GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE OF THE INSPECTOR GENERAL

AUDIT OF THE OUTSOURCING OF THE AGING AND DISABILITIES RESOURCE CENTER

CHARLES J. WILLOUGHBY
INSPECTOR GENERAL

OIG NO. 06-1-05MA(a) **December 8, 2006**

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Office of the Inspector General

Inspector General

December 8, 2006

Gregg A. Pane, MD
Director
Department of Health
825 North Capitol Street, N.E., Suite 4400
Washington, D.C. 20002

Dear Dr. Pane:

Enclosed is our final audit report summarizing the results of the Office of the Inspector General's (OIG) *Audit of the Outsourcing of the Aging and Disabilities Resource Center* (OIG No. 06-1-05MA(a)). This audit is part of our continuous coverage of the District's Medicaid Program. This report is the first in a series of reports planned to be issued as a result of audits covering Nursing Home Reimbursements.

On August 28, 2006, we issued a Management Alert Report (MAR 06-A-10) containing three recommendations informing the Director, Department of Health (DOH), of the results of our review regarding efforts to outsource the Aging and Disabilities Resource Center. We received a response to the MAR on October 24, 2006, and consider the actions currently on-going and/or planned to be responsive for Recommendations 1 and 3. The response regarding corrective actions for Recommendation 2 does not contain enough information for us to determine whether the corrective actions meet the intent of the recommendation.

In addition, DOH officials did not provide target completion dates for Recommendations 2 and 3. We ask that the Director, DOH, provide additional information regarding corrective action for Recommendation 2 and target completion dates for Recommendations 2 and 3 within 60 days from the date of this report.

DOH accepted our finding that Medical Assistance Administration, Office on Disabilities and Aging (MAA-ODA) officials were attempting to outsource (contract out) the Aging and Disabilities Resource Center without evaluating other options and providing documentation to support that doing so was in the best interest of the District of Columbia. However, DOH officials disagreed with the OIG assessment that the District lost the opportunity to provide a higher quality of life for District residents by diverting them from nursing home care during 2002 to 2005. Further, DOH officials believe that the OIG cost saving assumption does not take into consideration resident choice and the availability of affordable housing for the aged and adults with disabilities.

We re-examined our facts and conclusions and determined that our assessment regarding lost opportunities and our cost saving assumption are valid. We have incorporated clarifying language and additional information regarding actions taken by MAA-ODA officials as a result of our audit into the body of the final report as necessary. The full text of the DOH response is shown at Exhibit B.

We appreciate the cooperation and courtesies extended to our staff during the audit. If you have questions, please contact William J. DiVello, Assistant Inspector General for Audits, at (202) 727-2540.

Sincerely,

Charles J. Willoughby
Inspector General

Enclosure

CJW/hw

cc: See Distribution List

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AUDIT OF THE OUTSOURCING OF THE AGING AND DISABILITIES RESOURCE CENTER

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EXECUTIVE DIGEST

OVERVIEW

The District of Columbia Office of the Inspector General (OIG) has completed an audit of the outsourcing of the Aging and Disabilities Resource Center (ADRC). This audit is part of our continuous coverage of the District's Medicaid Program. This report is the first in a series of reports to be issued covering Nursing Home Reimbursements. Our audit focused on efforts by the Department of Health (DOH) Medical Assistance Administration, Office on Disabilities and Aging (MAA-ODA) to develop, operate, and manage an ADRC. One of the major purposes of the ADRC was to enroll District residents in the Home and Community-Based Services Elderly and Adults with Physical Disabilities Waiver Program (HCBS EPD Waiver Program).

The purpose of the HCBS EPD Waiver Program is to provide home and community-based services to individuals who, without such services, would require nursing home care. MAA-ODA officials manage the HCBS EPD Waiver Program. HCBS EDP Waiver Program information indicates that the MAA-ODA increased the number of participants from 102 (cumulative) in 2002 to 879 in 2005. However, the increase largely occurred without the ADRC and was accomplished via an ad hoc process managed by MAA-ODA in-house personnel.

CONCLUSIONS

MAA-ODA officials were, for the third time, attempting to outsource (contract out) the ADRC without evaluating other options and providing documentation to support that doing so was in the best interest of the District of Columbia (District). While participation in the HCBS EPD Waiver Program has increased, officials did not fill all of the slots approved by the Centers for Medicare and Medicaid Services (CMS), and lost opportunities to provide in-home nursing care for District residents and save money by diverting them from more expensive nursing home care.[1]

We estimate that had MAA officials filled all allotted HCBS EPD Waiver slots from 2002 to 2005, the District could have saved up to $33.8 million. In addition, we estimate that if MAA-ODA officials fill all of the allotted HCBS EPD Waiver slots in 2006,[2] the District can save $2.8 million.

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[1] "Diversion" as used in this report does not apply to nursing home residents who are eligible to transition back into the community, but rather to District residents with nursing home level-of-care needs who are eligible to remain in their homes via the HCBS EPD Waiver Program.
[2] The HCBS EPD Waiver Program for 2006 ends January 3, 2007.

EXECUTIVE DIGEST

SUMMARY OF RECOMMENDATIONS

In an OIG Management Alert Report (MAR 06-A-10), we directed three recommendations to the Director, DOH, which focused on actions needed before outsourcing the ADRC. We recommended that the Director, DOH: (1) request an extension of federal funds while MAA officials evaluate alternatives and prepare a cost-benefit analysis supporting whether ADRC services should be performed in-house or outsourced; (2) prepare and submit a cost estimate to the Office of Contracting and Procurement and a determination and findings to the Mayor for submission to the Council (if the determination was made to outsource the ADRC); and (3) establish appropriate, achievable HCBS EPD Waiver goals and methods for measuring and accomplishing those goals.

MANAGEMENT RESPONSES AND OIG COMMENTS

DOH provided a written response to our MAR on October 24, 2006, and we consider the actions currently on-going and/or planned to be responsive for Recommendations 1 and 3. The response regarding corrective actions for Recommendation 2 does not contain enough information for us to determine whether the corrective actions meet the intent of the recommendation. In addition, DOH officials did not provide target completion dates for Recommendations 2 and 3. We ask that the Director, DOH, provide additional information regarding corrective action for Recommendation 2 and target completion dates for Recommendations 2 and 3 within 60 days from the date of this report.

DOH accepted our finding that MAA-ODA officials were attempting to outsource (contract out) the ADRC without evaluating other options and providing documentation to support that doing so was in the best interest of the District of Columbia. However, DOH officials disagreed with the OIG assessment that the District lost the opportunity to provide a higher quality of life for District residents by diverting them from nursing home care during 2002 to 2005. Further, DOH officials believe that the OIG cost saving assumption does not take into consideration resident choice and the availability of affordable housing for the aged and adults with disabilities.

We re-examined our facts and conclusions and determined that our assessment regarding lost opportunities and our cost saving assumption are valid. We have incorporated clarifying language and additional information regarding actions taken by MAA-ODA officials as a result of our audit into the body of the final report as necessary. The full text of the DOH response is shown at Exhibit B.

INTRODUCTION

BACKGROUND

The District of Columbia Office of the Inspector General (OIG) has completed an audit of the outsourcing of the Aging and Disabilities Resource Center (ADRC). This audit is part of our continuous coverage of the District's Medicaid Program. This report is the first in a series of reports to be issued covering Nursing Home Reimbursements. Our audit focused on Department of Health (DOH) Medical Assistance Administration Office on Disabilities and Aging (MAA-ODA) attempts to develop, operate, and manage an ADRC.

