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Department of Health  
**Early Intervention Program**

Performance Audit

March 2000

Ernest A. Almonte, CPA, CFE  
Auditor General

State of Rhode Island and Providence Plantations  
General Assembly  
Office of the Auditor General

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Representative Robert A. Watson

We have completed a performance audit of the Early Intervention Program administered by the Department of Health. Our findings and recommendations are contained herein as outlined in the Table of Contents.

Sincerely,

Ernest A. Almonte, CPA, CFE  
Auditor General

# EARLY INTERVENTION PROGRAM

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## ***EXECUTIVE SUMMARY***

### ***Early Intervention Program – Department of Health – Performance Audit***

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Improvement is needed in the financial administration and structure of the system used to deliver services for the statewide Early Intervention (EI) Program. The Department of Health uses federal and state funds to provide a variety of services to children from birth to three years of age who have been identified with developmental challenges. The EI program is an entitlement program which must provide services to all eligible children and their families. EI services are provided primarily through five regional centers, each serving a designated geographic area. Total program expenditures were \$7.1 million for fiscal 1999 of which \$2.7 million was funded by federal funds and the remainder (\$4.4 million) by state funds.

One of the key challenges facing the EI program is determining whether current funding levels are adequate to provide needed services. Existing funding and reimbursement methods combined with poor accountability for funds provided to the regional centers all contribute to masking the existence and extent of underfunding for the program.

Improved accountability for program funds expended by the regional centers is needed to allow comparison between the cost of services provided and total reimbursement received and also to provide information necessary to assess the adequacy of program funding. We recommend that each regional center prepare an annual accounting of EI program costs and revenues from all sources.

The regional centers are reimbursed using a combination of grant based and fee-for-service methods. This combination not only makes it difficult to assess how each center's EI program revenues compared to the cost of services but creates the potential for both over and under recovery of costs. Further, inclusion of a grant based reimbursement component creates less incentive for the centers to be aggressive in obtaining third party reimbursement. We recommend that the combination of grant and fee-for-service methods be eliminated and that an exclusive fee-for-service arrangement be considered.

The current budget process and method of allocating funds to the regional centers should be improved to better identify the needs of the EI population and ensure funding is adequate to meet those needs. Funding is now allocated on a flat per-child basis using the number of children served as of the previous December 1. We recommend that a more detailed budget process be employed reflecting the expected number of children to be served and the services to be provided.

Since each regional center is an exclusive provider in its region, no competition is introduced into the system to promote effective or efficient service delivery. We recommend that the service delivery system be assessed and that proposals should be solicited from entities interested in and capable of providing services under the EI Program.

## ***EXECUTIVE SUMMARY***

### ***Early Intervention Program – Department of Health – Performance Audit***

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The EI program, by federal regulation, must be a payor of last resort meaning that all other potential sources of reimbursement have been exhausted prior to payment with EI program funds. Reimbursement from health insurers, particularly Medicaid, needs to be maximized to increase total funding available for the program. The centers together with the Department of Health should investigate having the centers become participating providers under other health plans to allow reimbursement.

A database is used to collect program data for each of the five regional centers providing services under the program. We found that improved collection of data and greater facility to extract and analyze program information would enhance the Department's ability to plan the financial aspects of the program in addition to improving the quality and quantity of information available to all involved in the administration of the program. We recommend that the Department continue development of a database that is reliable, timely and convenient to use and provides users with the ability to easily extract data in multiple forms.

We also recommend that some system be developed to measure the long-term benefits of the early intervention services provided to children enrolled in the program. This would involve tracking a child as they progress through school based programs. We believe that increasing demands for program accountability make it desirable for this data to be accumulated.

## **II. INTRODUCTION**

### **OBJECTIVES, SCOPE AND METHODOLOGY**

We conducted a performance audit of the Early Intervention Program to determine if the Department of Health was administering the program efficiently and effectively. Our audit was conducted in accordance with *Government Auditing Standards*. The period covered by our audit was primarily the fiscal years ended June 30, 1998 and 1999.

Our audit focused on evaluating the practices and procedures employed by the Department in administering the program. Our objective was to identify practices and procedures which could be improved or made more efficient. To achieve our audit objectives, we reviewed relevant policies and procedures, interviewed responsible personnel, observed key operations, visited certain centers funded by and providing services to the program and performed tests and other audit procedures as considered necessary in the circumstances.

The scope of our audit did not include evaluating the appropriateness or sufficiency of services provided to children or their families under the program as this was not within our specific area of expertise.

### **BACKGROUND**

The Early Intervention (EI) Program provides services to eligible children from birth to three years of age who have been identified with developmental challenges. These challenges include developmental delays, certain diagnosed conditions, or circumstances that put the child at risk for developmental delays. The program operates pursuant to both State (General Law sections 23-13-22 to 25) and federal law (U.S.C. Title 20, Chapter 33, sections 1431- 1445). The federal law provides the specific compliance requirements for the program, defines the objectives, eligibility requirements, allowable services, and time frames.

