REPORT NO. 2014-056
DECEMBER 2013

AGENCY FOR PERSONS WITH DISABILITIES

iBUDGET FLORIDA AND PRIOR AUDIT FOLLOW-UP

Operational Audit

STATE OF FLORIDA
AUDITOR GENERAL
DAVID W. MARTIN, CPA

DIRECTOR OF THE AGENCY FOR PERSONS WITH DISABILITIES

The Agency for Persons with Disabilities is created by Section 20.197, Florida Statutes, as a separate budget entity within the Department of Children and Families for administrative purposes only. The head of the Agency is the Director who is appointed by the Governor and subject to confirmation by the Senate. The following individuals served as Director during the period of our audit:

Barbara Palmer	From August 21, 2012
Michael Hansen	From August 19, 2011, through August 20, 2012
Bryan Vaughan, Interim	Through August 19, 2011

The audit team leader was Ying Ying Chen, CPA, and the audit was supervised by Karen Van Amburg, CPA. Please address inquiries regarding this report to Lisa Norman, CPA, Audit Manager, by e-mail at lisanorman@aud.state.fl.us or by telephone at (850) 412-2831.

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AGENCY FOR PERSONS WITH DISABILITIES

iBudget Florida and Prior Audit Follow-Up

SUMMARY

This operational audit of the Agency for Persons with Disabilities (Agency) focused on the Agency's implementation of iBudget Florida. The audit also included a follow-up on the findings noted in report No. 2012-120. Our audit disclosed the following:

iBUDGET FLORIDA

Finding No. 1: The Agency should take appropriate actions and establish procedures to ensure compliance with State law and promote the achievement of iBudget Florida objectives.

Finding No. 2: The Agency did not always ensure that clients' iBudget amounts were supported by adequate documentation evidencing that the amounts were calculated in accordance with Agency instructions.

Finding No. 3: Agency management had not established written procedures specifying the tools and processes to be used to monitor iBudget Florida expenditures and the available budget.

Finding No. 4: The Agency did not always timely complete or properly document client eligibility determinations.

Finding No. 5: The Agency did not periodically reconcile the claims payment data recorded in the Agency's systems used to plan and manage client services to the claims payment data included in the Florida Medicaid Management Information System.

QUALITY ASSURANCE REVIEWS – HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER PROGRAM

Finding No. 6: The Agency did not always timely followup with providers who were determined to be noncompliant during quality assurance reviews.

INDIVIDUAL AND FAMILY SUPPORTS (IFS) PROGRAM

Finding No. 7: The Agency did not properly document or periodically reevaluate client eligibility determinations for clients receiving services through the IFS Program.

CONSUMER-DIRECTED CARE PLUS (CDC+) PROGRAM

Finding No. 8: CDC+ Program funds were allowed to accumulate in consumer accounts instead of being reinvested.

TRAVEL REIMBURSEMENTS

Finding No. 9: Agency travel reimbursement requests were not always adequately supported or paid in accordance with the requirements of State law.

BACKGROUND

Pursuant to State law,[1] the Agency for Persons with Disabilities (Agency) is responsible for the provision of services to individuals with developmental disabilities and for the programmatic management of Medicaid waivers established to provide services to persons with developmental disabilities. The Agency served individuals in the State with autism, mental retardation, spina bifida, cerebral palsy, Prader-Willi syndrome, or Down syndrome, and children aged 3 to 5 years who were at high risk of being diagnosed with a developmental disability.

[1] Section 20.197(3), Florida Statutes.

The Agency's Central Office is located in Tallahassee and there are 14 field offices within six regions throughout the State. A map showing the Regional offices and field offices is included as **EXHIBIT A** to this report. The Central Office provides oversight and support to Regional and field office staff by establishing policies and procedures and providing training. The field offices are responsible for managing Agency client activities within their assigned regions. The field offices contract with Waiver Support Coordinators (WSCs) who interact directly with Agency clients and assist those clients and their caregivers in identifying necessary services and establishing a budget for those services.

FINDINGS AND RECOMMENDATIONS

iBudget Florida

In 2010, the Legislature found[2] that improved financial management of the existing Home and Community-Based Services (HCBS) Medicaid waiver program was necessary to avoid deficits that impede the provision of services to individuals who are on the waiting list for enrollment in the program. As shown in Table 1, Agency expenditures for the HCBS Medicaid waiver program have exceeded annual appropriations for 3 of the past 5 fiscal years, necessitating supplemental appropriations from the Legislature.

Table 1
HCBS Medicaid Waiver Program
Appropriations, Expenditures, and Number of Clients Served and on Waiting List
by State Fiscal Year

Fiscal Year	Annual Appropriations	Total Expenditures	Surplus/ (Deficit)	Supplemental Appropriations	Net Surplus/ (Deficit)	Number of Clients Served	Number of Individuals on Waiting List as of June 30
2008-09	$833,529,770	$825,979,525	$ 7,550,245	$ -	$ 7,550,245	30,175	18,925
2009-10	849,699,685	939,405,764	(89,706,079)	-	(89,706,079)	30,476	19,171
2010-11	805,826,618	941,396,779	(135,570,161)	166,292,241 [a]	30,722,080	30,256	20,376
2011-12	810,437,372	877,197,773	(66,760,401)	46,527,463 [b]	(20,232,938)	29,906	21,555
2012-13	877,061,351	837,799,425	39,261,926	40,265,838 [c]	79,527,764	29,521	22,432
Total Net Deficit for the 2008-09 Through 2012-13 Fiscal Years					**$7,861,072**		

[a] Provided by Section 25, Chapter 2011-69, Laws of Florida (2011-12 fiscal year General Appropriations Act), to cover 2010-11 fiscal year costs.

[b] Provided by Section 38, Chapter 2012-118, Laws of Florida (2012-13 fiscal year General Appropriations Act), to cover 2011-12 fiscal year costs.

[c] Provided by Section 26, Chapter 2013-40, Laws of Florida (2013-14 fiscal year General Appropriations Act), to cover 2012-13 fiscal year costs.

Source: Florida Accounting Information Resource Subsystem and the General Appropriations Acts (Chapters 2008-152, 2009-081, 2010-152, 2011-69, 2012-118, and 2013-40, Laws of Florida).

The Legislature further found that clients and their families should have greater flexibility to choose the services that best allow the clients to live in their community within the limits of an established budget. Therefore, pursuant to State law[3] the Agency for Persons with Disabilities (Agency), in consultation with the Agency for Health Care

[2] Chapter 2010-157, Laws of Florida.
[3] Section 393.0622, Florida Statutes.

Administration (AHCA), was required to develop and implement a comprehensive redesign of the service delivery system using individual budgets as the basis for allocating the funds appropriated for the HCBS Medicaid waiver program among eligible enrolled clients. The service delivery system, iBudget Florida, is to provide for, among other things, enhanced client choice within a specified service package; appropriate assessment strategies; an efficient consumer budgeting and billing process that includes reconciliation and monitoring components; a redefined role for support coordinators that avoids potential conflicts of interest; and a methodology and process that ensures the equitable allocation of available funds to each client based on the client's level of need, as determined by the variables in an allocation algorithm.

Pursuant to State law,[4] which provides for a gradual phase-in of iBudget Florida, the Agency began development of iBudget Florida in May 2011, initiated implementation in April 2012, and completed implementation in July 2013. Implementation of iBudget Florida was phased in across the State in six "waves" as shown in Table 2.

Table 2
iBudget Florida Implementation Schedule

Wave	Field Offices Included	Implementation Date	Number of Clients Served as of July 16, 2013
1	1 and 2	April 1, 2012	2,883
2	4, 12, and 13	July 1, 2012	4,725
3	3, 7, 14, and 15	October 1, 2012	5,561
4	8 and 23	January 1, 2013	6,133
5	9 and 10	April 1, 2013	3,826
6	11 and all Consumer-Directed Care Plus [a] Clients	July 1, 2013	5,831
Total Number of Clients Served as of July 16, 2013			**28,959**

[a] The Consumer-Directed Care Plus program is a Medicaid waiver program that provides a self-directed personal assistance services option designed to allow Agency clients, or their representatives, if applicable, to exercise decision-making authority in identifying, accessing, managing, and purchasing eligible services.

Source: Agency records.

