GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE OF THE INSPECTOR GENERAL

AUDIT OF THE RATE-SETTING PROCESS FOR INTERMEDIATE CARE FACILITIES FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES

CHARLES J. WILLOUGHBY
INSPECTOR GENERAL

OIG No. 08-2-17HC **June 29, 2010**

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Office of the Inspector General

Inspector General

June 29, 2010

Julie A. Hudman, Ph.D.
Director
D.C. Department of Health Care Finance
825 North Capitol Street, N.E., Suite 500
Washington, D.C. 20001

Dear Dr. Hudman:

Enclosed is our final report summarizing the results of the Office of the Inspector General's (OIG) *Audit of the Rate-Setting Process for Intermediate Care Facilities for People with Developmental Disabilities* (OIG No. 08-2-17HC).

As a result of our audit, we directed four recommendations to the Department of Health Care Finance (DHCF) for action we consider necessary to correct identified deficiencies. The DHCF provided a written response to a draft of this report on January 15, 2010. We reviewed the response and met with DHCF officials in February to discuss planned actions. DHCF generally agrees with the finding and disagrees with the potential monetary benefit. Also, DHCF agrees with three of the four recommendations. Because DHCF disagrees with the potential monetary benefit and because of numerous clarifying comments included in the response, we obtained additional documentation and reexamined our facts. We determined that significant conclusions and calculations are valid and clarified our position in the final report as needed. We also included Exhibit E, which addresses numerous points made by DHCF.

We consider actions taken and planned by the DHCF to meet the intent of the recommendations, with the exception of Recommendation 3. However, DHCF did not provide completion dates for planned actions for any of the recommendations. We request that the DHCF respond to Recommendation 3 and provide us with completion dates for all recommendations within 60 days of the date of this report. The full text of the DHCF response is included at Exhibit G.

While we did not direct recommendations to the five ICFs/DD providers included in our draft report, we provided each with a courtesy copy of the report. Three of the five providers furnished comments, which we address in Exhibit F. The full text of ICF/DD provider responses are included as Exhibits H-J.

We appreciate the cooperation and courtesies extended to our staff by the DHCF and ICF/DD providers. If you have any questions, please contact me or Ron King, Assistant Inspector General for Audits, at (202) 727-2540.

Sincerely,

Charles J. Willoughby
Inspector General

Enclosure

CJW/dyl

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AUDIT OF THE RATE-SETTING PROCESS FOR INTERMEDIATE CARE FACILITIES FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES

ACRONYMS/ABBREVIATIONS/SHORT TITLES

CFO	Chief Financial Officer
CMS	Centers for Medicare and Medicaid Services
CY	Calendar Year
District	District of Columbia
DCMR	District of Columbia Municipal Regulations
DHCF	Department of Health Care Finance
FY	Fiscal Year
ICF/DD	Intermediate Care Facility for People with Developmental Disabilities
IDI	Individual Development, Inc.
MMIS	Medicaid Management Information System
OCFO	Office of the Chief Financial Officer
ODA	Office on Disabilities and Aging
OIG	Office of the Inspector General
SPA	State Plan Amendment
State Plan	Medicaid State Plan

AUDIT OF THE RATE-SETTING PROCESS FOR INTERMEDIATE CARE FACILITIES FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES

TABLE OF CONTENTS

EXECUTIVE SUMMARY i

INTRODUCTION.....1

BACKGROUND 1

OBJECTIVES, SCOPE, AND METHODOLOGY.....2

PRIOR REVIEWS.....3

FINDING AND RECOMMENDATIONS.....4

EXECUTIVE COMPENSATION.....4

EXHIBITS 13

EXHIBIT A. SUMMARY OF POTENTIAL BENEFITS RESULTING FROM AUDIT.....13

EXHIBIT B. CONCERNS REGARDING INDIVIDUAL DEVELOPMENT, INC. (IDI).....14

EXHIBIT C: CRITERIA 16

EXHIBIT D. RATE-SETTING PROCESS.....19

EXHIBIT E. DHCF POINTS AND OIG CLARIFICATIONS 20

EXHIBIT F. ICF/DD REVENUE AND EXECUTIVE COMPENSATION 23

EXHIBIT G. DHCF RESPONSE.....26

EXHIBIT H. DC HEALTH CARE, INC. RESPONSE 33

EXHIBIT I. WHOLISTIC MANAGEMENT SERVICES, INC. RESPONSE....34

EXHIBIT J. IDI RESPONSE.....36

EXECUTIVE SUMMARY

OVERVIEW

Enclosed is the final report summarizing the results of the Office of the Inspector General's Audit of the Rate-setting Process for Intermediate Care Facilities for People with Developmental Disabilities (ICFs/DD). This audit was requested by the former Director of the Medical Assistance Administration (now Department of Health Care Finance (DHCF)), due to concerns over funds paid to privately-operated ICFs/DD, specifically Individual Development, Inc. (IDI). The overall objectives of the audit were to determine whether costs reported to DHCF by the ICFs/DD were accurate and supported and whether the ICFs/DD program was effectively managed. Based on initial observations, we focused on executive compensation. We address concerns related to IDI in Exhibit B.

During the course of our audit, we provided management with briefings concerning our observations and findings. At our briefings, we discussed proposed recommendations for correcting the identified deficiencies so that the DHCF could initiate corrective action prior to the approval of a new reimbursement methodology.

PERSPECTIVE

The DHCF has made improvements in the ICF/DD rate-setting process since 2008 when it was given legal authority to administer the Medical Assistance Program for the District of Columbia by the Department of Health Care Finance Establishment Act of 2007 (D.C. Law 17-109, effective Feb. 17, 2008). The purpose of the legislation was, in part, to establish a separate, cabinet-level agency responsible for the administration of a comprehensive, efficient, and cost-effective health care system serving the District's uninsured, under-insured, and low-income residents. Medicaid is the largest of the Medical Assistance Programs administered by the DHCF. DHCF authority is further delineated by federal and District criteria governing rate-setting for ICFs/DD (see Exhibit C).

At the time of our audit, the ICFs/DD reimbursement methodology had been in place for 14 years without modification. The DHCF considered the reimbursement methodology, which was based on provider costs, to be inflexible and inefficient. In 2008, the DHCF began developing a new, more flexible ICF/DD reimbursement methodology based on the needs of Medicaid beneficiaries. The proposed methodology uses at least six different acuity levels, removes the use of medians,[1] and requires ICF/DD providers to spend 80 percent of Medicaid revenue on direct care services.[2] Although the proposed methodology initially did not require desk reviews and field audits, DHCF officials included the requirement in a later version of the methodology.

[1] The average daily rate, established by the DHCF for the facility's current year expenditures, that represents the middle value in a distribution of average daily rates, above and below which lie an equal number of values.
[2] The draft DHCF policies and procedures include penalties for non-compliance with the 80/20 rule.

EXECUTIVE SUMMARY

DHCF submitted the District's State Plan Amendment (SPA) to the Centers for Medicare and Medicaid Services (CMS) for review and approval in August 2009. At the time of this report, the SPA was undergoing a legal sufficiency review. The DHCF details improvements in the reimbursement methodology in their response to our draft report. See the DHCF response in its entirety at Exhibit G.

CONCLUSION

Nine executives at five ICFs/DD providers received excessive compensation totaling up to $1.3 million in calendar year (CY) 2008. This condition occurred because DHCF reimbursement officials did not always comply with District and federal regulations to establish ICF/DD rates that were consistent with economy and efficiency. Specifically, DHCF officials did not establish cost-containment controls such as compensation limits or comply with the requirement to rebase medians[3] no later than October 1, 1999. Further, DHCF officials did not adequately implement existing internal controls, such as desk reviews and on-site audits. We also attribute this condition to a lack of management oversight because DHCF officials could have proposed legislation to reinstate the requirement to rebase medians at any time during the past 10 years. If ICF/DD providers continue to receive rates based on outdated medians until October 2012, when DHCF plans to rebase[4] the rates, ICF/DD executives may receive up to $4.7 million more in excessive compensation.

SUMMARY OF RECOMMENDATIONS

We recommended that officials establish and implement new and existing internal controls, provide adequate management oversight of the rate-setting process, and determine whether the rate-setting process resulted in excessive executive compensation to the ICFs/DD we did not include in our review. A summary of the potential benefits resulting from the audit is shown at Exhibit A.

MANAGEMENT RESPONSE

The Director of DHCF provided a written response to the draft of this report dated January 15, 2010. According to the response, the DHCF agrees with the report in general but disagrees with the monetary benefits. It is the Director's opinion that the SPA, infrastructure changes to support the new SPA, and the internal policies and procedures under development will mitigate our "prediction of future unchecked growth in executive compensation." In addition, the DHCF states that monitoring and oversight is structured to ensure delivery of services and that the agency has no authority to limit excessive compensation at the corporate level. Further, DHCF believes the agency does not have the regulatory authority to

[3] The average daily rate, established by the DHCF for the facility's current year expenditures, that represents the middle value in a distribution of average daily rates, above and below which lie an equal number of values.
[4] To rebase the rates means to reset the baseline to reflect spending as of a more current date.

EXECUTIVE SUMMARY

recalculate medians and that attempting to do so would violate Medicaid law and regulations and put federal financial participation (FFP) at risk. The response also contains several clarifying points and suggestions. DHCF requested that we meet with them and discuss how the proposed ICF/DD reimbursement methodology will address many of the challenges identified by our audit. The full text of the DHCF response is included at Exhibit G.

