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TO: **Loren Colman, Shirley Patterson York and Disability Division Staff**

FROM: **Anne L. Henry and Bud Rosenfield**

RE: **CDCS Budget Methodology Problems for the MR/RC Waiver**

DATE: **November 17 2004**

As we learn more about the MR/RC waiver CDCS budget methodology used by DHS to establish budgets for about 2,400 current CDCS participants, we have become increasingly concerned about very significant problems with the implementation of the methodology. We know that the process of developing a budget methodology for CDCS has been very challenging. We appreciate the changes you have made during the summer and in October based on information from counties, families and our office. However, we believe that the methodology is so flawed that its underlying purpose of providing equity to persons with similar needs will not be accomplished. As you will see, we ask that you freeze individual budgets at current levels for those cut because of the depth and scope of the problems.

Among the problems with the budget methodology identified so far, most significant are the following:

1. **Diagnostic Code-Related Problems**

The DD Screening Document has 4 fields, numbers 12, 13, 14 and 15, to record a person's ICD9 diagnostic codes. *See* Attachment A, Screening Document. The budget methodology views some of the codes as significant cost drivers and allocates substantial sums of money based on certain codes. However, there are several serious problems with the diagnostic code section which we believe undermine the basic validity and reliability of the budget methodology:

a. **Changing practice over time confounds the data used for the regression analysis. Edits for fields 12 and 13.**

Because the Screening Document was never intended for use as a precise instrument to provide funding to meet an individual's service needs, practice with respect to ICD9 code numbers has not been uniform over the years, across counties or within counties among case managers. For instance, full-

team screenings do not have to be done on adults more often than once every six years. Some full team screenings are even older, although we are aware the Department has taken steps to require screening for adults and every three years for children.

Some of the data from screening documents for the 11,700 MR/RC waiver recipients used in the regression analysis to establish the budget methodology will have ICD9 codes which were entered up to and beyond six years ago, some codes likely from assessments 10, 20 or more years old. In 1999, DHS added "edits" to fields 12 and 13 which require additional digits beyond the previously required three number codes. This change is extremely significant since the budget formula provides increased funds for services to those who have an ICD9 code with only three digits but provides no additional funding to persons *with the same condition* who have more than three digits entered on their Screening Document.

For example, an adult with a primary diagnosis of autism who had an ICD9 code of 299 entered six years ago in field 13 would receive $35 per day additional funding for services. However, if the same person had a full-team screening after the edits were imposed on fields 12 and 13, a case manager would likely have entered 299.0. This person, with an ICD9 four-digit code of 299.0, would get no additional funding for services. The resulting difference in funding is substantial and arbitrary, depending merely upon the date of the screening, or other factors detailed below, not related to individual service costs.

b. **Edits in Fields 12 and 13 can be overridden.**

A case manager or a case aide entering data for fields 12 and 13 can "override" or "force" the edit if they know how to do it. The edit for fields 12 and 13 is a "491 edit." The edit directs the data enterer to add "further subclassification" (code digits). However, the 491 edit can be forced by putting an F over the edit code with the ID number for the person entering the data. The number of times case managers or other data entry personnel have overridden the edits in fields 12 and 13 during the last six years and entered a three-digit ICD9 code rather than a five-digit ICD9 code is unknown, but the practice makes the entire data set unreliable. The practice of overriding an edit or not, for a person with autism, can lead to a difference of $12,775 per year. This arbitrary result is not related to service needs. If permitted, such results will create great unfairness in the budgeting process. *See* Attachment B, Chart #2 and #3.

c. **Difference in funding depending upon the field (12-15) used to enter diagnoses codes.**

Because the budget formula provides funds for only three-digit ICD9 codes and not four or five-digit ICD9 codes and because fields 12 and 13 require more than three digits but fields 14 and 15 do not, the same person could be given significantly different budget amounts depending upon which diagnosis is entered into which of the four diagnosis code fields.

For instance, the general category of cerebral palsy has the number "343" as an ICD9 category. The specific types of cerebral palsy are listed with more detail by 343.0 congenital diplegia, 343.1 congenital hemiplegia, 343.2 congenital quadriplegia, etc. Again, 343 was sufficient until the edits were added by DHS to fields 12 and 13 and can still be sufficient if the 491 edit is overridden. However, if 343 (or 299) is added in box 14 or 15, there is no edit requiring more code digits. Consequently, the person will receive a higher budget amount for services. Whether a person's diagnosis of cerebral palsy or autism is entered in fields 12 or 13 (which both require more digits than three digits and result in no extra funding) or in fields 14 or 15 which accept a three-digit ICD9 code (and provide increased funding) varies from case to case but has nothing to do with the person's service needs. Providing different budgets based on these arbitrary practices will not achieve DHS's stated goal of equity. *See* Attachment B, all charts.

