Department of Legislative Services
Office of Legislative Audits

Department of Health and Mental Hygiene

Developmental Disabilities Administration

Report Dated October 2, 2013

Audit Overview

- The Developmental Disabilities Administration (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 fiscal 2012, DDA served over 24,000 individuals with developmental disabilities and its expenditures totaled $805.5 million, consisting of $445 million general funds, $360 million 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.)

- The Office of Legislative Audits (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 liability of $20.6 million for which State general funds will be needed to fund. The liability 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. Prior to the completion of the federal audit, in May 2012, DDA implemented appropriate billing changes.

  Update – OLA's January 2014 Report on its Review of fiscal 2013 Budget Closeout Transactions noted that DHMH requested the federal oversight agency to consider mitigating the liability owed.

Key Audit Issues

- Service coordinators were not monitored to ensure DDA consumers received services in accordance with their individual service plans and that annual Medicaid eligibility reassessments were performed.

- Maximization of Federal Funds:
  - Methodology for determining certain federal reimbursement rates did not accurately reflect incurred costs. Tests of fiscal 2011 and 2012 rates for one program noted that DDA's costs were $2.4 million greater than reimbursements.
  - DDA did not ensure that certain provider claims were submitted for processing (and subsequent reimbursement). Federal funds totaling as much as $5.2 million were not obtained.
  - $2.2 million in claims rejected due to eligibility edits were not investigated.

- Inadequate monitoring of provider reported information and controls over certain accounting processes/systems need improvement.

Consumers' Services

DDA did not have procedures to verify consumers received services from providers as stipulated in annual service plans and that documentation was obtained for the consumers' medical eligibility assessments **(Finding 1 – repeat)**.

- As of June 30, 2012, DDA had contracts with 15 resource/service coordinators (RSC). These RSCs were responsible for monitoring 24,092 consumers with service expenditures totaling $759 million in fiscal 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 fiscal 2011 and 2012. DDA's federal billing rates for ISS program expenditures were understated because each year's rates were based on prior year costs without adjustment for actual costs, which historically increased every year. Further, DDA 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.

- Expenditures for the ISS program totaled $109 million during fiscal 2010 through 2012.

Federal Funds (Cont.)

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

- 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. 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 **(Finding 4 – repeat)**.

Federal Funds (Cont.)

DDA did not investigate federal fund reimbursement claims that were rejected by automated department of Health and Mental Hygiene (DHMH) Medicaid eligibility edits **(Finding 5 – repeat)**.

When DHMH Medicaid edits rejected claims for various reasons, such as consumer or provider not eligible on date of service, DDA advised that it generally did not determine the cause of the rejection to resolve the issue and resubmit the claim for reimbursement. OLA's review of 17,327 rejected claims found:

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

- 8,740 claims totaling $284,000 were erroneously rejected as conflicting with other claims. In 2010, DDA noted the error and although the edit was corrected, DDA did not resubmit the claims. At this time, the period for reimbursement has 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 in CTC. Consequently, DDA could have been paying providers more than it is responsible for.

Provider Payment Reconciliations

DDA did not ensure that annual reports from Fee Payment System (FPS) providers were submitted within six months of FYE and that certified attendance reports included the number of days that consumers obtained services, which was needed to perform the year-end payment reconciliation.

DDA also did not adequately monitor the timely completion of payment reconciliations performed by DHMH **(Finding 8)**.

- As of May 2012, 17 reports due for fiscal 2010 or 2011 had not been submitted, and DDA had only followed up with one provider.

- OLA's test of certified attendance reports from 45 providers found that 24 did not include the number of attendance days, and DDA had not initiated any follow-up. Since FPS providers are prepaid based on certain estimates (*e.g.*, attendance), such information is critical to identify any DDA under or overpayments at year-end.

Other Issues

- DDA allowed certain Alcohol Tax funds to be used for purposes not specified in its policies **(Finding 7)**.

- Accounts receivable processes were inadequate to ensure that all funds owed DDA were recovered.
  - Four local jurisdictions were not billed $1.4 million for 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)**.

- Adjustments to certain expenditures on the State's accounting records were unsupported **(Finding 11)**.

- Security access controls over critical PCIS2 data were not established. For example, terminated employees' access was not always immediately deactivated **(Finding 12 – repeat)**.

- Certain security events for the PCIS2 production database were not logged or subject to a documented review **(Finding 13 – repeat)**.

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 the timely submission and review of comprehensive annual provider reports; and

- implement appropriate control processes over the use of funds, accounts receivable, accounting adjustments, and Information Technology operations.