

**AGENCY FOR PERSONS WITH  
DISABILITIES**

**INDIVIDUAL AND FAMILY SUPPORTS PROGRAM  
AND PRIOR AUDIT FOLLOW-UP**

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**Operational Audit**



## DIRECTOR OF THE AGENCY FOR PERSONS WITH DISABILITIES

The Agency for Persons with Disabilities is created by Section 20.197, Florida Statutes. The head of the Agency is the Director who is appointed by the Governor subject to confirmation by the Senate. The following individuals served as Director:

Bryan Vaughn	From March 2011 to August 2011 (Interim)
Carl Littlefield	February 2011
James DeBeaugrine	From August 2008 to February 2011

The audit team leader was Ying Ying Chen, CPA, and the audit was supervised by Samantha Perry, CPA. Please address inquiries regarding this report to Jane Flowers, CPA, Audit Manager, by e-mail at [janeflowers@aud.state.fl.us](mailto:janeflowers@aud.state.fl.us) or by telephone at (850) 487-9136.

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## AGENCY FOR PERSONS WITH DISABILITIES

### Individual and Family Supports Program and Prior Audit Follow-Up

#### SUMMARY

This operational audit of the Agency for Persons with Disabilities (Agency) focused on the Individual and Family Supports (IFS) Program, and the status of Agency actions taken to correct the findings included in our report Nos. 2010-037, Residential Facility Licensing and Follow-Up on Prior Audit Findings, and 2008-025, Consumer-Directed Care Plus Waiver Program. Our audit disclosed the following:

#### IFS PROGRAM

**Finding No. 1:** The Agency's client eligibility determination processes needed improvement. We found instances in which the Agency did not correctly complete and document client eligibility determinations and instances in which the Agency provided IFS Program payments on behalf of ineligible clients.

**Finding No. 2:** The Agency did not always utilize Medicaid providers for IFS Program clients who were eligible for Medicaid Program services.

**Finding No. 3:** The Agency did not always timely terminate IFS Program payments for IFS clients after they had died. In addition, the Agency had not completely resolved instances in which the social security numbers of Agency clients matched those of individuals who were deceased, according to the official death records of the Office of Vital Statistics.

**Finding No. 4:** IFS Program expenditure transactions were not always correctly and properly recorded in the Agency's Allocations, Budget, and Contract Control (ABC) System and the Florida Accounting Information Resource (FLAIR) Subsystem.

**Finding No. 5:** The Agency did not appear to utilize the most cost-effective services provider based on a client's Medicaid status. In addition, the Agency did not always complete an assessment of need for Agency clients.

#### QUALITY ASSURANCE REVIEWS – HOME AND COMMUNITY-BASED SERVICES PROGRAM

**Finding No. 6:** The Agency did not always timely follow-up with providers who were determined to be noncompliant with quality assurance review requests.

#### CONSUMER-DIRECTED CARE PLUS PROGRAM

**Finding No. 7:** Due to the lack of fiscal controls, Consumer-Directed Care Plus (CDC+) Program funds were allowed to accumulate in consumers' accounts instead of being returned to the State.

**Finding No. 8:** Due to the lack of fiscal controls, CDC+ Program consumers were able to spend funds in excess of their monthly budgets, resulting in negative balances in their accounts.

#### BACKGROUND

The Agency for Persons with Disabilities (Agency) is responsible for all services provided under Chapter 393, Florida Statutes, to persons with developmental disabilities, including the operation of all state institutional programs and the programmatic management of Medicaid waivers established to provide services to persons with developmental disabilities. Each month, the Agency serves approximately 30,000 people in Florida who have autism, mental retardation, spina bifida, cerebral palsy, or Prader-Willi syndrome, or are children aged 3 to 5 who are at high risk of being diagnosed with a developmental disability. Information for each client is to be maintained in the Agency's Allocations, Budget, and Contract Control (ABC) System.

Appropriations to the Agency for the 2010-11 fiscal year totaled \$1,013,500,529 and are summarized as follows:

**Table 1  
Agency Funding**

Program Area	General Revenue	Trust Funds	Total
Home and Community Services Administration	\$ 12,978,160	\$ 10,694,286	\$ 23,672,446
Individual and Family Supports	3,980,000	15,056,771	19,036,771
Room and Board Payments	4,000,000	-	4,000,000
HCBS Waiver	309,880,161	495,946,457	805,826,618
Program Management and Compliance	19,911,097	16,582,336	36,493,433
Developmental Disabilities Public Facilities	63,859,814	60,611,447	124,471,261
<b>Total</b>	<b>\$414,609,232</b>	<b>\$598,891,297</b>	<b>\$1,013,500,529</b>

The Agency’s central office is located in Tallahassee, and Area Offices are located throughout the State.

**FINDINGS AND RECOMMENDATIONS**

**Individual and Family Supports Program**

Pursuant to Agency policy, the Individual and Family Supports (IFS) Program is to provide community-based care for disabled individuals who are either not eligible for the Home and Community-Based Medicaid (HCBS) waiver services, are waiting for HCBS waiver enrollment, or are enrolled in the HCBS waiver, but request nonwaiver services. IFS Program funds may also be used for Medicaid clients, but only for certain services not covered by Medicaid. In summary, IFS Program moneys are to be used to provide individual and family support only when assistance is not available through other Agency resources. Legislative appropriations for the IFS Program totaled approximately \$19 million in State and Federal Social Services Block Grant (SSBG) funding<sup>1</sup> during the 2010-11 fiscal year. Table 2 includes eligibility information for active Agency clients where the Agency made IFS Program payments on behalf of the clients during the period July 2009 through February 2011. As described in the following findings, our audit tests disclosed deficiencies in the IFS Program controls related to client eligibility determinations and IFS payments.