The primary objective of the program is to provide a statewide system to identify children with developmental challenges at an early age and provide appropriate services to lessen the impact of these developmental delays once the child enters school and throughout their life. Further, a basic tenet of the program is that identification and provision of services at an early age can eliminate or reduce future costs.

The EI program is organizationally located within the Rhode Island Department of Health's Division of Family Health. Services are coordinated and largely provided by five centers, each serving a specific region (Central, Southern, Eastern, Metropolitan and Northern). Certain services are provided on a statewide basis for children with visual impairments, hearing losses and severe behavioral concerns. Within the Department of Health, approximately six employees devote 100% of their time and seven more devote a portion of their time to administering the program.

As required by federal law, an Interagency Coordinating Council (ICC) serves in an advisory role to the Department and facilitates the coordination of resources among state departments. The Interagency Coordinating Council is comprised as follows:

- ❑ parents of infants or toddlers with disabilities
- ❑ public or private providers of Early Intervention services
- ❑ one representative of the General Assembly
- ❑ directors of the State agencies involved in the provision of or payment for Early Intervention Services
- ❑ director of the state agency responsible for child care
- ❑ an individual involved with personnel preparation
- ❑ a representative from the agency responsible for governance of health insurance
- ❑ an individual involved in special education
- ❑ an individual from a head start agency or program
- ❑ other members selected by the governor

The ICC is required by federal law to meet at least quarterly.

The program is funded by a combination of state and federal funds. All children and their families are eligible for services regardless of financial need provided they have been assessed and developmental challenges exist. Some services provided under the Early Intervention program are eligible for reimbursement by private insurers or the Medicaid program. The Department of Health's fiscal 1999 annual report for the Early Intervention program indicates that 47% of EI children had some form of private medical insurance (which provided minimal reimbursement for early intervention services) and 52% were covered by the Medicaid program.

An Individualized Family Service Plan (IFSP) is prepared for each child to document the specific services needed and the outcomes expected. Typical services provided to children at or through the regional centers include:

- ❑ comprehensive evaluation
- ❑ family training, counseling, and home visits
- ❑ service coordination services
- ❑ physical therapy
- ❑ occupational therapy
- ❑ speech/language therapy
- ❑ special instruction

Other services may be arranged by the regional centers with providers under contract to the centers. Parent consultants are employed at each center and also at the Department of Health to serve as liaisons and facilitators between the centers and the families.

Services under the Early Intervention program are generally only provided through age three. In certain exceptional instances, services may be extended to children beyond their third birthday when the child cannot gain immediate access to school-based services. Other programs (pre-school and special education programs) continue services in an educational setting after the age of three.

## **Governor's Task Force – Early Intervention Program**

A task force commissioned by the Governor to conduct a comprehensive evaluation of the Early Intervention Program issued a report in June 1999 which included ten recommendations. Some of the more significant recommendations (in terms of those that are relevant to our audit objectives) are summarized below:

- ❑ develop formal interagency agreements between the Departments of Education, Children, Youth and Families, Human Services and Health to provide a seamless system that provides continuity once a child leaves the EI program at age three.
- ❑ develop and implement a multi-level and independently supported quality assurance system the results of which will be used to make systemic policy changes and service delivery enhancements.
- ❑ develop processes to bring Early Intervention services and support to community locations where high risk newborns with critical needs receive healthcare.
- ❑ develop a wider array of services, service providers and service settings.
- ❑ fully fund the EI program – the Commission recommended a per child expenditure of \$5,700 (the average national per capita cost of Early Intervention services) – this was estimated by the Commission to have required approximately \$2.3 million in additional funding compared to the fiscal 1999 funding level.
- ❑ develop strategies which maximize revenues available to the program.

### **NOTEWORTHY ACCOMPLISHMENTS**

The Department of Health has implemented effective procedures to ensure that all children born in Rhode Island hospitals are assessed for diagnosed conditions or risk factors contributing to developmental delays. An effective process is in place to refer the child and their families to the appropriate regional center for further assessment and, if warranted, the commencement of Early Intervention services. The Department has been successful in enrolling children in its EI program – Rhode Island ranks among the top ten programs in the nation for percent of the population under the age of three enrolled in the EI program.

The Department of Health has formed a partnership with the University of Rhode Island which draws on faculty from varied disciplines such as human development and family studies, psychology, education, communication disorders, and physical therapy. The ultimate goal of the partnership is to assure quality services to young children with developmental challenges through ongoing needs assessments and continuous quality improvement.

