State of Rhode Island and Providence Plantations
Office of Management and Budget
OFFICE OF INTERNAL AUDIT
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January 3, 2019

Dear Director Boss:

The Office of Internal Audit has completed its audit of the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals. The audit was conducted in accordance with Rhode Island General Laws (RIGL) § 35-7-3. The recommendations included herein have been discussed with members of management, and we considered their comments in the preparation of this report.

RIGL § 35-7-3(b), entitled *Audits performed by bureau of audits*, states that, "Within twenty (20) days following the date of issuance of the final audit report, the head of the department, agency or private entity audited shall respond in writing to each recommendation made in the final audit report." Accordingly, management submitted its response to the audit findings and recommendations on January 2, 2019, and such response is included in this report. Pursuant to this statute, the OIA may follow up regarding recommendations included in this report within one year following the date of issuance.

We would like to express our sincere appreciation to the Division of Developmental Disabilities staff for the cooperation and courtesy extended to the members of our team during the course of this audit.

Respectfully yours,

Dorothy Z. Pascale, CPA
Chief

c—Jonathan Womer, Director, Office of Management and Budget
   Honorable Daniel DaPonte, Chairperson, Senate Committee on Finance
   Honorable Marvin Abney, Chairperson, House Finance Committee
   Rebecca Boss, Director of the Rhode Island Department of Behavioral Healthcare

AUDIT Executive Summary

Why the Office of Internal Audit Performed This Review

This limited scope audit was performed and based upon our risk assessment. The purpose of this engagement was to determine if operations at the Division of Developmental Disabilities are being administered efficiently and effectively in accordance with applicable laws, rules, and regulations and if adequate controls are in place to ensure safeguarding of assets and accurate reporting.

Background Information

The Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) has three major operational divisions: Behavioral Healthcare, Developmental Disabilities, and the state hospital system.

The Division of Developmental Disabilities is responsible for planning, funding and overseeing a community system of services and supports for adults with developmental disabilities.

The OIA Recommends:

• Updating agency guidance to provide specific documentation requirements for each service category.

• Publishing billing criteria standards to the BHDDH service provider information web site.

• Designing and implementing a control mechanism to provide assurance that invoiced services are provided.

• Evaluating the current billing code system to determine if it can be simplified without sacrificing data integrity.

• Implement stronger data validation controls into the new case management system currently under development.

• Enforcing billing standards to ensure that claims data is submitted in a uniform format.

• Integrate an electronic approval mechanism into the case management system.

Contents

Introduction

The Division of Developmental Disabilities funds a statewide network of privately-operated and publicly-operated community supports for adults with developmental disabilities. The Division is responsible for planning, administering, and providing supports for this adult population. The goal of the division is to foster a culture for individuals with developmental disabilities to live a satisfying and fulfilling life in an integrated, community-based setting. This is achieved through the implementation of their mission: to provide an integrated, community-based system of services and supports for adults with developmental disabilities (DD) while safeguarding the health and safety of people with DD, promoting human rights, and ensuring equitable access to and allocation of available resources to be responsive to the needs of each individual.

BHDDH uses the Supports Intensity Scale (SIS) assessment tool to evaluate the needs of each program participant and assign them to a tier of services from "A" being the lowest level of funding and "E" being the most intensive. The SIS is a standardized set of questions, published by the American Association of Intellectual and Developmental Disabilities (AAIDD), asked in an interview style setting. Present at this interview are: a BHDDH SIS assessor, the applicant, and at least one person who knows the applicant on a personal level.

Participants' behaviors and needs vary significantly from day-to-day. On a given day, an individual may have few symptoms of behavioral issues and therefore require limited assistance from staff members; the next day, the same individual may have extreme behavioral outbursts and require substantial assistance from staff and caretakers. The SIS assessment is intended to evaluate the needs of each individual. Once a SIS assessment has been completed, individuals create, with the assistance of an agency and/or plan writer, the individualized service plan (ISP) specific to the needs of the participant. These ISPs are designed to develop employment opportunities, continue to facilitate community integration as an alternative to institutional placements. Also considered is the expansion of services and community integration for individuals who require ongoing assistance but may successfully live outside of traditional residential settings.