**Table 2  
IFS Funds Paid on Behalf of Agency Clients  
July 2009 Through February 2011**

Program	Number of Clients	Amount
Consumer-Directed Care Plus	26	\$ 99,121
HCBS waiver - Tier 1 <sup>2</sup>	685	2,491,725
HCBS waiver - Tier 2 <sup>2</sup>	781	1,643,343
HCBS waiver - Tier 3 <sup>2</sup>	533	1,221,445
HCBS waiver - Tier 4 <sup>2</sup>	553	1,586,126
HCBS waiver Tier level to be determined	265	1,122,182
IFS Program only	4,826	14,714,354
<b>Total</b>	<b>7,669</b>	<b>\$22,878,296</b>

Source: ABC System.

<sup>1</sup> Federal funding sources included the Social Services Block Grant (Catalog of Federal Domestic Assistance [CFDA] No. 93.667).

<sup>2</sup> Individuals enrolled in the HCBS waiver are assigned to a tier level ranging from one (most intensive care needs) to four (least intensive care needs) based on eligibility criteria outlined in Section 393.0661, Florida Statutes.

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**Finding No. 1: Client Eligibility Determination**


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State law<sup>3</sup> defines the application and client eligibility determination requirements applicable to Agency services. Additionally, the Agency maintains policies and procedures describing the process to be used in all Area Offices for the determination of eligibility. To apply for Agency services, the applicant is required to submit a written Application for Services and to provide documentation including proof of identity and Florida domicile. Area Offices are responsible for processing the Application, making eligibility determinations, and maintaining the documentation in the Agency's central records.

Our review of the Application for Services and supporting documents for 44 clients where the Agency made IFS Program payments on behalf of the clients from July 2009 through February 2011, disclosed nine instances where the client did not appear to be eligible for Agency services, or where the Agency did not document the eligibility determination. Specifically, we noted the following:

- Current State law<sup>4</sup> provides that only applicants whose domicile<sup>5</sup> is in Florida are eligible for Agency services, including those services provided by the IFS Program and the HCBS waiver. The law further provides that domicile may not be established in Florida by any alien not classified as a resident alien. In four instances, the clients were not domiciled in Florida, as they were not United States citizens or resident aliens. The Agency made IFS Program payments from July 2009 through February 2011, totaling \$237,821 on behalf of the four clients. Of the \$237,821, approximately \$185,000 was paid for adult residential habilitation services. The clients had been active Agency clients since 1985, 2000, 2001, and 2003, respectively, and had not been court-ordered into Agency custody.<sup>6</sup> For one of these four instances, the case worker had indicated on the Application for Services, that the applicant was ineligible for Agency services. In addition, as of February 28, 2011, although they were ineligible, two of these four clients were on the HCBS waiver wait list.
- In three instances, documentation to support the client's reported domicile in Florida, including proof of US citizenship or resident alien status, was not available in Agency records. Therefore, a determination of whether the clients were eligible for Agency services could not be demonstrated by the Agency.
- In four instances, the clients' Application for Services was not correctly completed. In one instance, the client did not complete information related to residency status, and in three instances, the case worker did not document on the Application for Services, the determination of the applicant's eligibility.

Agency staff indicated that prior to the establishment of the Agency's policies and procedures for eligibility determination in 2006, documentation supporting residency was not always maintained and that in order to ensure their health and safety, the Agency had continued to serve a specific group of individuals who have no legal status. However, our review of State law at the time of application for four of the Agency clients noted above disclosed that in three of the instances, Florida domicile was a pre-existing eligibility requirement. In one instance, the client had applied in 1985, prior to the adoption of Florida domicile as an eligibility requirement.

The failure of the case workers to maintain eligibility documentation and correctly complete the Application for Services increases the likelihood that services will be provided to ineligible individuals. Also, Agency policies and

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<sup>3</sup> Section 393.065, Florida Statutes.

<sup>4</sup> Section 393.065(1), Florida Statutes.

<sup>5</sup> Section 393.063(12), Florida Statutes, defines domicile as the place where a client legally resides, which place is his or her permanent home. Domicile may not be established in Florida by a minor who has no parent domiciled in Florida, or by a minor who has no legal guardian domiciled in Florida, or by any alien not classified as a resident alien.

<sup>6</sup> According to Agency management, IFS Program funds may be used to provide services to individuals who are court-ordered into the Agency's care.

procedures did not require periodic redeterminations that clients were in compliance with Florida residency requirements. Such redeterminations would provide opportunities to ensure that services are provided to eligible individuals and families.

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**Recommendation:** We recommend that the Agency re-evaluate the client Applications approved prior to 2006. We also recommend that redeterminations of Florida domicile be made on at least an annual basis.

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**Finding No. 2: IFS Payments for Medicaid Clients**

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As indicated above, under the **Individual and Family Supports Program** heading, IFS Program funds may not be used to pay for services for Medicaid clients, when those services are covered by Medicaid. The Medicaid State Plan outlines which services are covered. For example, Medicaid covers emergency dental services for adults, but not routine dental care. State General Revenue funds<sup>7</sup> totaling \$251,534 from July 2009 through February 2011 were expended for IFS Program medical and dental care services.

Our review of 14 medical IFS payments and 40 dental service IFS payments made during the period July 2009 through February 2011, for Agency clients also enrolled in Medicaid, disclosed instances where the IFS Program payment was for a service that was available under the Medicaid State Plan. Specifically:

- In seven instances, the Agency made IFS Program payments totaling \$1,503 on behalf of Medicaid recipients for prescriptions and medical or visual services that were available under the Medicaid Program, as outlined in the Medicaid Physician Services Coverage and Limitations Handbook, Visual Services Coverage and Limitations Handbook, or the Florida Medicaid Preferred Drug List. In two other instances, based on the limited documentation provided, we could not determine whether the IFS Program payments totaling \$404 were for a service or prescription available under the Medicaid State Plan.
- In 27 instances, the Agency made IFS Program payments totaling \$12,275 on behalf of Medicaid recipients for dental services that were available under the Medicaid Program, as outlined in the Medicaid Dental Services Coverage and Limitations Handbook. Services provided by the IFS Program were not subject to the Medicaid rate guidelines, and the services were invoiced and paid at the provider's rates, which exceeded the related Medicaid rates by \$8,436. According to the Dental General Fee Schedule, the Medicaid cost for the dental services would have totaled \$3,839.

