Report of the Vermont State Auditor

October 14, 2014

DESIGNATED AGENCIES

State Oversight of Services Could Be Improved, But Duplicate Payments Not Widespread

Douglas R. Hoffer
Vermont State Auditor
Rpt. No. 14-05

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Douglas R. Hoffer
STATE AUDITOR

STATE OF VERMONT
OFFICE OF THE STATE AUDITOR

October 14, 2014

The Honorable Shap Smith
Speaker of the House of Representatives

The Honorable John Campbell
President Pro Tempore of the Senate

The Honorable Peter Shumlin
Governor

Harry Chen, M.D.
Acting Secretary
Agency of Human Services

Susan Wehry, M.D.
Commissioner
Department of Disabilities, Aging and Independent Living

Paul Dupre
Commissioner
Department of Mental Health

Dear Colleagues,

Attached is our audit report on the State's oversight of 11 nonprofit designated agencies (DAs).

Vermont's government paid the DAs about $300 million for services provided in fiscal year 2013, mostly for developmental disability and mental health services under programs operated by the Department of Disabilities, Aging and Independent Living (DAIL) and the Department of Mental Health (DMH). These programs provide a range of services to adults with mental illness, children and adolescents with severe emotional disturbances, and individuals with developmental disabilities.

Our audit objectives were to (1) summarize how DAIL and DMH fund developmental disability and mental health services provided by the DAs and ensure that clients receive the expected services and (2) determine whether DAs have received duplicate payments from Medicaid for services provided.

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DAIL and DMH funding of developmental disability and mental health services provided by the DAs is complicated because of the variety of programs and funding arrangements. These departments perform oversight of the DAs in a variety of ways, including periodic quality management reviews. However, these oversight mechanisms generally did not include a systematic comparison of budgeted to actual services for inclusive rate programs, which is a funding mechanism in which a single payment covers an approved range of services. Without such comparisons, DAIL and DMH cannot ensure that clients are receiving the planned services and that the payments being made reflect the services being performed and are not too much or too little.

We also performed detailed test work of potential duplicate payments at three DAs in which we reviewed supporting documentation and sought explanations of questioned claims. Although we found some payments for duplicate Medicaid claims involving the DAs, they were not widespread.

Nevertheless, our audit found that the various mechanisms that DAIL and DMH employ to prevent or detect duplicate payments could be improved. In particular, (1) policy documents that define what is and is not allowable were outdated or did not address certain situations, (2) edits in the Medicaid payment system that are supposed to prevent potential duplicate claims were not always set up correctly, and (3) DAIL and DMH oversight of the DAs did not routinely include reviewing the validity of claims that DAs had submitted and whether they were allowable.

This report contains a variety of recommendations to improve DAIL and DMH oversight of the DAs. In commenting on a draft of this report, DAIL and DMH outlined various initiatives that they planned to undertake in response to the recommendations.

I would like to thank the management and staff at DAIL and DMH as well as those of the DAs we visited for their cooperation and professionalism during the course of the audit.

Sincerely,

Doug Hoffer

Doug Hoffer
Vermont State Auditor

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Introduction

In accordance with statute,[1] Vermont's government contracts with 11 nonprofit designated agencies (DA) across the state to perform vital services to residents of specific geographic areas. Within their designated areas, the DAs generally provide a range of services to adults with mental illness, children and adolescents with severe emotional disturbances, and individuals with developmental disabilities. Other DA responsibilities include providing emergency mental health services, operating residential facilities for certain clients, and operating the state's only intermediate care facility for persons with developmental disabilities.

The State paid the DAs about $300 million for services provided in fiscal year 2013, mostly for developmental disability (DD) and mental health (MH) services under programs operated by the Department of Disabilities, Aging and Independent Living (DAIL) and the Department of Mental Health (DMH). We focused audit resources on the DAs because of the significant amount the State pays the DAs, the multiple programs that they support, and the importance of their services. Our audit objectives were to (1) summarize how DAIL and DMH fund DD and MH services provided by the DAs and ensure that clients receive the expected services and (2) determine whether DAs have received duplicate payments[2] from Medicaid for services provided.

As part of our methodology, 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.[3] Appendix I contains detail on our scope and methodology. Appendix II contains a list of abbreviations used in this report.

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[1] 18 V.S.A. 8907(a) states that "the commissioner of mental health and the commissioner of disabilities, aging, and independent living shall …ensure that community services to mentally ill and developmentally disabled persons throughout the state are provided through designated community mental health agencies. The commissioners shall designate public or private nonprofit agencies to provide or arrange for the provision of these services."

[2] We defined duplicate 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.

[3] 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. Because we were testing the results of our automated data analysis and looking for systemic issues that could lead to duplication rather than evaluating the control environment of individual DAs, the report does not identify the DA in which a particular example is being used for illustrative purposes.

Highlights: Report of the Vermont State Auditor

Designated Agencies: State Oversight of Services Could Be Improved, But Duplicate Payments Not Widespread

(October 14, 2014, Rpt. No. 14-05)

Why We Did this Audit	We focused attention on the oversight of the DAs because the State pays them millions of dollars to provide critical services in support of multiple State programs. Our audit objectives were to (1) summarize how DAIL and DMH fund DD and MH services provided by the DAs and ensure that clients receive the expected services and (2) determine whether DAs have received duplicate payments from Medicaid for services provided.
Objective 1 Finding	DAIL and DMH's funding of DD and MH services provided by the DAs is complicated because of the variety of programs and funding arrangements, and the departments did not have processes to ensure that clients in certain programs received expected services. DAIL and DMH use three methods to pay DAs for services—fee-for-service (FFS), capacity payments, and inclusive rates. • *Fee-for-service.* Payment is based on one specific service being performed on a given day for a given client. • *Capacity payments.* Payments are for a specific amount provided to a DA to support the ability to perform a specific function (e.g., MH crisis beds). • *Inclusive rates.* Payment encompasses a group of services for a given period of time (daily, monthly) and, in some cases, for a given client. For developmental disability and mental health services performed in fiscal year 2013, over half of the payments to the DAs were based on inclusive rates. DAIL and DMH had mechanisms in place to oversee the DAs, including a process to re-designate DAs every four years. Other oversight mechanisms included quality management and budget reviews of certain programs. However, neither department routinely compared budgeted to actual services for the programs for which DAs receive an inclusive rate. Without such a comparison, the departments are not positioned to know whether the actual services provided are consistent with those approved and could be paying too much or too little for the services actually performed. For example, DAIL has a central repository of all approved services and budgets for its $128 million DD home and community based services (HCBS) program, and DAs are paid a daily inclusive rate unique to each client. While DAs electronically submit monthly data to the State on actual services provided to each client, DAIL does not compare this actual data to clients' approved services because the data do not include all DD services. A recent DMH initiative demonstrates the importance of comparing actual services to budgeted services. In fiscal year 2014, DMH required DAs to perform and report on the results of self-audits of the amount of services provided versus the amount of services budgeted for the clients enrolled in one of its children's mental health programs that is paid on an inclusive rate basis. The DA self-audits for this program for the period July 1, 2013 to December 31, 2013 revealed that for 74 percent of clients, DMH paid for more services than were received. For those clients that received at least 10 percent fewer actual services than had been budgeted and paid, DMH recouped about $181,000 from the DAs.

Highlights (continued)

Objective 2 Finding	While the three DAs at which we performed detailed test work of potential duplicate payments were paid for some duplicate Medicaid claims, we did not find evidence of widespread payments for duplicate services. 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). The three DAs that received the highest amount of payments from the State had documentation or could provide adequate explanations for most of the potential duplicate Medicaid claim lines we reviewed. However, we observed four types of conditions that resulted, or could have resulted, in the State paying for duplicate services for the same client performed on the same date. 1. DAs were paid for an inclusive rate service as well as for a separate service covered by this rate. For example, three DAs were paid for 73 mental health claim lines totaling $8,256 in which they were paid for a service covered by a payment under an inclusive rate program. 2. DAs were inappropriately paid when clients were in a nursing facility or hospital. For example, three DAs were paid for 470 DD HCBS or DD targeted case management claim lines totaling $43,645 for clients in a nursing facility, which is prohibited. 3. DMH paid multiple providers for the same type of service for the same client on the same dates of service. In particular, there were 38 instances ($7,790) in which a DA was paid for a MH fee-for-service claim for a client enrolled in an inclusive rate program at another DA. 4. 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 documentation at the three DAs 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. The state employed various mechanisms to prevent or detect duplicate payments for services provided to DD and MH clients, including policies that define what is and is not allowed, system edits, and periodic post-payment reviews. However, each of these techniques warrants improvement. For example, DAIL's DD Medicaid provider manual was issued in 1995 and some of its requirements have been superseded, and it was not always clear which criterion was to be followed.
What We Recommend	We make a variety of recommendations to DAIL and DMH to improve their DA oversight. For example, we recommend the departments (1) develop a mechanism to determine the extent to which clients are receiving services of the number, type, and frequency for which they are paid an inclusive rate and (2) establish procedures that check whether DA claims meet their billing requirements and limitations.

