Audit Report

Department of Health and Mental Hygiene
Developmental Disabilities Administration

October 2013

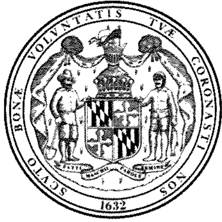
OFFICE OF LEGISLATIVE AUDITS
DEPARTMENT OF LEGISLATIVE SERVICES
MARYLAND GENERAL ASSEMBLY

- This report and any related follow-up correspondence are available to the public through the Office of Legislative Audits at 301 West Preston Street, Room 1202, Baltimore, Maryland 21201. The Office may be contacted by telephone at 410-946-5900, 301-970-5900, or 1-877-486-9964.

- Electronic copies of our audit reports can be viewed or downloaded from our website at http://www.ola.state.md.us.

- Alternate formats may be requested through the Maryland Relay Service at 1-800-735-2258.

- The Department of Legislative Services – Office of the Executive Director, 90 State Circle, Annapolis, Maryland 21401 can also assist you in obtaining copies of our reports and related correspondence. The Department may be contacted by telephone at 410-946-5400 or 301-970-5400.



DEPARTMENT OF LEGISLATIVE SERVICES
OFFICE OF LEGISLATIVE AUDITS
MARYLAND GENERAL ASSEMBLY

Karl S. Aro
Executive Director

Thomas J. Barnickel III, CPA
Legislative Auditor

October 2, 2013

Senator James C. Rosapepe, Co-Chair, Joint Audit Committee
Delegate Guy J. Guzzone, 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, 2009 and ending February 28, 2012. DDA plans, develops policies and regulations, and funds a Statewide system of services for individuals with developmental disabilities and their families.

Our audit disclosed that DDA did not adequately monitor vendors who were responsible for ensuring that consumers served under DDA programs were receiving stipulated services from providers. DDA did not obtain reports from the vendors, referred to as resource/service coordinators, or review their records to determine whether they were performing required monitoring visits and were verifying that consumers were receiving services specified in their individual service plans. The resource/service coordinators were responsible for monitoring 24,092 consumers with service expenditures totaling $759 million in fiscal year 2012.

DDA did not take certain actions to maximize the recovery of federal funds. DDA's methodology for determining federal reimbursement rates for contractual payment system programs did not accurately reflect the costs incurred. For one program, we estimated that, over a two-year period, DDA's related reimbursable costs exceeded its federal reimbursements by $2.4 million. For this same program, we noted that DDA may have lost the opportunity to claim as much as $5.2 million in federal funds over a three-year period due to its failure to ensure providers submitted required claims information. Our audit again disclosed that DDA did not process requests for federal reimbursement in a timely manner and did not investigate certain claims that were rejected by eligibility edits.

301 West Preston Street · Room 1202 · Baltimore, Maryland 21201
410-946-5900/301-970-5900 · Fax 410-946-5999/301-970-5999
Toll Free in Maryland 877-486-9964 · Fraud Hotline 877-FRAUD-11

DDA did not ensure that the consumers' contribution to care (CTC) amounts, which reduce DDA's payments to the applicable providers, were accurately recorded in its payment system. We determined that the total CTC amount as recorded by providers in the payment system was $4.8 million less than the consumers' ability to pay as determined by DHMH during the consumer eligibility determination process. Consequently, DDA may have paid more for consumers' care than it was responsible for.

Our audit also identified DDA expenditures totaling $610,000 funded from the tax on alcoholic beverages that were used for purposes other than those specified in DDA policies. Additionally, DDA did not have effective processes in place to ensure certain funds owed were recovered in a timely manner. For example, State law requires the 24 local jurisdictions to annually fund a portion of certain day habilitation and vocational service charges paid by DDA, but DDA did not bill 4 jurisdictions for their share over a multi-year period. Finally, documentation supporting accounting adjustments was lacking and computer system security and access controls were not sufficient to ensure the integrity of the data.

We determined that DDA's accountability and compliance level was unsatisfactory, in accordance with the rating system we established in conformity with State law. The primary factors contributing to the unsatisfactory rating were the significance of our audit findings and the number of repeat findings. In this regard, DDA sufficiently addressed only 7 of the 14 findings contained in our preceding report.

An executive summary of our findings can be found on page 5. The Department's response to this audit, on behalf of DDA, is included as an appendix to this report. We wish to acknowledge the cooperation extended to us during the course of this audit by DDA.

Respectfully submitted,

Thomas J. Barnickel III, CPA
Legislative Auditor

Table of Contents

Executive Summary 5

Background Information 7
Agency Responsibilities 7
Developmentally Disabled Services Delivery Process 7
Federal Liability 9
Status of Findings From Preceding Audit Reports 10

Findings and Recommendations 11

Consumers' Services
* Finding 1 – DDA Did Not Have Procedures to Verify That Consumers Received Required Services and That Documentation of Consumers' Medical Assistance Eligibility Reassessments Was Obtained 11

Federal Funds
Finding 2 – DDA's Methodology for Determining Federal Reimbursement Rates Did Not Reflect the Costs Incurred 13
* Finding 3 – DDA Did Not Have Adequate Procedures to Ensure That Providers Submitted All Claims to Obtain Federal Fund Reimbursement 14
* Finding 4 – Federal Fund Reimbursement Requests Were Untimely Resulting in a Loss of Interest Income of $262,000 15
* Finding 5 – DDA Did Not Investigate Rejected Claims With Potential Federal Fund Reimbursements Totaling $2.2 Million 16

Contribution to Care
Finding 6 – DDA Did Not Ensure That Consumers' Contributions to Care Were Proper, Which Could Affect DDA's Payments to Providers 17

Alcohol Tax Funds
Finding 7 – DDA Allowed Certain Funds From an Increase in the Alcohol Tax to be Used for Purposes Other Than Those Specified in its Policies 18

Provider Payment Reconciliations
Finding 8 – DDA Did Not Adequately Monitor the Submission of Annual Provider Reports and the Related Reconciliation Process 19

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

Accounts Receivable
Finding 9 – DDA Did Not Bill Local Jurisdictions $1.4 Million for Their Share of Day Habilitation and Vocational Service Charges 21
Finding 10 – DDA Did Not Recover Provider Overpayments That Were Identified Through Certain Program Audits 22

Maintenance of Accounting Records
Finding 11 – DDA Did Not Maintain Documentation to Support Accounting Adjustments Recorded in the State's Records 23

Provider Consumer Information System (PCIS2)
* Finding 12 – Proper Security Access Controls Had Not Been Established Over Critical PCIS2 Data 24
* Finding 13 – Certain Security Measures Over the PCIS2 Production Database Were Not in Effect 25

Audit Scope, Objectives, and Methodology 27

Agency Response Appendix

* **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 (DDA)
October 2013

As a result of our audit, we determined that DDA's accountability and compliance level was unsatisfactory, in accordance with the rating system we established in conformity with State law.

- **DDA did not monitor service coordinators to ensure consumers received services in accordance with individual service plans and that annual federal Medicaid eligibility reassessments were performed (Finding 1).**

  DDA should monitor its contracts with resource/service coordinators to ensure all required duties are performed timely and documented.

- **DDA's methodology for determining certain federal reimbursement rates did not accurately reflect the costs incurred. Our testing of fiscal year 2011 and 2012 reimbursement rates for one program noted that DDA's reimbursable costs exceeded reimbursements by $2.4 million (Finding 2).**

  DDA should revise its reimbursement methodology as practicable to better reflect actual costs incurred.

- **DDA did not ensure that certain provider claims for prepaid services were submitted for processing (Finding 3) or that federal fund reimbursement requests were timely (Finding 4). Federal funds and interest income totaling as much as $5.5 million were not obtained or were lost.**

  DDA should implement a process to ensure that all provider claims for prepaid services are submitted timely and processed. DDA should also ensure that requests for federal fund reimbursement are made in a timely manner.

- **DDA did not investigate federal fund reimbursement claims totaling $2.2 million that were rejected due to the Department of Health and Mental Hygiene (DHMH) Medicaid system edits. Our tests of certain of these claims identified $820,000 that was recoverable had DDA investigated and resubmitted the corrected claims (Finding 5).**

  DDA, in conjunction with the DHMH, should take immediate action to ensure that rejected federal reimbursement claims are promptly investigated, resolved, and recovered.

- **DDA did not ensure the accuracy of provider reported consumers' contribution to care (CTC) amounts and, consequently, may have paid providers more than it was responsible for, since the impact of CTC is to reduce DDA's payments to providers. Specifically, OLA's comparison of total CTC recorded by providers in DDA's payment system was $4.8 million less than the CTC calculated by DHMH during the consumer's eligibility determination process (Finding 6).**

  DDA should ensure the accuracy of CTC amounts recorded in its payment system and investigate the aforementioned differences.

