Audit Report

Department of Health and Mental Hygiene

Developmental Disabilities Administration

October 2003

Office of Legislative Audits
Department of Legislative Services
Maryland General Assembly

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DEPARTMENT OF LEGISLATIVE SERVICES
OFFICE OF LEGISLATIVE AUDITS
MARYLAND GENERAL ASSEMBLY

Karl S. Aro
Executive Director

Bruce A. Myers, CPA
Legislative Auditor

October 8, 2003

Delegate Van T. Mitchell, Co-Chair, Joint Audit Committee
Senator Nathaniel J. McFadden, Co-Chair, Joint Audit Committee
Members of Joint Audit Committee
Annapolis, Maryland

Ladies and Gentlemen:

We have audited the Developmental Disabilities Administration (DDA) of the Department of Health and Mental Hygiene for the period beginning January 1, 2000 and ending December 31, 2002.

Our audit disclosed that DDA did not take sufficient measures to maximize Federal Medicaid funding. Because eligibility certifications were not completed for the maximum number of clients allowed, we estimated that as much as $22 million in Federal funds were not claimed for services provided to clients during fiscal year 2002. Furthermore, we estimated that an additional $3.7 million in Federal funding could have been claimed for certain eligible services. Finally, DDA did not request reimbursement of Federal funds in a timely manner, resulting in a loss of interest income to the State General Fund of approximately $2 million for services provided during the same year.

Our audit also disclosed that DDA's oversight of service providers was deficient. For example, DDA generally did not verify the client level of care assessments completed by the providers that determined the daily rates paid to the providers. Furthermore, annual provider cost settlements were completed based on attendance data supplied by providers, rather than annual client attendance data that was attested to by certified public accountants.

Our audit also disclosed that DDA did not adequately manage the implementation of a client information system and as a result, vendor payments totaling approximately $2.4 million were made for a system that lacks certain functionality, and for which implementation was significantly delayed.

Respectfully submitted,

Bruce A. Myers, CPA
Legislative Auditor

Table of Contents

* **Denotes item repeated in full or part from preceding audit report.**

Executive Summary

Legislative Audit Report on the
Department of Health and Mental Hygiene
Developmental Disabilities Administration
October 2003

- **DDA did not take sufficient measures to maximize Federal Medicaid funding. For example, because eligibility certifications were not completed for the maximum number of clients allowed, DDA lost as much as $22 million in additional Federal fund revenue for services provided during fiscal year 2002. DDA also did not monitor service providers who submitted Federal reimbursement requests, on behalf of DDA, for certain services they provided to eligible clients. We estimate that $3.7 million of additional Federal funds could be recovered for these services during fiscal year 2002.**

  We recommend that DDA maximize the number of clients for whom Federal funds may be obtained. We also recommend that DDA identify all instances in which Federal funds were not obtained for eligible clients during the preceding two years and seek Federal reimbursement. Finally, we recommend that DDA ensure that providers submit Federal fund reimbursement requests for all eligible clients and services.

- **During fiscal year 2002, DDA generally requested Federal fund reimbursements 8 to 14 months after the services were provided and payments were made to the providers. These untimely reimbursement requests resulted in a loss of interest income to the State General Fund of approximately $2 million for services provided during that year.**

  We recommend that DDA ensure that requests for Federal fund reimbursement are made in a timely manner.

- **Providers were responsible for determining the level of care each client needed; however, DDA generally did not verify that these assessments were appropriate by reviewing medical records or observing the clients. Provider payments for each client can vary significantly depending on the level of care assessment.**

  We recommend that DDA verify the propriety of client level of care assessments completed by providers.

- **Fiscal year 2002 payment settlements were completed using monthly attendance reports submitted by providers, rather than attendance data attested to by certified public accountants.**

  We recommend that DDA compare the client attendance data used to complete the fiscal year-end payment settlements with the certified attendance data, investigate any significant variances, and adjust fiscal year-end settlements accordingly.

- **DDA did not adequately oversee the implementation of an information technology system. The vendor was paid approximately $2.4 million for a system that lacked functionality related to two of the system's four objectives, and was significantly delayed.**

  We recommend that DDA adequately manage contractual agreements.

- **DDA was unable to demonstrate that cumulative funding totaling approximately $184.5 million was used to eliminate the backlog of clients awaiting services as of January 1, 1998, as was intended by the budgetary initiative.**

  We recommend that DDA determine whether the intent of the waiting list initiative has been fulfilled and report the results of its review to the General Assembly's budget committees.

Background Information

Agency Responsibilities

The mission of the Developmental Disabilities Administration (DDA) is to provide leadership to assure the full participation of individuals with developmental disabilities and their families in all aspects of community life, and to promote their access to quality supports and services necessary to foster personal growth, independence, and productivity. DDA plans, develops, and directs a statewide system of services for the developmentally disabled and their families. DDA consists of a headquarters unit, four regional offices which administer community based services, and four residential centers (for example, Rosewood Center). Separate audits are conducted on these centers. This audit included the headquarters unit and the four regional offices.

Through private contractors, DDA offers to the developmentally disabled, various community based programs that include community residential services, day habilitation services, and vocational training. During fiscal year 2002, DDA's expenditures totaled approximately $410 million ($274 million general funds, $11 million special funds, and $125 million Federal funds).

Current Status of Findings From Preceding Audit Report

Our audit included a review to determine the current status of the two fiscal/compliance findings included in our preceding audit report of DDA dated August 8, 2000. We determined that the DDA satisfactorily addressed one of the two fiscal/compliance findings. The remaining item is repeated in this report.

Findings and Recommendations

Federal Funds

Background

The Developmental Disabilities Administration's (DDA) Federal funds, which totaled approximately $125 million during fiscal year 2002, consist entirely of Medicaid reimbursements. A written agreement between DDA and the Federal government specifies the medical and financial requirements clients must meet to be eligible for Medicaid reimbursement, and requires DDA to certify that the clients are Medicaid eligible. Services provided to Medicaid eligible clients are initially funded with State general funds, and reimbursement is subsequently requested for Federal funds. Reimbursement requests are prepared either by DDA or by providers, depending upon the type of services provided. The requests are submitted to the Department's Medical Care Programs Administration, which processes the related requests for Federal reimbursement through the Medicaid Management Information System.

Finding 1
DDA lost as much as $22 million in Federal revenue for services provided during fiscal year 2002 because eligibility certifications were not completed for the maximum number of clients for whom funding was allowed.