## Financial Summary – Early Intervention Program

	<u>Budget</u> <u>Fiscal 2000</u>	<u>Actual</u> <u>Fiscal 1999</u>	<u>Actual</u> <u>Fiscal 1998</u>
<b>Sources of Funding:</b>			
State appropriations	\$ 3,672,000	\$ 3,623,814	\$ 1,835,508
Federal grant – Special Education -- Grants for Infants and Families with Disabilities	1,840,000	1,790,094	1,559,653
Federal grant – Medicaid	946,000	932,619	688,638
Required State appropriation to match federal Medicaid funds	<u>773,000</u>	<u>769,248</u>	<u>586,414</u>
Total Funding provided	<u>\$ 7,231,000</u>	<u>\$ 7,115,775</u>	<u>\$ 4,670,213</u>

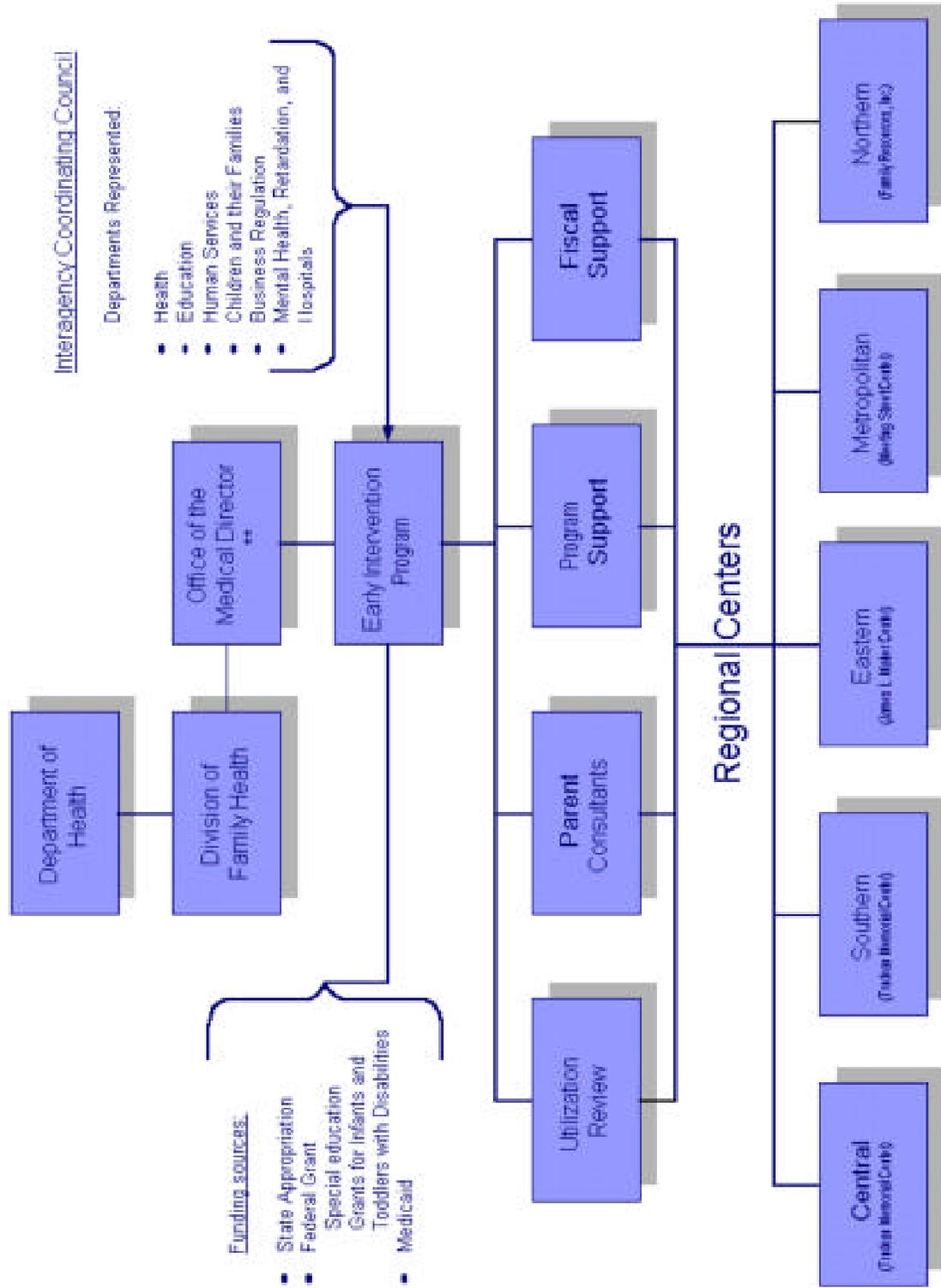
### **Program Expenditures:**

Program Administration:			
Personnel		\$ 699,294	\$ 466,133
Other		<u>109,015</u>	<u>93,451</u>
		808,309	559,584
Funding provided to regional centers:		5,024,999	3,122,623
Direct Medicaid Services		<u>1,282,467</u>	<u>988,006</u>
Total Program Expenditures		<u>\$ 7,115,775</u>	<u>\$ 4,670,213</u>

### **Notes:**

- Medicaid funds are used for the provision of direct services (\$1,282,467 in FY 1999 and \$988,006 in FY 1998) and for certain federally required program functions such as utilization review (\$419,400 in FY 1999 and \$ 287,046 in FY 1998) which are performed by the Department of Health.
- Services eligible for reimbursement by Medicaid are billed to the State's fiscal agent which pays the provider. The paid claims amount is then charged to the Department of Health's account. State funds are appropriated within the Department of Health's budget to match the federal Medicaid funds. The current federal and state share of Medicaid program costs are 54.05% and 45.95 %, respectively.
- Program administration expenditures shown above reflect only the Department of Health's costs to administer the program. Funding provided to the regional centers is for both program administration and program services.