- **DDA allowed the use of $610,000 derived from an additional tax on alcoholic beverages to purchase 23 vehicles for consumers on its waiting list, even though its policies did not specifically allow such funds to be used to purchase vehicles (Finding 7).**

  DDA should ensure that funds are used for purposes specified in its policies.

- **DDA did not ensure that annual reports required from certain providers were submitted timely and contained all necessary information to perform year-end payment reconciliations to identify any overpayments or underpayments to providers. Program expenditures subject to this process totaled $648 million during fiscal year 2011 (Finding 8).**

  DDA should establish a process to ensure the timely submission of comprehensive annual reports from providers.

- **Accounts receivable processes were inadequate to ensure that all funds owed DDA were recovered. Specifically, DDA did not bill certain local jurisdictions at least $1.4 million, representing their portion of day habilitation and vocational services charges, as required by State law (Finding 9) and did not recoup at least $390,000 in overpayments identified through routine audits of provider records (Finding 10).**

  DDA should establish the necessary processes to ensure that all appropriate amounts due are billed and collected timely.

- **DDA did not maintain documentation to support certain accounting adjustments (Finding 11) and had not established proper security access controls over critical Provider Consumer Information System II (PCIS2) data (Findings 12 and 13).**

  DDA should maintain appropriate documentation to support accounting adjustments and properly restrict access to its system data.

Background Information

Agency Responsibilities

The Developmental Disabilities Administration (DDA) is an administration within the Department of Health and Mental Hygiene (DHMH). The mission of 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 support and services necessary to foster personal growth, independence, and productivity. DDA also administers the Court Involved Service Delivery System which is responsible for serving individuals committed to DHMH by the courts.

For persons with developmental disabilities and their families, DDA plans, develops policies and regulations, and funds a Statewide system of services. DDA coordinates its work with other government, voluntary and private health, education, and welfare agencies. DDA consists of a headquarters unit, four regional offices which administer community-based services, two forensic residential centers under the Court Involved Service Delivery System (the System), and two residential centers, the Holly Center and the Potomac Center. Separate audits are conducted of the Holly Center and the Potomac Center. A third residential center, the Rosewood Center, was closed on June 30, 2009. This audit included the headquarters unit, the four regional offices, and the System, as well as a determination of the status of the findings from the Rosewood Center's closeout audit which was issued on December 22, 2009.

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. According to the State's records, during fiscal year 2012, DDA's expenditures totaled approximately $805.5 million ($445 million general funds, $.5 million special funds, and $360 million federal funds). According to DDA's records, 24,092 individuals with developmental disabilities were served through its programs in fiscal year 2012.

Developmentally Disabled Services Delivery Process

Consumer Eligibility and Provider Services

To obtain DDA services, a consumer submits an application to a DDA regional office and, upon DDA's approval, the consumer is assigned a category based on priority; the consumer is then generally placed on a waiting list. The consumer then submits an application for medical assistance to DHMH's Medical Care

Programs Administration (MCPA). If the consumer is eligible for assistance, federal funding is available to cover a portion of the service costs. The consumer meets with a DDA contractor, referred as a resource/service coordinator, who is responsible for planning, coordinating, and monitoring all services delivered to the consumer. As part of this responsibility, the resource/service coordinator assists with developing an annual individual service plan that describes the particular care, including specific services, that the consumer is to receive from a provider. When funding becomes available, the resource/service coordinator notifies the consumer and facilitates finding an appropriate service provider.

Provider Payments

DDA has a prospective payment system whereby providers are paid prior to services being rendered based on estimates of the services to be provided. At year-end the providers submit records of actual services to DDA from which a reconciliation to payments previously made is performed by DHMH's Division of Cost Accounting and Reimbursements. In addition, the residential consumers are responsible for paying the provider for a portion of their services which is referred as "contribution to care." According to DHMH's records, DDA provider and resource/service coordinator payments for fiscal year 2012 totaled $789 million.

DDA classifies its expenditures as either fee payment system (FPS) or contractual payment system expenditures. FPS payments are for DDA's four rate-based programs – Community Residential, Day Programs, Supported Employment, and the Community Supported Living Arrangements (CSLA) – which are established in State law or regulations and are based on the consumer's level of need and location within the State. The computer system used to process these payments is the Provider Consumer Information System II (PCIS2). According to DHMH's records, fiscal year 2012 expenditures for FPS totaled $678 million.

The contractual payment system relates to DDA programs, such as Individual Support Services (ISS), in which the rates vary by individual and provider and are based on the recommendations of the provider and resource/service coordinator, which are reviewed and approved by DDA personnel. Contractual payments are processed through the DHMH General Accounting Division. According to DHMH's records, fiscal year 2012 contractual payment system expenditures totaled $111 million.

Federal fund reimbursements, which cover approximately half the costs related to Medicaid-eligible consumers, are processed by MCPA. DDA federal fund reimbursements totaled approximately $360 million during fiscal year 2012.

The following table describes the programs within the FPS and an example of a program within the contractual payment system.

Payment Systems and Related Programs	
Payment System/Program Name	**Program Description**
Fee Payment System	
Community Residential Programs	Provide habilitation programs in group homes (which serve 4 - 8 consumers) and alternative living arrangements (which serve 1 - 3 consumers) in residential neighborhoods.
Day Programs	Provide resources to teach consumers to acquire and maintain the self-care for daily living and the skills necessary for entrance into the work force.
Supported Employment Programs	Provide support necessary for consumers to work in competitive employment in the community.
Community Supported Living Arrangements (CSLA)	Provide support for consumers to live in their own home. This includes help with activities of daily living and assistance with medical needs.
Contractual Payment System	
Individual Support Services	Provide resources within the community so that consumers may live independently or semi-independently, or remain at home to avoid disruption to the family unit. This includes services such as respite care, which would not be available under existing programs.

Federal Liability

DDA has a federal liability of approximately $20.6 million for which State general funds will be needed to fund. In the fall of 2011, DDA was notified by the federal Department of Health and Human Services Office of Inspector General (DHHS OIG) that it intended to audit DDA based on potential DDA federal reimbursement overbillings for certain residential service costs. As a result, in December 2011, DDA suspended billing the federal government for these residential services. DDA recommenced billings in May 2012 after researching the issue and implementing appropriate billing changes.

DDA's research confirmed improper billing practices. Specifically, contrary to the terms of its federal Medicaid waiver for residential services, DDA failed to reduce from its federal reimbursement requests the consumers' contribution to care (CTC) and a portion of consumer room and board charges. The CTC is the amount that the provider received from the consumer based on the consumer's ability to pay (including income such as Social Security Disability Insurance). However, DDA had been overbilling the federal government because its reimbursement requests included the CTC and, for room and board, it had only reduced its billings by $210 per month rather than the required $375 per month.

In July 2012, DHHS OIG initiated an audit that covered the period from July 2009 through June 2012 and issued its final report on September 9, 2013. The audit reached the same conclusion as DDA's research and calculated that DDA had overbilled the federal government by $20.6 million. The audit report recommended that DDA refund the overbilled amount to the federal government. In July 2013, DHMH, on behalf of DDA, in response to an earlier draft report of this audit agreed with the DHHS recommendations to refund $20.6 million. As of September 12, 2013, DHMH had not formally responded to the final report, but has 30 days from the final report date to present any comments or additional information for consideration prior to the final federal determination.

Status of Findings From Preceding Audit Reports

Our audit included a review to determine the status of the 14 findings contained in our preceding audit report on DDA dated November 20, 2009. We determined that DDA satisfactorily addressed 7 of these findings. The remaining 7 findings are repeated in this report. These 7 repeated findings appear as 6 findings in this report.

Our audit also included a review of the status of the three findings contained in our December 22, 2009 closeout audit of the Rosewood Center, a budgetary unit of DDA. We noted that DDA satisfactorily addressed one finding that related to record keeping and inventory deficiencies over equipment. The two remaining findings related to the lack of documentation to support the disposition of donated funds, bank accounts, and gift cards. Although we were advised that efforts were made to address these issues, these efforts were unsuccessful. Considering that the Rosewood Center closed on June 30, 2009, and the transactions in question occurred at least four years ago, no further action appears warranted.

Findings and Recommendations

Consumers' Services

Finding 1
Developmental Disabilities Administration (DDA) did not have procedures to verify that consumers received services from providers as stipulated in the related individual service plans and that documentation for the consumers' Medicaid eligibility reassessments was obtained.