The methodology underlying the SIS categorization system is a de facto acknowledgement of the difficulty in determining a service intensity on a service-by-service-basis. To overcome this weakness, the understanding between providers and BHDDH has been that the SIS assessment is the determinant of the average intensity of services required to be delivered to a given participant. Providers staff their programs in accordance with the assessed average needs of the participants therein and provide services according to the daily needs of the individual regardless of assigned tier. Our test work did not provide evidence that the providers failed to deliver the intensity of the services billed during the period in question.

Background

During November 2016, BHDDH implemented an updated version of the SIS assessment tool; this updated version is known as the SIS-A. Currently, Rhode Island is one of twelve states that use the SIS-A for budget allocation related to Developmental Disabilities. Due to a misinterpretation of certain questions within the SIS assessment interview, 46 individuals were incorrectly assessed at a higher tier level during the period of January 1, 2017- December 31, 2017. Because of this error, service providers designed treatment plans and billed for services for these individuals at a higher acuity level consistent with the SIS level assessment. Our test work included sampled transactions from this period to determine if the service providers delivered the higher level of services billed for each participant. All invoices were at the assessed SIS levels.

As explained within the "Recommendations and Management's Response" section of this report below, certain issues with documentation standardization and data integrity limit the ability to confirm the service delivery levels. In many instances, service providers can prove that services were delivered, but not at a specific intensity level.
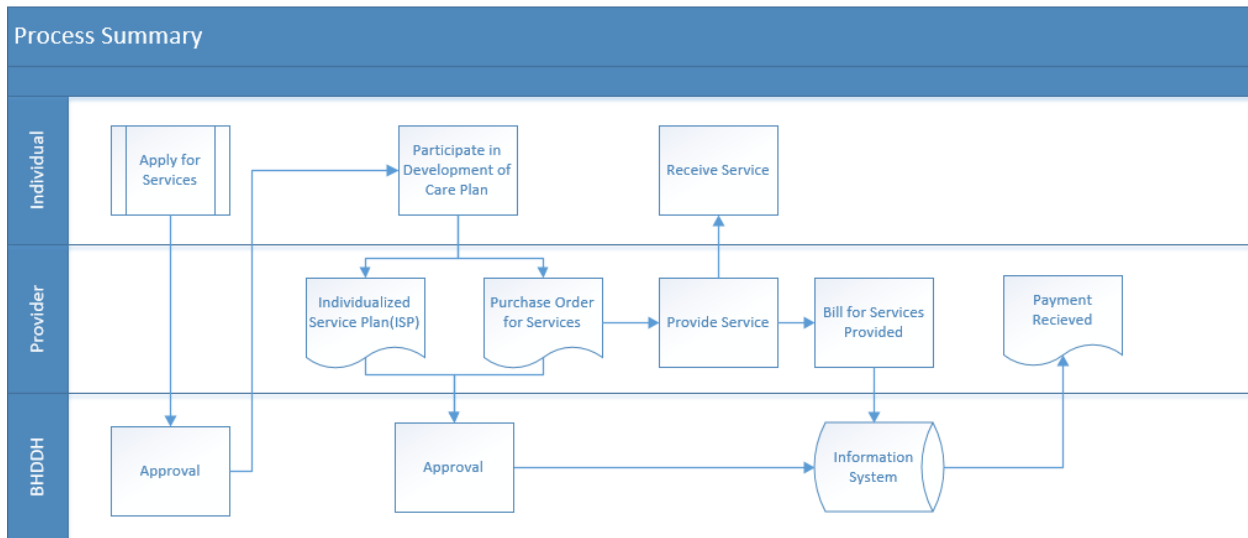
Recommendations and Management's Responses

Agency Budget Process Background

BHDDH is required by federal law to approve individualized care plans to all program participants receiving state services. As such, it must have processes in place to assess the needs of the participant, design treatment strategies, and budget the funds for those plans accordingly. Currently, BHDDH determines the needs of an individual using the SIS assessment, then an authorized provider designs an Individualized Service Plan (ISP) in coordination with the individual. Once the plan is designed, it is submitted to BHDDH along with a Purchase Order (PO) for approval. The POs are divided into four service categories which are independently calculated to form the overall budget:

- Support Services,
- Residential,
- Transportation, and
- Day Program Services.

