Developmental Disabilities Division
Adult Waiver Program

Management Audit Committee
January 2004

Management Audit Committee

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EXECUTIVE SUMMARY

Developmental Disabilities Division: Adult Waiver Program

Program Evaluation Division **January 2004**

Purpose

The Developmental Disabilities Division (the Division) in the Department of Health provides services to developmentally disabled Wyoming citizens. The Legislature's Management Audit Committee requested an analysis of program operations and outcomes, considering the following questions:

- How is eligibility determined for Home and Community Based programs, and have there been changes in the eligibility criteria?
- Does the Division regularly review and update its rules, and are the rules consistent with current practices?
- How does the Division ensure that cost-effective services are delivered?
- What is the Division's process for overseeing the purchase and delivery of client services?

This study focuses on the Adult Waiver, as it accounts for more than half of the Division's $104 million expenditures in FY '03.

Background

Wyoming citizens with developmental disabilities receive services through seven Division programs: Respite Care, Early Intervention, the Wyoming State Training School (WSTS), Targeted Case Management, and three Medicaid waivers: Adult, Children, and Acquired Brain Injury. Medicaid waiver programs are funded by federal and state dollars and administered by the Division. The waivers allow disabled people to live in community settings and to benefit from Medicaid funding otherwise available only to those living in institutions.

Since 2001, state-funded services for developmentally disabled adults with disabilities such as mental retardation, epilepsy, autism, deafness, and cerebral palsy have been provided solely through the Adult Waiver. In FY '03, the waiver served 1,008 clients ranging in age from 21 to 83, at an average cost of $57,032 per person. According to Division data, FY '03 expenditures for the waiver were $57.5 million, with the General Fund contributing 38 percent of the total.

Results in Brief

The Weston Consent Decree, the U.S. Supreme Court's Olmstead decision, and client choice have impelled Wyoming to serve developmentally disabled adults primarily through home and community services. We found that the Division could be more accountable and cost-effective in operating the Adult Waiver. The Division does not promulgate rules specifying key program procedures and policies. Further, in calculating client budgets it uses assumptions that inflate individual costs, and it lacks procedures to monitor and justify the cost for the waiver's most expensive services.

Principal Findings

In 2001, the Division changed both its eligibility standards and the way it assesses persons applying for the Adult Waiver. These changes broadened the range of people who qualify, and facilitated the movement of clients onto the Adult Waiver

from the State Contract program, which was eliminated. Using only the Medicaid HCBS waiver to serve developmentally disabled adults enables the state to capture federal matching funds. It also gives clients access to all waiver services to meet their needs, which can increase costs. People who are eligible for the Adult Waiver are by definition "at-risk for institutionalization" at the WSTS, and therefore subject to the federal Olmstead decision. Under this ruling, states have legal obligations to serve people in their communities rather than in institutions, if services can be reasonably accommodated. The Division should investigate alternative programs to support different disabled populations and seek broad input into this policy-making process.

Statutes and rules guiding the Developmental Disabilities Division do not specify how the Division will employ the Adult Waiver as the state's sole means of providing services to developmentally disable adults. Further, the Division has made major policy decisions related to the Adult Waiver, such as changing eligibility criteria, without formal public input or announcement. It lacks rules that establish critical decision-making procedures, including the priority in which people move off the waiting list into waiver services. Instead of rules, the Division relies on manuals and other provisional documents to convey its procedures and practices. We recommend that the Division promulgate formal rules, not provisional manuals, to establish important program rights, definitions, and procedures.

Federal and state policies require HCBS waiver programs to be cost effective. The Division relies primarily on a funding model, DOORS (not an acronym), to meet this requirement. The model is designed to allocate money according to participants' needs, within an established budget. However, information used to develop the model has not been externally validated, and we believe some Division decisions and practices interfere with the model's effectiveness in fairly and equitably allocating funds. We recommend the Department of Health contract for an independent analysis of the effect the DOORS model has on client service choices and program costs.

According to Division officials, funding for emergency cases and unanticipated IBA increases comes from unspent portions of all clients' IBAs. However, we could not clarify how the Division accounts for this funding. We believe proper management of these funds calls for standard procedures and clear accountability. The Division should establish a system to account for funds used for these purposes.

Although the Division cites both internal and external means of oversight for its adult waiver program, we believe fiscal oversight of state expenditures under the Adult Waiver needs to improve. The Division has in place a system of oversights that likely ensures clients receive acceptable care. However, this system does not fully protect the state's interest in making certain that the appropriate amounts of public funds are expended on necessary services. We recommend that the Division require more justification of rates for major services.

Agency Comments

The Department of Health agrees with the report's recommendations that it seek broader input into policy making, obtain an independent analysis of the DOORS model, improve accountability for emergency and forced rate funding, and require more justification of rates for major services. The Department partially agrees that it should promulgate formal rules, not provisional manuals, to establish important program rights, definitions, and procedures. The Department's response lists action steps intended to implement the recommendations, as well as specific completion dates.

Copies of the full report are available from the Wyoming Legislative Service Office. If you would like to receive the full report, please fill out the enclosed response card or phone 307-777-7881. The report is also available on the Wyoming Legislature's website at legisweb.state.wy.us

Recommendation Locator

Page Number	Recommendation Summary	Party Addressed	Agency Response
20	The Division should investigate alternative programs to support different disabled populations and seek broad input into this policy-making process.	Division	Agree
29	The Division should promulgate formal rules, not provisional manuals, to establish important program rights, definitions, and procedures.	Division	Partially Agree
40	The Division should obtain an independent analysis of the DOORS model and its affect on client services and program costs.	Division	Agree
41	The Division should establish a system to account for the money it uses to fund emergency cases and forced rates.	Division	Agree
48	The Division should require more justification of rates for major services.	Division	Agree

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INTRODUCTION

Scope and Acknowledgements

Scope

W.S. 28-8-107(b) authorizes the Legislative Service Office to conduct program evaluations, performance audits, and analyses of policy alternatives. Generally, the purpose of such research is to provide a base of knowledge from which policymakers can make informed decisions.

In July 2003, the Management Audit Committee directed staff to undertake a review of the Developmental Disabilities Division in the Department of Health. The Committee requested an analysis of program operations and outcomes. Based on preliminary research, this study focuses on the Division's Adult Waiver program and addresses the following questions:

- How is eligibility determined for Home and Community Based programs, and have there been changes in the eligibility criteria?
- Does the Division regularly review and update its rules, and are the rules consistent with current practices?
- How does the Division ensure that cost-effective services are delivered?
- What is the Division's process for overseeing the purchase and delivery of client services?

Acknowledgements

The Legislative Service Office expresses appreciation to those at the Department of Health, Developmental Disabilities Division who assisted in this research. We also gratefully acknowledge assistance from the Adult Waiver Program service providers, case managers, and members of the public.

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Chapter 1

Background

Report Focuses on Adult Waiver

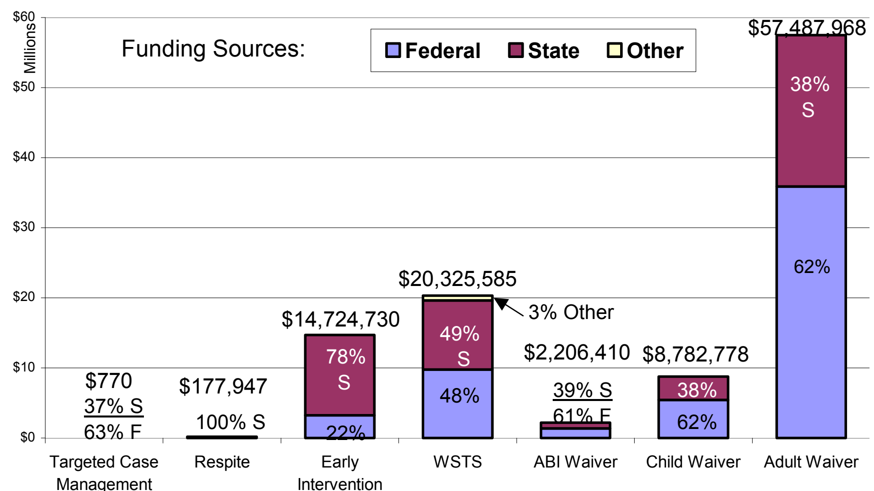
Wyoming faces a variety of challenges in meeting the needs of its citizens with mental retardation and other developmental disabilities. Increased demands for services place a strain on limited resources, forcing difficult decisions about how best to balance cost and need.

The Adult Waiver accounted for 55% of the Division's FY '03 expenditures.

Wyoming citizens with developmental disabilities receive services through the Developmental Disabilities Division (the Division) of the Department of Health. Seven Division programs provide services: Respite Care, Early Intervention, Wyoming State Training School, Targeted Case Management, and three Medicaid waivers: Adult, Children, and Acquired Brain Injury. This report focuses on the Adult Waiver, as it accounts for more than half of the Division's $104 million FY '03 expenditures.

Figure 1.1

Developmental Disabilities Program Expenditures, FY '03



Source: LSO analysis of Division Data

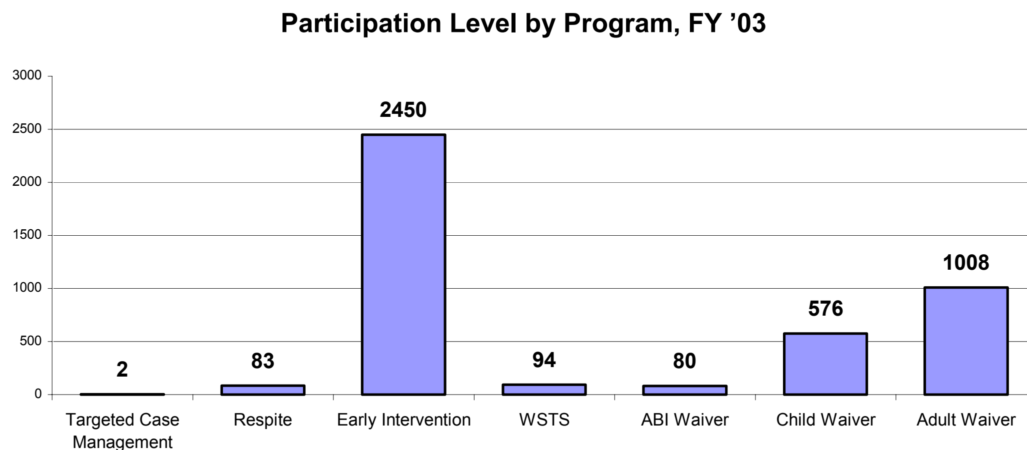
The Division's Six Other Developmental Disabilities Programs

The **Early Intervention Program** provides home services to children aged 0-2 years and preschool services to children aged 3-5 years. Both are federal programs governed primarily by the federal *Individuals with Disabilities Act* of 1997, and their services are considered entitlements, requiring the state to serve all who qualify. The State contributed 78 percent of the program's $15 million FY '03 budget; the remaining 22 percent were federal funds. Services are provided to 2,450 children, at an average cost per child (FY '03 expenditures divided by that year's number of participants) of $6,010.

The **Wyoming State Training School** (WSTS) in Lander is the state's only Medicaid-certified Intermediate Care Facility for the Mentally Retarded (ICF/MR), serving 94 developmentally disabled people in FY '03 at a cost of $20.3 million. The average cost per person was $216,230, with federal funds covering approximately half the cost.

Figure 1.2

Participation Level by Program, FY '03



Source: Division data

The **Respite Care Program** is a state program authorized by W.S. 35-1-628, providing respite services to families with children under 21 who are not eligible for the waiver. Respite services provide parents a short reprieve from continuous care for their child. The FY '03 budget was $178,000, with 83 children receiving services at an average cost per child of $2,144.

The **Targeted Case Management Program** is essentially a referral service to help individuals on the Adult and Child Waiver waiting lists find interim services. This service, currently provided to two adults, is available at no cost to the individual. FY '03 expenditures were $770, for an average per-person cost of $385.

The **Acquired Brain Injury Waiver Program** (ABI), started in July 2001, provides vocational, learning, and residential services to individuals from 21 to 64 years of age who have sustained a brain injury since birth. In FY '03, 80 individuals were served at a cost of $2.2 million, for an average cost per person of $27,580.

The **Child Waiver Program** provides services to eligible children from birth through age 20. Eligibility is similar to the Adult Waiver Program, but clinical eligibility is age-adjusted. Services for the 576 clients include case management, personal care, respite care, residential habilitation, and specialized therapies. FY '03 expenditures were $8.8 million, for an average per-child cost of $15,248.

Note: LSO analysis of FY 2003 data reported by Division

Medicaid Waivers Are Optional and Flexible

Under federal law, states have the option of providing home and community services to persons who would otherwise require institutional services that are reimbursable by Medicaid. For people in Wyoming with developmental disabilities, institutional care would be provided at the state's single Intermediate Care Facility for the Mentally Retarded (ICF/MR), the Wyoming State Training School (WSTS), and the cost of care would be covered by the state Medicaid plan.

States can control waiver program services, number of clients, and overall expenditures.

Wyoming obtained a waiver for adults with developmental disabilities in 1991. With home and community based service (HCBS) waivers, Medicaid "waives" its requirement that services be provided in institutional settings, to allow payment for non-medical services such as case management and habilitation services. These services are intended to keep people from being institutionalized and help them live more independently.

Medicaid gives states great flexibility in designing waivers. States can limit the availability of service geographically, target specific populations or conditions, and cap overall expenditures. In contrast to the standard Medicaid program, waiver programs can also limit the number of persons served.

Current Adult Waiver participation and cost

FY '03 Adult Waiver expenditures were more than $57 million.

According to Division data, FY '03 expenditures for the Adult Waiver were $57,487,968, with the state General Fund contributing 38 percent of the total. The average FY '03 cost per person served was $57,032. The Adult Waiver's 1,008 clients, ranging in age from 21 to 83, have various disabilities such as mental retardation, epilepsy, autism, deafness, and cerebral palsy. In addition to receiving services related to their disabilities, Adult Waiver participants also receive regular Medicaid benefits for their health care.

