TESTIMONY BEFORE THE HOUSE
COMMITTEE ON HUMAN SERVICES
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Thank you the opportunity to testify on the results of our designated agency audit.[1] This audit had two objectives. First, to summarize how the Department of Disabilities, Aging and Independent Living (DAIL) and the Department of Mental Health (DMH) fund developmental disability and mental health services provided by the designated agencies (DAs) and ensure that clients receive the expected services. Second, to determine whether DAs have received duplicate payments from Medicaid for services provided.

I believe that you have been provided with a copy of our final report. With your permission, I would like to take a few minutes to summarize our results for both objectives as well as to summarize our recommendations and DAIL and DMH's responses.

Objective 1

There are three primary ways in which DAIL and DMH fund developmental disability (DD) and mental health (MH) services performed by the 11 DAs.

- Fee-for-service claims are paid based on one specific service being performed on a given day for a given client.
- Capacity payments are a specific amount provided to a DA to allow them to have the ability to perform a specific function (e.g., MH crisis beds).
- Inclusive rates[2] cover groups of services under a single payment for a given period of time and, in some cases, for a specific client.

Attachment 1 summarizes the DAIL developmental disability and DMH mental health programs that fund DA-provided services. In total, the departments paid the DAs about $264 million for these programs for services performed in fiscal year 2013—$132 million each for DAIL and DMH programs.[3]

As it pertains to how DAIL and DMH ensure that clients receive expected services, both departments had mechanisms in place to oversee the DAs, including a process to re-designate DAs every four years—attachment 2 summaries the departments' oversight mechanisms. However, neither DAIL nor DMH routinely compared budgeted to actual services for the

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1 http://auditor.vermont.gov/sites/auditor/files/Final%20DA%20report%20II%2010.31.2014.pdf

2 The name of the rate depends on the program. For example, the CRT program refers to a case rate while the DD HCBS program uses the term "bundled service rate." For simplification purposes, we use the term "inclusive rate" in our report.

3 In total, the State paid the 11 DAs almost $302 million for services with dates of service in fiscal year 2013. Appendix III in our report lists the amount paid to each DA.

programs for which DAs receive an inclusive rate. Without a comparison of budgets to actuals for the clients in these types of programs, neither DAIL nor DMH are positioned to know whether the actual services provided are consistent with those approved and the State could be paying too much or too little for the services actually performed.

Objective 2

We used an automated data analysis tool to identify potential duplicate paid claims for Medicaid services provided in fiscal year 2013 and visited three DAs to review supporting documentation and obtain explanations.[4]

While the three DAs at which we performed detailed test work were paid for some duplicate Medicaid claims, we did not find evidence of widespread payments for duplicate services.[5]

Nevertheless, we observed four types of conditions that resulted, or could have resulted, in the State paying for duplicate services. Specifically, DAs were sometimes paid for an inclusive rate service as well as for a separate service covered by this rate or were inappropriately paid when clients were in a nursing facility or hospital. In other cases, DMH paid multiple providers for the same type of service for the same client on the same dates of service. Lastly, under certain circumstances, DAs can be paid for second and subsequent instances of the same mental health service provided to the same client on the same day. In over half of the 180 claim sets we reviewed related to these types of claims, the DA documentation was not specific enough to draw a conclusion about whether a separate service had been provided or whether the billings were duplicative or otherwise unallowable.

As part of this second objective, we also reviewed the controls the DAIL and DMH employed to prevent or detect duplicate payments. In summary, while these departments utilized policies, system edits, and periodic post-payment reviews, each of these techniques warrants improvement. For example, some DAIL and DMH billing prohibitions cannot be detected unless supporting documentation is reviewed, but the scope of the current DAIL and DMH reviews of DA documentation that support their billed services was limited.

Recommendations

We made six recommendations to DAIL and five recommendations to DMH. The departments generally agreed with our recommendations and cited specific actions they planned to take. We have not performed any work at DAIL or DMH since our report was issued so we do not know the status of their planned actions. Attachment 3 summarizes the issues, recommendations, and departmental responses.

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[4] The three DAs visited were Health Care and Rehabilitation Services of Southeastern Vermont, HowardCenter, and Washington County Mental Health Services, which accounted for about half of the state expenditures to the DAs. In total, we reviewed about 2,400 potential duplicate claim lines at the three DAs.