OIG COMMENT

We met with DHCF officials as requested, obtained additional documentation, and reexamined our facts. We determined that our significant conclusions and calculations are valid. We adjusted the final report as needed and included Exhibit E, which addresses the numerous points made by DHCF officials. We also added a Perspective section to this Executive Summary to include DHCF's progress in improving the ICF/DD reimbursement methodology. However, we disagree that progress made to date will mitigate the potential monetary benefits identified by this audit. In addition, we disagree with the DHCF position that the agency does not have the authority to limit executive compensation. See Exhibit C, which discusses the laws and regulations governing DHCF and the rate-setting process.

We consider actions taken and planned by the DHCF to meet the intent of the recommendations, with the exception of Recommendation 3. However, DHCF did not provide completion dates for planned actions. We request the DHCF respond to Recommendation 3 and provide us with completion dates for all recommendations within 60 days of the date of this report.

INTRODUCTION

BACKGROUND

The Department of Health Care Finance (DHCF), formerly the Medical Assistance Administration under the Department of Health, is the District of Columbia's (District) state Medicaid agency. The DHCF mission is to improve health outcomes by providing access to comprehensive, cost-effective, and quality healthcare services for residents of the District. DHCF is responsible for Intermediate Care Facility for People with Developmental Disabilities (ICF/DD) rate setting.

Intermediate Care Facilities for People with Developmental Disabilities. The ICF/DD program was established in 1971 as an optional Medicaid service under Section 1905(d) of the Social Security Act.[5] ICFs/DD are state- or privately-operated and managed facilities funded by Medicaid to diagnose, treat, and rehabilitate people with developmental disabilities in a protected setting. ICFs/DD can be institutional or residential facilities that provide ongoing evaluation, planning, 24-hour supervision, coordination, and integration for health or rehabilitative services to help individuals function at their greatest ability.

ICFs/DDs in the District are generally small companies operating institutional facilities that house four to eight clients. In fiscal years (FY) 2007 and 2008, the District funded 19 to 21 companies operating and managing up to 93 facilities.[6] About 500 clients resided in these facilities in FY 2008. According to the Medicaid Management Information System (MMIS), the DHCF paid ICFs/DD $73.5 million, $73.7 million, and $67.3 million in FYs 2007-2009, respectively.

Discretion in Reimbursement Methodology. Each state has broad discretion in determining the ICFs/DD reimbursement methodology and resulting rates paid to providers for services. Through State Plan amendments, the Centers for Medicare and Medicaid Services (CMS) reviews and approves reimbursement methodologies for compliance with requirements of the Social Security Act (the Act). For example, Section 1902(a)(30)(A) of the Act requires (in part) that State plans:

> assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the State Plan at least to the extent that such care and services are available to the general population in the geographic area.[7]

[5] *See* http://www.cms.hhs.gov/CertificationandComplianc/downloads/ICFMR_Background.pdf (last visited Dec. 7, 2009).
[6] The number of companies and facilities fluctuated somewhat because of company and facility closures and the opening of new facilities. The percentage of non-profit entities versus for profit entities was about 50 percent.
[7] Title 42 U.S.C. § 1396a(a)(30)(A).

INTRODUCTION

In general, CMS reviews State reimbursement methodologies and supporting documentation to ensure that the State plan methodology may be audited and is comprehensively described, and that reimbursement rates are economic, efficient, and sufficient to attract willing and qualified providers.

Until 1980, state Medicaid programs were required to determine rates based on the actual cost of services after they were provided. However, the "Boren Amendment" of the Omnibus Reconciliation Act of 1980 (Pub. L. No. 96-499) repealed this requirement. Most states responded by shifting to prospective payment systems because of concerns that providers paid on a full cost basis had no incentive to perform efficiently and might furnish unnecessary services.[8] In contrast, prospective payment systems set rates in advance, do not have to be related to the actual costs providers incur in furnishing services, and the state may set rate ceilings.[9] The District uses a prospective payment system and sets ceilings.

OBJECTIVES, SCOPE, AND METHODOLOGY

Our audit objectives were to determine whether cost reports submitted to DHCF were accurate and supported and whether ICFs/DD rate-setting process is effectively managed. The former Director of the Medical Assistance Administration (now DHCF) requested that our Office conduct the audit. During the audit, we focused our objective on executive compensation.

To accomplish our objectives, we reviewed applicable laws, regulations, policies, and procedures. We conducted interviews with DHCF officials and the Office of the Chief Financial Officer's (OCFO) Office of Audit and Finance, which served and was located at the DHCF offices. An incurred cost audit[10] was performed at one ICF/DD provider. We conducted site visits and held discussions with management of several ICF/DD providers. We also contacted 31 state Medicaid offices to benchmark ICF/DD reimbursement methodologies and executive compensation practices.

We expanded our review of executive compensation and requested calendar year (CY) 2008 payroll data for all ICF/DD providers that received Medicaid reimbursement in FY 2007 and were still operating ICFs/DD and receiving reimbursement in FY 2008. We received payroll data identifying positions and compensation, including owners and management positions such as the President, Chief Executive Officer, Director of Operations, or Executive Director. We compared executive compensation paid by District ICF/DD providers to surveys of compensation paid to executives at other non-profit health care entities in the District.

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[8] CONGRESSIONAL RESEARCH SERVICE, MEDICAID REIMBURSEMENT POLICY 4 (Oct. 25, 2004).
[9] *Id.*
[10] An incurred cost audit examines cost representations and determines whether incurred costs are reasonable, allocable, and allowable.

INTRODUCTION

We relied on computer-processed data from the MMIS to determine program size. Although we did not perform reliability assessments, we used the MMIS data only for presenting background about the program. We also relied on compensation data provided by the ICFs/DD payroll systems. We used the compensation data to identify which providers to review as well as to calculate excessive compensation. At one ICF/DD, we traced executive compensation data from the payroll system to supporting records and found no significant differences.

We conducted this performance audit in accordance with Generally Accepted Government Auditing Standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our finding and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our finding and conclusions based on our audit objectives.

PRIOR REVIEWS

We did not identify any prior reviews conducted in the last 5 years related to ICFs/DD and executive compensation.

FINDING AND RECOMMENDATIONS

EXECUTIVE COMPENSATION

SYNOPSIS

Nine executives at five ICFs/DD providers received excessive compensation totaling up to $1.3 million in calendar year (CY) 2008. This condition occurred because DHCF reimbursement officials did not always comply with District and federal regulations to establish ICF/DD rates that were consistent with economy and efficiency. Specifically, DHCF officials did not establish cost-containment controls such as compensation limits or comply with the requirement to rebase medians[11] no later than October 1, 1999. Further, DHCF officials did not adequately implement existing internal controls, such as desk reviews and on-site audits. We also attribute this condition to a lack of management oversight because DHCF officials could have proposed legislation to reinstate the requirement to rebase medians at any time during the past 10 years. If ICF/DD providers continue to receive rates based on outdated medians until October 2012 when DHCF plans to rebase[12] the rates, ICF/DD executives may receive up to $4.7 million more in excessive compensation.

DISCUSSION

The District implements federal Medicaid regulations through the Medicaid State Plan (State Plan) and 29 DCMR. The State Plan required DHCF to rebase the base-year data and medians no later than October 1, 1999. However, DHCF officials did not comply with this requirement before it was repealed effective December 10, 1999. Rebasing of rates to reflect spending as of a more current date is a basic tenet of sound reimbursement policy.

Cost-containment Controls. DHCF officials did not establish cost-containment controls such as compensation limits or updated medians. We contacted 31 states and of the 27 with privately-operated and managed ICFs/DD, 17 (or 63 percent) exercised some control over executive compensation. Controls included executive compensation limits based on amounts paid for similar positions in government ICFs/DD,[13] the number of beds managed, and amounts paid to state executives. At a minimum, each of the 17 states performed some type of reasonableness study to identify acceptable executive compensation.

Compensation Limits of Other States. The DHCF set rates that allowed five ICFs/DD providers to pay top executives compensation of $1.6 million, where it could have limited the cost to $900,000 if compensation limits used by other states had been in place. Our benchmarking showed that 17 states establish annual executive compensation limits of

[11] The average daily rate, established by the DHCF for the facility's current year expenditures, that represents the middle value in a distribution of average daily rates, above and below which lie an equal number of values.
[12] To rebase the rates means to reset the baseline to reflect spending as of a more current date.
[13] The District has no government-operated and managed ICFs/DD.

FINDING AND RECOMMENDATIONS

$33,000 to $180,000. In comparison, each District ICF/DD provider paid the top executive compensation ranging from $39,999 to $436,891.

We applied the $180,000 limit[14] to the highest and second highest paid executives at five providers and concluded that the providers paid $945,712 more than they would have if the District had established and enforced a conservative executive compensation limit. See Table 1 for a comparison of compensation paid by five District ICFs/DD providers to compensation limits established by other states.

Table 1. Executive Compensation Paid by Five District ICFs/DD Providers Compared to Executive Compensation Limits Established by Other States

	Highest Paid Executive			Second Highest Paid Executive			
D.C. Provider	**Salaries**	**Other States Limits**	**Excess**	**Salaries**	**Other States Limits**	**Excess**	**Total Excess per Provider**
Wholistic	$267,297	$180,000	$87,297	$92,414	$180,000	None	**$87,297**
Behavioral Research	285,500	180,000	105,500	233,900	180,000	53,900	**$159,400**
DC Health Care	436,891	180,000	256,891	406,259	180,000	226,259	**$483,150**
Metro Homes	325,403	180,000	145,403	145,440	180,000	(34,560)	**$110,843**
IDI	261,346	180,000	81,346	203,676	180,000	23,676	**$105,022**
Totals	**$1,576,437**	**$900,000**	**$ 676,437**	**$1,081,689**	**$900,000**	**$ 269,275**	**$945,712**

Compensation Limits Using Industry Standards. If DHCF had set rates to limit executive compensation based on industry standards,[15] the same five ICF/DD providers that paid out $1.6 million in executive compensation would have instead paid $790,000. For example, annual executive compensation paid by D.C. health care organizations in 2008 ranged from about $95,000 to $180,000.