Analysis

According to our estimates, DDA could have received as much as $22 million in additional Federal revenue for services provided during fiscal year 2002 if funding had been obtained for the maximum number of clients allowed. The written agreement between DDA and the Federal government places a cap on the maximum number of clients for whom Federal Medicaid funds may be obtained, which as of January 31, 2003, was 8,688. However, as of this date, DDA had only certified 7,471 active clients as eligible for Federal funding. DDA had identified another 2,000 clients who are receiving services, and who are medically eligible for Federal funding, but whose financial eligibility had not been determined.

DDA officials advised us that historically, about 80 percent of DDA clients are financially eligible for federal funding. Furthermore, we noted that DDA has been steadily increasing the number of clients for whom Federal funds are received. For example, in January 2001, Federal funding was only requested for approximately 5,300 clients when the cap on the number of clients for whom Federal funding could be received was 7,474. DDA officials also stated that eventually the number of clients for whom Federal funds are obtained will be maximized, but that the process for determining eligibility is time-consuming. DDA further advised that it

estimated the loss in Federal fund revenue applicable to fiscal year 2002 to be approximately $12.9 million; however, DDA could not adequately substantiate this assertion.

Recommendation 1
We recommend that DDA take immediate action to maximize the number of clients for whom Federal funds may be obtained.

Finding 2
DDA did not monitor the submission of Federal fund reimbursement requests by providers. An estimated $3.7 million in additional Federal funds could be recovered for one type of service provided during fiscal year 2002.

Analysis
DDA did not monitor providers who submitted Federal fund reimbursement requests to ensure recoveries were maximized. Based on our audit and discussions with management, an estimated $3.7 million in Federal funds was not recovered for one type of service provided to clients during fiscal year 2002 because the providers had failed to submit the reimbursement requests. DDA management advised that an additional $1.8 million was not recovered for another type of service for which providers did not submit claims during fiscal year 2002. Since Federal regulations allow DDA two years to submit the reimbursement requests, Federal funds may still be requested for these services.

For example, our test of 42 Medicaid eligible clients, who received services during the period from January to March 2002, disclosed that, as of April 2003, providers had not submitted 73 of the 126 reimbursement requests that should have been submitted over the three-month period. However, DDA did not withhold any provider payments for the failure to submit reimbursement requests, as permitted. In addition, in many instances, claims that were submitted for reimbursement requested amounts that were less than what they could have requested. As a result, DDA failed to recover Federal funds totaling approximately $80,500 for the clients included in our test.

State law authorizes DDA to withhold a portion of provider payments when Federal fund reimbursement requests are not submitted within 30 days of the end of each month. Reimbursement requests submitted by providers accounted for approximately $28 million of the Federal funds received by DDA during fiscal year 2002.

Recommendation 2

We recommend that DDA immediately identify all instances during the preceding two years in which Federal funds were not obtained for eligible clients, and obtain the Federal funds. We also recommend that DDA ensure that providers request the full extent available when Federal fund reimbursement requests are submitted. Finally, we recommend that, as authorized by State law, DDA consider withholding provider payments whenever properly completed reimbursement requests are not submitted within 30 days after the end of the month.

Finding 3

Federal fund reimbursements were not requested in a timely manner, resulting in a loss of interest income to the General Fund of approximately $2 million for services provided during fiscal year 2002.

Analysis

Federal fund reimbursement requests submitted by DDA for fiscal year 2002 were generally made 8 to 14 months after the services were provided and payments were made to the providers. Consequently, State general funds, which would have otherwise been available for investment, were used to finance Federal fund expenditures for extended periods. These untimely requests resulted in a loss of interest income to the State General Fund of approximately $2 million for services provided during fiscal year 2002.

A similar situation was commented upon in our two preceding audit reports. In its response to our preceding report, DDA stated that its new computer system, which was, at that time, expected to be operational in March 2001, would improve the timing of Federal fund reimbursement requests. However, the new computer system was not being used to request Federal funds as of June 2003, as commented upon in Finding 9 of this report. As further commented upon in Finding 7 of this report, the untimely submission of client attendance data contributed to this problem.

In addition to delays in the initial submission of Federal claims, we also noted that DDA did not promptly follow up on those claims that were rejected by the Department's Medical Care Programs Administration because, for example, an incorrect provider or client number was provided. DDA management personnel advised us that, as of April 2003, the last rejected claims that had been fully investigated and resolved related to services provided in September 2001. DDA did not maintain a record of the total claims that were initially rejected and

remained unresolved; however, we determined that claims for federal reimbursement totaling approximately $228,000 were rejected during March 2003.

Recommendation 3

We again recommend that DDA ensure that requests for Federal fund reimbursement are made in a timely manner. We also recommend that DDA promptly investigate and resolve claims submitted for federal reimbursement that are initially rejected.

Finding 4

DDA did not have assurance that certifications of client eligibility for Federal funds were properly performed.

Analysis

DDA lacked assurance that employees of service providers, who completed the initial client eligibility evaluations for Federal funding, possessed the minimum educational and experience qualifications required to certify client eligibility. For this reason, the eligibility evaluations should be properly reviewed and approved by a qualified DDA employee. However, certifications of client eligibility for Federal funding were approved by a DDA clerical employee who used a signature stamp to affix the signature of a DDA qualified management employee.

The agreement with the Federal Government specifies that only clients who require a certain level of care are eligible for Federal funding, and specifies the minimum educational and experience qualifications of the employee who performs the initial eligibility evaluation.

Recommendation 4

We recommend that a properly qualified DDA employee review, at least on a test basis, the Federal funding eligibility evaluations for clients whose eligibility certifications were previously approved with a signature stamp. We also recommend that DDA ensure that future certifications of client eligibility for Federal funding be completed by qualified employees.

Service Provider Payments

Background

The majority of DDA's expenditures for client services are made through the Fee Payment System (FPS). Expenditures processed through FPS for approximately 125 service providers totaled approximately $239 million during fiscal year 2002. Service providers are paid for each day a client is served. The daily payment rates vary depending upon the clients' type of service (such as residential or day) and assessed level of need, which is determined by the providers.

At the start of each quarter, FPS providers receive advance payments based primarily on client attendance in previous quarters, as reported by the providers. Annually, providers submit certified cost reports that reflect actual client attendance data. The Department's Office of Program Costs and Analysis prepares settlements that compare the amounts advanced to providers with the amounts earned by the providers based on actual client attendance. The year-end settlements result in an amount due to or from the providers.

Finding 5
DDA generally did not verify that client level of care assessments completed by providers were appropriate, and the assessments were not always completed.

