost estimate for day services includes transportation costs. For the family support cost estimate, we excluded one-time cash assistance payments.

Percent of State Funding Appears Understated

To have a reliable cost estimate of the waiting list, the percent of costs coming from the state must be known.

The third factor in estimating current funding needs to serve individuals on the waiting list is the percent of costs that would come from the state. It appears that DSPD may substantially overestimate the proportion of service costs paid with federal funds.

DSPD reports that it based estimated percent of state funds on current federal funding levels, but the information does not always correspond. For example, the actual percent of state funds for supported employment services in fiscal year 2001 was 42 percent, but the division's waiting list cost estimate assumes the state will only have to provide 31 percent of the costs. In our opinion, serving all those on the waiting list could have the opposite effect. That is, many individuals on the waiting list may not be eligible for federal matching funds, so the percent of costs paid by the state may increase rather than decrease.

Our estimate shows that the state would pay 50 percent of the cost to fund the waiting list (with the rest coming from Medicaid) rather than DSPD's estimate of 33 percent.

The percent of costs paid by the state largely depends on whether individuals are eligible for matching Medicaid funding. According to

DSPD, about 69 percent of those on the waiting list are eligible for federal matching funds while 31 percent are not. Thus, the federal government would pay about 70 percent of the cost of serving the 69 percent that are Medicaid eligible, assuming the services provided are eligible.

DSPD practices with respect to Medicaid eligibility are discussed in more detail in Chapter III; however, the availability of matching funds is not considered when setting service levels. If service costs are similar regardless of whether matching funds are available, then federal funding would pay for less than half the cost of the waiting list (70 percent of 69 percent is 49 percent). In contrast, DSPD's waiting list cost estimate assumes federal funding would provide about 67 percent of service costs.

Revised Cost Estimate Still Needs Better Data

Because we generally lack some confidence in DSPD's waiting list data, the audit-adjusted cost for funding the waiting list also lacks some accuracy. However, we are more confident in the waiting list funding figure of $7.5 million than the $10.5 million presented by DSPD. This revised cost of funding the waiting list is shown in Figure 10.

After adjustments, our audit estimate to fund the waiting list is $7.5 million compared to DSPD's $10.5 million.

Figure 10. Audit Cost Estimate for August 2001 Immediate Waiting List. Audit adjustments result in fewer people listed as waiting for immediate services, but they greatly increase the proportion of state funding needed to provide services.

Service	Number Waiting	Average Cost	Percent State	State Cost
Community Living	300	$ 27,000	50%	$ 4,050,000
Day Training	140	9,700	50	679,000
Supported Employment	230	6,000	50	690,000
Family Support	780	3,000	50	1,170,000
Support Coordination				904,000
Total Individuals	**1,290***			**$ 7,493,000**

** Some individuals are listed as waiting for more than one service.*

Figure 10 adjusts the DSPD waiting list in all three categories—number waiting, average cost, and percent state (the portion of state general funds needed to fund the waiting list)—to obtain the revised $7.5 million figure. However, our revised estimate is still based on DSPD's existing policies for determining client eligibility and service needs. If these policies were changed, then the amount of funding needed would be very different.

Cost of Funding Waiting List Depends on Policy

Although a revised cost figure is given, the actual funding need of the waiting list depends on policy decisions about whom to fund and what services to provide.

In the previous section, we reviewed the waiting list and the cost to fund it based on existing policy. Our main conclusion is that DSPD's information is not reliable. While we provided a revised estimate based on our work, that figure is really only a starting point. DSPD staff assured us that if the Legislature funded the current waiting list, many more individuals would come forward for services. In our opinion, the philosophy of the division about who has a critical-immediate need for services and what services they are provided must be examined to draw any meaningful conclusions about the funding needs. Thus, in this section we examine how waiting list funding needs are affected by two key issues:

- Decisions about who will be funded, and
- Decisions about what services to provide.

Funding Needs Depend On Types of People Funded

Despite what may have been said, not all individuals on the waiting list have "critical-immediate" needs. The terminology is misleading.

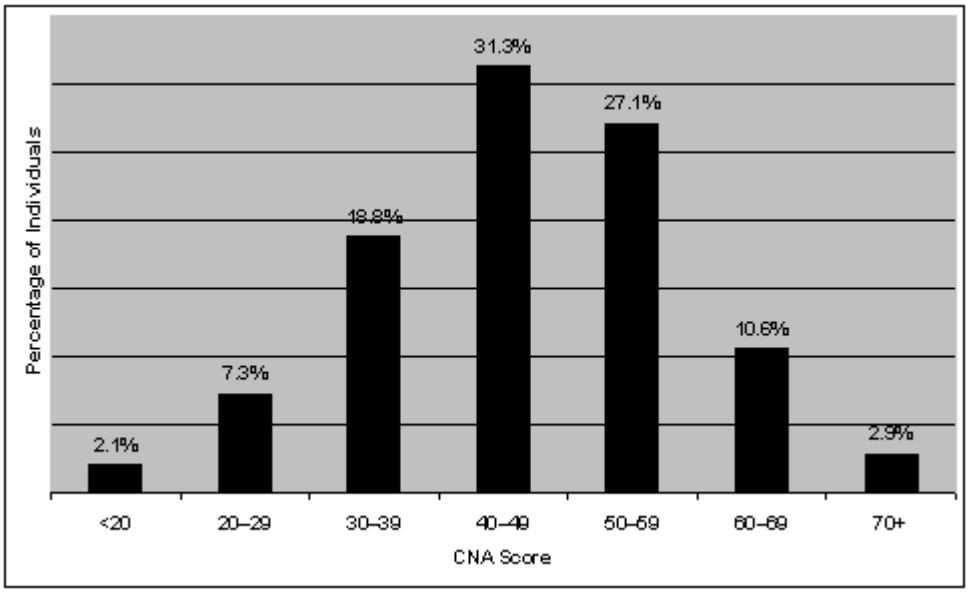
Waiting list funding needs vary greatly depending on the type of individuals included in the cost estimate. DSPD's practice has been to describe all individuals who qualify for division services and who would accept services, if offered, as having a "critical-immediate" need. In short, any individual on the waiting list is essentially termed a "critical" need. For example, as Figure 6 showed, DSPD told the Legislature in February 2001 that 1,931 individuals had "critical-immediate" needs. We think this terminology is misleading because it does not recognize the wide range of needs that are included. Using DSPD's current approach, even an individual with a CNA score as low as seven (one such currently exists on the waiting list) is seen to have critical needs. In reality, an individual

with a CNA score of seven would have low needs relative to an individual with a higher CNA of, perhaps, 60.

A wide-range of needs exist on the waiting list; some are less critical than others.

Another concern with describing all those eligible for and desiring services as having critical-immediate needs is that it does not help policy-makers weigh appropriation choices. DSPD staff told us some clients have a great need for service, but others have a relatively low level of need. The range of needs is also shown by the CNA scores of individuals on the waiting list. Figure 11 shows the distribution of CNA scores for all services types combined.

Figure 11. Waiting List Could be Shown by Need According to CNA Score. Rather than communicating that all individuals on the waiting list have "critical" needs, DSPD could show the range of need through a CNA frequency like the one below.



Some DSPD workers feel that the criteria to enter service may even be too lenient. A high degree of subjectivity exists on the eligibility form.

Another issue that some DSPD staff raised with us is the eligibility criteria for DSPD (see Appendix B for DSPD's eligibility policies, procedures and guidelines). Some workers feel that the criteria for qualifying for services should be more stringent so less severely disabled people do not qualify. DSPD Form 19 (see Appendix C) is used to determine service eligibility. Individuals must have three of seven boxes checked indicating substantial functional limitations in those areas. However, there seems to be considerable subjectivity in completing the form, and, in practice, some eligible individuals may not have a "severe,

chronic disability" as intended by statute. In comparison, waiver eligibility requires a higher level of disability than DSPD eligibility. DSPD Form 817 (see Appendix D) requires that individuals qualify under a level of care requirement.

The funding totals we provide, based on various policy scenarios, should not be viewed as precise estimates.

The remainder of this section provides examples of how different amounts to fund the waiting list are required based on which types of clients are served. It is important to reiterate that despite our efforts to adjust the waiting list data, concerns with the data provided by DSPD still exist. Therefore, the funding totals we provide in the coming sections, based on various policy scenarios, should not be viewed as precise estimates. Instead, the key message is that funding the waiting list depends on which portions of the waiting list the Legislature desires to fund.

The Legislature could decide to only fund individuals on the waiting list with higher CNA scores.

Funding Clients with High CNA Scores. Even if division staff continue to allow individuals to determine their own need for service, DSPD could more clearly identify high needs from low needs. Rather than referring to all needs as critical, the division should consider some type of classification system using CNA scores to differentiate among need levels. Figure 12 shows the estimated cost of different need levels on the waiting list.

Figure 12. Audit Cost Estimate for Funding Clients with Different Levels of CNA Scores. Funding only individuals with high CNA scores (scores over 50, for example) would reduce the funding needed to $2.9 million in state funds.

Need Level	CNA Score	Number	Estimated Cost	Cumulative Cost
1	60 or higher	164	$ 953,000	$ 953,000
2	50 to 59	336	1,952,000	2,905,000
3	40 to 49	426	2,474,000	5,379,000
4	39 or lower	364	2,114,000	7,493,000
Total Individuals		**1,290***		

**Individuals with higher CNA scores may tend to have higher service costs, but they may also be more likely to be eligible for federal matching funds. Because we have no reliable data on either effect, this figure assumes cost does not depend on CNA score.*

The Legislature could decide to only fund individuals on the waiting list eligible for Medicaid waiver funding.

Funding Individuals That Are Eligible for Federal Matching. Another policy option that the Legislature and DSPD could consider is to limit the waiting list funding to individuals eligible for the Medicaid waiver. In general, as discussed in Chapter III, individuals who do not qualify for the waiver either do not meet the disability level of care requirement or else do not have a high financial need. Figure 13 shows the estimated cost of funding the waiting list under that policy is $3.2 million in state funds.

Figure 13. Audit Cost Estimate for Funding Individuals Eligible for Federal Matching Funds. Funding only individuals who qualify for the waiver reduces the state funding needed to $3.2 million.

Service	Number Waiting	Average Cost	Percent State	State Cost
Community Living	210	27,000	30%	$1,701,000
Day Training	85	9,700	30	247,000
Supported Employment	155	6,000	30	279,000
Family Support	570	3,000	30	513,000
Support Coordination				445,000
Total Individuals	**890***			**$3,185,000**

** Some individuals are listed as waiting for more than one service.*

This policy option reduces the cost significantly but still serves most of the individuals because federal funding is maximized. Since only waiver eligible individuals are included, the federal Medicaid program pays 70 percent of service costs. Unless the match rate changes, the percentage of federal participation in service costs would only be less if non-eligible services were provided.

For about $1.2 million, the Legislature could fund those individuals with both high CNA scores and Medicaid waiver eligibility.

Funding Individuals With Both High CNA and Waiver Eligibility. Another option the Legislature could choose is to prioritize funding to those waiting list individuals who have relatively high CNA scores and who also qualify for Medicaid waiver funding. Under this policy option, the Legislature would, in theory, fund those with the highest need which are also those able to receive the majority of funding from federal dollars. For discussion purposes, we took the approximate top third of the waiting list (CNA score of 50 or above) and identified

only those in that group which DSPD believed would qualify for waiver funding. Our calculation is that it would take about $1.2 million to fund this client group.

Funding Needs Depend on What Services Are Funded

The Legislature could decide to prioritize funding to certain service types.

In addition to who is served, funding needs also depend on what services are provided. Services vary both in how much they cost and whether they are eligible for matching federal funding. Another important issue is how the need for service is determined.

Some DSPD staff and board members indicated to us that if the state could at least fully fund family support services, that action would alleviate many current burdens and delay future service needs. We are not aware of any evidence that supports this contention. However, if a policy decision was made to fund all requested family support services, the cost in state funds would be about $1.2 million, or for waiver eligible individuals, only about $500,000 (as shown in Figures 10 and 13 respectively), plus some additional support coordination costs. Under this option, the Legislature could choose to fully fund certain service needs first and then proceed to partially fund other needs.

The Legislature could decide to fund only those services that are eligible for federal matching funds.

Another important consideration is whether services are eligible for federal matching funds. Services like cash assistance and housing assistance are always paid with 100 percent state funds. In contrast, most other services to waiver eligible individuals require only 30 percent state funds. Chapter III addresses the importance of structuring the division's service delivery decisions to qualify for federal matching funding as much as possible.

Determining need should be a combination of professional judgement and individual service request.

Finally, identifying individuals' needs is very important. The division's waiting list is based on individuals' self-identified need or desire for service. Allowing individuals to determine their own need for service may be an outgrowth of the division's philosophy of self-determination. Self-determination is an important concept that is aimed at allowing individuals with disabilities to control their own lives. It helps ensure that individuals are not directed into services they do not want (e.g., an institution) by professionals. However, we are concerned that division staff may not use their professional judgement to question whether individuals need the services they request. Determining need based on a

combination of professional judgement and service requests, where both must exist, is another way to help control service demands.

