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Department of Health and Mental Hygiene – Developmental Disabilities Administration (DDA)

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Presentation to the Joint Audit Committee

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Audit Overview

- DDA plans, develops policies and regulations, and funds a Statewide system of services for individuals with developmental disabilities and their families.

- Through private contractors, DDA funds services to the developmentally disabled, with various community-based programs that include community residential services, day habilitation services, and vocational training.

- In FY 2012, DDA served over 24,000 individuals with developmental disabilities and its expenditures totaled $805.5 million, consisting of $445 million in general funds, $360 million in federal funds (primarily Medicaid reimbursements), and $500,000 in special funds.

- The report included 13 findings, 7 of which were repeated from the preceding audit report and appear as 6 findings in this report.

Audit Overview (cont'd)

- OLA determined that DDA's accountability and compliance level was unsatisfactory, in accordance with the rating system OLA established in conformity with State law. The primary factors contributing to the unsatisfactory rating were the significance of the audit findings and the number of repeat findings (**Findings 1, 3, 4, 5, 12, and 13** are repeated from the last audit).

- DDA has a federal liability of approximately $20.6 million. The liability amount is related to DDA federal reimbursement overbillings for certain residential service costs, as calculated by a federal audit covering the period from July 2009 through June 2012. In May 2012, prior to the completion of the federal audit, DDA implemented appropriate billing changes.

Key Audit Issues

- Service coordinators were not monitored to ensure that DDA consumers received services in accordance with their individual service plans.

- DDA missed opportunities to maximize federal fund recoveries:
  - Methodology for determining certain federal reimbursement rates did not accurately reflect incurred costs.
  - Certain provider claims were not obtained and submitted for processing (and subsequent reimbursement).
  - Claims rejected due to eligibility edits were not investigated.
  - Certain federal fund reimbursement requests were untimely.

- Year-end provider payment reconciliations were not performed timely and overpayments were not promptly recovered.

Consumers' Services

DDA did not have procedures to verify that consumers received services from providers as stipulated in annual service plans **(Finding 1)**.

- DDA had contracts with 15 vendors, referred to as resource/service coordinators (RSC), responsible for monitoring 24,092 consumers with service expenditures totaling $759 million in FY 2012.

- DDA did not obtain reports of the RSCs' monitoring efforts and did not directly review RSC records to ensure the delivery of service to consumers. OLA's test of 16 consumers monitored by 2 RSCs in 2011 found for 5 consumers that the records lacked sufficient evidence that the RSC verified the delivery of all required services.

Federal Funds

DDA's methodology for determining federal reimbursement rates for contractual payment system expenditures did not accurately reflect the costs incurred **(Finding 2)**.

- DDA's reimbursable costs for the Individual Support Services (ISS) program exceeded its reimbursements by $2.4 million in FYs 2011 and 2012. DDA's federal billing rates were understated because the annual rates were based on prior year costs without adjustment for actual costs, which historically rise every year. DDA also included all consumers in the cost calculation rather than just Medicaid-eligible consumers.

- DDA could not provide documentation supporting its ISS rate calculations and substantiating that the calculations had been reviewed by supervisors.

- ISS program expenditures totaled $109 million during FYs 2010 through 2012.

Federal Funds (cont'd)

DDA did not have adequate procedures in place to ensure that providers submitted all ISS expenditure claims for federal reimbursement **(Finding 3)**.

- DDA prepays ISS providers and requires them to submit claims for actual services rendered for federal billing purposes.

- OLA's review of ISS provider prepayments and federal reimbursements for FYs 2010 through 2012 found that claim documentation for $10.4 million of the $32.8 million prepayments were not submitted by providers. Consequently, DDA may have lost the opportunity to claim as much as $5.2 million in federal funds (50 percent of the $10.4 million).

Federal Funds (cont'd)

Federal fund reimbursement requests were not always timely, resulting in lost investment income of $262,000 during the period from July 2009 through February 2012 **(Finding 4)**.

OLA's test of $789 million in requests found that $89 million were submitted from 1 to 19 months after the claims could have been submitted.