Changes in Wyoming's system

From 1912 until 1989, the Wyoming State Training School (WSTS) provided the majority of services for people with developmental disabilities. Since then, community-based providers have become the dominant service providers. This shift was sparked by the 1990 filing of a civil class action lawsuit against WSTS and the State of Wyoming, Weston, et al. v. Wyoming State Training School, et al. (C90-0004), by the federally funded, non-profit Wyoming Protection & Advocacy System, Inc. (P&A).

Services shifted to a community-based focus after the Weston lawsuit.

The Weston lawsuit dramatically changed the face of service delivery to Wyoming persons with developmental disabilities. It was filed on behalf of "all individuals with mental retardation, currently at the WSTS, or who are currently, or may be in the future, at risk of placement at the WSTS…" The State of Wyoming and P&A negotiated a settlement, approved by the Federal Court, which resulted in a Consent Decree. According to the Division, the decree guided the progressive change from WSTS-centered services to community-based services (see Appendix B for Weston principles). The Division holds compliance with Weston principles as being imperative to avoid additional litigation and meet the state's commitment to the final written Settlement Agreement (January 1, 1995) "to continue to provide appropriate and necessary services and supports, including but not limited to residential and habilitation, to members of the class and other people with developmental disabilities." Funding for developmental disability services has more than tripled since the Consent Decree.

When the Division applied for the Medicaid HCBS Waiver in 1991, Wyoming became one of the last states in the U.S. to participate. Earlier, state General Funds supported most costs for services through WSTS and the State Contract program. The State Contract program provided funding for select community services for adults with mild developmental disabilities. The state was contracting with nine regional providers to provide these services. This program ended in 2001, when the state went solely with the Adult Waiver as a funding mechanism for adult services (see Chapter 2).

Since 1991, federal funds have covered more than 50% of waiver costs.

Since 1991, federal funds have supported more than half the cost of services for adults with developmental disabilities. For federal fiscal year '04 (October '04 through September '05), the Federal Financial Percentage (FFP), which varies according to state per capita income, will provide 57.9 percent of funding for the Adult Waiver, as well as for the Child and ABI Waivers.

U.S. Supreme Court's Olmstead Decision

Since 1999, the developmental disabilities world has been impacted by the U.S. Supreme Court's ruling in Olmstead v. L.C. (527 U.S. 581). The Court held that under Title II of the Americans with Disabilities Act, states are required to provide community-based treatment rather than placement in institutions to people with disabilities, where:

- the state's treatment professionals have determined that community placement is appropriate
- the transfer from institutional care to a less restrictive setting is not opposed by the affected individual, and
- the community placement can be *reasonably accommodated*, taking into account the resources available to the state and the needs of others with mental disabilities.

Olmstead requirements have limits, allowing states some flexibility.

Although the Court's ruling creates specific state requirements, it also sets limits. The Court said the state's responsibility, once it provides community-based treatment to qualified people with disabilities, is not boundless. States have some flexibility to take into account available state resources and the needs of other state citizens with mental disabilities. States need not make changes that would "fundamentally alter the nature of the service, program, or activity." Further, states may maintain a waiting list for community-based services, but the list must move at a reasonable pace. The decision thus left open many questions for states and lower courts to resolve.

Many developmentally disabled people need services

Most persons with developmental disabilities have mental retardation, but others have severe, chronic disability resulting from other life-long conditions that began before they were 22 years old. Adults with developmental disabilities can be highly dependent on public programs for meeting their needs for care. This population depends on long-term care services which can

include supervision and assistance with everyday activities such as help in dressing, using the bathroom, managing money, and keeping out of danger. Waiver programs offer a broad range of services in less restrictive settings than institutions, allowing the persons served to live in the community.

Adult Waiver service providers

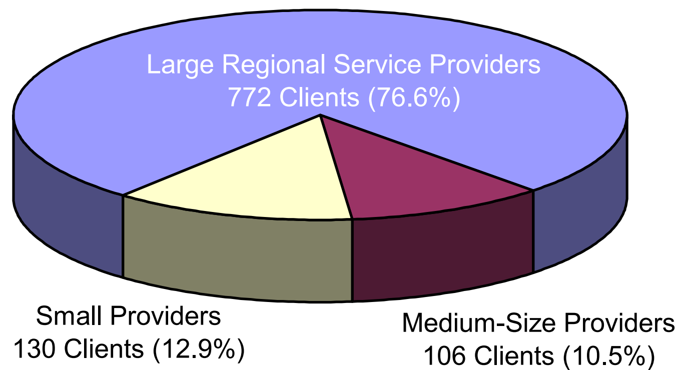
In the 1970's, regional service providers (RSPs) in Wyoming began to provide community-based care for people with developmental disabilities. By 1990, RSPs were the primary community providers, but after Weston, other providers began to emerge. Nevertheless, in 2003, nine RSPs still served more than three-quarters of all clients and received 78 percent of waiver funds.

Nine providers serve more than 75% of clients and receive more than 75% of funds.

Listed among all providers in FY '03 plans of care, nine RSPs served 50 clients or more; 18 medium-size providers served more than 10 clients but fewer than 50; and 321 small providers served ten or fewer clients (many of these provided home-based services to one or two clients). In addition, Figure 1.3 shows the number of clients served in terms of their main provider (usually a day and/or residential habilitation provider) by the provider's size.

Figure 1.3

Client Participation by Size of Main Provider FY '03



Source: LSO analysis of Division data

Applying for services

To receive Adult Waiver services, persons must meet defined financial and clinical criteria for eligibility (see Chapter 2). The Department of Family Services determines financial eligibility, while the Division determines clinical eligibility through IQ testing, a needs assessment, and other criteria. The Division uses an assessment tool called the Inventory for Client and Agency Planning (ICAP). Administered by a private consulting firm, the ICAP produces individual scores that indicate a person's level of functioning as well as his or her limitations and need for assistance.

Clients' FY '03 budgets for services ranged from $3,680 to $259,604.

When a client is determined eligible, the Division uses a statistical model called DOORS (not an acronym) to determine an Individual Budget Amount (IBA) for that client's services (see Chapter 4). In FY '03, IBAs ranged from a low of $3,680 to a high of $259,604.

Eligible applicants may be put on a waiting list

If no funding is available or if the program's participation cap has been reached, an eligible person may be put on a waiting list. According to Division officials, Wyoming has one of the smallest per capita waiting lists in the nation. As of August 2003, 68 persons were on the Adult Waiver waiting list. For the 62 of them for whom we have complete data, their range of time on the waiting list was 0 to 29 months, with an average of 11 months.

Clients on the waiting list have been waiting an average of 11 months.

The Division has latitude to determine that a person on the waiting list or a new applicant is in an emergency situation. In such cases, the individual may be added to the waiver immediately.

Client's needs and preferences determine services

At the outset of the application process, each client chooses a case manager from a list of Division-certified case managers to advocate for the preferences and choices of that client, review and monitor overall delivery of client services, and facilitate the client's independence and social integration. The case manager assembles and is a member of a planning team, which is responsible for annually creating the client's Individual Plan of Care (IPC).

The client is a member of and participates in the team's decision-making process. Clients' choices and preferences, provided for in both the Weston Settlement and Federal Medicaid "Freedom of Choice" law, should play an important role in a team's planning process. An IPC specifies the type and amount of services that will be provided to the waiver client. Teams may choose from any of 21 Adult Waiver services based on a client's needs and choices (see Figure 1.4).

Client choice plays an important role in planning for services.

IPCs most frequently include the following services:

- **Case Management** – Arranging and coordinating services and service delivery
- **Skilled Nursing** – Doctor-prescribed services provided by a registered nurse
- **Residential and/or Day Habilitation** – Training or assistance for skills such as daily living, mobility, and communications

Cost of services must stay within budget

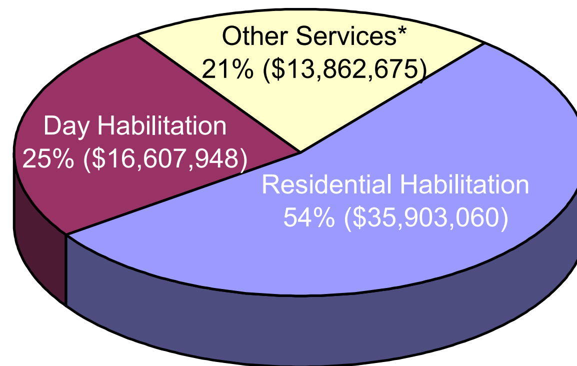
The Division establishes fee schedules for some services, while other fees vary by provider. The total cost of all services must be less than or equal to the IBA produced by the DOORS model. Plans with estimated costs more than the amount of the IBA require special authorization through the Division's forced rate process (see Chapter 5). Once a team has approved a client's plan, it goes to the Division for review and approval by a waiver specialist, after which the client can begin to receive services.

Residential and day habilitation services account for the majority of service costs.

Figure 1.4 shows that residential and day habilitation services accounted for 79 percent of the total amount budgeted for services in FY '03, thus dominating other service costs.

Figure 1.4

Waiver Services by Percent of Total Services Budgeted FY '03



Note: "Other Services" in Figure 1.4 above include the following 19 services: Skilled Nursing (4.1%), Pre Vocational (3.2%), Case Management (2.8%), Respite (2.3%), Psychological Therapy (1.9%), Personal Care (1.4%), Supported Employment (1.4%), In-Home Support (1.1%), Speech, Hearing and Language Therapy (0.9%), Occupational Therapy (0.7%), Subsequent Assessment (0.4%), New & Previous Medical Equipment (0.3%), Physical Therapy (0.2%), Dietician (0.1%), Initial Assessment (0.1%), New & Previous Environmental Modifications (0.1%), Respiratory Therapy (Less than 0.1%).

Source: LSO analysis of Division data

2003 federal review of Adult Waiver

States must provide CMS with six "assurances" for operating their waiver programs.

CMS (the federal Centers for Medicare and Medicaid Services, formerly HCFA) requires states to give the federal government six "assurances" that demonstrate they are meeting their responsibilities under the waiver. In late 2002, CMS conducted a scheduled review of Wyoming's Adult Waiver, during which its team interviewed Division staff, clients, guardians, and service providers. CMS also reviewed case files, IBAs, provider rates and total plan costs, forced rate letters, IPCs, and the standards and procedures used to justify higher rates. CMS issued its report in January 2003, focusing largely on the quality of the state's administrative authority over the Adult Waiver.

The report was critical of the way in which the waiver has been administered at the state level. Its findings and recommendations point to systemic problems in the state's administrative authority

that center largely around inadequate oversight and monitoring of the waiver. For example, the report commented that for certain clients, "the State may need to take a more integral role in team meetings and the decision-making process."

The federal review identified several issues, which this report examines more closely.

The Division responded to the report by accepting some federal recommendations and entering a statement of non-concurrence with others. CMS concluded that Wyoming had implemented changes that were directed to the findings and recommendations of the report, and that it was satisfied with the State's ability to operate the program. Over the next ten months, the Division made numerous procedural changes, issued a new provider manual, and established new requirements for requesting forced rates.

Since the federal review had identified serious questions that the Division was working to address, we focused more closely on the state's administrative structure and financial oversight. Although much at the Division was changing as we conducted research for this report, and we were hampered by inconsistent and incomplete data which we were often unable to reconcile, several themes consistently appeared. They became the focus of the following chapters: waiver eligibility, rules and policy making, cost-effectiveness of client services, and the need for more state-level oversight.

CHAPTER 2

Division Has Broadened Access to the Adult Waiver

The Division changed its eligibility standards and the way it assesses persons applying for the Adult Waiver to enable people with a greater range of disabilities to qualify. After briefly using a more stringent set of standards, the Division in 2001 modified both the standards and its assessment process to admit applicants with higher levels of functioning.

***Weston* principles guide the Division policy to serve a broad range of clients.**

These changes enabled remaining State Contract program clients, who had been unable to qualify under the more stringent criteria, to transition to the Adult Waiver. This transition was necessary for them to continue receiving services because the Division eliminated the State Contract program in favor of using only the waiver to fund services. The Division cites the Weston Consent Decree as the state's commitment to continue services to this group of clients. Further, admitting people with a greater range of disability to the waiver is consistent with the Division's mission to provide services to all individuals with developmental disabilities, and with its policy to use only the waiver to provide these services.

Decisions such as these have significant effects and warrant consideration by policy makers outside of the Division. Establishing a broader range of people as eligible for the waiver is important because the number of people served is a major determinant of total program costs. Further, by admitting people to the waiver, the Division is defining them as "at-risk of institutionalization" and therefore subject to the provisions of the U.S. Supreme Court's Olmstead decision.

To Qualify for the Waiver, Adults Must Be Wyoming Citizens Who Meet Both Financial and Clinical Eligibility Requirements

State Medicaid rules define a resident as someone who resides in Wyoming on a permanent and voluntary basis, and federal

Medicaid law does not allow states to set length-of-residency requirements. Residency will not be denied solely because a client is homeless. The Division does not accept waiver applications from persons who reside in other states or transfers from developmental disability programs in other states.

As for financial eligibility, state Medicaid programs must cover people who receive Social Security Administration's Supplemental Security Income (SSI) which provides a financial safety net for disabled, blind, or aged individuals who have low incomes and limited resources. Wyoming Medicaid rules expand this minimum by providing HCBS services to clients with incomes at or less than 300 percent of the maximum SSI benefit.

Clinical Eligibility Has Changed

Clinical eligibility is a state policy decision.

Requirements for clinical eligibility are important because they determine the range of people whose conditions qualify them for services. Medicaid gives states flexibility to determine clinical eligibility for waiver services. Since this determination is a policy decision that affects total program costs, as well as one about which confusion exists, we carefully reviewed the Division's procedures.

States set their own waiver eligibility criteria with minimal federal direction

Federal law and regulation specify only the general eligibility requirements for optional Medicaid home and community services (HCBS), such as being blind, aged, or disabled. States are permitted to use additional health and functional criteria to specify who, within the general eligibility group, receives services. To establish clinical eligibility for HCBS, states define the level of care that would qualify an individual for services in a hospital, nursing facility, or ICF/MR, and apply the same criteria to individuals who wish to be served in a community-based setting.