Intake Policy and Procedures Can Improve

DSPD can improve its intake process and waiting list procedures and provide better policy-making information.

Beyond the issue of funding the waiting list, our review of DSPD clients on the waiting list for services revealed other concerns. Because too little data is collected on potential clients at the intake process, there is inadequate information for policy-making. For example, DSPD does not determine clients' funding eligibility and specific costs of services as part of the waiting list database. Also, the waiting list has not been kept up-to-date, as our sample review confirmed. Client confusion also exists due to some of the current waiting list management and communication practices. Some confusion seems to result from people thinking that time waiting for services is an important factor in how the waiting list is prioritized.

Earlier in this chapter we discussed the importance of deciding who receives services and what services they receive as critical to determining funding needs. Because of these decisions, DSPD's intake processes for determining client eligibility and identifying service needs are very important. DSPD needs to insure its eligibility process accepts only those with "severe, chronic disabilities." Similarly, we feel DSPD should evaluate service requests to insure that they truly constitute needs rather than characterize all service requests as critical-immediate needs. In the remainder of this chapter, we discuss some additional items related to the client intake process.

Better Information Collection Needed at Time of New Client Intake

DSPD should obtain more complete data on new clients at its intake process.

Current DSPD practice at new client intake does not lend itself to detailed data gathering. For example, although the service requests are recorded, there is not a detailed cost estimate included with the individual's waiting list information. Further, the intake worker only gives a "best guess" as to whether an individual would qualify for federal funding through the Medicaid waiver. For reasons such as these, our previous analysis and presentation of several funding scenarios of the waiting list was based on incomplete information.

DSPD could remedy this lack of information by performing a more extensive Medicaid pre-qualification on each new client and by more fully estimating specific service costs. The effect would be that DSPD could give the Legislature waiting list cost estimates based on actual data rather than extrapolated data from those already in service. DSPD should review its entire intake process and not limit its review to the items discussed in this section. This same recommendation applies to the discussion items on waiting list management and communication which follow.

Waiting List Information Should Be Kept Current

The inaccuracies we found in the waiting list data exist partly because information is not kept current. Caseworkers sometimes do not maintain contact with clients to verify that the service is still needed. There also are no specific guidelines for removing a person from the waiting list if contact is lost. However, caseworkers are supposed to review critical needs assessments at least annually. Therefore, it would seem reasonable that if there was no contact for more than a year, the person would be removed from the immediate needs waiting list.

A lack of guidelines has led to out-dated information on the waiting lists.

Because there are no guidelines, each region has its own follow-up procedures. One office contacts clients every six months, whereas another has no set schedule for following up with clients. Another office that sends letters every six months assumes that the waiting list information is accurate if there is no reply. To keep waiting list information current, caseworkers need to have consistent follow-up procedures and remove individuals from the list when contact has been lost for more than a year.

Communication with Clients May Overstate Expectations

Caseworkers may be overstating waiting list placement to individuals.

Caseworkers also need to clearly communicate about the prioritization of the waiting list and that the amount of time people have waited does not mean they will receive services sooner. Caseworker communication may mislead clients into believing they will receive services sooner. For example, in our review of case files we found copies of letters informing clients they are

- "on the waiting list at a critical level," or
- "waiting to receive funding at a 'Priority 1' level."

Frequently, however, the client's CNA score was so low that there was little prospect that the individual would be offered services.

Because of these circumstances, we believe DSPD needs to review how waiting list movement is communicated to potential clients as well as the amount of credit given for time on the waiting list as part of its broader prioritization policy.

DSPD Should Review CNA Instrument

Advising clients to get on the list sooner because there is "about a two year waiting list" also gives the incorrect impression that a person moves to the top of the list based on how long he or she has been waiting.

The CNA score gives only 3 points out of a possible 100 for time on the waiting list. DSPD should review CNA weighting for legislative and division intent.

To the contrary, the CNA score gives very little credit for the amount of time a person waits for services. As shown in Chapter I, Figure 5, an individual's "Time on Waiting List" accounts for only three of a possible 100 points (3 percent) of their CNA score. Thus, those waiting do not necessarily "move up" the list based on time because three points contributes very little to the overall score. Also, others may be added over the course of time with higher CNA scores than those already on the list, making it even less likely for movement up the list.

Similarly, the severity of an individual's disability may not be as highly weighted as many people assume. An individual's ICAP (Inventory for Client Agency Planning) service score measures the level of services the individual needs due to his or her disability. DSPD uses the ICAP service score to help determine a person's "Ability to be Self-Directing" which receives up to 13 of the 100 points; however, some other items on the CNA form (see Appendix A) also relate to the individual's care needs. Still, the most highly weighted item is family dynamics, worth 25 points, and some other CNA items also seem related to family dynamics. We agree that family dynamics is an important consideration, but so are time waiting and severity of disability. Since the prioritization of clients is so important, DSPD should review the CNA weighting and make sure it reflects legislative and division policy intentions.

Recommendations

DSPD Need Identification Process

1. We recommend DSPD management and board review service eligibility guidelines and practices to insure eligibility is limited to those with severe, chronic disabilities.

2. We recommend DSPD management and board insure that the determination of individuals' service needs include a level of professional judgement as well as individuals' service requests.

3. We recommend DSPD review policies and procedures relating to new client intake and waiting list management and communication. Specifically, DSPD needs to

    - create a process whereby more detailed information is gathered at the time of new client intake,
    - implement waiting list management policies for keeping the list up-to-date, and
    - have uniform policies on the manner and frequency of communication between caseworkers and waiting list individuals.

4. We recommend DSPD review the Critical Needs Assessment instrument to insure it appropriately prioritizes individuals waiting for services. Specifically, DSPD should review whether individuals'

    - time waiting for services is adequately weighted, and
    - severity of disability is adequately weighted.

Communicating Funding Needs

5. We recommend DSPD review the manner in which waiting list information is presented to the Legislature. Specifically, DSPD needs to

    - review the current number of individuals waiting with immediate service needs, to insure it is not overstated,
    - update the cost figures and methodology used to estimate funding needs, and

- review the percentage of individuals on the waiting list who would require full state funding, so the amount of federal funding is not overstated.

6. We recommend DSPD provide the Legislature with more policy scenarios on funding different aspects of the waiting list—such as those provided in this chapter—in order for the Legislature to have more information on which individuals and services could be funded.

7. We recommend DSPD consider presenting the waiting list information by levels of need (rather than communicate that all individuals on the waiting list are "critical") in order for the Legislature to have better information for funding and policy decisions.

Chapter III
Better Management of Medicaid Waiver Eligibility Is Needed

Some DSPD clients receive services funded wholly with state dollars because either the person or the service does not qualify for federal matching funds through one of the three Medicaid home and community-based service waivers administered by DSPD. Our review of a sample of clients who did not receive federal waiver funds revealed several concerns. First, some individuals qualify for waiver funds, but the state does not receive them because paperwork has not been completed. In addition, other individuals do not qualify for federal waiver funds because they do not have either a severe enough disability or the financial need necessary to meet eligibility requirements. Given the limited resources available to provide services, serving these waiver ineligible clients raises important policy issues. Finally, this chapter also discusses some options to better maximize federal Medicaid funds.

In fiscal year 2001, over $6 million in state funds were spent on clients or services without any federal matching Medicaid funds.

DSPD receives federal matching Medicaid funds for the majority of its clients. The federal match rate is adjusted annually based on the state's per capita income; for 2002 the match rate is 70.36 percent. While most DSPD expenditures receive federal matching funds, a significant amount of state funds is spent on clients or services that do not qualify for a Medicaid waiver. In fiscal year 2001, over $6 million in state funds were spent on clients or services without any federal match. Those funds potentially could draw down an additional $14 million in federal funding to service individuals on the waiting list. Because of the potential to obtain federal matching funds, monitoring waiver eligibility is very important.

DD/MR Waiver is Largest of Three DSPD Administered Waiver Programs

The DD/MR waiver for clients with mental retardation is the largest of three Medicaid waivers.

DSPD administers three home and community-based service (HCBS) waivers that allow federal Medicaid funds to be used for people who live in the community instead of institutions. While management responsibility for the state's Medicaid program, including the waivers, rests with the Division of Health Care Financing in the Department of Health, DSPD completes many of the administrative tasks. The largest

program is for individuals with mental retardation and other developmental disabilities (DD/MR). DSPD also administers HCBS waiver programs for people with traumatic brain injuries and for people with physical disabilities. As shown in Figure 14, the DD/MR waiver is DSPD's largest waiver program.

Figure 14. DSPD Administers Three HCBS Waivers. In fiscal year 2001, state and federal expenditures for clients receiving DD/MR services exceeded $88 million with nearly $6 million for individuals who did not qualify for federal Medicaid waiver funds.

	Expenditures by Waiver Eligibility		
Client Group	Waiver (Federal & State)	Non-Waiver (State)	Total
DD/MR	$82,343,000	$5,863,000	$88,206,000
Traumatic Brain Injuries	1,447,000	23,000	1,470,000
Physical Disabilities	1,097,000	247,000	1,344,000
Total	**$84,887,000**	**$6,133,000**	**$91,020,000**

Figure 14 also shows the fiscal year 2001 expenditures for each client group that was not waiver eligible. We examined the non-waiver expenditures because of the amount of additional federal funds (about $14 million) DSPD could obtain if all its expenditures were waiver eligible. Since most non-waiver spending was for DD/MR clients, we concentrated our work in that area.

DD/MR waiver eligibility criteria include a person's disability level of care, financial need, and citizenship.

DD/MR Waiver Eligibility Requirements. Each waiver program has specific eligibility requirements that must be met in order to qualify for federal matching funds. The following summarizes the three DD/MR waiver eligibility criteria.

- **Disability Level of Care**. A person must have a specified severity of either mental retardation or a developmental disability that requires the care and services similar to a person with mental retardation. A person's level of care requirements must be such to require institutional services in an Intermediate Care Facility for People with Mental Retardation (ICF/MR) if not for the

availability of community services. Appendix C shows DSPD's Form 19 that determines whether a person has the functional limitations required to be eligible for DSPD services. Appendix D shows DSPD's Form 817 that is completed to verify an individual's level of care eligibility for the DD/MR waiver. Thus, less severely disabled individuals may qualify for DSPD services but not meet the level of care standard for waiver eligibility. In addition, the person's primary diagnosis must be mental retardation and not mental illness.

- **Financial Need**. A person must also qualify to receive a Medicaid card and meet the income and asset limits set by the Medicaid program. A person with more than the allowable income may "spend-down" to that income standard either with cash paid to the department or by incurring medical expenses not paid by Medicaid. Financial need requirements generally do not apply to children.

- **Citizenship/Residency**. Medicaid requirements also specify that a person be a United States citizen and a resident of the state.

Sample of DD/MR Clients Not Receiving Medicaid Waiver Funds

To learn why the state does not receive waiver funds in some cases, we reviewed a sample of DD/MR clients whose services were paid for wholly with state funds in July or August 2001. We eliminated services that are not eligible for waiver funding such as cash assistance and housing assistance. For clients whose expenditures appeared significant, we asked caseworkers to explain the reasons the person was not eligible for the DD/MR waiver. Also included in our sample are several clients that caseworkers identified to illustrate reasons why a client was ineligible. In all, we reviewed 77 of the approximate 400 non-waiver clients.

Some non-waiver clients are actually eligible for waiver funds. Others are ineligible because they do not meet eligibility criteria.

As shown in Figure 15, not all non-waiver clients are actually ineligible—a quarter of our sample was likely eligible for waiver funding. The remaining were ineligible because they did not meet one or more of the three eligibility criteria.

Figure 15. Sample Shows Some State Paid Clients Are Eligible For Waiver Funds.

Waiver Status	Number	Percent	FY 2001 Expenditures
Likely Eligible	21	27%	$ 224,000
Ineligible	56	73	1,084,000
Total	**77**	**100%**	**$1,308,000**

The next section discusses the importance of better monitoring of non-waiver clients so that the state receives federal funds for all clients that qualify for it. Then, the following section addresses some policy issues raised by providing services to individuals who are ineligible for waiver funding.

Better Monitoring of Non-waiver Clients Is Needed

DSPD needs to better monitor waiver eligibility to maximize federal matching funds.

From sample results we conclude that DSPD needs to better monitor the waiver eligibility of its clients to collect the maximum amount of federal matching funds. One-fourth of the non-waiver clients we sampled are likely eligible for waiver funding, and federal funds are lost because eligibility has not been established for these clients—either because the caseworker or client has not completed the paperwork or because the client chose not to receive waiver funding. According to DSPD rules, if eligible clients refuse to participate in the waiver, their funding is limited to the amount that would be needed for the state match if they were on the waiver. However, we found that, in practice, the rule is usually not enforced.

Many Non-waiver Clients Do Qualify for Waiver

In fiscal year 2001, payments exceeded $224,000 for the 21 sample clients who were likely eligible for the waiver. The Medicaid waiver would have paid over 70 percent ($157,000) had the person's waiver eligibility been established and had all services been waiver eligible.

Some non-waiver clients were likely eligible for matching waiver funds.