We applied the industry standard to the highest and second highest paid executives at five providers and concluded that the providers paid $1.3 million more than they would have if the District had established and enforced conservative executive compensation limits based on industry standards. See Table 2 for details.

[14] To be conservative, we calculated the excess compensation based on the highest amount allowed by other states ($180,000) even though that amount is based on what one state pays its governor. We also applied the $180,000 limit to the second in command although that executive would be expected to earn less than the top executive.

[15] D.C. Nonprofit Salary Ranges in Year 2008 obtained from Professionals for Non-Profits, http://www.nonprofitstaffing.com (last visited April 30, 2009).

FINDING AND RECOMMENDATIONS

Table 2. Executive Compensation Paid by District ICFs/DD Providers Compared to Industry Standards for Executive Compensation Paid to D.C. Health Care Organizations

	Highest Paid Executive			Second Highest Paid Executive			
D.C. Provider	**Salary**	**Industry Standard**	**Excess**	**Salary**	**Industry Standard**	**Excess**	**Total Excess per Provider**
Wholistic	$267,297	$180,000	$ 87,297	$92,414	$180,000	None	**$87,297**
Behavioral Research	285,500	130,000	155,500	233,900	95,000	138,900	**$294,400**
DC Health Care	436,891	150,000	286,891	406,260	110,000	296,260	**$583,151**
Metro Homes	325,403	150,000	175,403	145,440	110,000	35,440	**$210,843**
IDI	261,346	180,000	81,346	203,677	130,000	73,677	**$155,023**
Totals	**$1,576,437**	**$790,000**	**$786,437**	**$1,081,691**	**$625,000**	**$ 544,277**	**$1,330,714**

Rebasing Medians. DHCF officials did not comply with the requirement to rebase medians. Medians are generally used as ceilings to control costs. The only reason officials could give for not rebasing the medians was that using a prospective payment system negated the need. Neither could reimbursement officials support the basis for all medians that were established in 1996. Reimbursement officials informed us that they could not support the basis for the medians developed in 1996 because the rates were developed by a contractor and officials were unaware of any supporting documentation.

According to 29 DCMR § 969.2, the median established in 1996 would have been based on the median per diem rate for all facilities operating in the District of Columbia and participating in the Medicaid program in 1993. We question using medians year after year without assessing them for reliability and reasonableness and not making adjustments based on more recent cost information. The stagnant medians would be distorted for many reasons, but three primary examples include changes in compensation levels, the number of facilities managed, and resident demographics. First, medians established in 1996 do not reflect changes in compensation levels as well as owner duties and responsibilities. Typically, compensation levels change over time, and duties and responsibilities of owners might be higher in the first few years of operations. Second, the administrative costs related to acquiring or closing facilities between 1997 and 2000 were not included in the median because it was not rebased. Administrative costs should be allocated based on an equitable distribution, which cannot occur if medians are not rebased. Finally, resident acuity levels would not have remained constant between 1997 and 2000, and recalculation of the healthcare-related median would have been necessary to account for such changes. Potential changes in acuity levels are significant because the healthcare-related median is a large component of the overall median.

FINDING AND RECOMMENDATIONS

We also question the continued use of medians established in 1996 given that DHCF officials admitted not knowing the details of the formula used to set the medians and stated that documentation supporting the medians did not exist. Good business sense and informed decision making should be predicated on knowing the basis for medians and whether actual costs are reasonable, allowable, and supported. At least one of the states against which we benchmarked resets medians four times each year. Leaving the medians at levels established 14 years ago, with the exception of adjustments for inflation, does not appear to be consistent with setting economic and efficient rates.

Desk Reviews and On-Site Audits. DHCF officials did not adequately implement existing internal controls, such as desk reviews and on-site audits. According to 29 DCMR § 977.1, all annual cost reports must be reviewed via a desk review and Section 977.2 additionally requires on-site audits no less than once every 4 years. Of the 21 ICF/DD providers operating in FYs 2007 and 2008, none received desk reviews, whereas 16 on-site audits were performed in FY 2007 and none in FYs 2008 and 2009. The 16 audits were not performed to comply with the quadrennial on-site audit requirement but to establish permanent rates for 16 facilities that were being paid based on interim rates.

According to DHCF's reimbursement supervisor, he believed that the use of the prospective payment system negated the need for annual desk reviews. In addition, the supervisor indicated he was not aware of the quadrennial on-site audit requirement. He stated that as far as he was concerned, his office had informally eliminated the requirement for the audits following the introduction of the prospective payment system even though the audit requirement remained in the State Plan and the DCMR.

To respond to stakeholder concerns regarding ICF/DD costs and to demonstrate the need for audits, we performed an incurred cost audit[16] for one of the ICF/DD providers to determine whether incurred costs were allowable in accordance with District and federal requirements. We found excessive and unsupported executive compensation, payments without documented deliverables, and personal loans in violation of D.C. Code § 29-301.28 (2001). (See Exhibit B for a discussion of the unallowable incurred costs.) In addition, officials at the ICF/DD indicated that savings from cancelling a management contract and hiring an employee to manage the provider's facilities was not passed on to the District. These types of expense scenarios would typically be found during an on-site audit of the ICF/DD annual cost reports.

Management Oversight. DHCF management did not adequately oversee the rate-setting process. Top level reviews of actual performance could have identified that reimbursement officials discontinued practices required by the State Plan and DCMR. In addition, a management review could have identified that reimbursement officials had no documentation

[16] An incurred cost audit examines cost representations and determines whether incurred costs are reasonable, allocable, and allowable.

FINDING AND RECOMMENDATIONS

to support the basis of the medians developed in 1996. More importantly, a top level review could have identified the potential impact of these failures in conjunction with the repeal of the requirement to rebase base-year data and medians. Such a review could have resulted in the conclusion that annual desk reviews and on-site audits were even more necessary to identify and recoup unallowable costs.

This point is especially significant given that the final rulemaking eliminated the October 1, 1999, date for establishing new base-year per diem rates. The rulemaking states: "The rules delete the October 1, 1999, deadline for establishing new base year rates to afford MAA time to complete the audits of each ICF/MR cost report, review the audited cost data, and develop the new rates." 46 D.C. Reg. 10099 (Dec. 10, 1999). Had DHCF ensured that audits were conducted, the District could have shared in the savings experienced by one provider when it discontinued a management contract.

The General Accountability Office's (GAO) Standards for Internal Control in the Federal Government provide that control activities, such as policies and procedures, help ensure actions are taken to reduce risk.[17] All transactions and other significant events (such as the contractor setting the medians) need to be clearly documented, and the documentation should be readily available for examination. The documentation requirement should appear in management directives, administrative policies, or operating manuals and may be in paper or electronic form. Oversight does not have to be elaborate. A tool as simple as an Excel spreadsheet to identify and track ICF/DD base-year data, medians, established rates, changes in significant cost elements from the cost reports submitted annually, audits, and requests from providers for adjustments could assist management in producing useful reports and measuring performance.

Conclusion. While the District must maintain a sufficient number of ICFs/DD to provide quality care to some of the District's most vulnerable residents, paying excessive amounts to executives is not necessary to achieve this purpose. Neither is such action consistent with sound business practice in general or the practice of states against which we benchmarked.

Because the proposed reimbursement methodology does not require rebasing of rates until October 1, 2012, which will allow the opportunity for excess executive compensation to continue until that time, it is even more important for the District to audit annual cost reports. Further, performance of these audits will result in cost and statistical information from which DHCF can formulate sound reimbursement policies and rates, as well as periodically evaluate and update reimbursement policies and rates. We do not believe establishing rates that allow ICF/DD providers to pay executives $6 million in excessive compensation is consistent with economy and efficiency.

[17] GAO, STANDARDS FOR INTERNAL CONTROL IN THE FEDERAL GOVERNMENT (Nov. 1999).

FINDING AND RECOMMENDATIONS

RECOMMENDATIONS, MANAGEMENT RESPONSE, AND OIG COMMENTS

The Office of the Inspector General recommends that the Department of Health Care Finance:

1. Establish and implement cost-containment controls such as compensation caps, to ensure that ICF/DD rates do not result in excessive compensation to executives.

DHCF RESPONSE

DHCF stated that the agency reimburses ICFs/DD for services rendered to beneficiaries. Therefore, the DHCF oversight is structured to ensure delivery of services and not to monitor corporate operations. Also, DHCF stated that they do not currently have the authority to limit executive compensation. DHCF officials did indicate that their new payment methodology will mandate cost controls by requiring that ICFs/DD spend 80 percent of their Medicaid revenues on direct care services, which will limit administrative costs (including executive compensation) to 20 percent of Medicaid revenues. Finally, DHCF will aggressively explore including executive compensation limits in the new reimbursement methodology, and will issue new regulations establishing parameters around compensation of ICFs/DD executives by March 15, 2010. The full text of DHCF's response to each of the OIG's recommendations is included at Exhibit G.

OIG COMMENTS

We do not agree that DHCF lacks the authority to limit compensation or that the 20 percent limit on administrative costs will add sufficient internal controls on executive compensation. (See Exhibit C for a discussion of DHCF authority and the laws and regulations governing ICF/DD reimbursement rates and executive compensation.) Oversight of service delivery is an important function, and we are not advocating monitoring of corporate operations per se. However, officials should take action to ensure that DHCF reimburses for quality services at the lowest cost to the District.

