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AUDIT OF THE SOUTH CENTRAL LOS ANGELES REGIONAL CENTER FOR FISCAL YEARS 2020-21 AND 2021-22

August 1, 2024

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RESTRICTED USE

This audit report is solely for the information and use of DDS, CMS, Department of Health Care Services, and the regional center. This restriction does not limit distribution of this audit report, which is a matter of public record.

EXECUTIVE SUMMARY

The Department of Developmental Services (DDS) conducted a fiscal compliance audit of South Central Los Angeles Regional Center (SCLARC) to assess compliance with the requirements set forth in the Lanterman Developmental Disabilities Services Act and Related Laws/Welfare and Institutions (W&I) Code; the Home and Community-Based Services (HCBS) Waiver; California Code of Regulations (CCR), Title 17; Federal Office of Management and Budget (OMB) Circulars A-122 and A-133; and the contract with DDS. Overall, the audit indicated that the regional center maintains accounting records and supporting documentation for transactions in an organized manner.

The audit period was July 1, 2020, through June 30, 2022, with follow-up, as needed, into prior and subsequent periods. This report identifies some areas where the regional center's administrative and operational controls could be strengthened. The audit randomly sampled conflict of interest filings, and did not identify issues within the sample. However, this audit does not mitigate the concerns expressed by the Department to the Board of SCLARC in August 2023, which detailed numerous concerns with compliance with statute and regulations, including regarding conflict of interest filing and review, employee hiring and evaluation, caseload ratios, and other concerns.

A follow-up review was performed to determine whether the regional center has taken corrective action to resolve the findings identified in prior DDS audit reports. The results of the follow-up can be found in the Conclusions section.

Findings that need to be addressed:

Finding 1: Overstated Claims – SCLARC overstated claims for two vendors, totaling $2,242.85.

Finding 2: Individual Trust Accounts

A. Remaining Trust Balances for Deceased Individuals – SCLARC has 15 deceased individuals with remaining trust account balances.

B. Payments Made After Date of Death – SCLARC paid two vendors the personal and incidental funds for two individuals after their date of death.

Finding 3: Executive Director's Employment Agreement – SCLARC Board's Executive Committee did not complete the Executive Director's performance evaluations by May 31 of each year.

Finding 4: Targeted Case Management (TCM) – SCLARC did not report its equipment purchases in the Administrative Survey – Equipment Purchases (Attachment C) worksheets and had two employees that had 16 hours recorded on the TCM Time Study forms (DS 1916) that did not match their time sheets.

Finding that has been addressed and corrected:

Finding 5: Over/Underpayments Due to Incorrect Rates – SCLARC over/underpaid nine vendors due to incorrect application of the newly implemented reform rates. This resulted in overpayments totaling $41,121.92 and underpayments totaling $412,112.19.

BACKGROUND

DDS and South Central Los Angeles Regional Center for Developmentally Disabled Persons, Inc. entered into State Contract HD199019, effective July 1, 2019, through June 30, 2026. This contract specifies that South Central Los Angeles Regional Center for Developmentally Disabled Persons, Inc. will operate an agency known as the South Central Los Angeles Regional Center to provide services to individuals with developmental disabilities (DD) and their families. The contract is funded by state and federal funds that are dependent upon the regional center performing certain tasks, providing services to eligible individuals, and submitting billings to DDS.

This audit was conducted from May 16, 2023, through June 29, 2023, and by the Audit Section of DDS.

AUTHORITY

The audit was conducted under the authority of the W&I Code, Section 4780.5 and the State Contract between DDS and the regional center.

CRITERIA

The following criteria were used for this audit:

- W&I Code,
- "Approved Application for the HCBS Waiver,"
- CCR, Title 17,
- OMB Circulars A-122 and A-133, and
- The State Contract between DDS and the regional center, effective July 1, 2019.

VIEWS OF RESPONSIBLE OFFICIALS

DDS issued the draft audit report on June 18, 2024. The findings in the draft audit report were discussed at a formal exit conference on June 21, 2024. The views of responsible officials are included in this final audit report.

CONCLUSIONS

Based upon the audit procedures performed, DDS has determined that except for the items identified in the Findings and Recommendations section, the regional center was in compliance with applicable audit criteria.