Once the ISP and accompanying purchase order are approved by BHDDH administration, the provider is authorized to begin delivering services. The flow chart below depicts the process from application to payment.

Process Summary

Individual: Apply for Services → Participate in Development of Care Plan → Receive Service

Provider: Individualized Service Plan(ISP) → Purchase Order for Services → Provide Service → Bill for Services Provided → Payment Recieved

BHDDH: Approval → Approval → Information System

ISP and PO forms are approved through departmental signatures on original documents. Once the approvals are obtained, the information from the POs are input manually on a quarterly basis to the BHDDH information system. This information system is designed to process claims against the approved budgets as providers submit bills.

Improve Budgetary Approval Controls

Organizations must implement controls over the purchase of services to assure that third parties are authorized to provide services within an approved budget. This requires both an authorization and monitoring component within the control environment so:

- The authorization function includes an appropriate organizational representative who approves the service and the agreed-upon cost.
- The monitoring function is comprised of controls which ensure that the service provider is not paid more than the approved amount after the service has been delivered.

With these controls in place, it is unlikely that service providers would be overpaid for approved services or paid for unapproved services. The OIA requested a sample of 60 budget-quarters to assess the effectiveness of the associated controls. The planning, budgeting, and approval processes at BHDDH are paper-driven and require substantial human resources to organize, document, and review the documentation for each participant on a quarterly basis. The information systems currently in place are not integrated, and therefore require staff to perform significant manual data input and work duplication. BHDDH was unable to provide any supporting documentation for six (6) (10%) of the sixty budget-quarters requested[1].

The OIA performed test work on the remaining 54 budget-quarters noting:

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[1] See *Objective and Scope* on page 13 for more information about the documentation received from BHDDH.

- 32 instances (59%) of the tested samples lacked documented evidence of BHDDH staff ISP approval.
- None of the POs reviewed had documented evidence of approval by BHDDH staff.

In addition to the lack of documented approvals, the OIA found the following weaknesses with the purchase order controls:

- Request for additional funding (L9s) are documented in dollars on purchase order forms but the information system enforces the budgets based on units of service. This complicates budgetary approval for providers and participants while limiting the effectiveness of budgetary enforcement by BHDDH.
- The BHDDH information system uses only the "Health Care Procedure Code" (HCPC) to enforce budgets. However, these HCPS's may be altered by providers to more expensive treatment using "modifier codes." The OIA found one instance in which a provider overbilled for services using an unapproved modifier code. While the total overbilling for this control breakdown was not significant ($1,094 out of a total of $666,787 or 0.2% of services reviewed) it is a control weakness which should be addressed to reduce the risk of vendor overpayment.

Recommendations:
1. Integrate an electronic approval mechanism into the case management system. This system should have an automated control which requires that the ISPs and POs are approved by the assigned social worker before spending is authorized.
2. Implement automated controls which restrict provider service reimbursement over the budgetary limits approved in the purchase order.
3. Streamline additional funding requests by using the same authorization standards of "units of service" as purchase orders.
4. Improve information system to enforce HCPC modifier codes.

Management's Response:

As current practice, Division fiscal staff send submitted ISP packages (which include the PO) to the assigned social caseworker (SCW) for review via email. Once the SCW has sent an approval (also via e-mail), fiscal staff includes a hard copy of the approval along with the ISP and PO. These hard copies are filed. For the time frames included in the audit, all files were in storage due to the department's temporary relocation to a different office building, and staff were unable to access the files in the time-frame requested. A new process was enforced in 2018 that saves an electronic copy of the approval along with the ISP and PO.