Analysis

Although providers are required to complete Individual Indicator Rating Scale (IIRS) forms to assess each new client's required level of care, DDA generally did not verify the propriety of the assessments by reviewing supporting documentation (such as client medical records) or observing the client. Verifications of level of care assessments are essential since the assessments determine how much providers are paid. For example, in most areas of the state the annual rates for residential clients range from approximately $23,000 to $55,000 depending on the level of care provided.

Additionally, our test of level of care assessments for 50 clients disclosed that the assessments for 24 clients were not supported by IIRS forms. We were advised by DDA personnel that providers often did not complete the IIRS forms, but rather, determined the level of care for new clients by averaging the level of care assessments for other clients under their care.

State regulations require that client assessments be based on the IIRS forms, which consist of a series of multiple choice questions regarding client medical and supervision needs, such as the number of therapies needed per month. The forms are intended to ensure that the client level of care assessments are completed properly and consistently.

Recommendation 5

We recommend that DDA verify the propriety of client level of care assessments completed by providers by reviewing supporting documentation or observing the clients. We also recommend that DDA identify clients whose assessed level of care was not based on a completed IIRS form, and ensure that IIRS forms are completed for all such clients. Finally, we recommend that, in the future, level of care assessments be based on properly completed IIRS forms.

Finding 6

Fiscal year-end settlements were completed using monthly client attendance reports submitted by providers rather than certified attendance data.

Analysis

Although annual cost reports submitted by providers contained client attendance data that was certified by a certified public accountant, this data was not used to complete the fiscal year-end settlements. Instead, the settlements were completed using uncertified monthly attendance data submitted by the providers. Consequently, there was a lack of assurance that the fiscal year-end settlements, which determine amounts due to or from providers, were properly completed.

Our comparison of fiscal year 2002 attendance data reported by 20 providers with the attendance data reflected on the certified cost reports disclosed that, in 17 instances, the data did not agree. The potential financial impact of the disagreements ranged from overpayments of $45,000 to underpayments of $39,000. State law specifies that settlements are considered final one year after the cost reports are received. Since the fiscal year 2002 cost reports were due in January 2003, adjustments can still be made.

Recommendation 6

We recommend that DDA compare the client attendance data used to complete the fiscal year 2002 FPS settlements with the certified attendance data, investigate any significant variances, and adjust fiscal year-end settlements accordingly. We also recommend that future fiscal year-end settlements be completed in a similar manner.

Finding 7
DDA took no enforcement action against providers that did not submit required monthly client attendance data and annual cost reports by the required due dates.

Analysis
DDA took no substantive action, such as withholding provider payments, when providers failed to submit required client attendance and cost reports in a timely manner. Consequently, these reports were repeatedly submitted after the required due dates. For example, our test of 55 monthly client attendance reports from calendar year 2002 disclosed that 52 reports were not submitted within 15 days of the end of the month as required by State law. These included 22 reports that were submitted from 30 to 77 days late. The failure to obtain client attendance data, which supports actual services provided, prevents DDA from requesting Federal fund reimbursement for the related costs, as discussed in Finding 3 of this report. The failure to obtain annual costs reports prevents DDA from completing the providers' year end cost settlements.

During our audit period, State law authorized DDA to withhold a portion of provider payments if attendance data were not submitted by the required due dates. Effective July 1, 2002, State law authorized similar withholdings if cost reports were not submitted timely.

Recommendation 7
We recommend that DDA withhold provider payments when providers fail to submit client attendance data or cost reports timely, or document the reasons why provider payments were not withheld.

Finding 8
DDA did not ensure that enhanced funding paid to providers to increase the wages of direct service workers was used for that purpose, or that wage data reported by providers was accurate and timely.

Analysis
DDA did not verify that enhanced funding paid to providers, as required by State law to be used specifically to increase direct service worker wages, was actually used for that purpose. Providers submitted annual wage surveys to DDA indicating the wages paid to direct service workers; however, DDA did not review the surveys to identify providers whose wages may not have met the hourly minimums established by DDA. Nor did DDA verify the accuracy of the wage

data reflected in the surveys. The fiscal year 2003 wage surveys for 3 of 10 large providers we reviewed suggested that wages may not have been sufficiently increased to meet the hourly minimums. In these instances the wage surveys did not provide sufficient detail to make a determination. Finally, DDA did not ensure that all providers' surveys were submitted. Our review disclosed that approximately 20 percent were not submitted as required.

As a result of concerns regarding low wages paid to direct service workers by private providers serving DDA's clients, legislation was passed during the 2001 Session of the General Assembly. This legislation required the Department of Health and Mental Hygiene to calculate the disparity between wages and benefits paid to direct service workers in state institutions, and wages and benefits paid to comparable employees by private providers. The legislation further required DDA to increase provider rates so that this disparity could be eliminated by fiscal year 2007, and specified that such rate increases be used exclusively by providers to increase the wages of direct service workers. To eliminate the calculated disparity, the Department estimated that it would need to increase provider payments by approximately $16.2 million each year for five years.

Recommendation 8
We recommend that DDA, at least on a test basis, ensure that enhanced funding paid to providers to increase wages of direct service workers was used for that purpose, and that the annual wage surveys are accurate and submitted in a timely manner. For example, DDA could require the providers' independent auditors to attest to the accuracy of the wage data. We also recommend that DDA recover any funds paid to providers to increase wages that were used for other purposes.

Information Technology Contract

Background

In September 1999, DDA contracted with a vendor to enhance the Provider-Consumer Information System (PCIS) at an initial cost of approximately $1.3 million. The enhancement of PCIS was intended to provide DDA employees and providers with timely client information, process payments to providers, and submit claims for Federal reimbursement for Medicaid eligible clients. During fiscal years 2000 to 2002, the contract was amended on seven occasions, bringing the total contract cost to approximately $2.4 million. As of February, 2003, DDA had paid the vendor virtually the full contract amount.

The information technology contract was awarded through a statewide Network Management Services (NMS) agreement. The Department of Budget and Management established this agreement through a competitive process so that State agencies could obtain related services, such as information technology system upgrades, from competent vendors in a cost effective and timely manner. Agencies desiring to use the agreement must submit a technical service request to the Department of Budget and Management. The request is then submitted to the vendors participating in the statewide agreement, and the vendors submit proposals directly to the State agency requiring the service.

Finding 9
DDA did not adequately manage PCIS implementation, resulting in the vendor being paid approximately $2.4 million for a system that lacked certain functionality, and for which implementation was significantly delayed.