Medical Assistance Administration (MAA). MAA is the District's state agency responsible for administering Title XIX of the Social Security Act, the Medical Charities Program, the District's Medicaid Program, and other health care financing initiatives of the District. MAA also develops eligibility, service coverage, service delivery, and reimbursement policies for the District's health care financing program, and ensures improved access and efficient delivery of services.[3]

Title XIX of the Social Security Act requires that, in order to receive federal matching funds (i.e., for Medicaid costs), certain basic services must be offered to certain categories of the needy population of any state. As such, the District's Medicaid State Plan requires that the state agency (District of Columbia) must provide effective access to healthcare for the recipient population and maintain continuity of care.

Office on Disabilities and Aging (ODA). The ODA is an activity within MAA that is responsible for funding and monitoring long term care and Home and Community-Based Services (HCBS). ODA seeks to expand quality services and provide information on care options so that services can be received in the least restrictive setting.

Home and Community-Based Services. The purpose of HCBS is to provide home and community-based services to individuals who, without such services, would require nursing home care. This type of Medicaid waiver program is the result of a special arrangement between the state and federal government that allows the state to use Medicaid funding for specialized services provided to a target group of people and not to all people with Medicaid eligibility. The HCBS Elderly and Adults with Physical Disabilities (EPD) Waiver Program is authorized under section 1915(c) of the Social Security Act. (*See* 42 U.S.C. § 1396n (d) (LEXIS through P.L. 109-250, approved July 27, 2006)).

Elderly and Adults with Physical Disabilities Waiver Progam. HCBS are provided to the elderly and adults with physical disabilities through the EPD Waiver Program. Title 29 of

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[3] http://doh.dc.gov/doh/cwp/view,a,3,q,573226,dohNav GID, 1807.asp (last visited on Nov. 30, 2006).

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the District of Columbia Municipal Regulations (DCMR), Chapter 42, "Home and Community-Based Waiver Services for Persons who are Elderly and Individuals with Physical Disabilities," defines who may receive the waiver services. According to 29 DCMR § 4200.3, services may be provided only to individuals who:

> a) [h]ave had a determination by the MAA that the recipient is likely to require the care furnished in a nursing facility under Medicaid; b) [r]equire assistance with activities of daily living; c) [a]gree to participate in the waiver program by signing a Beneficiary Freedom of Choice form; d) [a]re age 65 or older; e) [a]re adults, age 18 or older, with physical disabilities; f) [a]re not inpatients of a hospital, nursing facility, or intermediate care facility for the mentally retarded; and g) [a]re Medicaid eligible with a maximum monthly income of three hundred percent (300%) of Supplemental Security Income (SSI).

The purpose of maintaining the elderly and adults with physical disabilities in their homes via the HCBS EDP Waiver is two-fold. First, many people maintain a higher quality of life in their homes with assistance from direct care providers. Second, the cost of home health care is much lower than the cost of nursing home care.

OBJECTIVES, SCOPE, AND METHODOLOGY

Our audit objectives were to determine whether: (1) the DOH and Office of Contracting and Procurement (OCP) adequately planned the procurement of the ADRC, (2) OCP followed procurement regulations when awarding the contract, and (3) MAA-ODA officials adequately monitored contractor performance. Because the third attempt by MAA-ODA officials to outsource the ADRC would have been complete before the issuance of an audit report, we focused on the outsourcing and issued MAR 06-A-10. We will address planning, contract award, and contract monitoring in more detail in a second report, which we plan to issue during FY 2007.

To accomplish our objectives under the revised scope, we reviewed MAA-ODA ADRC files and OCP contract files. We also conducted site visits to the ADRC and the headquarters office of the company awarded the ADRC contract (Contractor B). We conducted interviews with responsible MAA-ODA, OCP, ADRC, and Contractor B officials to obtain an understanding of the HCBS EPD Waiver Program and attempts to outsource the development, operation, and management of an ADRC to a commercial contractor. In addition, we met with Office on Aging (OA) officials and viewed or attended District of Columbia City Council hearings related to the ADRC.

We relied on computer-processed data provided by MAA-ODA officials regarding the number of HCBS EPD Waiver Program participants. Although we did not perform a formal

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reliability assessment of the computer-processed data, we traced selected data to supporting documents and records. We found errors that could affect the completeness, accuracy, and consistency of the data. For example, the computer-processed data was not always updated when participants died. When it was updated, MAA-ODA officials were not consistent in how the changes were recorded. In some cases, the name was removed from the spreadsheet in others, the name remained in the spreadsheet with a note regarding the death.

These errors did not preclude use of the computer-processed data to meet the audit objectives and would not change the conclusions in this report. However, use of the data could change the lost opportunities to save money and the estimated potential savings for 2006 cited in this report.

The audit was conducted in accordance with generally accepted government auditing standards and included such tests as we considered necessary under the circumstances.

FINDING AND RECOMMENDATIONS

FINDING: OUTSOURCING THE AGING AND DISABILITIES RESOURCE CENTER

SYNOPSIS

MAA-ODA officials were, for the third time, attempting to outsource (contract out) the ADRC without evaluating other options and providing documentation to support that doing so was in the best interest of the District of Columbia (District). While participation in the waiver program has increased, officials did not fill all of the HCBS EPD Waiver Program slots approved by the Centers for Medicare and Medicaid Services (CMS), and lost opportunities to provide in-home nursing care for District residents and save money by diverting them from more expensive nursing home care.[4]

We estimate that had MAA officials filled all allotted HCBS EPD Waiver slots from 2002 to 2005, the District could have saved up to $33.8 million. In addition, we estimate that if MAA-ODA officials fill all of the allotted HCBS EPD Waiver slots in 2006,[5] the District can save $2.8 million.

DISCUSSION

Criteria. DC Code § 2-301.07 (Supp. 2004) defines a "privatization contract" (hereafter referred to as outsourcing) as one wherein the District government enters into an agreement with a private-sector firm, non-profit organization, or other external entity to provide a good or service that has been provided by District government employees, departments, or agencies.

DC Code § 2-301.05b (a) (Supp. 2004) requires that "[before] issuing a solicitation [to outsource], the District government agency on whose behalf the solicitation will be issued shall prepare, [and submit to the contract specialist,] an estimate of the fully allocated cost associated with providing the relevant goods or services using District government employees." DC Code § 2-301.07 (29A) (Supp. 2004) defines "fully allocated cost" as the "total direct and indirect costs of providing a good, service, or function … including, [in

[4] "Diversion" as used in this report does not apply to nursing home residents who are eligible to transition back into the community, but rather to District residents with nursing home level-of-care needs who are eligible to remain in their homes via the HCBS EPD Waiver Program.
[5] The HCBS EPD Waiver Program for 2006 ends January 3, 2007.

FINDING AND RECOMMENDATIONS

part,] wages, salaries, … fringe benefits, … materials, supplies, … utilities, insurance, travel, and … general and administrative overhead."