On the fiscal side, when an ISP package is approved by a SCW, the division fiscal staff also review the PO for accuracy. If correct, fiscal staff sign a (hard copy) cover sheet and save with the ISP and PO and enter the amounts on the PO into the electronic debit authorization system. No authorizations are entered unless fiscal has reviewed the PO for accuracy. As noted above, the hard copies for the requested time frames were in long-term storage.

Regarding the issue of overbilling, the division is currently working on a strategy to exercise the appropriate controls on a purchase order's budget while still retaining flexibility for the consumer. As part of this review the Department will also review areas where the purchase orders and information system enforcement are consistent in terms of units of service and dollars. However, it is imperative that modifier codes continued to be used within the current billing system. These codes are tied to staff ratios and are used to deliver individualized services based on acuity.

Lastly, the division is in the process of implementing a new electronic case management system (Therap), to be implemented in FY2020. This system will also include a fiscal component that will allow for more efficient and streamlined authorizations, all within an electronic system, and will address the approval issues noted.

Responsible Party: Division Fiscal Staff- Evelyn Shapiro and Colleen Masterson (Leads)

Anticipated Completion Date: Approval process for hard copies will continue as noted above and new electronic storage is implemented immediately. The new case management system is currently being developed; the fiscal portion is estimated to come online in FY2020.

Lack of Guidance for Billing Documentation Requirements

To hold third parties accountable, organizations must clearly define expectations by documenting rules and performance measures. Third parties must be notified of these expectations. This can be accomplished in a variety of ways including through laws, published regulations, or contracts. The first step to establish a system of accountability is defining the responsibilities of all interested parties.

Billing guidance issued by BHDDH relies heavily upon a general requirement that providers maintain adequate documentation to support claims. The guidance states:

> *Ensure that you maintain sufficient documentation to support the services billed and the number of units billed. When services are defined by levels which presume specific staffing levels, then weekly schedules and/or payroll timesheets are examples of documentation to retain to support what was billed. Attendance sheets showing time in/out for Participants are another source of documentation. Refer to the rate models for staffing assumptions.*

The OIA reviewed all 17 service categories offered by BHDDH and was unable to find specific documentation requirements for 12 of the categories. Service provider billing criteria has been removed from published regulations and has not been made publicly available. While BHDDH administrative staff noted that DD staff visit service provider locations to discuss documentation and billing requirements, this is not an adequate mitigating control for clear and documented guidance.

The OIA reviewed a sample of 152 transactions for the period of October 1, 2016 through September 30, 2017 to evaluate the quality of support maintained by service providers for billed claims. The OIA found significant weaknesses with the support maintained by these providers.

- In 10 instances (6.5%) providers were unable to provide documentation to support the billed claim.
- In 31 instances (20.4%) the providers submitted documentation that the OIA classified as "weak" support for the claim[2].

Additionally, a standardized service provider documentation is lacking. OIA found material variation of the documentation maintained by service providers to support charges billed to BHDDH. For example, during our review of day program charges, the OIA found the following:

- 23% of service providers retained a participant signature as evidence
- 60% maintained a participant attendance sheet
- 40% included a detailed narrative/case note
- 33% included employee time sheets

The complete summary of support received is provided below:

Service Category	Total Number of Samples	Participant Signature	Attendance Sheet	Narrative/ Progress Report	Employee Timesheets
Assistive Technology	1	0%	0%	100%	0%
Attendant Care	2	100%	100%	100%	100%
Community Residence Supports/ SLA	40	0%	85%	20%	3%
Community-Based Supports	20	10%	90%	25%	65%
Day Activity Transportation	10	0%	80%	10%	20%
Day Program (center/community-based)	43	23%	60%	40%	33%
Day Program (Home-Based)	3	0%	67%	33%	33%
Homemaker Services	1	100%	0%	100%	100%
Job Coaching	3	0%	33%	33%	33%
Job Development	3	0%	0%	33%	0%
Job Retention	2	0%	0%	0%	0%
Natural Supports Training	2	0%	50%	0%	50%
Non-congregant residential supports	8	13%	100%	13%	0%
Prevocational Training	4	0%	100%	0%	25%
Respite Care	4	0%	100%	75%	25%
Support Coordination	4	0%	75%	25%	25%
Supports Brokerage, Self Directed program	2	100%	0%	0%	0%

This lack of required standardized supporting documentation with service providers indicates that a uniform understanding of documentation requirements does not exist.