Agency management indicated that the Area Offices were responsible for exploring all available funding options for which an individual was eligible; however, the Agency had not established written policies or procedures that directed staff to determine the availability of Medicaid services for Medicaid recipients. The absence of policies and procedures reduced the likelihood that services that were otherwise covered under Medicaid would be identified and be provided by Medicaid, rather than by the IFS Program.

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**Recommendation:** We recommend that the Agency establish policies and procedures that more reasonably ensure that Medicaid services are used when available. We also recommend that when non-Medicaid providers are used for Medicaid eligible clients, documentation be prepared and retained to demonstrate the unavailability of Medicaid services.

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<sup>7</sup> Federal Regulations (Title 42, Section 1397(d)(a)(4), United States Code) prohibit the expenditure of Social Services Block Grant (SSBG) funds on medical care other than family planning services, rehabilitation services, or initial detoxification of an alcoholic or drug-dependent individual.

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**Finding No. 3: Payments for Deceased Clients**

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According to Agency management, for clients in an active case status (i.e., status 20), a monthly vital statistics crosscheck is completed, which matches official death records from the State's Office of Vital Statistics to individuals with an active case in the ABC System. The crosscheck is conducted in order to identify Agency clients who have died and ensure the timely discontinuation of the payment of benefits. The Area Offices are to review the matching records produced by the crosscheck and obtain additional confirmation of the client's death. In the case of a confirmed death, a Report of Death form is to be prepared, and the case manager is to change the client's status in the ABC System to a code indicating that further payments for services should not be authorized.

Our audit included a crosscheck for 7,636 Agency clients where the Agency made IFS Program payments on behalf of the clients from July 2009 through February 2011. Our audit disclosed the following:

- The Agency made IFS Program payments totaling \$623 to providers on behalf of four clients for services provided on dates after the client's date of death.
- For 10 clients, the Social Security numbers listed in the ABC System for active status accounts matched the social security numbers shown by Office of Vital Statistics death records. Agency staff indicated that the clients were not deceased; however, the Agency did not provide for our review, records describing the steps that had been taken to establish that Office of Vital Statistics' records were in error. Such steps may include, for example, re-establishing the identification of the Agency's client through the observation of the client, photo identification, and social security card, and informing the Office of Vital Statistics of any potential death record errors. The Agency made IFS Program payments on behalf of the clients totaling \$87,469 from July 2009 through February 2011.
- The Agency processed IFS Program payments totaling \$2,700 that were recorded under a deceased applicant's social security number. Based on subsequent inquiries, Agency staff indicated that payments were for a different client with the same name whose account had been inappropriately combined with that of the deceased applicant.

Although the Agency had procedures for verifying a confirmed death, the Agency did not have procedures requiring Agency staff, in those instances in which client death is not confirmed, to attempt to seek resolution of the apparent errors and document the results. The lack of procedures could result in a failure to detect and correct payment and record errors. Subsequent to audit inquiry, Agency staff contacted the Office of Vital Statistics in order to seek resolution of the specific issues disclosed by our tests.

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**Recommendation:** We recommend that the Agency establish written policies and procedures that provide guidance for staff regarding the steps to be taken, including those relating to documentation, to resolve crossmatch errors. The procedures should include processes for informing the Office of Vital Statistics of potential death record errors. We also recommend the Agency recoup from providers payments made for the deceased clients.

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**Finding No. 4: IFS Program Expenditure Transactions**

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IFS Program service authorizations were to be recorded in the ABC System upon the Agency's authorization of the service. Subsequent to the completion of the service, the Area Office was to receive the provider's invoice and in the ABC System, review the authorized amount to ensure that the actual billed amount did not exceed the authorized amount. Documentation of the expenditure was to be submitted to the client services disbursement unit where staff was to review the supporting documentation, audit for proper FLAIR and ABC System coding, and then transmit the payment detail to FLAIR so that disbursement could be made to the provider. The ABC System utilized service codes to record the purpose of the expenditure, and the service codes corresponded with a unique FLAIR object

code. For example, ABC System service code 1069 for Adult Competency Restoration Training corresponded with object code 252031 in FLAIR. The Agency used the object codes to distinguish activities that, under the SSBG Program, are allowable and unallowable according to Federal Regulations.

Our test of expenditure transactions for 60 clients disclosed several instances where the Agency policies and procedures did not ensure the correct recording or payment of expenditures. Specifically, we noted the following:

- In three instances, due to undetected Agency employee errors, IFS Program payments exceeded the amounts due to providers. In one of these instances, the provider was paid for more service days than actually delivered, and in one instance, the provider was paid for more service days than authorized, resulting in overpayments totaling \$20,569. In the third instance, the overpayment totaling \$212 was due to a mathematical error.
- In 13 instances, the FLAIR object codes used were incorrect. According to Agency staff, the errors occurred when the transactions were manually entered into FLAIR, or when the object code was established in FLAIR for particular provider contracts.
- For three expenditure transactions totaling \$750, the service code used to record the payment in the ABC System was incorrect due to Agency employee error. The use of the incorrect service code also resulted in the expenditure being charged to an incorrect object code in FLAIR.

Absent effective operation of Agency controls, errors in payment and reporting will occur and escape detection. Increased supervisory monitoring of staff compliance with Agency procedures would better ensure the effective operation of established controls.

In addition to the above, our review also identified payments totaling \$38,850 charged to the IFS Program in error. The Agency recorded payments for monthly client monitoring to the IFS Program. According to Agency management, client monitoring was not a function of the IFS Program.