Caseworkers reported that eligibility had not been established for these clients either because the caseworker or client had not completed the paperwork or because the client chose not to receive waiver funding, as shown in Figure 16. In our opinion, these are poor reasons to forgo collecting federal matching funds, especially when many people are waiting to have the services they need funded.

Figure 16. Waiver Eligible Clients. Eligibility was not established for 21 clients who were likely waiver eligible either because paperwork was incomplete or the client chose not to receive waiver funding.

Reason	Number	Percent	FY 2001 Expenditures
Paperwork Incomplete	17	81%	$210,000
Refused Waiver Funding	4	19	14,000
Total	**21**	**100%**	**$224,000**

Waiver funds were lost because paperwork was incomplete.

Paperwork Was Incomplete. Caseworkers reported that the reason waiver eligibility had not been established for 17 clients was because the person's paperwork was incomplete, either because the caseworker was in the process of obtaining information or because the client had not returned needed information. Paperwork had been in process anywhere from five months to several years. Of course, paperwork should not take this long, and in some instances, caseworkers acknowledged that they had just overlooked seeking waiver eligibility.

For several clients, delays occurred because caseworkers were waiting to obtain additional documentation for a client before submitting the waiver application. In our opinion, caseworkers were sometimes overly cautious in making sure all their documentation was flawless. When we asked what the consequences were for having incomplete documentation for clients they were confident would meet eligibility requirements, caseworkers said that while there were no additional penalties, they were cautioned that years ago DSPD had to repay Medicaid for clients that auditors found were erroneously submitted as waiver eligible.

Waiver funds were lost because clients refused to apply.

Client Refused Waiver Funding. Four of the clients reviewed were likely eligible but refused waiver funding. Caseworkers reported that

clients sometimes do not want to bother with the process of applying for Medicaid. One person refused waiver funding because he felt that federal funds paid through Medicaid were akin to receiving welfare although he felt that accepting state funds was okay. Some clients who could be waiver eligible are content to receive only the state portion of funding. However, in almost all cases we could not verify that the amount paid was only the state portion.

Payments Exceed the State Funding Portion

Eligible clients who refuse to apply for the waiver are supposed to have their funding level reduced.

Clients who are eligible for the waiver but do not complete the required paperwork are supposed to have their funding level reduced. DSPD policy is that if an eligible individual chooses not to participate in the waiver, "the person shall only receive that portion of State assistance that would be used to pay the State match for supports covered by Medicaid" (Administrative Rule R539-1-1 (B) (2)). The idea behind this rule is that if someone prevents the state from obtaining federal matching funds it deserves, then the person should lose money, not the state. However, we found that payments for waiver eligible services made to most of the 21 clients we reviewed, who were waiver eligible, were more than the state portion.

Funding was not reduced, however, for those whose paperwork was incomplete.

We were often told that waiver eligible clients who do not complete the waiver paperwork only receive the state match. However, when asked about specific clients, caseworkers told us they did not authorize payments at a lower "state only" portion because if they did, providers would not give the level of services needed. For many types of service, it may not be feasible to reduce expenditures to only the state portion.

Caseworkers reported that they sometimes threaten to reduce payments to encourage clients to return their paperwork, but no one could show us where they actually reduced the payment amount. For example, one client who received $10,000 for supported employment has not returned the paperwork necessary to qualify for waiver funds. Caseworkers said the amount paid was more than the state portion and payments should probably be reduced until the paperwork is returned.

Waiver Ineligible Clients Are Costly

Clients were ineligible for waiver funds based on the severity of their disability, financial resources, or citizenship.

Nearly three-fourths of the 77 clients we reviewed were ineligible for DD/MR waiver funding because the person does not meet one or more of the waiver eligibility requirements pertaining to their severity of disability, financial resources, or citizenship as Figure 17 summarizes.

Figure 17. Waiver Ineligible Clients Are in Three Categories. Clients were ineligible for the waiver because their disability, financial resources, citizenship or residency do not meet waiver eligibility requirements.

Reason	Number	Percent	FY 2001 Expenditures
Disability Level-of Care	38	68%	$ 938,000
Financial	17	30	143,000
Citizenship	1	2	3,000
Total	**56**	**100%**	**$1,084,000**

Many Did Not Meet Disability Level of Care. For 38 individuals, caseworkers said their client's disability or level of care needs excluded them from waiver eligibility. Most often, workers indicated clients were too high functioning to meet the ICF/MR level of care requirements (31 clients). Sometimes workers said the client's primary diagnosis of mental illness instead of mental retardation excluded them from the waiver program (7 clients).

Clients did not qualify for the waiver because they were
- **too high functioning,**
- **did not meet the ICF/MR level of care standard, or**
- **were primarily mentally ill.**

Of the 31 individuals that did not meet the disability criteria to be on the waiver program, caseworkers cited evidence that they were too high functioning. For example, some caseworkers cited evidence such as an IQ (Intelligence Quotient) above 70 or an ICAP (Inventory for Client Agency Planning) evaluation of service needs to show the client was higher functioning than the level of care required for services in an institution (ICF/MR).

We also found some caseworkers applied a much more strict standard than others resulting in fewer individuals qualifying for the waiver. When we asked for the criteria they applied, caseworkers told us they had no

written guidelines; they just used their judgement. There is a Health Department rule on ICF/MR level of care requirement that could help guide DSPD staff. For something so important to controlling program costs, division management should ensure that appropriate criteria are known and properly applied.

For seven clients, caseworkers told us the person was ineligible for waiver funds because mental illness was the primary reason for their service needs. These individuals were dually diagnosed with both mild mental retardation and mental illness. DD/MR waiver services are not available to individuals whose primary condition is attributable to mental illness instead of mental retardation. Services for individuals with mental illness are the responsibility of local mental health authorities.

Some Did Not Meet Financial Eligibility. Caseworkers identified 17 clients as not meeting the financial eligibility requirements to be on the waiver. These clients were not required to "spend-down" to the Medicaid financial eligibility level either by incurring qualified expenses to offset their excess income or by paying the state the difference. DSPD policy states that

> when it is clear that a spend-down, necessary to participate in the waiver, equals or exceeds the cost of the appropriate service or support, the support coordinator may request an exception from the region director to allow full State funding.

One in Sample Did Not Have Citizenship. In one case we reviewed, the caseworker told us the individual was not waiver eligible because she was not a United States citizen.

Waiver Ineligible Clients with Mental Illness Are Costly

Clients whose disability is related more to mental illness than mental retardation are costly.

As shown in Figure 17, the cost to provide services to the 56 clients we reviewed who did not meet waiver eligibility requirements, was over $1 million in state funds in fiscal year 2001. We asked caseworkers why DSPD provides services to many of the high cost non-waiver clients. The three highest cost waiver ineligible clients, shown in Figure 18 accounted for a large portion ($358,000) of the expenditures. All three of these clients do not have severe enough mental retardation to qualify for waiver

funding but instead have a mental illness that contributes to their needing services.

Figure 18. Example of Highest Paid Waiver Ineligible Clients.

Client	General Fund Expenditures Fiscal Year 2001
A	$209,200
B	77,200
C	71,600
Total	**$358,000**

As shown in Figure 18, expenditures for client A exceeded $200,000. He was ineligible for waiver funding because serious behavioral problems likely accounted for his functional limitations more so than his borderline intellectual functioning. DSPD's Eligibility Committee questioned if he should even qualify for DSPD services and if the Division of Mental Health could "more appropriately provide necessary psychiatric interventions." According to a caseworker, this client continues to receive services through DSPD because it is unlikely that another agency will assume responsibility.

Similarly, client B's disability does not qualify for waiver funding because the person has only mild mental retardation but also has a mental illness that contributes to his impairments. This client started receiving residential services in 1987 before waiting list funding was a concern.

Client C was waiver ineligible, both because he was too high functioning and because his assets exceeded Medicaid limits. He has mild mental retardation although his behavior problems contributed mostly to his needing services. His caseworker said he was a transition student who started receiving residential services when he graduated from high school in 1995.

Non-waiver Spending Raises Important Policy Issues

Some important policy issues are raised by considering non-waiver eligible expenditures. Because of the high cost to the state of non-waiver expenditures, policymakers may want to limit these expenditures or at least have them separately budgeted and accounted for so they can be closely monitored and scrutinized.

Legislature could consider only providing services to those clients who are waiver eligible.

Non-waiver Eligible Clients Are Costly. It is important to recognize that non-waiver clients are costly and that the tradeoff of serving them is to not serve many waiting list clients who are waiver eligible. The state could serve more people because the Medicaid waiver would fund 70 percent of their services. Thus, for every $1 million of services provided to non-waiver clients, the state could provide $3.3 million of services to waiver eligible clients.

Policymakers may want to consider limiting services to waiver ineligible clients. Generally, clients who do not qualify for the waiver either do not meet the disability criteria or the financial criteria. Thus, they tend to be more high functioning in terms of their disability or have less financial need. While DSPD services are certainly valuable to these clients, state policymakers may want to focus state efforts on lower functioning clients with high financial need.

Consider limiting the amount of funds used for waiver ineligible services.

Non-waiver Eligible Services Pose Similar Issue. Expenditures for non-waiver services raise similar issues. Even if the client is waiver eligible, funds spent for non-waiver eligible services are not eligible for federal matching funds. Ineligible service costs include cash assistance grants and housing assistance. While these services are valuable to those who receive them, the state funds used to provide them could draw down additional federal funds if used for waiver eligible services to waiver eligible clients. For example, the $355,000 spent on grants to individuals on the waiting list in fiscal year 2001 could have been used to provide $1.2 million in eligible family support services with the federal matching funds. More people could have received services or the same people (if they were waiver eligible) could have received more services.

With better information, the Legislature could provide policy direction on which clients to fund.

Legislature May Want to Restructure Budget of Programs. While policymakers could simply limit non-waiver expenditures, another option is to more clearly budget and report them. Currently, the Appropriations

Act identifies DPSD programs by type of services; for example, residential, family support, etc. Instead, as shown in Figure 19, the Legislature could identify DSPD's non-waiver services as a separate program. Doing so would promote closer scrutiny and provide better accountability for non-waiver spending.

Figure 19. Current and Proposed Program Budget Structures. Isolating non-waiver expenditures in DSPD's program budget would promote greater accountability.

Current Program Budget Structure	Proposed Program Budget Structure*
Administration	Administration
Service Delivery	Service Delivery
State Development Center	State Developmental Center
Residential Services	DD/MR HCBS Waiver Services
Day Training Services	Brain Injury HCBS Waiver Services
Supported Employment	Physical Disabilities HCBS Waiver Services
Family Support	Non-waiver HCBS Services**
Services for Individuals with Physical Disabilities	
Transportation Services	

** If desired, additional detail by service type could be included on all four of the HCBS program categories shown.*
*** If desired, additional detail by client group could be included on non-waiver HCBS services.*

In conclusion, DSPD should provide better information about non-waiver expenditures to the Legislature. DSPD budgets should clearly identify its three clientele groups (DD/MR, Brain Injury, Physical Disability) and include separate funding for non-waiver expenditures. The Legislature could then provide greater direction about who and what services should be funded and appropriate funds accordingly. Other options for maximizing Medicaid waiver funds are discussed in the following section.

Consider Additional Options to Maximize Federal Waiver Funds

In recent years, legislative intent language directed DSPD to explore ways to "maximize federal funding . . . ." In addition to assuring that eligibility is established for individuals who are waiver eligible and limiting expenditures on waiver ineligible services, DSPD could use other options to follow the legislative directive to pursue "any appropriate additional federal waivers or funding or other creative mechanisms." Four approaches that seem promising but that were beyond the scope of this audit to examine in detail, include the following:

- Relax state ICF/MR eligibility requirements so more clients meet the waiver level of care criteria.
- Explore obtaining another HCBS waiver to cover individuals with a dual diagnosis of mental retardation and mental illness.
- Explore obtaining another HCBS waiver that only provides in-home services.
- Pursue ways to obtain additional federal funding for case management costs.

Long-term Implication of Any Changes Must be Evaluated. We include the four approaches described here as possibilities that policymakers could consider to obtain additional federal funding for costs the state is already incurring. However, it was beyond our scope to evaluate the long-term implications of possible changes. We think DSPD should work with Department of Human Services and Department of Health staff to determine whether these approaches could meet the long-term goals of the state.

It is especially important that potential future costs be considered. For example, individuals brought into one of the waiver programs receive a Medicaid card that they may not otherwise financially qualify for. Thus, in addition to the expected waiver expenditures that affect DSPD's budget, there also could be health care costs that affect the Department of Health's budget which must be anticipated. The long-range impact of the Supreme Court's *Olmstead* decision should also be considered.

In summary, the approaches discussed here should be considered by the Department of Human Services and Department of Health given the broader policy and legal environment that exists. Possible changes need

to be evaluated by considering potential long-term costs and outcomes. Any changes will also need to fit within the framework of Medicaid rules and regulations that guide the waiver programs.

Relax ICF/MR Eligibility Requirements

DSPD and the Department of Health could consider relaxing ICF/MR eligibility requirements in order to open eligibility to a broader range of clients.