The costs claimed during the audit period were for program purposes and adequately supported.

From our review of the four prior DDS audit findings, it has been determined that the regional center has taken appropriate corrective action to resolve those findings.

FINDINGS AND RECOMMENDATIONS

Findings that need to be addressed.

Finding 1: Overstated Claims

The review of the Operational Indicator Reports revealed two instances where SCLARC overpaid expenses for two vendors totaling $2,242.85. The overpayments were due to duplicate payments and overlapping authorizations. (See Attachment A)

CCR, Title 17, Section 57300(c)(2) states:

> "(c) Regional Centers shall not reimburse vendors:
>
> (2) For services in an amount greater than the rate established pursuant to these regulations."

Recommendation:

SCLARC must reimburse to DDS the overstated claims totaling $2,242.85. In addition, SCLARC must ensure its staff monitor the Operational Indicator Reports for errors that may have occurred while doing business with its vendors.

Finding 2: Individual Trust Accounts

A. Remaining Trust Balances for Deceased Individuals

The review of the individual trust accounts revealed SCLARC has not taken action to close the individual trust accounts for 15 deceased individuals. The 15 deceased individual accounts had remaining balances totaling $64,701.83. These remaining balances should have been transferred to the Department of Health Care Services (DHCS), if required by Medicaid, forwarded to the individual's beneficiaries, or escheated to the State if unclaimed for more than three years. SCLARC did not state a reason for the remaining balances. (See Attachment B)

California Code of Civil Procedure (CCP), Article 2, Section 1518(a)(1), states:

> "All intangible personal property, including intangible personal property maintained in a deposit or account, and the income or increment on such tangible or intangible property, held in a fiduciary capacity for the benefit of another person escheats to

this state if for more than three years after it becomes payable or distributable, the owner has not done any of the following:

(A) Increased or decreased the principal.

(B) Accepted payment of principal or income.

(C) Corresponded in writing concerning the property.

(D) Otherwise indicated an interest in the property as evidenced by a memorandum or other record on file with the fiduciary."

Recommendation:

SCLARC must follow-up to determine whether DHCS will collect the $64,701.83 from the deceased individual trust accounts. If DHCS is not seeking repayment from the deceased individuals, the funds must be forwarded to the individuals' beneficiaries, or escheated to the State.

B. <u>Payments Made After Date of Death</u>

The review of the individual trust accounts revealed SCLARC paid two vendors the personal and incidental funds for two individuals after their date of death. The total amount overpaid to the two vendors totaled $209. (See Attachment C)

CCR, Title 17, Section 50612 (e)(1)(c) states in part:

"The regional center purchase of service authorization shall contain the requirements for terminating payments to service providers…

1. The circumstances for terminating payments by the regional center shall include:

c. The death of the consumer"

Recommendation:

SCLARC must recover the improper payments made to the vendors, reimburse the funds to the individuals' trust account and disburse the deceased individuals' funds accordingly in order to close the account.

Finding 3: **Executive Director's Employment Agreement**

The review of the Executive Director's employment agreement revealed SCLARC did not have the Boards' Executive Committee complete the Executive Director's performance evaluations on time by May 31 of each year. The Executive Director's performance evaluations for FYs 2020-21 and 2021-22 were completed on November 10, 2021, and October 13, 2022, respectively.

Executive Employment Agreement between SCLARC and Dexter Henderson states in part:

> **"10. Evaluation.** A written performance evaluation of Henderson shall be performed by the Boards' Executive Committee on or before May 31 of each year during which this agreement is in effect. Henderson agrees that he has a duty to notify the Board on February 28 of the applicable year that his performance evaluation is due on May 31 of that year."

Recommendation:

SCLARC must ensure the Boards' Executive Committee conducts a performance evaluation of the Executive Director on or before May 31 of each year to ensure compliance with the terms of the Executive Director's employment agreement.

Finding 4: **Targeted Case Management (TCM)**

A. TCM Rate Study

The review of the TCM Rate Study worksheets for May 2021 and May 2022 revealed SCLARC did not report their equipment purchases in the Administrative Survey – Equipment Purchases (Attachment C) worksheets for both years. SCLARC did not provide a reason why the equipment purchases were not included.