Analysis
DDA did not have procedures to verify that consumers received services from providers as stipulated in the annual individual service plans and that documentation was obtained for the consumers' Medicaid eligibility reassessments. DDA's primary method of verifying that consumer services were provided, such as to address medical, social, and recreational needs, was to contract with vendors referred to as resource/service coordinators.

As of June 30, 2012, DDA had contracts with 15 resource/service coordinators for which fiscal year 2012 expenditures totaled $30.5 million. These resource/service coordinators were responsible for monitoring 24,092 consumers with service expenditures totaling $759 million in fiscal year 2012. Our review noted the following conditions:

- DDA did not monitor the performance of these resource/service coordinators to ensure the delivery of services in accordance with the individual service plans. Specifically, DDA did not obtain reports of the coordinators' monitoring efforts and did not directly review resource/service coordinator records. Consequently there was a lack of assurance that the required medical, habilitative, or rehabilitative services specified in the individual service plans were provided. Similar conditions were noted in our preceding audit report.

  Our test of 16 consumers monitored by two resource/service coordinators in 2011 revealed that, for 5 consumers monitored by one coordinator, the records did not contain sufficient evidence that the coordinator verified the delivery of all required services. For example, this coordinator documented the required six-month monitoring visits by recording the results in the consumers' progress notes. However, the progress notes were general and focused on the overall well-being of the consumers, providing few details to support that the coordinator had determined that services required by the consumers' individual plans were provided.

- DDA did not ensure that the resource/service coordinators performed annual eligibility reassessments resulting in a loss of Medicaid funds for certain DDA consumers. Specifically, according to DDA records, as of July 2012, 28 consumers had lost Medicaid eligibility as early as March 2009, because the resource/service coordinators did not provide the required eligibility reassessment documentation in a timely basis.

  Our test of 10 of these consumers disclosed that no action was taken to ensure that the resource/service coordinators had performed the reassessments and that the reassessments were overdue for periods of 11 to 37 months. Furthermore, for 6 of these consumers, DDA records contained correspondence from the Department of Health and Mental Hygiene's (DHMH) Division of Eligibility Waiver Services (DEWS) alerting DDA that the reassessments were not performed and that eligibility would be terminated after the annual reassessment dates; however, no DDA follow-up was evident. The value of the unreimbursed federal funds for these 10 consumers was $251,500. The use of State general funds will be required to the extent federal reimbursement is not obtained. Similar conditions were noted in our prior audit report.

Recommendation 1
We recommend that DDA ensure that consumers receive the stipulated services and that resource/service coordinators perform all required duties. Specifically, we recommend that DDA

a. establish procedures to verify, at least on a test basis, that the resource/service coordinators are ensuring that services are provided as required in the individual service plans and that adequate documentation is maintained (repeat);
b. monitor its resource/service coordinators to ensure that annual reassessments of consumers are performed, as required by federal regulations (repeat); and
c. determine if eligibility can be restored to the aforementioned 28 consumers and if federal reimbursement can be obtained for services provided to these consumers (repeat).

Federal Funds

Background

DDA's federal fund revenue, which totaled approximately $360 million during fiscal year 2012, consists almost entirely of Medicaid reimbursements. DDA has two Medicaid waivers with the federal government that specify the medical and

financial requirements that consumers must meet for Medicaid eligibility, and that require DDA to certify that the consumers are Medicaid eligible. Payments for services provided to Medicaid-eligible clients are initially funded by DDA with State general funds, and federal fund reimbursement is subsequently requested on a monthly basis, which covers approximately half the cost. The majority of reimbursement requests are submitted electronically, via DDA's Provider Consumer Information System II (PCIS2), to the Department of Health and Mental Hygiene's (DHMH) Medical Care Programs Administration (MCPA). MCPA processes the related requests for federal reimbursement through its Medicaid Management Information System (MMIS II).

Finding 2
DDA's methodology for determining federal reimbursement rates for contractual payment system expenditures did not accurately reflect the costs incurred. For one large program, reimbursements received were $2.4 million less than actual reimbursable costs for a two-year period.

Analysis
DDA's methodology for determining federal reimbursement rates for contractual payment system expenditures did not accurately reflect the costs incurred. The rates for these DDA programs, such as Individual Support Services (ISS), vary by individual and provider. Our review of the ISS program noted that DDA's related reimbursable costs exceeded its reimbursements by $2.4 million in fiscal years 2011 and 2012. In addition, DDA could not provide documentation supporting its rate calculations and substantiating that the rate calculations had been reviewed and approved by supervisory personnel. Expenditures for the ISS program totaled $109 million during fiscal years 2010 through 2012.

Annually, DDA determined a monthly consumer rate to bill the federal government for contractual payment system expenditures. However, this resultant billing rate was understated because each year's rate was calculated based on prior year consumer costs, without adjustments for actual costs, which historically have risen each year (as evidenced by the continually increasing federal fund reimbursable rates).[1] Furthermore, DDA included all consumers in its consumer cost calculation rather than just including Medicaid-eligible consumers.

---

[1] The evidence that costs continue to increase is that DDA annually increases its federal fund reimbursable rate which is a reflection of the costs paid to the provider. For example, the reimbursable rate for ISS increased eight percent from fiscal year 2011 to 2012.

We compared the 2011 and 2012 reimbursement requests for the ISS program, each of which was based on the prior year's average cost for all consumers, to the actual costs of those programs for Medicaid-eligible consumers. We noted that DDA's actual reimbursable costs exceeded the reimbursements received by $2.4 million.

DDA management advised that federal regulations allow DDA to establish a methodology for determining its costs for eligible consumers for purposes of obtaining federal reimbursement. Since its current methodology had been used for a number of years, it is uncertain whether the federal government would agree to a change in methodology.

Recommendation 2
We recommend that DDA

a. **attempt to revise its reimbursement methodology for contractual payment system expenditures to better reflect actual costs incurred and to maximize recovery of federal funds,**
b. **maintain documentation to support the contractual payment system reimbursement rate calculation, and**
c. **establish procedures to ensure that contractual payment system reimbursement rates are independently reviewed and approved.**

Finding 3
DDA did not have adequate procedures to ensure that providers submitted all claims for contractual payment system expenditures to obtain subsequent federal fund reimbursements.

Analysis
DDA did not have adequate procedures to ensure that providers submitted all contractual payment system expenditure claims for federal reimbursement. Our testing of the ISS program disclosed that DDA may have lost the opportunity to claim as much as $5.2 million in federal funds.

Specifically, DDA's procedure for the contractual payment system was to prepay the providers for anticipated services based on a percentage of the contract value. The providers were required to submit claims for actual services rendered either to DDA or to MMIS II for billing the federal government. However, DDA did not monitor the providers to ensure they actually submitted the claims to either DDA or MMIS II. Furthermore, since the providers were paid in advance, the providers did not need to submit the claims to receive their payments.

We reviewed the payments made to providers and the federal reimbursements received for the ISS program during fiscal years 2010 through 2012. Our review disclosed that claim documentation for approximately $10.4 million of the $32.8 million in prepayments made for claim-eligible services was not submitted by the providers either to DDA or MMIS II for federal reimbursement. As a result, DDA may have lost the opportunity to claim as much as $5.2 million in federal funds (50 percent of the $10.4 million). For example, we noted that certain providers had not submitted claims for extended periods. Our test of 10 providers disclosed that 5 providers did not submit any claims for a total of 17 service months; these unsubmitted claims related to a total of $448,000 in services that were prepaid by DDA. Although DDA advised that a portion of the claims that we identified related to specific services that were not Medicaid-eligible and, therefore, could not be reimbursed, DDA could not identify the ineligible services and related costs.

Since federal law only allows claims to be submitted for reimbursement within two years of the State's expenditures, and this payment procedure is used for other DDA contractual payment programs, DDA should promptly assess the impact this finding has on federal reimbursements for other programs. A similar condition was commented upon in our preceding audit report.

Recommendation 3
We recommend that DDA

a. **implement a process to ensure that all provider claims for prepaid services under the contractual payment system have been submitted to DDA or MMIS II for federal reimbursement (repeat), and**
b. **follow up on the $5.2 million in potential federal fund reimbursements to ensure that eligible claims are submitted and processed for federal reimbursement.**

Finding 4
Federal fund reimbursement requests were not made timely, resulting in a loss of interest income of $262,000.