DC Code § 2-301.05b (c) (Supp. 2004) requires that before awarding a privatization contract, the Mayor shall transmit to the Council a determination and findings that:

- [c]ompares the current fully allocated cost of providing the service using District government employees, departments, or agencies, … to the fully allocated costs associated with contracting for the service;
- [d]emonstrates that the privatization contract will provide savings of at least 5 [percent] over the duration of the contract, in terms of the total cost or the unit cost of providing the good or service;
- [a]ssesses the impact of the privatization contract on the District's economic and tax base, including the affects on employment opportunities for District residents, business creation, business development, and business retention;
- [d]escribes the expected impact of the privatization contract on the quality of goods or services provided to or on behalf of the District government, including performance targets and requirements for the contractor and potential affects of the contract on the health and safety of District residents; and
- [i]ncludes a written confirmation of review by the Chief Financial Officer, the Corporation Counsel, and the Chief Procurement Officer.

MAA-ODA Actions

The MAA-ODA requested that the Office of Contracting and Procurement (OCP) solicit and award a contract for the ADRC. However, we found no evidence that MAA-ODA officials prepared a cost benefit analysis that evaluated the cost of providing the ADRC services using District government employees versus the cost of contracted services.

MAA-ODA officials have made two previous unsuccessful attempts to contract for an ADRC. In the interim, the ad hoc process managed by MAA-ODA to place eligible participants in the HCBS EPD Waiver Program has had a measurable degree of success with about 72 percent of the allotted Waiver slots filled in 2005. Additionally, we estimate that based on past performance, 90 percent of the allotted HCBS EPD Waiver slots will be filled in 2006. Accordingly, we question the merits of outsourcing what appears to be a growingly successful in-house effort. The first two unsuccessful attempts to outsource the ADRC and the third (current) effort are discussed in the following paragraphs.

FINDING AND RECOMMENDATIONS

First Outsourcing Attempt. As early as June 26, 2001, MAA-ODA officials planned to outsource an ADRC based on successful implementation of ADRCs in other states,[6] without documenting that they evaluated alternatives to outsourcing. Preliminary research indicates that the Wisconsin model, which includes nine counties, each having an ADRC, is operated and managed by county and state government agencies. Many other states appear to operate in the same manner, although some states partner with, or outsource functions to, area agencies on aging, senior service networks, senior centers, and local health care non-profit organizations. Some states also outsource certain clinical tasks to contract nurses.

Vendor Research. MAA-ODA officials attempted to locate vendors qualified to develop, operate, and manage an ADRC but did not attempt to identify vendors that could perform individual functions such as marketing and outreach. MAA-ODA research included informal inquiries with District service providers and consumer groups, on-line research, informal contact with District non-profit leaders, recommendations from kickoff meeting participants, and contact with associations and membership organizations. We believe the research results were limited and may have been much different had the inquiries not been conducted with the preconceived idea of outsourcing all ADRC services.

Solicitation of ADRC Contractor. On May 20, 2002, OCP solicited a contractor to develop and manage an ADRC. OCP documents indicate that only two offerors responded to the human care services solicitation and that only one, Contractor A, was considered qualified to provide the required services. Contractor A is a component of a national non-profit organization functioning as the District's Medicare Quality Improvement Organization. Contractor A submitted a cost proposal for the base year and four option years.

Funding. According to the Real Choice Systems Change (RCSC) Grant[7] budget submitted by MAA-ODA officials to CMS, almost $6.2 million had been allocated to the ADRC for FYs 2003-2005. MAA-ODA officials could not provide documentation to support the planned source of funding for the remaining $2.3 million to cover the estimated cost after FY 2005. Of the $6.2 million, $3.3 million was listed as being allocated from local funds and $2.9 million was listed as being allocated from Medicaid Federal Financial Participation (FFP).[8]

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[6] Primarily Wisconsin.
[7] RCSC grants help states build the infrastructure and long-term support systems to enable individuals to live in the most integrated and suitable community setting, to have choices about living arrangements, and to exercise more control over services received.
[8] The federal government will match expenditures that it deems necessary to support the efficient and effective administration of the Medicaid program. Administrative FFP is typically 50 percent.

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A targeted local budget reduction of $18.4 million reduced funding for the ADRC by $258,000 in FY 2003. The targeted local budget reduction was the result of a gap-closing measure to realign the FY 2003 budget in accordance with a projected $323 million revenue shortfall for the District. On October 2, 2002, the Mayor submitted the proposed amendment of the District of Columbia FY 2003 Budget and Financial Plan, which included the $258,000 reduction for delaying implementation of the ADRC.

Actions Taken In Response to Funding Cuts. Instead of delaying implementation of the ADRC, MAA-ODA officials informed OCP of the need to renegotiate the project costs. Based on 12 costs that MAA-ODA officials wanted to reduce, eliminate, or renegotiate, Contractor A submitted a revised proposal and final list of deliverables for the base year with four option years.

However, the interim Executive Director of Contractor A submitted a letter to OCP 4 months later stating that contract language had increasingly reflected significant changes in the original scope of work in response to budget reductions and that a firm, explicit scope of work was needed to adequately propose the level of effort for developing and managing an ADRC.

Rather than revise the scope of work under the RFP, the decision was made (more than 2 years after the ADRC project kickoff) to cancel the solicitation and write a new statement of work to reflect the money that was available to fund the project. We believe inadequate funding was a contributing factor to the failure of the first outsourcing attempt,[9] but the primary factor was that MAA-ODA officials did not address Contractor A's concerns. MAA-ODA officials should have reviewed the scope of work, updated the ADRC research conducted in 2001, performed a cost benefit analysis, and considered alternative options before rushing out with a new procurement attempt.

DOH Response to the MAR. The DOH response indicates that there were no significant changes to the initial scope of work and that MAA leadership did not believe that changes to the initial scope of work were necessary. DOH officials also stated that at the time of the second solicitation, OCP and MAA believed that the first determinations and finding, prepared for the initial outsourcing attempt, was sufficient. In addition, the DOH response indicates that a contract was awarded to Contractor A but was cancelled after award for non-performance.

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[9] The Council of the District of Columbia Committee on Health Taskforce on Long-Term Care identified inadequate funding for the ADRC as an issue in its November 4, 2005, report and preliminary research indicates that Wisconsin funded ADRCs in two counties (with populations significantly lower than the District) at much higher annual levels.

FINDING AND RECOMMENDATIONS

OIG Comments. After issuing the MAR, we found a second scope of work related to the first outsourcing attempt. Although it appears that MAA-ODA officials reviewed the second scope of work, most of the "unacceptable" notations were later changed to acceptable. This change supports the DOH assertion that MAA leadership did not believe that changes to the initial scope of work were necessary.

Our review of the second scope of work found references to performing level-of-care determinations. We believe the level-of-care determination references were significant and that the requirement should have been removed because Contractor A was already responsible for performing this function under a separate contract. If the intent was for the ADRC contractor to begin performing level-of-care determinations after the expiration of the contract with Contractor A, the scope of work should have clearly stated this so that contractors could bid on performing that function in the appropriate option year(s).

We were unable to verify the existence of the determinations and finding referenced in the DOH response because MAA-ODA officials did not have a copy of the document and we were told that the responsible OCP official no longer works for the agency. In addition, OCP officials have been unable to locate the solicitation and contract files for the first outsourcing attempt.

The missing files also precluded us from determining whether a contract was awarded to Contractor A under the first outsourcing attempt, as stated by DOH officials. When MAA-ODA and OCP officials were unable to provide a copy of the signed contract, we used wording obtained from the OCP business clearance memorandum that describes the chronology of events leading to the second outsourcing attempt with Contractor B as support that the first solicitation was cancelled before contract award.