Analysis
DDA did not adequately manage the implementation of PCIS for which vendor payments totaled $2.4 million. DDA paid the vendor exclusively on labor hours and other costs (such as computer hardware purchases) reported, without consideration of satisfactory completion of deliverables. Moreover, DDA did not review documentation, such as vendor employee time records, to substantiate the propriety of amounts billed. Additionally, vendor responsibilities for three contract amendments totaling approximately $978,000 were not clearly defined. For example, none of the amendments contained time schedules specifying when project deliverables were due. Consequently, DDA could not determine if the amounts paid to the vendor were commensurate with the vendor's progress.

The vendor was paid the full contract price even though PCIS was not fully functional and was significantly delayed. Specifically, as of June 2003, PCIS could not process provider payments and submit Medicaid claims to the Medical Care Programs Administration. Processing provider payments and Medicaid claims were two of PCIS's four objectives. The contract required PCIS to be operational by September 2000.

Recognizing PCIS's limited functionality, DDA contracted with a consultant in October 2002, at a cost of approximately $232,000, to analyze and assess its status, and to document required modifications to the system. The consultant concluded that PCIS's problems were systemic resulting from serious design deficiencies; however DDA had not taken any legal action against the vendor. DDA advised that they are currently assessing their options with respect to the implementation of PCIS.

Recommendation 9

We recommend that DDA adequately manage system development contractual agreements. We also recommend that documentation substantiating vendor invoices, including the satisfactory completion of deliverables, be obtained and reviewed prior to vendor payment. Finally, we recommend that DDA, in consultation with the Office of the Attorney General, determine whether legal action is warranted against the vendor for the vendor's failure to fulfill its contractual obligations.

Finding 10

The selection of the vendor awarded the PCIS enhancement contract was not sufficiently documented.

Analysis

DDA did not sufficiently document the methodology used to award the PCIS enhancement contract. Specifically, DDA could not substantiate how it evaluated the technical and price components of the three proposals submitted, nor did the technical service solicitation specify how the price proposals and technical proposals would be considered in the vendor selection process. We noted that the bid price of the selected vendor was one-third higher that the price received from the vendor who submitted the lowest price proposal; however, the selected vendor's technical score was only four percent higher that the low bidder's technical score. In addition, the technical service solicitation did not specify how the price proposals and technical proposals would be considered in the vendor selection process. DDA could not substantiate why such a slight variance in technical scores offset such a large difference in bid prices.

Recommendation 10

We recommend that, in the future, DDA document and retain the basis of its decisions in selecting vendors.

Waiting List Initiative

Finding 11
DDA could not substantiate that its use of waiting list initiative funding during fiscal years 1999 to 2003 fulfilled the intent of the initiative.

Analysis
DDA could not substantiate that it fulfilled the intent of the waiting list initiative, a five-year budgetary initiative designed to reduce the number of developmentally disabled individuals waiting for community services. Specifically, the intent of the initiative was to provide sufficient funding to eliminate by June 30, 2003 the backlog of clients awaiting services as of January 1, 1998.

DDA initially established that there were 5,469 individuals awaiting services as of January 1, 1998. Although DDA advised us that this number was inaccurate, it could not determine the number of individuals who should have been on the waiting list. Nevertheless, DDA believes that it fulfilled the intent of the initiative because, over the five-year period ended January 2003, 6,796 new services were provided to clients. The extent to which these new services were provided to those on the 1998 waiting list (versus more recent applications) is uncertain. We were advised by DDA that due to increases in service requests, there were approximately 9,700 on the waiting list as of January 1, 2003. Since the extent of individuals awaiting services as of January 1, 1998 is unknown, there is no assurance that the intent of the initiative has been fulfilled. Furthermore, our test of 30 individuals on the initial January 1, 1998 waiting list disclosed that 7 individuals had not received services as of March 2003.

In addition, DDA advised that it determined during fiscal year 1999 that the January 1, 1998 waiting list was inaccurate. However, DDA continued to report that approximately 5,400 individuals were on the waiting list as of January 1, 1998 in its fiscal year 2001 through 2004 budget submissions.

During fiscal years 1999 to 2003, DDA received appropriations totaling approximately $184.5 million to provide funding to those on the waiting list and to continue funding these services.

Recommendation 11
We recommend that DDA determine whether the intent of the waiting list initiative has been fulfilled, and report the results of their investigation to the General Assembly's budget committees.

Community Supported Living Arrangements (CSLA)

Finding 12
DDA did not ensure that payments to providers of CSLA services were based on actual hours of service provided to clients, as required by State regulations.

Analysis
DDA did not ensure that payments to providers of Community Supported Living Arrangements (CSLA) services were based on actual hours of service provided to clients. Rather, providers submitted monthly reports indicating that services were provided to CSLA clients for the entire month. DDA then paid the providers based on the assumption that clients had received the required number of hours of service without obtaining documentation of the actual service hours provided to each client. We were advised by DDA management personnel at three of its regional offices that they primarily rely on client complaints to identify instances in which the required hours of service were not provided.

State regulations specify that providers will be paid certain hourly rates for each hour of service provided to CSLA clients. When a client begins receiving CSLA services, a service funding plan is completed that indicates the number of hours of service the client is to receive each week. During fiscal year 2002, expenditures on CSLA services totaled approximately $32.7 million.

Recommendation 12
We recommend DDA verify, at least on a test basis, that payments for CSLA services are based on actual service hours provided to clients. The verifications should include a comparison of actual provider service records to hours of services specified in the service funding plans, and could be performed by the regional offices' quality control units.

Audit Scope, Objectives, and Methodology

We have audited the Developmental Disabilities Administration (DDA) for the period beginning January 1, 2000 and ending December 31, 2002. The audit was conducted in accordance with generally accepted government auditing standards.

As prescribed by the State Government Article, Section 2-1221 of the Annotated Code of Maryland, the objectives of this audit were to examine DDA's financial transactions, records, and internal control, and to evaluate its compliance with applicable State laws, rules, and regulations. We also determined the current status of the findings contained in our preceding audit report.

In planning and conducting our audit, we focused on the major financial related areas of operations based on assessments of materiality and risk. Our audit procedures included inquiries of appropriate personnel, inspection of documents and records, and observation of DDA's operations. We also tested transactions and performed other auditing procedures that we considered necessary to achieve our objectives. Data provided in this report for background or informational purposes were deemed reasonable, but were not independently verified.

Our audit did not include certain support services provided to DDA by the Department of Health and Mental Hygiene. These support services (such as payroll, purchasing, maintenance of accounting records and related fiscal functions) are included within the scope of our audits of the Department's Office of the Secretary and Other Units. In addition, we did not audit DDA's Federal financial assistance programs for compliance with Federal laws and regulations because the State of Maryland engages an independent accounting firm to annually audit such programs administered by State agencies.