During each implementation wave, the Agency established individual budgets (iBudgets) for clients enrolled in the HCBS Medicaid waiver program. To establish each client's iBudget, State law[5] requires the Agency to use an allocation algorithm and methodology. According to State law, the algorithm is to use variables determined by the Agency to have a statistically validated relationship to the client's level of need for services provided through the HCBS Medicaid waiver program.[6] Under the law, the algorithm and methodology may consider individual characteristics, including, but not limited to, a client's age and living situation, information from a formal assessment instrument that the Agency determines is valid and reliable, and information from other assessment processes. The Agency may approve an increase to the amount allocated by the algorithm if a client has one or more of the needs specified in State law.[7] Increases to the algorithm amounts are to be funded from portions of the HCBS Medicaid

[4] Section 393.0662(3), Florida Statutes.
[5] Section 393.0662(1)(a), Florida Statutes.
[6] To ensure that the algorithm used appropriate variables, the Agency contracted with Florida State University, Department of Statistics for a statistical models study. The results of the study were provided to the Agency in a 2010 report titled *Statistical Models for Predicting Resource Needs and Establishing Individual Budgets for Individuals served by the Florida Agency for Persons with Disabilities*.
[7] Section 393.0662(1)(b), Florida Statutes.

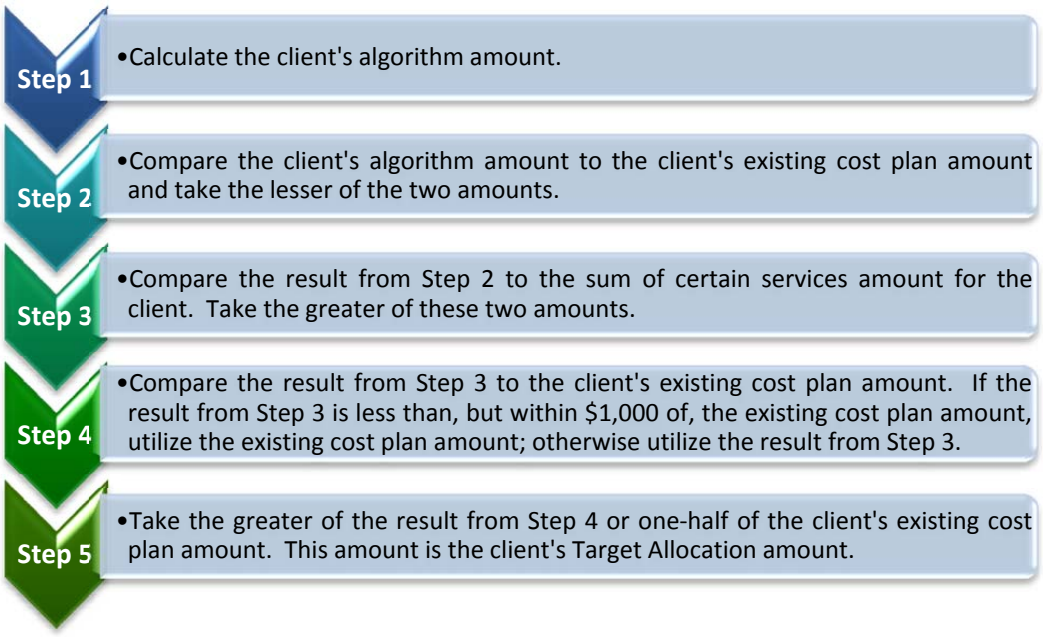
waiver program appropriation specifically reserved by the Agency for that purpose.[8] In addition, State law[9] requires the Agency to design the phase-in process to ensure that a client does not experience more than one-half of any expected overall increase or decrease to his or her existing annualized cost plan during the first year that the client is provided an iBudget due solely to the transition to iBudget Florida.

Pursuant to State law,[10] the Agency may adopt rules specifying the allocation algorithm and methodology; criteria and processes for clients to access reserved funds for extraordinary needs, temporarily or permanently changed needs, and one-time needs; and processes and requirements for selection and review of services, development of support and cost plans, and management of iBudget Florida. The Agency proposed and first noticed changes to its rules[11] in August 2012; however, due to litigation, the rules remained in draft form as of July 2013 when the final wave of clients was transitioned to iBudget Florida.

The methodology established in the proposed rules and employed by the Agency to transition clients to iBudget Florida, provided for a Target Allocation amount to be calculated for each client and then adjusted for extraordinary client needs in order to determine the client's transition period iBudget. The first step in the methodology was to calculate, utilizing the algorithm developed by the Agency's contracted statistician, an amount for every client. The resulting amounts were then prorated to ensure that, in total, the client algorithm amounts equaled the Agency's HCBS Medicaid waiver program appropriation, less the amount reserved for increases to fund the client needs specified in State law.[12] For the 2012-13 fiscal year, the client algorithm amounts totaled $810,437,372 (the Agency's HCBS Medicaid waiver program appropriation of $877,061,351 less the amount reserved $66,623,979). Once calculated, the Agency compared the client's algorithm amount to various other factors to determine the client's Target Allocation amount. Using the Agency's Target Allocation calculation methodology, as summarized in Chart 1, a client's calculated Target Allocation amount could be: (1) the algorithm amount, (2) the amount of the client's existing cost plan,[13] (3) the sum of certain services,[14] or (4) one-half of a client's existing cost plan amount.

[8] Section 393.0662(1)(b)3., Florida Statutes.
[9] Section 393.0662(3)(b), Florida Statutes.
[10] Section 393.0662(9), Florida Statutes.
[11] Department of Children and Families, Agency Rule 65G-4.0212, Florida Administrative Code.
[12] Section 393.0662(1)(b)3., Florida Statutes.
[13] The cost plan contains a list of services needed by the client including those provided by the family, generic community supports, and those requested from the HCBS Medicaid waiver program and documents the authorization for those services approved for payment.
[14] These services include ongoing adult day training and behavior and nursing services.

Chart 1
Target Allocation Calculation Methodology



Source: Compiled from Department of Children and Families, Agency Rule 65G-4.0212, Florida Administrative Code (as noticed on April 11, 2013), and Agency procedures.

Our audit of the Agency's iBudget Florida implementation Waves 1, 2, and 3 included an analysis of the Target Allocation amounts for clients transitioned to iBudget Florida in those waves. As shown in Table 3, our analysis found that the existing cost plan amount was used as the Target Allocation amount for the majority of clients.

Table 3
Analysis of Target Allocation Amounts
for Implementation Waves 1, 2, and 3

Target Allocation Amount	Number of Clients	Percentage of Total Clients
Existing Cost Plan	9,031 [a]	62.4%
Sum of Certain Services	3,256	22.5%
Algorithm	1,938	13.4%
Half the Existing Cost Plan	258	1.7%
Totals	**14,483**	**100.0%**

[a] Includes 7,009 clients for whom the algorithm amount exceeded the existing cost plan amount.

Source: Agency Wave calculation spreadsheets.

We also noted, as shown in Table 4, that during implementation Waves 1, 2, and 3, the Agency's Target Allocation calculation methodology resulted in a significant portion of the HCBS Medicaid waiver program funding being allocated in amounts that differed from the calculated algorithm amounts. For these implementation Waves, the Target Allocation amounts totaled approximately $416 million, or about $22 million more than the $394 million allocated by algorithm.

Table 4
Summary of Target Allocations for Waves 1, 2, and 3

Wave	Target Allocation Amount as a Percentage of the Algorithm Allocation Amount	Number of Clients	Algorithm Allocation Amounts	Changes for Steps 2-5 of the Agency's Target Allocation Calculation Methodology	Target Allocation Amounts
1	0-25 Percent	294	$ 5,387,571	$ (4,619,218)	$ 768,353
	26-50 Percent	420	9,251,492	(5,650,116)	3,601,376
	51-75 Percent	496	12,148,160	(4,352,677)	7,795,483
	76-99 Percent	494	14,023,373	(1,633,328)	12,390,045
	100 Percent	576	14,893,166	-	14,893,166
	101-125 Percent	466	11,212,456	1,099,087	12,311,543
	126-150 Percent	191	4,264,611	1,548,740	5,813,351
	151-175 Percent	88	1,727,373	1,071,155	2,798,528
	176-200 Percent	40	837,319	735,574	1,572,893
	Greater than 200 Percent	122	2,302,037	4,363,751	6,665,788
	Totals for Wave 1	**3,187**	**$76,047,558**	**$(7,437,032)**	**$68,610,526**
2	0-25 Percent	222	$ 3,896,569	$(3,313,416)	$ 583,153
	26-50 Percent	452	10,067,874	(5,920,315)	4,147,559
	51-75 Percent	759	23,570,367	(8,411,898)	15,158,469
	76-99 Percent	899	29,092,638	(3,238,143)	25,854,495
	100 Percent	576	11,876,316	-	11,876,316
	101-125 Percent	857	26,130,877	2,696,022	28,826,899
	126-150 Percent	426	12,582,523	4,777,293	17,359,816
	151-175 Percent	266	8,397,609	5,301,606	13,699,215
	176-200 Percent	167	5,429,582	4,756,600	10,186,182
	Greater than 200 Percent	453	15,980,863	25,028,326	41,009,189
	Totals for Wave 2	**5,077**	**$147,025,218**	**$21,676,075**	**$168,701,293**
3	0-25 Percent	331	$ 5,897,136	$(5,064,563)	$ 832,573
	26-50 Percent	466	10,782,405	(6,295,041)	4,487,364
	51-75 Percent	1,049	33,976,966	(11,975,617)	22,001,349
	76-99 Percent	1,127	37,197,838	(4,472,089)	32,725,749
	100 Percent	786	17,291,026	-	17,291,026
	101-125 Percent	1,041	28,823,157	2,995,045	31,818,202
	126-150 Percent	468	13,140,215	4,934,804	18,075,019
	151-175 Percent	311	8,181,722	5,158,059	13,339,781
	176-200 Percent	216	6,142,377	5,385,855	11,528,232
	Greater than 200 Percent	424	9,508,188	16,838,422	26,346,610
	Totals for Wave 3	**6,219**	**$170,941,030**	**$ 7,504,875**	**$178,445,905**
Grand Totals for Waves 1, 2, and 3		**14,483**	**$394,013,807**	**$21,743,918**	**$415,757,724**

Source: Agency iBudget Florida Target Allocation calculation spreadsheets.