Waiver eligibility standards must be the same as those at the institutions from which clients are being diverted.

Although Medicaid allows states great flexibility in establishing waiver programs, it is firm in holding that the level-of-care criteria for waivers must be the same as that for the institutions from

which waiver recipients are being diverted. This reflects the federal government's primary purpose for the waiver: to offer an alternative to institutionalization. It means that for Wyoming's Adult Waiver, eligible participants must otherwise require the level of care provided in the state's only Intermediate Care Facility for People with Mental Retardation (ICF/MR), the Wyoming State Training School (WSTS). Eligibility criteria for the Adult Waiver and the WSTS must be the same.

Division Has Had Three Versions of Waiver Eligibility Criteria Since 1991

Related Condition

A severe, chronic disability manifested before age 22 that is attributable to cerebral palsy, seizure disorder or any other condition other than mental illness that is closely related to mental retardation and requires similar services.

The first Wyoming Adult Waiver criteria were broad, requiring that waiver beneficiaries be 21 years or older with disabilities manifesting before age 22 that are likely to continue indefinitely. Further, the first criteria required persons to be determined mentally retarded by a licensed psychiatric professional or have a related developmental disability (see "Related Condition" description at left). In addition, beneficiaries had to have substantial functional limitations in three or more of the following areas of major life activity: self-care, language, learning, mobility, self-direction, independent living, and economic self-sufficiency.

ICAP Service Score

The Service Score reflects the level of care, supervision or training needed by individuals at home, or in educational and human service programs. The score is based on maladaptive (socially unacceptable behavior) and adaptive behavior (meets community expectations for personal independence, maintenance of physical needs, acceptable social norms and interpersonal relationships).

These criteria stayed in effect until 1999, when the Division significantly changed them by adding numerical assessment scores that limited eligibility. These scores were commonly called the "70/70" rule, which referred to a full-scale intelligence quotient (IQ) of 70 or below and Inventory of Client and Agency Planning (ICAP) Service Score of 70 or below (see ICAP Service Score explanation at left). A Division official said these more stringent criteria were instituted to contain numbers of potentially eligible people.

The latest change to the Adult Waiver clinical eligibility criteria occurred in 2001, when the state received Medicaid approval for "additional clinical eligibility targeting criteria to facilitate serving an increased number of individuals." This change removes the 70 IQ/70 ICAP Service Score requirements from consideration, as long as applicants demonstrate functional limitations in three or more of the areas of major life activity.

The Division determined that the "70/70" criteria were overly conservative.

The Division determined that the 1999 criteria were overly conservative because some developmentally disabled people without behavioral problems would be ineligible for services.

Although not explicitly stated in all of these Division statements of waiver eligibility, there are implicit requirements that the individuals accepted onto the waiver require ICF/MR level of care, and 24-hour-a-day supervision. All waiver participant files must include a formal statement that waiver applicants have these needs.

Wyoming definitions are similar to other states' and to the federal definition

Other states and the federal government define developmental disabilities much as Wyoming does in its waiver application. These definitions also include the functional limitations in three or more of the same areas of major life activity used in the Wyoming criteria. However, states differ in how they make the determination that potential waiver participants have these functional limitations.

Division Interprets Its Assessment Tool In a Way That Broadens Eligibility

Eligibility is determined with Service Score or Domain Scores.

We found that the way the Division assesses people applying for the waiver increases their likelihood of qualifying. First, as discussed above, the Division modified its eligibility criteria so persons with IQs and ICAP Service Scores above 70 could qualify *if* they demonstrated functional limitations in three or more of six areas of major life activity[1]. Second, it adopted scoring practices for assessing people in those functional areas; these practices have also had the effect of broadening eligibility.

ICAP experts emphasize that how a state uses the ICAP is a policy decision. While offering suggestions for its use, they say they realize states may want to use the test differently depending on their preferences and programs.

[1] The Division lists seven areas of major life activity in its eligibility criteria, but it scores on only six. The area "economic self-sufficiency" is not scored due to federal directive, according to Division officials.

ICAP Domain Scores used to assess functional deficits

The Division uses ICAP Domain Scores to determine whether a person has deficits in three functional areas. Domain Scores are based on the extent to which a person is able to accomplish major life activities according to social and community expectations, and they are intended to measure a person's adaptive behavior. The Division uses three of four possible ICAP Domain Scores, plus a person's mobility and mental retardation, to determine deficits in functional areas.

An ICAP assessment determines deficits in functional areas.

- Self-care deficits are determined through the Personal Living Domain score
- Language deficits are determined through the Social/Communication Domain Score
- Learning/cognition deficits are determined present if the person is mentally retarded
- Mobility deficits are determined present if the person does not walk, and
- Self-direction and Independent Living deficits are determined through the Community Living Domain Score.

Division uses a scoring approach that widens eligibility

The Division compares waiver candidates to normal-functioning adults of the same age up to age 41.

In making functional limitation determinations, the Division compares the Domain Scores of individuals assessed for the waiver with those of non-developmentally disabled people of the same ages up to the age of 41. According to experts, Domain Scores adjusted for age need not exceed the age of 17 because after that, differences between people's abilities have more to do with personal interest and less with functional capacity. Thus, comparing a developmentally disabled person to a normal functioning person of the same age, who has acquired skills and knowledge through education and life experience, measures a difference in self-motivation and interest rather than in functional capability (see Appendix C).

By using Domain Scores that are age adjusted to 41 as criteria for assessed scores, the Division is expanding the definition of who is eligible for the waiver. This scoring approach allows some people with higher scores to show deficits in functional areas.

Division's use of ICAP Service Score can broaden eligibility

Although the Division has expanded eligibility to be less reliant on the ICAP Service Score, this score is still used and can qualify persons who primarily have socially unacceptable behaviors. In computing the ICAP Service Score, maladaptive behavior problems (socially unacceptable behaviors) are weighted more heavily than these behaviors are in alternative ICAP scores available to determine eligibility. This score can be used to qualify persons whose functional disabilities stem primarily from socially unacceptable behaviors rather than developmental disabilities. For this reason, experts suggest using caution when making the policy decision to use the Service Score to determine eligibility.

Division may move towards suggested use of the ICAP

The Broad Independence Score is suggested for eligibility.

ICAP experts suggest using another ICAP score, the Broad Independence Score, which is the composite of four Domain Scores, to determine eligibility. They say it is more reliable than either the Service Score or the individual Domain Scores. The Division states that the Broad Independence Score "is the most accurate representation of the person's overall functional abilities," and has indicated it may be moving toward using this score.

Division Broadened Waiver Eligibility to Admit Less Challenged People

The waiver needed to cover clients served by the State Contract program, which was eliminated.

The Division broadened eligibility to allow people with milder disabilities to qualify for the waiver. Initially, the intent was to move onto the waiver less severely disabled people who had been served by the State Contract program, which was funded entirely by the state. This group represented what the Division terms as the "traditional Wyoming developmentally disabled clientele." Providers we interviewed confirmed that they would have lost existing State Contract clients when that program ended if the criteria had not changed so these clients could be admitted to the waiver.

State Contract Clients Who Transitioned to the Current Waiver

FY 1991	1
1992	22
1993	3
1994	6
1995	7
1996	9
1997	5
1998	3
1999	1
2000	6
2001	48
2002	54
2003	2
Total	**167**

Our analysis of Division data shows that many State Contract people did transition to the waiver after the stringent "70/70" criteria were relaxed. Of the 167 current waiver participants whose data indicates they were also State Contract clients, 62 percent moved onto the Adult Waiver since the 2001 eligibility change (see box to the left). Division officials say that many more State Contract clients transitioned to the waiver in the early 1990's, but current Division data did not show this.

Division officials maintain clinical eligibility is still stringent

Despite taking steps to broaden eligibility, Division officials maintain that current clinical eligibility criteria limit the waiver to people with the age-adjusted capacity of a seven year-old. Our analysis confirms that three-quarters of current waiver participants do have a cognitive equivalent of a seven year-old or less. However, a good portion of those added since the 2001 eligibility change have higher functional levels. For example, of waiver participants who have come onto the waiver recently (between FY '01 and '03), our analysis of Division data shows:

- 37 percent have a Service Score greater than 70, and
- 40 percent have a cognitive age above that of a seven year-old, using the ICAP Broad Independence Score.

The Adult Waiver is not just for those with mental ages of a 7-year old.

When all current Adult Waiver participants are considered, 24 percent have ICAP Service Scores higher than 70. Their scores range from the age-adjusted capacity of an eight year-old to that of a twelve year-old. Seven current Adult Waiver clients have an age-adjusted capacity above that of a twelve year-old.

Division Went Solely With the Waiver to Capture Federal Matching Funds

The Division eliminated the State Contract program so it could use only the Medicaid waiver to provide services to developmentally disabled adults. Its purpose in doing this was to provide services using a funding source that could better meet the state's obligations under the Weston Consent Decree. By funding services through the State Contract program rather than the waiver, the state was foregoing the federal match for those dollars.

The Weston Consent Decree encouraged federal participation.

Weston Consent Decree principles imply seeking federal funding to augment the state's resources, and perhaps a concentration on waiver use. One principle says that the state should strengthen its community service system by seeking partnerships at the federal, state, and area levels. Weston principles also call for a "single integrated means of provision of support to all Wyoming citizens with mental retardation."

Another benefit to the waiver-only approach, according to an expert in the field, is that it avoids inherent problems in financing community services that can occur with multiple funding streams and service requirements. This approach also facilitates providing services that clients choose, which is a major goal in the field of developmental disability services.

Access to more services can increase costs

Wyoming offers a single waiver for developmentally disabled adults that provides clients with up to 21 services. Medicaid requires states to provide all people enrolled in a specific waiver with the opportunity to access all needed services covered by that waiver. Thus, waiver participation has the potential to increase costs, as clients add the services they need or want. For example, we were told that most State Contract clients and their families wanted to transition to the waiver because it offered more services. Further, we found that the service costs for former State Contract clients who transitioned to the waiver did increase.

Some clients increase costs when transitioning to the Adult Waiver.

From the data, we can comment with confidence on only 70 current waiver participants who are former State Contract clients. These individuals transitioned to the Adult Waiver in FY '01 and '02, and we found that their costs changed in the first year after transition. The changes in their IBAs ranged from a decrease of $10,869 to an increase of $36,992, but averaged an increase of approximately $4,800 per client. While the state is responsible for only about 40 percent of the Adult Waiver costs, adult clients tend to stay on the waiver for life, which may be 50 years or more. Thus, eligibility decisions can have long-term funding consequences, and small initial increases in individual budgets can be compounded over the years.

Serving Adults with All Levels of Disability Through the Waiver Can Create Legal Obligations

Olmstead says states must provide community rather than institutional services, if it can reasonably do so.

Since 1991 when the waiver was implemented in Wyoming, it has been a Division policy to use it both to de-institutionalize people in response to Weston and to serve those people who were never institutionalized, including those served by the State Contract program. This policy choice has significant implications because the U.S. Supreme Court ruled in Olmstead that states must provide services to persons with disabilities in community settings rather than in institutions, if those services are desired and can be reasonably accommodated. Since Medicaid equates eligibility for the waiver with eligibility for ICF/MR institutional services, the Division's policy defines all waiver recipients as being at-risk of institutionalization, in the absence of home and community-based services.

The issue of entitlement to community-based services is still being litigated.

Having more eligible people can increase the number of persons waiting for services, and expose the state to lawsuits. As of November 2003, twenty-five states faced lawsuits from people with developmental disabilities who were waiting for home and community-based services. These suits aim to establish that Medicaid beneficiaries with disabilities should have the same entitlement to community services that they have to institutional services. Although some courts have found that eligibility for ICF/MR services does entitle one to home and community services, the issue is still being litigated and is not settled.

Wyoming Adults Must Be Waiver-Eligible To Get Division-Supported Services

Apart from legal ramifications, how Wyoming determines waiver eligibility is also a critical policy choice, because it in effect defines a threshold above which developmentally disabled adults receive *no* Division-supported services. The Division has stated an objective to "assure that all individuals with developmental disabilities in Wyoming, *including* those at-risk of institutionalization (LSO emphasis), have access to a choice of coordinated services that enhance their lives, foster self-

sufficiency, and maintain them in the least restrictive and most cost-effective environment." Yet to serve this broad population, the Division relies upon a funding mechanism limited to supporting those at-risk of institutionalization. This implies either that many less challenged individuals will have no Division supported services, or that developmentally disabled adults in Wyoming receiving services are, by definition, at-risk of institutionalization.

The Division funds a broad population with a funding mechanism limited to those at-risk of institutional care.

Other states have not relied exclusively on the waiver to fund services for developmental disabled adults. Some, including South Dakota, Kansas, Utah, and Nebraska, have state-funded programs to serve disabled people who are less disabled and do not qualify for waiver services. For example, South Dakota has a state-funded program for people who can generally live on their own except for a few intermittent supports.

Other states do not rely solely upon the Medicaid HCBS waiver.

Relying exclusively upon a single waiver to serve all developmentally disabled adults can deny services to people who do not qualify but who have some level of need. It can also give waiver participants access to services they may not need. Some states use the approach of broadening eligibility standards to serve people with a wider range of disabilities, but they control utilization (and therefore costs) by limiting the amount of services provided in a waiver. Still another approach is to design multiple waivers for developmentally disabled adults that offer different packages of services.

Recommendation: The Division should investigate alternative programs to support different disabled populations and seek broad input into this policy-making process.

The decisions of whom to serve and how to serve them through this large publicly-funded program are significant policy issues. The Division interprets state commitments through the Weston Consent Decree to serve all developmentally disabled adults in the state, "regardless of their funding eligibility or participation

The Division has led the state to serve all developmentally disabled adults through a single HCBS waiver.

in any particular government program" (a Weston principle). To this point, the Division has led the state to serve these individuals through a single, comprehensive Medicaid HCBS adult waiver. In 2001, the Division made related changes in waiver eligibility criteria and assessment practices so that clients traditionally served by the state would qualify. From what we heard, people who provide services for developmentally disabled adults and those who advocate on their behalf approve of these policies.