Background

18 VSA §8907(a) requires that DAIL and DMH ensure that community services for individuals with developmental disabilities or mental illnesses be provided through designated community mental health agencies (called designated agencies or DAs) within specific geographic areas.[4] The Agency of Human Services and certain of its departments sign annual master grant agreements with 11 DAs. These agreements set a budget for each DA by major program areas, which may be adjusted over the course of the year. The state also has other agreements with the DAs. For example, a significant source of DA funding, the DMH Success Beyond Six program, is covered under separate agreements between DMH and the DAs. Appendix III summarizes the total payments made in FY 2013 to each of the DAs.

Most of the payments to the DAs are funded by Medicaid and are paid via the Medicaid Management Information System (MMIS), which is operated by HP Enterprise Services. To receive payment the DAs generally submit professional service claims[5] to the MMIS that include codes to identify the provider(s) and describe the services provided. Regarding the codes that describe the service, each line of a professional service claim contains a procedure code that may also have an associated modifier code.[6] Together with the provider number, this information plays a role in the determination of how much the MMIS pays a DA for a particular claim[7] and for the system to perform checks (e.g., edits) on the validity of the claim (e.g., to check for duplicate claims or whether a service limitation was exceeded).

[4] The Clara Martin Center and the Upper Valley Services serve the same geographic area but provide different types of services. In general, the Clara Martin Center provides mental health services and alcohol and drug abuse treatment, and Upper Valley Services provides services to individuals with developmental disabilities.

[5] Depending upon the type of service that was performed, a Medicaid provider submits either a professional service claim or an institutional claim. The vast majority of DA claims submitted to the MMIS for payment are professional service claims.

[6] A procedure code is a five-character code used to describe medical services or other health care. Modifiers are a two character alpha-numeric code with a specific meaning that is used to further define the procedure code or to assist in claims adjudication.

[7] Each of the DAs had multiple provider numbers and they use certain provider numbers for specific types of claims (e.g., developmental disability and mental health claims are submitted under different numbers).

Objective 1: DA Funding Mechanisms are Complex and the Departments' Ability to Link Payments to Actual Services Performed Is Limited

DAIL and DMH provide funding to the DAs for developmental disability and mental health programs through a variety of complex mechanisms, including payments based on fee-for-service, capacity, and inclusive rates. While DAIL and DMH perform oversight reviews of DA activities, neither department assesses whether clients are receiving the expected services being paid for in all of the programs using inclusive rates, which is a funding mechanism in which a single payment covers an approved range of services. For example, DAIL maintains a spreadsheet of each client's approved services and budget, but it does not have a process to compare these approved, budgeted services to those the DA has actually provided. Without such a process, the State is not in a position to know whether the services provided are consistent with individuals' service plans.[8] Since under inclusive rates these service plans are generally the basis for payment, without this comparison the State could be paying too much or too little. For example, this year DMH began requiring DAs to perform self-audits of the amount of services provided versus the amount of services budgeted for the $2.2 million Enhanced Family Treatment (EFT) program, which is paid based on an inclusive rate. The DA self-audits for the period July 1, 2013 to December 31, 2013 revealed that 74 percent of clients received fewer services than budgeted and paid by DMH. For those clients that received at least 10 percent fewer actual services than had been budgeted and paid, DMH recouped about $181,000 from the DAs.

Description of How the State Funds Developmental Disability and Mental Health Services Performed by DAs

There are three primary ways in which DAIL and DMH fund DD and MH services at the DAs: fee-for-service, capacity payments, and inclusive rates. 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[9] cover groups of

[8] 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.

[9] 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 this report.

services under a single payment for a given period of time (daily, monthly) and, in some cases, for a specific client.[10] The following are a DAIL and DMH example of the types of services in an inclusive rate paid to a DA.

- *Example of basis for DD HCBS client's daily rate.* The daily rate at the beginning of fiscal year 2013 for one client was set at $149.66, consisting of the following expected services (1) 2 hours per week of service planning and coordination, (2) 20 hours per week of community supports, (3) 6 hours per week of respite, (4) 0.09 hours per week of clinical supports, (5) $503 per year for crisis, and (6) 365 days per year of home provider support. The daily rate was amended to a lower or higher rate during the course of the year to take into account hospitalizations and an increase in services, respectively.

- *Example of basis for DMH EFT client's daily rate*. The fiscal year 2013 daily rate for one client was set at $433.07 and was largely based on expected on-going monthly services of (1) 15 units[11] for service planning and coordination, (2) 109 units of individual community supports, (3) 4.35 units of individual therapy, (4) 30.42 units of therapeutic foster care, (5) 1 unit medication management, (6) 30.42 units of crisis supports, and (7) 30.42 units for crisis response.

Table 1 summarizes the DAIL DD and DMH MH programs that fund DA-provided services. In total, the departments paid the DAs about $264 million for these programs. In the case of DAIL, the department paid the DAs $132 million to provide developmental disability services to about 4,100 clients in fiscal year 2013.[12] DMH paid the DAs $132 million to provide mental health services to about 30,000 clients in fiscal year 2013.[13] The table also shows that about 70 percent of the payments were based on inclusive rates. Specifically, for services provided in fiscal year 2013, 99 percent and 35

[10] In its response to a draft of this report, DAIL commented that DAs are allowed to make internal adjustments, within reasonable parameters, to individuals' DD budgets when their needs change, which allows a DA to respond flexibly and quickly to the changing needs of individuals.

[11] The definition of a unit can vary depending on the service. For example, it can be a single session or service or it can be a certain number of minutes.

[12] All but 1,077 of these clients were derived from a summary of unique client numbers in the MMIS for all DAIL developmental disability service programs paid by this system. A different system pays the DAs for the Flexible Family Funding program so the 1,077 clients served by the program were taken from *Developmental Disabilities Services State Fiscal Year 2013 Annual Report* (Department of Disabilities, Aging and Independent Living). There may be some clients that received both Flexible Family Funding and other developmental disability services in the course of the fiscal year.

[13] The number of clients served is from table 1-1 in the *FY 2013 Statistical Report* (Department of Mental Health). This number is likely high because, according to the report, clients who were served by more than one DA were counted more than once.

percent of payments to the DAs for developmental disability and mental health programs, respectively, were based on inclusive rates.

Table 1: 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 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

Program	Description of Program	Funding Type	Basis of Payments to DAs	Fiscal Year 2013 Expenditures (in millions)[a]
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
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	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.

State Oversight of DA Developmental Disability and Mental Health Services

DAIL and DMH perform various types of oversight of the services provided by the DAs, although their ability to oversee the DAs has been negatively affected by budget cuts. DAIL's DD quality management currently consists of four full-time staff—down from seven in fiscal year 2007. According to the leader of the DD quality management team, to accommodate this reduction in staff, DAIL reduced the scope and frequency of its reviews. For example, the team used to review DD TCM services but now reviews only DD HCBS services. In the case of DMH, due to budget cuts and a reorganization their quality assurance functions were eliminated in 2009 and reporting, tasks, and functions reassigned to various units in the department. This led to a lack of coordination and fragmentation of activities. DMH hired a Director of Quality Management in August 2012, but she left this position in January 2014. As of July 2014, DMH had two quality management coordinators tasked with DA oversight. DMH has also named a new Director of Quality Management, who was to start in September. The scope of DAIL and DMH oversight activities is explained in Table 2.

Table 2: 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).

Type of Oversight	DAIL		DMH	
	Description	**Limitation**	**Description**	**Limitation**
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.
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.

Unlike FFS-based programs in which a provider receives payment for each unit of service billed, inclusive rates allow for reimbursement regardless of the number of services provided, thereby creating an incentive for providers to minimize service delivery. According to a 2008 consultant's report, one of the challenges involved in implementing an inclusive rate payment process is ensuring that each client receives the required amount of services to receive funding.[14]

[14] *Analysis of Designated Agency Reporting and Documentation Requirements* (The Pacific Health Policy Group, March 2008).