Relaxing ICF/MR eligibility requirements is an option that could be considered for increasing waiver eligibility. States set the eligibility criteria they choose for ICF/MR level of care and use them to determine eligibility for waiver services. As our sample of clients discussed shows, the most common reason DSPD clients are ineligible for the waiver is they do not meet the level of care criteria. Thus, if Utah were to relax its ICF/MR eligibility requirements, more clients who are now receiving services could be eligible for waiver funds.

The greatest concern about relaxing ICF/MR eligibility is that more people would be eligible and would therefore want to be placed in institutions. According to a leading researcher in a federal report entitled *Understanding Medicaid Home and Community Services: A Primer*, however, this idea is a misperception. Instead, the research shows that people were unlikely to go into an ICF/MR just because there were more relaxed eligibility requirements.

Consider Waiver for Dual Diagnosis Clients

DSPD could explore feasibility of another waiver for clients who are dually diagnosed with both mental retardation and mental illness.

DSPD also should consider the potential benefits of applying for a HCBS waiver for individuals who have a dual diagnosis of both mental retardation and mental illness. As discussed earlier, DSPD pays for services to some very expensive dual diagnosis clients solely with state funds. In addition, state appropriations have been directed to DSPD for dual diagnosis clients. In fiscal year 2002, $100,000 was added to the division's budget for these clients. If an HCBS waiver for dual diagnosis clients could be obtained, at least some of the expenditures now paid with state funds would be reimbursed with federal funds.

Reportedly, some states have HCBS waivers for dual diagnosis clients that cover at least clinic services, day treatment and psychiatric rehabilitation services. Other states with mental health waivers include Colorado, Kansas, Maryland, New York, Pennsylvania, and Vermont. Utah currently is implementing a pilot program that provides health care management to individuals with mental retardation and mental illness

instead of delivering services through separate agencies with little communication among service providers.

Consider Waiver for In-home Services

Another possibility to consider is a separate waiver for in-home services that excluded expensive residential services, but included other community services. Starting in January 2002, there is scheduled to be a system review of the state's waiver programs in light of the Supreme Court's *Olmstead* ruling. Department of Health staff suggested to us that the state may want to use this opportunity to look at ways to enhance public-private partnerships through waiver programs. An in-home services waiver could be aimed at providing the services needed to keep individuals at home with their families rather than in much more expensive residential placements. Thus, an in-home services waiver could contribute to controlling costs and keeping families together.

We did not study this proposal, but it seems to make sense in the current environment. One concern with the *Olmstead* ruling is that it may result in individuals becoming entitled to all services provided by a waiver program in which they participate. So, it may make sense to have a number of waivers that provide different service packages.

Increase Federal Funding Of Case Management Costs

DSPD could consider ways to cover more case management costs with federal funds.

DSPD should also consider ways to cover more of its current case management costs with Medicaid funds. DSPD staff told us they are already trying to increase the federal reimbursement of service delivery costs. In fact, DSPD recently submitted a time study to the Department of Health aimed at obtaining additional federal funds for case management. We think this is a good approach that the division should continue to pursue.

In addition, DSPD should consider the possibility of obtaining federal funding for case management costs to some individuals on the waiting list. Wyoming uses an approach called "targeted case management" to obtain federal funds for the time caseworkers devote to individuals on the waiting list. Even though HCBS waiver services are not provided to individuals on the waiting list, caseworkers may help them find other sources of assistance. If so, then federal reimbursement may be obtained

for waiver eligible individuals through the "targeted case management" approach.

Recommendations

1. We recommend DSPD periodically review the waiver eligibility of all individuals who are not receiving federal waiver funds in order to maximize the use of federal funds.

2. We recommend the Legislature consider the following ways of controlling non-waiver expenditures and providing greater accountability for them

    - requiring DSPD to report on non-waiver expenditures, and/or
    - restructuring DSPD program budgets so that non-waiver expenditures are separately budgeted and accounted for.

3. We recommend the Legislature consider providing DSPD additional policy guidance on non-waiver expenditures, including

    - whether different service guidelines should be used for clients who are ineligible for the waiver because they do not meet the disability level of care requirement,
    - whether different service guidelines should be used for clients who are ineligible for the waiver because they do not meet the financial need requirement, and/or
    - whether all services should be structured to meet waiver requirements so that non-waiver eligible services are provided only in extraordinary circumstances.

4. We recommend DSPD provide staff with better guidelines and training both for

    - applying the ICF/MR level of care requirements,
    - determining when non-waiver clients should receive only the state portion of funds, and
    - completing the waiver application process promptly.

5. We recommend DSPD and the Department of Human Services explore with the Department of Health the possibility of obtaining

additional federal funding for costs currently being paid entirely with state funds by

- relaxing state ICF/MR eligibility requirements so more clients meet the waiver level of care criteria,
- obtaining another HCBS waiver to cover individuals with a dual diagnosis of mental retardation and mental illness,
- obtaining another HCBS waiver that only covers in-home services, and
- obtaining additional federal funding for existing case management costs, including those to individuals on the waiting list.

Chapter IV
Better Guidance Needed for DSPD Decision-making Process

Legislators asked of the disabled population in need, "Are we getting the funding to the people who need it most?"

Legislators' question "Are we getting the funding to the people who need it the most?" asked us to evaluate DSPD's decision-making process. We found that decisions about which clients get funded for services by DSPD are often inconsistent and confusing. Policy clarification about client funding practices as well as better information about available funds and client needs can improve DSPD decision-making.

This chapter discusses a number of issues related to how DSPD decides which clients receive funding for what services. We found that practices sometimes differ among regions and offices because of different policy interpretations and departures from using the Critical Needs Assessment (CNA) prioritization model. We also found that in some instances a lack of reliable information may affect decision making.

DSPD Policy Clarification Needed

DSPD departs from the CNA model in some decision-making, leading to inconsistencies in funding, policy and practice.

Since the CNA identifies the greatest needs, funding and service delivery decisions should correspond with CNA scores. However, we found the division departs from the CNA model in making funding decisions. In practice, many other factors come into play as division staff decide how to distribute funds and who to bring into services. In some instances, we found inconsistencies among regions indicating that there was not a consistent state policy. This section addresses these topics:

- questions raised by how funds are distributed and used,
- inconsistent treatment of transition students, and
- unclear policies may cause inconsistent practices.

Funding Distribution and Use by Regions and Offices Raise Questions

The way DSPD distributes funds to its four regions has raised questions.

Our review of the way DSPD distributes funds to regions and offices and the way local decision-makers use the funds raise many questions. While it was outside the scope of this audit to examine the issues in detail,

this section describes three of them. First, regions' expenditures do not correspond closely with population even though funding is distributed on that basis. Second, regions' service spending patterns vary. Third, regions' use of federal matching funds varies.

New funds appropriated to DSPD must be distributed to the staff that make spending decisions. The DSPD state office distributes new funds to the regions based on population instead of CNA scores. In fact, the statewide list that includes each persons CNA score is not used for any distribution decisions. The state office also allocates each region's new funds evenly between "In-Home Supports" and "Out-of-Home Supports" instead of by the type of service with a higher CNA score. Regional offices then distribute the funds depending on how they are organized. The Western and Northern Regions allocate funds to offices based on population. In contrast, the Central Region allocates by support type. Only the Eastern Region, which has by far the fewest clients, considers clients' CNA scores when distributing funds among offices.

Although funding distribution is to be by population, we found in some cases that expenditures do not match population proportions very well.

Expenditures Differ from Funding Allocations. Distributing funds on a per capita basis is appropriate if service needs correspond with population. Assuming needs do correspond to population then it seems that service expenditures should correspond as well. However, we found that expenditures do not match population proportions very well. Figure 20 shows the difference between how funds are distributed to regions based on population and actual expenditures. Equalizing spending on a per capita basis would require a significant reallocation to the Northern Region from the other three regions.

Figure 20. Actual Service Expenditures* Do Not Correspond with Funding Distribution. The Northern Region's per capita spending is much lower than other regions.

	Central	Northern	Eastern	Western
FY 2002 Funding Distribution per Population	43.0%	26.3%	4.6%	26.1%
FY 2001 Service Expenditures*	43.6%	21.9%	5.6%	28.9%
Spending Transfer Needed to Equalize with Population	($ 528,000)	$3,876,000	($ 857,000)	($2,491,000)

** Total regional expenditures for services in FY2001 were $88 million.*

As mentioned above, it was beyond the scope of this audit to fully evaluate the reason for the differences shown in Figure 20. It could be that different policy or practices among regions lead to spending differences. Some regions may have greater need for certain services, and/or some regions may house more of the residential clients. Thus, dollars need to be split by need, not straight population. As discussed below, one reason for the relatively low spending in the Northern Region is that fewer federal matching funds are obtained.

Regions spend funds differently in the four major service areas:
- **community living,**
- **day services,**
- **supported employment, and**
- **family support.**

Regions Spend Funds Differently. We looked at how regions spend their funds and found some significant differences. Regional expenditure patterns may reflect different regional conditions or different policies. For example, regional conditions might differ because client need levels vary throughout the state or because service availability is limited in some locations. Alternatively, one region may simply provide different services than another as a matter of local policy. Figure 21 shows how each region allocated its expenditures among the four major service types in fiscal year 2001.

Figure 21. DSPD Regional Expenditures* Patterns in Fiscal Year 2001. The Central Region spends proportionally less for Family Support than any other region. (Total state and federal expenditures in each region are shown in parentheses.)

Service	Central ($37.0 M)	Northern ($18.5 M)	Eastern ($4.8 M)	Western ($24.5 M)
Community Living	74%	69%	76%	69%
Day Services	16	19	12	12
Supported Employment	6	6	1	10
Family Support	3	6	11	9
Total	**100%**	**100%**	**100%**	**100%**

** This figure includes the four main home and community-based services. Items such as transportation and grants to individuals on the waiting list are excluded.*

Our concern with differing spending levels among regions is that it may not reflect united policy direction.

One concern that surfaces from Figure 21 is that the Central Region spends only 3 percent of its funds on family support while other regions spend considerably more. Family support is considered an important service that may help avoid expensive residential placements. We do not know if the low family support spending reflects policy judgements or if other spending demands simply leave no more money available for family support. Also of note is the high spending for day services by the Northern Region. That high spending may reflect the region's policy on transition students.

Regions differ in how they maximize the use of federal Medicaid match funds.

Use of Federal Matching Funds Varies. One of the most significant differences we found among DSPD regions is their ability to obtain federal matching funds. Through the Medicaid program, the federal government pays over 70 percent of eligible expenditures. Thus, to maximize the state's ability to provide services, it is important to obtain matching funds as much as possible. Most of DSPD expenditures draw matching federal funds. However, Figure 22 shows that regions differ in how much of their state spending is not matched with federal funds.

Figure 22. Percent of Fiscal Year 2001 Regional Expenditures Not Matched by Federal Medicaid Funds. The Northern Region is less likely to obtain federal matching funds.

Region	Non-Matched General Fund Spending	State Medicaid Match	Total	Percent Non-Matched
Central	$2,289,100	$10,298,700	$12,587,800	18%
Northern	1,808,800	4,984,400	6,793,200	27
Eastern	160,700	1,354,100	1,514,800	11
Western	1,469,600	6,847,500	8,317,100	18

The high amount of non-matched spending by the Northern Region could result from many causes. Regional policy may be to provide specific services or to serve specific clients that are ineligible for federal funds. Or, local offices may simply be less likely to obtain matching funds because of procedural weaknesses.

Handling of Transition Students Illustrates Inconsistent Policy

How DSPD regions bring transition students into service (virtually automatically or by CNA score) is an example of inconsistent policy.

The different ways regions treat transition students illustrates some of the policy questions about who receives DSPD services. Children with disabilities may receive services in the public education system until they graduate from high school, usually at age 22. Many people feel it is critical for transition students, as those graduating are called, to continue their training by receiving DSPD day training services. Those people feel that if training is not continued, the benefits of many years of schooling may be lost. We found that some DSPD offices bring transition students into services even if their CNA score is very low, while other offices do not. However, there is no formal policy about the practice.

Some Offices Override CNA Scores to Serve Transition Students. The CNA is supposed to assure that clients with the highest score (and thus highest need) get funding. However, we found several instances where transition students with relatively low CNA scores received funding while other individuals with much higher CNA scores remained on the waiting list. For example, in the Northern Region, a transition student with a CNA of 26 received services before another client with a CNA of 70. In the Western Region, transition students with CNA scores of 24,

20, 18 and 16 each received services while other clients with scores in the 50s did not receive services.

Some regions give transition students automatic point values on portions of the Critical Needs Assessment.

CNA Scoring of Transition Students Varies. Some offices do not automatically bring transition students into services, but instead routinely provide them extra points on some CNA scoring areas. Transition students may automatically receive the maximum score of 10 points on each of the following two CNA areas:

> _____ **6. Resources/Supports Needed:** (Score range 0 to 10) Considering all supports/resources (i.e. other agencies, church, friends, community, family, school etc.) currently available to the family/ individual, what further DSPD supports does the family/individual need? (If scoring for a family support annual review, score as if DSPD services were not being received.)
>
> _____ **7. Projected Deterioration Issues:** (Score range 0 to 10) What will happen if this wait list service is not provided? Divorce, deterioration of other family members, imminent death of primary care giver, family falling apart, etc.