A broad range of state policymakers should be involved in these policy discussions.

However, a broad range of state policy makers beyond Division officials and advocates need to be involved in considering both the benefits and the potential alternatives to these policy decisions. In considering alternatives to serving developmentally disabled adults through the existing Adult Waiver, policy makers might also consider possible coordination with state's other long-term care waivers for adults[2]. The Legislature has twice indicated its interest in studying the continuum of long-term care through the Joint Labor, Health and Social Services Interim Committee (Laws 1999, ch. 20 and Laws 2001, ch. 184). Through such an open process, the Department of Health would receive formal input as well as broader understanding about the policies that guide Division services to developmentally disabled adults.

[2] These are the Long Term Care for Elderly and Physically Disabled Age 19 and Over Waiver, the Assisted Living Facility (ALF) Waiver, and the Acquired Brain Injury (ABI) Waiver.

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CHAPTER 3

Division Operates With Minimal Formal Rules and Makes Policies for the Adult Waiver With Minimal Input

There are no rules establishing critical procedures, such as how people move from the waiting list to the waiver.

Statutes and rules guiding the Developmental Disabilities Division do not specify how the Division will employ the Adult Waiver as the state's sole means of providing services to developmentally disabled adults. Further, the Division has made major policy decisions related to the Adult Waiver, such as changing eligibility criteria, without formal public input or announcement. It lacks rules that establish critical decision-making procedures, including the priority in which people move off the waiting list into waiver services. Rather than formally promulgated rules, the Division relies upon manuals and other provisional documents to convey its procedures and practices.

The Division relies on provisional documents to convey procedures and practices.

From a broad range of interviews with system stakeholders, we heard the perspective that the Division is unpredictable, especially with respect to determining who is added to the waiver. We did not conduct the detailed file reviews that would be necessary to substantiate this view. However, the existence of this perception about a program that administers more than $57 million in annual benefits to individuals is a concern. Promulgating rules reduces the likelihood of arbitrariness and supports a general sense of fairness in administration. Rules also bind administrators, facilitate oversight, and provide predictability about agency behavior.

The Adult Waiver has been in place in Wyoming for more than a decade and now provides an average of upwards of $57,000 in funding to more than 1,000 individuals, with the number of participants and costs increasing annually. While some Division procedures are primarily administrative, others affect the access developmentally disabled adults have to beneficial services. Thus, the Division and the Department of Health should take steps to formalize Adult Waiver substantive procedures and definitions by formally promulgating them in rules.

Rules Do Not Reflect the Use of the Waiver

Existing statutes are broad enough to authorize the current use of the waiver.

With the implementation of the Weston Consent Decree and the Adult Waiver, the state significantly changed the way it provides services to adults with developmental disabilities. Statutes have not been modified to reflect this major change, but they are still broad enough to encompass the implementation of the waiver by the Department of Health, through the Division. For example, Department of Health statutes (W.S. 9-2-102 through 9-2-109) charge the Department with administering a comprehensive state program for developmental disabilities, and with establishing policies and procedures for the operation of community-based programs. The Division also falls under the authority of the Wyoming Medical Assistance and Services Act (W.S. 42-4-101 through 42-4-118) in that this act lists federal home and community-based waiver services among the 28 it covers.

Adult Waiver program operates with minimal promulgated rules

Of concern, however, is the dearth of rules that describe how the Department of Health, through the Division, implements the Adult Waiver. The few specific rules for adult developmentally disabled programs and services are dated and for the most part, no longer applicable. They date from when services to developmentally disabled adults were provided under the Community Human Services Act (W.S. 35-1-611 through 35-1-628). Although the Division continues to list this act as its enabling state statutory authority, Division officials also say that it no longer applies to how services for developmentally disabled adults are provided under the waiver.

The rules that apply to the Adult Waiver are general, and apply to all state Medicaid HCBS waivers.

At present, the Division points to the Wyoming Medicaid Rules for Home or Community Based Waiver Services (Chapter 34) as the primary rules for the Adult Waiver program. These are very general rules that apply to all HCBS waiver services offered by the state, and they date from 1995. Chapter 34 provides little to no specificity about any of the waivers, and points readers to Division documents and Department of Health manuals and bulletins for details. For example, Chapter 34 states that eligibility will be pursuant to the standards and procedures specified in the state application to Medicaid to operate the waiver.

State waiver applications to Medicaid are not reviewed outside of the Department of Health

Department officials say applications and amendments are available on request.

The Adult Waiver application is not a publicly conceived or distributed document, although Department officials say it is available for review upon request. The Division, through the State Office of Medicaid, submits the application and subsequent amendments directly to Medicaid. The regional Medicaid office approves these changes, but such changes do not undergo a formal review process outside of the Division and the State Medicaid office. Even service providers, who are fundamentally affected by waiver provisions, reported that they do not have the opportunity to review this application or its amendments.

Division Makes Policy Decisions Independently

As the last chapter discussed, the Division made the major policy decision to eliminate the State Contract program and adopt the Medicaid HCBS waiver as the sole means for adult services. It also broadened eligibility so that more people can be designated at-risk for institutionalization. Although the Division said it had broad support for these policy decisions, its approach to gathering input is informal. Division officials told us they extensively communicated this information to providers, clients, and families through one-on-one and other meetings. However, providers along with advocate representatives told us that the Division makes most major decisions internally.

The Division's provisional method of establishing requirements lets it bypass rule promulgation procedures.

Because the Division does not establish its program requirements in rules, it is not bound to follow formal procedures for rule promulgation. These steps include sending copies of rules to the Governor and the Legislature, holding public hearings, summarizing public comments, and filing final rules with the Secretary of State. Further, the Division's informal approach does not allow for formal communication of impending policy change, or for announcement that policy changes have been made.

The Division maintains that the Legislature and the Governor approved its elimination of the State Contract program and broadening eligibility by approving appropriations based on

budget narratives in which these actions are specified. However, from our review of the Division's budget narrative for the biennium in which both these changes occurred (FY 2001-2002), there was no straightforward mention of these impending actions.

Eligibility criteria decisions affect costs, involve policy

State waiver officials told us that ultimately, the Legislature has the final say on any changes that increase costs, such as expanding the number of waiver slots. But the Division did not involve the Legislature in the decision to change eligibility criteria, or even directly communicate that it occurred. According to a primer produced by the U.S. Department of Health and Human Services, setting the clinical criteria for an optional Medicaid service is a fundamental component of state financial decision-making, since the number of people served is a major determinant of total program costs.

Eligibility criteria involve two competing policy objectives: ensuring service for those with needs, and controlling costs.

The primer also states that setting the clinical eligibility for waiver services involves competing policy objectives: ensuring that the criteria identify all individuals who have legitimate needs for assistance, while needing to control overall costs. By independently making the decisions to restrict eligibility in 1999 and to broaden it in 2001, the Division did not allow open policy discussions to occur.

Prevailing Perception Is That the Division Is Unpredictable

We talked with many individuals professionally involved in seeing that developmentally disabled citizens receive services. A common statement from almost all of them was that the Division's decisions and actions are unpredictable. The Division maintains that new issues and problems constantly occur in this field. We acknowledge that this is a complex program, complicated by the many individual circumstances presented by clients and providers. Nonetheless, the widespread perception that the Division is unpredictable and reactive is a concern.

There is a concern with how people move from the waiting list onto the waiver

Eligible people can move onto the waiver at any time, as long as there is funding for them.

People who qualify for waiver services cannot immediately access them unless there are empty slots on the waiver and available funding. In this case, individuals go on the waiting list, which is the subject of lawsuits in other states. Eligible people move onto the waiver at any time during the year when slots open up, as long as there is funding for them. Division officials determine who on the waiting list moves onto the waiver and they say they do this according to the severity of people's conditions and needs.

The Division has complete discretion in determining who moves up from the waiting list.

However, many stakeholders we interviewed said while this might be the Division's intention, it does not always happen. There was broad agreement, and also discomfort, that high-level advocacy moves people off the waiting list ahead of others with more severe problems. Another perception is that the Division moves people onto the waiver according to how their needs balance with available funding. Thus, a person with less expensive needs can move on sooner than a more severely disabled person. We did not review files to substantiate these perceptions, but note that without formal rules to determine the priority with which people move from the waiting list into services, the Division retains complete discretion in this important and contentious area.

The Division has been more forthright about its procedures for funding emergency placements. These are people who qualify for the waiver throughout the year, whom the Division admits to the waiver using existing funding, and before others on the waiting list. A Division manual, not formal rules, defines an emergency as a "condition of homelessness for currently served persons, or life or health threatening situations involving eligible persons with developmental disabilities." A Division official added that abuse, neglect, and potential for exploitation are also emergency considerations, and that the Division obtained extensive input on these criteria.

Division Uses Manuals That Change Annually

The Division cautions that information in its manuals is subject to change.

Chapter 34 of the Wyoming Medicaid Rules for HCBS Waivers allows the Division to issue "provider manuals, provider bulletins, or both to providers and/or other affected parties" to interpret the very general provisions of the actual rules. As a result, the Division issues an annual Adult Waiver provider manual designed to guide and aid primarily case managers, and other interested persons through the waiver process.

It supplements the manual with other publications, such as an eligibility determination handbook and many bulletins, which are issued throughout the year. The Division cautions that information in these documents is subject to change, because "There are no stated or implied guarantees contained in this manual or, for that matter, the Adult Waiver."

It relies on provisonal documents to convey policies and procedures that warrant a higher level of consistency.

Division manuals serve primarily to communicate administrative procedures and requirements to the many service providers involved in caring for developmentally disabled adults in the state. Most of the procedures in the provider manual are technical, step-by-step directions for the planning and provision of services. The Division's frequent changes in these procedures are understandably troublesome to providers, who must make corresponding changes in their business practices. But of more concern is that the Division relies upon provisional documents to convey program policies and procedures that warrant a higher level of consistency.

Division should distinguish management procedures from program rules of general applicability

Some aspects of the implementation of the Adult Waiver, such as eligibility criteria and how people will transition off the waiting list onto the waiver, are not internal management procedures but issues of public policy. The Wyoming Administrative Procedure Act requires all agency statements of general applicability that implement, interpret, or prescribe law or policy to be promulgated as rules.

Further, participating in the rulemaking process would require the Division to bring proposed changes to the attention of the public. This would give stakeholders as well as the general public an opportunity to study them and offer official and documented comments. The rulemaking process would thus allow interested parties outside of the Division to have formal input into its policies and decisions. Now, Division officials make decisions according to their reading of stakeholder consensus on issues, and their interpretation of what will keep the state current with national developments.

Recommendation: The Division should promulgate formal rules, not provisional manuals, to establish important program rights, definitions, and procedures.

Rules support a general sense of fairness in administration.

To establish policies and procedures for the Adult Waiver, the Division currently relies upon manuals that it acknowledges offer no guarantees. The Division and the Adult Waiver program could benefit from formally promulgated rules, which reduce the likelihood of arbitrariness and support a general sense of fairness in administration. At the least, we believe there are substantive issues defining waiver clinical eligibility, and procedural issues such as how the Division fills waiver openings that warrant formal rules.

Rulemaking would allow input from the Department of Health Advisory Council as well as legislative review.

The Division has tended to internally make policy decisions of which other state policy makers should be aware. The rulemaking process requires an opportunity for public comment, which would enable the public as well as affected persons to have some input. This would allow opportunity for input from the Department of Health Advisory Council, which statute requires be consulted on proposed Department rules and policies. Also, the process for legislative review of rules would facilitate the Legislature's review of policy changes.

Finally, we understand that the Department of Health has traditionally allowed the Division to operate with great autonomy,

so that it could advocate independently for its budget and manage its programs from a position of disciplinary expertise. However, we believe that the Department should temper this autonomy in decisions that affect important state policy. The Department of Health statutory Office of Planning and Administration (W.S. 9-2-105) could become involved in ensuring that the Division's program policies are more broadly determined, coordinated, and communicated.

CHAPTER 4

Division Practices Need to Ensure Cost-Effective Allocation and Use of Waiver Funds

Federal and state policies require states' HCBS waiver services to be cost effective. The Division has chosen to meet this requirement primarily through DOORS (not an acronym), a funding model designed to allocate money equitably, according to participants' needs and within an established budget. However, we found discrepancies between how the funding system is purported to work and how it actually works. These discrepancies raise questions as to how well the system contributes to the cost-effective allocation and use of funds.

The effect of DOORS on program costs and client choices should be studied.

Our concerns focus on administrative choices regarding the selection of DOORS variables, the lack of external validation of data on which the model is based, and the overriding of model results. These choices appear to drive rather than contain costs. The Division needs to be more forthright about the service choice and program cost implications of its administrative decisions. We recommend the Department of Health contract for an independent study to assess how the selection of variables and administrative adjustments to the model affect program costs and service choices for clients. We also recommend the Division develop an accounting system to track funds used for emergency cases and forced rate requests.

State Waiver Programs Must Demonstrate Cost Effectiveness

States have great latitude when designing waiver programs.

According to a U.S. Department of Health and Human Services primer on Medicaid, at both the federal and state levels, it is important that waiver services and supports be delivered in a cost effective and efficient manner. At the federal level, criteria for waiver cost effectiveness simply require average per-capita waiver costs to be less than the average per-capita institutional cost. At the state level, however, the focus becomes one of balancing ever-increasing demands for services with available resources.

Consequently, the federal government gives states great latitude in designing and implementing HCBS waivers, expecting state budget pressures will assure that the costs of providing needed services to developmentally disabled persons are no greater than necessary.

Cost containment is a key state responsibility

Financial analysis can help programs develop cost containment measures.

A recent Robert Wood Johnson Foundation study notes that state developmental disabilities directors are responsible for allocating funds within their budgets. According to the study, financial management analysis is essential in helping states develop ways to effectively reduce waiting lists and contain costs. The study recommends that each state develop strategies for overall funding allocation and rate setting, based on thorough financial management analysis.