Once each client's Target Allocation amount was determined, Agency iBudget implementation instructions required that the client and his or her Waiver Support Coordinator (WSC) be notified of the amount. For those clients whose Target Allocation amount represented a $1,000 or greater reduction from their existing cost plan, the instructions required that the client's WSC conduct an Allocation Implementation Meeting (AIM) to provide the client an opportunity to discuss the Target Allocation amount. During the AIM, the WSC was to conduct an individual review and complete a worksheet documenting the meeting, defining the client services needed, and proposing a revised Target Allocation amount. The AIM worksheet was to be signed by the client and the WSC and presented to Agency

Regional office staff for approval. Pursuant to the instructions, Agency Regional office staff were to only approve an increase to a client's Target Allocation amount if the client had an extraordinary need.[15] Field office staff were then to submit the approved revised amount for each client to the Agency Central Office for further review and approval and input into the newly developed iBudget Florida system.[16]

The WSCs were to utilize the approved final iBudgets to develop the clients' annual cost plans to provide services for the health and safety of the clients. Throughout the year, the WSCs were to use data from the iBudget Florida system to monitor each client's iBudget, compare client cost plans to payments for services, and make adjustments, as necessary, to ensure clients stayed within their iBudgets.

While the Agency has transitioned the HCBS Medicaid waiver program clients to iBudget Florida, the implementation has been the subject of ongoing litigation. As of October 15, 2013, there were 214 active cases with the Division of Administrative Hearings related to the Agency's implementation of iBudget Florida. There was also a case pending, as of September 2013, in the Federal Court in which it is alleged that the implementation of iBudget Florida constituted a due process violation on a class of impacted individuals. The impact of the outcome of this litigation on the Agency's financial management and utilization of the iBudget Florida delivery system is currently unknown.

As part of our audit, we evaluated the Agency's implementation of iBudget Florida for Waves 1, 2, and 3. We found, as discussed in finding Nos. 1 through 6, that improvements in Agency processes and tools would better enable the Agency to achieve the objectives of iBudget Florida specified in State law.

Finding No. 1: iBudget Florida Allocation Algorithm and Methodology

Pursuant to State law,[17] the Agency was to design a phase-in process to ensure that, during the first year a client was provided an iBudget, the client did not experience more than one-half of any expected overall increase or decrease to his or her existing annualized cost plan due solely to the transition to iBudget Florida. Our evaluation of the Agency's iBudget methodology as established in the Agency's proposed rules and employed for implementation Waves 1, 2, and 3 found that the Agency did not ensure that differences between the clients' iBudgets and existing cost plans were appropriately limited.

In April 2013, as part of a settlement agreement resulting from a challenge to the Agency's proposed rules, the Agency revised the proposed rules to provide that, for the first year, an increase or decrease to the client's existing cost plan was to be limited to no more than one-half the difference between the algorithm amount, together with any extraordinary needs, and the client's existing annualized cost plan. Should any reductions exceed this amount, funds in the amount of the excess reduction were to be available, in addition to the client's final iBudget, for one year. However, Agency management indicated that, as of July 2013, this provision had not been implemented due to ongoing legal challenges.

Additionally, pursuant to State law,[18] the Agency is to reserve portions of the appropriation for the HCBS Medicaid waiver program for adjustments to client iBudgets for extraordinary needs, significant one-time or temporary needs,

[15] Pursuant to Section 393.0662(1)(b)1., Florida Statutes, an extraordinary need would place the health and safety of the client, the client's caregiver, or the public in immediate, serious jeopardy unless an increase is approved.
[16] As part of the iBudget Florida implementation process, the iBudget Florida system was developed to maintain information on each client's demographics, budget, approved services, service providers, claims, and activities. Upon implementation of the iBudget Florida system in October 2011, the Agency maintained client information in both the iBudget Florida system and the Agency's Allocation, Budget, and Contract Control (ABC) system.
[17] Section 393.0662(3)(b), Florida Statutes.
[18] Section 393.0662(1)(b), Florida Statutes.

and significant increases in service needs after the approval of the client's cost plan. Although State law does not specify how the Agency is to calculate the reserve, it provides that the Agency may use the services of an independent actuary in determining the amount to be reserved. We noted that the Agency consulted with an independent actuary who recommended an appropriations reserve of 10 percent. However, for the 2012-13 fiscal year, the Agency designated $66,623,979 (7.6 percent), the difference between the Agency's 2011-12 and 2012-13 annual HCBS Medicaid waiver program appropriations (prior to any supplemental appropriations), as the reserve and did not document a determination regarding the appropriateness of a reserve amount that was less than what the actuary had recommended.

We also noted that the Agency's procedures did not provide for a periodic evaluation of the iBudget algorithm, Target Allocation calculation methodology, or reserve calculation process. In response to our audit inquiry, Agency management indicated that a policy had not been established to specify the frequency with which the algorithm utilized in formulating client iBudgets would be rerun; however, client cost plans would continue to be reestablished each year in accordance with existing Agency policies and procedures for the HCBS Medicaid waiver program. In addition, Agency management indicated that they intend to reevaluate iBudget Florida once a full year of data is available.

Absent a process to periodically evaluate the appropriateness of, and make necessary adjustments to, the iBudget algorithm, Target Allocation calculation methodology, and the reserve calculation process, the Agency has reduced assurance that the objectives of iBudget Florida, as specified in law, will be achieved.

Recommendation: We recommend that the Agency continue its efforts to ensure that the iBudget Florida allocation methodology is consistent with the requirements of State law. In addition, to ensure that the objectives of iBudget Florida are achieved, the Agency should establish procedures to periodically evaluate the appropriateness of iBudget algorithm, Target Allocation calculation methodology, and reserve calculation process.

Finding No. 2: Calculation of Client iBudgets

As previously discussed, the Agency proposed changes to its administrative rules for iBudget Florida that were still in draft form when the Agency transitioned the last wave of clients to iBudget Florida in July 2013. The rules included procedures for calculating client iBudget amounts and for notifying clients of their iBudgets.[19] Pending finalization of the proposed rules, and absent written policies and procedures for the iBudget Florida transition, the Agency communicated iBudget Florida implementation instructions during training for Regional and field office staff and the WSCs and also created various standard forms and worksheets to be utilized in the transition.

As part of our audit, we reviewed the Agency's iBudget calculations for 60 clients who were transitioned to iBudget Florida in implementation Waves 1, 2, and 3. We found that for 26 of the 60 clients, the Agency's application of the algorithm and methodology, as described in finding No. 1, resulted in a Target Allocation amount that was over $1,000 less than the amount of each client's existing cost plan. For 3 other clients, a Target Allocation amount had not been calculated.[20] For these 29 clients, the WSCs were responsible for meeting with and proposing the iBudgets.

[19] Department of Children and Families, Agency Rule 65G-4.0212, Florida Administrative Code.

[20] Target Allocations had not been calculated for the 3 clients due to specific circumstances. For example, one client was new to the HCBS Medicaid waiver program and was transitioning from an intermediate care facility for the developmentally disabled and, thus, had no existing annualized cost plan.

Our audit procedures disclosed that, for 16 of the 29 clients, the Agency could not provide sufficient documentation evidencing that the client iBudgets were calculated in accordance with Agency instructions. Specifically:

- For 6 of the 16 clients, the WSC calculated the iBudget amount using the forms and worksheets specified by the Agency; however, no documentation was available to support the amounts included in the worksheets. For example, one client's budget decreased by $14,432; however, there was no documentation, such as an itemization of the quantity and cost of needed services to support the amounts included in the budget calculation. These 6 clients' iBudgets totaled $213,729, which represented a total reduction of $58,063 from their existing cost plans.
- For the other 10 clients, the WSC calculated the client's iBudget amount without using the forms and worksheets specified by the Agency and no documentation was available to demonstrate that the amount was calculated in accordance with Agency instructions. These 10 clients' iBudgets totaled $472,300, which represented a total reduction of $54,674 from their existing cost plans.