[5] We defined duplicates payments as those inappropriately made for (1) the same or similar type of service provided on the same day on behalf of the same client, (2) services paid on a per-service basis for a client who is also enrolled on the same day in a similar program that is funded on an inclusive rate basis, and (3) services paid to a DA for a client who is receiving services in a facility (e.g., hospital).

Description of DAIL Developmental Disability and DMH Mental Health Programs and the Basis for Payments to the DAs

Program	Description of Program	Funding Type	Basis of Payments to DAs	Fiscal Year 2013 Expenditures (in millions)[a]
DAIL Developmental Disability Services				
DD Home and community based services (HCBS)	Provides home supports, work and community supports, service coordination, respite, clinical, and crisis services for children, adolescents, and adults.	Inclusive rate	Daily rate, approved by DAIL, for each individual client based on the individual's service plan.[b]	$128.0
The Bridge Program	Support to families in need of care coordination to help them access and/or coordinate medical, educational, social, or other services for children under the age of 22.	Inclusive rate	Monthly rate, approved by DAIL, based on the number of children enrolled in the program at a DA.	$0.7
Flexible Family Funding	Cash grants for children and adults that help the biological or adopted family or legal guardian support the person to live at home.	Capacity payment	Set amount (budget) to the DA paid quarterly that, in turn, is distributed to clients as cash payments.	$1.0
DD Targeted Case Management (TCM)	Service coordination, referral, monitoring, and advocacy to assist adults and children to gain access to needed services.	FFS	DAs bill separately for each individual service provided.	$0.4
Intermediate Care Facility/ Developmental Disabilities	Highly structured residential setting for up to six people needing intensive medical and therapeutic services.	Inclusive rate	One DA receives a per-diem rate paid every two weeks to cover necessary and ordinary costs related to a resident's care.	$1.2
Other	Various	Various	Various	$0.4
DMH Mental Health Services				
Community Rehabilitation and Treatment (CRT)	An array of rehabilitation, emergency, diagnosis-specific treatments, crisis stabilization, and support services to adults who have severe and persistent mental illness.	Capacity payment and Inclusive rate	DMH sets a yearly budget for each DA. Quarterly, the DA receives 1/4 the budgeted amount for capacity. Each month, the DA receives 1/12 the amount budgeted for treating clients, which may be adjusted based on actual services provided.	Capacity: $3.4 Inclusive rate $36.4
Adult Outpatient	Assessments, case management, and therapy to adults who experience non-severe mental health problems that disrupt their everyday lives.	Capacity payment and FFS	Set amount (budget) to the DA paid quarterly for capacity. FFS is based on individual services provided.	Capacity: $1.0 Fee-for-Service: $2.2
Other adult Services	Residential treatment programs, psychiatric care, and outreach services for adults.	Capacity payment	Set amount (budget) paid to the DA.	$9.7
Emergency Services	Assessment, support, and referral services to anyone of any age experiencing a crisis and includes having a set number of beds available for hospital diversion.	Capacity payment and FFS	Set amount (budget) to the DA paid quarterly for capacity. FFS is based on individual services provided.	Capacity: $9.5 Fee-for-Service: $ 0.9

Program	Description of Program	Funding Type	Basis of Payments to DAs	Fiscal Year 2013 Expenditures (in millions)[a]
Enhanced Family Treatment (EFT)	A package of intensive home and community-based MH services to children and their families.	Inclusive rate	Daily rate, approved by DMH, for each individual client based on the individual's service plan.	$2.2
Success Beyond Six (SBS)	Services to children in school-based settings to help keep students in their local schools and able to benefit from the education offered.	FFS and Inclusive rate	FFS–The DA bills for each individual service provided. In some cases, the DAs can only bill for the behavior intervention program while in others the DAs can bill for other services.[c] Inclusive rate–Seven DAs receive a specific amount per child per month for clinician services.	Fee-for-Service: $31.3 Inclusive rate: $4.3
Concurrent with Education; Mental Health Rehabilitation and Treatment (C.E.R.T)	Provides community support and service planning and coordination services to individuals and families in a school setting.	Inclusive rate	DAs bill for each day that service is provided for a minimum of 2 hours and receive a set daily rate.	$3.2
Private Non-Medical Institution (PNMI)	Residential treatment programs for children and adolescents.	Inclusive Rate	One DA receives a per-diem rate for this program to include a comprehensive spectrum of mental health services.	$0.7
Other children's services	Provides clinic-based services, support, outreach treatment, prevention and screening, and immediate response to children and their families.	FFS	DAs bill separately for each individual service provided.	$27.5

[a] Expenditures for inclusive rate and fee-for-service funding types were derived from a MMIS file of claims with dates of service in fiscal year 2013 (excluding about $235,000 in Medicare crossover claims). Expenditures for the capacity funding type were obtained from the State's primary financial system, VISION. We did not audit these amounts.