Staff in two regions told us they will give an automatic 10 points on both questions six and seven while staff in another region said they will only give an automatic 10 points on question seven. While these regions do not necessarily fund transition students, they give extra CNA points in order to give transition students a better opportunity to qualify for services based on their CNA score. (See Appendix A for the CNA form and guidelines.)

No formal policy on funding of transition students exists following vetoed legislation in 1995.

No Formal Policy on Funding Transition Students. The Legislature addressed, but did not resolve, the issue of transition students in 1995. In that year's General Session, House Bill 104 was passed stating that DSPD "shall ensure the provision of an appropriate array of quality daytime services and supports to persons with disabilities who leave public education programs . . . . " However, Governor Leavitt vetoed the bill because it " . . . would lead to large automatic increases in state funding." The Legislature did not attempt to override the veto and has not given additional statutory direction.

We could not find any written policy guiding DSPD's practices on transition students. Some DSPD staff fund transition students as if the 1995 legislation had been enacted. Other staff give transition students extra CNA points although there is no written policy that provides for that practice either. Based on existing law and written policy, provision of

services to transition students should be based on CNA scores just like other individuals seeking services.

Inconsistent Practices Among Offices May Result from Unclear Policies

Better policy guidance is needed to help staff make good decisions.

There are many areas besides transition students where policies are unclear and practices are inconsistent. Even the CNA instructions shown in Appendix A are confusing because procedure 2 says regions may include other factors while guideline 3 indicates regions must use the standardized criteria. Although individual DSPD staff strive to make good choices, the inconsistent practices among offices result in policy confusion and could lead to poor decision-making regarding the use of funds. Further, in some cases, these inconsistent practices result in people with high CNA scores on the waiting list not receiving funding. The issues discussed in this section include:

- bringing low CNA clients into service, and
- using out-of-date rules.

Clients With Low CNAs Are Brought Into Service. In addition to the transition students discussed above, DSPD sometimes brings other types of clients with relatively low CNA scores into service. Since a CNA score is indicative of who has the greatest need, the reasons for bypassing higher CNA clients should be well documented and clearly understood. Examples of people receiving services that we encountered included the following:

- An individual received supported living services with a CNA score of 32 although many individuals waiting for other services had higher CNA scores. Staff felt those waiting for supported living services should not compete with those waiting for other services because if they did, none would ever get funded.

Some individuals with low CNA scores have been funded ahead of those with higher scores. Clearer guidelines need to be set by DSPD and its board.

- Two individuals received DSPD funding because services they had been receiving from state Adult Protective Services were being terminated. Workers determined CNA scores for the two individuals, but they were only in the 30s, much lower than people on the waiting list. In an effort to assure that these two individuals did not "slip through the cracks," however, DSPD began providing services.

Since the CNA score is supposed to identify who has the greatest need, the DSPD board or management needs to set clear guidelines on when individuals with low scores can enter service.

Existence of out-of-date rules is evidence that better guidance is needed.

Out of Date Rules Exist. As with inconsistent practices discussed above, we encountered instances where practice did not match policy, or where policy was simply not updated to match practice. These inconsistencies make it difficult for staff to rely on published division rules and procedures. A few examples are found in out-dated administrative rules.

- **Waiting List Administrative Rule Out-dated.** According to DSPD rule, an "individual's need for the identified service will be rated as having a (1) critical, (2) immediate, or (3) future level of need. (*Utah Administrative Rule* R539-3-1(B)(1)). However, a few years ago DSPD decided to combine the critical and immediate categories, so now only two categories are used, without an update in the written policy.

- **Supported Employment Administrative Rule Out-dated.** By DSPD rule, before any client receives federal matching funds for supported employment services, there must be evidence in the individual's file of "deinstitutionalization from a nursing facility or intermediate care facility" (*Utah Administrative Rule* R539-8-3(B)(c)(2)). However, in 1997 the federal government removed the "prior institutionalization" pre-requisite so that criteria no longer applies.

The effect of these out-of-date rules is debatable. We did not find instances where staff made mistakes because of the rules, but the out-of-date rules contribute to a sense of uncertainty in the division's practices. As with unclear policies, it is sometimes hard to know where to go for a definitive answer about what practices should be followed. While DSPD staff comply with state policy as they understand it, they deserve clearer guidance.

Better Information Needed on Available Funds and Demands for Funds

Better information in the following areas is needed to make funding decisions:
- **use of attrition money**
- **use of funds for non-waiting list individuals**

To help insure services are delivered to those who need it the most, DSPD needs reliable information about all available funds as well as the various types of demands on its funds. Much of the discussion about DSPD's budget has focused on the need for additional appropriations to fund individuals on the waiting list. While those topics are very important, decision makers also need to understand how much on-going funding becomes available for reallocation each year and what additional demands on funds exist besides the waiting list. In this section, we briefly address two concerns with the availability of reliable information about:

- funds available for reallocation due to client attrition, and
- funds spent on non-waiting list individuals.

Better Information Needed on Attrition Funds

Although they have not been adequately tracked, attrition funds—funds which become available when a client leaves DSPD services—appear to constitute a significant amount of available funds. For the most part, attrition funds appear to go towards funding service upgrades for current clients rather than bringing individuals off the waiting list into services. A waiting list committee suggested that dedicating funds made available through attrition to fund the waiting list was a viable waiting list reduction strategy.

Attrition funds (funds which come available when a client leaves DSPD service) are not adequately tracked.

Attrition Funds Are Not Adequately Tracked. Attrition funds become available when a person passes away, moves, or otherwise no longer receives services from the division. Some regions also include in their attrition dollars, the funds that are freed up when services are decreased. Although the division state office has attempted to determine how much attrition money is available and how it was spent, the information regions provide is not consistent.

In fiscal year 2001, there could have been over $845,000 available in attrition funds.

Amount of Attrition Funds Is Significant. As shown in Figure23, we estimate at least $845,000 in state general funds became available in fiscal year 2001 because of attrition. By comparison, newly appropriated funds distributed to regions for In-Home and Out-of-Home supports were $1.3 million in state general funds. Based on the 70 percent federal match rate, we estimate that as much as $2.8 million in services could

have been provided to people on the waiting list had all attrition funds been used for that purpose.

Figure 23. Attrition Funds Compared With New Fund Distribution. Regions' attrition funds could be a significant way to fund the waiting list.

Region	FY 2001 Attrition Funds General Fund	FY2002 New Fund Distribution
Central	$ 380,000	$ 580,000
Western	315,000	352,000
Northern	126,000	355,000
Eastern	24,000	62,000
Totals	**$845,000**	**$1,349,000**

Unfortunately, the information tracked by regions is incomplete and inconsistent. We could not determine how much attrition should be carried to the next year. Some regions track only the savings for that year instead of the savings that would be carried into the following year. One region more carefully tracks both the amount of money saved for one-time services and those that are continuing. However, other regional budget staff could not be sure that all attrition funds were accounted for or if regional offices consistently tracked attrition information.

Attrition funds are largely being used to fund upgrades in service for existing DSPD clients rather than fund waiting list clients.

Attrition Funds Used at Discretion of Regions. While some attrition funds were used to provide services to people on the waiting list, most were used to fund upgrades to people already receiving services. Using attrition to fund upgrades may distort the effect of waiting list appropriations. Legislators have expressed concerns that additional appropriations intended to fund the waiting list have little impact because the number of people receiving DSPD services has not grown as quickly as expenditures. When attrition funds are used to upgrade services rather than fund additional people from the waiting list, fewer people are receiving services at a higher cost.

Better Information Needed on Funding Demands

DSPD staff told us that they have many demands on their funds besides the waiting list. The division reports it is required to serve some individuals that may not be on the waiting list or have a CNA score. In addition, clients already in service sometimes need service upgrades that require spending increases. These are valid uses of funds, but we think the amount of money used to meet these demands should be better tracked.

DSPD needs to better account for its use of funds to track non-waiting list clients such as DCFS age-out clients and court-ordered clients.

Cost of Mandatory Client Groups Should Be Better Tracked. DSPD funds some groups of clients by mandate rather than critical needs assessment. These groups include the following:

- **DCFS Age-out Clients.** Children with disabilities who are in the custody of the Division of Child and Family Services (DCFS) are automatically brought into the DSPD waiver program if they meet the waiver criteria. Doing so enables the state to obtain federal matching funds, and since DCFS pays the state match, there is no cost to DSPD initially. However, when the individual ages-out of DCFS custody, DSPD needs to begin paying the state portion of the service costs.

- **Court-Ordered Clients.** Courts sometimes mandate DSPD provide services to people with disabilities regardless of the severity of their needs. Services for some clients who do not meet waiver eligibility criteria are financed using only state general funds. An emergency services committee has separate funding to cover these individuals.

Since some client groups get funding regardless of CNA score, they may take funds otherwise used for waiting list clients.

Since these clients get funding regardless of a CNA score, they may take funds that otherwise would be used for waiting list clients with even greater needs. It is not clear how great an impact these client groups have on division finances because these clients have not been very well tracked in the past.

Cost of Service Upgrades Should Be Better Tracked. As mentioned above, attrition funds are often used to upgrade services to clients already receiving services rather than funding people from the waiting list. However, there is no reliable information on the amount spent on service upgrades, an amount which may be sizable.

While service upgrades are usually legitimate, they should be better tracked.

There are a variety of reasons why individuals may need more costly services. Concerns about a person's health and safety is often an issue. For example, one client received upgraded services when his behavior had become so aggressive that he required additional staff to prevent "critical injuries or death" to others in the program. Therefore, as reported by the legislative fiscal analyst, the growth in the number of clients served has not kept us with the growth in costs.

Recommendations

1. We recommend DSPD review funding allocation practices to ensure they correspond with service needs.

2. We recommend DSPD management and board establish clear policy and procedures concerning transition students to guide how staff

    - determine CNA scores to prioritize service needs compared to other individuals, and
    - decide whether to provide funding for services to transition students.

3. We recommend DSPD management and board establish clear policy and procedures to guide staff on when individuals with low CNA scores should be offered services.

4. We recommend DSPD management and board assure rules, policies and procedures are kept current and that DSPD staff are more adequately trained on uniform usage.

5. We recommend DSPD track the following in order to identify the impact on DSPD finances:

    - the amount of attrition funds that become available,
    - the amount of funding used for service upgrades for clients already receiving services, and
    - the number and cost of mandatory clients requiring funding because they age out of DCFS or are court-ordered into services.

6. We recommend DSPD establish clear policy and procedures to guide how staff

    - use attrition funds,
    - decide whether to provide funding for service upgrades for clients already receiving services, and
    - determine service and funding levels for mandatory clients.

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Appendices

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Appendix A — Critical Needs Assessment

Form 2-2

Utah DHS-DSPD
4/00

DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES

DD/MR OR BRAIN INJURY CRITICAL NEEDS ASSESSMENT

TOTAL SCORE (100 points possible)

check one: ❒ new MR/DD assessment ❒ annual review for family support only ❒ new Brain Injury assessment

Person's Name: _____ ID Number: _____ Date: _____

Date of Birth: _____ I.Q. : _____ Worker: _____

(For DD/MR only): ICAP Service: ___ Maladaptive: ____ (For BI only): Brain Injury Assessment Score:____

Desired / needed Services:
Residential: ❒SL ❒GH ❒SA ❒PP ❒HH
Day Supports: ❒SE ❒DT ❒SS
Family Support: ❒RP ❒FS ❒ MAG
Other: _____

Division services currently received: (list service code)
Residential:_____ annual $:_____
Day Services:_____ annual $:_____
Supported Living:_____ annual $:_____

Diagnosed Conditions:
(check all that apply)
- ❒ Blind
- ❒ Cerebral Palsy
- ❒ Mental Retardation
- ❒ Deafness
- ❒ Brain or neurological damage
- ❒ Mental Illness (formal Diagnosis)
- ❒ Epilepsy or seizures
- ❒ Autism
- ❒ Other_____

_____ **1. Ability to be Self-Directing**: (0 to 13 points)

Note: Up to **3 additional discretionary points** may be given (up to 13 point max). Reasons for these points must be documented.

FOR PERSON WITH DD/MR

Based on ICAP Service Score:

SCORE	POINTS
0-10	13
11-20	12
21-30	11
31-40	10
41-50	9
51-60	7
61-80	5
81-90	1
90-100	0

FOR PERSON WITH BRAIN INJURY

Based on Brain Injury Assessment Score: (sum of Part II and Part IV)

SCORE	POINTS
97-116	10
85-96	9
73-84	8
61-72	7
49-60	5
37-48	4
25-36	3
13-24	1
0-12	0

_____ **2. Problem Behaviors**: (0 to 15 points) *Extra points up to the maximum may be given for low frequency highly dangerous behaviors such as suicidal attempts, sexual offenses, etc.*

FOR PERSON WITH DD/MR

Based on ICAP maladaptive score:

SCORE	POINTS
0 to -14	0
-15 to -23	3
-24 to -27	6
-28 to -32	9
-33 to -36	12
-37 up	15

FOR PERSON WITH BRAIN INJURY

Based on Brain Injury Assessment score part VI

SCORE	POINTS
0-10	0
11-17	3
18-22	6
23-27	9
28-31	12
32-35	15

DD/MR OR BRAIN INJURY CRITICAL NEEDS ASSESSMENT

_____ **3. Family Dynamics**: (Score range 0 to 25)
Composition, stability, coping skills, employment, income, financial stability, no insurance for child with disability, elderly parents, other children with special needs at home, health of primary care giver, Social Security Income, Medicaid, etc.