The TCM Rate Study Process and Instructions states:

> ". . . To continue to receive federal funds, each regional center must provide actual cost information on the administrative services that support the federal programs delineated in the Waiver and the State Plan . . . *for audit purposes, all information provided on these attachments should coincide with the center's general ledger and payroll records.*"

Instructions for the Administrative TCM Rate Study, Attachment C, state:

> "Equipment purchases in excess of $5,000 must be scheduled showing a description of the asset, cost, and date of purchase…"

Recommendation:

SCLARC must follow the instructions for the TCM Rate Study and ensure that the expenses reported on the Rate Study worksheets reconcile to the Year-End General Ledger and ensure that equipment purchases in excess of $5,000 are properly recorded in Attachment C of the TCM Rate Study.

B. TCM Time Study

The review of 24 sampled employee DS 1916s revealed two employees had 16 hours recorded on the DS 1916s that did not match their time sheets. This occurred because the service coordinator supervisors did not properly review the DS 1916s.

The TCM Rate Study Process and Instructions state:

> "All regional center case management staff (category CM) will complete the DS 1916 during the rate study. The total hours worked during the day, including overtime must be shown."

TCM Rate Study Process and Instructions, pg. 2 states:

> "For each day work was performed, enter the number of hours spent on each function outlined on the time sheet… It is permissible for regional centers to use modified time sheet formats for recording time during rate studies; however, a DS 1916 must ultimately be completed, signed and submitted for each position required to complete a time sheet."

TCM Rate Study Process and Instructions, General Instructions states:

> "8. The total hours worked during the day, including overtime must be shown."

Recommendation:

SCLARC must re-evaluate its current procedures and determine if additional controls need to be implemented to ensure that service coordinator supervisors are reviewing and reconciling the DS 1916s to time sheets prior to submission to DDS.

Finding that has been addressed and corrected.

Finding 5: <u>Over/Underpayments Due to Incorrect Rates</u>

The sampled review of 98 POS vendor files revealed nine vendors were reimbursed at incorrect rates. SCLARC overpaid two vendors for services provided to the individuals totaling $41,121.92. In addition, SCLARC underpaid seven vendors for services provided to the individuals totaling $412,112.19. The over/underpayments to the nine vendors occurred when SCLARC did not utilize the newly implemented rates that were issued in April 2022. (See Attachment D)

SCLARC provided additional documentation indicating it has collected overpayments to the two vendors totaling $41,121.92 and made payments to the seven vendors totaling $412,112.19.

CCR, Title 17, Section 57300(c)(2) states:

> "(c) Regional Centers shall not reimburse vendors:
>
> (2) For services in an amount greater than the rate established pursuant to these regulations."

Recommendation:

SCLARC must apply the appropriate reform rates to ensure vendors are paid correctly.

EVALUATION OF RESPONSE

As part of the audit report process, the regional center was provided with a draft audit report and requested to provide a response to the findings. Its response is provided as Appendix B. DDS' Audit Section has evaluated the response and will confirm the appropriate corrective actions have been taken during the next scheduled audit, unless otherwise described.

Finding 1: Overstated Claims

SCLARC agrees with the recommendation to reimburse DDS $2,242.85 for the overstated claims and stated it will ensure the Operational Indicator Reports are monitored.

Finding 2: Individual Trust Accounts

A. Remaining Trust Balances for Deceased Individuals

SCLARC agrees with the recommendation to ensure the remaining funds from the deceased individual trust accounts are submitted to DHCS, beneficiaries, or escheated to the State. SCLARC provided documentation indicating it escheated $43,068.14 to the state on June 1, 2024, and stated it will remit the remaining $21,633.39 in November 2024.

B. Payments Made After Date of Death

SCLARC agrees with the recommendation and will reimburse the $209 into the deceased individual trust accounts.

Finding 3: Executive Director's Employment Agreement

SCLARC agrees with the recommendation to ensure the Boards' Executive Committee completes the Executive Director's performance evaluation on or before May 31 of each year.

Finding 4: Targeted Case Management (TCM)

A. TCM Rate Study

SCLARC agrees with the recommendation and will ensure the expenses reported on the TCM Rate Study worksheets reconcile to the year-end general ledger and equipment purchases over $5,000 are properly recorded.