Neither DAIL nor DMH had processes that routinely compared budgeted to actual services for the programs for which DAs receive an inclusive rate. In the case of DAIL, the department 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.[15] 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.

The fiscal year 2013 master grant agreements state that the DAs are to work collaboratively with the Agency of Human Services to provide complete and accurate information through the monthly service reports for the DD programs. This work was not performed and, according to a DAIL program manager, is not planned. This appears to be inconsistent with DAIL's prior and current DD System of Care plans, which state that it will focus on modernizing system administration and oversight by implementing improved reporting of service and financial data to improve service quality.[16]

In contrast to DAIL, DMH utilizes the monthly service data electronically submitted by the DAs. However, DMH 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. Additionally, without access to the planned services for each client, the actual service data reported monthly is of limited value because there is nothing with which it can be compared. The DMH System of Care Plan states that DMH will conduct program and service monitoring to manage the quality of MH services provided by the DAs.[17] In its response to a draft of this report,

[15] According to DAIL, the data on actual services submitted by the DAs monthly does not include services provided by contracted workers who are paid through a fiscal employer/agent.

[16] *Vermont State System of Care Plan for Developmental Disabilities Services, FY 2012 – FY 2014* (Department of Disabilities, Aging and Independent Living) and *Vermont State System of Care Plan for Developmental Disabilities Services, FY 2015 – FY 2017* (Department of Disabilities, Aging and Independent Living).

[17] *System of Care Plan, Fiscal Year 2012-2014* (Department of Mental Health).

DMH stated that this statement in the System of Care Plan refers to a macro level of service that requires person-centered treatment planning and implementation and does not include a level of detail such as knowing the number, type and frequency of services that have been specified for each client. Instead, DMH pointed to the minimum standards review of charts that it conducts as a process that it uses to review whether services are provided in accordance with treatment planning. However, as Table 2 shows, DMH looks at only a few charts every four years. Accordingly, the minimum standards chart review process does not provide a systematic way for DMH to determine if services provided were in line with the individuals' service plans.

In the case of DMH's CRT and EFT programs, DMH did evaluate the dollar value of actual services performed. Regarding CRT, DMH reviewed actual services reported by the DAs every month in order to determine whether adjustments to a DA's overall CRT budget were warranted. Adjustments are based, in part, on whether services have been provided within the last 105 days and whether the total dollar value of the actual services performed are within three percent of the budget. Regarding EFT, in fiscal year 2014,[18] DMH's Child, Adolescent, and Family Unit required DAs to perform and report on the results of self-audits of the amount of services provided versus the amount of services budgeted for the clients enrolled in the EFT program.[19] If the self-audit determines that the cost of actual services provided by the DA is under the budgeted amount (called the error rate) by greater than 10 percent then the amount under the budget is subject to recoupment.

The DA self-audits performed for the EFT program demonstrate the benefit of comparing budgeted services to actual services. The self-audits for the period July 1, 2013 to December 31, 2013 revealed that for 74 percent of EFT clients DMH paid for more services than were received. For those clients that received at least 10 percent fewer actual services than had been budgeted and paid, DMH recouped about $181,000 from the DAs.

DAIL and DMH also rely on the MMIS to provide controls related to the claims that are submitted for payment. For example, the MMIS has controls to ensure that the State is paying the approved amount for a claim, i.e., the system is generally coded to pay claim lines based on a set rate. However, for

[18] According to DMH, the EFT self-audit process was suspended between fiscal years 2011 and 2013 and was restarted in fiscal year 2014.

[19] DMH's instructions note that the department may perform an audit to verify the results of the self-audit.

certain DAIL and DMH programs (e.g., DD HCBS, EFT) , the 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. This is a financial risk to the State since it relies solely on the DA to accurately bill for the procedures. For claims with dates of service in fiscal year 2013, there were about 222,000 claims lines for about $137 million that were paid based on the rate the DA submitted.

By far the program with the most claims that are paid based upon the amount billed is DAIL's DD HCBS program ($128 million for claims with dates of service in fiscal year 2013). DAIL mitigates the financial risk of these claims by performing a quarterly review of the amount the DA was paid versus what was approved for each client. However, this review has not been timely. Due to an unexpectedly lengthy absence by the staff member assigned to this task, as of mid-June 2014, DAIL had completed this review for fiscal year 2013 claims for only seven of the ten DAs that performed DD services. In addition, DAIL did not perform this type of review for other DD codes that are listed as pay-as-billed in the MMIS. Instead, according to the DAIL financial manager, they review a summary of DA billings for the other six codes that are listed as pay-as-billed in the MMIS at the macro level to check that expenditures remain within approved funding levels for the programs as a whole. DA claims for dates of service in fiscal year 2013 for these codes totaled about $800,000, so it is understandable that the department does not focus as much attention on these codes as it does on the DD HCBS code. Nevertheless, given the risk that a provider may, intentionally or unintentionally, bill an incorrect amount in a claim using a pay-as-billed code, periodic detailed confirmation on a sample basis that the amount approved equals the amount billed would seem prudent.

DMH paid about $8 million in claim lines billing procedure codes that were listed as pay-as-billed for claims with dates of service in fiscal year 2013. DMH reported that for 5 of the 11 of the procedure codes that can be billed this way, it relied on the edit in MMIS that limits the total amount paid per client per day to $700. However, one of these five DMH procedure codes was not covered by the MMIS edit that enforces this limit, therefore this control was not working for this code. For the remainder of the pay-as-billed codes that are not covered by the $700 per day limit, DMH ran monthly reports to verify amounts being billed. These reports compare total dollars billed by each DA to either a spreadsheet of individual client budgets or to rates based on a budget approval process or a rate setting process. For these pay-as-billed procedure codes, the monthly reports showed enough detail to determine if claims were in line with approved rates.

Objective 2: Evidence of Widespread Duplicate Payments to DAs Absent, but Prevention and Detection Methods Could Be Improved

Our analyses of potential duplicate Medicaid claims paid to the DAs did not find evidence of widespread payments for duplicate services, but DAIL and DMH's prevention and detection processes could be improved. The three DAs we visited had documentation or could provide adequate explanations for most of the 2,400 potential duplicate claim lines we reviewed. Nevertheless, we observed four types of conditions that resulted, or could have resulted, in the State paying for duplicate services for the same client performed on the same date.

1. DAs were paid for an inclusive rate service as well as for a separate service covered by this rate.

2. DAs were inappropriately paid when clients were in a hospital or nursing facility.

3. DMH paid multiple providers for the same type of service for the same client on the same dates of service.

4. Documentation at the DAs did not always explicitly support that the second and subsequent instances of the same MH service provided to the same client on the same day were for separate activities.

In addition, while the state employs various mechanisms to prevent or detect duplicate payments for services provided to DD and MH clients, including policies that define what is and is not allowed, system edits that prevent potential duplicate claims from being paid, and periodic post-payment reviews, each of these could be improved.

Payments to DAs

Section 1902(a)(30)(A) of the Social Security Act, as amended requires that states provide methods and procedures to safeguard against unnecessary utilization of care and services and assure that Medicaid payments are consistent with efficiency, economy and quality of care. Payments for the same service or types of service for the same client for the same dates of service would not meet this standard. We defined duplicate 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).

To identify possible duplicate payments for the same service or type of service provided to the same client on the same or overlapping dates of service, we constructed a variety of tests (detailed in Appendix I) based on DAIL and DMH policies.[20] We used our automated data analysis tool to apply these tests to Medicaid claims paid by the MMIS for services provided during fiscal year 2013. To determine whether the results of our automated data analysis included actual duplicates, we reviewed documentation and/or obtained explanations at three DAs of about 2,400 claim lines (in some cases we reviewed all of the claim lines in the test results while in others we reviewed a non-statistical sample). Because we targeted specific types of transactions with certain attributes, the results of our analyses cannot be projected to the entire population of DA claims in the MMIS. In addition, because we were testing the results of our automated data analysis and looking for systemic issues that could lead to duplication rather than evaluating the control environment of individual DAs, this report does not identify the DA in which a particular example is being used for illustrative purposes.

For most of the potential duplicate Medicaid claim lines reviewed at the three DAs we were able to conclude based on their supporting documentation or explanations that the questioned claim lines were not duplications. However, our analysis disclosed four types of conditions that resulted, or could have resulted, in the state paying for duplicate services.

DA Paid for Both an Inclusive Rate Service and for a Separate Service Covered by this Rate

DAIL and DMH prohibit certain services from being charged when a DA is receiving an inclusive rate for a client. For example, DAs that are paid for clients receiving DD HCBS services cannot also charge for DD TCM for that client on the same date of service. DMH has similar restrictions.