# Early Intervention Program



\*\*Prior to February 2000, the Early Intervention Program reported to the Office of Special Healthcare Needs

### III. FINDINGS AND RECOMMENDATIONS

#### SERVICE DELIVERY AND PROGRAM FUNDING

##### Overview

Early Intervention (EI) services are provided to children and families primarily through five regional centers, each serving a designated geographic area. Funding, which consists of state appropriations and federal grants, is passed through the Department of Health to the centers. Allocations to each center are based on the number of children served as of December 1 of the preceding fiscal year. When children have other private medical insurance or are eligible for Medicaid, the centers bill those insurers directly on a fee-for-service basis. EI children in need of therapy services (speech and language, occupational and physical therapy) who are enrolled in the RItE Care program (Medicaid managed care) are supposed to receive those services through their RItE Care plans and providers.

Determining whether the program is adequately funded has become a critical and controversial issue. As an entitlement program, created pursuant to both federal and state law, services must be provided to all eligible children (and their families). Funding for the program increased significantly in fiscal 1999 primarily due to \$2 million of additional state funding provided through a supplemental budget amendment. Funding levels, based on per-child expenditures, actually decreased in each of the prior two fiscal years (1998 and 1997). Funding for the current fiscal year (2000) is essentially the same as amounts appropriated for fiscal 1999.

<u>Fiscal Year</u>	<u>Children enrolled (1)</u>	<u>percentage change</u>	<u>per child expenditures</u>	<u>percentage change</u>
1995	1,352		\$2,851 (1)	
1996	1,578	+ 16.7 %	\$2,965 (1)	+ 4.0 %
1997	1,751	+ 11.0 %	\$2,764 (1)	- 6.8 %
1998	2,005	+ 14.5 %	\$2,490 (1)	- 9.9 %
1999	1,983	- 1.0 %	\$3,181 (2)	+ 44.1%

(1) Source: reported by the Department of Health in annual reports prepared for the Early Intervention program for the fiscal year indicated. The number of children enrolled reflects active cases during a 15-month period beginning July 1 and ending September 30. These enrollment numbers differ from the December 1 census which reflects active cases on that date rather than a period of time. The December 1 census is used to allocate funding to the regional centers.

(2) Calculated based on total program expenditures of \$7,115,775 less \$808,309 expended for program administration divided by the number of children enrolled in the program.

Because each regional center is an exclusive provider in its region, parents do not have a choice in selecting a service provider (within their region) and therefore no competition is introduced into the system to promote effective and efficient service delivery. The current budget process and method of allocating funds should be improved to better identify the needs of the EI population and ensure funding is adequate to meet those needs. Improved accountability for the funds expended by the regional centers is needed to allow comparison between the cost of services provided and total reimbursement received and also to provide information needed to assess the adequacy of program funding. Reimbursement from health insurers, particularly the

Medicaid program, needs to be maximized to increase the total amount of funding available for the program.

### **Service Delivery System**

Families seeking services under the Early Intervention Program are referred to a regional center based on where they live. In the majority of cases, families use the designated regional center. At either the parent's request or because of the service required, services may be provided out of region on an exception basis. Additionally certain services (visual impairments, hearing losses and severe behavioral concerns) are provided at one location statewide. While the existing regional service delivery system does ensure that all EI children have access to comprehensive services, the regional delivery system should be assessed to ensure that this is the most effective and least costly mode of providing services. Additionally, since each provider is exclusive to its region, no competition is built into the existing service delivery model.

Most of the centers have been on contract with the Department since 1991. The Department should solicit proposals to identify other providers which are capable and interested in providing services under the EI program. Through this solicitation, innovative ideas for service delivery may also be discovered. Further, federal law requires that early intervention services be provided, "to the maximum extent appropriate ... in natural environments, including the home, and community settings in which children without disabilities participate". Expanding the number and types of providers within the system may allow more services to be provided in a natural environment consistent with the intent of the law.

Several federal programs have been recently created which have applicability to the EI program and may be potential resources to the Department. For example, a federal program entitled – Special Education – State Program Improvement Grants for Children with Disabilities (CFDA 84.323) could provide funding to the Department for program enhancements. In general, obtaining these grants requires submission of an application outlining a specific project consistent with the objectives of the federal programs. Supplemental funding for these purposes would allow all current funding to be available for services.

### **RECOMMENDATIONS**

1. Assess the current mode of service delivery and solicit proposals from entities interested in and capable of providing services under the Early Intervention program.
2. Investigate the possibility of obtaining other federal grants to fund program enhancements.