It should be noted that the excessive executive compensation identified by the audit was funded with as little as 3 percent of revenue received in 2008 by the ICF/DD providers (see Exhibit F). This percentage is significantly below the 20 and 12 percent DHCF plans to apportion to indirect care expenses and salaries, respectively. Although DHCF regulations and implementing policies and procedures had not been issued as of the date of this final report, other parameters around executive compensation satisfy the intent of our recommendation.

FINDING AND RECOMMENDATIONS

The Office of the Inspector General recommends that the Department of Health Care Finance:

2. Implement existing internal controls, such as performing audits of cost reports, to identify and recoup unallowable costs and to verify that reimbursement rates are accurate.

DHCF RESPONSE

DHCF stated that its regulatory structure is targeted to oversight of individual facilities, not the corporate or parent organization of each facility. However, the DHCF Health Care Accountability Administration will launch a review to determine whether OIG-examined ICFs/DD were inappropriately reimbursed or submitted fraudulent cost reports. DHCF also stated that they will work with the Office of Attorney General to explore recovery options for improperly paid reimbursements.

OIG COMMENT

We consider actions planned by DHCF to be responsive to the intent of our recommendation. DHCF officials do not specifically state that they will perform audits and the response was focused on costs incurred by providers examined during this audit under the current rate-setting practices. However, the proposed policies and procedures planned under the new ICF/DD reimbursement methodology indicate DHCF's intention to audit annual cost reports for allowable costs, including executive compensation. Performing the required audits is critical to the success of the new reimbursement methodology because the audits should identify unallowable costs. Although we did not find any indication of fraud on the part of the ICF/DD providers, it is prudent of the DHCF to request that the Health Care Accountability Administration further review the OIG-examined ICFs/DD.

The Office of the Inspector General recommends that the Department of Health Care Finance:

3. Immediately review executive compensation of the ICF/DD providers not included in our audit to identify and recoup any executive compensation determined to be unreasonable.

DHCF RESPONSE

DHCF explained that audit processes under the new reimbursement methodology will contain detailed formulas for calculating allowable wages, salaries, and benefits. Officials also stated that the new methodology would include explicit policy on allowable costs related to executive compensation guidelines for auditors and desk reviewers. In addition, DHCF is in the process of benchmarking limits on executive compensation and

FINDING AND RECOMMENDATIONS

will issue new regulations to enforce those limitations. The full text of DHCF's response is included at Exhibit G.

OIG COMMENT

The planned action is not responsive to our recommendation. The purpose of our recommendation was for DHCF to review compensation paid to the 12 ICFs/DD providers in 2008 that were not addressed in detail by our audit. A comparison of revenue to executive compensation paid in 2008 indicated that other providers may have also overpaid their executives. Executive compensation for these 12 providers ranged from 4 to 13 percent of 2008 ICF/DD revenue and is consistent with the 3 to 16 percent of ICF/DD revenue that funded the excessive executive compensation paid by the 5 providers discussed in the OIG draft audit report.

Not only should DHCF request a voluntary refund from the five providers discussed in this report, but officials should also apply a conservative compensation limit – similar to those shown in Tables 1 and 2 of this report – to the other 12 providers and request a voluntary refund of any excessive compensation. When the new reimbursement methodology regulations and DHCF implementing policies and procedures become effective, it should not be necessary for DHCF to request a voluntary refund because providers will not be able to argue that vague DHCF regulations contributed to the excessive compensation. Instead, DHCF officials should be able to apply the criteria, recoup unallowable costs, make the appropriate changes to reimbursement policies, and adjust rates when needed. We request DHCF to reconsider its response to the recommendation and provide revised comments and a date for completion in response to the final report.

The Office of the Inspector General recommends that the Department of Health Care Finance:

4. As part of management oversight, perform a periodic evaluation of the reimbursement office to determine whether actual operations comply with District and federal laws and regulations.

DHCF RESPONSE

DHCF stated that a review of all internal operations was initiated when it was established as a cabinet-level agency. Subsequently, DHCF implemented an organizational realignment to better target staffing with departmental functions and developed an array of internal policies and procedures. DHCF stated that they will pursue the addition of a position to enhance oversight of ICFs/DD and those internal policies and procedures will

FINDING AND RECOMMENDATIONS

contain provisions for periodic evaluation of ICFs/DD reimbursement activities to ensure compliance with District and federal laws.

OIG COMMENT

We consider planned actions to meet the intent of our recommendation.

EXHIBIT A. SUMMARY OF POTENTIAL BENEFITS RESULTING FROM AUDIT

RECOMMENDATIONS	DESCRIPTION OF BENEFIT	AMOUNT AND TYPE OF BENEFIT	AGENCY REPORTED ESTIMATED COMPLETION DATE	STATUS[18]
1	**Compliance, Internal Control, and Economy and Efficiency.** Obtains reasonable assurance that the District does not fund excessive compensation to executives.	Potential Monetary Benefits of $6 Million	TBD	Open
2	**Internal Control.** Obtains reasonable assurance that the rate-setting process results in rates consistent with economy and efficiency.	Non-Monetary	TBD	Open
3	**Economy and Efficiency.** Identifies and recoups excessive executive compensation.	Monetary – Not Determined	TBD	Unresolved
4	**Internal Control and Economy and Efficiency.** Enhances operational efficiency and reduces the risk of fraud, waste, and abuse.	Non-Monetary	TBD	Open

[18] This column provides the status of a recommendation as of the report date. For final reports, "**Open**" means management and the OIG are in agreement 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. If a completion date was not provided, the date of management's response is used. "**Unresolved**" means that management has neither agreed to take the recommended action nor proposed satisfactory alternative actions to correct the condition.

EXHIBIT B. CONCERNS REGARDING INDIVIDUAL DEVELOPMENT, INC. (IDI)

This audit was initiated at the request of the former Director of the Medical Assistance Administration (now Department of Health Care Finance (DHCF)), due to concerns over funds paid to privately-operated ICFs/DD, particularly IDI. Concerns and the results of our review are shown below.

Concern No. 1. IDI received excessive payments for its ICFs/DD.

Results. IDI received excessive payments of at least $175,750 in CY 2008. A detailed review of 3 months of CY 2008 costs for 3 of 11 facilities operated by IDI identified $148,750 of unsupported consulting fees and $27,000 of other cost inefficiencies.[19] Consulting fees are allowable costs based on an evaluation of whether the fees are reasonable and customary. As described in the audit report, DHCF did not perform desk audits or on-site audits that could have determined the reasonableness of these consulting fees.

Concern No. 2. IDI corporate officers received excess compensation and inappropriate personal loans.

Results. IDI corporate officers received excess compensation in CY 2008 of between $105,000 and $156,000 and inappropriate personal loans of $359,321.

Excess Compensation. The IDI president (and board chairman) received compensation of about $261,000 in CY 2008 while the Chief Executive/Financial Officer received compensation of about $204,000. We consider this compensation to be excessive based on industry standards[20] of $180,000 and $130,000 for the top two positions in health care companies. As described in the audit report, DHCF did not establish executive compensation limits. See pages 5 and 6 of this report for more detailed information about excessive compensation paid to IDI and other ICF/DD providers.

We also question whether the compensation of the IDI president complies with 29 DCMR § 972.3, which states that the salary of owners of a facility performing management duties may be included as allowable costs to the extent their time is documented. Not only did the IDI president not personally prepare or certify his time, but during the time that our audit team was on-site at the IDI offices, the president's Chief Executive/Financial Officer appeared to perform the day-to-day management of the company.

[19] The $175,750 ($148,750 plus $27,000) represents the annual amount of unsupported consulting fees and other cost inefficiencies identified during our review of costs for the 3 month timeframe. The $148,750 consists of unsupported consulting fees of $12,395 per month and other cost inefficiencies of $2,250 per month.
[20] We used a D.C. non-profit salary survey performed by Professionals for NonProfits, http://www.nonprofitstaff.com (last visited April 30, 2009).

EXHIBIT B. CONCERNS REGARDING INDIVIDUAL DEVELOPMENT, INC. (IDI)

Personal Loans. The IDI president (and board chairman) and another board member received loans from IDI totaling $359,321 in 2001 and 2002. According to D.C. Code § 29-301.28 (2001), "[n]o loans shall be made by a [non-profit] corporation to its directors or officers." In addition, these loans were still outstanding in CY 2008, more than 5 years later.

Concern No. 3. IDI payroll does not appear valid because the 2006 federal tax filing indicates that non-management compensation totaled $5.6 million, which would support about 112 employees at an annual salary of about $50,000 and IDI does not employ that many people.

Results. We determined that IDI paid 254 and 245 full-time or part-time employees for pay periods ending October 25, 2008, and January 17, 2009, respectively. The payroll represented 206 and 197 full-time equivalents, respectively. The average annual salary of each of these full-time equivalents was $31,826 or a total yearly average of $6.4 million. IDI also contracted for nursing assistants and licensed practical nurses for coverage when facilities were short personnel.[21] To verify the accuracy of the payroll, we traced sample payroll transactions to accounting and payment records. We also visited 10 of 11 facilities and performed physical labor checks to validate that employees existed.

Concern No. 4. IDI made inappropriate payments to related organizations, which did not represent arms-length transactions.

Results. IDI made payments of $48,000 to individuals affiliated with the IDI Board of Directors, but we could not determine the reasonableness of this amount because IDI did not have documentation to support the deliverables. Title 29 DCMR § 972.17 allows the use of related organizations to furnish supplies and services under the prudent buyer concept. As described in this audit report, DHCF did not perform desk audits or on-site audits that could have determined the reasonableness of these payments and whether the transactions represented arms-length transactions.

[21] The amount of annual contracted services was minimal compared to the yearly average salaries of $6.4 million.