We found instances related to both DAIL and DMH inclusive rate programs in which DAs were paid for a FFS claim that was covered by the inclusive rate. Specifically, there were 98 DD fee-for-service claim lines at two DAs totaling about $4,000 in which the service was covered by the DD HCBS program. For example, one DA was paid a DD TCM claim line for a person who also received DD HCBS from that DA, a program that includes case management, so the state effectively paid twice for this service. In this and

[20] DMH recently revised one of its relevant policies, *Medicaid Fee-For-Service Provider Manual* effective July 1, 2014. Because the scope of our audit was fiscal year 2013, our work was performed based on the previous manual dated in 2004. Unless otherwise noted in the report, discussion of the DMH FFS provider manual refers to the 2004 document.

similar cases at another DA, it appears that the DAs were approved to provide and bill DD HCBS services retroactively and did not refund the earlier DD TCM billing as required.

Regarding payments for mental health services, we identified 73 claim lines paid to three DAs totaling $8,256 in which they were paid for a service covered by an inclusive rate, such as C.E.R.T. or SBS. For example, a DA was paid $1,075 for community support and MH TCM services conducted at a school location at the same time that it was paid for providing C.E.R.T. services to the same client, which is prohibited.

We also identified 1,899 potential duplicates in the paid claims data for one DA, totaling $729,452, in which there were claims for the same client on the same day for both SBS inclusive rate and SBS fee for service. Because this is allowed in some cases, we randomly chose a non-statistical sample of 60 claims to review the supporting documentation. For 43 of the 60 claims, we were able to determine that the FFS claim was not a duplicate of the SBS inclusive rate claim. In six cases, the DA reported that a system error had caused claims to be incorrectly submitted.[21] However, for the remaining eleven claims the DA did not provide requested information that would allow us to reach a conclusion about whether the claims were duplicates. We provided the claim data to DMH for their follow-up.

DAs Inappropriately Paid When Clients Were in a Nursing Facility or Hospital

DAIL and DMH limit the payment for certain services to DAs for clients that are located in a facility, such as a hospital or a nursing facility. Nevertheless, we found DA claims that were paid even though the client was in such a facility. In many of these cases, the DAs explained that they were unaware that the client was in a nursing facility or hospital. In others, it appeared that it was an oversight.

- *Clients Residing in Nursing Facilities.* DAs are prohibited from billing the DD HCBS rate or DD TCM for clients in a nursing facility. All three of the DAs were paid for DD HCBS and/or DD TCM claim lines for clients in a nursing facility. In total these three DAs were inappropriately paid $43,645 for 470 claim lines for clients in nursing homes. For example, a client was in a nursing facility for 38 nights, but the DA continued to bill the DD HCBS inclusive rate and was paid $8,650 during this timeframe. The Medicaid payment system, MMIS, did not have an edit to prevent such claim lines from being paid.

[21] In total the DA reported that 157 claims lines totaling $2,561.21 had been incorrectly submitted.

- *Clients in Hospitals.* DAIL and DMH limit the services that DAs can bill for clients that are hospitalized. In the case of DAIL's DD TCM program and DMH's MH services, only services related to discharge planning can be charged. However, the three DAs had 101 claim lines totaling about $10,380 in which the documentation did not support that the service pertained to discharge planning. Regarding DAIL's DD HCBS claims, if a client is in a hospital, the DA is to reduce the amount paid under the DD HCBS rate to cover only personal care type services through home supports, service planning, and administration for up to 30 days of hospitalization. However, the DAs did not always reduce the DD HCBS daily rate as required. For example, a client was hospitalized for four nights, but the DA did not reduce the DD HCBS daily rate as required.

DMH Paid Multiple Providers for the Same Type of Service for the Same Client on the Same Dates of Service

Although DMH's inclusive rate programs cover a group of services, there were cases in which other providers were paid for services that were otherwise covered in the inclusive rate paid to the DA. DMH does not have a process in place to determine whether the services covered by an inclusive rate that are provided by another DA or non-DA providers are valid.

- *CRT Program.* Under the CRT program, a client is assigned a "home" DA from whom it receives MH services and for which the DA is paid an inclusive rate. However, for claims for dates of services in fiscal year 2013, there were 38 instances ($7,790) of a DA that was not the client's "home" DA being paid for a FFS MH claim. For example, one DA was paid $2,366.70 to provide five emergency evaluations to CRT clients assigned to another DA. The CRT inclusive rate covers emergency evaluations; therefore the CRT rate paid to the "home" DA included the service for which the other DA was paid.

- *Private Non-Medical Institutions.* In the case of DA clients that lived in Private Non-Medical Institutions (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. According to the DMH Medicaid fee-for-service manual, the per-diem rate for this program includes a comprehensive spectrum of mental health services and therefore no other MH claims are reimbursable for clients in these institutions. However, we identified 375 potential duplicate claim lines (totaling about $40,000) in which a DA was paid for a mental health service for a client located in a Private Non-Medical Institution. When we brought this to the attention of DMH officials, they stated that each

Private Non-Medical Institution provides different services and therefore some of the mental health claim lines may have been allowable if that particular institution did not provide those services. However, 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.

- *EFT Program.* We identified 383 claim lines in which the DA received payment for EFT, which provides a package of intensive home and community-based mental health services to children and their families, while at the same time another provider was paid for a FFS claim for a MH service to that same client. We provided 15 of these claim lines to an official from DMH's children's unit for review. According to this official, four of the 15 claim lines were incorrectly paid to the other provider because the service was covered by the EFT inclusive rate paid to the DA. In an example of one of these claims, a DA was paid $427.07 to provide EFT services, which include psychotherapy. A different, non-DA provider was paid $91.18 to provide one hour of psychotherapy for the same client on the same date of service. According to an official in DMH's children's unit, only a review of the documentation supporting the FFS claim and the individual's service plan can determine whether the service to the client by the other provider was already being paid for through the EFT payment to the DA.

Claims for Repeat Services on the Same Day Not Always Supported

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. In these circumstances, the claim lines submitted by the DAs include procedure code modifiers 76 or 77.[22] These modifiers identify claim lines as the second or subsequent instances of the same service provided to the same client on the same day and therefore the edits in the MMIS will not deny payment of these claim lines as duplicates. Almost 50,000 claim lines with modifiers 76 or 77 were paid to the DAs for dates of service in fiscal year 2013 for about $7.2 million.

We reviewed 180 sets of claim lines using one or more of these modifiers (60 at each of the three DAs visited) to determine whether separate services were

[22] Modifier 76 is supposed to be used for a repeat procedure by the same provider while modifier 77 is used if it is a different provider.

provided.[23] There were errors in 15 of these sets in which a service should not have been charged. For example, one DA was paid for six claim lines that were duplicate transactions. Officials at this DA could not always explain why this had occurred, but in some cases the errors appeared to have been caused by a mistake that happened when a correction to the original claim was being made.

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. The DMH fee-for-service provider manual[24] requires DAs to maintain documentation of the services provided, including a requirement to describe in narrative form the activities that they perform in support of a client. The manual states that if a DA chooses to use a monthly summary, it must provide sufficient information to be an audit trail to billed Medicaid services. According to the manual, all clinical and support notes must include the date the service was rendered and a summary of the service rendered. In addition, the manual states that checklists without narrative are not acceptable as clinical or support notes. Moreover, the manual requires that the provider's time sheet match Medicaid billing and the client's individual clinical record.

We were able to match DA time sheets to MMIS mental health billings in almost all cases. However, we were often unable to link these time sheets to individual clinical records because the records did not (1) summarize the service rendered or (2) include the dates of the services provided. In the first case, at one DA the clinical records for 12 percent of the claim lines reviewed in our modifiers 76/77 test did not describe the activity performed for the client. At times the clinical record was just a checklist without narrative support or the narrative simply listed the name of the procedure code being charged and did not describe the specific service the staff member provided.

In the second instance, all three DAs used weekly or monthly narrative summaries for some of the services they provided but these narratives usually did not include the dates associated with services provided. In such cases it was not possible to link a specific service to the time billed on the time sheet for a particular client. For example, at one DA a staff member recorded performing a MH TCM service 54 times for one client in May 2013.[25] We

[23] These 180 sets were based on a non-statistical random selection of claim lines with modifiers 76 and 77.

[24] Almost all of the 180 sets of claims that we reviewed were mental health FFS claims.