Recommendation:
5. Update agency guidance to provide specific documentation requirements for each service category and communicate to the service providers.
6. Compile all provider billing guidance into a single comprehensive handbook.

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[2] For the five service categories in which documentation requirements were defined in BHDDH policies, the OIA classified any service which did not meet all those requirements as "weak." In the absence of formal policies for the remaining twelve service categories, the OIA discussed and agreed upon minimum documentation standards with BHDDH management.

7. Publish billing criteria standards to the BHDDH provider information web site.

Management's Response: In the past, a provider billing information was provided and published on the Division's website. With past changes in administration and with the process of regulations reform, this information was removed from the website. The Division is currently working on updating the provider billing manual, which will be a single document available to all providers and will include standards for documentation, as well as documented policies and procedures for the DD Fiscal Unit. The document will be updated as necessary and communicated to providers. This document will be published on the BHDDH provider information website.

Responsible Party: Division Fiscal Staff- Evelyn Shapiro and Colleen Masterson (Leads)

Anticipated Completion Date: By the end of CY 2019.

No Billing Verification Function

Effective controls over the purchase of services provide management with assurance that purchases are:

- Necessary to achieve the mission and operation of the business;
- Authorized by appropriate organizational decision-makers; and
- Delivered in accordance with contract terms.

Review and confirmation of billings is important to ensure that services paid for were provided.

DD providers invoice the state for services through an electronic billing system. These invoice lines are automatically processed and paid in accordance with the approved care plan established for the program participant. BHDDH does not have controls or processes in place to oversee and monitor service provider billings and ensure services are delivered.

The Developmental Disabilities unit has not identified a service delivery confirmation process as a necessary control to mitigate the risk of service provider overpayments or services delivered out of scope of the contracted terms. In a standard business environment, this is achieved through matching invoices to bills of lading or by an authorized representative approving a service invoice. The nature of the services rendered by providers limit the practicality of this system because of the high volume of transactions that occur during each billing period. Additionally, the complexity of the evidentiary documentation maintained by providers requires time and expertise by BHDDH staff to perform a review. Verifying each service would require significant expense to review all transactions before payment.

Without adequate controls in place, service providers may bill the state without providing services or without providing the level of service required. The OIA reviewed a sample of 152 transactions over a 9-month period to test these controls. We found 49 transactions (32% of our sample) in which the documentation maintained by the providers did not fully support the charges paid. These questioned charges totaled $68,837.

Service Category	Sum of Paid Amount	Sum of Unsupported Charge
Assistive Technology	$ 2,014.75	$ -
Attendant Care	$ 1,258.40	$ (38.00)
Community Residence Supports/ SLA	$ 247,835.10	$ (18,355.32)
Community-Based Supports	$ 41,822.41	$ (5,535.22)
Day Activity Transportation	$ 7,603.10	$ (2,916.52)
Day Program (center/community-based) or Prof Supports while at Day Program	$ 102,429.03	$ (23,582.79)
Day Program (Home-Based)	$ 4,534.88	$ (155.33)
Homemaker Services	$ 2,056.40	$ -
Job Coaching	$ 4,345.18	$ (275.52)
Job Development	$ 6,171.12	$ (3,851.52)
Job Retention	$ 1,875.00	$ -
Natural Supports Training	$ 496.63	$ -
Non-congregant residential supports	$ 47,004.21	$ (2,090.59)
Prevocational Training	$ 8,244.40	$ (4,803.36)
Respite Care	$ 14,283.84	$ (4,715.88)
Support Coordination	$ 2,111.14	$ (1,017.40)
Supports Brokerage, Self Directed program	$ 1,850.00	$ (1,500.00)
Grand Total	**$ 495,935.59**	**$ (68,837.45)**

Of the $68,837 questioned costs, $18,355 (27%) occurred in the day program and $23,583 (34%) in community residence supports.