B. TCM Time Study

SCLARC agrees with the recommendation to ensure the service coordinator supervisors are reviewing and reconciling the DS 1916s to the timesheets prior to submitting these documents to DDS.

Finding that has been addressed and corrected.

Finding 5: Over/Underpayments Due to Incorrect Rates

SCLARC agrees with the recommendation to apply the appropriate reform rates increase to ensure the vendors are paid correctly. In addition, SCLARC took corrective measures to collect the overpayments to the two vendors totaling $41,121.92 and made payments to the seven vendors totaling $412,112.19.

ATTACHMENTS A-D

SOUTH CENTRAL LOS ANGELES REGIONAL CENTER

To request a copy of the attachments for this audit report, please contact the DDS Audit Section at (916) 654-3695.

APPENDIX A

SCOPE, OBJECTIVES, AND METHODOLOGY

DDS is responsible, under the W&I Code, for ensuring that persons with intellectual and developmental disabilities receive the services and supports they need to lead more independent, productive, and integrated lives. To secure these services and supports, DDS contracts with 21 private, nonprofit community agencies/corporations that provide fixed points of contact in the community for serving eligible individuals and their families in California. These fixed points of contact are referred to as regional centers. The regional centers are responsible under State law to help ensure that such persons receive access to the programs and services that are best suited to them throughout their lifetime.

DDS also is responsible for providing assurance to the federal Department of Health and Human Services, Centers for Medicare, and Medicaid Services (CMS), that services billed under California's HCBS Waiver program are provided and that criteria set forth for receiving funds have been met. As part of providing this assurance, the Audit Section conducts fiscal compliance audits of each regional center no less than every two years and completes follow-up reviews in alternate years.

In addition to the fiscal compliance audit, each regional center also is monitored by the DDS Federal Programs Operations Section to assess overall programmatic compliance with HCBS Waiver requirements. The HCBS Waiver compliance monitoring review has its own criteria and processes. These audits and program reviews are an essential part of an overall DDS monitoring system that provides information on the regional centers' fiscal, administrative, and program operations.

This audit was conducted as part of the overall DDS monitoring system that provides information on the regional centers' fiscal, administrative, and program operations. The objectives of this audit were:

- To determine compliance with the W&I Code,
- To determine compliance with the provisions of the HCBS Waiver Program for the Developmentally Disabled,
- To determine compliance with CCR, Title 17 regulations,
- To determine compliance with OMB Circulars A-122 and A-133, and
- To determine that costs claimed were in compliance with the provisions of the State Contract between DDS and the regional center.

The audit was conducted in accordance with the Generally Accepted Government Auditing Standards issued by the Comptroller General of the United States. However, the procedures do not constitute an audit of the regional center's financial statements. DDS limited the scope to planning and performing audit procedures necessary to obtain reasonable assurance that the regional center was in compliance with the objectives identified above.

DDS' review of the regional center's internal control structure was conducted to gain an understanding of the transaction flow and the policies and procedures, as necessary, to develop appropriate auditing procedures.

DDS reviewed available annual audit report(s) that were conducted by an independent CPA firm. This review was performed to determine the impact, if any, upon the DDS audit and, as necessary, develop appropriate audit procedures.

The audit procedures performed included the following:

I. Purchase of Service

DDS selected a sample of Purchase of Service (POS) claims billed to DDS. The sample included consumer services and vendor rates. The sample also included consumers who were eligible for the HCBS Waiver Program. For POS claims, the following procedures were performed:

- DDS tested the sample items to determine if the payments made to service providers were properly claimed and could be supported by appropriate documentation.

- DDS selected a sample of invoices for service providers with daily and hourly rates, standard monthly rates, and mileage rates to determine if supporting attendance documentation was maintained by the regional center. The rates charged for the services provided to individual consumers were reviewed to ensure compliance with the provision of the W&I Code; the HCBS Waiver for the Developmentally Disabled; CCR, Title 17, OMB Circulars A-122 and A-133; and the State Contract between DDS and the regional center.