Analysis
Federal fund reimbursement requests were not always timely, resulting in lost income to the State's General Fund of approximately $262,000 during the period from July 2009 through February 2012. Specifically, our test of 32 federal fund reimbursement requests which (for the federal portion) totaled approximately $789 million, disclosed that $89 million in reimbursement requests were made from 1 to 19 months after the claims could have been submitted for reimbursement. For example, in December 2011, DDA's reimbursement request

contained $27.6 million in claims that were made 1 month to 12 months after DDA could have submitted the claims, resulting in the loss of interest income totaling $26,700. In this regard, State general funds, which would have been otherwise available for investment, were used to finance federal fund expenditures. A similar situation was commented upon in our preceding audit report.

DDA management personnel were unable to explain why the submissions were not timely.

Recommendation 4
We recommend that DDA ensure that future requests for federal fund reimbursements are made in a timely manner (repeat).

Finding 5
DDA did not investigate rejected claims with potential federal fund reimbursements totaling $2.2 million.

Analysis
DDA did not investigate federal fund reimbursement claims that were rejected by MMIS II as part of its automated eligibility edit functions. Such rejected reimbursements related to 36,194 claims and totaled approximately $2.2 million in fiscal years 2011 and 2012.

In this regard, when MMIS II rejected claims for various reasons, such as because the consumer or provider was not eligible on the date of service, DDA advised that it generally did not determine the cause of the rejections so the issues could be resolved and the claims resubmitted for reimbursement. Our review of 17,327 rejected claims, which were selected for review based on the frequency of particular rejection codes, noted that $820,000 was recoverable had DDA investigated and resubmitted the corrected claims. Specifically, we noted the following conditions:

- One provider was responsible for 8,587 of these rejected claims with federal reimbursement claims totaling $536,000 during a 23-day period in November 2010. These rejections occurred because MMIS II indicated that the provider temporarily lost Medicaid eligibility. Upon our bringing this to the attention of DDA management, these claims were resubmitted for reimbursement and DDA received reimbursement on September 14, 2012. DDA and MCPA personnel were unable to explain why the provider lost Medicaid eligibility. Similar conditions were commented upon in our three preceding audit reports.

- MMIS II rejected 8,740 claims for federal reimbursement totaling $284,000 because it erroneously identified them as conflicting with other claims. In 2010, DDA noted the error and, in conjunction with MCPA, modified MMIS II so that similar future claims were not rejected. However, DDA did not resubmit the erroneously rejected claims even though, at the time, they were within the period that rejected claims could have been resubmitted. Since more than two years have now elapsed since the dates of service, federal regulations prohibit reimbursement requests for these claims and, consequently, these funds are lost. DDA management personnel were unable to explain why these erroneously rejected claims were not resubmitted. A similar condition was noted in our preceding audit report that DDA lost the opportunity to obtain federal funds because claims were not corrected and resubmitted within required time frames.

Recommendation 5
We recommend that DDA, in conjunction with MCPA,

a. take immediate action to ensure that rejected federal fund reimbursement claims are timely investigated, resolved, and recovered (repeat); and

b. maintain documentation supporting its actions taken to resolve rejected claims (repeat).

Contribution to Care

Finding 6
DDA did not ensure that the consumers' contribution to care amounts for residential services were proper, which could affect the amounts of DDA's payments to providers.

Analysis
DDA did not ensure the accuracy of the consumers' contribution to care (CTC) amounts recorded in PCIS2, which affect the amounts of DDA's payments to providers. CTC relates to the amount consumers in fee payment system (FPS) residential services are required to pay the providers for their care. DDA's payments to the provider are reduced by the CTC amounts.

Under DDA's payment process, the providers received CTC directly from the consumers' payers (such as from the U.S. Social Security Administration), and recorded the CTC into PCIS2 without any verification from DDA. Specifically, DDA did not compare the provider-recorded amounts with the CTC calculated by

DEWS during each consumer's eligibility determination process. Consequently, DDA could be paying more for consumers' care than it is responsible for.

We compared the total CTC recorded by the providers in PCIS2 and the CTC calculated by DEWS for eligibility purposes for the period from January 2009 to February 2012. We noted the providers recorded that the consumers had paid $21.4 million, while DEWS had calculated the consumers' ability to pay at $26.2 million—a difference of $4.8 million. We were advised by DDA management that providers may record less CTC than the amount calculated by DEWS because providers used some of those funds for uncovered services (such as dental work). However, neither DHMH's policy nor DDA's payment policy provide for such adjustments of the DEWS-calculated CTC.

Subsequent to our review, we were advised that DDA intends to modify its CTC procedures so that DEWS, rather than the providers, will record the calculated amounts in PCIS2.

Recommendation 6
We recommend that DDA

a. ensure the accuracy of CTC receipt amounts recorded in PCIS2, and
b. investigate the aforementioned differences and take appropriate action.

Alcohol Tax Funds

Finding 7
DDA allowed certain funds derived from a tax increase on alcoholic beverages to be used for purposes other than those specified in its policies.

Analysis
DDA allowed the use of funds derived from an additional tax on alcoholic beverages for purposes that were not specified in its policies. According to DDA records, a portion of the funds budgeted in fiscal year 2012 to provide certain consumers on the waiting list with services of short duration (SSD) were used to purchase 23 vehicles for consumers. These vehicles individually cost more than $15,000 and collectively cost $610,000. According to DDA policies, SSD are individualized support services that should be simple and meaningful, and that are intended to prevent an immediate crisis and avoid future crises. DDA's detailed policies specified the allowable uses of the SSD funds, including vehicle and housing adaptations; however, the policies did not specifically allow SSD funds to be used to purchase vehicles.

We were advised by DDA personnel that the vehicle purchases were emergency procurements and, therefore, the standard policies were not followed. However, its policies did not define what constituted an emergency situation and did not contain provisions that allowed for policy deviations for those situations. Furthermore, our review of five vehicle purchases ranging in cost from $30,600 to $41,300 and totaling $188,000 disclosed that, although there was documentation indicating the need for transportation for the consumers, there was no indication that DDA had authorized the purchases based on the existence of an emergency.

Senate Bill 994 of the 2011 General Assembly Session increased the State's alcoholic beverage tax from six percent to nine percent. This tax increase funded a fiscal year 2012 supplementary appropriation of $15 million for individuals in the crisis prevention and crisis resolution categories of DDA's consumer waiting list. DDA provided applicable individuals in crisis resolution with full DDA services and those in crisis prevention with SSD. According to DDA records, fiscal year 2012 SSD expenditures totaled $10.9 million for approximately 1,100 consumers. In fiscal year 2013, the SSD program was discontinued.

Recommendation 7
We recommend that DDA ensure that funds are used for purposes specified in its policies.

Provider Payment Reconciliations

Finding 8
DDA did not adequately monitor the submission of annual provider reports and the related payment reconciliation process.

Analysis
DDA did not ensure that annual reports required from FPS providers were submitted timely and contained all information needed to perform the year-end payment reconciliations. Additionally, DDA did not adequately monitor the timely completion of the payment reconciliations performed by DHMH's Division of Cost Accounting and Reimbursement (DCAR). State law and regulations require that providers annually submit reports that contain cost and attendance data as well as independently certified attendance reports. Since DDA pays providers prior to services being rendered based on certain estimates (such as attendance) these reports are used by DCAR to determine any underpayments or overpayments based on actual services provided. FPS program expenditures subject to the reconciliation process totaled $648 million during fiscal year 2011.

Our review of the submission of these reports and the reconciliation process noted the following conditions:

- DDA did not routinely follow up with providers who did not submit the annual cost reports within six months of the fiscal year end as required by State law and whose independently certified attendance reports did not include the number of days that consumers obtained services. Our review of the reports due for 2010 and 2011 disclosed that, as of May 1, 2012, 17 reports for fiscal years 2010 or 2011 due from providers that received payments totaling $9.8 million had not been submitted; however, DDA had only followed up with one provider to request the delinquent report. In addition, our test of the certified annual attendance reports for 45 providers noted that 24 reports did not include the number of attendance days and DDA did not initiate any follow-up to obtain the required information. For these 24 attendance reports, the certifications stated that the providers' attendance numbers were accurate; however, the reports did not include the actual number of attendance days that had been certified by the independent accountants. Consequently, DDA lacked assurance that the numbers of days reported by the providers, which were used to perform the payment reconciliations, were the same numbers certified by the accountants.

- DDA did not adequately monitor the fiscal year-end payment reconciliations performed by DCAR to ensure their timely completion. We tested 24 reconciliations for fiscal year 2010 which identified overpayments totaling $3.9 million. Our test disclosed that 9 reconciliations, with overpayments totaling $1.2 million, were completed between 42 and 108 days after the one-year period established by law. Because of certain provisions of State law, the untimely completion of the reconciliations increases the risk that overpayments identified are not recovered. Specifically, State law provides that when a reconciliation is not completed within one year of the cost report's submission, the provider's cost report determination is considered final. As of August 2012, $415,000 was outstanding relating to 5 of the aforementioned 9 reconciliations.