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**Recommendation:** We recommend that the Agency recoup the overpayments from the three providers. In addition, in order to prevent errors in payments and coding, we recommend that the Agency enhance the level of supervisory monitoring of staff compliance with applicable Agency policies and procedures.

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#### **Finding No. 5: Utilization**

According to Agency policies and procedures, for clients enrolled in the HCBS waiver, the CDC+ Program, or included on the waiver wait list, a Questionnaire for Situational Information (QSI) is to be administered at the time of eligibility determination, at least once every three years, and when the client has a significant change in condition or circumstance. In addition, the QSI is to be reviewed annually for possible changes at the time of annual support plan development. Through obtaining data in the areas of functional status, behavioral status, physical status, life changes, and community inclusion, the QSI was to be used in the evaluation of the client's needs for assistance. A final estimated level of support ranging from one (basic) through five (intensive) was to be calculated based on the QSI results. As required in State law,<sup>8</sup> the QSI results and other factors such as client characteristics, including, but not limited to age, were to be used by Agency staff to assign clients eligible for enrollment in the HCBS waiver to a tier level ranging from one (most intensive care needs) to four (least intensive care needs).<sup>9</sup>

Our review of the 20 clients where the Agency had made the largest amounts of IFS Program payments on their behalf from July 2009 through February 2011 totaling \$2,658,225 and averaging \$132,911, disclosed the following:

<sup>8</sup> Section 393.0661(3), Florida Statutes.

<sup>9</sup> The eligibility criteria for tiers one through four are outlined in Section 393.0661, Florida Statutes.

- Agency policies and procedures did not require a QSI to be completed for individuals not enrolled in the HCBS waiver, the CDC+ Program, or the waiver wait list. As a result, for five of the 20 clients where the Agency made the most amount of IFS Program payments on their behalf, no documented assessment of client need had been performed. IFS Program funds paid on behalf of these clients ranged from \$99,733 to \$120,638. Contrary to its policy, the Agency had not completed a QSI for one client who was on the waiver wait list.
- As noted previously, IFS Program funds may be used for Medicaid clients, but only for certain services not covered by Medicaid. Our tests disclosed instances in which IFS Program funds were used for services covered by Medicaid. One client was enrolled in the HCBS waiver at the tier one level. Tier one clients were those who have intensive medical or adaptive service needs that cannot be met in tier two, three, or four and that were deemed essential for avoiding institutionalization, or who possessed behavioral problems that were exceptional in intensity, duration, or frequency and presented a substantial risk of harm to themselves or others. The Agency had made IFS payments totaling \$204,006 with SSBG funds for adult residential habilitation services at an authorized amount of \$363 per day for 350 days per year since 2008. According to Agency management, because the Medicaid-eligible client received the habilitation services from a non-Medicaid provider, IFS funds were used to pay for the care rather than Medicaid funds through the HCBS waiver. Agency management indicated that the client was eventually transferred to a Medicaid provider at a much lower rate of \$543.42 per month.
- For one client, the Agency had made IFS payments totaling \$222,657 with SSBG funds of which \$221,430 was for habilitation services at an authorized amount of \$363 per day for 365 days per year since 2008. The client's HCBS waiver classification of tier four (least intensive), made the client ineligible for habilitation services under the HCBS Medicaid waiver. However, the appropriateness of the waiver classification was unclear, as we noted that the client's QSI score was rated at level five (intensive). An HCBS waiver tier classification that was more consistent with the QSI score would have qualified the client for habilitation services under the HCBS Medicaid waiver. Agency management indicated that at the time of the client's need for services, the only available placement was at a facility that did not accept the HCBS Medicaid waiver; therefore, the client's tier level would not have affected the payment. However, Agency records substantiating the unavailability of a Medicaid provider were not provided for our review.

Absent a requirement to complete a QSI for all clients, the Agency lacks records to show that the care and support provided was consistent with the assessed level of need. In addition, the maintenance of records explaining the basis for provider selection, particularly for services required by Medicaid-eligible clients, would better enable the Agency to demonstrate the cost-effectiveness of the IFS expenditures made for provider care.

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**Recommendation:** We recommend that the Agency consider completing a QSI for all Agency clients, including those who receive only IFS funded assistance. In addition, the Agency should take greater care in locating and utilizing Medicaid providers for HCBS Medicaid waiver clients, and when non-Medicaid service providers are utilized, documenting the circumstances justifying their use.

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<b>Quality Assurance Reviews – Home and Community-Based Services Program</b>
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The HCBS waiver was created to provide community services to individuals as an alternative to institutional care. To ensure that services were provided by qualified persons, the Agency implemented a quality management strategy (QMS) based on the HCBS Waiver Quality Framework Model developed by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS). The three quality management functions featured by QMS are discovery, remediation, and improvement. To assist the Agency in the discovery activity, the Delmarva Foundation for Medical Care (Delmarva), under contract with the Agency for Health Care Administration (AHCA),<sup>10</sup> provided quality assurance oversight of providers and person-centered reviews for recipients served by the

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<sup>10</sup> The AHCA entered into a new contract with Delmarva effective January 1, 2010.

Agency in the Developmental Disabilities Services, HCBS waiver, and CDC+ Programs. The remediation and improvement activities are responsibilities of the Agency.

Our follow-up procedures disclosed that the Agency had resolved the deficiencies identified in our report No. 2010-037. However, additional deficiencies related to the Agency's remediation activities were identified.