- If applicable to this audit, DDS selected a sample of individual Consumer Trust Accounts to determine if there were any unusual activities and whether any account balances exceeded $2,000, as prohibited by the Social Security Administration. In addition, DDS determined if any retroactive Social Security benefit payments received exceeded the $2,000 resource limit for longer than nine months. DDS also reviewed these accounts to ensure that the interest earnings were distributed quarterly, personal and incidental funds were paid before the 10th of each month, and proper documentation for expenditures was maintained.

- If applicable to this audit, the Client Trust Holding Account, an account used to hold unidentified consumer trust funds, was tested to determine whether funds received were properly identified to a consumer or returned to the Social Security Administration in a timely manner. An interview with the regional center staff revealed that the regional center has procedures in place to determine the correct recipient of unidentified consumer trust

funds. If the correct recipient cannot be determined, the funds are returned to the Social Security Administration or other sources in a timely manner.

- If applicable to this audit, DDS selected a sample of Uniform Fiscal Systems (UFS) reconciliations to determine if any accounts were out of balance or if there were any outstanding items that were not reconciled.

- DDS analyzed all bank accounts to determine whether DDS had signatory authority, as required by the State Contract with DDS.

- DDS selected a sample of bank reconciliations for Operations (OPS) accounts and Consumer Trust bank accounts to determine if the reconciliations were properly completed on a monthly basis.

II. Regional Center Operations

DDS selected a sample of OPS claims billed to DDS to determine compliance with the State Contract. The sample included various expenditures claimed for administration that were reviewed to assure that accounting staff properly input data, transactions were recorded on a timely basis, and expenditures charged to various operating areas were valid and reasonable. The following procedures were performed:

- A sample of the personnel files, timesheets, payroll ledgers, and other support documents were selected to determine if there were any overpayments or errors in the payroll or the payroll deductions.

- A sample of OPS expenses, including, but not limited to, purchases of office supplies, consultant contracts, insurance expenses, and lease agreements were tested to determine compliance with CCR, Title 17, and the State Contract.

- A sample of equipment was selected and physically inspected to determine compliance with requirements of the State Contract.

- DDS reviewed the regional center's policies and procedures for compliance with the DDS Conflict of Interest regulations, and DDS selected a sample of personnel files to determine if the policies and procedures were followed.

III. Targeted Case Management (TCM) and Regional Center Rate Study

The TCM Rate Study determines the DDS rate of reimbursement from the federal government. The following procedures were performed upon the study:

- DDS examined the two TCM Rate Studies submitted to DDS during the audit period and traced the reported information to source documents.

- A review of the recent Case Management Time Study (required to be submitted every three years) is conducted if the study was not reviewed during the prior audit. DDS selected a sample of the Case Management Time Study Forms (DS 1916) for examination and reconciled them to the corresponding payroll timesheets to ensure that the forms were properly completed and supported.

IV. Service Coordinator Caseload Survey

Under the W&I Code, Section 4640.6(e), regional centers are required to provide service coordinator caseload data to DDS. The following average service coordinator-to-consumer ratios apply per W&I Code Section 4640.6(c)(1)(2)(3)(A)(B)(C):

"(c) Contracts between the department and regional centers shall require regional centers to have service coordinator-to-consumer ratios, as follows:

(1) An average service coordinator-to-consumer ratio of 1 to 62 for all consumers who have not moved from the developmental centers to the community since April 14, 1993. In no case shall a service coordinator for these consumers have an assigned caseload in excess of 79 consumers for more than 60 days.

(2) An average service coordinator-to-consumer ratio of 1 to 45 for all consumers who have moved from a developmental center to the community since April 14, 1993. In no case shall a service coordinator for these consumers have an assigned caseload in excess of 59 consumers for more than 60 days.

(3) The following coordinator-to-consumer ratios shall apply:

(A) All consumers enrolled in the Home and Community-based Services Waiver program for persons with developmental disabilities, an average service coordinator-to-consumer ratio of 1 to 62.

(B) All consumers who have moved from a developmental center to the community since April 14, 1993, and have lived continuously in the community for at least 12 months, an average service coordinator-to-consumer ratio of 1 to 62.

(C) All consumers who have not moved from the developmental centers to the community since April 14, 1993, and who are not described in subparagraph (A), an average service coordinator-to-consumer ratio of 1 to 66.