Because MAA-ODA officials wanted to outsource the ADRC quickly, OCP officials recommended using the General Services Administration (GSA) Supply Schedule to seek competition and save time. However, we found no documentation to support that MAA-ODA officials evaluated the impact outsourcing to a commercial contractor might have on the program, especially since other states did not use commercial contractors to develop, operate, and manage ADRCs.

Second Outsourcing Attempt. In March 2004, OCP issued a Request for Quotations (RFQ) to several Mission Oriented Business Integrated Services (MOBIS) GSA Schedule contractors to develop, manage, and operate an ADRC. Services provided by MOBIS contractors include consulting, facilitating, conducting surveys, developing and providing training, providing support products, supporting competitive sourcing efforts, and introducing new services. However, none of these services are remotely related to developing, operating, and managing an ADRC.

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Company B Contract. Only one company, Contractor B, responded to the RFQ. OCP awarded Delivery Order POHC-2004-F-011 (hereafter referred to as contract) under GSA Schedule Contract GS-23F-8008H to Contractor B on August 15, 2004. The base year of the contract (valued at $982,711) covered the period of August 15, 2004, to August 14, 2005, with four option years. The value of the four option years totaled $3.8 million.[10]

The purpose of the contract was to improve access to information and linkage to long term care and chronic care service. Linkage refers to all aspects of service links and client referrals to agencies and providers of care along the continuum of aging and disabilities care. The performance milestones, on the other hand, were to screen the target population and place or enroll eligible persons in the HCBS EDP Waiver. The performance milestones are shown in Table 1.

Table 1. Performance Milestones

Milestone	Base year	Option Year 1	Option Year 2
Persons screened	1,125	1,375	1,625
Persons placed[11]	300	450	650

Performance Milestones Not Met. Even though the performance milestones were significantly lower than the number of slots allotted for the HCBS EDP Waiver (See Table 2, p. 11), Contractor B did not meet the performance milestones in the base year and was not on target to meet the milestones by the end of option year one. For example, of the 879 actual participants through December 31, 2005, 345 were enrolled after the ADRC began operations in January 2005. Of the 345, up to 296 were placed by the ad hoc process managed by MAA-ODA personnel, and at least 49 were presumably referred by Contractor B. We could not validate the number referred by Contractor B because staff did not manually track referrals before August 2005, and the database was not designed to identify referrals to the HCBS EPD Waiver Program. Of the 49 referrals made from August 1, 2005, to December 31, 2005, 35 were not listed by MAA-ODA as being HCBS EPD Waiver participants. Contractor B officials could not explain the difference and were unable to retrieve names or other identifying information from the applicable tables in the database.

According to Contractor B officials, they could not legally enroll candidates in the HCBS EPD Waiver Program or complete level-of-care determinations as required by the

[10] Option Year 1 valued at $900,832, Option Year 2 valued at $941,802, Option Year 3 valued at $973,804, and Option Year 4 valued at $1,009,691.
[11] Placed in HCBS EPD Waiver program (cumulative).

FINDING AND RECOMMENDATIONS

contract.[12] In addition, Contractor B officials argued that socio-economic, psychological, and legal impediments affected their ability to meet the performance milestones. For example, they argued that a large number of potential referrals:

- exceeded the income eligibility requirements,
- did not meet the nursing home level of care,
- did not want strangers coming to their homes,
- did not have appropriate residences for services, and
- lacked a support system to enable them to remain in their homes.

We understand Contractor B's concerns and believe the variables noted above are valid. However, MAA-ODA officials should have already considered the type and frequency of variables that would affect the program's performance goals and should have included them in a formula for determining the performance milestones included in the contract. Three days before OCP notified Contractor B (April 27, 2006) that the contract would be terminated for convenience, effective May 31, 2006, OCP officials, at the request of MAA-ODA officials, modified the contract to decrease the performance milestones.

In addition, the variables noted above should have been considered before requesting HCBS EPD Waiver slots from CMS. The CMS approved 1,460 slots for the five waiver years beginning January 4, 2002, and ending January 3, 2007. MAA-ODA officials plan to renew the waiver, which we believe is a necessary component of long term care. We also believe an ADRC would play an important role in the process. However, the two unsuccessful outsourcing attempts and the District's inability to fill allotted waiver slots indicate that MAA-ODA officials also need to identify appropriate, achievable goals and ways to accomplish those goals before outsourcing an ADRC.

The second outsourcing attempt failed, in part, because MAA-ODA officials did not evaluate the program and determine whether outsourcing was a viable option, given that contractors cannot legally enroll participants in the HCBS EPD Waiver Program. Further, MAA-ODA officials did not determine the impact on the program of operating and managing the ADRC in-house, given that level-of-care determinations were already being performed by Delmarva Foundation for Medical Care under another contract.

DOH Response to the MAR. MAA-ODA officials partially agreed with our conclusion and indicated that OCP's failure to modify the contract, after Contractor B raised concerns regarding their ability to enroll participants, contributed to the failure of the second outsourcing attempt.

[12] Only the Department of Health can legally enroll participants in the HCBS EPD Waiver program and level-of-care determinations can be made only by certified organizations or individuals, which are limited in number.

FINDING AND RECOMMENDATIONS

OIG Comments. We disagree. Although OCP should have modified the contract, OCP officials are not knowledgeable about MAA-ODA program needs and are not responsible for the scope of work. MAA-ODA officials were responsible for writing a clear, concise scope of work based upon program needs and determining whether outsourcing was a viable option. Even if the contract had been modified, we identified other issues with the contractor's performance, which could have contributed to the failure. We will discuss the lack of a solicitation amendment and contract modification as well as the additional issues in a second audit report, which we plan to issue in FY 2007.

Lost Opportunities. Based on the number of slots allotted for the HCBS EPD Waiver Program and the number of actual participants, we believe the District lost the opportunity to provide a higher quality of life for District residents by diverting them from nursing home care during 2002 to 2005. Table 2 shows the number of allotted slots and reported actual participants in the HCBS EPD Waiver Program from 2002-2005 and the estimated participation for 2006.

Table 2. Lost Opportunities to Divert Residents

Year	Slots Allotted (Cumulative)	Actual Participants (Annual)	Actual Participants[13] (Cumulative)	Slots Not Filled	Percentage of Slots Not Filled
2002 (1-4-2002 to 1-3-2003)	495	55	102[14]	393	79
2003 (1-4-2003 to 1-3-2004)	740	110	212	528	71
2004 (1-4-2004 to 1-3-2005)	980	326	538	442	45
2005 (1-4-2005 to 1-3-2006)	1,220	341	879	341	28
2006 (1-4-2006 to 1-3-2007)[15]	1,460	432	1,311	149	10

Consequently, we believe the District lost the opportunity to save up to $33.8 million and we estimate that if MAA-ODA officials fill all of the allotted slots, the District can save $2.8 million for 2006. Table 3 (see p. 12) calculates costs associated with unfilled HCBS EPD Waiver slots.

[13] Not verified.
[14] The 102 actual participants are cumulative from 1999. CMS approved the first HCBS EPD Waiver for the period of January 4, 1999, to January 3, 2002. Our audit focused only on the first HCBS EPD Waiver renewal, which CMS approved for a 5-year period beginning January 4, 2002.
[15] 2006 actual participants, slots not filled, and the percentage of slots not filled are estimates based on data available as of April 30, 2006. We estimated the participants for 2006 by multiplying the highest number of average monthly participants in previous years (28) by the highest decrease in the percentage of slots not filled in previous years (26 percent), adding the results, and multiplying the total (36) by 12 months.