DDA's management is responsible for establishing and maintaining effective internal control. Internal control is a process designed to provide reasonable assurance that objectives pertaining to the reliability of financial records, effectiveness and efficiency of operations including safeguarding of assets, and compliance with applicable laws, rules, and regulations are achieved.

Because of inherent limitations in internal control, errors or fraud may nevertheless occur and not be detected. Also, projections of any evaluation of internal control to future periods are subject to the risk that conditions may change or compliance with policies and procedures may deteriorate.

Our reports are designed to assist the Maryland General Assembly in exercising its legislative oversight function and to provide constructive recommendations for improving State operations. As a result, our reports generally do not address activities we reviewed that are functioning properly.

This report includes findings relating to conditions that we consider to be significant deficiencies in the design or operation of internal control that could adversely affect DDA's ability to maintain reliable financial records, operate effectively and efficiently and/or comply with applicable laws, rules, and regulations. Our report also includes significant instances of noncompliance with applicable laws, rules, or regulations.

The Department's response, on behalf of DDA to our findings and recommendations, is included as an appendix to this report. As prescribed in the State Government Article, Section 2-1224 of the Annotated Code of Maryland, we will advise the Department regarding the results of our review of its response.

APPENDIX

STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Robert L. Ehrlich, Jr., Governor – Michael S. Steele, Lt. Governor – Nelson J. Sabatini, Secretary

October 7, 2003

Mr. Bruce Myers, CPA
Legislative Auditor
Office of Legislative Audits
301 West Preston Street
Baltimore, Maryland 21201

Dear Mr. Myers:

This is in response to your September 22, 2003 letter that included the draft audit report for the Developmental Disabilities Administration for the period beginning January 1, 2000 and ending December 31, 2002. Attached you will find the Department's response and plan of correction that addresses each audit recommendation. I will work with the appropriate Directors of Administration, Program Directors and Deputy Secretary to promptly address all audit exceptions. In addition, our Division of Internal Audits will follow-up on the recommendations to ensure compliance.

If you have any questions or require additional information, please do not hesitate to contact me at 410-767-6505 or Ellwood Hall of my staff at 410-767-5684.

Sincerely,

Nelson J. Sabatini
Secretary

cc: Ms. Diane K. Coughlin, Director, DDA, DHMH
Mr. Ellwood Hall, Chief, Division of Internal Audits, Office of the Inspector General, DHMH
Ms. Arlene H. Stephenson, Deputy Secretary for Public Health Services, DHMH

Draft Audit Report
Developmental Disabilities Administration
January 1, 2000 – December 31, 2002
Response to Findings and Recommendations

Federal Funds

Finding 1
DDA lost as much as $22 million in Federal revenue for services provided during fiscal year 2002 because eligibility certifications were not completed for the maximum number of clients for whom funding was allowed.

Recommendation 1
We recommend that DDA take immediate action to maximize the number of clients for whom Federal funds may be obtained.

Administration Response:
DDA does not concur that $22 million in revenue was lost. The Administration estimates that up to an additional $12.9 million could have been obtained if all eligible people were enrolled in the waiver. DDA cannot collect FFP under the following circumstances because of governing federal rules and regulations: Individuals residing in State Residential Centers who receive day services in the community; individuals residing in domiciliary care settings; payments made to providers to cover absence and vacancy days; and other expenditures resulting in disallowance by the Centers for Medicare and Medicaid Services, the federal agency with waiver oversight.

As the auditors indicate in their analysis, DDA has steadily increased the number of individuals in the waiver. Since 1998, the Administration has expanded the waiver by more than 122%, as 4192 individuals have enrolled**.** The number of slots remained underutilized because of a number of factors. First, the slot projection contained in the waiver was for a five-year period. Unsure of the demand for waiver-covered services under the expansive Waiting List Initiative (WLI), DDA deliberately requested a large number of slots. The Administration was not cognizant at that time that additional slots could be granted from CMS with little difficulty. DDA predicted that more people would choose traditional, waiver-covered services under the WLI; however, many more individuals chose support services, which are not waiver covered services. DDA continues to make waiver enrollment and FFP collection a top priority for the Administration and will continue to aggressively enroll eligible individuals in the waiver.

The Administration is working diligently and aggressively to pursue federal resources wherever available. DDA has devoted considerable resources to enroll eligible individuals into the waiver to enable the collection of Federal Financial Participation (FFP). These ongoing efforts reveal that a portion of individuals served by DDA are ineligible for participation in the waiver, most typically as a result of assets or resources in excess of the allowable amounts. Furthermore, a

contingent of individuals served by DDA has refused enrollment in the waiver. DDA, identifying this as an impediment to federal fund collection, has secured emergency regulations to require that individuals access services through the waiver when they are eligible to do so.

Draft Audit Report
Developmental Disabilities Administration
January 1, 2000 – December 31, 2002
Response to Findings and Recommendations

Finding 2
DDA did not monitor the submission of Federal fund reimbursement requests by providers. An estimated $3.7 million in additional Federal funds could be recovered for one type of service provided during fiscal year 2002.

Recommendation 2
We recommend that DDA immediately identify all instances during the preceding two years in which Federal funds were not obtained for eligible clients, and obtain the Federal funds. We also recommend that DDA ensure that providers request the full extent available when Federal fund reimbursement requests are submitted. Finally, we recommend that, as authorized by State law, DDA consider withholding provider payments whenever properly completed reimbursement requests are not submitted within 30 days after the end of the month.

Administration Response:
The Administration agrees that Federal funds were not processed timely; however in June 2003, DDA submitted federal claims to MMIS for Community Supported Living Arrangements (CSLA) and Supported Employment services back to 7/01/01. Claims for these two services totaled $3.4 million - $1.6 million for CSLA and $1.8 million for Supported Employment services.

To monitor and aggressively manage this process, DDA implemented a new management initiative, in March 2003, effective with the April attendance data and federal billing submissions that tightens tracking and control of federal claims. The new procedures include the Administration withholding a portion of providers' quarterly payments, or taking licensure actions, for late submissions as permitted by regulation. This initiative reduces the length of time between when a service is delivered and a federal claim submitted to 2½ months. It also tracks individuals for whom we expect to receive federal reimbursement to assure claims for their services are submitted timely.

Draft Audit Report
Developmental Disabilities Administration
January 1, 2000 – December 31, 2002
Response to Findings and Recommendations

Finding 3
Federal fund reimbursements were not requested in a timely manner, resulting in a loss of interest income to the General Fund of approximately $2 million for services provided during fiscal year 2002.