As participant numbers and costs continue to rise nationwide, the need for cost containment has become increasingly important. Program costs in Wyoming are particularly sensitive to changes in the federal Medicaid match rate, since the waiver is the only funding source for adult services. A change in match rate can shift more program costs back to the state. Since the waiver began in 1991, the maximum federal match rate has fluctuated from a high of 69 percent in FY '92, to a low of 58 percent in FY '04. Federal participation is expected to continue this decrease in FY '05.

Division Aims to Be Cost-Effective

Cost effectiveness is a primary waiver goal.

The Division's objective for the waiver program is "to assure that individuals with developmental disabilities in Wyoming, including those at risk of institutionalization, have access to a choice of coordinated services that enhance their lives, foster self-sufficiency, and maintain them in the least restrictive and most cost-effective environment." The Division emphasizes "it is vital that the state manage its resources effectively and efficiently."

Division officials maintain that the DOORS funding model supports the goals of achieving a system that is person-centered, portable, predictable, and fair and equitable. To achieve these

goals, each waiver client must be able to control the use of his or her funds (person-centered), use those funds anywhere in the state (portable), and plan for all services from year to year (fair, equitable, and predictable).

Division Sought a Better Way To Allocate Waiver Funds

DOORS addresses problems seen in previous funding approaches.

Prior to developing DOORS in 1998, the Division used traditional funding approaches such as setting conventional rate schedules and cost caps, using funding tiers, and conducting ad hoc negotiations with provider agencies. It developed DOORS in response to specific problems encountered with those approaches. For example, ad hoc negotiations had led to increases in costs and variations in payments among providers and clients.

Division developed new funding approach

The DOORS model was officially implemented for all Adult Waiver clients in FY ’99. Since then, the Division has implemented three new versions of the model and is currently preparing a fifth version.

The goal of DOORS is to allocate more funds to needier clients.

Using stepwise multiple regression, the Division identified a number of individual characteristics and service choices that explain variations in client funding. The objective of the model is to allocate resources across a broad range of clients so that clients with greater disabilities who require more services are allocated IBAs greater than clients with less severe disabilities who require fewer services. DOORS also enables the Division to cost out services for those individuals determined eligible for the waiver but who must wait for services.

Division’s Financial Practices Have Been Questioned by CMS

The 2003 CMS review identified problems with the Division’s system for demonstrating the DOORS model’s ability to produce reasonable individual funding levels (IBAs). It also questioned the Division’s process for approving requests for additional

funding that were on the order of three to four times the amounts that DOORS had set as the individuals' IBAs (see Chapter 5).

We have concerns similar to those noted by CMS.

Rather than replicating CMS' approach and conducting another case file review, we analyzed the Division's client, ICAP, allocation, and expenditure data for the current Adult Waiver population. In our analysis, we took a much broader approach to reviewing program operations, and this approach identified many of the same concerns CMS noted. An additional concern is that although the Division provided much of the data we used to analyze and describe its practices, we were unable to reconcile many numbers from Division reports, electronic data, and interviews. Because of gaps and inconsistencies in the data, we chose to examine the issue of cost effectiveness by concentrating largely on Division practices and procedures that work to undermine this purpose.

Certain Division Practices Override the Model's Inherent Neutrality

In theory, DOORS is capable of meeting the Division's expectations and could contribute to a more cost-effective use of public money. The Division's primary intent in creating DOORS was not to develop a cost containment system, but to better support client choice of services and providers. Nevertheless, Division officials believed that allocating a set level of funds within the context of these goals would also address cost containment and cost effectiveness issues.

The Division revises the DOORS model frequently.

Despite these admirable goals, several Division practices have undermined the cost containment potential of the model. These practices include: selecting model variables that support certain providers, not obtaining external or internal validation of the data used to develop and revise the model, and administratively overriding model results.

Selection of variables

The Division chooses which variables to include in DOORS. Some examples of variables in the formula are: clients' living arrangements, work settings, the types of services received in the

past as well as functional and medical information from the ICAP assessments. The decision to include or exclude a statistically significant variable is a subjective administrative decision. Such decisions dictate how the available funding will be allocated to different clients, as well as how funds are likely to be budgeted in each client's plan.

The Division has made choices about variables that tend to increase costs. For example, the model excludes blindness, a variable that would help hold costs down because blind individuals tend to be less costly than similarly disabled non-blind individuals. In addition, the model allocates funds to clients for services they need or prefer but to which they may not have access.

The Division implements policy preferences through its choice of model variables.

Similarly, the Division has chosen to include residential and day habilitation in the DOORS model as a living arrangement variable. As a result, individuals who choose group residential settings receive relatively more funding than individuals who have equivalent needs, based upon their disabilities, but a different residential preference. This funding outcome creates a policy that supports those providers who offer group residential settings. The Division's choice to include these variables may dissuade clients from choosing less expensive residential placements.

DOORS has been based on unvalidated financial and clinical data

In developing and subsequently revising DOORS, the Division assumed that past services offered to individuals were both reasonably priced and necessary. Assuming that existing service costs bore a reasonable relationship to need, the Division accepted past cost and utilization data without systematically validating this data. The Division also could not demonstrate that it obtained independent external validation of the cost and clinical data that were used in the model.

Other states validate cost and clinical information.

In terms of clinical data, Division officials and others admit that ICAP results on which the first model was based were unreliable. Unlike Wyoming, Nebraska validates its clinical information by requiring that each participant requesting behaviorally related

services undergo clinical observation and psychological assessment by institutional professionals. Also in contrast to Wyoming, South Dakota validates actual costs each year, by verifying provider contact time with every waiver client over a one-month period.

Administrators adjust model results

Not all adjustments are clearly driven by client needs.

The Division has the ability to override model features and adjust model results. In some cases, these adjustments address changes in client needs, but in others, the adjustments are not clearly driven by individual client needs. For example, the Division has administratively adjusted model results up six percent for inflation, and applied a hold harmless provision to maintain past funding levels for individuals served by certain providers. By taking these actions, the Division has in effect regulated certain providers' incomes through the manipulation of individuals' IBAs.

In addition, we could not clarify how the Division allocates or accounts for funding IBA increases for existing waiver clients and for emergency cases. According to Division officials, funding for emergency cases and forced rate requests comes from unspent portions of all clients' IBAs. However, providers indicated in interviews they consistently spend between 97 and 99 percent of client IBAs. The Division did not explain how, under these circumstances, it can guarantee enough funding is available to serve more clients or to increase budgets for existing clients who need additional funding.

Average program costs and waiting list costs differ

The Division bases cost projections on averages, rather than actual cost data.

The Division has attributed the average per-client cost of services to the cost of serving persons on the waiting list, even though these two figures differ greatly. As a result, the average cost to serve those on the waiting list may have been overstated in budget requests. For example, when requesting additional funding in the 2003 Session to cover persons on the waiting list, the Division applied the average per-person cost for services of those already on the Adult Waiver. The Division estimated the average cost to serve a waiver participant at $61,733, and this was the figure on which it based a request for more funding.

Instead of using the average cost for those already receiving services, the Division could have used more precise cost estimates. DOORS calculates an IBA for each eligible person, and totaling the IBAs of those on the waiting list should accurately represent their expected initial costs of services.

Waiting list costs may have been lower than average program costs.

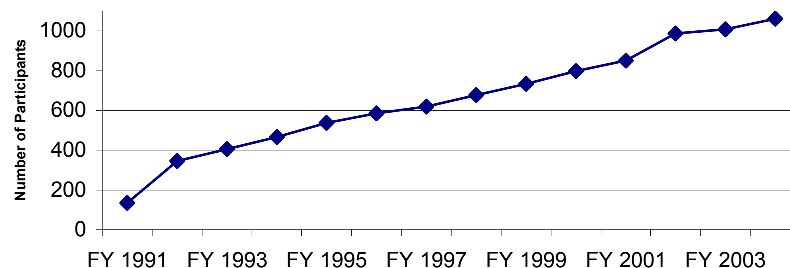
Our analysis shows that individuals on the waiting list as of August 2003 (FY '04) had IBAs that averaged $16,850, and only one of them had an IBA higher than $61,733. Our analysis also shows that current waiting list individuals have milder disabilities than most persons already on the waiver. Thus, unless the waiting list in FY '03 had markedly different characteristics than the current list, it seems likely that the average expected cost for their services could have been considerably less than was stated.

DOORS Favors a Traditional High-Cost System

Expanded eligibility criteria have allowed more participants to be added to the Adult Waiver (see Figure 4.1). Program costs have also increased, in part because the DOORS model provides relatively more funding for clients who choose traditional and expensive day habilitation and group home residential habilitation services.

Figure 4.1

Annual Waiver Participation, FY '91-'04



Source: Division Data*

* Through FY '03. FY '04 figure is based on the Division's most recent waiver amendment, increasing participation to 1,062 by the end of FY '04.

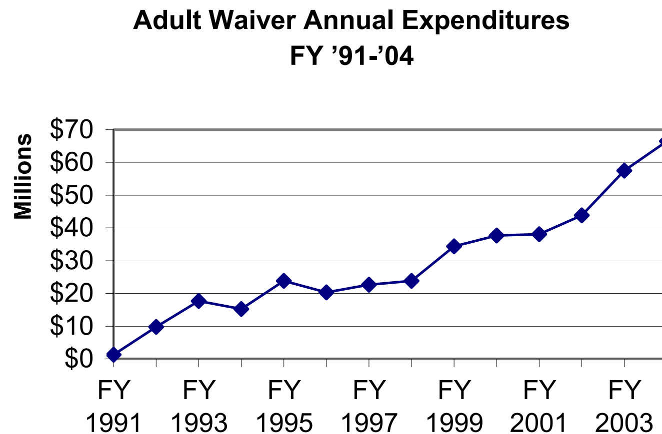
Adult Waiver costs are increasing

Adult Waiver expenditures have increased for the last three biennia.

Adult Waiver costs have risen dramatically since 1991, the first year of the waiver. Division expenditure information shows program costs increasing from approximately $24 million in FY '98 to a projected $66 million in FY '04 (see Figure 4.2). This represents a 167 percent increase in Adult Waiver expenditures over the three most recent biennia, or a tripling of the state contribution. Although the Legislature appropriated Footnote 9 funding during the 2002 Session specifically to increase wages for direct care staff, our calculations show that less than one-third of the increases during the three biennia can be attributed to this appropriation.

Figure 4.2

Adult Waiver Annual Expenditures
FY '91-'04



Source: Division data*

* Data provided by the Division up through FY '03. FY '04 shows anticipated expenditures based on total biennium appropriations for FY '03-'04.

Residential and day habilitation services account for most of waiver funds

The Division has not established some obvious cost controls.

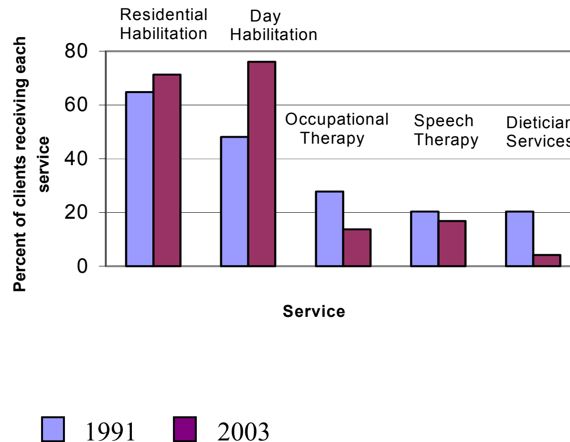
DOORS provides an incentive to use more costly services such as residential and day habilitation, and not less costly services such as family residential placements. The Division's system centers on client and team choices, and it sets few requirements for how planning teams should allocate clients' budgets. The Division also has not established obvious cost controls such as maximum rates for habilitation services (see Chapter 5).

The financial effect of including residential and day habilitation in the DOORS model can be seen in the increasing proportion of total program costs accounted for by these services. In FY ’03, these two services accounted for almost 80 percent of all budgeted dollars. As the proportion of total program dollars supporting these two services has increased, the proportion of dollars for other possibly more targeted therapeutic services has decreased (see Figure 4.3).

Almost 80% of Adult Waiver funds are spent on two services.

Figure 4.3

Proportion of waiver clients receiving various services 1991 and 2003



Source: Division data

Use of other waiver services is decreasing.

By allocating the greatest portion of funding to services such as residential and day habilitation, DOORS does not encourage the development of other services covered by the waiver. According to the Division, the model enhances client choice by making funds portable. Portable funds are said to encourage competition and help contain costs. However, very few communities in Wyoming, a highly rural state, offer any real choice in providers or available services. The DOORS model essentially supports the same service structure that existed prior to the Adult Waiver, and many clients outside of cities such as Cheyenne, Casper, and Sheridan have few options from which to choose. The limited infrastructure that exists is illustrated in maps in Appendix D.

DOORS model could help meet the demands of a changing client mix that has changing needs

It is important to note that increasing program costs are a result of a dynamic, not static, funding environment. This is because both the client mix and client needs are constantly changing. A strength of DOORS is that it can be used to adjust IBAs within the program's entire budget in response to these changing needs.

Recommendation: The Division should obtain an independent analysis of the DOORS model and its effect on client services and program costs.

We believe DOORS can be used to fairly and equitably allocate program funds. However, its variables and underlying assumptions have not been validated, and certain Division decisions and practices have interfered with its inherent neutrality. To restore the original potential of the model, the Division needs to demonstrate that its own practices and procedures are valid. Therefore, the Department of Health should contract for a review of the DOORS model that includes an assessment of:

- how the selection of variables affect Adult Waiver program costs and clients' service choices, and
- how administrative adjustments have affected Adult Waiver program costs and service infrastructure development.

Standard procedures can help ensure funding practices are fair and equitable.

This review should culminate in a report that the Department makes available to interested parties by December 1, 2004.

Once this review has been completed and there has been sufficient time to comment on the results, the Division should develop written guidelines and procedures for using, updating, and implementing new versions of the model. Adherence to standard procedures can help ensure that future adjustments to the model itself or to the funding results are fair, equitable, and cost-effective. Overall, these steps will provide the opportunity to promote lower cost service options while maintaining an emphasis on individual choice, health, and safety.