(4) Notwithstanding paragraphs (1) to (3), inclusive, an average service coordinator-to-consumer ratio of 1 to 40 for all consumers five years of age and younger.

(5) (A) Notwithstanding paragraphs (1) to (3), inclusive, enhanced service coordination, including a service coordinator-to-consumer ratio of 1 to 40, shall be available to consumers identified as having low or no purchase-of-service expenditures, as identified in the annual Budget Act.

(6) (A) Notwithstanding paragraphs (1) to (3), inclusive, an average service coordinator-to-consumer ratio of 1 to 25 for all consumers with complex needs.

(7) For purposes of paragraph (3), service coordinators may have a mixed caseload of consumers three years of age and younger, consumers enrolled in the Home and Community-based Services Waiver program for persons with developmental disabilities, and other consumers if the overall average caseload is weighted proportionately to ensure that overall regional center average service coordinator-to-consumer ratios as specified in paragraph (3) are met. For purposes of paragraph (3), in no case shall a service coordinator have an assigned caseload in excess of 84 for more than 60 days."

DDS also reviewed the Service Coordinator Caseload Survey methodology used in calculating the caseload ratios to determine reasonableness and that supporting documentation is maintained to support the survey and the ratios as required by W&I Code, Section 4640.6(e).

V. Early Intervention Program (EIP; Part C Funding)

For the EIP, there are several sections contained in the Early Start Plan. However, only the Part C section was applicable for this review.

VI. Family Cost Participation Program (FCPP)

The FCPP was created for the purpose of assessing consumer costs to parents based on income level and dependents. The family cost participation assessments are only applied to respite, day care, and camping services that are included in the child's Individual Program Plan (IPP)/Individualized Family Services Plan (IFSP). To determine whether the regional center was in compliance with CCR, Title 17, and the W&I Code, Section 4783, DDS performed the following procedures during the audit review:

- Reviewed the list of consumers who received respite, day care, and camping services, for ages 0 through 17 years who live with their parents and are not Medi-Cal eligible, to determine their contribution for the FCPP.

- Reviewed the parents' income documentation to verify their level of participation based on the FCPP Schedule.

- Reviewed copies of the notification letters to verify that the parents were notified of their assessed cost participation within 10 working days of receipt of the parents' income documentation.

- Reviewed vendor payments to verify that the regional center was paying for only its assessed share of cost.

VII. Annual Family Program Fee (AFPF)

The AFPF was created for the purpose of assessing an annual fee of up to $200 based on the income level of families with children between the ages of 0 through 17 years receiving qualifying services through the regional center. The AFPF fee shall not be assessed or collected if the child receives only respite, day care, or camping services from the regional center and a cost for participation was assessed to the parents under FCPP. To determine compliance with the W&I Code, Section 4785, DDS requested a list of AFPF assessments and verified the following:

- The adjusted gross family income is at or above 400 percent of the federal poverty level based upon family size.

- The child has a DD or is eligible for services under the California Early Intervention Services Act.

- The child is less than 18 years of age and lives with his or her parent.

- The child or family receives services beyond eligibility determination, needs assessment, and service coordination.

- The child does not receive services through the Medi-Cal program.

- Documentation was maintained by the regional center to support reduced assessments.

VIII. Parental Fee Program (PFP)

The PFP was created for the purpose of prescribing financial responsibility to parents of children under the age of 18 years who are receiving 24-hour, out-of-home care services through a regional center or who are residents of a state hospital or on leave from a state hospital. Parents shall be required to pay a fee depending upon their ability to pay, but not to exceed (1) the cost of caring for a child without DD at home, as determined by the Director of DDS, or (2) the cost of services provided, whichever is less. To determine compliance with the W&I Code Section 4784, DDS requested a list of PFP assessments and verified the following:

- Identified all children with DD who are receiving the following services:

  (a) All 24-hour, out-of-home community care received through a regional center for children under the age of 18 years;

  (b) 24-hour care for such minor children in state hospitals;

  (c) provided, however, that no ability to pay determination may be made for services required by state or federal law, or both, to be provided to children without charge to their parents.

- Provided DDS with a listing of new placements, terminated cases, and client deaths for those clients. Such listings must be provided not later than the 20th day of the month following the month of such occurrence.