Recommendation 3
We again recommend that DDA ensure that requests for Federal fund reimbursement are made in a timely manner. We also recommend that DDA promptly investigate and resolve claims submitted for federal reimbursement that are initially rejected.

Administration Response:
The Administration concurs. The Administration claims Medical Assistance funds for about 7,676 Medicaid waiver consumers. The current process is complicated and requires a number of resources. Currently DDA claims federal funds in two processes—tape billing for residential and day services and billing forms from the providers of CSLA, Individual Family Care, and Supported Employment services. The bulk of DDA's recovery of federal funds is generated from the tape billing process. The tape billing process begins with attendance document submission to DDA's Division of Rate Setting. The Division verifies the accuracy of the data and submits it to the Department's data entry keypunching section. After the data is keyed, a tape is generated and DDA's Federal Billing Division verifies the data. If the data is not correct or is incomplete, the division attempts to correct for the final tape billing submission. Once the tape is submitted to Medicaid Management Information Systems (MMIS), a subsequent tape for the same month cannot be processed. Due to the limitations of DDA's tape billing program only one tape can be submitted to MMIS for a given month. We are investigating a temporary correction for this, so that subsequent tapes can be submitted. The Provider-Consumer Information System (PCIS2) will correct this issue. PCIS2 was successfully tested for submitting federal claims previously, and we expect the system to be submitting federal claims electronically this fiscal year.

Until PCIS2 is submitting claims, DDA has tightened management control to decrease the time for claims processing. The Administration has taken action to improve productivity in three areas: keying of data, providers' submission of attendance documents, and providers' submission of federal billing forms. In the area of keying of data, the Administration is monitoring the production of personnel doing the keying and augmenting keying staff when necessary. To achieve more timely submission of documents by providers, the Administration will impose financial and licensing sanctions for noncompliance. This new

management initiative took effect in March 2003 and allows DDA to submit claims 2½ months after the end of the billing month.

Draft Audit Report
Developmental Disabilities Administration
January 1, 2000 – December 31, 2002
Response to Findings and Recommendations

Finding 4
DDA did not have assurance that certifications of client eligibility for Federal funds were properly performed.

Recommendation 4
We recommend that a properly qualified DDA employee review, at least on a test basis, the Federal funding eligibility evaluations for clients whose eligibility certifications were previously approved with a signature stamp. We also recommend that DDA ensure that future certifications of client eligibility for Federal funding be completed by qualified employees.

Administration Response:
The Administration concurs. Staff that meets Qualified Mental Retardation Professional (QMRP) standards initially reviewed and signed all initial and recertification level of care forms for people who were entering or already enrolled in the DDA waiver. Because of workload issues, the QMRP trained and supervised another individual who reviewed and signed the documents on behalf of the QMRP. Effective immediately, the Administration will only have appropriately qualified staff perform this function, and the appropriate staff will sign instead of stamp certification.

Draft Audit Report
Developmental Disabilities Administration
January 1, 2000 – December 31, 2002
Response to Findings and Recommendations

Service Provider Payments

Finding 5
DDA generally did not verify that client level of care assessments completed by providers were appropriate, and the assessments were not always completed.

Recommendation 5
We recommend that DDA verify the propriety of client level of care assessments completed by providers by reviewing supporting documentation or observing the clients. We also recommend that DDA identify clients whose assessed level of care was not based on a completed IIRS form, and ensure that IIRS forms are completed for all such clients. Finally, we recommend that, in the future, level of care assessments be based on properly completed IIRS forms.

Administration Response:
The Administration does not concur that the propriety of the client level of care was not verified. When an individual enters a service funded by the Fee Payment System (FPS), a service funding plan (SFP) is developed by the provider, and the provider submits the SFP along with an initial "A matrix" (temporary Individual Component) to the regional office. The A matrix is a form that enters the consumer into FPS and authorizes the State to pay the provider the average of all Individual Components for the consumers served by the provider. The provider receives the A matrix payment until the provider completes an Individual Indicator Rating Scale (IIRS) within thirty-five days of the service start date and submits it with supporting documentation to the regional office. Supporting documentation may include medical and behavioral assessments and a copy of the individual program plan developed during the initial team meeting. When the regional office approves the IIRS, a "C matrix" (permanent Individual Component) is entered into the FPS, and the provider is paid the C matrix amount to the service start date.

There are several steps in this process that help assure the validity of the IIRS and C matrix. First, prior to authorizing new services, the regional offices assign a resource coordinator to the prospective consumer. The resource coordinator is responsible for visiting the consumer and developing a person-centered plan. This plan delineates the needs and preferences of the consumer based on direct observation and interviews with the consumer and the consumer's family and advocates. The person-centered plan becomes the basis for the SFP, which is reviewed and signed by the consumer, family, and resource coordinator. The

SFP delineates the needs and preferences of the consumer with proposed services and associated costs. The SFP is forwarded to the Regional Office for review and is available for comparison to the IIRS when it is submitted.

When the regional office receives the IIRS and C matrix, the staff reviews it for validity. At this time, the staff requests additional documentation when appropriate and takes other steps to corroborate the IIRS. The providers are responsible for maintaining all documentation to support the individual component assessment for each consumer. Regional office staff by this point often have become very familiar with the individual being served and can make good judgements as to the validity of the C matrix. This knowledge along with the documentation and the family and resource coordinator participation help assure accurate scores. Although the Administration thinks this process results in valid IIRSs, DDA will examine the utilization review procedures to determine if changes should be made to increase the level of scrutiny of this part of the rate-setting process.

The Administration concurs that permanent matrices should be based on an assessed level of care, and this is the Administration's current policy. In reviewing the legislative auditor sample, nine of the transactions listed as missing the IIRS form were A matrices which do not need IIRSs. The other transactions should have had IIRSs. The Administration has implemented a procedure in which the regional staff will sign a form confirming they have reviewed the IIRS for an individual and submit it along with the form establishing a permanent C matrix. For those instances where providers do not submit IIRSs within a reasonable period of time, the Administration will change their paid matrix level for the consumer to a 1:1.

Draft Audit Report
Developmental Disabilities Administration
January 1, 2000 – December 31, 2002
Response to Findings and Recommendations

Finding 6
Fiscal year-end settlements were completed using monthly client attendance reports submitted by providers rather than certified attendance data.

Recommendation 6
We recommend that DDA compare the client attendance data used to complete the fiscal year 2002 FPS settlements with the certified attendance data, investigate any significant variances, and adjust fiscal year-end settlements accordingly. We also recommend that future fiscal year-end settlements be completed in a similar manner.