We also analyzed the calculation of the final iBudgets for the 60 selected clients and noted, as shown in Table 5, that the total cost plan amounts exceeded the algorithm allocation by $857,528 (50.4 percent). Approximately 12 percent of the difference pertained to adjustments made subsequent to the Target Allocation determination.

Table 5
Summary of Selected Cost Plan Calculations

Algorithm Allocation Amounts	$1,702,830
Net Increase Resulting from Changes for Steps 2-5 of the Agency's Target Allocation Calculation Methodology	706,187
Target Allocation Amounts	$2,407,542
Net Increase Resulting from Adjustments Made Subsequent to Target Allocation Determination	105,624
Final iBudget Cost Plan Amounts	**$2,560,358**

The lack of sufficient documentation to support client iBudget calculations resulted from ineffective implementation of Agency instructions for calculating and documenting iBudgets and insufficient review of proposed iBudgets by Agency staff prior to approval. The absence of finalized rules and established policies and procedures may have also contributed to the lack of documentation. Without appropriate documentation, the Agency could not demonstrate that client iBudgets were calculated in accordance with Agency instructions, or that the amounts represented an equitable allocation of available funds based on each client's level of need, as required by State law.

Recommendation: We recommend that the Agency establish written policies and procedures that require the maintenance of documentation to support iBudget calculations and address the review of iBudget amounts by Agency staff prior to approval.

Finding No. 3: iBudget Florida Monitoring

Agency management utilized multiple reports to continuously monitor iBudget Florida expenditures and available budget. For example, Agency management generated and reviewed monthly reports reflecting expenditure totals and appropriation balances, weekly expenditure reports, and monthly reports showing expenditures by service type, total cost plan budgeted amounts by service, and clients by age. However, Agency management had not developed written procedures specifying the reports to be reviewed, the frequency with which the reports should be generated and reviewed, or the criteria to be used to identify any negative trends that may require Agency action to prevent budget deficits.

As previously mentioned, the Legislature established iBudget Florida to improve the financial management of the HCBS Medicaid waiver program and avoid deficits that impede the provision of services to individuals on the waiting list for enrollment in the program.[21] Written procedures specifying the tools and processes to be used to monitor iBudget Florida expenditures and available budget would provide additional assurances regarding the effectiveness and consistent quality of the Agency budgetary monitoring performed, especially in the event of staff turnover.

Recommendation: We recommend that the Agency establish written procedures specifying the tools and processes to be used to monitor the Agency's iBudget Florida expenditures and budget.

Finding No. 4: Documentation of Client Eligibility

State law[22] defines Agency services application and client eligibility determination requirements, including those for the HCBS Medicaid waiver program. In addition, the Agency established policies and procedures prescribing the process to be utilized to determine client eligibility. Those policies and procedures require applicants to submit an Application for Services form (Application) and provide documentation, such as proof of identity and evidence of Florida domicile. Agency field office staff were responsible for processing Applications and making determinations of client eligibility.

In addition to the eligibility determinations performed upon each client's initial application for Agency services, Agency procedures require the WSCs to annually complete an HCBS Waiver Eligibility Worksheet (Eligibility Worksheet) for each client. The WSCs were also required to complete an Eligibility Worksheet before each client's transition to iBudget Florida. The Eligibility Worksheet documented the WSC's evaluation of client eligibility, and was to be signed by the client indicating his or her election to participate in the HCBS Medicaid waiver program. To support the eligibility determination, the WSCs were to maintain appropriate client eligibility documentation, which was generally in paper form.

As part of our audit, we examined Applications and supporting eligibility documentation for 60 clients who were transitioned to iBudget Florida during implementation Waves 1, 2, and 3. We found that:

- For 15 of the 60 clients, the client's eligibility for services was not adequately supported. Specifically:
  - For 10 clients, an Application was not available. The Agency made payments totaling $48,023 on behalf of these 10 clients during the period July 1, 2011, through December 31, 2012. Subsequent to our audit inquiry, an Application was provided for 1 of the clients.
  - The section of the Application documenting the Agency's initial determination of client eligibility was not complete for 3 client Applications. The Agency made payments totaling $12,885 on behalf of these 3 clients during the period July 1, 2011, through December 31, 2012.
  - For 10 clients (including 7 clients for whom an Application was unavailable and 1 client whose Application was incomplete), eligibility for Agency services was not supported by appropriate documentation. For example, evidence of Florida domicile, U.S. citizenship or resident alien status, or to support the client's confirmed diagnosis of a specified disorder or syndrome was not documented. The Agency made payments totaling $30,205 on behalf of these clients during the period July 1, 2011, through December 31, 2012.

[21] Section 393.0662, Florida Statutes.
[22] Section 393.065, Florida Statutes.

- For 20 of the 60 clients, the WSCs did not complete an Eligibility Worksheet evaluating client eligibility before the clients' transition to iBudget Florida. For these clients, the Agency completed the Eligibility Worksheets from 10 to 283 days after the clients' iBudget Florida implementation dates.

Absent the timely performance of periodic evaluations of client eligibility, the completion of Applications and Worksheets to properly document eligibility determinations, and the maintenance of appropriate documentation supporting client eligibility, the Agency has limited assurance, and cannot effectively demonstrate, that services were only provided to eligible individuals. In response to our audit inquiry, Agency management stated that maintenance of client eligibility documentation was the responsibility of the WSCs and that documentation was sometimes misplaced or not forwarded when the client changed to another WSC. Notwithstanding this response, the Agency's reliance on the contracted WSCs to maintain the required client eligibility documentation limits the Agency's ability to ensure that documentation is available to demonstrate that services were provided only to eligible individuals as required by State law. Maintenance of all applicable client eligibility documentation in a central location, such as in electronic format on a secure Agency network, would better allow the Agency to verify that all the appropriate documentation has been obtained and is available to demonstrate the Agency's compliance with State law.

Recommendation: We recommend that the Agency ensure that client eligibility determinations are properly documented and supported by appropriate client eligibility documentation. Such documentation should be maintained in a central location to facilitate the Agency's verification of, and enhance management's assurances related to, client eligibility. We also recommend that the Agency ensure that annual evaluations of client eligibility are timely performed and documented on Eligibility Worksheets in accordance with Agency procedures.

Finding No. 5: Information System Reconciliations

During the period of our audit, the Agency maintained two systems to track client information and to plan and manage client services: the ABC system and the iBudget Florida system. The ABC system included information on client demographics, client cost and service plans, paid claims, budgets, contracts, invoices, facilities, and vendors. The Agency's non-Medicaid vendor invoices were processed through the ABC system and uploaded to the Agency's accounting records. Medicaid provider claims for services provided to Agency clients were paid through the Florida Medicaid Management Information System (FMMIS) maintained by AHCA. Weekly, AHCA provided the Agency a Medicaid paid claims file from FMMIS and the Agency loaded the file information into the ABC system. The HCBS Medicaid waiver program information in the ABC system was then loaded in the iBudget Florida system. The iBudget Florida system claims information was used by the field office staff and the WSCs to track expenditures for client services and monitor client budgets.

Reconciliations between client payment data included in the Agency's information systems (ABC and iBudget Florida) and FMMIS Medicaid provider claim payment data are necessary to reasonably ensure the accuracy and completeness of the HCBS Medicaid waiver program expenditures and to timely identify discrepancies that may require corrective actions. Our audit disclosed that the Agency did not perform reconciliations between the ABC and iBudget Florida systems data and the FMMIS data during the period July 1, 2011, through December 31, 2012.

In the absence of Agency-performed reconciliations, we compared for the 2011-12 fiscal year, the payments made on behalf of Agency HCBS Medicaid waiver program clients as recorded in FMMIS to those recorded in the ABC system. Our comparison disclosed that payment amounts recorded in FMMIS exceeded those amounts recorded in the ABC system by $74.4 million (8.5 percent). In response to our audit inquiry, Agency management

indicated that the Agency was in the process of developing written procedures for performing payment reconciliations between the ABC, iBudget Florida, and FMMIS systems.

Absent reconciliations of the ABC, iBudget Florida, and FMMIS system data, the Agency cannot ensure that HCBS Medicaid waiver program expenditures are accurate and complete or that any discrepancies will be timely identified and corrected. Also, as a result, the Agency lacks assurance that the data used for monitoring client expenditures and budgets and for reporting HCBS Medicaid waiver program information is reliable.

Recommendation: We recommend that the Agency continue its efforts to establish and implement procedures requiring the periodic reconciliation of the claims payment data recorded in the ABC, iBudget Florida, and FMMIS systems.