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Table 3. Lost Opportunities to Save Money

Year	Slots Not Filled	Annual Nursing Home Cost	Nursing Home Cost for Slots Not Filled	Annual Home Care Cost	Home Care Cost for Slots Not Filled	Potential Lost Savings	District Share (30 % FFP)
2002	393	$75,626	$29,721,018	$8,903	$3,498,879	$26,222,139	$7,866,642
2003	528	75,626	39,930,528	9,381	4,953,168	34,977,360	10,493,208
2004	442	75,626	33,426,692	9,684	4,280,328	29,146,364	8,743,909
2005	341	75,626	25,788,466	10,538	3,593,458	22,195,008	6,658,502
Total Lost Opportunities to Save						**$112,540,871**	**$33,762,261**
2006	149	75,626	11,268,274	11,871	1,768,779	9,499,495	2,849,849
Estimated Potential Savings for 2006						**$9,499,495**	**$2,849,849**

DOH Response to the MAR. MAA-ODA officials disagreed with the OIG assessment that the District lost the opportunity to provide a higher quality of life for District residents by diverting them from nursing home care during 2002 to 2005. For example, DOH officials state that MAA surpassed the number of approved persons who can participate in the HCBS EPD Waiver to over 1800 persons since the program's inception. In addition, MAA-ODA officials indicate that all targeted nursing home diversion milestones projected for the District were met for each Waiver year from 2003 to 2006.[16] Further, DOH officials believe that the OIG cost saving assumption does not take into consideration resident choice and the availability of affordable housing for the aged and adults with disabilities.

OIG Comments. We have given credit to MAA-ODA officials in the MAR and this final report for increasing participation in the HCBS EPD Waiver Program from 102 (2002) to 879 (2005) participants. However, MAA-ODA officials have been unable to provide documentation to support that over 1800 persons have participated in the HCBS EPD Waiver Program since its inception.

In addition, MAA-ODA officials could not provide documentation to support the number of "nursing home diversions" that occurred because of the efforts of the ADRC staff or the use of the HCBS EPD Waiver Program. OIG Report 05-1-06MA(b), *Audit of Selected District Agency key Result Measures* issued August 17, 2006, found that MAA-ODA officials could not support that the agency met the targeted nursing home diversion milestones for FY 2005.

MAA-ODA's targeted nursing home diversion milestones were designed to measure the number of nursing home residents who transitioned back into the community. As

[16] These numbers were reflected in the Mayor's performance measures.

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indicated in footnote 1, we excluded this population from our definition of diversion for purposes of this report. We made this distinction for two reasons. First, the contract (as written) awarded to Contractor B focused on diverting persons from being admitted to nursing homes rather than transitioning them back to the community from nursing homes. Second, the Council of the District of Columbia Committee on Health Taskforce on Long-Term Care made the same distinction and recommended creating a Nursing Facility Transition Program to help nursing home residents who wish to move to the community.

As reported in the MAR, the underlying assumption is that MAA-ODA officials would request slots they believe are needed and will be used. The expectation is that for every participant who does not enter the program or who leaves the program, another person is waiting to be served. This expectation applies to clients who choose not to participate, as well as to clients who cannot participate because of the lack of appropriate housing.[17] It appears that this expectation has held true in half of the 38 states with an aged/disabled HCBS Waiver Program.[18] Wisconsin, Indiana, and New Jersey (three states mentioned in MAA-ODA 2001 planning documents) had waiting lists in 2003 and 2004.

In a 2001 fiscal impact statement to support the need for an ADRC, MAA-ODA officials calculated the average annual cost of nursing home care as $75,626 and the average annual cost of home health care as $22,285. However, a 2002 letter from CMS indicates that the approved HCBS EPD Waiver Program per capita expenditure estimate for the allotted slots ranged from $8,903 to $11,871 for home health care. We used the CMS approved HCBS EPD Waiver Program per capita expenditure estimates for the home health care costs because it appears that the fiscal impact statement included home health care costs incurred under the State Medicaid Plan (which are outside the HCBS EPD Waiver Program).

To be conservative, we did not adjust the nursing home care costs for inflation. In addition, we did not attempt to project savings over more than one year because participants move in and out of waiver programs and nursing homes based on needs that often change. We have not verified the estimates, which originated from the Medicaid Management Information System (MMIS) operated by Affiliated Computer Services, the MAA fiscal intermediary.

Third Outsourcing Attempt. In May 2006, MAA-ODA officials were preparing a Request for Proposal to outsource the ADRC for the third time without evaluating alternatives and supporting that doing so was in the District's best interest. When we asked MAA-ODA

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[17] ADRC staff could not provide documentation to support how many clients were turned away for these reasons.

[18] KAISER COMMISSION ON MEDICAID AND THE UNINSURED, MEDICAID 1915(C) HOME AND COMMUNITY-BASED SERVICE PROGRAMS: DATA UPDATE" 25 (JULY 2005).

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officials about the lack of a cost estimate, they indicated that MAA management[19] wanted the procurement pushed forth quickly as initially envisioned and defined by the previous MAA-ODA Chief. In addition, MAA-ODA officials provided the following reasons for outsourcing the resource center:

- in-house costs far exceed the cost of outsourcing;
- MAA has no budget authority for the personnel needed to keep the ADRC in-house;
- training and retaining qualified employees in-house takes time;
- MAA does not have space for ADRC staff; and
- federal support is contingent upon having the resource center.

We determined the reasoning to be without merit.

Cost. MAA-ODA officials could not provide documentation to support that the cost of keeping the functions in-house exceeded the cost of outsourcing. In addition, other factors discussed previously regarding failure of the second outsourcing attempt indicate that future outsourcing of the ADRC might be doomed for failure.

Further, other options existed which were not adequately considered and addressed. The Wisconsin model builds on the Older Americans Act senior information and assistance program by offering a seamless flow for consumers to link to Medicaid and other program eligibility.[20] However, MAA-ODA officials could not provide documentation to show that they held meaningful dialogue with the District Office on Aging (OA), whose programs also build on the Older Americans Act, regarding a collaborative effort. When asked, MAA-ODA officials stated that they spoke with OA officials, but the agency did not have enough personnel, space, or funds to assist. Meaningful dialogue would have included discussions regarding potential solutions to staffing, space, and funding issues.

Personnel, Space, and Training. Advance planning would have allowed MAA to request budget authority for additional personnel, as well as funding to rent office space. Furthermore, contractors may also have problems training and retaining qualified employees as this is not an issue unique to the District government.

Federal Support. MAA-ODA officials provided funding documentation in July 2006, and we verified that two of the grants (RCSC and Community-Integrated Personal Assistance Services and Supports (CPASS)) awarded by the CMS that were to be used, in part, to create

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[19] We were told that these management officials no longer work for MAA.
[20] CHRISTINA NEILL, AN ANNOTATED HISTORY OF WISCONSIN'S AGING AND DISABILITY RESOURCE CENTERS 2 (AUGUST 6, 2004).

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the infrastructure to build a cost-effective HCBS system, would expire in September 2006.[21] We contacted CMS officials and confirmed that second extensions (also known as deviation requests) are a normal occurrence but must be requested by the receiving agency. Although CMS officials stated that approval is not guaranteed, they indicated that deviation requests are generally approved as long as the agency provides adequate justification for the request and that the approval process typically takes about 2 weeks.