[25] Each of these charges were recorded on the staff member's time sheet as well as submitted to the MMIS as a claim.

could only identify one specific meeting (undated) in the case manager's monthly progress note. The rest of the narrative provided general statements like she "continued to maintain contact" with certain individuals, such as the client or the parent. The lack of dates and specificity in the narrative descriptions leads to the risk that a staff member could charge for services not provided and it would not be detectable.

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. According to the DMH fee-for-service provider manual, one minute to 14 minutes of service is one unit and 15 minutes to 30 minutes is two units.[26] If a 30-minute service was billed as two 15-minute services, the provider would receive twice the payment, four units instead of two (four units of MH TCM in fiscal year 2013 was $95.68 versus $47.84 for two units). In the case above, 53 of the 54 procedures claimed by the staff member in one month were listed as 15 minutes of service (two units), and there were 18 days in which two or more MH TCM 15-minute claims were submitted to the MMIS. Since the summary narrative did not include specific dates and services provided, we could not determine whether the multiple charges for each day were for separate activities on the part of the staff member.

Duplicate Claim Prevention and Detection

The State employs various mechanisms to prevent or detect duplicate payments for services provided to DD and MH clients, including policies that define what is and is not allowed, system edits that prevent potential duplicate claims from being paid, and periodic post-payment reviews. However, each of these techniques has flaws and limitations.

DAIL and DMH Policies

Under the fiscal year 2013 master grant agreements, DAs are required to maintain a financial system that provides adequate fiscal control and ensures the accuracy of financial reporting. In addition, the agreements require the DAs to follow various State funding and administrative regulations, including Medicaid provider manuals and program guidelines that are specific to the DAIL developmental disability and DMH mental health programs.

[26] DMH does not allow DAs to bill for targeted case management for services provided for 1-14 minutes (or one unit).

DAIL's DD Medicaid provider manual was issued in 1995[27]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. Since DD TCM claim lines are paid on a per-unit basis, DAs could be receiving double the reimbursement for these types of claims (two units instead of one). Although our testing did not directly address how often the DAs charged two units for 15 minutes of DD TCM, we did identify examples in which this occurred.[28] In another example, in some cases the DAIL provider manual prohibits DAs from charging certain codes if the client is in the Vermont State Hospital. However, this hospital became defunct in 2011 and its functions have been taken over by other entities. According to a DAIL program manager, DAIL did not send out any specific instructions to the DAs regarding how they were supposed to apply the criteria in the DAIL DA provider manual given the change in circumstances.[29] According to DAIL's three-year Vermont State System of Care Plan for DD services effective July 1, 2014, one of the department's planned actions is to develop a work plan and timeline to provide updates to policies and guidelines, including its DD provider manual.

DMH's provider manuals and program guidelines were more recent[30] and the Department recently issued an update to its FFS provider manual, effective July 1, 2014. However, neither the new FFS provider manual nor the CRT provider manual explicitly address how the DAs should be paid for related MH services provided to clients for whom another DA is receiving an inclusive rate (e.g., CRT, EFT). Specifically, the manuals do not address whether or under what circumstances the DA that provided the service, but

[27] *Division of Mental Retardation Medicaid Manual*, July 1, 1995.

[28] For claims with dates of service in fiscal year 2013, the three DAs were paid $74,000 for about 3,000 DD TCM claims lines that were for two units. It is not possible to determine how many of these claims were for 15 minutes without looking at the documentation supporting each claim since a DA could also receive two units for 16-30 minutes of service.

[29] This program official pointed out that DAIL's 2013 System of Care Plan stated that DD HCBS funding cannot be continued when a client is in a psychiatric hospital.

[30] *Medicaid Fee-For-Service Procedures Manual*, effective January 1, 2004; *Community Rehabilitation and Treatment (CRT) Program Designated Agency Provider Manual, Third Edition*, March 2004; and *Guidelines and Procedures for Home and Community Based Enhanced Family Treatment*, September 2010.

was not paid the inclusive rate, can either submit a claim to Medicaid or seek payment from the other DA.

MMIS Edits

The HP Enterprise Service's MMIS processes non-drug claims against hundreds of edits[31] and audits[32]—called Error Status Codes (ESC). ESCs are pivotal to ensuring the integrity of the Medicaid payment process because they check the validity of claims before payment is made. Once the system determines that a claim line meets the criteria in the ESC and "sets" the edit, a table in the system determines the disposition of the claim line (e.g., may deny payment of the claim line or suspend payment until further review by an HP Enterprise Services employee).

We identified and reviewed the logic of 20 ESCs that pertained to our duplicate payment objective.[33] Examples of such ESCs are those that (1) check for duplicate and near-duplicate professional service claims, (2) prevent DAs from billing MH claims for CRT clients, and (3) limit the number of claims that can be billed for certain procedure codes to once a day or once a month.

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.

These missing procedure code/modifier combinations in the ESCs accounted for some of the duplicate payments found. For example, there are two ESCs that work in concert to check whether a provider has inappropriately charged a FFS claim line during the same dates of service as a DD HCBS or EFT claim and vice versa. These ESCs did not include all of the relevant procedure codes, and there were FFS claims paid with these missing procedure code/modifier combinations for the same client on the same dates of service as a DD HCBS claim. Similarly, the ESC designed to prevent DAs

[31] An edit is a computer system inspection of claim data for validity, accuracy and the relationship of information within the claim.

[32] An audit compares each new claim to the beneficiary's claims history. For example, a limitation audit checks whether a beneficiary has exceeded certain criteria, such as the number of units (e.g., office visits or type of procedure) allowed in a given period of time.

[33] We reviewed the ESCs rules as set forth in the HP Enterprise Service's procedure manual, checked for consistency with these rules by reviewing the MMIS tables that support the ESCs, determined the disposition of claims that "set" the edit, and inquired of HP Enterprise Services claims personnel. We did not review the programming code in the system itself.

from being paid for separate claims for mental health services for CRT clients did not include all relevant procedure codes/modifier combinations. As a result, the three DAs we visited had been paid for FFS mental health claim lines for CRT clients that would have been denied had these procedure code/modifier combinations been in place.

DAIL and DMH review the MMIS ESCs on an ad hoc and as needed basis. A more regular schedule for reviewing the ESCs that are pertinent to DAIL and DMH would provide more assurance that the logic and coding used in the ESCs are up-to-date. This is particularly advisable since DMH has just issued a new MH FFS provider manual and DAIL is planning on revising its DD provider manual.

DAIL and DMH Post-Payment Reviews of DA Billing

Some DAIL and DMH billing prohibitions cannot be detected unless supporting documentation is reviewed. For example, to determine whether DAs are limiting their billing for services related to discharge planning provided to clients that are in hospitals requires reviewing client records, because there is no procedure code that is exclusive to discharge planning. In other cases, according to DMH officials, whether a DA is allowed to bill for MH services is dependent upon the individual's service plan.

The DAIL 1995 DD provider manual and the DMH CRT and FFS provider manuals (both previous and new version) call for audits of DA billed services to ensure that the DAs have sufficient support for their charges (to be conducted annually in the case of DD and FFS MH and periodically in the case of CRT). However, as previously described, the scope of the current DAIL and DMH reviews of DA documentation that support their billed services was limited. These reviews encompassed only certain programs and focused on quality management and meeting standards. The reviews 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.

Conclusions

DAIL and DMH paid the 11 DAs $264 million in fiscal year 2013 to provide services that are critical to the wellbeing of Vermonters with developmental disabilities and mental illnesses. These departments perform oversight of the DAs in a variety of ways, including periodic quality management reviews.

However, these oversight mechanisms generally did not include a systematic comparison of budgeted to actual services for inclusive rate programs. Without such comparisons, DAIL and DMH cannot ensure that clients are receiving the planned services and that the payments being made reflect the services being performed and are not too much or too little.

On a positive note, although we found some payments for duplicate Medicaid claims involving the DAs, they were not widespread. Nevertheless, one concern was that for those sets of claims that involved multiple payments for the same service to the same client on the same day, DA documentation was often not specific enough to draw a conclusion about whether a separate service had been provided or whether the billings were duplicative or otherwise unallowable. Moreover, while both DAIL and DMH utilized mechanisms that would prevent and detect duplicate payments, improvements in policies, system edits, and post-payment reviews are warranted.

Recommendations

We recommend that the Commissioner of the Department of Disabilities, Aging and Independent Living:

1. 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.

2. 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.

3. 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.

4. 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.

5. 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.

6. 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.

We recommend that the Commissioner of the Department of Mental Health:

1. 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.