Quality Assurance Reviews – HCBS Medicaid Waiver Program

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

To ensure HCBS Medicaid waiver program services were provided in accordance with established standards and appropriate for individual client needs, AHCA contracted with the Delmarva Foundation for Medical Care (Delmarva)[23] for Statewide quality assurance oversight. For providers of Agency services, Delmarva was responsible for performing quality assurance reviews as specified in Agency operating procedures. Agency operating procedures also detailed any resulting remediation required by the Agency and the applicable provider. Based upon their selection methodology, Delmarva subjected all providers to review and assigned a compliance rating of zero percent (no compliance) to 100 percent (full compliance) for each provider review. To ensure any noted compliance deficiencies were timely addressed, the Agency required follow-up and remediation efforts be completed within 90 days of the receipt of any report with noted noncompliance. The Agency relied on field office staff to monitor the Delmarva reports and ensure that follow-up and remediation of any noncompliance occurred within the 90-day time frame established by the Agency. In January 2011, the Agency established a spreadsheet to serve as a central tracking mechanism for documenting and monitoring noncompliance issues noted by Delmarva and the field offices, as well as, consumer complaints. Pursuant to Agency procedures, any noncompliant provider who was not responsive to remediation efforts was to be terminated from the waiver program and AHCA was to be notified of the applicable provider's program termination.

As similarly noted in our report No. 2012-120, finding No. 6, our evaluation of the Agency's procedures and tests of Agency follow-up efforts disclosed that the procedures, as implemented, did not effectively ensure the timely follow-up on provider noncompliance identified in Delmarva reviews. Specifically, of the 3,736 reviews Delmarva conducted during the period July 2011 through December 2012, we identified 13 that related to active providers with a zero percent compliance rating. Our audit tests disclosed that for 2 of the 13 reviews, the Agency did not initiate action to address the remediation of noncompliance issues until 100 and 476 days, respectively, after receipt of the Delmarva review report. In these instances, Agency action was completed 109 and 502 days, respectively, after receipt of the Delmarva review report. One of the two providers was paid approximately $58,271 for services provided subsequent to being designated as noncompliant.

The Agency formed a workgroup in December 2012 to review and, as applicable, revise Agency operating procedures to better ensure the timely follow-up and remediation of provider compliance deficiencies noted in Delmarva review

[23] A quality improvement organization recognized by the CMS as a peer review organization.

reports and to address other quality assurance issues. As AHCA has responsibility for Medicaid program administration, the workgroup's recommendations were to be provided to AHCA for consideration. In response to our audit inquiry, Agency management indicated that, subject to AHCA review and approval, implementation of revised procedures related to Agency actions for addressing compliance deficiencies noted in the quality assurance review reports was tentatively scheduled for December 2013.

Delays in following up on compliance deficiencies noted during quality assurance reviews limits the Agency's ability to initiate timely remediation actions or to terminate nonresponsive providers from the HCBS Medicaid waiver program for material nonperformance or fraud. As a result, the Agency's ability to ensure the quality of services provided to individuals under the Agency's care is diminished.

Recommendation: We recommend that the Agency continue to work with AHCA to enhance procedures for the timely remediation of provider compliance deficiencies. For noncompliant providers that are nonresponsive to remediation efforts, such procedures should address the timely termination of the provider from the HCBS Medicaid waiver program.

Individual and Family Supports (IFS) Program

Finding No. 7: IFS Client Eligibility Determinations

The Agency administered the Individual and Family Supports (IFS) Program to provide services to individuals who were either ineligible for the HCBS Medicaid waiver program or on the waiver waiting list, or to provide services requested by HCBS Medicaid waiver program enrollees that were not provided under the waiver. For the 2012-13 fiscal year, the Legislature appropriated approximately $16.4 million for the IFS Program from State and Federal funding[24] sources. According to Agency management, it was the Agency's practice to exhaust all other available funding sources before approving expenditures from IFS Program funding.

State law[25] defines the Agency services application and client eligibility determination requirements, including those applicable for IFS Program services. State law[26] requires that only applicants whose domicile is in Florida are eligible for IFS Program services and that the domicile may not be established in Florida by any alien not classified as a resident alien. Additionally, the Agency established policies and procedures prescribing the process to be used by the field offices to determine IFS Program client eligibility. Beginning in 2006, the procedures required the applicant to submit a written application and provide certain documentation, including proof of identity, evidence of U.S. citizenship or resident alien status, and support for Florida domicile. On the application, clients were to provide demographic information and indicate the types of services requested. The application also included sections where Agency personnel were to document the determination of client eligibility in accordance with Agency procedures.

In our report No. 2012-120, finding No. 1, we noted that the Agency's client eligibility determination processes for the IFS Program needed improvement. Specifically, we disclosed 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. We recommended that the Agency reevaluate the client applications approved prior to 2006 and that Agency procedures require verifications of the client's Florida domicile be made on at least an annual basis.

[24] Federal funding sources included the Social Services Block Grant (Catalog of Federal Domestic Assistance No. 93.667).
[25] Section 393.065, Florida Statutes.
[26] Sections 393.065(1) and 393.063(12), Florida Statutes.

As part of this audit, we performed follow-up procedures that included an evaluation of Agency client eligibility determination procedures and an examination of documentation supporting selected client eligibility determinations. We found that Agency procedures had not been revised to require a reevaluation of client eligibility or annual verifications of the clients' Florida domicile and that Agency staff had not performed such actions. Additionally, our examination of the applications and other supporting documents for 25 clients, on whose behalf payments totaling approximately $201,949 were made from IFS Program moneys during the period July 1, 2011, through December 31, 2012, again disclosed instances in which the Agency had provided services to ineligible clients or had not documented client eligibility in accordance with Agency procedures. Specifically:

- The Agency provided IFS Program-funded services to 2 clients who were ineligible. For 1 client, the Agency paid approximately $502 for claims submitted on the client's behalf after the Agency had determined the client ineligible. In addition, subsequent to our audit inquiry, the Agency determined that the other client was ineligible and dismissed the client from the IFS Program. Payments made on behalf of this client totaled approximately $218.
- For 5 clients, the Agency was unable to provide documentation of the determination of client eligibility as the client files did not contain applications. Agency payments made on behalf of these 5 clients totaled $130,692.
- The client files for 4 clients (including 2 of the 5 without applications) did not contain sufficient documentation supporting the client's Florida domicile at the time of application. Only 1 of these clients had initially applied for services prior to the Agency's establishment of procedures in 2006 requiring documentation of Florida domicile. Additionally, the files for 2 of the 4 clients did not contain sufficient proof of U.S. citizenship or resident alien status at the time of application.
- The Agency did not appropriately document the eligibility determination on 6 clients' applications.

Procedures requiring a periodic reevaluation of client eligibility and that the client's Florida domicile be annually verified would provide assurance that IFS Program services are being provided only to eligible individuals. Adherence to established procedures for documenting client eligibility at the time of application, as well as the development of procedures for periodically reevaluating client eligibility, would assist the Agency in ensuring eligibility determinations are properly made and documented and updated for any relevant changes in a client's status.

Recommendation: We again recommend that the Agency periodically reevaluate client eligibility determinations and that each client's Florida domicile be verified annually. Additionally, we recommend that the Agency enhance its procedures to better ensure that client eligibility determinations are properly documented and appropriately updated.

Consumer-Directed Care Plus (CDC+) Program

Finding No. 8: CDC+ Program Account Balances

The Consumer-Directed Care Plus (CDC+) Program is a self-directed personal assistance services option designed to allow Agency clients (consumers) or their representatives, if applicable, to exercise decision-making authority in identifying, accessing, managing, and purchasing eligible services.[27] In March 2008, the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) approved a Medicaid State Plan amendment (MSP amendment) establishing the CDC+ Program as a permanent Medicaid State Plan option. For the 2011-12 fiscal year, Agency expenditures relating to the 1,927 CDC+ Program consumers totaled approximately $52.2 million.

[27] Title 42, Sections 441.450 through 441.484, Code of Federal Regulations.

Consumers who voluntarily enrolled in the CDC+ Program were to receive HCBS Medicaid waiver program care and support plans (support plans) that included an identification of risks and potential mitigation strategies. The support plans were to be used in developing individual purchasing plans that specify how monthly budgets would be used to meet the consumer's care needs. With the assistance of a consultant, hired by the consumer to provide information, counseling, training, or assistance as needed, the consumers were to develop their own care strategies and hire employees or contract with vendors for needed services. The consultant was to review and approve the consumer's purchasing plan to ensure proposed services were appropriate and cost-effective, and that an emergency back-up plan was in place.

The Agency was responsible for deposits into consumer accounts and, in accordance with the consumer's purchasing plan, for allocating the deposits into accounts for services, cash, savings, and one-time and short-term expenditures. The Agency also made payments to providers for services, including one-time and short-term expenditures, in accordance with the consumer's purchasing plan. Pursuant to CDC+ Program policy, consumers were not to purchase goods or services that were not included in their approved purchasing plan. Consumers could 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 of when the purchase was first identified in their purchasing plan. The Agency provided consumers with monthly statements to assist them in managing their budgets.