When we briefed the Deputy Director, MAA about the need to evaluate options before outsourcing the ADRC again, the Deputy Director indicated that such an evaluation was time consuming and could result in the loss of federal funding (e.g. grant monies and Medicaid FFP). Although we are sensitive to the potential loss of federal funds, we are concerned that MAA would attempt to maintain access to those funds by seeking to again outsource the ADRC, knowing the potential for failure when other options have not been explored.

In addition, it does not appear that the District was entitled to the 50% administrative FFP received under the ADRC contract. Medicaid administration activities can include outreach and enrollment, case management, provider monitoring, planning and development, network development, auditing, and quality improvement activities.[22] MAA-ODA officials have not been able to provide documentation supporting which activities performed by ADRC staff qualified to receive administrative FFP or that officials requested approval to receive administrative FFP (or any other type of FFP) for those activities.

Further, Contractor B officials did not submit a weekly report as required by the contract to diligently track hours spent on Medicaid-related tasks for all ADRC staff. The weekly report was to be used by MAA-ODA officials to determine the accuracy of federal reimbursement. MAA-ODA officials have not explained why they allowed Contractor B to report this information telephonically before November 2005, and why written reports provided after that date do not include the hours spent on Medicaid-related tasks. Because MAA may not be entitled to the administrative FFP, we question the concern raised by the Deputy Director, MAA, regarding the loss of FFP.

Other Alternatives

The concept of "one stop shopping" is to bring as many of the players involved in the process as possible to a centralized location. Two of the ways MAA-ODA officials attempted to

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[21] These grants were originally due to expire in September 2005 but MAA applied for and received a no cost extension with a new expiration date of September 2006.

[22] THE LEWIN GROUP, AGING AND DISABILITY RESOURCE CENTER, HOW TO SECURE MEDICAID FEDERAL FINANCIAL PARTICIPATION (FFP) FOR ADRC FUNCTIONS: THE BASICS 1 (APRIL 19, 2006)

FINDING AND RECOMMENDATIONS

accomplish this goal was to require ADRC staff to perform health assessments and to co-locate Income Maintenance Administration officials at the ADRC. However, MAA-ODA officials did not consider other alternatives that could prove to be more cost effective to consumers. Examples of alternatives include performing the ADRC services in-house; partnering with the OA; issuing short-term contracts to senior service networks, senior centers, and local health care non-profit organizations for select ADRC functions; or using some creative combination of these alternatives.

MAA-ODA officials stated that many of the services provided by the ADRC were "new" services and not subject to the cost estimate and determination and findings requirements. However, the OA provides information and assistance to the elderly and funds a Senior Service Network of 24 community-based, nonprofit organizations providing direct services to the District's elderly citizens.[23] Six Lead Agencies[24] distribute information about the variety of services and programs offered to seniors throughout the city and ways to access them. In addition, the Department of Human Services Income Maintenance Administration officials provide eligibility determinations, and MAA-ODA officials provide admission services. Although case management providers perform health assessments, MAA-ODA officials review and approve the assessments.

DOH Response to the MAR. The DOH response to the MAR indicates that MAA-ODA officials performed a significant review of the contract scope of work after the termination of the Contractor B contract and considered outsourcing some of the ADRC functions, outsourcing all ADRC functions, and bringing all ADRC functions in-house.

OIG Comments. The Company B contract was terminated effective May 31, 2006, and we continued our field work through July 2006, during which time we continuously requested supporting documents related to the decision to outsource the ADRC. MAA-ODA officials did not provide supporting documentation. Based on the DOH response to the MAR, on November 1, 2006, we requested documentation to support the significant review. As of the date of this report, MAA-ODA officials had not provided the documentation.

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[23] Other states use senior service networks to provide ADRC services.
[24] Lead agencies are comprehensive service-delivery organizations that plan and deliver direct services to the District's elderly residents and their caregivers.

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CONCLUSION

We believe MAA-ODA officials must evaluate alternatives to outsourcing the ADRC and prepare a cost-benefit analysis supporting whether it is more cost effective and in the District's best interest to perform the ADRC functions in-house or to outsource them. If the decision is made to outsource the ADRC or certain functions, it is important that MAA-ODA officials, in conjunction with OCP officials, adequately plan the procurement and submit a determination and findings to the Mayor for submission to the Council.

RECOMMENDATIONS

We recommend that the Director, Department of Health:

1. Request that CMS issue a second no cost extension (deviation request) for the RCSC and CPASS grants while MAA officials evaluate alternatives and prepare a cost-benefit analysis supporting whether ADRC services should be performed in-house or outsourced.
2. If a determination is made to outsource the ADRC, prepare and submit a cost estimate to the OCP and a determination and findings to the Mayor for submission to the Council.
3. Establish appropriate, achievable HCBS EPD Waiver goals and methods for measuring and accomplishing those goals before outsourcing the ADRC.

DOH RESPONSE (Recommendation 1)

DOH concurred with the recommendation. In its response, DOH stated that MAA requested a second no cost extension, which was denied. DOH officials also indicated that MAA-ODA officials applied for a new RCSC grant, but CMS did not award the grant to the District. DOH's full response is included at Exhibit B.

OIG COMMENT

DOH's corrective actions are responsive. However, we are concerned about the loss of federal funds. Because CMS officials indicated that second no cost extensions were common, we again contacted CMS and talked to project officers who were more familiar with MAA-ODA performance under the RCSC and CPASS grants. The project officers stated that they denied the second no cost extension because they were not satisfied with the way MAA-ODA officials have managed the RCSC and CPASS grants. We did not verify the amount of funds lost on the expired RCSC and CPASS grants. However, the amount of the new RCSC grant MAA requested and did not receive was almost $3 million over a 5-year

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grant period. The loss of federal funds underscores the importance of properly planning and managing acquisitions and the use of grant monies.

DOH RESPONSE (Recommendation 2)

DOH concurred with the recommendation and stated that officials would conduct a thorough analysis before making any further decisions about whether to bring ADRC functions in-house or to outsource them. However, DOH officials also stated that MAA plans to outsource key portions of the ADRC in FY 2007 until it can request the budget enhancements and make budget and personnel shifts needed to bring the ADRC in-house.

OIG COMMENT

In the MAR, we question the merit of outsourcing what appears to be a growingly successful in-house effort. Without knowing the key functions DOH plans to outsource for FY 2007, we cannot determine whether the corrective actions meet the intent of the recommendation. In addition, DOH officials did not provide a target completion date for submitting the cost estimate to OCP and a determination and findings to the Mayor for submission to Council. Although MAA-ODA officials indicate that OCP is responsible for preparing and submitting the determination and findings, OCP officials cannot do so without the necessary information from MAA-ODA.

DOH RESPONSE (Recommendation 3)

DOH concurred with the recommendation. In its response, DOH stated that MAA would establish appropriate, achievable, and reasonable goals and methods for measuring success before considering outsourcing the ADRC functions.

OIG COMMENT

DOH's corrective actions are responsive and meet the intent of the recommendation, but officials did not provide a target completion date for planned actions.

