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December 4, 2013

Mary Mayhew, Commissioner
Department of Health and Human Services
11 State House Station
Augusta, ME 04333-0011

Dear Commissioner Mayhew,

The Office of the State Auditor conducted a limited procedures engagement of a Department of Health and Human Services' vendor who is providing Housing and Direct Care Mental Health Services.

We have completed our report and DHHS personnel has responded to our concerns in writing. Their responses have been incorporated into our report and the report is attached to this letter.

Our report will be available on the Office of the State Auditor website at <http://www.maine.gov/audit/reports.htm>, in the section for Other Reports.

We thank Social Services Director Eileen Cummings, Acting Director of Policy Beth Ketch, Director of Audits Herb Downs, Director of the Rate Setting Unit Colin Lindley, Office of Aging and Disability Services Associate Director Gary Wolcott, and Health Facilities Survey Manager Michael Swan along with members of their staff for their assistance during this engagement.

Sincerely,

A handwritten signature in blue ink that reads "Pola A. Buckley".

Pola A. Buckley, CPA, CISA
State Auditor

Cc: Honorable Margaret Craven, Senate Chair, Health and Human Services Committee
Honorable Richard Farnsworth, House Chair, Health and Human Services Committee
Ricker Hamilton, Deputy Commissioner of Programs, DHHS
Eileen Cummings, Director, Social Services, DHHS
Herb Downs, Director, Division of Audit, DHHS
Beth Ketch, Acting Director of Policy, DHHS
Colin Lindley, Director, Rate Setting Unit, DHHS
Gary Wolcott, Associate Director, Office of Aging and Disability Services, DHHS
Michael Swan, Health Facilities Survey Manager, DHHS

Enclosure

Office of the State Auditor
Report on Limited Procedures Engagement
DHHS Vendor Providing Housing and Direct Care Mental Health Services
Report Issued on December 4th, 2013

Summary

The Office of the State Auditor performed a limited procedure engagement related to a single vendor that provides housing and direct care services to DHHS mental health clients. Our procedures included learning the history of the vendor and the environment in which it operates, understanding the services being provided, and reviewing the State's payments to the vendor. Our audit identified the following areas of concern:

- the resident's share¹ of the cost of housing and direct care services is not being deducted from automated payments to the vendor,
- in a non-transparent fashion, the value associated with room and board, a non-allowable component of the services provided, is incorrectly being charged along with direct care service costs that are eligible for federal financial participation and
- the method of reimbursement for Routine Service Costs warrants review because the vendor claims that their expenditures are underfunded.

Background

The typical client served by the vendor receives food, shelter, and supervision of daily activities such as medication management, and assistance with personal hygiene. The residents are either a Public Ward of the State where DHHS serves as the guardian of last resort or they are under Private Guardianship where a family member, friend, attorney or other interested person serves as guardian. In both cases, a petition is filed with and an appointment of guardianship must be made by the Probate Court.

In the summer of 1989, in response to severe overcrowding and the deaths of patients at the Augusta Mental Health Institute, Maine Advocacy Services filed a class action lawsuit on behalf of specific AMHI residents against the Commissioners of the Department of Mental Health and the Department of Human Services as well as the Superintendent of the Augusta Mental Health Institute (AMHI). The resulting "AMHI Consent Decree" required the defendants to develop, fund and support less restrictive community housing and residential services as an alternative to the institutional setting. As a way of de-institutionalizing patients and also as an alternative to the more costly nursing home setting, Private Non-Medical Institutions (PNMIs) emerged. Presently, there are several categories of PNMIs defined in Chapter III Section 97 of the MaineCare Benefits Manual. Appendix F Non-Case Mix Medical and Remedial Facilities is the section applicable to this vendor. Appendix F facilities are licensed and staffed to provide long term mental health services to clients in three distinct categories:

- those who have suffered brain injury,
- those with developmental disabilities and
- those who are in need of adult protective services.