_____ **4. Special Medical Needs**: (0 to 10 points)
Serious physical health problems, uncontrolled seizures, sleep problems, mental illness, dementia or related conditions, feeding tubes, special adaptive equipment, oxygen dependent, nursing, medication, treatments, etc.

_____ **5. Protective Service Issues**: (0 to 10 points)
Homeless, abuse, neglect, exploitation, financial exploitation, previous referral with Child/Adult Protective Services, etc.

_____ **6. Resources/Supports Needed**: (0 to 10 points)
Considering all supports/resources (i.e., other agencies, church, friends, community, family, school, etc.) currently available to the family/individual, what further Division funded supports does the family/individual need? If scoring for a family support annual review of allocation, score as if Division funded services were not being received.

_____ **7. Projected Deterioration Issues**: (0 to 10 points)
What will happen if this wait list service is not provided? (divorce, deterioration of other family members, imminent death of primary care giver, family falling apart, etc.)

_____ **8. Accessibility of Supports**: (0 to 7 points)
Time without services from any agency (1 point per year up to a maximum of 3 points)
Availability of supports, medical miles, travel time for rural areas (up to 4 points)

TOTAL SCORE (100 points possible)

2-2	Waiting List and Critical Needs Assessment for Developmental Disability Supports	Part 19 of 1
Authorizing Utah Code: 62a-5-103	Rule: R539-3-1	DD Supports
Approved: 1/15/99	Rule Effective:	Printed: 1/00
Form(s): 2-2 and 909	Guideline(s): CNA Instructions	

POLICY

Following the determination of eligibility, the **Person**'s priority for support is determined. Each **Region** uses the critical needs assessment to score and prioritize the **Person**'s level of need. **Person**s with the highest critical needs scores receive support first. The **Support Coordinator** shall assess with the **Person/Representative** the array of supports that may be needed. When funding is unavailable, the **Person** will be placed on a list to wait for funding for supports from the **Division**. If a support desired by the **Person/Representative** is unavailable, the **Person/Representative** may accept an available support while waiting for the selected support. **Person**s who have been determined eligible for the **Division**'s **Medicaid Waiver** can choose to wait for **Division** support services or seek services available through **Medicaid** in an Intermediate Care Facility for Persons with Mental Retardation (ICF/MR)

PROCEDURES

1. The **Support Coordinator** will complete the waiting list information requested on **Form 909**, within ten days following the determination of eligibility. If the **Person** requires and could use support services on the day of intake, the **Person** has an immediate need; otherwise, the **Person** has a future need.

2. A critical needs assessment **Form 2-2** shall be completed for all **Person**s with an immediate need for support services. The critical needs assessment determines the critical needs score of each **Person** by using the following criteria:
   A. severity of the disabling condition,
   B. needs of the **Person** and/or family,
   C. length of time on the waiting list,
   D. appropriate alternatives available, and
   E. other factors determined by the **Region** to reflect accurately on the **Person**'s need.

3. The **Region** Critical Needs Assessment Committee:
   A. determines the **Person**'s critical needs score,
   B. rank orders the critical needs scores within each **Region** to determine the order in which each **Person** receives funding, and
   C. enters the **Person**'s name and score on the waiting list.

4. **Region** staff ensure that the critical needs assessment score and ranking remains current by updating the critical needs assessment score as necessary. A **Person**'s ranking may change as critical needs assessments are completed for new **Applicant**s.

5. A child age 16 who is currently in a school district special education program and meets all eligibility requirements for **Division** services is automatically determined to have a future need for supported employment/day training. No age limitations apply to a **Person** placed on the waiting list for community living support or family support.

GUIDELINE 2-2

CRITICAL NEEDS PRIORITIZATION PROCESS FOR PERSONS ELIGIBLE FOR FUNDING DUE TO DEVELOPMENTAL DISABILITY OR BRAIN INJURY

The following guidelines should be implemented in order to standardize the critical needs assessment process across the state:

1. **Committee involvement.** A committee process should be used in the ranking of persons with critical needs. The committee must have some representation from outside the Division. At least one member should be a parent, a consumer, or an advocate in order to insure that the process is as objective as possible. Private provider representation is allowable, but not mandated, as some areas of the state could have potential conflicts of interest with provider representation. Persons should be placed on committees with a designated term of membership in order to insure consistency from meeting to meeting.

2. **Frequency of meetings.** Critical needs meetings are still to be on an as needed basis, and scheduling is at the discretion of each region office.

3. **Assessment criteria.** The critical needs criteria have been standardized in the Form 2-2, in the Forms section. This assessment is to be used statewide effective immediately. 3. **Assessment criteria.** Scores on items 1 and 2 of Form 2-2, **Ability to be Self Directing** and **Problem Behaviors** respectively will be based on one of two assessment tools. For individuals with Developmental Disablities the ICAP will be used. For individuals with Brain Injury, the Brain Injury Comprehensive Screening Form will be used. Scores for items 3-8 will be determined by the Critical Needs Committee. Accessability of supports, item 8, now asseses the time a person has been without services from any agency rather than the time on the waitlist. Other agencies could include but are not limited to schools, mental health, rehabilitation, family services, etc.

4. **Scoring the critical needs assessment.** The new assessment instrument has a maximum score of 100. Each member of the committee should fill out the assessment Form 2-2 as client scenarios are presented and reviewed. The various scores should be presented and serious discrepancies among the scores should be discussed. Ideally, the committee will come to consensus on a critical needs score. Averaging the scores of committee members is also acceptable, however, the method of arriving at a final score must be consistent for each committee. If a committee chooses to use the consensus method, that method should be used for each client reviewed in each meeting. Consistency in method is necessary for a defensible process.

5. **Committee guidelines.** Each critical needs committee should develop some written guidelines which describe committee membership, term of membership, and committee process, (i.e., consensus vs. averaging method).

6. **Critical needs review.** Persons with critical needs should be reviewed on some sort of consistent basis. A review should be conducted at least annually. Also, if a person waiting for services moves from one region to another or within an area in the same region served by a different committee, the person should be given a new critical needs assessment.

7. **Who should complete the critical needs rating?** Every member should complete an assessment unless they are the staff member presenting the person's scenario or have a potential conflict of interest.

Appendix B — Eligibility and Intake Policies, Procedures and Guidelines

2-1	Eligibility and Intake for Developmental Disability Supports		Part 21 of 3
Authorizing Utah Code: 62a-5-101	Rule: R539-1-1 and R539-1-2		DD Supports
Approved: 3/11/99	Rule Effective:		Printed: 4/00
Form(s): 2-1, 19, 490S , 522-I or 522-F, 824 and ICAP		Guideline(s): 2-1F and 2-1RC	

POLICY

This policy does not apply to **Applicant**s who meet the separate eligibility criteria for personal assistance and brain injury outlined in **Division** policy 3-1 and 4-1 respectively. **Applicant**s who have a disability due to only mental illness, hearing impairment and/or visual impairment, learning disability, behavior disorder or the aging process, do not qualify for services under this policy.

The **Division** will serve those **Applicant**s who meet the definition of disabled in **Utah Code Annotated** 62A-5-101. These are **Applicant**s who have a severe, chronic disability:

a. attributable to mental or physical impairment or a combination of mental and physical impairments;
b. likely to continue indefinitely;
c. resulting in a substantial functional limitation in three or more of the areas of major life activity defined below, (self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency); and
d. requiring a combination or sequence of specialized interdisciplinary or generic care, treatment, or other services that may continue throughout life and must be individually planned and coordinated.

Substantial functional limitations in the seven areas of major life functions are defined as follows: (when determining limitations in the areas listed below, age appropriateness must be considered)

1. Self-care - An **Applicant** who requires assistance, training and/or supervision with eating, dressing, grooming, bathing or toileting.
2. Expressive and/or receptive language - An **Applicant** who is limited in expressive and/or receptive language. Expressive impairments are noted when an **Applicant** lacks functional skills and/or requires the use of assistive devices to communicate. Receptive impairments are noted when an **Applicant** does not demonstrate understanding of requests or is unable to follow two-step instructions.
3. Learning/Cognitive Development - An **Applicant** who has obtained a valid and reliable IQ score of two standard deviations or more below the mean on a individually administered standardized intelligence test, (e.g., a score of 75 or below on the Wechsler Intelligence Scale for Children or Adults, WISC III or WAIS III or a score of 73 or below on Stanford-Binet, Fourth Edition). IQ test scores over the developmental period should consistently yield scores two standard deviations below the mean.
4. Mobility - An **Applicant** with a mobility impairment who requires the use of assistive devices to be mobile and who cannot physically self-evacuate from a building during an emergency.
5. Capacity for independent living - Age appropriate abilities must be considered. An **Applicant** who is unable to locate and use a telephone, cross streets safely, or understand that it is not safe to accept rides, food or money from strangers. An adult who is unable to complete basic survival skills in the areas of shopping, preparing food, housekeeping or paying bills. An **Applicant** who is a significant danger to self or others without supervision.
6. Self-direction - A child (age 6-18) who is unable to make age-appropriate decisions concerning self-protection. An adult who is unable to provide informed consent for medical/health care, personal safety, legal, financial, habilitative or residential issues and/or who has been declared legally incompetent.
7. Economic self-sufficiency - An adult who receives Social Security Administration disability benefits and who is unable to work more than 20 hours a week or is paid less than minimum wage without employment support. The economic self-sufficiency functional limitation applies only to adults (age 18 or older).

2-1	Eligibility and Intake for Developmental Disability Supports	Part 22 of 3
Authorizing Utah Code: 62a-5-101	**Rule: R539-1-1 and R539-1-2**	**DD Supports**
Approved: 3/11/99	**Rule Effective:**	**Printed: 4/00**
Form(s): 2-1, 19, 490S , 522-I or 522-F, 824 and ICAP	**Guideline(s): 2-1F and 2-1RC**	

The intake process will include determination of eligibility for **Division** funding. The **Applicant** shall be provided with information concerning service options and a copy of the **Division**'s Guide to Services.

Region staff shall determine if **Applicant**s found eligible for state funds are also eligible to receive federal matching funds through the **Waiver**. Matching federal **Medicaid** funds are available through the Home and Community-Based **Waiver** for People with Mental Retardation and Developmental Disabilities. To be determined eligible for **Waiver** funding **Applicants** must:

a) meet all state eligibility requirements including having a disability that results in substantial functional limitation(s) in three or more of major life activities 1 through 6, (economic self sufficiency is not allowed as a functional limitation for **Waiver** eligibility); and
b) require the **Level of Care** provided in an Intermediate Care Facility for People with Mental Retardation, (per **Code of Federal Regulations**, 42 CFR Part 441 Subpart G).

The **Applicant** or the **Applicant**'s **Representative** must be a **Resident** of the state of Utah prior to the **Division**'s final determination of eligibility. **Applicant**s who are found eligible for **Waiver** funding but who choose not to participate in the **Waiver**, will receive only the state paid portion of support.

PROCEDURES

1. The following documents are required to determine eligibility for developmental disabilities services funding.

   A. A **Division Form 19** (Eligibility for Services) signed by a licensed physician, licensed psychologist or certified school psychologist. For children six years of age and younger, letters from two licensed or certified professionals working in the disability field will be accepted in lieu of the **Form 19**, providing the letters state:
      i. the child is at serious risk of a disability, and
      ii. the disability is likely to continue indefinitely.
   B. Inventory for Client and Agency Planning (ICAP) assessment;
   C. Social History and/or Social Summary **Form 824** - completed by or for the **Applicant** within one year of the date of application; and
   D. Psychological evaluation, or for children six years or younger, a developmental assessment.

2. An **Applicant**'s eligibility for funding for developmental disability supports is determined by the following process:

   A. **Region** staff perform an assessment within 15 business days of the day that all required information is received and either:

      i. determine the **Applicant** eligible or ineligible for funding for developmental disabilities supports, or
      ii. forward the **Applicant**'s name and intake information to the State Eligibility Committee for placement on the Committee's next meeting agenda. The Committee shall review the **Applicant**'s information and determine if the **Applicant** is eligible for funding.

   B. A **Qualified Mental Retardation Professional** (**QMRP**) evaluates criteria to determine if a **Person** found eligible for state funding is also eligible for **Waiver** services.

3. **Person**s found eligible for the **Waiver** who are over the age of 11 (see **Utah Code Annotated**, Section 62A-5-402 through 62A-5-403) shall be provided with a list of Intermediate Care Facilities for People with Mental Retardation (ICFs/MR) and asked to choose between receiving services in the community or in an Intermediate Care Facility for People with Mental Retardation (ICF/MR). **Person**s under age 11 may only be admitted to an Intermediate Care Facility for Persons with Mental Retardation by following Procedure 4D, of **Division** Policy 1-6.