### **Auditee Views**

*The Department concurs with these recommendations. The Department is now developing a solicitation process with input from the Interagency Coordinating Council and the community.*

## Early Intervention Program Funding

Many individuals associated with or interested in the EI program believe that the program is significantly underfunded. If the program is significantly underfunded, a fact that we could not prove or disprove, then various factors contribute to masking that underfunding. These include:

- ❑ Funding is allocated to each center for the fiscal year on a flat per child basis using the previous December 1 census. The regional centers then develop their budgets to work within the predetermined allocations. This allocation process may not adequately reflect that services provided and associated costs vary widely for each child. Further, if more children are enrolled than anticipated or the mix of services provided is more costly than anticipated, the regional centers may limit certain services to stay within their funding allocations. This is not consistent with the intent of the EI program which, by federal and state law must provide services to all eligible children and their families.
- ❑ A full accounting is not available at each regional center to detail the full cost of all EI services provided and the amount of program support received from all sources including State appropriations and federal grants passed-through the Department of Health, and reimbursements from Medicaid and private medical insurance. While audited financial statements are available for each of the centers; none of the financial statements contained sufficient detail to allow the comparison of all EI costs and revenues. Costs that exceeded program support at the regional centers would be one obvious indicator of underfunding. Capturing accurate program financial information is essential to assessing whether the program is underfunded and by how much.
- ❑ The centers are reimbursed through a combination of direct grant and fee-for-service basis. The salaries of program staff at the centers are funded, in whole or in part, through the grants passed through the Department of Health. Staff may also provide services that are reimbursed on a fee-for-service basis at the same time. This combination of reimbursement methods makes it difficult to assess the financial status of the program at each center. (This issue is discussed in further detail in another section of this report.)

Because of these factors, we could not determine whether any center was underfunded and was limiting services to keep its costs within the amounts allotted for the year. Unless the centers have other sources of funding or are willing to have other programs subsidize the EI program, the centers most likely manage the program to keep costs within the amounts allocated by the State.

While the current budget model (flat per child allocation) is easy to administer, it does not adequately measure the amount needed to provide services in an entitlement type program and then may impose unintended limits that may affect the type and or quantity of services provided to a child.

The budget process should begin at the regional centers with each center preparing estimates of the number of children expected to be served, the types of services to be provided, the staffing required to provide those services and the total amount of funding required. These

budgets should then be reviewed and revised as needed by the Department of Health to prepare an overall budget request for the EI program.

### RECOMMENDATIONS

3. Revise the budget preparation process used to prepare the annual budget request by obtaining detailed budgets from each regional center reflecting the number of children expected to be served and the estimated services to be provided and use these budgets as the basis for the State budget request for the Early Intervention program.
4. Require that each center prepare an annual accounting of Early Intervention program costs and revenues from all sources. This schedule of program revenues and expenses should be included as supplementary information in each center's annual audited financial statements.

### Auditee Views

*The Department concurs with these recommendations.*

### **Reimbursement to the Regional Centers**

The combination of methods used to reimburse the regional centers makes it difficult to assess how each center's EI program revenues compared to the cost of services provided. The centers are compensated for services provided based on a combination of a grant to the centers and also a fee-for-service basis (when Medicaid or other medical insurers can be billed). For example, a regional center may budget 100 percent of a service coordinator's salary to EI, but Medicaid may also be billed for the EI service coordination provided to a Medicaid client. This creates the possibility that a center may be reimbursed twice for the same cost – an employee's salary could be reimbursed under the grant funds provided by the Department of Health and that employee could also provide services that are billed on a fee for service basis to Medicaid or another insurer. Conversely, a service coordinator's salary may be budgeted 80 percent to EI grants with the remaining 20 percent to be recovered through billings to insurers. If actual billings were less than the 20 percent anticipated, the center would recover less than 100% of its costs. We found no reliable evidence of either situation since a full accounting of total reimbursement to the centers and their actual costs was not available.

Further, this combination of reimbursement methods provides less incentive for the centers to be aggressive in obtaining third party reimbursement (Medicaid or other health insurance). The grant funding is assured regardless of the actual number of children enrolled or services provided. However, the Department's per-child allocation provides the regional centers with predictable and stable revenues. This allows the centers to have continuity in staffing and lessens any incentive to deliver costlier or unneeded services.

The Department should reevaluate the methods used to reimburse the regional centers for their costs of administering the EI program. One option would be to reimburse the centers exclusively on a fee for service basis where the centers would only be paid for each unit of service provided to a child or his/her family. Under a fee-for-service payment method, there is an incentive for the regional centers to deliver the full extent of services a child and his/her

family needs because they will be paid for each unit of service they deliver. A fee for service system may also allow better accountability since the existing combination of reimbursement methods would be eliminated.

On the negative side, a center may have incentive to deliver additional and potentially unnecessary or more expensive services to increase total revenues. A fee-for-service method would also complicate budgeting for the program by the Department of Health because the amount needed would be more difficult to anticipate and the “cap” that is now effectively part of the budget process would be removed. One possibility would be to include the EI population within the State’s caseload estimating conference. The conference forms a consensus opinion of the estimated participants in federal/state entitlement programs which is then used as to budget program costs.

If the number of providers is expanded and/or the regional concept is disbanded and more choice of providers is incorporated into the service delivery system, a fee-for-service reimbursement method may be the only feasible and practical approach.