EXHIBIT A: SUMMARY OF POTENTIAL BENEFITS RESULTING FROM AUDIT

Recommendation	Description of Benefit	Amount and Type of Benefit	Status[23]
1	Compliance and Internal Control. Ensures that federal funds are not lost while the new procurement is planned and that criteria requiring cost-benefit analysis is followed.	Nonmonetary	Closed
2	Compliance and Internal Control. Ensures that policies requiring levels of approval are followed.	Nonmonetary	Open
3	Compliance and Internal Control. Ensures that future opportunities to save money are not wasted.	Lost savings of $33,762,261 and Estimated Potential Savings for 2006 of $2,849,849	Open

[23] This column provides the status of a recommendation as of the report date. For final reports, "**Open**" means Management and the OIG agree on the action to be taken, but action is not complete. "**Closed**" means management has advised that the action necessary to correct the condition is complete. "**Unresolved**" means that management has neither agreed to take the recommended action nor proposed satisfactory alternative actions to correct the condition.

EXHIBIT B: MANAGEMENT RESPONSE

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health

Office of the Director

October 19, 2006

Mr. Charles Willoughby
Inspector General
Office of the Inspector General
717 14th Street, NW
Washington, D.C. 20005

Dear Mr. Willoughby:

This letter is written in response to your letter of August 28, 2006 concerning an on-going Office of the Inspector General (OIG) Audit of Nursing Home Reimbursements (Project No. 06-1-05MA). Specifically, I am responding to the first audit segment focus on the award and administration of a delivery order for to develop, operate and manage an Aging and Disabilities Resource Center (ADRC) and your Management Alert Report (MAR No. 6-A-10). We have reviewed in detail your MAR and accept your findings.

We have also responded to some of the MAR findings and conclusions and would ask that you consider the enclosed response to your MAR report, which provides more details. In addition, we have begun work to address the OIG concerns articulated in the MAR. The following corrective actions have already been taken:

- First, the Medical Assistance Administration (MAA) cancelled the outsourced contract with . effective May 31, 2006.

- Second, MAA requested a no cost extension for MAA's Real Choice Systems Change Grant, which utilized the ADRC as part of the work plan. The Centers for Medicare and Medicaid Services (CMS) granted MAA a one-time extension from October 1, 2005 through September 30, 2006. MAA sought a second extension, which was not granted. MAA also sought an additional RCSC grant but was notified on September 18, 2006 that the MAA proposal was not accepted and the District was not awarded a new RCSC grant.

- Third, MAA conducted a more detailed cost benefit analysis of outsourcing the ADRC vs. keeping the services in-house as well as drafted a fiscal impact statement. The fiscal impact statement is being reviewed internally.

825 North Capitol Street, N.E., Washington, D.C. 20002 (202) 442-5955

EXHIBIT B: MANAGEMENT RESPONSE

Charles Willoughby – Project No. 06-1-05MA & MAR No. 6-A-10
October 19, 2006
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- Fourth, as a result of the cost benefit analysis and internal discussions MAA will give strong consideration to bringing ADRC services in-house. However, MAA will plan to outsource key portions of the ADRC in FY 2007 until it can request the budget enhancements and make budget and personnel shifts needed to bring the ADRC in-house. MAA fully intends to optimize the ADRC capacity and services provided in-house as soon as possible and by FY 2008. Specific ADRC goals and deliverables with a timeline are being developed to reflect the best approach for best serving District residents going forward.

Thank you for your time and efforts on behalf of District residents and we pledge our support in addressing all OIG areas of expressed concern.

Sincerely,

Gregg A. Pane, MD
Director

Enclosure

cc: Robert T. Maruca, Senior Deputy Director, MAA
Robert L. Cosby, Chief, Office on Disabilities and Aging, MAA

EXHIBIT B: MANAGEMENT RESPONSE

Response to the District of Columbia Office of Inspector General Management Alert Report on Outsourcing the District's MAA Aging and Disabilities Resource Center (ADRC)

1. **For the third time, attempting to outsource contract the ADRC without evaluating other options and providing documentation to support that doing so is in the best interest of the District of Columbia (District).**

Response: *The Medical Assistance Administration (MAA) has worked with the Office of Contracting and Procurement (OCP) and OCP has awarded two contracts on behalf of MAA, one to and one to did not begin work after contract award due to funding disagreement with OCP and the contract was not awarded (September 2003). The second contract with was terminated for convenience (May 31, 2006) by OCP at the request of DOH after 19 months. This was based on performance challenges and inconsistencies. A fiscal impact statement (FIS) and government estimate were done prior to the first solicitation and award. Evaluation of the first contract was not done as contractor never began work. There were no significant changes to the initial Scope of Work (SOW) and MAA leadership did not believe that changes to the initial SOW were necessary. After the contract was terminated, significant review of the contract SOW was done by MAA-ODA Staff. A variety of alternative options were considered, including: Outsourcing a portion of ADRC Scope; Outsourcing all ADRC services; and, bringing all ADRC functions in-house, as recommended by OIG. A new government estimate and FIS were strongly recommended by the OIG. MAA is preparing a FIS and once completed MAA will share it with the OIG.*

2. **Officials did not fill all of the HCBS EPD Waiver program slots approved by the Centers for Medicare and Medicaid Services (CMS), and lost opportunities to provide in-home nursing care for District residents and save money by diverting them from more expensive nursing home care.**

Response: *Officials have not filled all HCBS EPD Waiver slots. It is not unusual to have waiver slots unfilled. Many 1915 (c) Waivers in States throughout the United States are not automatically filled to capacity. Within the past two years, MAA-ODA has doubled the number of persons in the EPD Waiver. Further, MAA has surpassed the number of approved persons that can participate in the EPD Waiver to over* ***1800 persons*** *served since inception. It is estimated that given current forecasts MAA will reach the ceiling of 1440 continuous enrollment before the end of the current waiver cycle (January 2007). At the present rate of growth the Waiver is on track to meet 85 -90% of capacity within the final year of the current five year Waiver period. MAA has made great gains in the numbers of persons enrolled in the EPD Waiver. The EPD Waiver has grown considerably from less than 600 persons two years ago to over 1100.*

MAA has lost some opportunities to provide in-home nursing care due to the following reasons. The primary reason that more persons are not diverted from nursing homes is that there is not adequate housing for this population. Older persons and persons with disabilities cannot participate without a place to live. In short there is a shortage of affordable housing stock. MAA

EXHIBIT B: MANAGEMENT RESPONSE

has attempted to increase awareness about the EPD Waiver in nursing homes, hospitals and in the community. More work is needed, but there has been substantial progress, in fact more than ever before. The cost saving assumption does not take into consideration resident choice and/or availability of ADA accessible housing for those requiring care. MAA has had discussions with the DC Housing Authority but they cannot reserve space for MAA clients.