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**Finding No. 6: Follow-Up Procedures for Noncompliance with Provider Reviews**

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The standard Medicaid Waiver Services Agreement, to be signed by all providers upon enrollment as a Medicaid waiver provider, requires providers to cooperate during monitoring, audits, inspections, and investigations and allows the suspension or termination of a provider for unacceptable performance or nonperformance. Our audit included an evaluation of the Agency's remediation activities and an evaluation of whether the Agency followed up with providers that were determined to be noncompliant with Delmarva's attempts to perform a provider performance discovery review (PDR). Delmarva performed 1,863 PDRs between March 2010 and September 2010. For 45 of the 1,863 PDRs, the provider was determined to be noncompliant (generally due to the provider not participating in the quality assurance monitoring). Upon further review, as of March 8, 2011, 36 of those providers remained active, while 9 had been terminated. For 19 of 35 providers,<sup>11</sup> the Agency did not perform timely follow-up actions. Specifically, we noted the following:

- In 14 instances, the Agency had not requested or recommended termination of the provider's status as a Medicaid provider, until prompted to do so by our audit inquiry. In 4 of the instances, the provider had continued to receive payments totaling \$40,861 for Medicaid claims.
- In 5 instances, although noncompliant with the PDR, the provider continued to receive payments for Medicaid claims. Payments of \$111,633 were made subsequent to the date of noncompliance with the PDR requirement.
- In 4 of the 19 instances, the Agency referred the provider to the AHCA Bureau of Medicaid Program Integrity for investigation of possible fraud or Medicaid overpayments and recoupment, subsequent to our audit inquiry.

The Agency was in the process of revising policies and procedures related to quality management; however, they had not been finalized as of April 1, 2011. A lack of clear guidance through the policies and procedures may have contributed to the Agency's failure to timely follow up with noncompliant providers.

Delays in follow-up may inhibit the Agency's ability to timely detect material nonperformance or fraud and lessened the Agency's ability to ensure the safety of individuals under the Agency's care.

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**Recommendation: We recommend that the Agency provide guidance to applicable Agency staff outlining the responsibilities for following up with and terminating or suspending noncompliant providers.**

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**Consumer-Directed Care Plus Program**

The CDC+ Program offers individuals (consumers) the option to control and direct Medicaid funds through individual care plans and budgets in a home and community-based setting. Upon conclusion of the 5-year CDC+ 1115 Research and Demonstration Waiver in February 2008, CMS approved a 1915(j) Medicaid State Plan Amendment, thereby making the CDC+ Program a permanent Medicaid State Plan option. The CDC+ Program is a self-directed personal assistance services (PAS) option designed to allow individuals, or their representatives if applicable, to exercise decision-making authority in identifying, accessing, managing, and purchasing PAS. Agency

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<sup>11</sup> In one instance the provider was suspended as a Medicaid provider prior to audit testing.

expenditures relating to 1,368 CDC+ consumers for the 2009-10 fiscal year, totaled approximately \$36 million while Agency expenditures relating to 1,805 CDC+ consumers for the 2010-11 fiscal year, totaled approximately \$55 million.

In our report No. 2008-025, we noted deficiencies in the Agency's fiscal controls related to the CDC+ Waiver Program. Those deficiencies had allowed funds to accumulate in consumer accounts instead of being returned to the State. Our follow-up testing disclosed that similar deficiencies continued to exist.

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**Finding No. 7: Consumer Funds**

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As a condition of enrollment in the CDC+ Program, consumers, based on an assessment of need, were to receive HCBS waiver care/support plans that were to include an identification of risks and potential mitigation strategies. Upon completion of this process, each consumer was to develop a purchasing plan to specify how the monthly budget was to be used to meet the consumer's care needs. With the assistance of a consultant, who was hired by the consumer to provide information, counseling, training, or assistance as needed, the consumers were to develop their own care strategies and hired employees or contracted with vendors for needed services. The consultant was to review and approve the purchasing plans to ensure that the proposed services were adequate, purchases were cost-effective and related to the consumer's needs, and an emergency back-up plan was in place. Deposits into the consumers' accounts were made by the Agency, as allocated in the purchasing plan, into accounts for services, cash, savings, and one-time expenditures and short-term expenditures. In accordance with Program policy, consumers were not to purchase goods or services that were not included in their approved purchasing plan. In addition, consumers were able to accumulate funds in their savings account over time to make special purchases specifically identified in their purchasing plan; however, the purchase was to be made within 2 years. The Agency provided the consumers with monthly statements to assist them in managing their budgets.

In report No. 2008-025, finding No. 1, we noted that the Agency did not have procedures in place to monitor consumers' accounts to ensure that funds, in excess of the approved savings plan at the time of the consumers' annual eligibility redetermination, were returned to the State, as required in the 1115 Research and Demonstration Waiver. Upon commencement of the 1915(j) Medicaid State Plan Amendment in March 2008, the State was to require that consultants perform monthly monitoring of consumers in order to assess the consumer's spending and service utilization in comparison with the purchasing plan. Federal regulations<sup>12</sup> also required the State to flag significant budget variances and bring them to the attention of the consumer and case manager. Additionally, safeguards were also required to identify budget problems on a timely basis so that corrective action could be taken, if necessary. As a benchmark, Agency staff developed draft reinvestment procedures which listed 1.5 times the amount of the consumer's monthly budget as an allowable balance to cover routine monthly services. This benchmark was also used when the Program was operated under the waiver.

Our follow-up audit procedures disclosed that Agency procedures required a review of a consumer's budget only if a change in the consumer's health or living situation occurred, and that no evaluation of utilization or prior spending was required. The failure to assess the consumer spending and service utilization in comparison with the purchasing plan contributed to consumers accumulating large balances. Specifically, as shown in Table 3, our review of 1,713 consumer account balances as of February 28, 2011, disclosed that while the majority of account balances were less than \$5,000, numerous account balances had increased to amounts that appeared to be excessive. From Agency data, we identified 33 accounts with balances greater than \$50,000, with the highest balance totaling \$220,197. While consumers are allowed to save for larger purchases, upon further evaluation of 20 consumers' accounts and