Effective July 2013, the Agency implemented iBudget Florida for all CDC+ Program consumers. While the implementation of iBudget Florida affected how a consumer's monthly allocation was calculated, the process for selecting services and administering client accounts remained the same.

In our report No. 2012-120, finding No. 7, we noted that the Agency did not have procedures in place to monitor consumer accounts to ensure that funds, in excess of the amount approved for savings at the time of the consumers' annual eligibility redetermination, were returned to the State as required by the Medicaid waiver. The MSP amendment required consultants to perform monthly monitoring of consumers to assess consumer spending and service utilization in comparison to the approved purchasing plan. Federal regulations[28] required the State to flag significant budget variances and bring them to the attention of the applicable consumer and consultant and to establish safeguards to timely identify budget problems and to permit corrective action when necessary.

As part of our follow-up testing, we evaluated the Agency's procedures and performed analytical procedures related to CDC+ Program consumer account balances. We noted that Agency staff had developed reinvestment procedures and drafted a methodology that would provide for annual evaluations of consumer accounts, allowing consumers to retain two times their monthly budget amount; however, the methodology had not been finalized as of July 2013. Periodic comparisons of consumers' spending and service utilization to their purchasing plan, as required by the MSP amendment, may have prevented some consumers from accumulating the large unexpended account balances disclosed by our audit procedures. Specifically:

- Our review of 1,927 active CDC+ Program consumer account balances as of December 31, 2012, identified 42 accounts with balances greater than $50,000, with the greatest balance totaling approximately $325,385. These 42 accounts included 21 of the 33 consumer accounts identified during our prior audit as having excessive account balances as of February 28, 2011. We noted that, since February 2011, the account balances for 18 of the 21 consumer accounts had actually increased by 1 to 48 percent, with an average increase of 20 percent, while the balances in the other 3 consumer accounts had decreased by an average of 10 percent.

[28] Title 42, Section 441.464, Code of Federal Regulations.

- Our audit also identified 9 accounts for consumers who had been classified as inactive from the CDC+ Program for over one year. As of December 31, 2012, these 9 accounts had balances totaling approximately $95,000 and ranging from approximately $2,195 to $21,010. Despite the consumers' inactive status, the Agency had not reinvested the residual account balances. Subsequent to our audit inquiry, the Agency initiated reinvestment of these balances.

In response to our audit inquiry, Agency management indicated that following the promulgation of an AHCA rule[29] in November 2012, the Agency developed procedures including a CDC+ Program handbook that was incorporated into the rule. The procedures and handbook address the identification and reinvestment of excess funds, including the funds in inactive consumer accounts.

Recommendation: We recommend that the Agency finalize and implement its methodology to ensure that excessive CDC+ Program consumers' account balances are identified and timely reinvested.

Travel Reimbursements

Finding No. 9: Employee Mileage Reimbursements

State law[30] establishes requirements for the reimbursement of State business travel expenses. Among the requirements, State law[31] specifies that all mileage claimed for reimbursement shall be shown from point of origin to point of destination and that vicinity mileage necessary for the conduct of official business is allowable, but must be shown as a separate item on the expense voucher.

Additionally, the Department of Financial Services (DFS) has developed rules[32] for State agencies to follow when reimbursing travel expenses. The rules provide that State agencies may not pay for mileage between an employee's residence and their headquarters or regular work location.[33] The rules also define the point of origin as the geographic location of the traveler's official headquarters or the geographic location where travel begins, whichever is the lesser distance from the destination.[34]

The Agency established written travel policies and procedures[35] for authorizing and obtaining reimbursement for official travel performed on behalf of the Agency. According to Agency management, Agency employees may be reimbursed for mileage from the employee's residence if their residence is closer to the destination than their headquarters; however, the Agency's policies and procedures did not require employees to document that their residence was closer than their headquarters when requesting reimbursement for mileage from their residence.

Agency travel expenditures totaled $915,288 during the period July 2011 through December 2012, and included $599,574 for mileage reimbursements. We reviewed Agency documentation and performed procedures to verify the amounts paid for 25 mileage reimbursements totaling $13,993. To evaluate the reasonableness of the mileage, we accessed the Department of Transportation's Florida Official Intercity Highway Mileage Web site (for intercity mileage), as well as an online mapping service (for vicinity mileage). We found that:

[29] AHCA Rule 59G-13.088, Florida Administrative Code.
[30] Section 112.061, Florida Statutes.
[31] Section 112.061(7)(d)3., Florida Statutes.
[32] DFS Rules, Chapter 69I-42, Florida Administrative Code.
[33] DFS Rule 69I-42.008(4), Florida Administrative Code.
[34] DFS Rule 69I-42.002(15), Florida Administrative Code.
[35] Agency Policy and Procedure OP 15-010, *Travel Policies and Procedures*.

- For 13 reimbursements totaling $7,074, the total mileage claimed was greater than that indicated by the online mapping service and the reimbursement requests did not document how the Agency determined the reasonableness of the mileage claimed. The differences between the mileage claimed and the mileage indicated by the online mapping service totaled 879 miles and ranged from 29 to 192 miles per reimbursement.
- For 13 of the 25 reimbursements, contrary to DFS rules, the travelers claimed mileage for a total of 51 trips between their residences and their headquarters or regular work locations. Mileage reimbursements for these 51 trips totaled $1,252.
- For 2 of the 25 reimbursements, the destination addresses for a total of 42 trips were not documented to support the mileage claimed and reimbursed. Mileage reimbursements for these 42 trips totaled $870.

Without adequate support for mileage reimbursement requests and procedures that provide for sufficient review of the allowability and reasonableness of the mileage claimed, the Agency cannot demonstrate that amounts reimbursed for mileage were calculated and paid in accordance with the requirements of State law and DFS rules.

Recommendation: To ensure compliance with State law and DFS rules, we recommend that the Agency enhance its travel policies and procedures to require mileage reimbursement requests be supported by adequate documentation and that, prior to reimbursement, the reasonableness and allowability of the claimed mileage be verified. In addition, for travelers who claim mileage to and from their residences, we recommend that the Agency obtain and maintain documentation evidencing that the destination was closer to the traveler's residence than their headquarters.

PRIOR AUDIT FOLLOW-UP

Except as discussed in the preceding paragraphs, the Agency had taken corrective actions for the findings included in our report No. 2012-120.

OBJECTIVES, SCOPE, AND METHODOLOGY

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 2013 through July 2013 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 iBudget Florida. The overall objectives of the audit were:

- To evaluate management's performance in establishing and maintaining internal controls, including controls designed to prevent and detect fraud, waste, and abuse, and in administering assigned responsibilities in accordance with applicable laws, administrative rules, contracts, grant agreements, and guidelines.
- To examine internal controls designed and placed in operation to promote and encourage the achievement of management's control objectives in the categories of compliance, economic and efficient operations, the reliability of records and reports, and the safeguarding of assets, and identify weaknesses in those internal controls.

- To identify statutory and fiscal changes that may be recommended to the Legislature pursuant to Section 11.45(7)(h), Florida Statutes.

Our audit also included steps to determine whether management had corrected, or was in the process of correcting, all deficiencies noted in our report No. 2012-120.

This audit was designed to identify, for those programs, activities, or functions included within the scope of the audit, deficiencies in management's internal controls, instances of noncompliance with applicable governing laws, rules, or contracts, and instances of inefficient or ineffective operational policies, procedures, or practices. The focus of this audit was to identify problems so that they may be corrected in such a way as to improve government accountability and efficiency and the stewardship of management. Professional judgment has been used in determining significance and audit risk and in selecting the particular transactions, legal compliance matters, records, and controls considered.

As described in more detail below, for those programs, activities, and functions included within the scope of our audit, our audit work included, but was not limited to, communicating to management and those charged with governance the scope, objectives, timing, overall methodology, and reporting of our audit; obtaining an understanding of the program, activity, or function; exercising professional judgment in considering significance and audit risk in the design and execution of the research, interviews, tests, analyses, and other procedures included in the audit methodology; obtaining reasonable assurance of the overall sufficiency and appropriateness of the evidence gathered in support of our audit's findings and conclusions; and reporting on the results of the audit as required by governing laws and auditing standards.

Our audit included the selection and examination of transactions and records. Unless otherwise indicated in this report, these transactions and records were not selected with the intent of statistically projecting the results, although we have presented for perspective, where practicable, information concerning relevant population value or size and quantifications relative to the items selected for examination.

An audit by its nature, does not include a review of all records and actions of agency management, staff, and vendors, and as a consequence, cannot be relied upon to identify all instances of noncompliance, fraud, abuse, or inefficiency.