[b] DAIL and DMH call the documents used to support the services to be provided to their clients' Individual Support Agreement and Individual Plan of Care, respectively. For simplification purposes, our report uses the term individual's service plan to denote the part of the DAIL and DMH documents that include the number, type, and frequency of services to be provided by the DA.

[c] If a child is receiving inclusive rate Success Beyond Six, no other school-based services may be billed as FFS except under the behavior intervention program.

Summary of DAIL and DMH Oversight of DA Services

Type of Oversight	DAIL		DMH	
	Description	**Limitation**	**Description**	**Limitation**
Re-designation review	Determines whether the DA meets State required qualifications, including that a written Individual Support Agreement is created for each person when required. In conjunction with the re-designation review, DAIL performs a Quality Management review as described below.	• Re-designation occurs every 4 years. • Does not include all programs, such as DD TCM and Bridge.	Determines whether the DA meets State required qualifications, including that a written Individual Plan of Care is created for each person and that the DA has a Utilization Review and Management program. As part of the re-designation process, DMH performs a minimum standard chart review in which it looks at records for clients in the CRT, Emergency Service, and children's programs to determine whether the records are consistent with DMH standards.	• Re-designation occurs every 4 years. • Small number of charts are selected (8-20 based on the most recent reviews) and not all programs are covered (e.g., adult outpatient).
Quality management	A biennial examination of each DA in which documentation of 10-15 percent of DD HCBS clients are reviewed to assess delivery of services in accordance with Individual Support Agreements and DAIL's *Guidelines for the Quality Review Process of Developmental Disability Services*.	• 2-year intervals. • Does not include all programs, such as DD TCM and Bridge.	See re-designation process.	See re-designation process.
Budget review	For some programs, the business office reviews actual expenditure reports to ensure that the DAs do not overspend the funds approved.	Not routine for all programs.	For CRT, DMH prepares a monthly comparison report of the actual to budgeted dollar value of services provided and makes adjustments to DA payments if certain criteria are met. For EFT, DMH staff run a monthly report that shows the total expenditures by DA and compares the actual amount spent to the budgeted amount.	Not routine for all programs.

Type of Oversight	DAIL		DMH	
	Description	**Limitation**	**Description**	**Limitation**
DA self-audit	None.	Not applicable.	DMH requires that DAs perform a self-audit once per fiscal year for the EFT program, including comparing the cost of services provided to the child's individual budget for services. The DAs are required to submit their reports to DMH, which may audit them to verify the results.	Only pertains to $2.2 million EFT program. Not required in fiscal years 2011 to 2013.

Summary of Findings, Recommendations, and Departmental responses

Audit Report		Department Response	
Issue	**Recommendation**	**Agreed?**	**Plans**
Department of Disabilities, Aging and Independent Living			
DAIL did not have processes that routinely compared budgeted to actual services for the programs for which DAs receive an inclusive rate. DAIL has a central repository of all DD HCBS approved services and budgets. However, while DAs electronically submit monthly data on the actual services provided to each client to a system operated by the Department of Health, DAIL does not use this data to compare actual to budgeted services because the actual data do not include all DD services provided by the DAs. In addition, DAIL officials reported that they have had difficulty obtaining regular and on-going access to this data over the years. Without actual service data, DAIL is not in a position to know whether the services provided are consistent with individuals' service plans. Moreover, since the basis for DD HCBS payments are the approved and budgeted services, DAIL could be paying too much or too little based on the actual services performed.	Develop a mechanism to determine the extent to which clients are receiving services, including the number, types, and frequency, for which DAIL is paying an inclusive rate to the DAs. For example, this mechanism could entail developing a system that tracks actual services against individuals' service plans or requiring DAs to periodically submit comparison data to DAIL.	Yes	DAIL will: (1) Supplement the comparisons it performs as part of its quality assurance process with separate and additional oversight of activities, including, but not limited to, on-site compliance reviews of both programmatic financial information, interviews with providers, and other information gathering activities (April 1, 2015). (2) Re-affirm the DA master grant agreement requirement for DAs to maintain accurate and up-to-date information that reflects each individual's actual living circumstances and plan of services. (3) Require the DAs to conduct self-audits at the end of state fiscal year 2015 and annually thereafter and report their findings and any changes made to DAIL. (4) Obtain service and payment data from the Monthly Service Report and from the F/EA and conduct state audits of DD HCBS services Implementation of these steps will begin immediately with the first DAIL audit occurring based on state fiscal year 2016 data.
For certain DAIL programs, the Medicaid Management Information System (MMIS) is coded to pay DA claim lines based on what the DA bills and is not limited by a set rate in the system. DAIL mitigates the financial risk of these claims for the DD HCBS program by performing a quarterly review of the amount the DA was paid versus what was approved for each client. DAIL did not perform this type of review for other DD codes that are listed as pay-as-billed in the MMIS.	Except for DD HCBS, develop a process to perform periodic detailed confirmation, on at least a sample basis, that the amount approved equals the amount the DAs billed for services that are coded as pay-as-billed in the MMIS.	Yes	Beginning in 2015, DAIL will run reports on a sample of individuals receiving other DD services on a quarterly basis.

