CHAPTER 5

Division Needs to Improve Monitoring to Ensure Fiscal Accountability

The Division imposes few controls on rates for major services.

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.

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.

Peer reviews and advocacy groups focus on consumer protection.

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.

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 process for increasing individual budgets needs clarification.

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.

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

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.

Most client plans include residential and day habilitation services.

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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