In conducting our audit we:

- Interviewed selected Agency personnel, reviewed policies and procedures, and examined records to obtain an understanding of internal controls and processes and procedures related to the implementation and administration of iBudget Florida.
- Evaluated the Agency's reconciliation process to determine whether the process provided for the timely and appropriate reconciliation of amounts paid from FMMIS to the amounts recorded in the ABC and iBudget Florida systems and used to track expenditures for client services and monitor client iBudgets.
- Performed analytical procedures to determine whether payments made on behalf of Agency clients during the period July 2012 through December 2012 did not exceed the clients' authorized iBudgets.
- Performed analytical procedures utilizing FMMIS payment data and ABC system client data to determine whether clients were transitioned to iBudget Florida in accordance with scheduled implementation dates.
- Examined eligibility records for 60 Agency clients from iBudget Florida implementation Waves 1, 2, and 3 to determine whether the Agency appropriately determined and documented eligibility for HCBS Medicaid waiver program services.
- Evaluated the Agency's processes for applying the iBudget Florida algorithm and methodology and for calculating the required budgetary reserve to determine whether the Agency complied with the requirements of State law.

- Examined the Target Allocation amounts for 60 iBudget clients from implementation Waves 1, 2, and 3 to determine whether the Agency calculated the amounts in accordance with proposed rules, timely notified the clients of the transition to iBudget Florida, and transitioned the clients to iBudget Florida in accordance with the Agency's implementation schedule.
- Examined cost plans for 60 iBudget clients from implementation Waves 1, 2, and 3 to determine whether the Agency appropriately established and approved client annual cost plans.
- Examined 60 HCBS Medicaid waiver program payments made during the period July 2011 through January 2013 on behalf of clients included in implementation Waves 1, 2, and 3 to determine whether the methods for determining client service delivery were proper, whether there was evidence that services were provided, and whether services rendered were billed and paid correctly.
- Evaluated Agency actions taken to correct the deficiencies noted in our report No. 2012-120. Specifically, we:
  - Examined eligibility records for 25 clients who received IFS Program services during the period July 2011 through December 2012 to determine whether the clients were eligible to receive the services through the IFS Program.
  - Examined IFS Program payments made during the period July 2011 through December 2012 on behalf of 25 clients to determine whether the payments were authorized, allowable, documented, mathematically correct, correctly coded, and made in accordance with applicable laws, rules, regulations, and Agency policies and procedures.
  - Analyzed IFS Program payments made during the period July 2011 through March 2013 on behalf of Medicaid clients to verify that the services were properly funded by the IFS Program and not reimbursable under the Medicaid program.
  - Examined IFS Program payments made during the period July 2011 through December 2012 on behalf of 25 clients to determine whether the Agency completed an assessment of need for Agency clients and that payments were not made for Medicaid-eligible services.
  - Analyzed 9 of 61 instances occurring during the period July 2011 through December 2012 where the dates recorded in Agency records for client services paid by the IFS Program appeared to be subsequent to the clients' dates of death recorded in the Department of Health, Office of Vital Statistics, death records to determine whether payments were made to providers for services with dates subsequent to the dates of the clients' death.
  - Reviewed 13 Delmarva Foundation quality assurance review reports received by the Agency during the period July 2011 through December 2012 that showed a score of zero percent compliance to evaluate the adequacy, timeliness, and frequency of Agency follow-up actions to address the noncompliance issues noted.
  - Performed analytical procedures to evaluate the reasonableness of CDC+ Program clients' account balances as of December 2012.
- Reviewed 35 travel reimbursement vouchers paid during the period July 2011 through December 2012 totaling $28,335.40, including 25 vouchers with mileage reimbursements totaling $13,993.48, to determine whether the reimbursements were properly documented, authorized, and paid in accordance with governing laws, rules, and Agency policies and procedures.
- Reviewed applicable laws, rules, and other State guidelines to obtain an understanding of the legal framework governing Agency operations.
- Observed, documented, and evaluated the effectiveness of, selected Agency administrative processes and procedures for the budgetary control process.

- Observed, documented, and evaluated the effectiveness of, selected Agency administrative processes and procedures for the assignment and use of motor vehicles with acquisition costs totaling $111,545 as of December 31, 2012.
- Observed, documented, and evaluated the effectiveness of, selected Agency administrative processes and procedures for the management of Agency contracts with related expenditures totaling approximately $9.5 million for the period July 1, 2011, through December 31, 2012.
- Observed, documented, and evaluated the effectiveness of, selected Agency administrative processes and procedures for the management of wireless devices with related costs totaling $179,048 for the period July 1, 2011, through December 31, 2012.
- Communicated on an interim basis with applicable officials to ensure the timely resolution of issues involving controls and noncompliance.
- Performed various other auditing procedures, including analytical procedures, as necessary, to accomplish the objectives of the audit.
- Prepared and submitted for management response the findings and recommendations that are included in this report and which describe the 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.

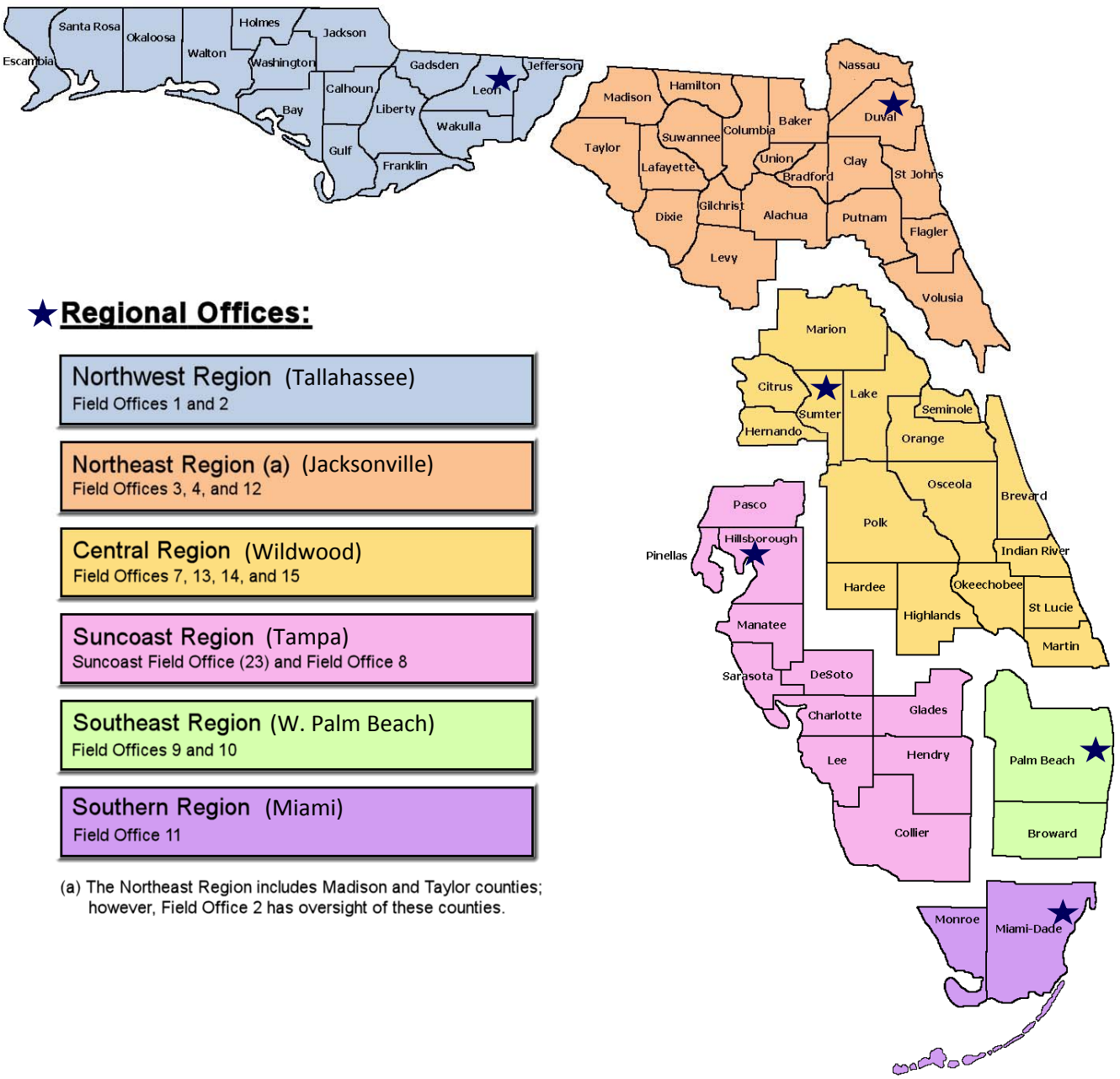
David W. Martin, CPA
Auditor General

MANAGEMENT'S RESPONSE

In a response letter dated December 6, 2013, the Director of the Agency concurred with our audit findings and recommendations. The Director's response is included as **EXHIBIT B**.