¹In many cases, the resident has financial resources available to contribute to their cost of care. Programs such as Social Security, Social Security Disability Insurance and Supplemental Security Income are the most common sources of a resident's income. Other private sources may also be available.

Statewide, there are three providers at seven sites licensed to provide adult protective services to about fifty clients. This vendor operates three of the seven separate sites, each with six beds serving a total of eighteen clients.

We are aware that the Center for Medicaid Services (CMS) has expressed concern regarding federal participation in the cost of services being provided by PNMIs. In the case of Appendix F facilities, CMS has expressed concerns over the bundling of prospective rates, non-transparent room and board, and the lack of clinical supervision. A bundled rate exists when a single rate is used to pay for services prospectively² at the time they are provided, regardless of the number of units of service, types of service or the level of practitioners who are providing the service. Room and Board costs are not medical and remedial and therefore not eligible for federal financial participation. Since the State is classifying only an incidental amount of \$1 per day as Room and Board and charging it to the General Fund using a separate object code, it appears that in a non-transparent fashion, federal reimbursement is being collected for unallowable Room and Board costs by improperly classifying them as Direct Care Services. The lack of clinical supervision over paraprofessionals who are providing mental health services calls into question the medical and remedial necessity of the services and therefore the allowability of the services for federal financial participation.

Procedures

We met with DHHS personnel as follows:

- the Office of Aging and Disability Services to gain an understanding of the history of the vendor, the service they provide and the environment in which they operate,
- the Division of Licensing and Regulatory Services to gain an understanding of the licensing and facility survey process,
- the Rate Setting Unit to gain an understanding of the prospective reimbursement methodology,
- the Division of Audit to gain an understanding of the cost report settlement process, and
- the Office of MaineCare Services (OMS) to review the results of our expenditure test.

We toured all three of the vendor's facilities with their Administrator in order to become familiar with the services provided. We also discussed the Administrator's regulatory concerns.

We met with personnel employed by the vendor's bookkeeping service in order to become familiar with their accounting and cost report filing process. We also discussed their concerns regarding the claims processing and reimbursement process.

We examined \$7.5 million paid to the vendor from fiscal year 2008 and ending approximately half way through fiscal year 2013. We tested the population of expenditures paid to the vendor for the period July 1, 2012 to December 30, 2012 for compliance with the daily rate established by DHHS's Rate Setting Unit and for the proper deduction of Cost of Care. Cost of Care is a term used to describe the dollar amount available from sources other than the State that must pay for services being provided to clients prior to Medicaid financial participation.

Results

We gained an understanding of the environment in which this vendor operates as a Private Non-Medical Institution (PNMI) by meeting with staff employed by the Office of Aging and Disability Services.

² Subject to annual cost settlement

From our meeting with the Division of Licensing and Regulatory Services, we learned that this vendor has been providing quality services to clients and has a history of facility surveys that are free of deficiencies. Our less formal observations are consistent with their comments to us.

From our meetings with the Rate Setting Unit, we learned that reimbursement rates for Direct Care Service Costs are driven principally by amounts reflected in the vendor's most recently available Medicaid cost report examined by the DHHS Division of Audit. We obtained their agreement that the \$1.00 daily rate for Room and Board is an arbitrary amount without any basis in the rules for reimbursement, nor is there any foundation for the rate in the vendor's historical costs.

From our meetings with the DHHS Division of Audit, we gained an understanding of the process by which the vendor's Medicaid Cost Reports are examined. We reviewed in detail one audited cost report for one of the vendor's facilities and found that all settlement calculations were consistent with the MaineCare rules for reimbursement.

Based on our walk-through of each of the vendor's three facilities, we were left with the impression that the facilities are clean, secured and well maintained. The facility's Administrator, a dedicated and long serving employee expressed his concerns regarding current reimbursement methodologies. He knew that the State systematically overpays them and that the money must be repaid. He noted that in the past, he has written to DHHS expressing concerns about the fact that, separately from the overpayment issue, the vendor has not been able to recover their operating costs.