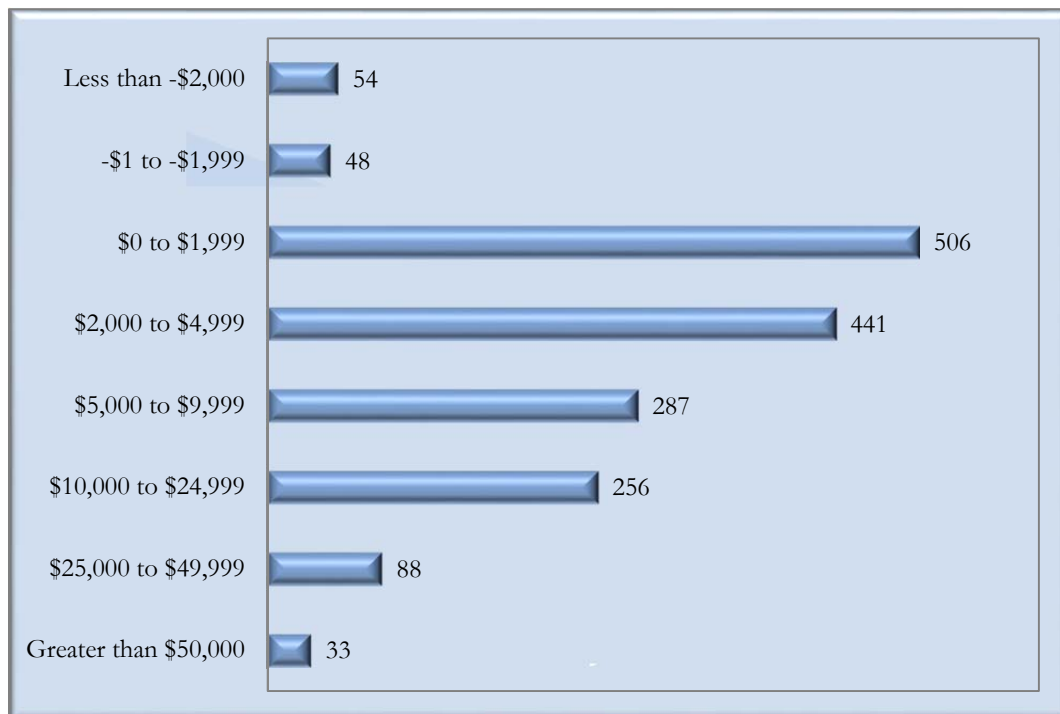
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<sup>12</sup> Title 42, Section 441.464, Code of Federal Regulations.

purchasing plans, the consumers did not have an identified specific special purchase in their purchasing plan for the majority of accounts.

Our audit also identified 77 consumers, who had been disenrolled from the CDC+ Program for over 1 year, as of February 28, 2011, whose balances had not been recouped by the State. Subsequent to audit inquiry, Agency staff submitted a request to AHCA on July 28, 2011, to reinvest (transfer) the balances totaling \$349,719 for 108 consumers. The Agency’s request included 31 consumers with negative balances (expenditures in excess of amounts budgeted) totaling \$65,633 and 77 consumers with positive balances totaling \$415,352.

**Table 3  
CDC+ Consumer Account Balances by Range with Consumer Count**



Source: CDC+ Fiscal/Employer Agent files.

**Recommendation:** We recommend that the Agency take the steps necessary to ensure compliance with the requirements of Federal regulations governing CDC+ Program consumer accounts.

**Finding No. 8: Negative Consumer Account Balances**

As described above in Finding No. 7, consumers were to receive funds for goods or services as outlined in their purchasing plans. Our review of 1,713 consumer account balances as of February 28, 2011, disclosed 102 instances totaling \$565,892, where a consumer’s account balance was negative. The largest deficit account balance was over \$38,000. Additionally, as noted above, the Agency identified 31 consumers who had been disenrolled from the CDC+ Program for over 1 year and had negative account balances totaling \$65,633.

Allowing consumers to spend more than their budgeted allocation increases the risk that the Agency will not be able to recover the overspent funds if the consumer disenrolls from the CDC+ Program.

According to Agency staff, the Agency has made numerous changes to address negative balances including implementing consumer corrective action plans and a change in the Agency's payment processing system, expected to be implemented in 2012, which will suspend any claims that will result in a negative balance.

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**Recommendation:** We recommend that the Agency continue efforts to implement changes to the payment processing system to address negative consumer account balances.

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### PRIOR AUDIT FOLLOW-UP

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Except as discussed in the preceding paragraphs, the Agency had taken corrective actions for the applicable findings included in report Nos. 2008-025 and 2010-037.

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### OBJECTIVES, SCOPE, AND METHODOLOGY

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The Auditor General conducts operational audits of governmental entities to provide the Legislature, Florida's citizens, public entity management, and other stakeholders unbiased, timely, and relevant information for use in promoting government accountability and stewardship and improving government operations.

We conducted this operational audit from January 2011 to August 2011, in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

This operational audit focused on the IFS Program and a follow-up of prior audit findings. The overall objectives of the audit were:

- To evaluate the effectiveness of established internal controls in achieving management's control objectives in the categories of compliance with controlling laws, administrative rules, and other guidelines; the economic, efficient, and effective operation of State government; the relevance and reliability of records and reports; and the safeguarding of assets.
- To evaluate management's performance in achieving compliance with controlling laws, administrative rules, and other guidelines; the economic, efficient, and effective operation of State government; the relevance and reliability of records and reports; and the safeguarding of assets.
- To determine whether management had corrected, or was in the process of correcting, all applicable deficiencies disclosed in our report Nos. 2008-025 and 2010-037.
- To identify statutory and fiscal changes that may be recommended to the Legislature pursuant to Section 11.45(7)(h), Florida Statutes.

In conducting our audit we:

- Interviewed selected Agency personnel.
- Obtained an understanding of internal controls and tested processes and procedures related to areas within the scope of the audit.
- Reconciled the payment data in the ABC System to related data in FLAIR.
- Performed analytical procedures to determine the level of services received by Agency clients where the Agency made an IFS payment on behalf of the client from July 2009 through February 2011.