EXHIBIT C. CRITERIA

Criteria governing rate-setting for ICFs/DD include the Social Security Act, Code of Federal Regulations, District's State Plan, and 29 DCMR. DHCF officials are required to conduct rate-setting activities and enforce cost containment responsibilities within this legal framework in adherence to the overarching powers and duties granted by DHCF's enabling statute, D.C. Code § 7-771.07. D.C. Code § 7-771.07 (12) requires DHCF to exercise any other power or duty necessary to fulfill DHCF purposes as subscribed in D.C. Code § 7-771.03. D. C. Code § 7-771.03 states, among other things, that DHCF shall:

> ***
>
> (2) Develop a comprehensive, *efficient, and cost-effective health-care system* for the District's uninsured, under-insured, and low-income residents; [and]
>
> ***
>
> (4) Ensure that District health-care programs maximize available federal financial assistance…. (Emphasis supplied).

Social Security Act. Section 1902(a)(30)(A) of the Social Security Act (codified at 42 U.S.C. § 1396a(a)(30)(A)) requires that States:

> assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the [State] Plan at least to the extent that such care and services are available to the general population in the geographic area[.]

Code of Federal Regulations. The Code of Federal Regulations (CFR) at 42 C.F.R. § 447.250(a) contains guidance in implementing payment rates consistent with the Act. It states that the State Plan is required to:

> provide for payment for hospital and long-term care facility services through the use of rates that…are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated facilities to provide services in conformity with State and Federal laws, regulations, and quality and safety standards.

42 CFR Part 413 states that a "reasonable allowance of compensation for services to owners is an allowable cost provided that the services are actually performed in a necessary function." 42 CFR § 413.102. The CFR states that "[r]easonableness requires that the compensation allowance [][b]e such an amount as would ordinarily be paid for comparable services by comparable institutions; and [d]epend[s] upon the facts and circumstances of each case." *Id.* § 413.102(b)(2). The CMS Provider Reimbursement Manual 15 states that "[a]ny payments to an owner in excess of a reasonable level do not constitute compensation or any other allowable cost." *Id.* § 906.

EXHIBIT C. CRITERIA

DCMR. Title 29 DCMR § 968.1 implements the District's State Plan and governs the reimbursement of ICFs/DD by the District of Columbia, and states:

> Each [ICF/DD] shall be reimbursed on a prospective basis at a facility-specific per diem rate for all services provided. The facility-specific per diem rate shall be developed by establishing a base year per diem rate for each facility, subject to ceiling and indexed annually for inflation, subject to adjustments.

Per Diem rate is defined in 29 DCMR § 982.1 as "the average daily rate established by [the District] for the facility's current year expenditures." Prospective payments are "a predetermined rate based on prior year and anticipated allowable expenditures…." *Id.* Ceilings are predetermined rates that set the upper limit of reimbursement, while a median is the middle value in a distribution, above and below which lay an equal number of values. *Id.*

Title 29 DCMR § 968.2 also states that the base year costs shall be calculated using the lower of actual audited costs or a percentage of the peer group median costs for those cost categories subject to the median ceilings. Section 968.13 provides that healthcare-related expenditures,[22] routine and support expenditures,[23] and administrative and general expenditures[24] are subject to the median ceilings. Title 29 DCMR § 968.12 states: "A facility's capital-related cost per diem shall be calculated by dividing total allowable capital-related costs by total inpatient days for all ICF/MR patients." Capital-related expenditures[25] are calculated based on reasonableness. See Exhibit D for a detailed description of the rate-setting process.

GAO Standards for Internal Control. GAO's Standards for Internal Control in the Federal Government provides the following:

> Internal control is a major part of managing an organization. It comprises the plans, methods, and procedures used to meet missions, goals, and objectives and, in doing so, supports performance-based management. Internal control also serves as the first line of defense in safeguarding assets and preventing and detecting errors and fraud . . . . Internal control should provide reasonable assurance that the objectives of the agency are being achieved . . . .[26]

[22] Healthcare-related expenditures include nursing, counseling, physician services, medical supplies, laboratory, physical and speech therapy, patient activities, social services, and transportation. *Id.* § 968.5.
[23] Routine and support expenditures include, but are not limited to, dietary costs, housekeeping, and plant operations and maintenance. *Id.* § 968.6.
[24] Administrative and general costs include items such as administrative and general salaries, insurance, travel and entertainment, program development, and medical records. *Id.* § 968.9.
[25] Capital-related costs include items such as equipment rental, facility rental, depreciation, property insurance, and real estate taxes. *Id.* § 968.11.
[26] GAO STANDARDS FOR INTERNAL CONTROL IN THE FEDERAL GOVERNMENT 4 (Nov. 1999).

EXHIBIT C. CRITERIA

These standards provide definitions and fundamental concepts pertaining to internal control at the federal level. However, the standards may be useful to others at any level of government. Although District government agencies are not required to follow these standards, they can use GAO's standards to provide the overall framework for establishing and maintaining internal controls and identifying areas susceptible to fraud, waste, abuse, and mismanagement.

State Plan. The District's State Plan is silent regarding regulation of compensation to Medicaid service provider facility owners. However, the State Plan provides that the Medicare Principles of Reimbursement in 42 CFR Part 413, and its interpretive guidance (Provider Reimbursement Manual (PRM) 15) shall be used to resolve issues that are not addressed in the State Plan. In general, PRM 15 requires a determination as to the reasonableness of a person's compensation to include benchmarking with compensation paid to other individuals in similar circumstances. After using the benchmarking data to produce ranges of reasonable compensation, DHCF officials would have applied other criteria such as qualifications and responsibilities of the owner, number of facilities managed, number of residents, types of services provided, and number and type of personnel employed.

Conclusion. DHCF officials are authorized to regulate Medicaid facility owners' compensation for reasonableness and may disallow payments to an owner in circumstances where executive compensation is determined to be unreasonable in accordance with Medicare regulations and guidelines. These regulations, policies, and procedures remain in effect until the new reimbursement methodology and DHCF implementing policies and procedures are implemented.

EXHIBIT D. RATE-SETTING PROCESS

Once ICFs/DD have been licensed, certified, and enrolled to participate in the District Medicaid program as providers,[27] they contact DHCF reimbursement officials to obtain a per diem rate for billing the District.

To determine a per diem rate, DHCF reimbursement officials perform the following steps:

1. Query the Medicaid Management Information System to determine whether the provider is a valid Medicaid provider (e.g., in the system as an active provider with an assigned provider number).

2. Obtain the acuity level of each client residing in the facility from the DHCF Office of Chronic & Long-Term Care.[28]

3. Review a proposed budget from the facility showing first year estimated expenses for the categories of health care, routine and support, administrative and general, and capital-related.

4. Compare the per diem rate request by expense category (excluding capital-related expenses) to the median[29] for that category and use the lower amount.

5. Review the capital-related[30] per diem request, associated expenses, and the support for the expenses and use the amount provided if reasonable.

6. Combine the four per diem rates to establish a total per diem rate.

7. Contract with CPA firms to perform an audit of provider cost reports after at least 1 year of operation for purposes of changing the provider from an interim per diem rate to a permanent per diem rate.

8. Adjust permanent per diem rates for cost of living increases when appropriate.

[27] The District assigns a provider number to each facility.
[28] The DHCF Office of Chronic and Long Term Care was previously the DHCF Office on Disabilities and Aging (ODA). In the draft audit report, we mistakenly cited the D.C. Department on Disabilities Services (DDS) rather than ODA.
[29] According to reimbursement officials, medians were established in 1996 based on audited 1993 cost reports.
[30] The median does not apply to capital-related expenses.

EXHIBIT E. DHCF POINTS AND OIG CLARIFICATIONS

We added Exhibit E to the final report because of numerous points made by DHCF in the response to the OIG draft report.

DHCF RESPONSE

DHCF officials state that specific provisions of the DHCF new reimbursement system "will mitigate OIG's prediction of future unchecked growth in executive compensation."

OIG COMMENTS AND CLARIFICATIONS

We disagree. The DHCF update of the State Plan and implementing policies and procedures does contain controls and incentives for ICF/DD providers to control the amount of compensation paid to executives. However, as discussed in the final report, at least one of those controls – limiting administrative costs to 20 percent – is not sufficient. More importantly, the potential monetary benefits identified by our audit will not be mitigated until audits are actually performed on a regular basis.

For example, the policies and procedures in effect during the time of our audit field work require on-site audits not less than every 4 years. However, DHCF officials did not enforce compliance with that requirement. The SPA and the DHCF implementing policies and procedures, which are in draft, do not specify how often audits should be performed. As a result, there is no reasonable expectation that audits will be conducted in the future if policies and procedures do not clearly contain the requirement. Further, given that DHCF has not met the projected effective date of the SPA and implementing policies and procedures, the best case scenario for obtaining and auditing cost reports and initiating recoupment efforts is May 2012. If the provider appeals the decision, recoupment efforts will not be complete until after October 2012.

The future use of the audits and other cost containment controls being developed by the DHCF is critical to identifying and eliminating unallowable costs when setting reimbursement rates. Setting rates based on cost data containing unallowable costs violates District and federal policy, and could cause rates to be inflated. Audits are also important tools for giving DHCF officials the information needed to make holistic decisions that take into consideration the cost aspect of ICF/DD services, which can be compared to providers' performance in terms of furnishing quality of care.

DHCF RESPONSE

Civil monetary penalty and other alternative sanctions for ICF/DD providers not in compliance with quality of care requirements will serve as strong incentives for providers to use Medicaid revenues for high quality service to residents rather than high executive compensation.