Recommendation: The Division should establish a system to account for the money it uses to fund emergency cases and forced rates.

As discussed on page 36, we were unable to determine how the Division administers the funds it uses for these purposes. We believe this is a process that warrants standard procedures and more accountability.

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CHAPTER 5

Division Needs to Improve Monitoring to Ensure Fiscal Accountability

Although the Division cites both internal and external means of oversight for its adult waiver program, we did not find adequate controls to ensure fiscal accountability. The Division has in place a system of oversights that likely ensures clients receive acceptable care. However, this system does not fully protect the state's interest in making certain that the appropriate amounts of public funds are expended on necessary services. External sources of oversight, by accreditation and advocacy organizations outside the Division, focus largely on the quality of provider services and client satisfaction.

The Division imposes few controls on rates for major services.

Oversight from Division staff and from outside groups does not focus on whether the state is getting what it is paying for, or conversely, whether the state is paying for something it is not getting. Two services, residential and day habilitation, account for more than three-fourths of expenditures for client services, yet the Division imposes few controls over provider rates for these services. We identified practices that appear to allow provider rates to increase, and we recommend the Division enhance its financial oversight to ensure accountability for Adult Waiver funds.

External Oversight Does Not Focus on Financial Accountability

The Division must be able to ensure that funds are properly managed and effectively applied, so that clients receive appropriate types and amounts of services. The Division cites numerous sources of outside oversight for the Adult Waiver, including external peer reviews, advocate interest groups, federal reviews, periodic contracted audits, the Medicaid Fraud Control Unit, and the state Office of Medicaid. However, we found none of them focuses on fiscal accountability.

The Commission on Accreditation of Rehabilitation Facilities (CARF), a nationally recognized peer review organization, conducts quality assessment surveys for providers that serve more than three persons. These surveys typically focus on the provider's general accounting and business practices. Advocacy groups such as the Governor's Planning Council on Developmental Disabilities and the Wyoming Protection and Advocacy System, Inc., are primarily concerned with consumer protections against abuse and neglect.

Peer reviews and advocacy groups focus on consumer protection.

The Division contracts for audits of service providers, but these do not necessarily make detailed comparisons of expenditures and the services called for in clients' plans of care. The 2003 CMS report noted that a recent financial audit did not contain enough information to assure CMS reviewers that services billed for matched the services provided. Additionally, the Medicaid Fraud Control Unit within the Office of the Attorney General investigates reported fraud by service providers, but does not typically examine financial practices within the Division.

The Office of Medicaid provides limited fiscal oversight.

Because the Adult Waiver utilizes Medicaid funding, the Division and the state Office of Medicaid (Office) work together under a memorandum of understanding that gives the Division primary responsibility and blanket authority to administer the waiver. The Office's role includes overseeing waiver amendment and renewal applications, reviewing federal audits, auditing to prevent overpayments, and sometimes authorizing changes in individual plans of care. Other than these activities, the Office exercises limited oversight of the Division's fiscal practices relative to the management of its provider payment system.

Internal Controls Also Do Not Focus on Fiscal Oversight

The Division has established several systems to monitor expenditures for client services. These include case managers, local planning teams, area resource specialists (ARS), waiver specialists, and in some instances, the State Level of Care Committee (SLOCC).

Case managers and planning teams focus on client needs

Providers can exert strong influence over plans of care.

Case managers advocate for the preferences and the best interest of the person served. They serve on the planning team, where all team members have input in allocating the client's IBA. After a plan is approved and services have begun, the case manager maintains client service records from information furnished by providers. Frequently, however, case managers are employees of the primary service provider organization represented on the planning team. This can allow the provider to exert a disproportionate influence on team decisions regarding both choice and amount of services in the plan of care.

The state's interest is not represented on planning teams

Typically, planning teams allocate most of the funds in clients' budgets.

A plan of care reflects the client's interests, with input from case managers and other team members. Typically, the team knows the individual client's IBA and usually allocates as much of it as possible when selecting from the 21 waiver services. No one person on the team is charged with controlling costs or looking out for the state's fiscal interest because, the Division says, all parties work together to devise a cost-effective plan. However, we believe this system gives the planning team little incentive to economize, and more incentive to use the entire amount of funding in the plan of care.

Area resource specialists provide limited financial oversight

Area resource specialists (ARS) monitor case managers and confirm that the case manager is keeping a running tally of service units provided to each client. They also conduct provider evaluations and resolve conflicts that may arise between clients and providers. Nine ARSs monitor hundreds of service providers and over 1,000 plans of care, but the Division has not made financial oversight one of their priorities.

Waiver specialists review plans of care for proper format, but usually do not question the plan itself

After the planning team completes a plan of care, one of the four waiver specialists at the state level reviews it for completeness, checking such items as eligibility, proper signatures, required

documentation, and mathematical computations. In particular, waiver specialists confirm that the cost of the planned services will not exceed the client's IBA. Generally, they do not question specific services or service rates in the plans of care.

Division Process to Review Requests for Additional Funding Has Been Criticized

Planning teams can request extra funds for clients.

The 2003 CMS review of the Adult Waiver criticized the state's method of handling requests for increases in client funding. If a planning team determines that a client's IBA is not high enough to cover the costs of necessary services, it can request additional funding. This process, commonly called requesting a "forced rate," must demonstrate that the client is at "extreme risk." The Division defines extreme risk as circumstances that are "truly life threatening to the person served," and also as those health and safety issues that place an individual in "real and imminent jeopardy." The Division's State Level of Care Committee (SLOCC) reviews these requests and may either fund them in whole or in part, or deny them.

SLOCC process remains unclear

The CMS review was especially critical that a representative of the Office of Medicaid was not involved in reviewing and approving SLOCC requests. Further, they found that in some cases, SLOCC was not a group effort but consisted of one Division official. Since the CMS review, the Division has been requiring three signatures to authorize a forced rate, and an ARS must contact the case manager and the client to confirm the need for the requested additional funding.

The process for increasing individual budgets needs clarification.

However, Division and Office of Medicaid officials still had different understandings of the forced rate threshold that would prompt a full-scale SLOCC review. The Office of Medicaid stated that it only becomes involved in a SLOCC review if the requested increase is more than 10 percent higher than the original budgeted amount. The Division states that the Office will not become involved unless the requested increase is $10,000 above the budgeted amount. Further, the Division's written response to the CMS review states that the Office of

Medicaid will become involved in requests to increase an individual's budget only if the request is twice the size of the original amount.

System Allows Providers to Set Rates Charged for the Most Expensive Services

Most client plans include residential and day habilitation services.

Residential and day habilitation services are the largest expenditure categories in the Adult Waiver. Most clients receive these services, and their costs far outweigh all other service costs combined. In FY '03, nearly three-quarters of all plans of care included residential or day habilitation, or both. These two services accounted for 79 percent of the cost for all budgeted services, leaving 21 percent of clients' individualized budgets to fund other needed care such as skilled nursing, physical therapy, or occupational therapy.

The Division does not set rates for residential and day habilitation. Instead, it authorizes each local planning team to negotiate rates with providers. We learned of two practices that potentially bias this negotiating process, so that in effect, providers can set their own rates for residential and day habilitation services. First, the case manager and other members of the planning team are often employees of the organization that provides residential and day habilitation services. Second, we learned from interviews that providers can come to the planning team having already decided the rates for these two services.

In effect, some providers set their own rates for these two major services.

The 2003 CMS review noted that the Division represented the costs of day and residential habilitation services as average costs, but actually used them more as baseline figures for these services. Similarly, we found that in FY '03, the actual average costs were 89 percent higher for day habilitation and 61 percent higher for residential habilitation than the averages approved by CMS at that time. Daily costs ranged from $13 to $481 for day habilitation and from $34 to $613 for residential habilitation. Waiver specialists do not routinely question rates set for these services. For example, a Division official said a residential habilitation rate would have to be over $200 per day before a waiver specialist would inquire as to its appropriateness.

Certain Provider Practices Show Need for More Division Controls

A client's IBA is for that individual's use.

An IBA is for the use of the client to whom it is allocated. However, some providers told us that in practice, they need to pool funds from some clients' individual budgets to meet other clients' needs. This can occur when, for example, the Division denies a request for a forced rate. The Adult Waiver does not allow for this practice in that it requires that "services are actually provided and billing is specific to recipients." Although the Division states it is unaware that providers pool client funds, some providers have told us this is their practice.

When setting rates, providers include varying overhead costs

Medicaid does not allow providers' overhead costs to affect rates.

Medicaid Adult Waiver funds are not intended to cover provider overhead costs. According to the state Office of Medicaid, waiver funds are for direct care support and costs directly related to the delivery of services, not for the costs of running a business such as secretarial and insurance expenses. However, some providers include these kinds of costs when calculating their residential and day habilitation rates. One provider stated that to set rates, "We direct-cost base it, overhead load it, and arrive at the rate." Most providers say their overhead exceeds 90 percent, with the highest being 119 percent.

The Division is aware of this practice and recently attempted to impose requirements that would have controlled charges for overhead, but it rescinded the new requirements when providers objected. As of this writing, the Division has not introduced new controls related to including overhead in provider rates.

Recommendation: The Division should require more justification of rates for major services.

We believe fiscal oversight of state expenditures for the care of developmentally disabled adults under the Adult Waiver needs to improve. Although the Division claims it is subject to oversight

from many sources, actual fiscal oversight was not clearly demonstrated during our evaluation. The combination of external and internal controls is not sufficient to ensure that reasonable amounts of public funds are expended for planned services.

The Division could begin to exert some control by having representation on the planning teams when rates are negotiated with providers. If that is not feasible, then the Division should implement additional controls at the waiver specialist review level to ensure that residential and day habilitation rates are justified.

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CHAPTER 6

Conclusion

In less than a decade, Wyoming's method of providing services to developmentally disabled adults has shifted from a largely institutional focus to a community-based system. Many more adults now receive services in community settings that they and their guardians prefer to institutionalization. To accomplish this goal rapidly and effectively, it appears much of the decision-making has been done by Division officials moving quickly and with great flexibility to make the changes they deemed necessary.

This report recommends how the Division could make the Adult Waiver more accountable and cost-effective.

This report focuses on the current system, and makes recommendations as to how the Division could make the Adult Waiver more accountable and cost-effective. The Division needs to update rules so that basic processes such as eligibility determination are made accessible to the public. Further, the Division should demonstrate the validity of the assumptions used in the formula that determines clients' individual budgets. Also, we recommend that the Division develop procedures to monitor and justify the cost for the waiver's most expensive services.

Medicaid gives states great flexibility to design home and community-based service waivers. States can fashion waivers in ways that best meet their needs for serving people with developmental disabilities who would otherwise need institutional care. To this point, the Division has made the policy decisions about who will be served and with what services through the Wyoming Adult Waiver, the single option for Division services.

With costs and demand for services increasing, the state might reconsider offering a single, comprehensive waiver.

With costs for existing waiver participants increasing, and with ongoing demand for services from new applicants, there is need for more open policy discussion. For example, the Division could initiate a policy discussion of who should be covered on the Adult Waiver, with what services, and at what cost to the state. This might lead to a consideration of whether using one waiver is the most effective and economical means of serving an increasingly diverse adult population. Medicaid allows states to

operate multiple HCBS waiver programs for the same target population – with different cost limitations for each program, based on participant needs, living situations, or other factors. Nebraska, for example, has three different waivers to serve developmentally disabled adults who qualify for institutional care.

Additional waiver programs may more effectively target services to participants with different needs.

As the Division has broadened eligibility requirements, the range of health and safety needs of participants has also widened. A single waiver can be stretched to provide services to each of these participants, but it may be time for the state to consider one or more additional waivers that could more effectively target services to particular sub-groups.

The state could also consider offering a wider variety of residential placement services, or providing a state-only funded program with limited service options. Currently, all surrounding states we surveyed had state-only funded programs to complement their waivers. Policy decisions such as these need to be made in the most open and participatory of environments. Further, it is essential that the Division provide reliable and valid cost and clinical information on which to base discussions and decisions.

AGENCY RESPONSE

Developmental Disabilities Division: Adult Waiver Program

MEMORANDUM

DATE: December 18, 2003

TO: The Honorable April Brimmer Kunz
Chairman, Management Audit Committee
c/o Barbara Rogers, Program Evaluation Manager
Legislative Service Office

FROM: Deborah K. Fleming, Ph.D., Director
Wyoming Department of Health

SUBJECT: Developmental Disabilities Division Adult Waiver Review

REF: Ref: F-2003-865

The Wyoming Department of Health (WDH) appreciates the opportunity to respond to the Legislative Service Office (LSO) staff report on the Developmental Disabilities Division (DDD), which focused on the Medicaid Adult Developmental Disabilities Home and Community-Based Waiver.

There are a number of areas in which the Department agrees with the information and analysis provided by LSO staff. There are also a number of areas in which the Department is not in agreement. We appreciate your careful review of this information, and stand ready to answer any questions you may have.

Most importantly, we believe that we have a common goal – the provision of quality services and supports to individuals with developmental disabilities in a manner that is cost-effective and meets state and federal statutory and regulatory requirements. We believe the Department and Division are fulfilling this mission, and have been nationally recognized for doing so. The LSO recommendations provide good opportunities to continue to enhance and improve the operations of the Division. In that spirit, and with the common goal in mind, we accept or partially accept the recommendations as noted below, and include action steps intended to implement them, along with specific completion dates.

Chapter 1. Background

"We are confident in the ability of the state to operate the waiver in accordance with the six assurances required for waiver approval. The DDD is very conscientious in addressing concerns and assuring the health and welfare of waiver consumers." Federal CMS Adult Waiver Review 2002

The adult waiver has undergone a number of successful federal reviews since its inception. These have included both commendations and recommendations, to which the Division has always been responsive. The State of Wyoming has never received any sanctions as a result of noncompliance. Wyoming DD waiver renewals, expansions, or modifications have always been approved – in many instances by the same federal regional officials who conducted reviews. As an example, the most recent federal communication (December 11, 2003) approved required fiscal reports "assuring cost-effectiveness."