Recommendation 8
We recommend that DDA

a. establish a process to follow up with providers who do not submit required reports on a timely basis,

b. ensure that the certified independent attendance reports include the number of attendance days, and

c. establish monitoring procedures to help ensure timely completion of the year-end payment reconciliations.

Accounts Receivable

Finding 9
DDA did not bill four local jurisdictions for their share of day habilitation and vocational service charges totaling $1.4 million.

Analysis
DDA did not bill 4 of the 24 local jurisdictions for their share of day habilitation and vocational service charges totaling $1.4 million. Effective in 1987, State law required DDA to use local funds to pay for a specific portion of day habilitation and vocational services provided by DDA providers. The law limited the amount to be paid to DDA for these services to the amount paid by each jurisdiction in 1984 which, according to documentation from 1987, totaled approximately $2.7 million. Our review disclosed the following conditions:

- Two jurisdictions that annually owed DDA a total of $210,000 for day habilitation and vocational services have not been billed since at least 2007. The lost revenue from these jurisdictions for the period from 2007 through 2012 totaled approximately $1.3 million. Furthermore, according to DDA management, due to the lack of available records, it is uncertain whether these jurisdictions were billed prior to 2007.

  DDA management advised us that the failure to bill these jurisdictions may have been appropriate if the jurisdictions had directly paid the providers rather than DDA. At our request, DDA management contacted these two jurisdictions and was informed that, for part of the period, they had paid the providers directly. However, as of May 2013, DDA could not substantiate this and could not demonstrate that this would have been permissible under State law.

- One jurisdiction's fiscal year 2011 billing totaling $61,500 was incorrectly cancelled because of a dispute over the identity of the responsible governmental unit within the local jurisdiction. Subsequently DDA determined that the billing was accurate but did not reinstate the receivable.

- One jurisdiction was not billed for fiscal years 2010 through 2012 and, consequently, DDA was not paid $34,500.

DDA management advised us that this matter was being discussed to determine the course of action to be taken. As of May 2013, this matter had not been resolved.

Recommendation 9
We recommend that DDA
a. **bill the local jurisdictions as appropriate in accordance with State law; and**
b. **in conjunction with legal counsel, investigate and pursue the unbilled amounts and take appropriate action.**

Finding 10
DDA did not recover provider overpayments that were identified through audits related to the Community Supported Living Arrangement (CSLA) program.

Analysis
DDA did not recover provider overpayments which we estimated to be at least $390,000 that were identified through audits of CSLA provider records. Specifically, DDA contracted with a vendor to perform periodic audits of claims paid for services related to its CSLA program. For selected consumers, the auditors compared the number of hours for which the providers were paid, according to DDA records, with the number of hours that services were rendered, according to provider records, to determine if there were overpayments.

Our review of all of the CSLA audits performed that identified overpayments for fiscal years 2010 and 2011 claims noted that there were 74 overpayments which we estimated totaled at least $390,000. As of July 2012, DDA had not taken any action to collect these overpayments. For 58 of these overpayments, totaling $253,000, no action had been taken for at least eight months. DDA management advised us that it had not followed up on these audit results because certain of the audit reports did not include the overpayment amounts, but simply reported the excess hours billed by providers.

In fiscal year 2011, there were 1,763 CSLA consumers with payments for services totaling $67.5 million; DDA's audit vendor performed 354 CSLA consumer audits.

Recommendation 10
We recommend that DDA
a. **take timely action to recover overpayments identified through CSLA audits, and**
b. **require its audit vendor to include the value of overpayments in its reports.**

Maintenance of Accounting Records

Finding 11
DDA did not maintain documentation to support accounting adjustments recorded in the State's records.

Analysis
DDA did not maintain documentation to support journal entries that adjusted expenditures recorded on the State's accounting records. Specifically, our test of adjustments totaling $31.7 million from five expenditure journal entries processed in fiscal years 2011 and 2012 disclosed that adjustments from four journal entries totaling $31 million were not supported. The only documentation for these journal entries was instructions to process them.

Generally, these journal entries either transferred expenditures between general and federal funds or between fiscal years. Such journal entries may be appropriate. For example, DDA initially charges all expenditures to general funds and, upon receipt of the related federal funds, processes an adjusting journal entry to reallocate the expenditures. However, without support for these transactions, DDA cannot demonstrate that federal fund expenditures or the fiscal years' appropriations were properly charged.

In response to concerns noted by DDA in its fiscal year 2011 closeout process, and which we commented upon in our *Statewide Review of Budget Closeout Transactions for Fiscal Year 2011,* dated January 2012, DDA contracted with a forensic auditor to review its closeout processes for fiscal years 2007 through 2011. In July 2012, the auditor issued a report that noted similar concerns to those noted above regarding unsupported journal entries. Specifically, the auditor tested 75 journal entries totaling $366 million during the aforementioned period and noted that 74 journal entries totaling $365 million were unsupported.

Recommendation 11
We recommend that DDA maintain adequate supporting documentation for all adjustments recorded in the State's accounting records.

Provider Consumer Information System

Background
DDA operates the Provider Consumer Information System II (PCIS2) which provides a mechanism for providers to access and enter program information into a centralized database using an Internet connection. For example, providers use

PCIS2 to determine payment rates and to enter consumer attendance information. DDA employees can also access PCIS2 via local area networks.

According to DDA's records, during fiscal year 2012, DDA processed provider payments using PCIS2 totaling approximately $678 million and, as of September 11, 2012, there were 1,084 system users of which approximately half were provider employees.

Finding 12
Proper security access controls had not been established over critical PCIS2 data.

Analysis
DDA did not establish proper controls over critical PCIS2 data (such as sensitive consumer information, service rates, and consumer attendance) used to process provider payments and to submit related federal fund reimbursement requests to MMIS II. Specifically, our review disclosed the following conditions:

- Although DDA had an informal policy requiring immediate deactivation of access to PCIS2 for terminated employees, the policy was not followed. Our test of all 37 DDA employees with PCIS2 access who had left DDA employment during the period from January 1, 2010 to September 13, 2012 disclosed that, as of September 17, 2012, 30 of these employees had logons that were not deactivated timely. For example, 15 of these logons remained active for periods ranging from 93 to 793 days after separation.

- DDA granted access capabilities to 290 provider employees that allowed them to modify critical demographic data (such as the spelling of consumers' names and consumer medical assistance data). Since DDA personnel are responsible for establishing client records and recording medical assistance information on the system, non-DDA personnel do not need and should not have modification access to these data. Furthermore, improper data modification could cause differences between demographic information in PCIS2 and MMIS II, thereby preventing or delaying DDA from obtaining federal reimbursement. A similar condition was commented upon in our two preceding audit reports.

Recommendation 12
We recommend that DDA establish proper security access controls over critical PCIS2 data. Specifically, we recommend that DDA

a. immediately deactivate user logons of terminated employees,
b. grant modification access capabilities to critical data only to individuals with a need for such access (repeat), and
c. immediately eliminate unnecessary modification access (repeat).

Finding 13
Certain security measures over the PCIS2 production database were not in effect.

Analysis
Certain security measures over the PCIS2 production database were not in effect. Specifically, we noted the following conditions:

- The database was not configured to log the use of critical database statements or privileges although the capability to perform such logging existed within the database software. These events should be logged and monitored to help ensure the security of this database. A similar condition was commented upon in our two preceding audit reports.

- We were advised that logs of modifications to many critical tables were reviewed; however, documentation to substantiate these reviews did not exist. A similar condition was commented upon in our preceding audit report.

- An unsecure service was enabled on the database that could allow users to run commands as a privileged user. This service was intended only to accept requests from the database server but, local users on the server hosting this database could execute commands using this service without authentication.

Accordingly, significant database security violations could go undetected, thereby permitting unauthorized or inappropriate activities to adversely affect the integrity of the database.

Recommendation 13
We recommend that DDA

a. **log all critical security related events for the PCIS2 database (repeat);**
b. **review all applicable database logs on a timely basis, investigate questionable items, document these reviews and investigations, and retain the documentation for verification purposes (repeat); and**
c. **determine if the unsecure service is needed and either disable this service or implement appropriate controls to mitigate the security risk of using this service.**

Audit Scope, Objectives, and Methodology

We have audited the Developmental Disabilities Administration (DDA) of the Department of Health and Mental Hygiene for the period beginning January 1, 2009 and ending February 28, 2012. The audit was conducted in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

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. The areas addressed by the audit included the waiting list initiative, federal funds, provider fee payment systems, procurements and disbursements for client services, and accounts receivable. We also determined the status of the findings contained in our preceding audit report on DDA, as well as our December 22, 2009 closeout audit of the Rosewood Center, a budgetary unit of DDA.