2. Develop a list of services that each Private Non-Medical Institution 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.

3. 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.

4. 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.

5. 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.

Managements' Comments

The Commissioner of DAIL provided written comments on a draft of this report on October 1, 2014, which is reprinted in Appendix IV. The Commissioner of DMH provided written comments on a draft of this report on October 3, 2014, which is reprinted in Appendix V. Both DAIL and DMH agreed with the accuracy of the overall content of the report, but provided technical comments. Our evaluations of these technical comments are contained in the appendices.

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In accordance with 32 V.S.A. §163, we are also providing copies of this report to the commissioner of the Department of Finance and Management and the Department of Libraries. In addition, the report will be made available at no charge on the state auditor's website, http://auditor.vermont.gov/.

To address our first objective, we obtained and reviewed a variety of documents that describe how DAIL's developmental disability and DMH's mental health programs worked, the basis for payments made to the DAs, and how the departments performed oversight. For example, we reviewed the DA master grant agreements, the DA re-designation manual, spreadsheets that summarize DD HCBS clients' approved services, and reports used to compare planned versus actual DA CRT services. In addition, we reviewed the results of recent re-designation and quality management reviews performed by DAIL and DMH. We also interviewed DAIL and DMH program, financial, and quality management officials.

To address our second objective, we obtained an extract of MMIS Medicaid claims data from HP Enterprise Services for dates of service in fiscal year 2013 that had been paid as of November 13, 2013. We imported the MMIS claims extract file into our automated data analysis tool, IDEA®. We reviewed this data for reasonableness, such as confirming that the data was not garbled and that the contents of the fields were reasonable (e.g., that the "from" dates of service were not subsequent to the "to" dates of service). We also confirmed that the dates of service in the file were consistent with fiscal year 2013 and checked a sample of the claims against the on-line MMIS data and confirmed that the data was the same. We determined that the MMIS claims extract was sufficiently reliable for the purpose of our objective.

We used IDEA® to perform a variety of tests to identify potential duplicate payments.[34] We designed these tests by reviewing DAIL and DMH DA provider manuals and program guidelines. In addition, we validated our understanding of the requirements and exceptions outlined in these documents as well as the relevant MMIS procedure code and modifier combinations through discussions with DAIL and DMH program and financial officials.

The following are the categories of tests that we performed:

- Claims for the same client, same date of service, and same procedure code/modifier combination.
- Claims for inclusive rate procedure code/modifier combinations (e.g., DD HCBS, EFT) that were for the same client on the same date of

[34] 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).

service as other claims for services that are included as part of the inclusive rate.

- Claims for DD and MH services for clients that were located in facilities, such as hospitals and nursing facilities, on the same dates of service.

- Claims that used modifiers 76 or 77, which identify claim lines as the second and subsequent instances of the same service provided to the same client on the same day.

Once we identified potential duplicate claims, we visited three DAs— Health Care and Rehabilitation Services of Southeastern Vermont, HowardCenter, and Washington County Mental Health Services—which are the DAs that received the most State payments in fiscal year 2013. We provided these DAs with copies of the results (in some cases a non-statistical sample of the results) and requested supporting documentation or explanations. As needed, we also sought additional clarification from DAIL and DMH staff on how to interpret their criteria in light of the DAs' supporting documentation.

In all we reviewed the documentation or requested explanations supporting 499 claim lines at Health Care and Rehabilitation Services of Southeast Vermont, 970 claim lines at HowardCenter, and 924 claim lines at Washington County Mental Health Services. Because we targeted specific types of transactions with certain attributes, the results of our analyses cannot be projected to the entire population of DA claims in the MMIS.

As part of objective two, we also analyzed 20 MMIS error status codes that we identified as potential duplicate payment controls. These ESCs generally fell into four categories: (1) ESCs specifically designed to look for duplicate or near duplicate claims, (2) ESCs that limited the number of times certain procedure code/modifier combinations could be charged in a given month or day, (3) ESCs that prevent certain procedure code/modifier combinations to be claimed on the same date of service as other procedure code/modifier combinations, and (4) ESCs that limit the amount that can be claimed for certain types of services on a given day.

To perform this analysis, we reviewed the ESC rules as set forth in the HP Enterprise Services' procedure manual and checked that the tables in the MMIS were consistent with these rules. We also inquired of HP Enterprise Services claim personnel and DAIL and DMH staff members. We did not review the programming code in the system itself.

Appendix I
Scope and Methodology

We performed our work between September 2013 and August 2014 primarily at the offices of DAIL and DMH in Williston and Montpelier, respectively. We also conducted site visits to Health Care and Rehabilitation Services of Southeastern Vermont in Springfield, HowardCenter in Burlington, and Washington County Mental Health Services in Barre. We conducted this performance audit in accordance with generally accepted government auditing standards, which 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.

Appendix II
Abbreviations

C.E.R.T.	Concurrent with Education; Mental Health Rehabilitation and Treatment
CRT	Community Rehabilitation and Treatment
DA	Designated Agency
DAIL	Department of Disabilities, Aging and Independent Living
DD	Developmental disability
DMH	Department of Mental Health
EFT	Enhanced Family Treatment
ESC	Error status code
FFS	Fee-for-service
HCBS	Home and community based services
MH	Mental health
MMIS	Medicaid Management Information System
SBS	Success Beyond Six
TCM	Targeted Case Management

Appendix III
Total Fiscal Year 2013 Payments Made to Each DA

DA	Location	Total Fiscal Year 2013 Payments (in millions)[a]
Clara Martin Center[b]	Randolph	$ 7.8
Counseling Service of Addison County	Middlebury	17.3
Health Care and Rehabilitation Services of Southeastern Vermont	Springfield	36.8
HowardCenter	Burlington	69.7
Lamoille County Mental Health Services	Morrisville	12.1
Northeast Kingdom Human Services	Newport	28.9
Northwestern Counseling and Support Services	St. Albans	29.9
Rutland Mental Health Services	Rutland	23.8
United Counseling Services	Bennington	12.7
Upper Valley Services[c]	White River Junction	14.4
Washington County Mental Health Services	Montpelier	48.6
Total, all DAs		$ 301.9[d]

[s] Derived from a MMIS file of claims with dates of service in fiscal year 2013 and the State's primary financial system, VISION. We did not audit these amounts.
[b] Clara Martin Center is not under contract with the state to perform DD services.
[c] Upper Valley Services is not under contract with the state to perform MH services.
[d] Does not add due to rounding.

Appendix IV
Comments from the Commissioner, Department of Disabilities, Aging and Independent Living and Our Evaluation

VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING
COMMISSIONER'S OFFICE
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October 1, 2014

Mr. Douglas R. Hoffer
Vermont State Auditor
Office of the State Auditor
132 State Street
Montpelier, Vermont 05633-5101

Dear Mr. Hoffer:

Thank you for sending the draft report of your audit *Designated Agencies: State Oversight of Services Could Be Improved, But Duplicate Payments Not Widespread*.

DAIL recognizes the fact that the State provides significant funding to the Designated Agencies (DAs) for services provided to thousands of Vermonters each year. Last year, we celebrated the 20th anniversary of the closing of the Brandon Training School; and we are proud of Vermont's reputation as a national leader in developmental services. While we have accomplished much, we believe there are always opportunities to improve, including in how we manage these important services. DAIL appreciated the opportunity to have your office examine our management of services provided by the DAs to people with developmental disabilities. As has been our previous experience with other audits, I compliment Ms. Lambert and Mr. Pritchard on their professionalism throughout this process.

I have reviewed the draft report with my senior staff. Overall, we found the report to be accurate and the recommendations sound. We have provided comments, as you requested, on the findings, conclusions and recommendations and have also outlined for you what actions we plan to take with regards to the recommendations included in the report. Please note that our response focuses solely on those comments related to developmental disabilities services (DS), as I understand that this report has been provided under separate cover to Commissioner Dupre at the Department of Mental Health to respond to aspects dealing with the management of mental health services.

Thank you again for this thoughtful look at DAIL's management of developmental disabilities services provided by the DAs.