- Informed parents of children who will be receiving services that DDS is required to determine parents' ability to pay and to assess, bill, and collect parental fees.

- Provided parents a package containing an informational letter, a Family Financial Statement (FFS), and a return envelope within 10 working days after placement of a minor child.

- Provided DDS a copy of each informational letter given or sent to parents, indicating the addressee and the date given or mailed.

IX. Procurement

The Request for Proposal (RFP) process was implemented so that regional centers outline the vendor selection process when using the RFP process to address consumer service needs. As of January 1, 2011, DDS requires regional centers to document their contracting practices, as well as how particular vendors are selected to provide consumer services. By implementing a procurement process, regional centers will ensure that the most cost-effective service providers, amongst comparable service providers, are selected, as required by the Lanterman Act and the State Contract. To determine whether the regional center implemented the required RFP process, DDS performed the following procedures during the audit review:

- Reviewed the regional center's contracting process to ensure the existence of a Board-approved procurement policy and to verify that the RFP process ensures competitive bidding, as required by Article II of the State Contract, as amended.

- Reviewed the RFP contracting policy to determine whether the protocols in place included applicable dollar thresholds and comply with Article II of the State Contract, as amended.

- Reviewed the RFP notification process to verify that it is open to the public and clearly communicated to all vendors. All submitted proposals are evaluated by a team of individuals to determine whether proposals are properly documented, recorded, and authorized by appropriate officials at the regional center. The process was reviewed to ensure that the vendor selection process is transparent and impartial and avoids the appearance of favoritism. Additionally, DDS verified that supporting documentation is retained for the selection process and, in instances where a vendor with a higher bid is selected, written documentation is retained as justification for such a selection.

DDS performed the following procedures to determine compliance with the State Contract:

- Selected a sample of Operations, Community Placement Plan (CPP), and negotiated POS contracts subject to competitive bidding to ensure the regional center notified the vendor community and the public of contracting opportunities available.

- Reviewed the contracts to ensure that the regional center has adequate and detailed documentation for the selection and evaluation process of vendor proposals and written justification for final vendor selection decisions and that those contracts were properly signed and executed by both parties to the contract.

In addition, DDS performed the following procedures:

- To determine compliance with the W&I Code, Section 4625.5: Reviewed to verify that the regional center has a written policy requiring the Board to review and approve any of its contracts of two hundred fifty thousand dollars ($250,000) or more before entering into a contract with the vendor.

- Reviewed the regional center Board-approved Operations, Start-Up, and POS vendor contracts of $250,000 or more, to verify that the inclusion of a provision for fair and equitable recoupment of funds for vendors that cease to provide services to consumers; verified that the funds provided were specifically used to establish new or additional services to consumers, the usage of funds is of direct benefit to consumers, and the contracts are supported with sufficiently detailed and measurable performance expectations and results.

The process above was conducted in order to assess the current RFP process and Board approval for contracts of $250,000 or more, as well as to determine whether the process in place satisfies the W&I Code and State Contract requirements.

X. Statewide/Regional Center Median Rates

The Statewide and Regional Center Median Rates were implemented on July 1, 2008, and amended on December 15, 2011, July 1, 2016, and April 1, 2022. Regional centers may not negotiate rates higher than the set median rates for services. Despite the median rate requirement, rate increases can be obtained from DDS under health and safety exemptions where regional centers demonstrate the exemption is necessary for the health and safety of the consumers.

To determine compliance with the Lanterman Act, DDS performed the following procedures during the audit review:

- Reviewed sample vendor files to determine whether the regional center is using appropriately vendorized service providers and correct service codes, and is paying authorized contract rates and complying with the median rate requirements of W&I Code Section 4691.9.

- Reviewed vendor contracts to verify that the regional center is reimbursing vendors using authorized contract median rates and verified that rates paid represented the lower of the statewide or regional center median rate set after June 30, 2008. Additionally, DDS verified that providers vendorized before June 30, 2008, did not receive any unauthorized rate increases, except in situations where required by regulation, or health and safety exemptions were granted by DDS.

APPENDIX B

SCLARC'S RESPONSE TO THE AUDIT

To request a copy of the attachment for this audit report, please contact the DDS Audit Section at (916) 654-3695.