EXHIBIT A

AGENCY REGIONS AND FIELD OFFICES



★**Regional Offices:**

Northwest Region (Tallahassee)
Field Offices 1 and 2

Northeast Region (a) (Jacksonville)
Field Offices 3, 4, and 12

Central Region (Wildwood)
Field Offices 7, 13, 14, and 15

Suncoast Region (Tampa)
Suncoast Field Office (23) and Field Office 8

Southeast Region (W. Palm Beach)
Field Offices 9 and 10

Southern Region (Miami)
Field Office 11

(a) The Northeast Region includes Madison and Taylor counties; however, Field Office 2 has oversight of these counties.

EXHIBIT B

MANAGEMENT'S RESPONSE

agency for persons with disabilities
State of Florida

Rick Scott
Governor

Barbara Palmer
Director

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December 6, 2013

David W. Martin, CPA
Auditor General
State of Florida
G74 Claude Pepper Building
111 West Madison Street
Tallahassee, FL 32399-1450

Re: Preliminary and Tentative Audit Findings – Agency for Persons with Disabilities, iBudget Florida and Prior Audit Follow-Up Operational Audit

Dear Mr. Martin:

I appreciate this opportunity to respond to the preliminary and tentative audit findings and recommendations concerning your operational audit on the *iBudget Florida and Prior Audit Follow-Up*. Our response is enclosed as required by section 11.45(4)(d), Florida Statutes.

I appreciate the effort of you and your staff in assisting to improve our operations. If you have any questions or need additional information, please contact Carol Sullivan, Director of Audit at (850) 414-7166.

Sincerely,

Barbara Palmer

Barbara Palmer
Director

BP/cs
Enclosure

http://apdcares.org

EXHIBIT B (CONTINUED)

MANAGEMENT'S RESPONSE

BACKGROUND

In addition to the background information contained in the Preliminary and Tentative Audit Findings, the agency would like to offer the following additional information. In order to develop the iBudget Florida wavier program, the Agency established a stakeholder workgroup that met for several years beginning in 2009. The stakeholder group provided specific feedback and consensus on the development of the iBudget algorithm formula and the program services and limitations. This stakeholder group also provided review of all documents created for the iBudget Florida report that was submitted to the legislature as well as the rules for program implementation.

IBUDGET FLORIDA

Finding No. 1: iBudget Florida Allocation Algorithm and Methodology

Finding: The Agency should take appropriate actions and establish procedures to ensure compliance with State law and promote the achievement of iBudget Florida objectives.

Recommendation: We recommend that the Agency continue its efforts to ensure that the iBudget Florida allocation methodology is consistent with the requirements of State law. In addition, to ensure that the objectives of iBudget Florida are achieved, the Agency should establish procedures to periodically evaluate the appropriateness of iBudget algorithm, Target Allocation calculation methodology, and reserve calculation process.

Agency Response: The Agency concurs. The Agency will follow the courts' direction as it relates to the settlement agreement. The Agency will also review and update our procedures as necessary as it relates to the iBudget algorithm, Target Allocation calculation methodology and the reserve calculation process.

Finding No. 2: Calculation of Client iBudgets

Finding: The Agency did not always ensure that clients' iBudget amounts were supported by adequate documentation evidencing that the amounts were calculated in accordance with Agency instructions.

EXHIBIT B (CONTINUED)

MANAGEMENT'S RESPONSE

Recommendation: We recommend that the Agency establish written policies and procedures that require the maintenance of documentation to support iBudget calculations and address the review of iBudget amounts by Agency staff prior to approval.

Agency Response: The Agency concurs. The Agency will continue to follow Rule 65G and review and update our procedures as necessary as it relates to the documentation required to determine a client's budget.

Finding No. 3: iBudget Florida Monitoring

Finding: Agency management had not established written procedures specifying the tools and processes to be used to monitor iBudget Florida expenditures and the available budget.

Recommendation: We recommend that the Agency establish written procedures specifying the tools and processes to be used to monitor the Agency's iBudget Florida expenditures and budget.

Agency Response: The Agency concurs. The Agency will develop written procedures specifying the reports, processes and frequency for monitoring the Agency's iBudget Florida expenditures and budget.

Finding No. 4: Documentation of Client Eligibility

Finding: The Agency did not always timely complete or properly document client eligibility determinations.

Recommendation: We recommend that the Agency ensure that client eligibility determinations are properly documented and supported by appropriate client eligibility documentation. Such documentation should be maintained in a central location to facilitate the Agency's verification of, and enhance management's assurances related to, client eligibility. We also recommend that the Agency ensure that annual evaluations of client eligibility are timely performed and documented on Eligibility Worksheets in accordance with Agency procedures.

Agency Response: The Agency concurs. APD has consulted with AHCA and CMS and is awaiting written guidance to share with regional staff and Waiver Support Coordinators (WSCs). APD will issue a procedure as to how staff and WSCs are to conduct and validate individual eligibility determination based upon missing documentation once the instructions from AHCA have been received. State Office will

EXHIBIT B (CONTINUED)

MANAGEMENT'S RESPONSE

also provide training to regional staff and WSCs as to how to conduct record reviews on individual files that have missing eligibility documentation.

Finding No. 5: Information System Reconciliations

Finding: The Agency did not periodically reconcile the claims payment data recorded in the Agency's systems used to plan and manage client services to the claims payment data included in the Florida Medicaid Management Information System.

Recommendation: We recommend that the Agency continue its efforts to establish and implement procedures requiring the periodic reconciliation of the claims payment data recorded in the ABC, iBudget Florida, and FMMIS systems.

Agency Response: The Agency concurs. The Agency will continue its efforts to develop and implement procedures for the periodic reconciliation of the claims payment data in the ABC, iBudget Florida and FMMIS systems.

QUALITY ASSURANCE REVIEWS – HCBS MEDICAID WAIVER PROGRAM

Finding No. 6: Quality Assurance Reviews – HCBS Medicaid Waiver Program

Finding: The Agency did not always timely follow-up with providers who were determined to be noncompliant during quality assurance reviews.

Recommendation: We recommend that the Agency continue to work with AHCA to enhance procedures for the timely remediation of provider compliance deficiencies. For noncompliant providers that are nonresponsive to remediation efforts, such procedures should address the timely termination of the provider from the HCBS Medicaid waiver program.

Agency Response: The Agency concurs. All 13 providers have been terminated. In 2013, the Bureau of Quality Management began revising the current Quality Management Operating Procedure to establish clear

EXHIBIT B (CONTINUED)

MANAGEMENT'S RESPONSE

guidelines for immediate follow-up that includes a termination review of Noncompliant providers.

INDIVIDUAL AND FAMILY SUPPORTS (IFS) PROGRAM

Finding No. 7: IFS Client Eligibility Determinations

Finding: The Agency did not properly document or periodically reevaluate client eligibility determinations for clients receiving services through the IFS Program.

Recommendation: We again recommend that the Agency periodically reevaluate client eligibility determinations and that each client's Florida domicile be verified annually. Additionally, we recommend that the Agency enhance its procedures to better ensure that client eligibility determinations are properly documented and appropriately updated.

Agency Response: The Agency concurs. Program staff will develop a Business Process to detail all requirements of the Individual and Family Supports (IFS) Program to include eligibility determination, documentation requirements, service availability and limitations, review process, implementation and tracking requirements, among other things.

CONSUMER-DIRECTED CARE PLUS (CDC+) PROGRAM

Finding No. 8: CDC+ Program Account Balances

Finding: CDC+ Program funds were allowed to accumulate in consumer accounts instead of being reinvested.

Recommendation: We recommend that the Agency finalize and implement its methodology to ensure that excessive CDC+ Program consumers' account balances are identified and timely reinvested.

Agency Response: The Agency concurs. The Agency in coordination with AHCA completed the Rule Development process. The CDC+ Rule (59G-13.088) was adopted in November 2012 and since then, the Agency has taken steps to perform analysis of the excess funds and worked with technology staff to automate the process used to identify funds for

EXHIBIT B (CONTINUED)

MANAGEMENT'S RESPONSE

reinvestment. The Agency anticipates the implementation of the reinvestment methodology and notice of the reinvestment of funds going out to the first wave of consumers with account balances in excess of $50,000 in the near future.

TRAVEL REIMBURSEMENTS

Finding No. 9: Employee Mileage Reimbursements

Finding: Agency travel reimbursement requests were not always adequately supported or paid in accordance with the requirements of State law.

Recommendation: To ensure compliance with State law and DFS rules, we recommend that the Agency enhance its travel policies and procedures to require mileage reimbursement requests be supported by adequate documentation and that, prior to reimbursement, the reasonableness and allowability of the claimed mileage be verified. In addition, for travelers who claim mileage to and from their residences, we recommend that the Agency obtain and maintain documentation evidencing that the destination was closer to the traveler's residence than their headquarters.

Agency Response: The Agency concurs. The Agency will review and enhance its travel policies and procedures regarding travel reimbursement and proper documentation.