d. **Practitioner Diagnostic Practices**

Because the screening data used for the regression analysis is from a variety of practitioners who have completed diagnostic assessments over a long period of time, likely at least a decade, practice with respect to the number of digits entered for an ICD9 code will and does vary, leading to different codes being used to describe the same conditions for MR/RC recipients. An expert in diagnosis has told us that there is no reason for three-digit codes to be used at all. Accepted practice among health care practitioners is to use the more specific ICD9 codes required for billing.

e. **ICD9 Code Definitions Changed on October 1, 2004, *see* Attachment A**

The ICD9 code terminology changed on October 1, 2004, further confounding the reliance upon the diagnostic codes as a means of providing funds for services. *See* Attachment C.

f. **Variable Practice with Respect to Filling All Fields (12-15) with Diagnoses Codes**

If a person has a related condition, "V79.8" is entered in field 12 and then specific ICD9 codes for the related conditions can be entered in the other data fields, 13, 14 and 15. The practice of entering diagnoses codes among case managers varies widely. We understand from families that some case managers entered three diagnoses for a person with related conditions who had three diagnoses and some did not. It simply was never important to enter every diagnosis the person had on the DD Screening Document. The DD Screening Document's purpose was to establish eligibility, a yes or no question which could be answered by entering an ICD9 code for mental retardation only or by entering V79.8 for related conditions in field 12 and one other diagnosis in field 13. Entering all fields with diagnoses codes was never important. We, therefore, question the validity of the underlying regression analysis because the diagnostic code information from the pool of 11,700 persons varies for arbitrary reasons unrelated to the actual condition of the person. *See* Attachment B, Charts 1, 2 and 3.

g. **Recent DHS action to require updated screenings and new HIPPA coding requirements.**

Apparently, when the Department gave new individual budgets to counties based on the October 2004 change, individual CDCS participants whose screenings were over six years old for adults and three years old for children were not given new budgets and counties were instructed to conduct new screenings. Also, the new HIPPA billing code requirements has led some counties to require proper ICD9 diagnostic codes for all fields on the screening document. To the extent that individuals had three-digit ICD9 codes in field 13, 14 or 15 in their old screening documents and the new screening process results in a more specific four or five-digit code, the individual will obtain a lower budget amount simply because of an updated screening. This result further degrades the budget methodology which was developed using the person's old screening data, including the three-digit ICD9 code in field 13. That three-digit code was found to be significantly related to cost in the regression analysis and yet cannot be used by the very same person in new screenings due to subsequent changes. This is a significant problem which further undermines the reliability of the budget methodology.

2. **Practice with Regard to Field 35, Vocational**

The practice among counties and within counties among case managers for entering a number regarding the vocational needs of a child in school does not create a consistent or reliable data set. Many children have a 09 code in field 35 which means "not applicable." However, the DD Screening Code Book suggests by example that children be coded a "99" which is defined on the Screening Document as "unknown (justify in notes)." The significance of the arbitrary variability for the vocational field is that funding is subtracted from the budget if a child has a 09 entered, but funding is not subtracted from the budget if the code of "99" is entered. This result defies logic. The appropriate code for a child according to the Code Book is a "99" which gives an example: "Person is child not yet exploring vocational skills." Given the results of the regression analysis, we can only assume that most children have a code of 09 despite the directions in the Code Book. In three metro counties, with over 2,000 CDCS participants, 90 percent of those under 18 are screened for vocational services as "09" rather than "99," despite the code book example. As children are re-screened and parents review the Code Book, these mistakes will become clear but the entire budget methodology becomes more unreliable.

3. **Derivative Variables**

Several variables, including the DT&H service authorization level (field 43) used in the budget methodology, are derived from other assessments of the person. Use of these derivative variables is questionable in a regression analysis because they are not related equally or equivalent to the other variables. Use of derivative variables along with independent variables violates an important principal for statistical analyses of the type used for the budget methodology: colinearity.

4. **Non-Linear Rankings Within Variables.**

The expressive communication and mobility rankings from the screening document are not clearly separate levels of functioning. For instance, a person who uses an augmentative communication aid is rated at seven while a person whose speech is unintelligible even to familiar listeners is rated only as a four. The ratings from one to eight are not mutually exclusive nor are they separate enough to be ranked so that number three means that you need less support than number four and number seven means that you need less support than number six. Use of non-linear rankings to provide funding for support services for persons with developmental disabilities is in error.

The mobility rankings provide another example of non-linear rankings. Again, the ranks are not mutually exclusive. For instance, a person who uses an electric wheelchair may be quite independent and yet is ranked at 06, whereas a person who walks aided (walker, crutches, assistance of a person, etc.), may, in fact, need

quite a bit more support from staff, but is ranked lower, "03." Use of a regression analysis requires linear variables and rankings which are separate and distinct from each other and are more than or less than the variable next to it.