Chapter 2. Division has Broadened Access to the Adult Waiver

"Wyoming has employed Medicaid funding heavily to finance DD services. This has benefited Wyoming financially, while further narrowing the number of qualifying people. Wyoming's eligibility criteria for child and adult services are more stringent than is typical in other states. These criteria mean that the individuals who are presently served or will qualify in the future have especially severe impairments." Human Services Research Institute, 2003

"Wyoming has had the best client specific data in the U.S. for almost 15 years. Wyoming has been a national leader in attempting to define eligibility…" Brad Hill, Managing Author, Inventory for Client and Agency Planning (ICAP), 2003

The "broadening" of eligibility described by LSO actually constituted an adjustment based on practical experience to bring waiver eligibility back to its original intent: to cover clients who had been Division of Community Programs/DD traditional clientele for decades. **The purpose of implementing the waiver in the first place was not to eliminate DD individuals from services, but to provide those services using a funding source which could better meet the State's obligations under the Weston lawsuit in a cost-effective manner.**

Further, this perception of "broadening" is belied by the fact that the percentage of the total Wyoming adult population served by various state programs for adults with developmental disabilities has changed very little over the past 30 years.

It is true that there are more adults on the waiver now than at its inception, but when one also includes the number of adults with DD served at various times through state-funded contracts, the Wyoming State Training School, the Wyoming State Hospital, and other programs, the overall proportion of adults served has remained within a variance of less than one-tenth of one percent, as shown in Figure 1. **What has changed is not the universe of people supported by the State, but the location, type of service and funding source, with the waiver being the most cost-effective method due to its ability to capture federal participation**.

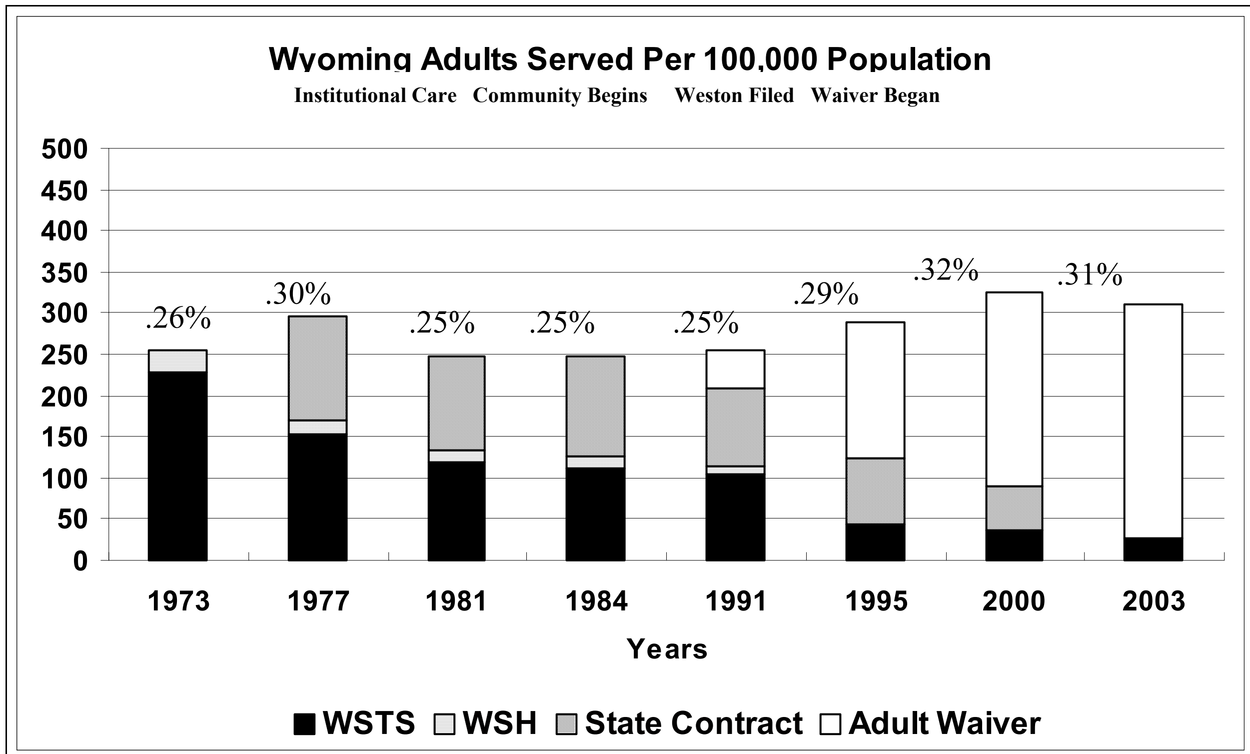

Figure 1

It is also important to recognize that the number of individuals to be served through the adult waiver has been specified in every budget narrative presented to the WDH Director, the Governor and the legislature. **The Division has never exceeded the maximum number of individuals authorized in the budget process.**

LSO Recommendations: The Division should seek broader input into its policy making for the Adult Waiver.

Agree–action plan underway.

♦The Division will promulgate rules regarding program eligibility, to supplement current Medicaid and Division regulations as guided by the Office of Medicaid and the Office of the Attorney General by December 31, 2004. Broad input will be obtained, using the following methods: publication of proposed regulations, widespread notification to stakeholders of opportunities for input, statewide hearings utilizing videoconferencing from multiple sites, solicitation of written input from other agencies, and close coordination with entities having a statutory interest in these issues, such as the Governor's Planning Council on Developmental Disabilities and the Department of Health Advisory Council.

Chapter 3. Division Operates With Minimal Formal Rules and Makes Policies for the Adult Waiver With Minimal Input

"Statutes, rules, and regulations governing the DD adult waiver are unrelated to the Administrative Rules promulgated in 1988 by the Division of Community Programs. The DD adult waiver is a Medicaid program and as such is governed by the statutes, rules and regulations promulgated by the State for the provision of services under the Wyoming Medical Assistance Act (W.S. 42-4-101 et seq.). It is specifically authorized by W.S. 42-4-103 (xvii).

"Taken together, the Medicaid Administrative Rules, the DFS Eligibility Rules, the Developmental Disability rules that have been promulgated since the inception of the waiver, and the CMS-approved Waiver itself constitutes a significant body of guidance and control for the operation of the DD Adult Waiver." Wyoming Department of Health, Office of Medicaid 2003

Although, as noted below, the Division agrees that we should continue to enhance formal decision making and clear communication with stakeholders, it is important to recognize that there has been extensive interaction with key decision makers (including legislators) about essential elements of this system, as well as interaction with thousands of stakeholders around Wyoming over the past decade. For example, over 350 providers, advocates, and family members received copies of the most recent revision of the adult waiver provider manual for comment before it was issued.

The Division has documented active participation and input for many years with stakeholders such as the federally-mandated Governor's Planning Council on Developmental Disabilities, currently associated with the office of the Wyoming Attorney General, which has always had legislative membership; the Division's own statutorily-authorized advisory council, which was heavily involved in the early development of waiver policy, and has had representation on the Department of Health Advisory Council, also with legislative membership; and a wide variety of other stakeholders, including hundreds of family members, consumers, agency representatives, and government officials who were invited to participate in statewide Wyoming Tomorrow system planning processes co-sponsored by the Division over a multi-year period.

The Division promulgated case management rules that govern team processes through the Administrative Procedures Act, and has regularly solicited broad input when updating waiver manuals under the provisions of Medicaid statutes. **The process for revising and issuing waiver manuals has always been accomplished with input from, and guidance by, the Office of the Attorney General. These manuals have provided a firm foundation for an unbroken record of success in any hearings or court challenges to Division waiver procedures or practices.**

LSO Recommendation: The Division should promulgate formal rules, not provisional manuals, to establish important program rights, definitions, and procedures.

Partially-Agree. Waiver manuals are issued under auspices of the Wyoming Medical Assistance Act (W.S. 42-4-101 et seq.).

♦With consultation and guidance from the Office of the Attorney General and the Office of Medicaid, the Division will review, update, and promulgate rules, as appropriate, in the following area:

- Division of Community Programs Rules (1988)
- Management of Waiting Lists
- Development and Modifications of Manuals and Bulletins issued by DDD under Medicaid Authority

♦The Division will expand the use of hearings, public town meetings, interviews, surveys, Internet, statewide videoconferencing, and email responses to harvest additional input into its policy making for the Adult Waiver. Implementation: in process.

Chapter 4. Division Practices Need to Ensure Cost-Effective Allocation and Use of Waiver Funds

"The DOORS methodology promotes fairness and equity and, equally as important, promotes individual and family choice. The federal Centers for Medicare and Medicaid Services (CMS) has identified DOORS as a "Promising Practice" for other states to consider because it promotes consumer choice and control and clearly promotes the goals and objectives embodied in President Bush's New Freedom Initiative."
Gary Smith, HSRI, principal author of CMS Medicaid Primer

The objective of the DOORS model is to allocate scarce resources across a broad range of clients in such a way that the clients with greater disability and who require more services are allocated an Individual Budget Amount (IBA) with a higher dollar cap than those with less disability who require less services.

A variety of questions related to the DOORS funding distribution model were raised by LSO, most based on similar questions in a federal review report. The Division responded effectively to CMS concerns and has established revised procedures for the review and revision of requests for changes in a client's IBA. The final federal response noted, "The State implemented changes that we feel address the findings and recommendations mentioned in this report. **It is important to note that we are confident in the State's ability to operate this program. We also commend the State for being innovative with its DOORS methodology."**

While the Division believes further study will be valuable, it should also be recognized that the Wyoming DOORS model has already been the subject of extensive internal and national study, with input from a variety of independent experts. For example, see Having It Your Way: Understanding State Individual Budgeting Strategies (Moseley, Gettings, & Cooper, 2003) and Wyoming DOORS Setting IRAs for HCB Waiver Services, Smith 1999. As noted above, this kind of study culminated in the publication of information about DOORS as a "Promising Practice" by CMS. CMS has also within the past year requested, and provided funding for, Wyoming DDD staff to travel to Washington and Milwaukee to provide training to top-level federal and state administrators in Wyoming's service-delivery and rate-setting methodologies. Forty-eight states have requested information or consultation about Wyoming's system. Rhode Island, Pennsylvania, Montana, Utah, and North Carolina have paid for the costs of Wyoming DDD staff to train their staff and stakeholders about the Wyoming system.

LSO Recommendation: The Division should obtain an independent analysis of the DOORS model and its affect on client services and program costs.

Agree–action plan underway.

♦A study focusing on enhancing the DOORS model by incorporating specific cost elements with clinical characteristics will be completed by December 31, 2004, with the assistance of the CMS-approved External Professional Advisory Committee. On the recommendation of CMS this group was developed and has been functioning since August 2003. This group is composed of experienced nationally-recognized experts in this specialty area from the CMS-sponsored Human Service Research Institute, as well as experts from the states of Nebraska and South Dakota (referenced by LSO in their report) who were primary architects in the development of those systems.

♦The Division will develop and publish written guidelines and procedures for using and updating new versions of the DOORS model by December 31, 2004. This will be done with extensive and broad community input and hearings, including multiple stakeholders, legislators, and the public.

Recommendation: The Division should establish a system to account for the money it uses to fund emergency cases and forced rates.

Agree–action plan underway.

♦The current adult waiver database contains this information now. New reports and analysis of emergency cases and forced rates will be added by September 1, 2004. This will allow us to be able to use our standard computer system to routinely report on and evaluate these areas.

Chapter 5. Division Needs to Improve Monitoring to Ensure Fiscal Accountability

The Division, Department, and Medicaid utilize a number of methods to assure financial accountability. These include individual caps on expenditures, mandatory preapproval of service plans, individualized review of requests for expenditures outside previously authorized limits, and a number of other review and audit elements.

While the Division agrees that it can continue to enhance monitoring, it is important to recognize that it has always served the number of people authorized by the legislature and no more, within the budgets approved by the legislature for this purpose. The dollars spent are the dollars approved. When specific instructions have gone with the funding, for example, footnote 9 salary increases to direct service staff, or provider cost of living, the specific requirements have been incorporated in the applicable DOORS funding model, and the result tracked and reported in detail. **In all instances, adult waiver cost increases identified by LSO were in direct response to legislative budgetary mandates.**

The Division pays a great deal of attention to fiscal accountability in its plan approval and monitoring process. It always gets more requests for more money or more services from local teams than it can approve. Eighty-five percent of requests to exceed a prior authorization are turned down. Any unspent dollars between plan authorization and plan use are recaptured and applied to emergency high-cost situations. During FY 03 electronic billing reports demonstrate a reduction of $250,000 during that period.

LSO Recommendation: The Division should require more justification of rates for major services.

Agree–action plan underway.

♦The Division will use the DOORS cost study in Chapter 4 to develop additional individual service rates with price screens and service rate filters that control provider rates contributing to the overall cost of each individual adult waiver plan of care (individual budget). This will allow additional preapproval controls for waiver specialists in the Cheyenne office, and teams and Area Resource Specialists in the field. To be published and implemented by December 31, 2004, with appropriate public and stakeholder input.

♦Currently the Division is sampling 100 team meetings a year with Area Resource Specialists and back-checking in local communities with the client and/or guardian on the need for every single forced rate request from providers. The Division will increase the fiscal training of Area Resource Specialists and Individually-Selected Service Coordinators to increase their effectiveness in promoting cost-effectiveness in individual client team meetings.

♦The Division will identify a fiscal officer specifically charged with the responsibility to coordinate and oversee the Division's comprehensive program of fiscal accountability assurance. This will include expanding the independent CPA audits of services and billings, continuing to implement federal review recommendations, and publishing an annual report of fiscal accountability and results. To be implemented by December 31, 2004, subject to availability of necessary position and consultant funding.

♦The Division and Department have managed the adult waiver since its inception in accordance with the identified expectations and regulations of the state and federal government. The adult DD waiver is currently undergoing a regular four-year Medicaid waiver audit. The Developmental Disabilities Division and the Wyoming Department of Health will invite the WDH fiscal office and the office of the State Auditor to join in this review of the adult Medicaid DD waiver, and use this as an opportunity to seek recommendations to further update and strengthen processes and procedures.