Examples of documentation weaknesses leading to the questioned costs above include but are not limited to:

- Miscalculations of units of service provided by service providers
- SLA charges supported only by employee time sheets; no evidence of participant occupancy included
- No documentation of trip destination for transportation charges
- Backup did not identify participant under care

Recommendation:
8. Design and implement a control mechanism to provide assurance that invoiced services are provided. To improve oversight of vendors, consider performing risk assessments to identify the level of effort needed for each provider and implementing a system of statistical sampling to gain assurance about service provider billing compliance.

Management's Response: The Department agrees that oversight and monitoring of providers' billing documentation practices must be enhanced. The Department is developing an internal auditing system for the DDOs and the most utilized services. The Department does not have the appropriate resources to provide this level of oversight and needs two FTE positions to implement this system and will work with OMB and EOHHS to obtain these resources.

Responsible Party: Carmela Corte (BHDDH CFO), Jonathan Womer/Tom Mullaney (OMB Director and Budget Officer)

Anticipated Completion Date: Fiscal year 2020

Improve Billing Data Integrity
Provider Billing

To obtain reliable and useful data, billing systems must capture information at the relevant level of detail while identifying and minimizing errors. It should also be sufficiently practical, user-friendly, and cost-effective to obtain provider compliance.

Clinical billing data is used for a variety of purposes which all require a high degree of accuracy including:

- Macro analysis of claims information for budgeting and trend analysis
- Accurate remuneration of service providers
- Insight into service needs of program participants
- Evaluation of service providers and determination of conformance with approved care plans

There are inherent cost-benefits associated with different billing data collection approaches. A simplified billing concept such as a flat-fee or per diem rate has lower associated expenses and documentary requirements but may not provide the level of detail required for complex data analysis. More robust billing structures such as fee-for-service provide a much greater detail about the services delivered but are expensive to implement and oversee.

BHDDH currently utilizes a fee-for-service based structure which has unique billing codes for each type of service. These codes are further modified based upon the tier level of the participant and the staff ratio of the activity billed. Many charges require providers to maintain detailed records of services provided in 15-minute or hour-long increments to bill in compliance with the system.

BHDDH staff acknowledged the inherent difficulty of supervising groups of high-needs participants while concurrently documenting group ratios and specific participant activities. Staff expressed awareness of the complexity and inefficiency of the current billing structure, noting that providers often bill using a single code to streamline the billing process. As a result of this perspective towards providers, BHDDH staff designed the billing system to accept claims data in forms that create limitations to data analysis. For example, The OIA found claims processed which:

- Are not billed for each instance of service, instead monthly services are aggregated and billed within a single billing line.
  - Zero of the claims covering multiple service days included specific dates of service
- Are subdivided into smaller time increments to charge for partial service delivery: for example, a one-hour service code was billed at 15-minute increments.
- Are submitted at incorrect billing codes, tier levels, or approved rates. Our test work identified:
  - 22 out of 152 (14%) instances in which providers billed at the incorrect[3] tier level

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[3] In twelve of these cases, the rates were billed at a higher level than assigned; the remaining 10 cases were billed at a lower tier level.

- 51 out of 152 (34%) instances in which providers billed for an incorrect rate within the selected tier

For 24 out the 51 instances in which an incorrect rate was billed, providers billed a flat rate of $7,000 or $12,000 even though the final charges allowed were as low at $308. This indicates that current practices are not meeting the needs of the providers or BHDDH management.

Effect of Billing Practices on Data Analysis

The weaknesses in data limit BHDDH's ability to monitor billing accuracy, identify trends in services rendered, project budgetary needs and determine the effect of policy changes on service costs. The OIA was similarly limited in its test work and analysis by the quality of the data received.

For example, the OIA performed a review of automated controls over duplicate payments. BHDDH and Medicaid rules specify that an individual may only be billed for inpatient services at one facility per day. As such, BHDDH must ensure that they do not compensate providers for residential services on dates in which the participant is hospitalized. This is accomplished by automatically suspending authorization for DD services for dates in which a hospital billing is received.