Administration Response:
The Administration concurs. The Division of Program Cost and Analysis (DPCA) will compare the attendance data on all FPS settlements to the certified attendance data on the cost report, investigate significant variances, and adjust the FPS settlements accordingly. This will be done by DPCA for FY 2002 FPS settlements and all future FPS settlements.

Draft Audit Report
Developmental Disabilities Administration
January 1, 2000 – December 31, 2002
Response to Findings and Recommendations

Finding 7
DDA took no enforcement action against providers that did not submit required monthly client attendance data and annual cost reports by the required due dates.

Recommendation 7
We recommend that DDA withhold provider payments when providers fail to submit client attendance data or cost reports timely, or document the reasons why provider payments were not withheld.

Administration Response:
The Administration concurs with this finding regarding attendance documents and has taken action to assure the more timely submission of those documents. In March 2003, DDA implemented a new management initiative, effective with the April attendance data and federal billing submissions, that tightens tracking and control of federal claims and the submission of attendance documents. As a result, all providers submitted April attendance timely.

DDA tracks providers' attendance submission and requires that attendance be submitted 30 days after the end of the service month. If DDA has not received the attendance, it notifies the provider by certified mail that the documentation must be received within five business days or a portion of the provider's next quarterly payment will be withheld, or licensure action taken, as permitted by regulation. This initiative reduces the length of time between when a service is delivered and a federal claim submitted to 2½ months.

The Administration does not concur with this finding regarding annual cost reports as the Administration was not authorized to withhold payments or impose fiscal sanctions on providers for cost reports during the period mentioned in the audit findings. The authorization was granted to the Administration through the 2002 passage of SB230 which took effect on July 1, 2002. Since the law took effect, the Administration has used its ability to impose fiscal sanctions to greatly increase compliance with cost-reporting requirements. It should be noted that during the Administration's testimony in support of SB230 before the Senate Finance Committee, the committee expressed their strong desire that the Administration work with delinquent providers before imposing fiscal sanctions. With this in mind, the Administration makes certain that providers have sufficient opportunity to comply and that circumstances that interfere with a provider's

compliance—such as turnover in key fiscal staff—are taken into account when deciding to impose sanctions. For providers with outstanding reports from previous years, the Administration will establish a new deadline which will give DDA the authority to impose penalties if necessary.

Draft Audit Report
Developmental Disabilities Administration
January 1, 2000 – December 31, 2002
Response to Findings and Recommendations

Finding 8
DDA did not ensure that enhanced funding paid to providers to increase the wages of direct service workers was used for that purpose, or that wage data reported by providers was accurate and timely.

Recommendation 8
We recommend that DDA, at least on a test basis, ensure that enhanced funding paid to providers to increase wages of direct service workers was used for that purpose, and that the annual wage surveys are accurate and submitted in a timely manner. For example, DDA could require the providers' independent auditors to attest to the accuracy of the wage data. We also recommend that DDA recover any funds paid to providers to increase wages that were used for other purposes.

Administration Response:
The Administration concurs that providers should be penalized if State payment increases for wage enhancements are not used for that purpose. The Administration also agrees that accurate and complete data is needed to gauge the progress of the wage and benefit increases.

Over 95% of providers completed the FY03 wage survey, and DDA is working with the Attorney General's office to impose fiscal sanctions on the six providers that did not return surveys. The Community Services Reimbursement Rate Commission (CSRRC) spent a considerable amount of time confirming the data in the surveys for FY02 and FY03. Once the CSRRC was confident the data did not contain significant errors, they compared wages for the two fiscal years and found providers on average gave wage increases in keeping with the rate increases in the Fee Payment System (FPS) and CSLA Payment System. DDA is conducting a follow-up survey for the two fiscal years to determine the amount of money each provider dedicated to increases in wages and benefits. As part of the survey, providers are being asked to give the dollar amount of their total payroll, the percentage of their payroll funded by DDA revenue, and the dollar amounts given in FY03 for direct-support wage and fringe benefit increases.

In addition to confirming that the money for wage and benefit increases was used for those purposes system wide, DDA will examine multi-year survey results for a sample of providers to determine if raises and benefit increases were made. If a provider did not use the money for wages and benefits as intended, DDA will work with the Attorney General's office to attempt recovery the money.

Draft Audit Report
Developmental Disabilities Administration
January 1, 2000 – December 31, 2002
Response to Findings and Recommendations

The auditors recommend that the Administration determine if the wage data reported in the CSRRC wage survey is accurate by requiring providers' auditors to attest to the accuracy of the data. DDA is considering methods to ascertain the accuracy, including spot auditing the data. However, having providers' auditors attest to the data may be unfeasible, or very expensive, since providers have to fit their employee job functions into the universal job functions listed in the CSRRC survey—a process that is less than precise and requires a significant amount of program judgement. The Administration will, nevertheless, examine the feasibility of an auditor attestation.

Draft Audit Report
Developmental Disabilities Administration
January 1, 2000 – December 31, 2002
Response to Findings and Recommendations

Information Technology Contract

Finding 9
DDA did not adequately manage PCIS implementation, resulting in the vendor being paid approximately $2.4 million for a system that lacked certain functionality, and for which implementation was significantly delayed.

Recommendation 9
We recommend that DDA adequately manage system development contractual agreements. We also recommend that documentation substantiating vendor invoices, including the satisfactory completion of deliverables, be obtained and reviewed prior to vendor payment. Finally, we recommend that DDA, in consultation with the Office of the Attorney General, determine whether legal action is warranted against the vendor for the vendor's failure to fulfill its contractual obligations.

Administration Response:
The Administration does not agree that it did not adequately manage the implementation of the Provider-Consumer Information System (PCIS2) and does not agree that the contractor was improperly paid. The Department asked the Office of the Attorney General if there is any recourse regarding the vendor's performance under the contract. Their advice has been that the time and materials approach of the contract taken with the surrounding circumstances of the transaction would present significant legal hurdles in maintaining an action for recovery at the present time.

A time-and-materials contract was appropriate for the development of PCIS2. When the Administration entered a contract with the vendor, it was for designing an information system from the ground up. There were not enough known specific characteristics of a finished system to enter a fixed-price contract at that time. The vendor's first tasks were to interview staff, assess the Administration's needs, and present design options to DDA as far as what a finished system would entail. They did that; and although it can be argued that it could have been done better, without specifications of what "better" is, it is difficult to argue they should not have been paid. Regarding any additional work needed, the vendor likely could have performed the work if the Administration continued to pay them. However, the Administration chose not to authorize additional work under a time-and-materials contract with the vendor.