   A. If the **Person/Representative** chooses to receive services in an Intermediate Care Facility for People with Mental Retardation (ICF/MR), the **Region Director** will write a letter of referral.
   B. **Person**s/**Representative**s choosing to move to an Intermediate Care Facility will be asked by the **Region** staff if they want their name placed on the waiting list for future placement in community-based services. If the **Person/Representative** requests, **Region** staff shall place the **Person**'s name on the waiting list.

4. If funding is unavailable for a **Person** who chooses to receive services from a community **Provider**, the **Person**'s name is entered on the waiting list in accordance with **Division** policy 2-2, Waiting List and Critical Needs Assessment.

5. A **Person/Representative** may petition the **Region Director** for a hardship exception of the requirement to use **Medicaid** funding.

6. A Notice of **Agency Action**, **Form 522**, and a Hearing Request, **Form 490S**, are mailed to each **Person/Representative** upon completion of the determination of eligibility or ineligibility for funding (see Policy 1-5 Notice of Hearing for **Agency Action**). The Notice of **Agency Action**, **Form 522**, should inform the **Person/Representative** of eligibility determination and placement on the waiting list.

GUIDELINE 2-1 FUNDING

MAXIMIZING STATE AND FEDERAL FUNDING

1. All persons who are eligible for waiver services are required to be in the waiver, or the only funds that will be available to them to purchase services are the State funds that would be used to pay the state match for supports covered by Medicaid.

2. All persons receiving supports with State funding only, but who are eligible for waiver services, should be converted immediately to the appropriate waiver. Support coordinators should work with each person/family to assist them in this process.

3. Persons who are new to supports and who are eligible for a waiver will be placed on the appropriate waiver at the time of entry into services.

4. When it is clear that a spend-down, necessary to participate in the waiver, equals or exceeds the cost of the appropriate service or support, the support coordinator may request an exception from the region director to allow full State funding. Approval for this exception rests with the region director.

5. All decisions made in relationship to this policy have the option of appeal, following review by the supervisor, region director, division director, and/or the formal department appeals process.

GUIDELINE 2-1 RELATED CONDITIONS

RELATED CONDITIONS THAT MAKE A PERSON ELIGIBLE FOR HOME AND COMMUNITY-BASED WAIVER SERVICES

1. Code of Federal Regulations (42 CFR 435.1009) states that eligibility for waiver services be based on conditions attributable to a) cerebral palsy, epilepsy, or autism, or b) any other conditions, other than mental illness, found to be closely related to mental retardation because the conditions result in impairments similar in general intellectual functioning or adaptive behavior similar to that of persons with mental retardation and requires treatment or services similar to those required for these persons.

2. The Division uses the following definitions to define any other condition:

   a) Intellectual impairment* two standard deviations below the mean (e.g., 70 or less) shall suggest presumptively the eligibility of the person, if all other conditions (e.g., impaired adaptive functioning deficits occur concurrently and required services are similar to those needed by persons with mental retardation,** etc.) are satisfied.

   b) Intellectual impairment* at least one standard deviation below the mean (e.g., 85-71) may suggest eligibility, if all other conditions (e.g., impaired adaptive functioning deficits occur concurrently and required services are similar to those needed by persons with mental retardation,** etc.)

   c) Intellectual impairment* within one standard deviation of the mean (e.g., 86-100) presumptively precludes eligibility, except for persons who also have the diagnoses of cerebral palsy, epilepsy or autism and if all other conditions (e.g., impaired adaptive functioning deficits occur concurrently and required services are similar to those needed by persons with mental retardation**) are satisfied.

   d) Intellectual impairment* above the average mean (e.g., 100) precludes eligibility for all persons for the developmental disabilities waiver.

   e) No person shall be eligible for any Division service if they score 90 or higher on the Inventory of Client Agency Planning (ICAP).

Persons currently receiving services who do not meet these criteria should not be terminated from services, but shall be annually re-evaluated for continuing needs, and their continuing status should be reported by the region director to the division director.

* as measured by an individually administered, standardized test of general intelligence.

** an array of services, supportive individuals, and receptive settings which meet an individual's needs that may range from pervasive and of lifelong duration to intermittent or short-term.

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Appendix C — Form 19 Eligibility for Services

DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES

ELIGIBILITY FOR SERVICES

The following is to be completed and signed by a licensed psychologist, certified school psychologist or physician. Mark each area of major life activity in which the person has a current, substantial, functional limitation that is likely to continue indefinitely as defined below. Please evaluate whether or not the person can perform the activities listed under each functional limitation on their own without being supervised or monitored. When determining limitations in the areas listed below, age appropriateness must be considered. **Persons who have a disability due only to mental illness, hearing impairment and/or visual impairment, learning disability, behavior disorder or the aging process, do not qualify.**

I certify that _____*(person's name)* has a substantial, chronic functional limitation in the following areas of major life activity: *(Check all areas that apply)*

☐ **1. Self-Care.** A person who requires assistance, training and/or supervision with eating, dressing, grooming, bathing or toileting. *(Age appropriate activities must be considered.)*

☐ **2. Expressive and/or Receptive Language.** A person who lacks functional communication skills and/ or requires the use of assistive devices to communicate or does not demonstrate an understanding of requests or follow two-step instructions. *(Age appropriate activities must be considered.)*

☐ **3. Learning.** A person who has obtained a valid and reliable IQ score of two standard deviations or more below the mean on an individually administered standardized intelligence test, *(e.g., a score of 70 or below on the Wechsler Intelligence Scale for Children or Adults, WISC III or WASC III or a score of 68 or below on Stanford-Binet, Fourth Edition).* IQ test scores over the developmental period should consistently yield scores two standard deviations below the mean.

☐ **4. Mobility.** A person with a mobility impairment who requires the use of assistive devices to be mobile and who cannot physically self-evacuate from a building during an emergency. *(Age appropriate activities must be considered.)*

☐ **5. Capacity for Independent Living.** A person who is unable to locate and use a telephone, cross streets safely, or understand that it is not safe to accept rides, food or money from strangers. An adult who is unable to complete basic survival skills in the areas of shopping, preparing food, housekeeping or paying bills. A person who is a significant danger to self or others without supervision. *(Age appropriate activities must be considered.)*

☐ **6. Self-Direction.** A child (age 6-18) who is significantly below average in making age appropriate decisions. An adult who is unable to provide informed consent for medical/health care, personal safety, legal, financial, habilitative, or residential issues and/or who has been declared legally incompetent. (Age appropriate activities must be considered.)

The Economic Self-Sufficiency Functional Limitation Definition Applies Only to Adults (age 18 or older)

☐ **7. Economic Self-Sufficiency.** An adult who receives disability benefits and who is unable to work more than 20 hours a week or is paid less than minimum wage without employment support. *(Age appropriate activities must be considered.)*

Diagnosis/Comments:	
Name: (Please Print)	Telephone:
Address: (Street, City, State, Zip Code)	
Signature/Degree/Title:	Date:

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Appendix D — Form 817 DD/MR Waiver Level of Care Determination

Utah DHS-DSPD
1/00
Form 817

DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES

DD/MR WAIVER
LEVEL OF CARE DETERMINATION

Person's Name (Last, First, Middle Initial)

Person's Data Entry Number

Region/Office

Worker Number

Data Entry

Initials:

Date:

Based on formal assessments, the individual must meet **all** requirements in item 1, and **one** requirement in item 2 below, to meet the level of care requirements for placement in an intermediate care facility for people with mental retardation.

1. Requires care above level of room and board as documented by **all** of the following criteria (check all that apply).
   - [ ] Substantial functional impairment in three or more of the six areas of major life activity as defined in Policy 2-1, Eligibility and Intake for Developmental Disability Support.
   - [ ] Onset of condition was before age 18 for mental retardation or before age 22 for developmental disabilities.
   - [ ] Primary condition is not attributable to mental illness.
   - [ ] Requires at least weekly intervention by or under the supervision of a health care professional or trained support provider.
   - [ ] Cannot be maintained in less restrictive environment without Home and Community-Based Waiver services.

2. Plus **one** of the following (check one box):
   - [ ] Has mild, moderate, severe, or profound Mental Retardation.

     Specify level of Mental Retardation:_____. Code:_____.

   - [ ] Has a developmental disability and requires care and services similar to that of an individual with mental retardation.

     Specify developmental disability:_____. Code:_____

I hereby certify that but for the provision of Home and Community-Based Waiver services the individual would require the level of care provided in an intermediate care facility for people with mental retardation.

Qualified Mental Retardation Professional:_____. Date:_____.

Annual Reviews: I hereby certify that the individual's condition and diagnosis have not changed; therefore, there is a demonstrated need for continuing services under the Home and Community-Based Waiver.

Qualified Mental Retardation Professional:_____. Date:_____.
Qualified Mental Retardation Professional:_____. Date:_____.
Qualified Mental Retardation Professional:_____. Date:_____.
Qualified Mental Retardation Professional:_____. Date:_____.
Qualified Mental Retardation Professional:_____. Date:_____.
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Qualified Mental Retardation Professional:_____. Date:_____.
Qualified Mental Retardation Professional:_____. Date:_____.
Qualified Mental Retardation Professional:_____. Date:_____.
Qualified Mental Retardation Professional:_____. Date:_____.

Instructions for Completing the Form 817

PURPOSE:
The form 817 is an eligibility form used for data entry and documenting a person's diagnosis and eligibility for Home and Community-Based Waiver Services.

COMPLETING THE FORM:
Person's Name: The name under which the person is open on State data-base. Person's Data Entry Number: The person's identification number from the State database.

Level of Care Documentation: This section documents the person's eligibility for an intermediate care facility for people with mental retardation and Home and Community-Based Waiver services. Check the appropriate boxes.

Information regarding the person's developmental disability and/or level of mental retardation should be obtained from assessment documents (medical and psychological reports) and written in the spaces provided along with the appropriate code from the International Classification of Diseases. Listed below are the levels of mental retardation and the most common developmental disabilities:

Codes from the International Classification of Diseases, 9th Edition (look up additional codes in the book itself):

3170 Mild Mental Retardation
3180 Moderate Mental Retardation
3181 Severe Mental Retardation
3182 Profound Mental Retardation
3450 Epilepsy
3430 Cerebral Palsy
2990 Autism

Signature Area: Initial signature must be on or before the date the person enters Home and Community-Based Waiver services. The region staff who completes the document must be a Qualified Mental Retardation Professional or the document must be reviewed and co-signed by a supervisor who is a Qualified Mental Retardation Professional.

Annual Reviews: Annually, the Qualified Mental Retardation Professional must review the person's diagnostic information and eligibility for Home and Community-Based Waiver services. If the diagnostic information or level of care information changes, a new form 817 must be completed. If the diagnostic information or level of care remains the same, the professional signs and dates the original form 817.

DISPOSITION OF FORM:
Once completed, the person's level of mental retardation code and/or the person's developmental disability code must be entered into the State database for payment to occur.

Placement in the person's record: File the completed form 817 in the eligibility section of the person's record.

Agency Responses

December 11, 2001

Wayne L. Welsh
Auditor General
Office of the Legislative Auditor General
130 State Capitol
Salt Lake City, UT 84114

Dear Mr. Welsh:

Thank you for the opportunity to respond and comment on the report entitled "A Performance Audit of the Division of Services for People with Disabilities" (Report #2001-12) which was recently completed by your office. In general, I commend the auditors for the breadth of coverage they were able to give to a review of the Division of Services for People with Disabilities' waiting list given the time constraints of the audit. Although we have points of disagreement on certain aspects of the findings of the audit, I find the recommendations to be generally useful and manageable. We were aware of many of the weaknesses in our waiting list management system identified by the audit and have been working to address those. The audit provides some additional ideas as to how we might attend to those areas needing improvement. In concert with the Board of Services for People with Disabilities, where appropriate, the Division will give serious attention to those recommendations in our efforts to continue to improve our responsiveness to the needs of people with disabilities.

Four sections follow. The first details some areas of agreement with the audit findings.
The second offers some points of clarification that I believe are necessary to a more complete understanding of some of the auditors' conclusions. The third section addresses some points of disagreement with findings described in the report. The final section provides a brief overview of a plan to reform our traditional approach to providing services, a plan that holds promise for addressing the most immediate needs of those on the waiting list in a more timely and cost-effective manner.

Points of Agreement

Conflicting data on waiting list numbers. The auditors conclude that the Division's waiting list (of August, 2001) overstates the actual number waiting by 24% (p. 14). From their review of a sampling of waiting list files and discussion with Division staff, auditors concluded that 24% of the waiting list includes people who no longer desire services, have moved or are deceased, or are already in services. The Division also recently completed a review of the waiting list for the
purpose of verifying both numbers and immediate service needs. In November, the Division commissioned Dan Jones and Associates to conduct a telephone survey of a sample of people waiting for services. That survey revealed that 17% of the people on the waiting list fall into the three categories described above. Thus, we would agree that there is a portion of the waiting list who have either left the state or no longer report an immediate need for services. As the disparate data of the audit and the Dan Jones survey reveal, the actual percentage needs to be verified. In all probability, that percentage fluctuates with time.

