PERFORMANCE AUDIT REPORT

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

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

Executive Summary

with Conclusions and Recommendations

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

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Legislative Post Audit Committee
Legislative Division of Post Audit

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LEGISLATURE OF KANSAS

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May 15, 2006

To: Members of the Kansas Legislature

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

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

These findings are supported by a wealth of data, not all of which could be included in this report because of space considerations. These data may allow us to answer additional questions about the audit findings or to further clarify the issues raised in the report.

If you would like a copy of the full audit report, please call our office and we will send you one right away

Barbara J. Hinton
Legislative Post Auditor

EXECUTIVE SUMMARY

LEGISLATIVE DIVISION OF POST AUDIT

Overview of the Physical Disability Waiver Program

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

..... page 3

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

..... page 5

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

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

..... page 7

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

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

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

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

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

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

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

..... page 10

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

..... page 11

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

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