The OIA reviewed payment data for DD residential programs and Medicaid Hospitalizations for the one-year period October 1, 2016 to September 30, 2017. The OIA found a total of only $15,545 (0.15%) in questioned payments out of a total of $10.3M in total expenditures for the period under review. This control appears to be operating effectively. However, we were unable to expand this test to include day services because the available data does not provide information about the specific date of service. Theoretically, the control would be effective at preventing billings for day services if providers included specific service dates with their billing files. However, given that providers use aggregated billing lines without detail about specific service dates as discussed above, the duplicate payment control may not be operating as intended.

Recommendation:
9. Evaluate the current billing code system to determine if it can be simplified without sacrificing data integrity.
10. Implement stronger data validation controls into the case management system which enforce billing standards and ensure that claims data is submitted in a uniform format.
11. Offer consistent training to service providers for proper billing practices.

Management's Response: Certain services (for example, center- and community-based day services) are pre-set to be billed in 15-minute increments, with the intent that this allows providers greater flexibility. Other services are billed on per diem or per service units. Providers can only bill on these pre-determined unit increments. Most services also employ the use of modifiers to denote staff ratios – lower staff to consumer ratios beget a higher rate. When creating authorizations for consumers, the budget for certain services is calculated using predetermined ratios based on a consumer's tier (for example, community-based day services for a tier A consumer are budgeted at a 1:5 staff ratio). However, in certain situations, either due to specific consumer needs or the operational structure of a provider, services may be provided at a lower staff to consumer ratio than budgeted (for example, a tier A consumer receives certain community-based day services at a 1:1 staff ratio). The provider can bill at the higher rate, but still cannot go over the consumer's total authorized dollars for the quarter. This allows the greatest flexibility to meet a consumer's needs while still maintaining budgetary controls.

Additionally, some consumers choose to self-direct their services through a fiscal intermediary (FI), which allows the consumer to hire his or her own support staff and set rates independently of what a DD provider would pay. In these instances, the FI bills for these services at the rate that is determined between the consumer and staff, which, in some cases, is less than the rate approved by the Division. In no cases can the rate exceed the agreed upon rate. These self-direct consumers are still held to the same overall dollar authorization amount as non-self-direct consumers.

As noted earlier in this document, a new case/fiscal management system is being implemented. In combination, the Department is engaging with analysts to examine and evaluate the existing code and rate structure to ensure both flexibility for consumers and to ease the administrative burden of staff and providers, and thus lead to more specific and detailed billing by providers. Division fiscal staff currently offer informal training to providers but will also work to establish periodic formal trainings to encourage proper billing practices.

Responsible Party: Division Fiscal Staff - Evelyn Shapiro and Colleen Masterson (Leads)

Anticipated Completion Date: The fiscal portion of the new case management system is scheduled for implementation in FY2020. Division fiscal staff will establish formal provider trainings beginning in the first half of CY 2019.

Objective and Scope

The OIA conducted a limited scope audit of the Division of Developmental Disabilities. The purpose of this engagement is to determine if operations are being administered efficiently and effectively in accordance with applicable laws, rules, and regulations and if adequate controls are in place to ensure safeguarding of assets and accurate reporting.

The OIA encountered a client-imposed scope limitation during its testing of budgetary controls. We requested a sample of 60 budgetary-quarters for a selection of participants. Out of this original sample, BHDDH personnel were able to provide supporting documentation for 11 of the requested samples. They stated that the relevant documentation was being held in a shipping container due to the movement of the department between buildings at the Cranston Campus. BHDDH provided an alternative quarter for the remaining 49 participants sampled. It is unlikely that this scope limitation significantly affected the outcome of our testing procedures.

Methodology

As part of our audit work we gained an understanding of the operations of the Division of Developmental Disabilities. To address our audit objective, we performed the following:

- Interviewed personnel, including financial and administrative staff;
- Researched Rhode Island General Laws and departmental rules and regulations;
- Reviewed processes of the oversight of service providers;
- Tested a sample of claims to verify that quarterly budgets were not exceeded; and
- Tested a sample of claims to ensure services were provided.