### RECOMMENDATION

5. Eliminate the combination of methods (grants and fee-for-service) currently employed to reimburse the regional centers. Evaluate the feasibility of reimbursing the centers exclusively on a fee-for-service basis.

### Auditee Views

*The Department concurs with this recommendation.*

### Billings to Insurers

The Department should seek ways to maximize revenues from private and public health insurers for the EI program. As provided in federal law, the EI program is required to be a payor of last resort. Therefore, when either public or private health insurance is available, those resources should be utilized first. Maximizing revenue from all sources is important to expand resources available to the program -- Medicaid is the most likely source of additional revenue since the Department of Health reports that 52% of the EI population is Medicaid eligible and Medicaid covers a wider array of EI services than most private health care insurers.

We could not determine whether the regional centers had identified all billable costs to the Medicaid program. However, we did find that one center has, at times, delayed billing the Medicaid program for eligible services because it afforded the center a financial advantage. Due to the interplay of budgeting procedures and Medicaid program requirements, one center stopped billing Medicaid in April 1998 for the remainder of the fiscal year because, had it continued to bill Medicaid, other state funds would have been reduced by the amount of state funds required to match the federal Medicaid share. In this instance the center retained all its funding for the fiscal year and was still able to be reimbursed by Medicaid in the next fiscal year. However, the state funded 100% of these costs when approximately 54% of those expenditures could have been recovered through Medicaid. Therefore, the center’s advantage was at the expense of total resources available to the program.

As discussed earlier in this report, the current method of reimbursement provides little incentive for the centers to be aggressive in seeking reimbursement from private or public health insurers. We also noted that the centers are not participating providers under certain health insurance plans and therefore are precluded from being reimbursed for services even when the families have health insurance coverage. Further, because the private insurance plans typically cover fewer services that are offered to EI children and their families, this coverage is not viewed as a significant resource to the program. The centers, along with the Department of Health, should investigate the advantages of having the centers enrolled as participating providers so that they can bill these health insurance plans.

The regional centers also indicated that they need more guidance on which services can be billed to Medicaid in order to maximize funds from that source. The Department and the Department of Human Services (which administers the Medicaid program) should join efforts in providing training to the regional centers on how to maximize revenue from the Medicaid program. Because of the turnover in accounting personnel at the regional centers, training should be provided periodically. Enhanced training would also decrease the likelihood of overbilling. We found that one regional center billed Medicaid incorrectly for service coordination/case management services. The DHS contract allows these services to be billed in one half-hour increments at \$60 per hour. However, one regional center billed in 15-minute increments, resulting in reimbursements of \$120 per hour. The regional center estimated the over-billing of federal and state Medicaid funds at \$128,910.

#### RECOMMENDATIONS

6. Require the regional centers to bill all private and public insurers for allowable EI services whenever medical coverage exists in order to maximize total funds available for the program.
7. Provide the regional centers with periodic training in Medicaid billing procedures and allowable costs with the goal of maximizing Medicaid revenue.
8. Maximize Medicaid revenue by billing Medicaid for all potential units of service within the fiscal year that the services were provided.
9. Investigate the benefits of having the regional centers become participating providers in various health insurance plans to allow the centers to bill those plans for services provided.

#### Auditee Views

*The Department concurs with these recommendations. The regional center has agreed to reimburse the excess payment amount to the Medicaid program.*

#### **Fiscal Accountability at the Regional Centers**

We visited selected regional centers and tested some of their expenditures for the EI program. In many instances, the centers could not provide us with documentation to support the expenditures. This missing information included vouchers, invoices, employee timesheets,

calculations supporting costs allocated to the program, and support for amounts reported by the centers' external auditors. The cause for the missing documentation was attributed to high personnel turnover in the business offices of the centers.

The centers provide the Department of Health with documentation on a monthly basis which is intended to support the amounts allocated and paid to the center based on the per child allocation. These are considered "billings" but, in reality, funding to the centers is predetermined based on a flat per-child amount as previously described. We noted numerous transactions that were charged to EI but not billed to the Department when tracing amounts to the center's accounting records. When reviewing some specific expenditures charged to the Department, we noted instances in which the Department may have been overbilled and in other instances underbilled. Some monthly "billings" included inaccurate descriptions of both job titles and consultants charged. In two instances, the employees' salaries that were charged to the Department exceeded the amounts that were actually paid to the individuals that month. No reconciliation of the amounts "billed" to the Department for the EI program and the amounts classified as EI expenditures in the centers' accounting records was available.

Strong consideration should be given to improving accountability for funding provided to the regional centers. The existing monthly billing process provides little assurance that services have been provided and inadequate support for funds disbursed to the centers. Further, the billings require considerable effort to prepare for little benefit. The Department should explore the possibility of eliminating the monthly "billings" from the regional centers and replacing it with a more meaningful measure of services provided. This data would be supplemented by an annual accounting of the EI costs and program support for each center (see recommendation 4). If an exclusive fee-for-service billing approach replaces the existing combination approach, the annual accounting of EI costs and program support could be the basis used to substantiate the fees charged for services.