Draft Audit Report
Developmental Disabilities Administration
January 1, 2000 – December 31, 2002
Response to Findings and Recommendations

The Administration does not agree that it did not adequately manage the development of PCIS2 and feels the data system is largely operational. When the vendor's contract ended, PCIS2 was managing complex data sets for thousands of consumers, accepting attendance data for people in rate-based services, and the federal billing part of the system had been successfully tested by the vendor. The Administration is able to generate reports from PCIS2 to help it manage the service system. The Administration chose not to continue the contract with the vendor to have them complete the Payment module, and the Administration made the decision to significantly alter the design of the Contracts module toward the end of the vendor's contract because of poor cost-benefit ratio of our original requirements. There were design characteristics that were inefficient, such as the email notification system and the architecture of the code, but the Administration did not specify outcomes for those items and did not have the information and knowledge to do so when it entered the contract. Implementation problems—exclusive of the Contracts and Payments modules—the Administration faced were the need for significant data cleanup (which only DDA could do), slow transmission of data, and some bugs and enhancements that needed correcting. It was through a subsequent small procurement that the Administration discovered the inefficient architecture of the code. Since the Administration did not specify in the original time-and-materials contract the architecture required, it is difficult to say whether the State would have a case against the vendor for unsatisfactory performance.

The Administration's experience with this contract illustrates the extreme difficulty any organization faces when contracting for complex information technology systems. If an organization is building a system from scratch, it is doubtful any vendor will accept the work on a fixed-price contract unless it is significantly padded to cover their risk. When one enters a time-and-materials contract, it is difficult to control the cost while getting the outcome one wants—an outcome that usually is shaped during the development of the system. The best way to manage the process is to constantly evaluate the progress of the system development and the cost-benefit of the current contract. That is what the Administration did; and it decided at a certain point to not continue with the vendor, to get an independent assessment of the code, and to do a focused fixed-price contract based on the assessment of the code and the Administration's refined knowledge of desired outcomes.

The Administration agrees with the recommendation to review the vendor's employees' time records and has requested and received vendor timesheets for the PCIS2 development contract. The Administrative Officer for Information Systems and the Administration's CFO reviewed a representative sample of timesheets during July 2003 for both prime contractor staff (CSC) and sub-contractor staff (CNSI). A total of 19% of CSC staffs' timesheets were

reviewed. A total of 8% of CNSI pay period's timesheets were reviewed. Invoices were tied to timesheets and substantiated the validity of labor changes. The Administration agrees to substantiate, at least on a test basis, the validity of labor charges included on vendor invoices on future time and materials contracts.

Draft Audit Report
Developmental Disabilities Administration
January 1, 2000 – December 31, 2002
Response to Findings and Recommendations

Finding 10
The selection of the vendor awarded the PCIS enhancement contract was not sufficiently documented.

Recommendation 10
We recommend that, in the future, DDA document and retain the basis of its decisions in selecting vendors.

Administration Response:
The Administration concurs and agrees to follow approved procedures for document retention when selecting vendors. When the Administration solicited proposals to develop the web-based Provider-Consumer Information System (PCIS2) during the spring of 1999, this was done through the statewide Network Management Services (NMS) agreement. The Administration complied with all of the requirements of the process as they were defined at the time and conducted a thorough evaluation of the proposals received, involving external stakeholders in the analysis. All the necessary documentation was prepared during the evaluation phase. There were, however, no formalized procedures for maintaining procurement documentation in place as a part of the NMS process. A review team of stakeholders made the decision to award the contract to the vendor but the rationale was not retained. In the future, the Administration will retain the justification on file.

For all future Information Technology contracts procured through a statewide agreement, the Developmental Disabilities Administration will follow the protocol established by the Department as defined in the Resource Guide prepared by the Office of Contract Policy, Management and Procurement (OCPMP) and will retain documentation for 3 years or until after the legislative audit for the period that includes award of the contract, whichever is longer.

Draft Audit Report
Developmental Disabilities Administration
January 1, 2000 – December 31, 2002
Response to Findings and Recommendations

Waiting List Initiative

Finding 11
DDA could not substantiate that its use of waiting list initiative funding during fiscal years 1999 to 2003 fulfilled the intent of the initiative.

Recommendation 11
We recommend that DDA determine whether the intent of the waiting list initiative has been fulfilled, and report the results of their investigation to the General Assembly's budget committees.

Administration Response:
The Administration does not concur. As clearly articulated in documents announcing the Waiting List Initiative and in subsequent reports to the legislature on the progress of the Initiative, the intent of this five-year project was to provide relief to individuals and their families who applied to DDA for services before January 1, 1998. One of the goals of the Initiative was to provide at least one new or additional service to individuals waiting. Additionally, the Initiative sought to prioritize more expensive services to those individuals who had older caregivers. DDA is confident in its fulfillment of this intent and is proud of the substantial numbers of people who have received services since the inception of the Initiative.

Despite admitted difficulty with the comprehensiveness and accuracy of the data generating the waiting list at the outset of the Initiative, DDA instituted methodologies to ensure that no individual or family who applied for services by January 1, 1998 was penalized for flawed data. Through FY2003, 8252 individuals who were or who should have been on the list as of January 1, 1998 have been served. DDA recognizes that adjustments should have been made to the reporting figures contained in the Managing for Results items related to the Waiting List Initiative. However, it is important to note that the Administration not only met the goal contained in the MFR, but exceeded it by 2783 people or 50%.

Draft Audit Report
Developmental Disabilities Administration
January 1, 2000 – December 31, 2002
Response to Findings and Recommendations

Community Supported Living Arrangements (CSLA)

Finding 12
DDA did not ensure that payments to providers of CSLA services were based on actual hours of service provided to clients, as required by State regulations.

Recommendation 12
We recommend DDA verify, at least on a test basis, that payments for CSLA services are based on actual service hours provided to clients. The verifications should include a comparison of actual provider service records to hours of services specified in the service funding plans, and could be performed by the regional offices' quality control units.

Administration Response:
The Administration partially disagrees and partially agrees. The Community Supported Living Arrangements (CSLA) Payment System is designed to assure that a person receives the needed amount of support over an extended period of time. A person getting an average of ten hours of support a week may receive twenty hours per week for the first two weeks of the month and no support for the last two. The CSLA payment system, then, has been designed to average the hours provided from the service start date to the service end date. Verifying that an individual is receiving a certain number of hours of support each week is not in keeping with the payment system or service model. The CSLA payment system structure is very different from a facility-based service model, such as residential services, in which a program site is constantly staffed at a certain level.

The Administration agrees that some type of performance audit should be done. The Administration will determine the best way to implement performance audits with available resources.

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