5. **Invalid or Meaningless Variables.**

Use of occupational therapy as a variable does not make sense. The reason that someone may be receiving occupational therapy likely has little to do with their need for support services and much more to do with their age or the availability of therapy in their particular area of the state. This variable paints a false picture of need. Someone may well need occupational therapy but not be able to get it because it is not available in their area or they do not have a therapist who is able to document their need in a coherent way in order to obtain prior authorization from the Department's reviewers at CDMI.

CONCLUSION

The budget methodology is flawed because it contains invalid and unreliable variables (*i.e.* diagnoses, risk status), derivative variables (*i.e.* DT&H status), and variables that cannot be ranked in a linear fashion (*i.e.* expressive communication, mobility), none of which should be used in a regression analysis to determine individual CDCS budgets.

Because of the serious flaws in the budget methodology, The ARC of Minnesota and our office request that DHS take action to limit negative effects on MR/RC CDCS participants until a new and better methodology can be developed and implemented. We are most concerned about the difficult disruption for families caused by the CDCS budget methodology problems.

Counties are under pressure to re-screen people as well as to develop detailed alternative service options for current CDCS users. In addition, persons not yet using CDCS want assistance to understand the new option and decide whether to use it.

Given these disruptive circumstances and significant budget methodology problems, we request that DHS:

1. **Freeze current budgets.** Allow those with reductions to keep their current budgets and those with increases to maintain them until a new reliable, valid budget methodology can be implemented. Budget changes, either up or down, for CDCS users could be made by counties based upon documented individual needs. New CDCS participants could be given a choice between an amount based on the October methodology or a budget from the county using current county policy for budget setting. If a new CDCS person gets a budget above the state set amount, documentation of the reasons could be required.

2. **Suspend Re-screenings.** Re-screenings could then be suspended if being done only for CDCS budget reasons.

3. **Develop New Budget Methodology.** Develop a new budget methodology which is valid, reliable, and fair by working with consultants already under contract, county staff, persons and families using the MR/RC waiver, advocacy agency staff and others with expertise in assessment and budget setting.

Families should not be subject to further uncertainty and disruption. The budget methodology development process should involve current recipients, their families, service providers, county staff, advocates and outside experts to assure development of a budget methodology that is reasonable, valid, reliable, and fair.

We appreciate your consideration of our requests and are available to work with Department staff on these matters. Thank you.

ALH:nb

ATTACHMENT B
Diagnosis Coding Related Problems

Budget variations possible for Person X whose records indicate the following diagnoses found in different order on different documents in the file:

- Severe mental retardation (318.1)
- Cerebral palsy (343)
- Autism (299)
- Epilepsy (345)

Each example of the screening document fields show how Person X could be given different budget amounts depending upon how the diagnostic fields are coded. ***NOTE:*** These examples show ***only*** fields 12-15 diagnosis related problems. The full budget methodology has 28 variables, many of which have flaws, but these examples show only four of them.

1.

Field 12	**Field 13**	**Field 14**	**Field 15**	**Budget Amount from diagnosis fields**
318.1 $15.384				$5,615.16 per year

Case manager or aide did not enter the other three diagnosis codes in fields 13, 14 and 15.

2.

Field 12	Field 13	Field 14	Field 15	Budget Amount from diagnosis fields
318.1 $15.384 Mental retardation	299 $35.518 + autism			$18,579.23 per year

The case manager "forced" the 491 edit and entered 299, three digits only in field 13 and did not enter the other two diagnoses.

3.

Field 12	Field 13	Field 14	Field 15	Budget Amount from diagnosis fields
318.1 $15.384 Mental retardation	299.0 $0 + autism			$5,615.16 per year

Case manager or aid arbitrarily add ".0" to 299 due edit on field 13 requiring a more specific code and did not enter 345 (epilepsy) or 343 (cerebral palsy) in fields 14 and 15.

4.

Field 12	Field 13	Field 14	Field 15	Budget Amount from diagnosis fields
318.1 $15.384	299.0 $0	345 $7.004	343 $8.394	$11,235 per year

mental retardation + autism + epilepsy + cerebral palsy

5.

Field 12	Field 13	Field 14	Field 15	Budget Amount from diagnosis fields
318.1 $15.384	343.0 $0	345 $7.004	299 $35.518	$21,135.69 per year

mental retardation + cerebral palsy + epilepsy + autism

6.

Field 12	Field 13	Field 14	Field 15	Budget Amount from diagnosis fields
318.1 $15.384	345.0 $0	299 $35.518	343 $8.394	$21,643.04 per year

mental retardation + epilepsy + autism + cerebral palsy

7.

Field 12	Field 13	Field 14	Field 15	Budget Amount from diagnosis fields
318.1 $15.384	299 $35.518	345 $7.004	343 $8.394	$24,199.50 per year
mental retardation	+ autism	+ epilepsy	cerebral palsy	

Case manager or aid "forced" the 491 edit and entered the three-digit code 299 in field 13.

Person X's budget could vary up to $18,584 per year due to arbitrary practices related to diagnoses coding, unrelated to Person X's need for services.