Audit Report		Department Response	
Issue	**Recommendation**	**Agreed?**	**Plans**
DAIL's DD Medicaid provider manual was issued in 1995 and some of its requirements have been superseded. To illustrate, based on the 1995 manual, a DA should charge two units for a service between 15-30 minutes. However, a modification of the Medicaid State Plan, effective in 2008, and the DD rate chart states that one unit should be charged for 15 minutes for DD TCM services. The three DAs we visited stated that their understanding was that two units should be charged for a 15-minute service based on the provider manual. Moreover, DAIL officials provided contradictory interpretations about whether one or two units should be charged for a 15-minute service.	Update its DA provider manual related to developmental disability programs to reflect current practices. In the interim, written communication should be expeditiously sent to the DAs to specify the number of units that can be charged for 15 minutes of DD TCM services.	Yes	DAIL will confirm the correct billing unit for DD TCM with the Department of Vermont Health Access (DVHA) and will issue a clear statement of the definition upon confirmation with DVHA. DAIL has already begun updating its Provider Medicaid Manual (completion date of July 1, 2015)
DAs are prohibited from billing the DD HCBS rate or DD TCM for clients in a nursing facility. The Medicaid payment system, MMIS, did not have an edit (called Error Status Code or ESC) to prevent such claim lines from being paid.	Request and help develop an ESC that prevents DD HCBS or DD TCM claims from being paid when a client is in a nursing home.	Yes	DAIL will work with DVHA to develop the necessary ESC that will prevent non-allowed DD claims from being paid when a client is in a nursing home and will ensure that the edit is working, with periodic checks going forward beginning in February 2015.
Nine of the 20 ESCs appeared to be set up in a manner that would achieve expected results (would set or not set the ESC appropriately for a given claim). However, there were 11 ESCs that included many, but not all, relevant procedure code/modifier combinations. DAIL reviews the MMIS ESCs on an ad hoc and as needed basis. A more regular schedule for reviewing the ESCs that are pertinent to DAIL would provide more assurance that the logic and coding used in the ESCs are up-to-date.	Periodically review the ESCs that pertain to DAIL programs, including, at a minimum, immediately after the planned revision to the DD provider manual is completed.	Yes	DAIL will work with DVHA to review the ESCs that pertain to DD programs immediately after the DD provider manual and annually after that.
DAIL's reviews of the DAs did not routinely include reviewing the validity of claims that DAs have submitted and whether they were allowable. In addition, there was no process in place to perform post-payment comparisons of related services provided to the same client by multiple providers in order to identify providers that are billing for services covered by inclusive rates paid to other providers.	Include as part of the re-designation review/quality management reviews, procedures that check whether DA DD claims meet DAIL billing requirements and billing limitations, and whether claim documentation meets DAIL standards and seek reimbursement, as appropriate.	Yes	DAIL will incorporate a description of the financial audit process in the updated Medicaid Provider Manual. DAIL will use Medicaid claims reports to identify billing practices that do not adhere to DAIL billing requirements and limitations. Reviews will occur initially at the end of state fiscal year 2016 and as part of the resignation review process after that. In instances in which DAIL identifies that billing requirements and/or limitations have not been met, it will seek reimbursement, when appropriate.