Chapter 6. Conclusion

In the United States there are currently 218 different waivers dealing with developmental disabilities, with a wide variety of provisions. Newly available specialty waivers, such as the President's New Freedom Initiative waivers or single service waivers, are used by some states to limit the amount of services and costs available to local teams for a person served. Individual budgeting systems with individualized spending caps are also used by many states, including Wyoming, to limit costs. Some of these approaches have been endorsed, but some have been viewed unfavorably by CMS, or led to litigation. The merits of these various waiver options and opportunities will be identified and considered by the CMS-approved External Professional Advisory Committee and the Division, and reviewed with stakeholders and decisionmakers.

The Division and the Department of Health appreciate the efforts made by the staff and management of the Legislative Service Office. It is our firm belief that all are working toward common goals – a cost effective system which meets the needs of individuals with developmental disabilities while at the same time demonstrating good stewardship of state resources. We will implement the LSO recommendations as described above, and believe this will continue to improve the statewide service system for adults with developmental disabilities.

DKF/RC/jf/jg

c: Robert Clabby, Administrator, Developmental Disabilities Division
Phyllis J. Sherard, Ph.D., Deputy Director of Programs

APPENDICES

Developmental Disabilities Division:
Adult Waiver Program

APPENDIX A

Department of Health Statutes

Department of Health

9-2-101. Creation; definitions; divisions.

(a) The department of health is created.

(b) As used in W.S. 9-2-101 through 9-2-108:

(i) "Department" means the department of health;

(ii) "Director" means the director of the department.

(c) The department is the successor to the board and department of health.

(d) Repealed by Laws 1991, ch. 221, § 3.

(e) The department consists of the director who is the chief administrative officer and such divisions as the director may create.

(f) The director shall appoint and prescribe the duties of officers of the institutions in title 25 under the direct authority and control of the department.

9-2-102. Department of health; duties and responsibilities; state grants.

(a) The department of health is the state mental health authority, the developmental disabilities authority and the substance abuse authority. The department through its divisions has the following duties and responsibilities to:

(i) Administer comprehensive state programs for mental health, developmental disabilities and substance abuse services;

(ii) Provide a coordinated network of programs and facilities offering the following services to persons afflicted with mental illness or developmental disabilities or for substance abuse: diagnosis, treatment, education, care, training, community living, habilitation and rehabilitation;

(iii) Establish minimum standards and approve policies and procedures for the establishment and operation of community-based mental health, substance abuse and developmental disabilities programs receiving state support;

(iv) Establish minimum standards for all mental health, substance abuse and developmental disabilities services supported by state funds.

(b) Repealed By Laws 1998, ch. 81, § 3.

(c) The program may include state grants based on a formula for state and local participation.

(d) Repealed By Laws 1998, ch. 81, § 3.

(e) Repealed by Laws 1984, ch. 31, § 2.

(f) Repealed by Laws 1991, ch. 161, § 4; ch. 221, § 3.

(g) Repealed by Laws 1991, ch. 161, § 4; ch. 221, § 3.

(h) Repealed by Laws 1991, ch. 161, § 4; ch. 221, § 3.

(j) Repealed by Laws 1991, ch. 161, § 4; ch. 221, § 3.

(k) Repealed by Laws 1991, ch. 161, § 4; ch. 221, § 3.

(m) Repealed by Laws 1991, ch. 161, § 4; ch. 221, § 3.

(n) Repealed by Laws 1991, ch. 161, § 4; ch. 221, § 3.

9-2-103. Division administrators; appointment; qualifications; salaries, tenure and removal generally; necessary personnel.

(a) The director shall appoint a separate administrator for the divisions of the department of health and he may discharge the administrators as provided in W.S. 9-2-1706(c)(ii). The administrator for a division dealing primarily with public health shall:

(i) Have theoretical knowledge and practical and managerial skill and experience which fits him for the position, as determined by the director; and

(ii) Repealed By Laws 1998, ch. 20, § 2.

(iii) Administer a program for the supervision of volunteer physicians who provide medical care, assistance or medical administrative services without charge for the medical services rendered in an eligible program in compliance with rules and regulations promulgated by the department. To qualify as an eligible program, the medical services shall be provided in any hospital, clinic, health care facility or institution owned or operated by the state, University of Wyoming or any local government. A disclosure statement shall be signed in advance by the recipients informing them of the physician's limited liability under the program.

(b) Repealed by Laws 1987, ch. 185, § 2.

(c) Repealed by Laws 1991, ch. 221, § 3.

(d) Where the director meets the qualifications specified in subsections (a) and (e) of this section and so chooses, the director may serve as the state health officer.

(e) The director shall appoint a state health officer who shall be licensed in Wyoming as a physician and who shall carry out the statutory duties and any other duties assigned to him by the director. The state health officer shall:

(i) Answer directly to the director;

(ii) Not be assigned to any division within the department;

(iii) Have support staff to carry out the duties assigned to him.

9-2-104. Allocation, transfer and abolition of powers, duties and functions within department.

(a) The governor may, after consultation with the director of the department and the departmental advisory council:

(i) Repealed by Laws 1991, ch. 221, § 3.

(ii) Designate the department as the single state agency for the administration of state plans for health and medical services, mental health and developmental disabilities, to administer upon such terms as the governor directs.

9-2-105. Office of planning and administration; created; duties and powers of administrator.

(a) The office of planning and administration is created and shall be under the authority of the director.

(b) The administrator of the office of planning and administration shall:

(i) Coordinate all program administration, including all budget requests, grant applications and plans;

(ii) Advise, consult and cooperate with all departmental agencies, all other state departments, agencies, subdivisions and the federal government;

(iii) Require that all administrators within the department cooperate with the office and report to the office on all matters pertaining to program planning, budgeting and administration; and

(iv) Perform planning as determined by the director.

9-2-106. Duties and powers of director of department.

(a) The director shall:

(i) Consult with the departmental advisory council and establish general policy to be followed in the department in administering programs;

(ii) Disburse and administer all federal funds or other monies allotted to the department;

(iii) Prescribe by rule, order or regulation the conditions under which these monies shall be disbursed and administered;

(iv) Enter into agreements, not inconsistent with the laws of this state, required as conditions precedent to receiving funds or other assistance. Funds appropriated by the legislature for operation of the department shall be used for the specified purposes only, and the director, in accepting funds from any other source, shall not consent to impairment of the department's statutory responsibilities;

(v) Hold hearings, administer oaths, subpoena witnesses and take testimony as provided by the Wyoming Administrative Procedure Act [§§ 16-3-101 through 16-3-115] in all matters relating to the exercise and performance of the powers and duties vested in the department;

(vi) With the assistance of the attorney general bring actions in the courts of the state in the name of the department for the enforcement of public health, mental health and medical services laws; and

(vii) Promulgate reasonable rules and regulations after consultation with the departmental advisory council, in compliance with the Wyoming Administrative Procedure Act, for the implementation of all state and federal public health, mental health and medical services laws.

(b) Notwithstanding paragraph (a)(iv) of this section, the director may use funds appropriated by the legislature for the operation of the department to pay health or medical insurance premiums for any resident of Wyoming upon a determination by the director or his designee that:

(i) Due to an injury or illness, the person or his family is or may become unable to pay health or medical insurance premiums;

(ii) The person is or may become eligible for medical services which would be paid for by the state; and

(iii) Payment of the premiums may be less expensive for the state than payment of the medical services.

(c) Health or medical insurance premiums paid for in accordance with subsection (b) of this section shall be reviewed periodically to ensure payment of the premiums does not exceed the cost for provision of medical services. The authority granted under subsection (b) of this section shall terminate effective June 30, 1996.

(d) The director may authorize the Wyoming state training school, the Wyoming state hospital, the Wyoming pioneer home, the veterans' home of Wyoming and the Wyoming retirement center to provide services to persons with conditions other than those specified in the provisions governing those state institutions in title 25 of the Wyoming statutes when the director determines that there is a need for such services, that the services can be provided effectively by the institution, that the services will be delivered in a manner that assures the safety of all individuals served by the institution and the services provided are statutorily authorized for any of these institutions, the service needs are similar to those authorized for any of these institutions or the services are necessary to protect the public health and safety. The director may promulgate rules and regulations and policies and procedures necessary to implement this subsection. Nothing in this subsection shall be construed to authorize the director to eliminate services that are otherwise required by statute. The director shall report to the joint labor, health and social services interim committee no later than October 1 of odd numbered years with respect to the status of any actions taken under this subsection and the results of those actions.

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APPENDIX B

Weston Principles

Stipulated Agreement: Weston, et al. v. Wyoming State Training School (C90-0004) 1991.

Article II
General Principles and Covenants

2.02 Principles. The following principles guide this Agreement:

a) Services and supports shall be tailored to the distinct and unique characteristics and circumstances of each class member.

b) Each class member's IPP shall include a time frame for transitioning to the least restrictive living environment and day programming feasible for that individual.

c) Admissions of class members to WSTS shall be limited to cases of emergency medical or respite care, which shall be provided for the shortest time necessary to serve the needs of the class member. Such temporary placements shall be reviewed by the IDT at intervals of no more than thirty (30) days beginning form the date of admission of the class member until such placement ends.

d) During the pendency of this Agreement, there shall be no new admissions to WSTS, except those subject to the provisions of Appendix "A".

e) Life in the community is a basic human right, not a privilege to be earned.

f) Each class member has a right to participate in normal every day life.

g) Each class member can grow and develop.

h) All class members and employees shall be treated with dignity.

i) Class member autonomy shall only be subject to State intrusion to the absolute minimum extent necessary to receive the appropriate supports and services.

j) A class member's rights shall be cherished, valued, protected and actively promoted.

k) Services shall be provided in a manner which meets the needs of class members regardless of their funding eligibility or participation in any particular government program.

l) Class members, parents and guardians are expected to play an active and meaningful role in the development and implementation of appropriate supports and services in accordance with the class members' IPP.

2.03 Community System Principles. The service delivery system shall be designed in a manner to insure that necessary supports and services are provides as individually required.

a) Generic service, are those services available generally n the community, shall be utilized first. Where such service are not available and cannot reasonably be developed generically, the services shall be obtained from existing provider of developmental disability services. Where such services are not available or cannot be provided in a timely fashion, new services shall be developed.

b) The system shall be a single integrated means of provision of support to all Wyoming citizens with mental retardation.

c) Control of the system shall be at the individual level in order to insure responsiveness to class member's needs, changing circumstances, and the local environment.

d) The system at the community level shall provide services to persons with varying degrees and types of disabilities, including those with medical and behavioral disabilities. Regional hospitals, medical professionals, and health care providers shall be used as necessary for health care supports. Community mental health centers and programs shall assist in the development of behavioral supports.

e) The system shall provide services and supports to class members of all ages.

f) The system shall be strengthened by the intentional inclusion of partnerships at the federal, state, and area levels. Planning and implementation shall specify the unique role to be played by each.

g) Appropriate safeguards must be implements at all levels (e.g. at the level of class member planning; at the level of system planning.)

h) The State undertakes the goals and objectives of the Agreement for the class members with the understanding by the parties that success is measured herein by the ultimate outcome for the class.

APPENDIX C

Adult Waiver Eligibility Criteria

<u>DD ADULT WAIVER</u>

Client must be 21 years of age or over,
a United States citizen and currently a resident of Wyoming

DEFINTION OF MENTAL RETARDATION AND REALTED CONDITION
AND CRITERIA FOR ICF/MR LEVEL OF CARE

The person has a confirmed diagnosis of Mental Retardation manifested before age 22. The individual has a full scale intelligence quotient equal to or less than 70 and an Inventory of Client and Agency Planning (ICAP) Service score equal to or less than 70 or when the ICAP score is not equal to or less than 70, the person has an ICAP deficit in 3 or more of the following areas:

Self care: Personal living domain score equal to or less than criterion.
Language: Social/communication domain score equal to or less than criterion.
Learning/cognition: Item C1 indicates mental retardation (C1 cannot equal 1).
Mobility: Non-ambulatory (C9>1).
Self-direction: Community living domain score equal to or less than criterion.
Independent living: Community living domain score equal to or less than criterion.
(ICAP domain criteria listed below)

A related condition means an individual who has severe , chronic, disability manifested before age 22 that is attributable to cerebral palsy, seizure disorder or any other condition other than mental illness that is closely related to mental retardation and requires similar services. The person with a related condition has an ICAP Service Score equal to or less than 70 or when the ICAP score is not equal to or less than 70, the person has an ICAP deficit in 3 or more of the following areas:

Self care: Personal living domain score equal to or less than criterion.
Language: Social/communication domain score equal to or less than criterion.
Learning/cognition: Item C1 indicates mental retardation (C1 cannot equal 1).
Mobility: Non-ambulatory (C9>1).
Self-direction: Community living domain score equal to or less than criterion.
Independent living: Community living domain score equal to or less than criterion.
(ICAP domain criteria listed below)

ICAP DOMAIN CRITERION

AGE	PERSONAL LIVING	SOCIAL/COMMUNICATION	COMMUNITY LIVING
21	509	509	518
22	510	511	520
23	512	515	521
24	516	516	524
25	517	518	525
26	520	519	527
27	522	521	529
28	525	522	530
29	528	522	530
30	531	523	530
31	533	524	531
32	534	524	531
33	534	525	531
34	534	525	531
35	534	525	531
36	534	526	531
37	534	526	530
38	534	526	530
39	534	527	530
40	534	527	530
41	534	527	530
The above age-specific criteria were set to approximate two standard deviations below the mean of the general population, i.e. "Significantly subaverage."			

APPENDIX D

Provider Locations: Selected Adult Waiver Services

Appendix D is available only in hard copy form.
To obtain a copy of this attachment, contact:

Wyoming Legislative Service Office
213 State Capitol Building   Cheyenne, Wyoming 82002
Telephone: 307-777-7881 Fax: 307-777-5466
Website: http://legisweb.state.wy.us