Federal Funds (cont'd)

DDA did not investigate federal fund reimbursement claims that were rejected by automated DHMH Medicaid eligibility edits. Claims could be rejected for various reasons, such as consumer or provider not eligible on the date of service **(Finding 5)**.

OLA's review of almost 50 percent of the 36,194 claims rejected in FY 2011-12 found:

- One provider was responsible for 8,587 rejected claims totaling $536,000 during a 23-day period in November 2010, due to temporarily losing Medicaid eligibility. Upon OLA bringing this matter to DDA's attention, the claims were resubmitted and DDA received reimbursement.

- 8,740 claims, for $284,000, were erroneously rejected as conflicting with other claims. In 2010 DDA noted the error and while correcting the edit, did not resubmit the claims. When discovered, the period for reimbursement eligibility had past.

Contribution to Care

DDA did not ensure the accuracy of consumers' contribution to care (CTC) recorded by providers in its computer system (PCIS2). Certain consumers receiving residential services are required to make financial contributions for the cost of their care. CTC reduces DDA's provider payments **(Finding 6)**.

- Although DHMH calculates the CTC during the consumer's eligibility determination process, providers were permitted to record CTC into PCIS2 without any DDA verification. CTC amounts (e.g., Social Security payments) are received directly by the providers.

- OLA's comparison of DHMH calculated CTC to provider recorded CTC in PCIS2 from January 2009 to February 2012 found that DHMH had calculated an additional $4.8 million CTC. Consequently, DDA could have been paying providers more than it is responsible for.

Alcohol Tax Funds

DDA allowed the use of funds derived from an additional tax on alcoholic beverages for purposes that were not specified in its policies **(Finding 7)**.

- DDA received a $15 million supplemental appropriation in FY 12 funded by an alcohol beverage tax to address DDA's consumer waiting list. A portion of these funds were allocated for services of short duration (SSD). SSDs were to be simple and meaningful and prevent an immediate or future crisis.

- DDA SSD policies specifically allowed vehicle adaptations, but not vehicle purchases. DDA authorized the purchase of 23 vehicles costing $610,000 for consumers.

- In FY 2012 SSD expenditures totaled $10.9 million for 1,100 consumers. The SSD program was discontinued in FY 2013.

Provider Payment Reconciliations

DDA did not ensure that annual reports from Fee Payment System providers were submitted within 6 months of FYE and contained certain information needed to determine any underpayments or overpayments to providers based on actual services **(Finding 8)**.

- As of May 2012, 17 reports due for 2010 or 2011 had not been submitted for providers that received payments of $9.8 million and DDA had only followed up with one provider.

- Certified attendance reports prepared by certain provider auditors stated the attendance data reported by providers were accurate, but the auditors' reports did not include the number of days.

- Payment reconciliations for certain providers were not performed within one year of their report submissions.

Other Issues

- Accounts receivable processes did not ensure that all funds owed DDA were recovered.
  - Certain local jurisdictions were not billed $1.4 million for their share of day habilitation and vocational services charges, as required by law **(Finding 9)**.
  - DDA did not recoup at least $390,000 in overpayments identified by routine audits of provider records **(Finding 10)**.

- DDA did not maintain documentation to support journal entries that adjusted expenditures recorded on the State's accounting records **(Finding 11)**.

- Proper security access controls over critical PCIS2 data (including sensitive consumer information) had not been established. For example, terminated employees' access was not always immediately deactivated, as required, and provider employees had been granted unnecessary access capabilities to modify critical consumer data **(Finding 12)**.

Conclusions

DDA needs to:

- monitor RSC to ensure all required duties are performed timely and documented.
- maximize the recovery of federal funds by revising its reimbursement methodology as practicable to better reflect actual costs, ensuring provider claims and reimbursement requests are submitted timely, and promptly investigate and resubmit rejected claims.
- ensure the accuracy of CTC amounts recorded in its payment system.
- ensure that funds are used for purposes specified.
- ensure the timely submission and review of annual provider reports.
- implement appropriate control processes over accounts receivable, journal entries, and IT.