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, inspections of documents and records, and observations 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 audit of the Department's Office of the Secretary and Other Units. In addition, our audit did not include an evaluation of internal controls for federal financial assistance programs and an assessment of DDA's compliance with federal laws and regulations pertaining to those programs because the State of Maryland engages an independent accounting firm to annually audit such programs administered by State agencies, including the DDA.

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 findings regarding significant instances of noncompliance with applicable laws, rules, or regulations. Other less significant findings were communicated to DDA that did not warrant inclusion in this report.

As a result of our audit, we determined that DDA's accountability and compliance level was unsatisfactory. The primary factors contributing to the unsatisfactory rating were the significance of our audit findings, and the number of repeat audit findings from our preceding report. Our rating conclusion has been made solely pursuant to the aforementioned law and rating guidelines approved by the Joint Audit Committee. The rating process is not a practice prescribed by professional auditing standards.

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
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

October 1, 2013

Mr. Thomas J. Barnickel III, CPA
Legislative Auditor
Office of Legislative Audits
Department of Legislative Services
301 W. Preston Street, Room 1202
Baltimore, MD 21201

Dear Mr. Barnickel:

The Department of Health and Mental Hygiene (Department) respectfully submits the enclosed response to the Office of Legislative Audit's (OLA) draft report of the audit of the Developmental Disabilities Administration (DDA), covering the period from January 1, 2009 to February 28, 2012.

The unsatisfactory determination by OLA is consistent with our own internal assessment of the longstanding weaknesses in this agency. We have stated publicly that our commitment to Marylanders with disabilities includes rooting out and addressing challenges within the DDA. OLA's audit has provided important findings to support this effort.

In June, I appointed a new acting director for the DDA supported by experts from a national firm with experience turning around agencies that serve individuals with developmental disabilities. This new team is capable of identifying and understanding the many challenges facing our system and is actively working to address them. While their efforts will help to transform many aspects of the DDA's operations, a key focus of their work is addressing areas where we have historically had a lack of fiscal and operational controls, many of which resulted in audit findings documented in your draft report.

With a focus on improving the fairness and transparency of key policies, changes are being designed and implemented in consultation with advocates and providers. Some of the critical projects underway include strengthening internal leadership and controls within the agency, promoting consistency across regional offices, creating a more efficient and effective path for families to tailor services to each individual's needs, and developing a standard approach to audits of providers. The DDA's new leadership team along with the consulting team is developing a plan to modernize our fiscal system and improve accountability and compliance. Additionally, the plan includes a long-overdue review of provider rates to help increase standardization across the system.

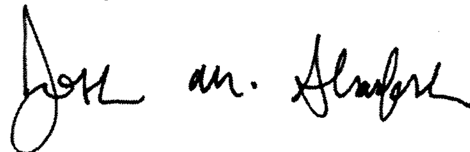
While every effort will be made to improve the system's operation, it is critical to note the underlying weaknesses associated with the DDA's statutory prospective payment system. These weaknesses, as highlighted by the Department of Legislative Services in their review of the DDA's 2014 budget, continue to impede the DDA's ability to achieve the fiscal control and stability necessary for a program of the DDA's size, scale and complexity. The system impacts the DDA's ability to accurately budget, reconcile payments against services delivered, and presents challenges for the timely and complete claiming for federal funds.

Despite all of these challenges, the DDA's support to Marylanders with intellectual and developmental disabilities has expanded significantly with almost 21,000 individuals currently receiving services. One finding highlights services of short duration provided to individuals in the Crisis Prevention category of the DDA's Waiting List. In 2012, the Alcohol Tax provided funding for an innovative program designed to invest in fulfilling the needs of these individuals so they may avoid crisis and remain in their homes and with family. DDA reviewed and approved key investments which changed the lives of individuals – allowing them to maintain employment, stay in school, and foster relationships in the community. These outcomes reflect the core values of the DDA.

Strengthening the DDA's fiscal and programmatic operations is critical to Maryland's ability to support individuals with intellectual and developmental disabilities. Addressing the findings contained in the audit in a manner that creates sustained and meaningful change is our priority. I am personally invested in the reform of the DDA and will work closely with the Administration to promptly address all audit findings and continue the transformation of the DDA. In addition, our Office of the Inspector General will follow-up on the recommendations to ensure compliance and remediate the unsatisfactory finding.

If you have any questions or require additional information, please do not hesitate to contact me at (410) 767-4639.

Sincerely,



Joshua M. Sharfstein, M.D.
Secretary

cc: Mr. Patrick Dooley, Acting Director, DDA
Mr. Thomas V. Russell, Inspector General. DHMH
Mr. Ellwood L. Hall, Jr., Assistant Inspector General, Audits, DHMH

Administration's Response to Findings and Recommendations

Consumers' Services

Finding 1
Developmental Disabilities Administration (DDA) did not have procedures to verify that consumers received services from providers as stipulated in the related individual service plans and that documentation for the consumers' Medicaid eligibility reassessments was obtained.

Recommendation 1
We recommend that DDA ensure that consumers receive the stipulated services and that resource/service coordinators perform all required duties. Specifically, we recommend that DDA

a. **establish procedures to verify, at least on a test basis, that the resource/service coordinators are ensuring that services are provided as required in the individual service plans and that adequate documentation is maintained (repeat);**
b. **monitor its resource/service coordinators to ensure that annual reassessments of consumers are performed, as required by federal regulations (repeat); and**
c. **determine if eligibility can be restored to the aforementioned 28 consumers and if federal reimbursement can be obtained for services provided to these consumers (repeat).**

Administration Response:

The DDA partially concurs with this finding and agrees that services specified in an individual plan should be provided and that resource coordinators should assess service delivery and work to minimize periods of ineligibility for federal funds by assisting individuals in filing the necessary applications. The DDA's legacy resource coordination system began transitioning in July 2013 to include increased monitoring and follow up activities, automated service delivery documentation, and standardized performance measures under Medicaid's Targeted Case Management. As part of the implementation, regulations were promulgated specific to service and operational requirements for resource coordination services. COMAR 10.09.48.06 requires resource coordinators as part of their monitoring and follow up activities to include an assessment of "services being rendered as specified in the individual plan" and "the individual's needs and supports to maintain eligibility for Medicaid, waiver, DDA services, and any other relevant benefits or services." Requirements of monitoring and follow up are specifically set forth in describing frequency based upon coordination service category and waiting list priority.

Yet, beyond assessing the need to maintain eligibility, it is not the sole responsibility of the resource coordinator to ensure that annual reassessments are performed. Individuals lose Medical Assistance and thus waiver eligibility for various reasons such as failure to provide information (e.g. bank statements, etc.), change in resources, and eligibility letter request for information sent to a wrong or bad address. While the DDA works closely with resource coordinators and providers to ensure individuals maintain eligibility and receive services, full attainment of federal funds may not be possible as the responsibility to apply and provide personal financial documents ultimately falls to the individual. The DDA is taking steps to maximize waiver enrollment and minimize provision of state funded services to individuals eligible for the waiver, yet the DDA will not cease providing services, potentially impacting an individual's health and safety, due to a lapse in eligibility. As a result, totally eliminating this issue may not be controllable.

a. The DDA has established a Resource Coordination Module within the Provider Client Information System (PCIS2) which includes a monitoring form template that must be completed at least quarterly. The module is currently in use with several providers and use will be expanded to all

resource coordination provider agencies through information capture through direct entry or upload from third party systems. Components of the monitoring template include assessing whether individuals are receiving all services identified in their plan at the time of the contact. It also includes a section related to eligibility for which resource coordinators must assess Medicaid eligibility, waiver eligibility, financial documentation needed to support eligibility, and recertification or reapplication of other benefits. Reports will be created to assess service delivery performance and compliance with regulations.

b. The DDA will monitor resource coordination providers' compliance with COMAR 10.09.48.04 which requires resource coordination agencies to support operational requirements including an submission of an annual quality plan which includes specific goals and performance measures including "resource coordinators will address continuous financial eligibility for waiver eligible individual's Medical Assistance 100% of the time".