Audit Report		Department Response	
Issue	**Recommendation**	**Agreed?**	**Plans**
Department of Mental Health			
DMH did not have processes that routinely compared budgeted to actual services for the programs for which DAs receive an inclusive rate. While DMH utilizes the monthly service data electronically submitted by the DAs, it does not have a central repository of individuals' service plans showing the number, type, and frequency of services that have been prescribed for each client. Without knowing what services have been prescribed, DMH does not have the data that would allow it to determine whether clients are receiving expected services or whether it is paying too much or too little given the services actually performed.	Develop a mechanism to determine the extent to which clients are receiving services, including the number, types, and frequency, for which DMH is paying an inclusive rate to the DAs. For example, this mechanism could entail developing a system that tracks actual services against individuals' service plans or requiring DAs to periodically submit comparison data to DMH.	Not explicitly	DMH will research what mechanism(s) could be reasonably implemented to address this recommendation until the new MMIS is implemented.
In the case of DA clients that lived in a PNMI (residential treatment programs for children and adolescents that may or may not be operated by a DA), we could not determine whether or the extent to which DAs were paid for services also provided by these institutions because DMH did not have documentation of what services were covered by each institution's per-diem rate. Accordingly, we were unable to determine the extent to which the FFS MH services paid to DAs for clients in a Private Non-Medical Institution were appropriately or inappropriately paid.	Develop a list of services that each PNMI can and cannot bill and evaluate whether an MMIS ESC can be implemented to prevent DAs from charging for similar services already provided by these institutions.	Yes	DMH has initiated processes to ensure that these controls will be in place. A memo detailing our intent and the process by which included services at the PNMI facilities should be identified has been drafted and sent to the Department of Rate Setting for approval. Once approved, DMH will establish mechanisms with DVHA and HP Enterprise Services (which operates the MMIS) which may allow concurrent services to be billed. DMH expects to have this in place by the end of fiscal year 2015.
For certain procedures, a DA can be paid for multiple instances of the same service being performed for the same client on the same day (almost all were MH claims). In over half of the claim sets reviewed, the DA documentation was not specific enough to draw a conclusion about whether a separate service had been provided or whether the billings were duplicative or otherwise unallowable. Another risk pertained to the amount of time recorded by DA staff members in their time sheets for an individual activity and whether it could be manipulated to result in an additional number of claims billed to Medicaid. Specifically, if a 30-minute service was billed as two 15-minute services, the provider would receive twice the payment (i.e., four units instead of two).	Issue instructions to the DAs specifying under what circumstances a DA can bill for services performed on the same day for the same client in 15-minute increments and about whether or to what extent the DA that provides services to a client for whom a different DA receives an inclusive rate can bill Medicaid for those services.	Yes	DMH will update its Medicaid Manual to establish clear billing and documentation standards by the end of fiscal year 2015.

Audit Report		Department Response	
Issue	**Recommendation**	**Agreed?**	**Plans**
Nine of the 20 ESCs appeared to be set up in a manner that would achieve expected results (would set or not set the ESC appropriately for a given claim). However, there were 11 ESCs that included many, but not all, relevant procedure code/modifier combinations. DMH reviews the MMIS ESCs on an ad hoc and as needed basis. A more regular schedule for reviewing the ESCs that are pertinent to DMH would provide more assurance that the logic and coding used in the ESCs are up-to-date.	Review the ESCs that pertain to DMH programs and ensure that they are up-to-date in light of the new MH FFS provider manual and, in the future, periodically review the ESCs to ensure that they remain current.	Yes	DMH will work with HP to identify the relevant ESCs and begin a review process. Communications with HP will occur by October 31, 2014 and, barring any issues to identifying all of the ESCs, should be completed by the end of fiscal year 2015. On-going ESC review will be added to the business office functions at DMH, to be performed as needed, but no less than bi-annually.
DMH's reviews of the DAs did not routinely include reviewing the validity of claims that DAs have submitted and whether they were allowable. In addition, there was no process in place to perform post-payment comparisons of related services provided to the same client by multiple providers in order to identify providers that are billing for services covered by inclusive rates paid to other providers.	Include as part of the re-designation review/quality management reviews, procedures that check whether DA MH claims meet DMH billing requirements and billing limitations, and whether claim documentation meets DMH standards and seek reimbursement, as appropriate.	Not explicitly	DMH will work with DVHA and the Agency of Human Services to identify the human resources and/or collaborative functions necessary to carry out this activity by the end of fiscal year 2015.