- Performed analytical procedures to determine whether Social Services Block Grant funds were expended for IFS Program activities that are not authorized in Title 42, Section 1397(d)(a)(4), United States Code.
- In order to identify improper payments, reperformed and evaluated the monthly vital statistics crosscheck which matches the name and social security numbers in the official death records of the Office of Vital Statistics to the names and social security numbers of individuals with an active case in the Agency's ABC System.
- Examined eligibility records for 40 Agency clients to determine whether they were eligible for the IFS Program. Additionally, we examined 51 IFS Program expenditures totaling \$35,092 for the 40 clients.
- Examined eligibility records for 4 Agency clients who did not have a social security number in the ABC System to determine whether they were eligible for the IFS Program.
- Examined eligibility records for 40 Agency clients who received supported living in-home subsidies. Additionally, we examined 56 IFS Program expenditures totaling \$28,380 for the 40 clients.
- Examined the provider license for 40 non-Medicaid providers to determine whether the service paid for by IFS Program funds was performed by a licensed provider.
- Evaluated IFS Program utilization for 20 clients where the Agency had paid the largest amounts of IFS Program funds on behalf of the clients, excluding supported living in-home subsidies.
- Examined 14 IFS Program medical payments totaling \$2,405 and 40 IFS Program dental service payments totaling \$42,906 for Agency clients also enrolled in Medicaid to determine that the service was not covered by the Medicaid Program.
- Evaluated the Agency's corrective actions taken to resolve findings disclosed in our report No. 2010-037. Specifically, we:
  - Examined the licensing files for 15 residential facilities to determine whether:
    - Residential facility applications contained the statutorily required elements.
    - Agency staff documented facility resident capacity calculations.
    - Area Office licensing staff reviewed appropriate facility-maintained documentation to verify the qualifications of facility staff.
  - Determined whether the Agency had adopted rules, as required by State law, related to license application procedures, requirements for monitoring group home and foster care facilities, and the frequency of facility staff background screenings.<sup>13</sup>
  - Reviewed 10 Delmarva provider performance discovery review reports and evaluated the adequacy and timeliness of Agency follow-up to address the issues noted.
  - Reviewed the Agency files for 45 providers who were determined to be noncompliant with Delmarva's attempts to perform a provider performance discovery review, and evaluated the adequacy and timeliness of the Agency's follow-up activities.
- Evaluated the Agency's corrective actions taken to resolve finding No. 1 of report No. 2008-025. Specifically, we:
  - Obtained an understanding of the Agency's methodology and controls for periodically comparing CDC+ consumers' funding amounts to actual expenditures to ensure that excess funds did not accumulate in the consumers' accounts.
  - Evaluated the balances in consumer's accounts to determine whether excess funds had accumulated.
- Performed an analysis to determine whether purchasing cards were timely cancelled and collected for cardholders whose employment terminated.

<sup>13</sup> Section 393.067(1), (5), and (8), Florida Statutes.

- Reviewed purchasing card expenditures totaling \$20,611 to determine whether the expenditure was authorized, approved, and supported.
- Reviewed the purchasing cardholder profile for 10 Agency purchasing card holders to determine whether purchasing cards were issued in accordance with Agency guidelines.
- Performed various other auditing procedures, including analytical procedures, as necessary, to accomplish the objectives of the audit.
- Communicated on an interim basis with applicable Agency officials to ensure the timely resolution of issues involving controls and noncompliance.
- Prepared and submitted for management response the findings and recommendations that are included in this report and which describe those matters requiring corrective actions.

**AUTHORITY**

Section 11.45, Florida Statutes, requires that the Auditor General conduct an operational audit of each State agency on a periodic basis. Pursuant to the provisions of Section 11.45, Florida Statutes, I have directed that this report be prepared to present the results of our operational audit.



David W. Martin, CPA  
Auditor General

**MANAGEMENT’S RESPONSE**

In a response letter dated March 5, 2012, the Director of the Agency for Persons with Disabilities provided responses to our audit findings and recommendations. The Director’s response is included as **EXHIBIT A**.

EXHIBIT A  
MANAGEMENT'S RESPONSE



Rick Scott,  
Governor

■ ■

Michael Hansen,  
Director

■ ■

Central Office

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4030 Esplanade Way  
Suite 380  
Tallahassee,  
Florida  
32399-0700

(850) 488-4257

Fax:

(850) 922-6456

■ ■

Toll Free:

(866) APD-CARES

(866-273-2273)

March 5, 2012

David W. Martin, CPA  
Auditor General  
State of Florida  
Claude Pepper Building  
111 West Madison Street  
Tallahassee, FL 32399-0950

Re: Preliminary and Tentative Audit Findings – Agency for Persons with Disabilities – Individual and Family Supports Program and Prior Audit Follow-Up

Dear Mr. Martin:

Pursuant to Section 11.45(4)(d), Florida Statutes, attached is our response to the preliminary and tentative findings and recommendations in your operational audit on the Individual and Family Supports Program and Prior Audit Follow-Up.

I appreciate this opportunity to respond to your preliminary findings and trust that this response satisfies your requirements. If you have any questions or need additional information, please contact Carol Sullivan, Director of Audit at (850) 414-7166.

Sincerely,

Michael P. Hansen  
Director

MH/cs

Enclosure

<http://apdcare.org>

**EXHIBIT A**  
**MANAGEMENT'S RESPONSE (CONTINUED)**

**INDIVIDUAL AND FAMILY SUPPORTS PROGRAM**

**Finding No. 1: Client Eligibility Determination**

**Recommendation:** We recommend that the Agency re-evaluate the client Applications approved prior to 2006. We also recommend that redeterminations of Florida domicile be made on at least an annual basis.