From our discussions with the vendor's bookkeeping service, we gained an understanding of the claims and accounts receivable process as well as the process for filing the annual Medicaid cost report. The president of the bookkeeping service company expressed the same concerns as the Administrator regarding the vendor's finances and noted that past attempts to communicate concerns with the Department of Health and Human Services did not result in a response from the State agency.

In our examination of expenditures paid to this vendor between fiscal year 2008 and mid-way through fiscal year 2013, consistent with our expectations, we found that there was no significant change in the annual level of payments made to this vendor for Residential Treatment and Personal Care Services provided to Medicaid eligible clients.

From our test of expenditures paid to the vendor for the first half of fiscal year 2013, we concluded as follows:

- All payments were made based on the correct approved daily rate.
- A total of \$85,785 in Cost of Care was not deducted from payments to the vendor, thus the vendor was overpaid by this amount.

Conclusions and Recommendations

Currently, payments to the vendor are not being reduced by the applicable amount of Cost of Care. We learned that this vendor owed DHHS \$274,213 for overpayment of claims as of April of 2013. We recommend that DHHS initiate a system change the effect of which will allow Cost of Care to be deducted from all payments to the vendor.

For the period fiscal year 2008 through fiscal year 2012, the vendor claims they were underfunded by \$578,077. We recommend that the Department of Health and Human Services meet with the vendor to review their concerns regarding adequate funding.

The last examination and cost settlement performed by the DHHS Division of Audit for this vendor related to fiscal year 2009. We recommend that The Department of Health and Human Services “catch-up” on their annual cost settlements with this vendor.

We thank the dedicated workers employed by the vendor and its agent as well as the many dedicated persons employed by the Department of Health and Human Services for providing their insights and feedback regarding these matters.

Agency Response

Response to Recommendation 1:

Originally, the MIHMS system was not properly designed to collect Cost of Care from PNMI's.

Based on the recommendations of a separate auditor examining Cost of Care for a sample of sixty PNMI's and Nursing Homes, we have requested a MIHMS Change Request (CR) to have cost of care deducted from all lines on a PNMI claim. Work is currently progressing on this CR (#36287) by State and Fiscal Agent systems staff. Once the system has been updated, we will adjust all claims where the COC overpayment has not been paid to the Department by the provider.

We described the current cost of care collection process to the auditor. A designated State employee receives and reviews reports of members with uncollected cost of care for prior months. This individual attempts to work directly with the PNMI's to set up repayment plans or to recoup the money. As the auditor noted, the PNMI's are aware of the overpayment and can refund the money.

Response to Recommendation 2:

The Department does not have a copy of the vendor's documentation supporting their claim that they have been underfunded by \$578,077. The Department reimburses residential care facilities based on the applicable Principles of Reimbursement. To be allowable for reimbursement, costs must be reasonable and necessary. In addition, reimbursable cost is capped. If the facility incurs cost in excess of their cap, the excess cost is not allowable for reimbursement.

We would refer the provider back to Chapters II and III of the MaineCare Benefits Manual for an explanation of covered services and determination of reimbursement. In addition, as noted in Chapter 115, Principles of Reimbursement for Residential Care Facilities – Room and Board Costs, “Reimbursement for specified room and board costs shall be provided on a “reasonable cost-related basis” rather than by simply reimbursing the provider's costs. In determining what is a reasonable cost-related basis, all payments must relate to the care of the member and be based on the “reasonable cost.” Reasonable costs include all allowable, necessary and proper costs incurred in rendering room and board to members who are receiving Medical and Remedial Services under the MaineCare program, subject to the Principles relating to specific items of revenue and cost. Costs may not be shifted from Medical and Remedial Services to room and board.”

Response to Recommendation 3:

The Department has a strategy to “catch up” on all of its cost report audits. Audit of the vendor's cost reports is part of that strategy. The vendor's audits should be complete by June 30, 2014.