### RECOMMENDATIONS

10. Require the centers to maintain supporting documentation for all EI program costs.
11. Explore the possibility of replacing the monthly "billings" from each regional center with a more meaningful measure of services provided. Assess the propriety of costs reimbursed and the adequacy of funding by analyzing an annual accounting of EI program costs and revenue for each center.

### Auditee Views

*The Department concurs with these recommendations.*

### MONITORING

The Department can improve its fiscal monitoring of the regional centers. The fiscal monitoring reviews, which are performed annually, generally take from a couple of hours to a couple of days to complete and few deficiencies are noted. The regional centers are notified in advance which monthly "billings" will be reviewed.

The Department's files on these reviews contained little or no documentation of work performed or deficiencies found. None of the files documented the regional centers' billing and accounting procedures and policies.

Because of the deficiencies in supporting documentation for program costs for the centers we visited and the high turnover in accounting personnel at the centers, the Department should be more active and thorough in monitoring the fiscal aspects of the centers' operations.

Audits of each centers' financial statements are performed annually; however, the Department did not obtain the single audit report from two of its regional centers and those same regional centers did not have copies on file. These reports are useful monitoring tools to learn whether any significant deficiencies were noted during the centers' annual audits.

The Department performs annual site reviews of program compliance in addition to the fiscal reviews. On a quarterly basis, the liaisons review the status of the corrective actions taken by the centers to resolve the findings. The work performed and findings from the annual and quarterly reviews were well documented; however, we noted that in several instances the same findings were repeated in the 1998 and 1999 reviews. The findings from these reviews should be resolved in a timely fashion. For instance, two regional centers were cited for not maintaining current licenses or certificates on file for certain of their professional staff in both fiscal 1998 and 1999.

#### RECOMMENDATIONS

12. Expand the fiscal monitoring reviews performed at the regional centers.
13. Improve documentation of the fiscal monitoring at each center such as the procedures performed, records reviewed, the centers' control procedures, and any findings and conclusions.
14. Cease notifying regional centers which months' bills will be reviewed prior to the site visit.
15. Enforce resolution of findings in a timely manner.

#### Auditee Views

*The Department concurs with these recommendations.*

#### **EARLY INTERVENTION EXCHANGE OF INFORMATION OPERATION DATABASE**

The Department of Health needs improved data on the children and families served by the Early Intervention (EI) Program to more effectively administer the program. Improved collection of data and greater facility to extract and analyze program information would enhance the Department's ability to plan the financial aspects of the program in addition to improving the quality and quantity of information available to all involved in the administration of the program. For example, tracking information about the existence of health insurance coverage for program

participants is key to ensuring that all financial resources available to the program are being maximized.

The Department presently maintains the Early Intervention Exchange of Information Operation (EIEIO) database. The database is intended to collect program data from each of the five regional centers providing services under the program. Both the Department of Health and the five regional centers have access to the information contained in the database. One of the primary uses of the database is to maintain the census of all children enrolled in the program. The December 1 census is used to allocate funding to each of the regional centers. In addition, summary data is also reported to the U.S. Department of Education - Office of Special Education Programs and the RI General Assembly; therefore, the reported data could influence future funding levels to the Department.

We found that the database contained incomplete or inadequate information for certain key areas. For example, a summary report showed that over 65% of the children participating in the program were diagnosed with developmental delays in fiscal 1998 and 1999; however, no further detailed information could be obtained to better identify the category or type of developmental delay. Developmental delay is a very broad diagnosis which is insufficient to analyze other information contained in the database. It would be beneficial if the database could allow correlation of diagnosis or category of developmental delay with the types and quantity of services provided. This would then allow more refined estimates of funding required. The various diagnoses and/or categories of developmental delays should correspond to the types of services required and also the number and types of therapists and consultants needed to provide those services at a center.

We also found that a report from the database reflected health coverage information as "unknown or other" for over 50% of the clients at one regional center. Whether the center had the information but failed to record it in the database could not be determined. Identification of client's health coverage is key since the EI program is intended to be a payor of last resort -- private health insurers or the Medicaid program should be billed before EI program funding is used.

Further, the Department's ability to extract information from the database is limited because queries to the database cannot be performed without the help of a computer programmer. The Department's computer programmers are not readily available to assist the EI program because they must prioritize all the requests received from the various divisions within the Department. During the audit we requested certain summary reports from the database that could not be obtained or could not be obtained without the help of a computer programmer. The following information could not be provided:

- summary reports on services rendered and paid for;
- summary reports to compare services provided arrayed by diagnosis; and
- summary report on the time frame between assessment and commencement of services.

Although efforts are made to accumulate and input a significant amount of data on program participants, this data is most often not accessible which adversely impacts the effectiveness of program administrators.

Four of the five regional centers maintain their own internal databases in addition to the EIEIO database to meet their own needs and because the centers have difficulty extracting the information from the EIEIO database. Ad-hoc reports cannot be produced at the regional centers. Maintaining multiple systems is duplicative and adds to the overall administrative burden and related costs for the entire program.