   In an effort to achieve real time notification of loss of eligibility, the DDA receives an MMIS generated report that reflects people who have or will lose their eligibility. This report is shared with both the DDA's regional offices and resource coordination providers and must be thoroughly analyzed to determine follow up actions needed. The DDA will develop guidance for resource coordination providers and provider training related to their monitoring requirements, assessing the delivery of services as indicated in the plan, use of the MMIS report, and documentation of activities captured within DDA's PCIS2.

   The DDA will then follow up with each notified resource coordination provider to monitor their activities regarding re-enrollment. Although each of these entities is responsible for assisting and reminding the individual, it is ultimately the responsibility of the individual or family to submit the required application. Those families who are not responsive will receive letters from DDA indicating that their enrollment in services will be in jeopardy if they do not comply within 30 days.

c. DDA concurs with the recommendation and has investigated the status of the 28 people identified by OLA during the audit. All 28 were contacted by the DDA and provided information to reapply for the waiver. Of those 28, 17 were re-enrolled in the waiver (8 during the audit period), 4 were denied enrollment due to failure to provide information, 1 was overscaled (resource in excess of the financial eligibility criteria), 3 refused to apply, 2 left services, and 1 application remains pending at DEWS.

Federal Funds

Finding 2
DDA's methodology for determining federal reimbursement rates for contractual payment system expenditures did not accurately reflect the costs incurred. For one large program, reimbursements received were $2.4 million less than actual reimbursable costs for a two-year period.

Recommendation 2
We recommend that DDA

a. attempt to revise its reimbursement methodology for contractual payment system expenditures to better reflect actual costs incurred and to maximize recovery of federal funds,
b. maintain documentation to support the contractual payment system reimbursement rate calculation, and
c. establish procedures to ensure that contractual payment system reimbursement rates are independently reviewed and approved.

Administration Response:

The DDA concurs with this finding and recognizes that the methodology used to determine reimbursement rates for contractual payment system expenditures needs to be improved in order to maximize the recovery of federal funds for eligible costs.

a. The DDA is actively working to implement a revised reimbursement methodology for the contractual payment system. As recommended, the DDA will pursue a reimbursement methodology that reflects the full cost of providing services and aligns with the DDA's Community Pathways waiver. The waiver states:
    - Payment for non-rate-based services (i.e. FISS, assistive technology and adaptive equipment, environmental modifications, behavioral support services, etc.) are based on the specific needs of the individual and the piece of equipment, type of modifications, or service design and delivery method as documented in the IP.
    - Services are limited to those reimbursable under Medicaid. FFP will not be claimed for waiver services which are not included in the plan or that are covered by other resources, including Medicaid State Plan.

   On the basis of these requirements for the payment and reimbursement of non-rate-based services, the DDA will work with DHMH's Medicaid representatives and providers to develop a new reimbursement methodology. The DDA will have a revised methodology by March 1, 2014.

b. In parallel with the development of revised methodology, the DDA will maintain detailed documentation of the reimbursement rate calculation.

c. The DDA will establish procedures to have DHMH Medicaid staff perform an independent review of the final methodology and corresponding rates.

Finding 3
DDA did not have adequate procedures to ensure that providers submitted all claims for contractual payment system expenditures to obtain subsequent federal fund reimbursements.

Recommendation 3
We recommend that DDA

a. implement a process to ensure that all provider claims for prepaid services under the contractual payment system have been submitted to DDA or MMIS II for federal reimbursement (repeat), and
b. follow up on the $5.2 million in potential federal fund reimbursements to ensure that eligible claims are submitted and processed for federal reimbursement.

Administration Response:

The DDA concurs with this finding.

a. The DDA will establish a procedure with deadlines by which providers of contractual services will be required to submit federal claims. If claims are not submitted by these deadlines, the DDA will withhold a portion of the next payment, as allowed under Health –General §7-306.1(e) (2). The DDA Federal Billing Administrator will track via MMIS the status of the submitted claims and will review, with assistance from the provider and respective regional office, any denied FFP claim to provide additional information to facilitate correction and resubmission.

b. Of the $5.2 million in potential federal funds identified during the OLA analysis period, $1.3 million is not eligible for FFP because the services provided were not waiver eligible. Of the $3.9 million eligible for FFP, processed claims thus far have resulted in collection of $1.1 million in federal funds. The DDA's Federal Billing Unit continues to review the $2.8 million in remaining claims identifying missing information and working with providers to obtain the necessary information to support the submission of these claims. The DDA will continue to pursue submission of these claims up until 2 years from the date of service delivery as allowed under federal regulations.

Finding 4
Federal fund reimbursement requests were not made timely, resulting in a loss of interest income of $262,000.

Recommendation 4
We recommend that DDA ensure that future requests for federal fund reimbursements are made in a timely manner (repeat).

Administration Response:

The DDA concurs in part with this finding.

In FY 2002, OLA cited potential loss of interest of $4 million. For the FY07-09 OLA audit period, the DDA was successful in reducing this amount down to $421,000 and for this audit this amount has been almost cut in half.

Because the DDA's prospective payment system requires the reconciliation of projected to actual attendance after payment has already been made, and providers are not required to certify their attendance records until the 30th of the month following service, there will always be a lost interest amount. The timeliness of certified attendance is also impacted by error reports which can be submitted after the certification deadline.

The DDA will initiate a more rigorous management of attendance certification timelines and will develop a process to appropriately levy the appropriate penalties under Health General §7-306.1(e1) which includes payment deviations, however, as stated above, the DDA has made substantial and significant progress in resolving this finding and under the current system, this amount will never be zero.

Finding 5
DDA did not investigate rejected claims with potential federal fund reimbursements totaling $2.2 million.

Recommendation 5
We recommend that DDA, in conjunction with MCPA,
a. take immediate action to ensure that rejected federal fund reimbursement claims are timely investigated, resolved, and recovered (repeat); and
b. maintain documentation supporting its actions taken to resolve rejected claims (repeat).

Administration Response:

The DDA partially concurs with this finding. During the audit period OLA identified 36,000 rejected claims, resulting in a potential federal fund reimbursement of $2.2 million. Of these rejected claims, OLA concluded that only 17,327 were eligible for federal reimbursement amounting to $820,000 in possible collections. The DDA has already resubmitted 8,587 claims and collected federal reimbursement totaling $536,000. The remaining 8,740 of denied claims representing $284,000 in federal reimbursement were not resubmitted for payment and are no longer eligible for reimbursement due to the two year time limit on resubmissions.

a. Since January 2013, DDA has enhanced the process and now reviews weekly reports of rejected claims, investigates the rejected claims, makes the necessary corrections and resubmits the claims for payment. The Federal Fund Billing Administrator tracks the claims and the subsequent payments.

b. Since January 2013, the Federal Fund Billing Administrator maintains a hard copy and an electronic copy of the files which document the review process and what action was taken to enable the resubmission of rejected claims.

Contribution to Care

Finding 6
DDA did not ensure that the consumers' contribution to care amounts for residential services were proper, which could affect the amounts of DDA's payments to providers.

Recommendation 6
We recommend that DDA
a. ensure the accuracy of CTC receipt amounts recorded in PCIS2, and
b. investigate the aforementioned differences and take appropriate action.

Administration Response:

The DDA concurs with this finding. Since the audit was performed, the DDA has undertaken a significant review of contribution to care and the potential differences in calculations based on federal regulations. Based on our analysis, the DDA's historic approach to contribution to care was not in alignment with certain instructions in the Medicaid rules. Moving forward, the DDA is aligning its process with these instructions. The key milestones in this process are to identify what the Medicaid guidelines are for contribution to care, and to implement a plan to require individuals and families to contribute these amounts.

a. The manner in which contribution to care payments were calculated for individuals receiving residential services was not consistent with Medicaid guidelines and federal regulations. The DDA has been working on a revised process to calculate contribution to care payments. In revising the current process, the goal has been to meet all state and federal requirements as well as provide clear guidance to individuals, families, and providers regarding their obligations. The DDA has been meeting with stakeholders on this process and expects to have a revised process that is compliant with federal guidelines implemented by late fall 2013 and the new system will ensure the accuracy of CTC receipt amounts recorded in PCIS2.

b. The differences between the calculations entered by providers in PCIS2 and the Division of Eligibility Services in the Medicaid Assistance program will be remedied through the revised process as described previously.

Alcohol Tax Funds

Finding 7 **DDA allowed certain funds derived from a tax increase on alcoholic beverages to be used for purposes other than those specified in its policies.**

Recommendation 7
We recommend that DDA ensure that funds are used for purposes specified in its policies.