Sincerely,

Susan Wehry, M.D.
Commissioner

Appendix IV
Comments from the Commissioner, Department of Disabilities, Aging and Independent Living and Our Evaluation

DAIL Comments on Audit of SFY 13 DA Master Grant

	Introduction	
Pg #	**Document Location**	**DAIL Comment**
1	Paragraph 1 and throughout the report: use of the term "client."	In DS, "clients" are referred to as "consumers," "individuals," or "person." Therefore, as written, the report may not be clear to all readers. Similar to the footnote added that explains the use of the term "support plan," we suggest adding a comment to clarify that "client" refers to these terms.
	Highlights: Report of the State Auditor	
2	Objective 1, Paragraph 3, last sentence.	It would be helpful to clarify, "…DAIL does not compare this data to clients' approved services because the data *on actual services provided* do not include all DD services." The reason for this is that the MSR does not include data for contracted workers who are paid through the Fiscal Employer/Agent (F/EA).
3	Highlights, Objective 2, last paragraph, "For example, DAIL's DD provider manual was issued in 1995…"	There are a number of manuals used in managing DS. For clarity, we suggest revising to read, "DD *Medicaid* provider manual," as we believe this is the manual that is being referenced.
	Background	
4	Paragraph 1 and footnote 4: description of "developmentally disabled and mentally ill."	We recognize that you may be citing specific language from a statute that has not recently been updated. However, Vermont recently passed legislation promoting the use of respectful language. A key tenet of respectful language is using "people first" language, putting the person before his or her disability or label. We request that the language be changed to read "…ensure that community services *for people with developmental disabilities and mental health needs*." The same change can be made in footnote 4 regarding *people with developmental disabilities*.
	Objective 1: DA Funding Mechanisms	
5	Paragraph 1 and throughout: funding through a variety of complex mechanisms and inclusive rates.	One important piece of information that is missing from the description of "inclusive" rates is that where DS is concerned, and as approved by the Centers for Medicare and Medicaid Services (CMS), the State allows agencies to make internal adjustments, within certain reasonable parameters, to individuals' budgets when their needs change. This allows agencies to respond flexibly and quickly to the changing needs of individuals. The Medicaid Provider Manual and DDS System of Care Plan outline the circumstances under which funds may be moved, as well as when they must be suspended or

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			terminated. DAs are expected to document when these adjustments are made. This is important to note, as it is permissible and helps to articulate how an inclusive rate is different and unique from the other mechanisms of payment.
See comment 6 on page 38	7	Table: DAIL Developmental Disability Services, Bridge Program, Basis of Payment	A correction is needed: The monthly rate approved by DAIL is not based on the individual's service plan, but the same case rate based on enrollment.
See comment 7 on page 38	9	State Oversight of DA DS: "DAIL's DD quality management currently consists of four full-time staff- down from 7 in fiscal year 2008."	During the audit process, DAIL provided data on staff changes over time. In FY 04 there was 12 quality staff (some with additional responsibilities), 7 in FY 07 and 4 FTE in FY 09. These changes also occurred while the number of people served has gradually increased. Also, in this paragraph, it is valuable to note that while DAIL has reduced the scope and frequency of reviews, the process does include an examination of whether those sampled are receiving services in accordance with their support plan. This can also include a comparison of what is included in an individual's budget and DAs can and have been instructed to make changes when needed.
See comment 8 on page 38	9	Table 2: Summary of DAIL Oversight of DA Services, Quality Management.	It is also worth noting that DD HCBS clients are reviewed to assess delivery of services in accordance with Individual Support Agreements, and also in accordance with the *Quality Standards, Policies and Procedures*.
See comment 9 on page 38 See comment 10 on page 38	10	Paragraph 2, description of submission and availability of data.	It would be helpful to clarify as follows: "However, while DAs electronically submit monthly data on the actual services provided to each client *to DMH*." DAIL does not receive the data directly. Similar to the comment re: page 2, we suggest further clarification to the next sentence: "*DAIL does not use this data to compare actual to budgeted services because: 1) the data do not include all DD services (does not include services paid through the F/EA) and 2) DAIL has limited access to the electronic data submitted by the DAs.*"
	11	Paragraph 2: *"The fiscal year 2013 master grant agreements state that the DAs are to work collaboratively with the Agency of Human Services to provide complete and accurate information through the monthly service reports for the DD programs. This work was not performed and, according to a DAIL program manager is not planned.*"	While it is factually true to say that this work has not happened, this work requires a significant investment in Information Technology to both develop and implement. This remains a long-term goal and will be integrated with the State's broader efforts of integration. In the meantime, we have outlined some interim steps we will take to ensure complete and accurate reporting (see DAIL response to Recommendation #1).
	12	State Oversight of DD Services: Bottom	Regarding the timeliness by DAIL financial reviews, we

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Comments from the Commissioner, Department of Disabilities, Aging and Independent Living and Our Evaluation

	paragraph.	are pleased to report that all SFY 13 and SFY 14 reviews have now been completed.
Objective 2: Evidence of Duplicate Payments, Prevention and Detection Methods		
16	Bullet 2: "…*the DA is to reduce the amount paid under the DD HCBS rate to cover only home help services*."	As written, this will be unclear to readers as the term "home help services" is not used in DS. We suggest: "...the DA is to reduce the amount paid under the DD HCBS rate to cover *personal care type services through home supports, service planning and administration for up to 30 days of hospitalization*."
20	DAIL and DMH Policies, 2nd Paragraph, Footnote 25: "*For claims with dates of service in fiscal year 2013, the three DAs were paid $74,000 for about 3,000 DD TCM claims lines that were for two units. It is not possible to determine how many of these claims were for 15 minutes without looking at the documentation supporting each claim since a DA could also receive two units for 16 – 30 minutes of service*."	The comment contained in Footnote 25 is an important point to make, since there really is no way to know if or how many of the claims for two units were for only 15 minutes. We believe this comment is important enough to include in the text of the report in paragraph 2, versus in a footnote.
22	DAIL Post Payment Reviews of DA Billing: Paragraph 1: *"For example, to determine whether DAs are limiting their billing for services provided related to discharge planning."*	This section is referring to Targeted Case Management (TCM). Therefore, we suggest making this clear in the report. "For example, *with regards to Targeted Case Management*,…."
Recommendations		
23	First line: Department Name	Please correct the Department name: Department of *Disabilities*, Aging and Independent Living.
23	Recommendation #1: *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.*	DAIL agrees with this recommendation. The long-term solution will happen as part of the State's broader health reform integration efforts and through the planning that is happening currently around developing a new Medicaid Management Information System (MMIS) and other improvements. The timeline for this work to be completed is likely 3- 5 years out. However, we agree that we cannot wait for the implementation of the long-term solution to make some changes. In the meantime, DAIL will: 1) Continue to conduct comparisons that we currently do of individual consumer's plans and services provided as part of our on-going quality assurance. In addition, by April 1, 2015, we will supplement the on-going comparisons that are completed as part of the quality assurance process with separate and additional oversight of activities, including, but not limited to, on-site compliance reviews, of both programmatic and

See comment 11 on page 38

See comment 12 on page 38

See comment 13 on page 38

		financial/billing information, interviews with providers and other information gathering activities. The increased oversight and compliance reviews will provide a clearer analysis of how the developmental services system is working and what changes and improvements need to be made in our management going forward ; 2) Re-affirm the DA Master Grant 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 SFY 15 and annually thereafter and report their findings and any changes made to DAIL; 4) Obtain service and payment data from the MSR 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 SFY 16 data.
23	Recommendation #2: *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.*	DAIL agrees with this recommendation. Beginning in 2015, DAIL will run reports on a sample of individuals receiving other DS services (e.g., Bridge, PASRR – nursing facility day rehabilitation) on a quarterly basis.
24	Recommendation #3: *Update its DA provider manual related to developmental disability programs to reflect current practices. In the interim, written confirmation should be expeditiously sent to the DAs to specify the number of units that can be charged for 15 minutes of DD TCM.*	DAIL agrees with both recommendations. DAIL will confirm the correct billing unit for TCM with DVHA and will issue a clear statement of the definition upon confirmation from DVHA. DAIL has already begun updating the Provider Medicaid Manual. This is a detailed process that will require confirmation of all information from multiple sources. Going forward, DAIL will review the Medicaid provider manual at least annual and will update it as needed. The anticipated completion date for updating the manual is July 1, 2015.
24	Recommendation #4: *Request and help develop an ESC that prevents claims from being paid when a client is in a nursing home.*	As written, this recommendation is not accurate, as some claims are payable when a client is in a nursing home. We suggest: "Request and help develop an ESC that prevents *DD* claims from being paid when a client is in a nursing home, *excluding nursing facility day rehabilitation (PASRR)*." With this clarification, DAIL agrees with the recommendation. 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 period checks of the edits going forward, beginning in February, 2015.