Confusing terms. I would agree that the terms "critical" or "critical-immediate" are misleading (p. 19). Until three years ago, the Division classified those waiting and eligible for services into three categories: critical need, immediate need, and future need. The waiting list has been reclassified to the descriptors immediate need and future need. The critical needs assessment process rank orders the immediate needs list. Although Division policy, forms, and waiting list data bases were revised to reflect this change, the older terms continue to be used by some people within and beyond the Division and they continue to appear on some documents. The critical needs assessment instrument and process, should we retain them, should also be re-titled.

Need for improvement in Division's information systems. We found multiple points of disagreement over cost figures presented in the report. I would concede, though, that some of the Division's data tracking is fragmented across region and state levels and, therefore, lacks the uniformity required for ease of retrieval and efficiency of use of those data. Some of the information errors (e.g., deleting names from the waiting list as people enter services) are attributable to the transition to a new waiting list data base. Regardless of the cause, however, the Division is committed to assuring the integrity of the data necessary both for accountability and for sound decision-making. I have assigned a group--comprised of individuals within and beyond the Division with expertise in research, information technology, and fiscal management—to address the needed improvements in the Division's data systems.

Policy choices as to the inclusiveness or exclusiveness of eligibility for Division services. I agree with the findings of the audit that the legislature could choose to prioritize funding among different configurations of the current waiting list (e.g., serve only persons eligible for Medicaid matching funds). I would assert that this is a question of public policy that appropriately rests with the legislature. The Division will continue to abide by policy direction provided by state statute, which at present, compels us to serve the most critical with no distinction among funding streams.

Points of Clarification

Information gathered at intake. The auditors recommend that more assessment be completed and information be gathered at the time of intake including funding eligibility and specific costs of services (pp. 23-25). The Division has made a conscious decision to collect at intake only information necessary to establish a person's eligibility for Division services, determine
broad categories of services needed (e.g., in-home services including family support, day services, and/or transportation or out-of-home services), and evaluate the urgency of service need (through the critical needs assessment). Changing service needs are documented through subsequent contacts with the person.

Because an applicant is likely to have an extended wait for services and because their needs are rarely static, we have not required them to undergo assessments that must be completed by other agencies, that will become obsolete with the wait, and that will need to be repeated to be current at service entry. Medicaid eligibility, for example, has a financial need component that must be based on current income. More detailed service needs assessment and additional
eligibility determinations are completed as the person approaches the top of the waiting list and is likely to be funded.

Maximizing use of Medicaid funds. The audit found 21 individuals (of a sample of 77) whose services are fully state funded and whom the auditors believe to be eligible for Medicaid matching funds (p. 22). The report makes reference to Division rules that require those who are eligible to participate in Medicaid or have their budgets reduced to only the state dollars that would be required to draw a match of Medicaid funds. That rule was implemented two years ago. Since then, the Division has increased the number of persons receiving Medicaid matching funds by 6%. Thus, although the auditors discovered some persons who still need to be converted to Medicaid, the audit does not present the number of people who have been required to participate in Medicaid waivered services since implementation of this Division requirement.

Points of Disagreement

Formal evaluation and professional judgement in the assessment of need for services. There are a number of observations in the report (pp. 13, 23, 27) and a recommendation that suggest that persons applying for services simply choose the services they would like to receive and that the Division imposes no evaluation or restriction on those declared choices. It is accurate to conclude that those who apply for Division services, most often parents of the person with a disability, know what supports they are lacking and what they are seeking from the Division (e.g., parents describe their need for a break or respite from the constant demands of care, the person will be graduating from school but continues to need the types of training and supervision that supported employment or other adult day services would provide, an aging and ailing parent is finding that they may not be able to continue to provide the physical care an adult son or daughter requires). Thus, people can and do describe or identify the services they are seeking.

It is not accurate to conclude, as the auditors do, that Division staff do not apply professional judgment in establishing and verifying the services the person might need. A number of assessments are completed and considered in the intake process including (a) diagnoses and evaluation of the person's functional limitations provided by a physician or licensed psychologist (Division Form 19), (b) completion by the intake worker of a standardized assessment to establish the severity and nature of the person's service needs (the Inventory for Client and Agency Planning), (c) completion of a Critical Needs Assessment, (d) a home visit and interview and/or observation of the person who is applying for services, and (e) a clinical review and prioritization for services completed by a Critical Needs Assessment team. Disputes over eligibility determination or priority of need are reviewed by region and/or division administrators, a state level eligibility committee, and/or a department hearing officer, any or all of whom may request additional formal assessments. The Division's Eligibility Committee reviews assessments for an average of 85 persons per year who disagreed with their home regions' determinations of their eligibility and/or level of need. A small percentage of these individuals go on to request a department level administrative hearing. Certainly there would be no need for these additional steps of due process if Division staff were not applying professional judgement that, at times, contradicts individual or family preferences.

Local control. The report questions differences in the way the four regions of the Division direct waiting list funds allocated to them on the basis of population. That region expenditures do not exactly mirror population proportions may be largely explained by two facts. First, region expenditures incorporate funds beyond their waiting list allocations including funds transferred from the Division of Child and Family Services (DCFS) for the state match for DCFS children in out-of-home services with the Division. Second, a small percentage of persons in services move across regions taking their service funding with them.

The report suggests that other differences in the way that regions distribute waiting list funds may be a result of a lack of clarity in Division policy. In fact, regions are obligated to use waiting list funds exclusively to bring new people into services or to add services for which people are waiting. They are also obligated to distribute funds to assure attention to both out-of-home services (i.e., up to 24-hour residential and day services) services and in-home services (family support and day services). They must assure that funds are directed throughout the region to reflect population distribution and need. Finally, within the boundaries of the preceding
restrictions, they must apply funds to those with the most significatn needs as determined by local or regional Critical Needs Assessment process. Even with those uniform expectations, some room remains for local discretion to direct funds in a way that is congruent with local priorities, conditions, and cultures. I would hold that some regional-local differences are appropriate in the interests of maintaining control and building service capacity at the local level.

Division Planning for a New Way of Doing Business

One could clearly conclude from the audit report that the Division could invest greater effort and staff resources to assure greater precision in the management and cost analysis of its waiting list. As an alternative, the Division could invest greater effort and resources to the discovery of viable solutions to the waiting list. As mentioned briefly in the report, over the past year the Division has articulated a goal to eliminate the waiting list and has taken that challenge to our various stakeholders and to local citizens through a series of town meetings held throughout the state. This pursuit responds to legislative intent language for the Division to "maximize its ability to serve individuals on the waiting list" referenced in the report (p. 7).

At the entrance meeting with members of the legislative audit team who completed the study reported here, I indicated that, while an audit was being conducted of the approach we have traditionally taken to managing the waiting list and bringing people into services, the Division would be at work on the design of a very different way of attending to the waiting list and delivering services. This is the next major stage of a systems change process that has been underway in this Division for the past four years. Based upon our experiences during the change process, a plan for a new way of doing business has taken shape and has received broad support. Critical elements of the plan include:

- Earlier intervention to address the needs that the majority identify at the point of application to services (e.g., respite care, assistance with medical expenses, adult day services),
- Supporting the person in the context of the family as the Division's primary response,
- Shifting the locus of ultimate responsibility and control from the Division to the family,
- Providing specific, flexible, time-limited as well as ongoing supports, and
- Ultimately eliminating the waiting list by providing necessary supports at application and following verification of eligibility and need.

I believe the time, energy, and other resources of the Division are better spent on implementation of this new approach than on efforts to improve and refine the waiting list management processes that have been applied for all of the 15 years that the Division has had a waiting list. The Division has submitted its plans and recommendations to the Department of Human Services and to the Governor's Office for their review and consideration. The policy issues raised in this audit, along with those options highlighted in the Division plan, appropriately set the stage for Legislative and Executive Branch discussion and decision-making.

I appreciate being able to provide a response on behalf of the Division of Services for People with Disabilities. I am eager to proceed to address the recommendations generated by this audit.

Sincerely,

Sue Geary, Ph.D., Director
Division of Services for People with Disabilities

January 10, 2002

Mr. Wayne L. Welsh, Auditor General
Office of the Legislative Auditor General
130 State Capitol
P.O. Box 140151
Salt Lake City, UT 84114-0151

Dear Mr. Welch:

Thank you for the opportunity to prepare a response to **A Performance Audit of the Division of Services for People with Disabilities** (Report No. 2001-12). The Division of Health Care Financing, functioning as the State Medicaid Agency, welcomes input into the ongoing performance improvement of the Medicaid 1915c Home and Community-Based Services (HCBS) waiver program. We are committed to supporting the Division of Services for People with Disabilities, as our contract administrative management agency for three waivers, in responding appropriately to the recommendations contained in your report.

This response is meant first and foremost to recognize the quality of the audit report and the professional manner demonstrated by your staff who met with me to discuss details of the State Medicaid program. I find the contents of the report thought provoking and value the opportunity to incorporate many of your recommendations into the current system review of the waiver program being conducted jointly by the Department of Health and the Department of Human Services. I offer the following comments for your consideration relating to specific elements of the report that address Medicaid issues of heightened importance and in strong support of the authors' emphasis that serious policy discussions need to occur before final actions are determined.

Definition of Service Need

The 1915c HCBS waiver program was designed by Congress to provide specialized services to targeted populations as an alternative to institutionalization in a hospital, nursing facility, or intermediate care for the mentally retarded (ICF/MR). It is important to recognize that waiver enrollment is meant to alleviate the imminent risk of institutionalization absent the provision of waiver services. Discussions relating to the appropriate definition of *critical need* as it pertains to the waiver program must center on preventing institutionalization. The fact that persons with varying levels of disabilities living in the community have needs important to their ability to be independent and remain active in the community does not, by itself, deem them eligible for Medicaid waiver services.

Although there have been periodic discussions over the years at the national level about moving to a block grant approach in Medicaid to allow greater flexibility to the states in the design of programs, so far nothing major has come of the discussions. For now, the 1915c Waiver program continues to be restricted by federal law and regulation to its current focus on serving persons at imminent risk of institutionalization rather than as a more prevention and early intervention model.

Waiver Target Populations

Each 1915c HCBS waiver is designed to serve a specific target population. The State defines the criteria for participation and thereby determines the breadth of disabilities covered by the waiver. This is important in terms of your discussion of reducing the size of the waiting list by limiting services to those persons meeting the eligibility criteria for the 1915c waivers. Eliminating state-only funded programs runs the risk of eliminating services to entire groups within the disabilities population that were not included in the targeted groups defined for the waivers. A version of your alternate discussion of a combined approach, involving broadening the target population while restricting services to those necessary to prevent institutionalization, may be more equitable.

Waiver Services As An Entitlement

Guidelines issued by the Centers for Medicare and Medicaid Services (CMS) in response to the Supreme Court Olmstead decision indicate that once a person is enrolled into a 1915c waiver, that person is entitled to the services covered by the waiver that are necessary to prevent institutionalization. Under this interpretation, if the state's professional assessment of the person identified the need for a covered service, the state cannot withhold the service for financial reasons. As it relates to waiver-eligible persons, the concept of providing only one or two services, such as family support, regardless of assessed need, conflicts with the CMS position that each waiver client must be treated individually based on assessed need.

Client Need Determination Versus Professional Determination

Although I fully agree that professional determination of need is a critical element of the service planning process, care must be exercised to assure that DSPD support coordinators remain focused on identifying immediate needs rather than fostering enhanced packages that go beyond this level of service. Because support coordinators are knowledgeable of a full array of services available to promote independence and community integration, experience in many states have shown a tendency to start with the services the client requests and to build upon them to achieve a more comprehensive package that more fully benefits the individual but reduces the distribution of resources across a larger number of clients. Provisions must be in place to assure that the professionals determining the level of need do not foster an enhanced perception of need in the clients based on their knowledge of the full array of potential services that can be accessed and the availability of funds at that point in time. This comes back to the core discussion of clearly defining what constitutes need and the process for standardized assessment.

Unanticipated Growth of Needs

The discussion of transition clients in the report point out a practice that is well intentioned but may lead to substantial unanticipated cost increases in future years. As the report indicates, enrollment in a 1915c waiver programs opens the door to companion Medicaid programs and results in cost increases across the Medicaid budgets of both Human Services and Health. In addition, waiver planning must recognize the program implications that occur as a waiver enrollee moves from the status of a dependent child to adult status. A person entering a 1915c waiver as a child with the associated support network of parents and guardians may utilize low cost services for a number of years. Suddenly when that person reaches adult age, the support network is no longer obligated to provide natural supports and the responsibility falls to the waiver program under the previously discussed CMS guideline of entitlement to assessed needs. A move from home-supported services to 24-hour supervised living arrangements can result in two-fold or greater increases in the per client cost.

Relax ICF/MR Eligibility Requirements

I disagree that the Health Department could relax the ICF/MR eligibility requirements under current federal regulations. If this were possible, it could clearly open eligibility to a broader range of clients as stated in the audit report, but there are policy issues and potential costs that would require serious consideration before moving in this direction

I want to again thank you for the opportunity to respond to the report. If you have questions about the above comments, please contact me.

Sincerely,

/s/

Michael Deily, Director
Division of Health Care Financing

cc: Rod Betit