3. **Requires that "[before] issuing a solicitation [to outsource], the District government agency on whose behalf the solicitation will be issued shall prepare, [and submit to the contract specialist,] an estimate of the fully allocated cost associated with providing the relevant goods or services using District government employees."**

Response: *MAA has completed an estimate of the fully allocated cost associated with providing the relevant goods or services using District employees. This estimate is on file and will be considered in any future decisions made by MAA.*

4. Requires that before awarding a privatization contract, the Mayor shall transmit to the Council a determination and findings that:

- **compares the current fully allocated cost of providing the service using District government employees, departments, or agencies, … to the fully allocated costs associated with contracting for the service;**
- **demonstrates that the privatization contract will provide savings of at least 5 [percent] over the duration of the contract, in terms of the total cost or the unit cost of providing the good or service;**
- **assesses the impact of the privatization contract on the District's economic and tax base, including the affects on employment opportunities for District residents, business creation, business development, and business retention;**
- **describes the expected impact of the privatization contract on the quality of goods or services provided to or on behalf of the District government, including performance targets and requirements for the contractor and potential affects of the contract on the health and safety of District residents; and**
- **includes a written confirmation of review by the Chief Financial Officer, the Corporation Counsel, and the Chief Procurement Officer.**

Response: *MAA is preparing a FIS as well as a government estimate. MAA has been informed that OCP has responsibility for the determination and findings statement. At the time of the second solicitation it was believed by OCP and MAA that the first determination and findings was sufficient. There has not been a written confirmation of review by the Chief Financial Officer, the Corporation Counsel and Chief Procurement Officer but the FIS documentation is been prepared and will be submitted to the Office of the Chief Financial Officer. Once MAA*

EXHIBIT B: MANAGEMENT RESPONSE

receives their findings we will submit to the Office of the Attorney General and Chief Procurement Officer.

5. Services may be provided only to individuals who:

> **a) have had a determination by the MAA that the recipient is likely to require the care furnished in a nursing facility under Medicaid; b) require assistance with activities of daily living; c) agree to participate in the waiver program by signing a Beneficiary Freedom of Choice form; d) are age 65 or older; e) are adults, age 18 or older, with physical disabilities; f) are not inpatients of a hospital, nursing facility, or intermediate care facility for the mentally retarded; and g) are Medicaid eligible with a maximum monthly income of three hundred percent (300%) of Supplemental Security Income (SSI).**

Response: *MAA-ODA, as a matter of course, routinely met and continues to have all persons approved to the EPD Waiver meet all of the requirements identified above as CMS conditions of participation in the EPD Waiver.*

6. Found no evidence that MAA-ODA officials prepared a cost benefit analysis that evaluated the cost of providing the ADRC services using District government employees versus the cost of contracted services.

Response: *MAA-ODA staff did not prepare a new cost benefit analysis as it was believed that there was no major change from the original ADRC SOW. Since the OIG has recommended that a more recent cost benefit analysis be don,e MAA has completed a new cost benefit analysis which is being staffed and will then be submitted to OCP.*

7a. did not meet the performance milestones in the base year and were not on target to meet the milestones by the end of option year one.

Response: *It is correct that did not meet all of the performance milestones in the base year and were not on target to meet the milestones by the end of the option year one (second year of funding). As a result of the OIG initial questions and audit and because many questions were asked of MAA about , the contract was terminated at the request of MAA.*

7b. The second outsourcing attempt failed, in part, because MAA-ODA officials did not evaluate the program and determine whether outsourcing was a viable option, given that contractors cannot legally enroll participants in the HCBS EPD Waiver program.

Response: *That the second outsourcing attempt failed because of MAA-ODA officials did not evaluate the program is partially correct. A review of the contract was done by both OCP and during best and final negotiations with OCP, which is part of the routine OCP negotiation process. Although questioned whether it was possible for them to enroll*

EXHIBIT B: MANAGEMENT RESPONSE

persons in the EPD Waiver no documentation was developed to reflect this. The changes were not made to the contract.

8. **Based on the number of slots allotted for the HCBS EPD Waiver program and the number of actual participants, we believe the District lost the opportunity to provide a higher quality of life for District residents by diverting them from nursing home care during 2002 to 2005. Table 2 shows the number of allotted slots and reported actual participants in the HCBS EPD Waiver program from 2002-2005 and the estimated participation for 2006.**

Response: *While MAA acknowledges that there have been lost opportunities, the MAA-ODA Staff respectfully disagrees with the OIG assessment in that the numbers of persons accepted into the EPD Waiver have been increasing since EPD Waiver inception. All targeted Nursing Home diversion milestones projected for the District have been met for each Waiver year from 2003 to 2006. (These numbers are reflected in the Mayor's performance measures.) These increases in diversion numbers of persons have been more dramatic within the past year (2006). As stated previously, the number of slots in the program are the maximum allowed, they are not a target.*

9. Preparing a Request for Proposal to outsource the ADRC for the third time without evaluating alternatives and supporting that doing so was in the District's best interest.

Response: *MAA did request that OCP prepare a new request for proposal based upon plans shared with Councilmember David Catania and community interest in seeing a new RFP in place as soon as possible. MAA did not initially evaluate alternatives. Since the OIG audit began a more thorough evaluation of alternatives has been done.*

10. MAA-ODA officials could not provide documentation to support that the cost of keeping the functions in-house exceeded the cost of outsourcing.

***Response*:** *MAA-ODA officials did not provide the OIG with cost benefit analysis that included the cost of keeping the functions in-house exceeded the cost of outsourcing. Since that time an analysis has been done.*

11. Advance planning would have allowed MAA to request budget authority for additional personnel, as well as funding to rent office space. Furthermore, contractors may also have problems training and retaining qualified employees.

Response: *It is acknowledged that more advance planning always helps. MAA officials did not pursue requests for budget authority for personnel positions. MAA also did not pursue space as MAA did not have a community-based presence and drop in type of facility that was easily reached, and was handicapped accessible. This was largely a management decision. This decision was made because MAA did not have budget authority in earlier years and the District had a budget shortfall. In later years it was acknowledged that it is very time-consuming to request budget enhancements, approval and to get personnel positions filled. Getting personnel positions has taken a minimum of six or more months. Since 2002 there have been budget shortfalls and most recently DOH- MAA has had a space problem. It was believed that MAA*

EXHIBIT B: MANAGEMENT RESPONSE

could outsource these services more quickly and MAA-ODA could provide ADRC staff with adequate training as needed. The issue about training and retaining qualified employees and contractors remains one of concern and importance for both in-house and outsourcing staff options.

12. We believe MAA-ODA officials must evaluate alternatives to outsourcing the ADRC and prepare a cost-benefit analysis supporting whether it is more cost effective and in the District's best interest to perform the ADRC functions in-house or to outsource them.

Response: *MAA has evaluated alternatives to outsourcing and conducted a cost benefit analysis.*

13. Adequately plan the procurement and submit a determination and findings to the Mayor for submission to the Council.

Response: *MAA will plan for a new procurement and in the short term consider a one year outsourced contract which will act as a stop gap measure for FY 2007 as the budget is already in place. MAA will also request a budget enhancement for FY 2008 to request bringing ADRC staff in-house.*

OIG RECOMMENDATIONS

1. **Request that CMS issue a second no cost extension (deviation request) for the RCSC and CPASS grants while MAA officials evaluate alternatives and prepare a cost-benefit analysis supporting whether ADRC services should be performed in-house or outsourced.**

   Response: *MAA has pursued a second no cost extension from CMS for the C-PASS and RCSC grants and have been told that an additional extension is* ***not possible.***

2. **If a determination is made to outsource the ADRC, prepare and submit a cost estimate to the OCP and a determination and findings to the Mayor for submission to the Council.**

   Response: *A thorough analysis will be made before any further decisions to bring ADRC functions in-house or out-sourced.*

3. **Establish appropriate, achievable HCBS EPD Waiver goals and methods for measuring and accomplishing those goals before outsourcing the ADRC.**

   Response: *MAA will establish appropriate, achievable and reasonable goals for methods for measuring success before considering outsourcing.*