See comment 14 on page 38

24	Recommendation #5: *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.*	DAIL agrees with this recommendation. DAIL will work with DVHA to review the ESCs that pertain to DD programs immediately after the revision of the DD provider manual and annually after that.
24	Recommendation #6: Include as part of the re-designation review/quality management reviews, procedures that check whether the DA DD claims meet DAIL billing requirements and billing limitations, and whether claim documentation meets DAIL standards and seek reimbursement, as appropriate.	DAIL agrees with this recommendation. 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 SFY 16 and as part of the re-designation review process after that. In instances where DAIL identifies that billing requirements and/or limitations have not been met, it will seek reimbursement, when appropriate.

Appendix IV
Comments from the Commissioner, Department of Disabilities, Aging and Independent Living and Our Evaluation

The following presents our evaluation of comments made by the Commissioner of the Department of Disabilities, Aging and Independent Living.

Comment 1	No change to the report was made as we believe that the possibility of misinterpretation is unlikely.
Comment 2	Clarified language in report.
Comment 3	Clarified language in report
Comment 4	Revised language in report.
Comment 5	Added footnote 10.
Comment 6	Corrected.
Comment 7	Corrected.
Comment 8	Based on additional discussion with a DAIL quality management official, added DAIL's *Guidelines for the Quality Review Process of Developmental Disability Services* to Table 2.
Comment 9	The monthly service data is submitted electronically to the Department of Health.
Comment 10	Added information regarding DAIL access to DA's monthly service data as well as footnote 15 to specify the types of DD services that are not included in this data.
Comment 11	Clarified language in report.
Comment 12	Wording in the report was not changed as this sentence also pertains to DMH programs, not just the DAIL program cited.
Comment 13	Corrected.
Comment 14	Clarified language in report.

Appendix V
Comments from the Commissioner, Department of Mental Health and Our Evaluation

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Agency of Human Service

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MEMORANDUM

TO: Doug Hoffer, Vermont State Auditor

FROM: Paul Dupre, Commissioner, Department of Mental Health

DATE: October 3, 2014

RE: Comments to draft report entitled *Designated Agencies: State Oversight of Services Could be Improved, But Duplicate Payments Not Widespread*

We have reviewed the draft report dated September 15, 2014 regarding the Designated Agency service and payment oversight. First, the DMH would like to recognize the professionalism and consistent communication that occurred throughout the audit process. Both Linda Lambert and Michelle Pheeney were collaborative in their approach to the work undertaken with DMH. While we agree with the accuracy of the overall content contained within this report, below are comments and further clarifications that DMH offers up for consideration.

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Comments from the Commissioner, Department of Mental Health and Our Evaluation

DMH Comments on Audit of SFY 13 DA Master Grant

Introduction		
Pg #	**Document Location**	**DMH Comment**
9	Paragraph 1	The Quality Management Unit was reconstituted in August of 2012 with the hiring of a new Director of Quality Management While she was reassigned to another position within the Department, she maintained oversight and supervision of the Quality Management Unit, as Director of Mental Health Services to whom the Quality Management Director reports. Focus of the newly reconstituted Quality Management Unit and coordinators is system development and oversight accountability with the exception of fee-for-service audit activity
9	Table, Re-designation review row, Description column.	Site visits occur during both Agency review and Agency Designation processes, as well as intermittently throughout a given year. The designation process is a priority for review and revision in FY15-16.
10	Table, Budget review row, Limitation column	DMH reviews DA annual budgets for all programs, including, but not limited to CRT and EFT. CRT and EFT, which are service based, receive additional scrutiny; however, DMH provides oversight of the entire DA budget. Year-end utilization reconciliations, audit reviews, and key performance measures are some of the tools used to monitor the fiscal health of the organizations charged with providing services to our mandated populations.
10	DA self-audit row, Limitation column	While the DA self-audits were required for fy14, this is not a new activity. It was performed by DMH thru fy10, but was suspended pending the new IFS rules (which were delayed).
11	Paragraph 3	DMH believes that a central repository of treatment plans/individual plans of care is unrealistic given the current technological tools available. Given that these plans are not uniform and are mostly electronically stored, shifting this information to a central location would be a huge IT and programmatic undertaking and would require extensive protections for compliance with state and federal confidentiality regulations.
11	Paragraph 3	The System of Care Plans refer to a macro level of service provision that requires person-centered treatment planning and implementation. The System of Care Plan does not include a level of detail alluded to in this report. Minimum standards review of charts is one of the means by which we review services provided in accordance with treatment planning. This is a process that takes place in the absence of billing data.

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11	Paragraph 4	See comment above
15	Paragraph 4	If a service is provided outside of the school, it is allowed concurrently to Success Beyond Six services (C.E.R.T, SBS bundle, and SBS BI services).
16-17	Starting with last bullet on pg .16	It is important to note that while the CRT program pays for Emergency Services, payment for such is not made to the home DA unless such services are provided. DMH agrees that FFS billing should not occur for a client enrolled in CRT, but a duplicate payment would only be made if both providers record the service.
17	Paragraph 2	DMH, DRS and DCF/FSD Licensing are familiar with the PNMI programs and what services are available at each. Collectively, the Departments do not have that information documented concisely to clearly differentiate what is allowable or not.
	Recommendations	
	Recommendation #1: *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 individual service plans or requiring DAs to periodically submit comparison data to DMH.*	DMH is a partner with DVHA (and all of AHS) to determine the best reimbursement, oversight and accountability model(s) to ensure that taxpayer dollars are being spent on necessary services while simultaneously embracing the performance based mandate of the State of Vermont. The State's health reform integration efforts and planning in development of a new Medicaid Management Information System (MMIS) will provide a stronger framework with which DMH can manage DA encounter data/payments. DMH will research what mechanism(s) could be reasonably be implemented to address this recommendation until the new MMIS is implemented.
	Recommendation #2: *Develop a list of services that each Private Non-Medicaid Institution 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.*	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 out to the Department of Rate Setting for approval. Once approved, DMH will establish mechanisms with DVHA and HP which may allow concurrent services to be billed. DMH expects to have this in place by the end of fy 15.
	Recommendation #3: *Issue instructions to the*	We concur with this recommendation. DMH will update its

Appendix V
Comments from the Commissioner, Department of Mental Health and Our Evaluation

	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 ad inclusive rate can bill Medicaid for those services.	Medicaid Manual to establish clear billing and documentation standards by the end of fy 15.
	Recommendation #4: *Review the ECSs 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 ECSs to ensure that the remain current.*	DMH agrees that the ECSs in place should be reviewed, especially in light of the new manual and the new CPT codes that were effective 1/1/2014. DMH will work with HP to identify the relevant ECSs and begin a review process. Communications with HP will occur by 10/31/14 and, barring any issues to identify all of the ECSs, should be able to complete the review process by end of fy 15. 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.
24	Recommendation #5: *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*	DMH agrees that an important function of its oversight activities is to ensure that billings are appropriate and comply with DMH billing standards. DMH will work with DVHA and AHS to identify the human resources and/or collaborative functions necessary to carry out this activity by end of fy 15.

Appendix V
Comments from the Commissioner, Department of Mental Health and Our Evaluation

The following presents our evaluation of comments made by the Commissioner of the Department of Mental Health.

Comment 1	According to DMH's Medicaid Managed Care Quality Plan, the agency review is part of the re-designation process.
Comment 2	Based on additional communication with DMH regarding their budget reports, no change was made to the report.
Comment 3	Changed language to reflect that the EFT self-audit process was not performed in fiscal years 2011 – 2013.
Comment 4	The sentence to which DMH refers is a statement of the current condition. While our recommendation does not mandate a technology solution, we continue to conclude that without a systematic comparison of budgeted to actual services that DMH cannot ensure that clients are receiving the planned services and that payments being made reflect the services being performed and are not too much or too little.
Comment 5	Added DMH's statement regarding the System of Care Plan. However, as Table 2 shows, DMH looks at only a few charts at each DA every four years. Accordingly, the minimum standards chart review process referenced in DMH's comments does not provide a systematic way for DMH to determine if services provided were in line with the individuals' service plans.
Comment 6	Added footnote 18.
Comment 7	Added language to the report that the services in question were performed at a school location.
Comment 8	Under the CRT inclusive rate program, the "home" DA receives a set monthly payment to cover all mental health services to CRT clients, including emergency services. Therefore, if another DA is paid for an emergency service involving the CRT client of the home DA the State has effectively paid for that service twice. While DMH has a process in place in which it may adjust a DA's CRT rate based on actual services provided, this process considers the DA's overall (not individual) CRT budget. Accordingly, the circumstance referenced by DMH meets our definition of duplicate payments.