**Agency Response:**

The Agency concurs that applications should be re-evaluated annually. The Agency will provide training to all area staff involved in eligibility determinations to ensure procedures for documenting determinations are followed. Upon promulgation of the rule for determination of a developmental disability, the operating procedure, outlining the steps for eligibility determination, will be updated and re-issued.

**Finding No. 2: IFS Payments for Medicaid Clients**

**Recommendation:** We recommend that the Agency establish policies and procedures that more reasonably ensure that Medicaid services are used when available. We also recommend that when non-Medicaid providers are used for Medicaid eligible clients, documentation be prepared and retained to demonstrate the unavailability of Medicaid services.

**Agency Response:**

The Agency concurs with this finding. The Agency will develop policy and training for Agency staff regarding the use of services available on the Medicaid State Plan and procedures for documentation when these services are not available through Medicaid State Plan.

**Finding No. 3: Payments for Deceased Clients**

**Recommendation:** We recommend that the Agency establish written policies and procedures that provide more guidance for staff regarding the steps to be taken, including those related to documentation, to resolve crossmatch errors. The procedures should include processes for informing the Office of Vital Statistics of potential death record errors. We also recommend the Agency recoup from providers payments made for deceased clients.

**EXHIBIT A**  
**MANAGEMENT'S RESPONSE (CONTINUED)**

**Agency Response:**

The Agency concurs with this finding. The Agency will establish policy and training to ensure clients identified by Vital Statistics are closed in the ABC system. The policy will address the process the Area staff will follow when the information provided by the Office of Vital Statistics appear to be in error.

**Finding No. 4: IFS Program Expenditure Transactions**

**Recommendation:** We recommend that the Agency recoup the overpayments from the three providers. In addition, in order to prevent errors in payments and coding, we recommend that the Agency enhance the level of supervisory monitoring of staff compliance with applicable Agency policies and procedures.

**Agency Response:**

The Agency concurs with this finding. The Agency is taking steps to recoup the overpayments to the three providers. In addition, ABC tables are being updated to reflect inactive service codes which will prevent the incorrect object codes from being used in FLAIR.

**Finding No. 5: Utilization**

**Recommendation:** We recommend that the Agency consider completing a QSI for all Agency clients, including those who receive only IFS funded assistance. In addition, the Agency should take greater care in locating and utilizing Medicaid providers for HCBS Medicaid waiver clients, and when non-Medicaid service providers are utilized, documenting the circumstances justifying their use.

**Agency Response:**

Section 393.0661(3), Florida Statutes that was cited as criteria for Finding No. 5 does not apply to IFS funding but to services provided through the developmental disabilities waiver. However, the Agency does agree with the specific findings as they relate to IFS funding. The agency assessment, the Questionnaire for Situational Information (QSI), was developed and implemented in 2008 as a tool for assessing an individual's level of need for support in the areas of functional, behavioral and physical needs. The tool was administered to all 50,000 individuals on the Medicaid waiver and waitlist over a two year period.

The purpose of the QSI is to assist in determining an individual's level of need for support in several areas including functional, behavioral and physical needs. The agency directed area staff to complete assessments on all individuals receiving waiver funded services however in some unique situations, for example individuals in jail or individuals

**EXHIBIT A**  
**MANAGEMENT'S RESPONSE (CONTINUED)**

who were placed in an intensive behavior program or psychiatric program, it was determined that the assessment could be postponed until the individual was released from jail or the situation had stabilized to the point that a valid assessment could be conducted.

The agency has begun to conduct data runs to determine if there are individuals who have no QSI or an outdated QSI. When these runs are completed, the agency will provide the list of those with no QSI or an outdated QSI to area offices. In the future, the list will be provided to the area administrator to be used as a management tool for area assessors.

There are situations in which an individual requires a specific placement due to his or her unique needs. In some instances, that placement is available only from a non waiver provider and is intended to be short term. We will instruct area staff and waiver support coordinators to clearly document the needs and justification for using IFS funds to pay for the service.

**QUALITY ASSURANCE REVIEWS – HOME AND COMMUNITY-BASED SERVICES PROGRAM**

**Finding No. 6: Follow-Up Procedures for Procedures for Noncompliance with Provider Reviews**

**Recommendation:** We recommend that the Agency provide guidance to applicable Agency staff outlining the responsibilities for following up with and terminating or suspending noncompliant providers.

**Agency Response:**

The Agency concurs with this finding. A formal process has been developed to track and address non-compliant providers of Delmarva reviews. This process includes notification by Delmarva to the respective Area Administrators and Central Office Operations and Quality Assurance Units. The new process also includes Central Office retrieval of monthly reports of non-compliant providers and tracking to ensure follow up on each case.

Additionally, the Central Office is pulling data for 2011 of all non-compliant providers from Delmarva and will address any case that has not been resolved to date.

**EXHIBIT A**  
**MANAGEMENT'S RESPONSE (CONTINUED)**

**CONSUMER-DIRECTED CARE PLUS PROGRAM**

**Finding No. 7: Consumer Funds**

**Recommendation:** We recommend that the Agency take the steps necessary to ensure compliance with the requirements of Federal regulations governing CDC+ Program consumer accounts.

**Agency Response:**

The Agency concurs with this finding. The Agency has begun analyzing consumer accounts for excess funds. The reinvestment of funds is a currently a manual process and requires staff analysis to ensure the proper methodology is implemented in identifying the excess funds. The Agency is currently working with AHCA to finalize the CDC+ Rule that would provide the authority to reinvest the excess funds.

**Finding No. 8: Negative Consumer Account Balances**

**Recommendation:** We recommend that the Agency continue efforts to implement changes to the payment processing system to address negative consumer account balances.

**Agency Response:**

The Agency concurs with this finding. APD is currently implementing consumer corrective action plans for mismanagement of budget. To further enhance internal controls and financial integrity of the program, APD is designing a process to "pend" participant/consumer submitted claims if the consumer does not have sufficient funds in their account to allow payment.