EXHIBIT E. DHCF POINTS AND OIG CLARIFICATIONS

OIG COMMENTS AND CLARIFICATIONS

We agree that sanctions are needed. However, without audits of annual cost reports, DHCF will not be able to identify which providers are providing quality of care at the lowest cost to the District. Such data is invaluable for developing and updating sound reimbursement policies. Further, only connecting these sanctions to quality of care does not directly address rates that allow providers to pay excessive compensation or the need for DHCF to recoup such unallowable costs. As a result, we believe that DHCF must also focus on the cost aspect when developing reimbursement policies, procedures, and methodology.

DHCF RESPONSE

DHCF has the authority to review facility-by-facility cost reports, not corporate.

OIG COMMENTS AND CLARIFICATIONS

DHCF is technically correct. However, corporate costs are allocated to cost centers (e.g., individual facilities). Each participating facility (irrespective of parent organization ownership status) submits an annual cost report in accordance with 29 DCMR § 976.1. Corporate costs are included in each facility's cost reports and, therefore, are subject to DHCF's review via desk reviews and on-site audits.

DHCF RESPONSE

The OIG implies that DHCF pays ICF/DD corporate staff. DHCF does not have the authority to control how much revenue is allocated at the ICF/DD corporate level.

OIG COMMENTS AND CLARIFICATIONS

We clarified the report to indicate that the current rates allow ICF/DD providers to pay executives excessive compensation. We believe that DHCF can contain costs without controlling how much revenue is allocated at the ICF/DD corporate level. The laws and regulations in effect provide DHCF with the tools (desk reviews and on-site audits) for identifying unallowable costs. It is our experience that most unallowable costs occur in the indirect cost category, which is where the majority of corporate expenses reside. Once identified, DHCF would have been responsible for correcting the deficiencies in the reimbursement methodology that allowed providers to pay their executives excessive compensation.

EXHIBIT E. DHCF POINTS AND OIG CLARIFICATIONS

DHCF RESPONSE

ICFs/DD do not diagnose people with developmental disabilities and by definition ICF/DD services are habilitative in nature, not rehabilitative. Also, ICFs/DD may appear home-like in the District of Columbia but they are institutional settings.

OIG COMMENTS AND CLARIFICATIONS

Because the source of our information is federal laws, regulations, and fact sheets, we did not change the language regarding diagnosis and rehabilitation in the final report to reflect these differences. However, we clarified that District ICFs/DD are institutional facilities.

EXHIBIT F. ICF/DD REVENUE AND EXECUTIVE COMPENSATION

We added Exhibit F to the final report to respond to comments submitted by three of the five providers we addressed in the draft report.

PROVIDER COMMENTS

The five providers cited as paying excessive executive compensation in the draft report were provided copies of the report and three returned comments. The following is a summary of those comments and OIG responses when necessary. The full text of ICFs/DD provider responses is included as Exhibits H-J. We performed an incurred cost audit of IDI to address issues raised by the D.C. Council. As a result, IDI's comments addressed issues in addition to excessive executive compensation.

Individual Development Incorporated (IDI)

IDI stated that Medicaid regulations do not mandate or limit the dollar amount of executive compensation other than imposing a 15 percent ceiling on administrative costs of which executive compensation is included.

IDI questioned the OIG's use of a salary study that IDI could not locate on the Internet. As a substitute, IDI made general comments about the nature of such studies and how these studies are usually general in nature and based on a national level with non-profit functions of a vastly different nature than IDI. IDI also noted that its clients are the most fragile in the District and that IDI cut spending by discontinuing a $1.2 million management contract in favor of in-house management at a savings of over $500,000 since 2002. IDI also noted that when compared to other providers included in the audit, its executives received lower compensation.

IDI noted that the regulations regarding the propriety of loans is an old provision of the D.C. Nonprofit Corporation Act instituted to protect the financial integrity of non-profits with members and donors. IDI stated that the proposed modern model acts do not contain this provision or make it optional. It is IDI's opinion that the old provision did not contemplate a non-profit such as itself that has no contributors; no membership; and is managed by a self-perpetuating board of directors who receive revenue from fees for service. According to IDI, the Act's only penalty for noncompliance is repayment of the loan. The full text of IDI's response is included at Exhibit J.

OIG COMMENTS

The OIG notes IDI's comments. However, we stand by our conclusion that IDI, along with the other providers discussed in this report, paid compensation to their executives that exceeded reasonable amounts. Further, we did not identify the 15 percent ceiling on administrative costs during our audit. Although the State Plan is silent regarding regulation

EXHIBIT F. ICF/DD REVENUE AND EXECUTIVE COMPENSATION

of compensation to Medicaid service provider owners, it mandates the use of Medicare Principles of Reimbursement in 42 CFR Part 413, and its interpretive guidance (Provider Reimbursement Manual (PRM) 15) to resolve issues not addressed in the State Plan. In general, PRM 15 requires a determination as to the reasonableness of a person's compensation to include benchmarking with compensation paid to other individuals in similar circumstances. After using the benchmarking data to produce ranges of reasonable compensation, other criteria should have been applied. Other criteria include qualifications and responsibilities of the owner, number of facilities managed, number of residents, types of services provided, and number and type of personnel employed.

The primary focus of this audit was to question excessive executive compensation paid by ICF/DD providers. As discussed in other parts of this final report, ICF/DD providers paid this excessive compensation with as little as 3 percent of revenue. IDI's comments further support our argument for periodic audits to identify changes in provider expenses, such as when officials discontinued the management contract to save $500,000 annually. If this change had been identified, the rate established for IDI could have been reduced and the District could have shared in the savings experienced by IDI.

The D.C. Council's concern with the loans related not only to the propriety of borrowing funds from the company but also the length of time the loans have been outstanding. There is the concern that the loans may be forgiven given that they originated 9 years ago (in 2001).

DC Health Care, Inc.

DC Health Care, Inc. wanted to clarify that its executive salaries were apportioned between ICF/DD and non-ICF/DD services and, as such, allocated executive compensation of $336,873 and $299,509 of the $436,891 and $406,259, respectively, to ICF/DD expenses. DC Health Care, Inc. stated that it has already taken steps to reduce salaries effective January 2010. The full text of DC Health Care, Inc.'s response is included at Exhibit H.

OIG COMMENTS

We note DC Health Care, Inc.'s comments. However, we did not perform an incurred cost audit at DC Health Care, Inc. and, therefore, cannot determine whether the provider properly apportioned the executive compensation based upon the time spent managing each service. We further note that even if we validated those figures, the executive compensation of $336,873 and $299,509 that officials state they paid the top two executives for managing the ICFs/DD is still excessive, as the modified amounts exceed our conservative limit of $180,000 by $156,873 and $119,509, respectively.

EXHIBIT F. ICF/DD REVENUE AND EXECUTIVE COMPENSATION

Wholistic Management Services (Wholistic)

Wholistic responded to the Director of DHCF and provided the OIG with a copy. Wholistic highlighted what it characterized as mitigating factors to account for its executive's salary. First, Wholistic stated that DHCF had not stipulated the scope and breath of ICF/DD executive compensation. Wholistic believed that an analysis should be done per each ICF/DD provider to better show an overall context to reasonableness of compensation given the 24-hour nature of the facilities.

In addition, Wholistic was troubled that the draft report did not reflect the entire ICF/DD community. The provider believes it is essential to the integrity of the process that all providers be evaluated under the same or similar analysis. Wholistic was also disturbed by, and expressed concern about, the creditability of the audit because the draft audit report addressed only minority-owned providers. Finally, Wholistic pointed out that only its highest paid executive received a salary considered excessive by the OIG and, when measured against the entire executive staff, Wholistic is within parameters identified by the standards. The full text of Wholistic's response is included at Exhibit I.

OIG COMMENTS

Wholistic's comments are noted. The OIG reviewed executive compensation of the entire ICF/DD community even though the draft report focused on the ICF/DD providers with the highest amount of compensation paid to the top two executives. The fact that other executives at Wholistic were paid compensation within acceptable limits does not negate the fact that the top executive received compensation of $267,297 in CY 2008, which is $87,297 more than the conservative limit of $180,000 discussed throughout this final report.

EXHIBIT G. DHCF RESPONSE

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance

Office of the Director

January 15, 2010

Charles Willoughby
Inspector General
Office of the Inspector General
717 14th Street, NW, Fifth Floor
Washington, DC 20005

Dear Mr. Willoughby:

Thank you for the opportunity to comment on the draft report summarizing the results of the Office of the Inspector General's (OIG) Audit of the Rate-Setting Process for Intermediate Care Facilities for Persons with Developmental Disabilities (OIG No. 08-2-17HC).

The Department of Health Care Finance (DHCF) has reviewed the draft and, in general, DHCF agrees with several of the OIG findings. However, DHCF has addressed many of the OIG-identified challenges in the new Intermediate Care Facilities for Persons with Developmental Disabilities (ICFs/DD) State Plan Amendment (SPA) and draft rules through:

- First, the new DHCF payment methodology which will be in effect March 1st, 2010 will mandate that ICF/DDs spend 80 percent of the rate on direct care services, which will limit administrative costs including executive pay.

- Second, DHCF will also be issuing new regulations to establish parameters around salaries of executives in the ICF/DDs by March 15th, 2010.

Detailed DHCF comments are included in Attachment A: 1) an overview of the SPA and why the DHCF SPA will address many OIG concerns; 2) suggested enhancements to the OIG analysis; and 3) comments on the recommendations. In brief, under the auspices of the DHCF proposed ICFs/DD reimbursement system, DHCF also is in the process of adding ICF/DD program staff, regulatory authority as well as internal policies and procedures to enhance ICFs/DD financial ICF/DD oversight. The Department believes that the new SPA and related regulations, as well as infrastructure changes to support the new SPA, address many OIG concerns. DHCF suggests a meeting to review this document.