The Department has recognized the limitations of its existing database and is in the process of developing a new database. The new database is expected to provide for accurate, timely, and convenient data capture. It should also allow for ad-hoc query and reporting requirements and support the electronic transfer of data from the regional level to the state level. In addition to some of the more obvious information needs which are not being met by the existing database, an improved database could provide a wealth of information that, if easily accessible, would aid in the administration of the EI program.

### RECOMMENDATION

16. Continue development of a database that is reliable, timely, and convenient to use and provides users with the ability to easily extract data in multiple forms.

### Auditee Views

*The Department concurs with this recommendation.*

### LONG-TERM RESULTS

Information is not being tracked, statewide, to measure the long-term benefits of the early intervention services provided to children enrolled in the program. Once a child is discharged from the EI program, the Department has no further contact with the family. However, services may continue through other programs that are administered by both the State and local educational agencies including preschool and special education programs.

Generally, there are two types of successful outcomes:

- (1) The child is no longer in need of services and is discharged from the EI program.
- (2) The child is transitioned into the pre-school program, but requires less intensive services because he/she has benefited from the early intervention services received.

At the time of discharge, the EI regional centers accumulate data on whether a child is no longer in need of services or has moved on to the pre-school program. Monitoring the child who has entered the pre-school program and continues on to the Special Education program becomes more complicated and requires the cooperation of the local school districts and the State Department of Education. Ideally, some system should be developed to measure if a child's successes in school can be attributed to receiving early intervention services and allow comparison to children who had not received such services. While we acknowledge the difficulty in measuring the long-term results of the early intervention services, we believe that the increasing demands for program accountability make it desirable for this data to begin to be accumulated.

Since one of the responsibilities of the federally mandated Interagency Coordinating Council (ICC) is to facilitate the coordination of resources among state departments, it would appear this is matter which they should initiate and elicit the support and cooperation from the various Departments involved.

#### RECOMMENDATION

17. Initiate a system to assess the long-term benefits of children receiving early intervention services as they are provided services through other related programs.

#### Auditee Views

*The Department concurs with this recommendation.*

#### **PARENT CONSULTANTS**

The results of the 1998 and 1999 family surveys indicate that the role of the parent consultants employed by the regional centers is important but may be underutilized. In both fiscal years, approximately one-third of the respondents to the family surveys were not aware of the Parent Consultant working in their region. The parent consultants serve (1) in a supportive role to families enrolled in the program, (2) as facilitators, and (3) in a quality assurance role to ensure the program is working in the best interest of the child and their family.

The parent consultant positions are part-time positions at the regional centers. At the time of our audit, one parent consultant position was vacant at a regional center. We met with some parents who indicated that they could have used some type of family support group when they first came to the EI program. However, we also interviewed the parent consultants, who explained that when they organize monthly meetings for families, few, if any, families actually attend. The Department should work with the centers to determine how to better utilize these positions for the overall benefit of the program.

#### RECOMMENDATION

18. Analyze the role of parent consultants in conjunction with the regional centers to better utilize these positions for the overall benefit of the program.

#### Auditee Views

*The Department concurs with this recommendation.*

#### **DOCUMENTATION OF COSTS ALLOCATED TO THE EI PROGRAM**

The salaries of certain Department employees allocated to the EI program were not adequately supported by time sheets that reflected actual hours worked. Approximately \$699,000 and \$466,000 of Department's personnel costs were allocated to the EI program in fiscal years 1999 and 1998, respectively. Since the EI program is funded with a combination of state appropriations, federal grants and Medicaid funds, employee salaries are allocated in different ways based on their job functions.

In general, time sheets were maintained to support charges to the Medicaid funded portion of the program but not the portion of the program funded by State appropriations and other federal grants.

For employees who spent all of their time on EI related activities, their salaries were allocated to the state and federal EI program and the Medicaid program. The portion allocated to Medicaid is based on the ratio of Medicaid eligible children to all children enrolled in the program. When only a portion of an employee's time was spent on EI program activities, time sheets only indicated an amount for the Medicaid portion of the EI program. The time sheets should reflect all time available and if appropriate a specific amount of time for the EI program. The EI program time should then be allocated to the various funding sources for the EI program in the same manner as those who spend all their time on EI related activities.

We found two instances where 50% of an employee's salary was allocated to components of the EI program. This appeared excessive based on their responsibilities. Time sheets were not maintained in either of these instances. The Department explained that although these two employees may not have spent 50 percent of their time on the EI program, other employees did spend time on the program and their salaries were not charged to EI. We concur that other DOH employees work on the EI program but were not charged to the program. For these instances it does not appear that there is a net overcharge to the program.

Payroll charges to the EI program should reflect the actual efforts to the program and should be supported by time records. The current procedures for charging personnel and tracking employee time do not adequately support the charges to the program. OMB Circular A-87 requires that the distribution of salaries or wages be supported by personnel activity reports or equivalent documentation for all employees who work on multiple activities or cost objectives.

### RECOMMENDATION

19. Maintain adequate documentation (employee time sheets or annual certifications) as required by federal cost principles to support personnel charges to the EI program and its funding components.

### Auditee Views

*The Department concurs with this recommendation.*