Administration Response:

The DDA disagrees with this finding. The Services of Short Duration (SSD) initiative was launched in FY 2012 to provide an individually tailored set of services for individuals in the Crisis Prevention category of the DDA Waiting List. According to the SSD Manual provided to interested individuals, “The intent of Services of Short Duration is to help children and adults with developmental disabilities *avoid crisis situations* and to remain in their own or in their family home.” These services were not provided in response to specific emergencies but rather to prevent individuals from going into crisis.

The SSD Request for Services Forms lays out different categories for which an individual could apply for funding. These categories included specialized equipment, transportation, and an additional category for “other.” The SSD User Guide also specifically mentions “vehicle adaptations” as a specific use of these funds.

As part of this Manual, DDA acknowledged that there may be circumstances that warranted approving an individual grant over the set limit of $10,000. In these cases, “Understanding the unique needs and circumstances of each person, the DDA will utilize an exception protocol to meet funding requests above $10,000. Request will be reviewed and may be approved by the DDA.”

For requests above $10,000, the DDA applied the exception protocol as outlined in the SSD Manual. While some requests were denied, 23 vehicle requests were approved, as noted in the audit report, in accordance with the exception protocol contained in the SSD manual.[1]

---

1 Auditor’s Comment: As noted in the finding, we acknowledge that the purpose of the SSD program was to prevent a crisis situation. Previously, DDA represented that these vehicle purchases were emergency procurements, which DDA’s policy did not address. Regardless of the characterization of the purchases as “emergency” or “crisis,” the policy did not specifically provide for the purchase of vehicles, only for vehicle adaptations. Given the significant expenditures involved, it would seem reasonable that the policy would specifically identify vehicle purchases as an allowable use if that was the intent. Nevertheless, the SSD program has been discontinued.

Provider Payment Reconciliations

Finding 8
DDA did not adequately monitor the submission of annual provider reports and the related payment reconciliation process.

Recommendation 8
We recommend that DDA

a. **establish a process to follow up with providers who do not submit required reports on a timely basis,**
b. **ensure that the certified independent attendance reports include the number of attendance days, and**
c. **establish monitoring procedures to help ensure timely completion of the year-end payment reconciliations.**

Administration Response:

The DDA concurs with this finding.

a. The DDA will develop and implement a process to manage the submission of cost reports by late fall 2013. The process will outline an internal and external schedule detailing report submission timelines, contact periods to follow up with providers, and penalties in accordance with Health-General §7-306.1(e), (f) and (g).

b. The process to be developed and implemented will include a review of year end reports for completeness (i.e. presence of attendance dates among other requirements) and notification to providers when reports are insufficient.

c. Beginning September 2013, the DDA fiscal staff and the Division of Cost Accounting and Reconciliation (DCAR) staff initiated biweekly meetings to prioritize the audits to enable a more timely completion and to troubleshoot issues with individual reconciliations to facilitate DCAR's review. This process has enabled DCAR to address the back log of reconciliations pending from previous fiscal years.

Accounts Receivable

Finding 9
DDA did not bill four local jurisdictions for their share of day habilitation and vocational service charges totaling $1.4 million.

Recommendation 9
We recommend that DDA
a. bill the local jurisdictions as appropriate in accordance with State law; and
b. in conjunction with legal counsel, investigate and pursue the unbilled amounts and take appropriate action.

Administration Response:

The DDA partially concurs with this finding. Of the four (4) local jurisdictions identified by OLA, three (3) jurisdictions pay local share payments directly to the providers. The invoice for fourth identified jurisdiction was incorrectly cancelled and an invoice will be reissued by the DDA.

a. Health General §7-705 states that the DDA shall also use local funds to support day habilitation and vocational services. Although 21 of the 24 jurisdictions reimburse DDA for their local share paid to day habilitation and vocational services providers, notes identified in the DDA's files indicate that three counties pay their local share to providers directly. In FY 13, 21 of the 24 jurisdictions were invoiced and payments from 20 of these jurisdictions resulted in a collection of $2.4 million. The remaining county will be re-invoiced for their local share.

b. The DDA has contacted the three local jurisdictions to confirm that their local share is paid directly to the providers. If confirmation is unavailable or if this is no longer the arrangement, the DDA will consult with the Office of the Attorney General to determine if the DDA can pursue payment for previously unbilled amounts.

Finding 10
DDA did not recover provider overpayments that were identified through audits related to the Community Supported Living Arrangement (CSLA) program.

Recommendation 10
We recommend that DDA

a. take timely action to recover overpayments identified through CSLA audits, and
b. require its audit vendor to include the value of overpayments in its reports.

Administration Response:

DDA concurs with this finding.

a. In reviewing the previous utilization review and recovery process, the DDA identified gaps in reporting requirements, lack of clear rules regarding recoveries, inadequate reporting, and appeals process for providers. The DDA is developing an updated recovery process that will be used to collect funds corresponding to deficiencies in service provision identified through prior utilization reviews.

b. In order to remedy these deficiencies, the DDA has recently executed a contract for a new vendor to conduct Utilization Reviews of providers. As part of this new contract, the DDA is undertaking a comprehensive review of the audit, recovery, and appeals process. The DDA is developing this revised process in collaboration with the Department's Office of the Inspector General, the new vendor, and the provider community. The DDA expects that the new Utilization Review process will be implemented by late fall 2013 and will include the value of overpayments in its report.

Maintenance of Accounting Records

Finding 11
DDA did not maintain documentation to support accounting adjustments recorded in the State's records.

Recommendation 11
We recommend that DDA maintain adequate supporting documentation for all adjustments recorded in the State's accounting records.

Administration Response:

The DDA concurs with the finding.

The DDA has improved processes and now captures supporting documentation that forms the basis of all journal entries made in the accounting system (including federal funds splits, year-end accruals, etc.). For example, for fiscal 2013's year-end closing, backup documentation was maintained that includes the raw financial data which served as the basis for the year-end adjustments.

Provider Consumer Information System

Finding 12
Proper security access controls had not been established over critical PCIS2 data.

Recommendation 12
We recommend that DDA establish proper security access controls over critical PCIS2 data. Specifically, we recommend that DDA

a. immediately deactivate user logons of terminated employees,
b. grant modification access capabilities to critical data only to individuals with a need for such access (repeat), and
c. immediately eliminate unnecessary modification access (repeat).

Administration Response:

The DDA concurs with this finding.

a. Upon identification, the accounts indicated in this finding were deactivated. In September 2013, the DDA initiated a monthly review of all employees with active PCIS2 accounts to ensure timely termination of those that have separated from service. Additionally, the DDA has changed the feature in PCIS2 that automatically terminates accounts after one year of inactivity to 60 days as required by Department of Information Technology policy.

b. This finding focused on a discovery that service providers had the ability to modify all information on the demographics screen in PCIS2 for the people they served. Access was intended to allow them to change a person's address only, not the complete file including Medical Assistance numbers. The ability to modify critical data is now only granted to users within the DDA that have a need for such access.

c. Upon discovery, the privilege that allowed providers to modify information in the demographics screen in PCIS2 was revoked. The only people that have rights to modify this information now are DDA's regional office staff. All modifications to critical data within the PCIS2 are maintained in the systems journal tables are reviewed on monthly basis to ensure no inappropriate modifications have been made.

Finding 13
Certain security measures over the PCIS2 production database were not in effect.

Recommendation 13
We recommend that DDA

a. log all critical security related events for the PCIS2 database (repeat);
b. review all applicable database logs on a timely basis, investigate questionable items, document these reviews and investigations, and retain the documentation for verification purposes (repeat); and
c. determine if the unsecure service is needed and either disable this service or implement appropriate controls to mitigate the security risk of using this service.

Administration Response:

The DDA concurs with this finding.

a. The feature that logs all security related events for the PCIS2 was turned on following the prior audit finding in 2009. In October of 2011, the Administration upgraded to a newer version.. During this upgrade, the audit log feature was inadvertently turned off. Upon discovery in December 2011, the software feature that logs critical database statements or privileges that had been turned off was turned back on. All security related events are currently logged.

b. The DDA will coordinate with the Department's Office of Information Technology to develop a process for independent review of all applicable logs and the maintenance of related documentation by late fall 2013.

c. The unsecure service noted in this finding has been disabled and no longer poses a security risk.

Audit Team

Joshua S. Adler, CPA, CFE
Audit Manager

Richard L. Carter, CISA
Information Systems Audit Manager

James M. Fowler
Senior Auditor

John C. Venturella
Information Systems Senior Auditor

Michael A. Klausmeier
Sandra C. Medeiros
Evan E. Naugle
Peter Rorick
Matthew D. Straw
Staff Auditors

Colin S. Rau
Staff Auditor Intern