Again, DHCF looks forward to a dialogue with OIG on the report. Our Associate Director for the Office of Chronic & Long-Term Care, Michael Cheek, will coordinate a follow-up meeting to review our comments.

825 North Capitol Street, N.E., Washington, D.C. 20002 (202) 442-5988 Fax (202) 442-4790

EXHIBIT G. DHCF RESPONSE

Charles Willoughby - OIG No. 08-2-17HC
January 15, 2010
Page 2

Should you have questions about this letter during the interim, please contact [redacted] on 202-[redacted] or via e-mail at [redacted]@dc.gov.

Sincerely,

Julie Hudman, Ph.D.
Director

cc: John McCarthy, Deputy Director, DHCF
[redacted] Health Care Policy and Planning, DHCF
[redacted] Associate Director, Office of Chronic & Long-Term Care, DHCF

Enclosures: Attachment A

825 North Capitol Street, N.E., Washington, D.C. 20002 (202) 442-5988 Fax (202) 442-4790

EXHIBIT G. DHCF RESPONSE

Attachment A -- DHCF Comments
Report No. OIG No. 08-2-17HC
January 15, 2010

Below are the Department of Health Care Finance's (DHCF) comments and suggestions. Our responses are broken into three categories: a) ICF/DD SPA and how it will ameliorate many of the OIG-identified challenges; b) suggested, clarifying comments on OIG research; and c) recommendation comments.

ICFs/DD SPA. In 2008 DHCF initiated development of the new ICFs/DD reimbursement methodology. The current Medicaid reimbursement system for ICFs/DD was initiated in fiscal year (FY) 1997. With the exception of implementing one-to-one services and inflation adjustments, DHCF has not modified the current system since inception.

The proposed methodology was developed in collaboration with the provider community, advocates, and sister agencies, specifically the Department on Disability Services (DDS). The proposed approach moves away from an inflexible and inefficient rate-setting methodology that is based on provider costs to a more flexible methodology based on the needs of Medicaid beneficiaries. Specifically, the new system replaces the outdated and inflexible medical and behavioral acuity criteria with a new "Level of Need (LON)" determination methodology. ICF/DD residents will be assigned one of the seven major LON categories.

Approved by the Council of the District of Columbia in July 2009, the SPA subsequently was submitted to CMS in August 2009 for review and approval. Currently, DHCF is responding to CMS questions on the SPA. The SPA will become effective on the first day of the quarter, following the quarter in which CMS approval occurred. The proposed SPA will make a number of changes that address OIG concerns:

1. Establishes a new requirement that 80 percent of each provider's "beneficiary service revenue" must be spent on direct patient care and active treatment services. Providers unable to meet these requirements will be subject to recoupment. Such a requirement will make it challenging for providers to allocate Medicaid revenues for rendered services to administrative overhead, including high levels of executive compensation.

2. Envisions a more detailed cost report with precise completion instructions. It is DHCF's intention to use enhanced cost reports for further refinement of the methodology. DHCF also will be implementing a regular cycle of provider training on how to complete such submissions. DHCF believe that the more detailed cost reports will make it difficult for ICFs/DD to circumvent the requirement discussed in item one, above.

3. Creates civil monetary penalty and other alternative sanctions for ICFs/DD that are not in compliance with quality of care requirements. Similar to item two, above, DHCF believes that the new civil monetary penalties and other alternative sanctions will serve as strong incentives for ICF/DD providers to ensure that Medicaid revenues are targeted to ensuring high quality service to residents, rather than high executive compensation.

1

EXHIBIT G. DHCF RESPONSE

Based on OIG's recommendations, DHCF also will require additional cost report information, such as:

- Requirements that ICF/DD providers report separately from their cost reports all contractual services provided by non-related parties that exceed an established threshold. In addition, ownership equity information for contracted entities with less than five owners must be provided. DHCF believes that such reporting requirements will make related parties transactions more visible to the Department. Such information will be particularly important when considering whether the provider is eligible for a temporary rate adjustment under the new SPA financially distressed provisions.

- Detailed formulas for calculating allowable Owner and Related-Party Hours, Hourly Wage Rates and Benefits. The Department believes that having an explicit policy on allowable costs will provide clear executive compensation guidelines for auditors and desk reviewers.

Additionally, DHCF has begun to collect information on states that impose limits on ICF/DD executive compensation and will aggressively explore including such requirements in our new system.

Suggested, Clarifying Comments. Below, DHCF offers clarifications on DHCF's current regulatory authority as well as comments on the research supporting the OIG analysis.

1. ***Regarding recalculation of medians, the District of Columbia State Medicaid Plan does not contain the authority or intent for regular median recalculation.*** The state plan at 4.19D, part II, Section V makes clear that medians are determined by base year costs of all then existing providers, with subsequent inflation adjustments, only. The State Medicaid Plan does not provide DHCF with the authority to regularly recalculate medians.

   DHCF agrees that taken alone, Section 969.7 of the current regulations, under "Computation of Ceilings," defines acuity categories and Section 969.8 would appear to require regular recalculation of medians. However, these regulatory provisions are intended to define and establish permanent ceilings, or medians, for all non-capital costs. When read in tandem with the Medicaid State Plan, the intent of the regulation, which DHCF agrees is vague, becomes clear -- recalculation of the health-care related median is prohibited under the Medicaid State Plan. If DHCF had rebased the medians, DHCF would have been in violation of Medicaid law and regulations. In turn, such violations would have put federal financial participation (FFP) at risk.

2. ***DHCF has the authority to review facility-by-facility cost reports, not corporate.*** DHCF sets rates and reviews cost reports for individual facilities, not corporate entities. Currently, DHCF does not have the authority under District laws and regulations to dictate how providers spend their Medicaid revenue at the corporate level. While DHCF recognizes the value of such reviews, legal authority and greatly enhanced administrative

2

EXHIBIT G. DHCF RESPONSE

resources would be needed. However, DHCF is addressing this issue with the new reimbursement system requirement that 80 percent of revenues be targeted to direct care. Additionally, DHCF is planning to include in regulation OIG suggestions based on the draft report sample of states.

3. ***DHCF offers the following additional comments on the OIG analysis:***

- **Excessive Compensation –** Beginning in the Executive Summary, OIG drafting appears to imply that DHCF pays ICF/DD corporate staff. DHCF suggest the following language, "DHCF reimburses for rendered health care services based on established rates. The Department currently does not have the authority to control how such revenue is allocated at the ICF/DD corporate level."

- **ICF/DD Overview –** On page one, OIG notes that ICFs/DD "diagnose, treat, and rehabilitate people with developmental disabilities." First, ICFs/DD do not diagnose – their contracted physicians issue orders for care. Medical diagnostic services occur in acute care settings. Second, by definition, ICF/DD services are habilitative in nature, not rehabilitative. Also on page one, OIG notes that, "ICFs/DD can be institutional or residential facilities…." While ICFs/DD may appear home-like in the District of Columbia, they are institutional settings as per the federal definition.

- **New Reimbursement System will Address Future Executive Pay Escalation –** OIG draws the conclusion that, "if [current DHCF] practice continues until October 2012 when DHCF plans to rebase the rates, ICF/DD executives may receive up to $4.7 million more in excessive compensation." However, the OIG estimate is premised on the State Plan and does not include the array of executive compensation checks and balances that will be included in the implementing regulation. Therefore, the OIG scenario will not occur because of the new reimbursement system currently under review by CMS and related regulations. On pages two and three of this document, DHCF describes specific provisions contained in the new reimbursement system that will mitigate OIG's prediction of future unchecked growth in executive compensation.

- **Exhibit D. Rate-Setting Process** -- On page 16, item two, OIG indicates that DHCF, "Obtains from the Department on Disability Services [(DDS)] the acuity level of each client residing in the facility." This is inaccurate. DHCF determines ICF/DD resident acuity levels and conveys that information to DDS and the ICF/DD providers.

Recommendation Comments. Based on the information, above, DHCF offer the following observations on the OIG recommendations:

3

EXHIBIT G. DHCF RESPONSE

- **Recommendation #1: Establish and implement cost-containment controls such as compensation caps to ensure that ICF/DD rates do not result in excessive compensation to executives.**

  DHCF Response: DHCF reimburses for services rendered to ICF/DD beneficiaries, not for corporate operations. Therefore, our monitoring and oversight is structured to ensure delivery of services not to monitor corporate operations. Specifically, DHCF currently lacks the authority to limit executive compensation. However, under the new reimbursement system which is currently under CMS review, DHCF includes a requirement that at least 80 percent of Medicaid revenues be targeted to direct care; the new system should be implemented expeditiously. Additionally, DHCF is working with HRLA to add local licensing requirements for a distinct Governing Body (i.e., a Board of Directors) composed of persons who are not managerial or executive staff with the provider agency. Such a requirement will add an internal provider check on executive salaries.

- **Recommendation #2: Implement existing internal controls, such as performing audits of cost reports, to identify and recoup unallowable costs and to verify that reimbursement rates are accurate.**

  DHCF Response: DHCF's current regulatory structure, as noted above, is targeted to oversight of individual facilities, not the corporation or parent organization of each facility. However, the DHCF Health Care Accountability Administration will launch a review of ICF/DD service delivery and billing to determine whether OIG-examined ICFs/DD were inappropriately reimbursed for services or submitted fraudulent cost reports. Additionally, DHCF will work with the Office of the Attorney General to explore other recovery options under District law and regulation.

- **Recommendation #3: Immediately review executive compensation of the ICF/DD providers not included in our audit to identify and recoup any executive compensation determined to be unreasonable.**

  DHCF Response: The audit processes under the new reimbursement system will contain detailed formulas for calculating allowable owner and related-party hours, hourly wage rates and benefits. DHCF's inclusion of explicit policy on allowable costs will provide clear executive compensation guidelines for auditors and desk reviewers. Additionally, DHCF has begun collecting information on states that impose limits on ICF/DD executive compensation and will issue new regulations to enforce executive pay limitations.

- **Recommendation #4: As part of management oversight, perform a periodic evaluation of the reimbursement office to determine whether actual operations comply with District and federal laws and regulations.**

  DHCF Response: As part of the transition from the Department of Health Medical Assistance Administration (MAA) to an independent Department, DHCF has undertaken

4

EXHIBIT G. DHCF RESPONSE

a review of all internal operations. Subsequently, DHCF implemented an organizational realignment to better target staffing with departmental functions and has developed an array of internal policies and procedures. As part of this broader effort, DHCF will pursue the addition of ICF/DD program staff FTE to enhance oversight and support implementation of the new reimbursement system. Additionally, DHCF will draft internal policies and procedures to guide DHCF ICF/DD staff oversight activities. Such internal policies and procedures will contain provisions for periodic evaluation of ICF/DD reimbursement activities to ensure practices comply with District and federal laws.

5

EXHIBIT H. DC HEALTH CARE, INC. RESPONSE

DC Health Care, Inc.
429 Florida Avenue, N.E.
Washington, D.C. 20002

January 4, 2010

Attn.[redacted]
DAIG –Audits

Charles J Willoughby
Inspector General
717 14th St NW
Washington, DC 20005

Ref.08-2-17HC

Dear Sir,

Thank you for the report on rate setting process for Intermediate Care Facilities.

We would like to bring to your kind attention that the salary referred on pages five and six of the report includes non ICF salary also. Since the report is solely on ICF the highest salary should be $336,873.32 and the second highest is $ 299,509.84 as per the payroll data (on page 1 of 26) provided to the auditors. The W2s reflects the salaries paid for ICF as well as non ICF programs. Please see attachments 1 and 2.

Based on your recommendations we have taken the steps to reduce the salaries of the executives effective January, 2010.

We also want to express our willingness to work with the DC Department of Health Care Finance on the implementation of the rate setting process and other reforms.

If you need any further information please feel free to call me or [redacted] at 202-547-2008.

Sincerely,

Gracy Stephen

Gracy Stephen
President

☎: 202-547-2008/ 547-2333/ 547-2018
✉: dchealth@verizon.net
🖷: 202-547-2331
web: www.dchealthcare.com

EXHIBIT I. WHOLISTIC MANAGEMENT SERVICES, INC. RESPONSE

WMS
WHOLISTIC MANAGEMENT SERVICES, INC.

1221 MASSACHUSETTS AVENUE, NW, SUITE 1, WASHINGTON, DC 20005
PHONE 202-347-5334 FAX 202-347-1916 whs118@aol.com

Julie A. Hudman, Ph.d
Director
DC Department of Health Care Finance
825 North Capitol Street NE, Suite 500
Washington, DC 20001

January 7th, 2010

Dear Ms. Hudman,

This letter is an official response to the Office of Inspector General's report on ICF/DD's and excessive Executive Compensation completed on or about December 21st 2009. It is our position, that though Executive Compensation is a critical factor in the audit process the report as configured does not discuss mitigating factors. We would like to provide you with additional information that we believe will add context to better understanding the nuance involved this issue. Nonetheless, please be advised that we intend to comply with any regulation put forth by your agency that establishes how ICF/DD's should treat executive compensation. As stated in the report, your agency has yet to stipulate what the scope and breath of executive compensation is in ICF/DD. With that being said, we believe analysis per ICF, (we operate 8, in addition to 13 waiver settings and an Active Treatment Program with a roster of 95), provides a better overall context to what is reasonable in terms of compensation given the 24 hour ongoing nature and degree of scrutiny inherent in an executive position.

In addition and most importantly, we are troubled that the report does not reflect the entire ICF/DD community. We believe that it is essential to the integrity of the process and that all ICF/DD providers be evaluated under the same or similar analysis as this report. Moreover, a comprehensive analysis of the entire system is needed. The fact that providers identified by the OIG report are all minority-owned providers is disturbing and may seriously undermine the credibility of this process.

EXHIBIT I. WHOLISTIC MANAGEMENT SERVICES, INC. RESPONSE

Also, we believe the reports failure to acknowledge that our second-in-command staff in addition to our CEO/President in the aggregate substantially reduce the roughly $87,297 identified as excessive compensation is unfair. In fact, no other staff, except the President/CEO earns a six figure salary. By shifting or reallocating resources to suit the caps determined by the report the excess identified is virtually eliminated. Again, we reiterate, that we intend to fully comply with any regulatory scheme that addresses this issue.

Additionally, we would like to kindly remind you that we consider ourselves one of your premier ICF providers. This is supported by the fact that: we have received numerous commendations on the quality of services from the Evans Court Monitor; we are actively involved in the DC Coalition of Providers for Persons with Intellectual Disabilities which provides leadership on policy to the District as well as best practice on issues that affect with adults Intellectual Disabilities; and we have gone 18 months without a Condition of Participation or an Immediate Jeopardy in any of our ICF's (I believe no other ICF provider can assert this).

We look forward to dialoguing with you on the matter as we work collectively to address the relevant issues of the day. Please feel free to contact us if any issues or concerns pertaining to this letter. We thank you in advance for your anticipated dialogue.

Very Truly Yours,

Ilara Z. Thomas

President and CEO

EXHIBIT J. IDI RESPONSE

INDIVIDUAL DEVELOPMENT, INC.

Chairman of the Board and President
David W. Wilmot

Vice President
Frederick D. Cooke, Jr.

Secretary and Treasurer
A. Scott Bolden

Chief Executive Officer
Ronald C. Raghunandan

February 26, 2010

Mr. Charles J. Willoughby
Inspector General
DC Office of the Inspector General
717 14th Street, N.W.
Washington, DC 20005

RE: **RESPONSE OF IDI TO CONCERNS CITED IN OIG No. 08-2-17HC (EXHIBIT B)**

Dear Inspector Willoughby:

Please accept this Memorandum in response to the Concerns Regarding IDI (Exhibit B) cited by the Office of the Inspector General (OIG) in its draft Audit of the Rate-Setting for Intermediate Care Facilities for People with Developmental Disabilities dated December 21, 2009 which we received on January 25, 2010 (referred to as the Audit).

Concern No 1 - Excessive Payments

IDI cannot determine from the Finding the particular consulting fees and cost inefficiencies to which OIG refers. However, IDI believes the consulting fees are reasonable and customary as well as necessary to performing the duties of IDI under its provider agreements.

Concern No, 2 - Excess Compensation and Loans

A. Excess Compensation

The Medicaid regulations do not mandate or limit the dollar amount of executive compensation other than imposing a 15% ceiling on General Administrative Costs of which executive compensation is one cost element.

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1420 N Street, NW, Suite 9
Washington, DC 20005
202-518-0314 202-518-9685 Fax

Operations Office
6401 New Hampshire Avenue, 2nd Floor
Hyattsville, Maryland 20783
301-270-8702 301-270-8012 Fax

EXHIBIT J. IDI RESPONSE

Page 2
February 26, 2010

Without any regulation on the issue, OIG determined that the compensation was excessive by referring to a salary study performed by "Professionals for NonProfits" at www.nonprofitstaff.com. When accessing this URL, a website identified as "scionnonprofitstaffing.com" appears. Scion describes itself as a recruitment and placement agency for nonprofit organization employees. No such salary study appears on the website. Consequently, IDI is unable to adequately respond to this Concern. However, upon information and belief, this study as well as other such studies view salaries in general terms as an average across all types of nonprofit organizations at a national level. They do not consider differences based on regional or local circumstances or the vastly different functions and purposes of nonprofits. In particular, they do not distinguish between nonprofits which perform charitable /educational functions and nonprofits which perform fee for service functions on a business basis under contract such as IDI.

Moreover, any salary comparison within the ICF/DD community of providers must take into account the fact that the individuals in IDI are among the most medically fragile in the system. Note that prior to 2002, IDI was managed by a management consulting company to which IDI paid a management fee of about $1.2 million a year. This fee was paid under General Administrative Costs. In 2002, due to deficiencies in the performance by the management company, IDI took the management function "in house". IDI estimates that the difference between the executive compensation and the management fee has resulted in savings of over $500,000.00 since 2002.

Note that based on Table 1 of the Audit at p.5, the compensation of IDI is the lowest in the Highest Paid Executive Category and the second lowest in the Second Highest Paid Category.

B. Personal Loans

The provision to which the Finding refers is contained in the current DC Nonprofit Corporation Act (referred to as the Act) which was enacted in 1962. The Act has not been amended in any substantive manner since the date of enactment. At the time of enactment, most nonprofits were membership based organizations in which members contributed or donated to the corporation and elected its directors. The intent and purpose of this provision was to protect the integrity of the financial contributions and donations made by members and donors.

The provision does not contemplate a nonprofit like IDI. IDI has no members, no membership contributions, no donations, is managed by a self perpetuating board of directors and its revenues derive solely from fees for services rendered on a business basis under a contract. Consequently, members and donors, which are the classes of persons which the

EXHIBIT J. IDI RESPONSE

Page 3
February 26, 2010

provision was meant to protect, do not exist in IDI. Other than liability for repayment, the provision does not prescribe any particular penalty. Note that the proposed modern model acts on nonprofit corporations which have been recommended for adoption either do not contain this provision or make it optional to the corporation.

Concern No. 3 - Payroll

This Finding does not require a response.

Concern No. 4 - Payments to Related Organizations

IDI believes it can support the deliverables.

Please feel free to contact me if you have any questions or concerns.

Sincerely,

David W. Wilmot
Chairman of the Board and President