
Program Audit:
Department of
Mental Health
Administrative Agents

*Prepared for the Committee on Legislative Research
by the Oversight Division*

Jeanne Jarrett, CPA, Director

Audit Team:

Julie Miller, CPA, Team Leader, Frances Hayes, Maggie Solt, CPA

May, 1997

Programa de
Desenvolvimento
de Recursos
Humanos

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10/2023

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COMMITTEE ON LEGISLATIVE RESEARCH

OVERSIGHT SUBCOMMITTEE

THE COMMITTEE ON LEGISLATIVE RESEARCH, Oversight Division, is the audit agency of the Missouri General Assembly as established in Chapter 23 of the Revised Statutes of Missouri. The programs and activities of the State of Missouri cost approximately \$13 billion annually. Each year the General Assembly enacts laws which add to, delete or change these programs. To meet the demands for more responsive and cost effective state government, legislators need to receive information regarding the status of the programs which they have created and the expenditure of funds which they have authorized. The audit work of the Oversight Division provides the General Assembly with a means to evaluate state agencies and state programs.

THE OVERSIGHT DIVISION conducts its audits in accordance with government auditing standards set forth by the U.S. General Accounting Office. These standards pertain to auditors' professional qualifications, the quality of audit effort and the characteristics of professional and useful audit reports.

THE COMMITTEE ON LEGISLATIVE RESEARCH is a permanent joint committee of the Missouri General Assembly comprised of the chairman of the Senate Appropriations Committee and nine other members of the Senate and the chairman of the House Budget Committee and nine other members of the House of Representatives. The Senate members are appointed by the President Pro Tem of the Senate and the House members are appointed by the Speaker of the House of Representatives. No more than six members from the House and six members from the Senate may be of the same political party.

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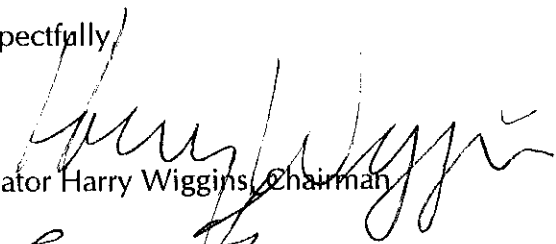
May, 1997

Members of the General Assembly:

As authorized by Chapter 23, RSMo, the Committee on Legislative Research adopted a resolution in May, 1996 directing the Oversight Division to perform a program audit of Administrative Agents which included the examination of records and procedures in the Department of Mental Health to determine and evaluate program performance in accordance with program objectives, responsibilities, and duties as set forth by statute or regulation.

The accompanying report includes Oversight's comments on internal controls, compliance with legal requirements, management practices, program performance and related areas. We hope this information is helpful and can be used in a constructive manner for the betterment of the state program to which it relates.

Respectfully,


Senator Harry Wiggins, Chairman


Representative Larry Thomason, Vice-Chairman



STATE OF MISSOURI
COMMITTEE ON LEGISLATIVE RESEARCH
OVERSIGHT DIVISION

JEANNE JARRETT, CPA
Director

**PROGRAM AUDIT OF THE DEPARTMENT OF MENTAL HEALTH-
ADMINISTRATIVE AGENTS**

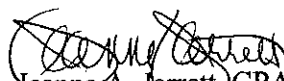
The Committee on Legislative Research directed the Oversight Division to perform a program audit of Administrative Agents which included the examination of records and procedures in the Department of Mental Health to determine and evaluate program performance in accordance with program objectives, responsibilities, and duties as set forth by statute or regulation.

The Department of Mental Health has divided the state into twenty-five service areas and appointed an "administrative agent" who makes assessments of and provides services to adults with severe and persistent mental illness and children with severe emotional disturbances, including persons released from state operated residential facilities. Beginning in the 1980's, community mental health centers were created to provide outpatient services separate from a residential setting. In fiscal year 1997, nineteen of the centers were operated as private centers (private contractors) with \$106 million in state money being appropriated for the services they rendered. This amount does not include federal medicaid money billed to the Department of Social Services by the private vendors. Six of the centers were state-operated with approximately \$34 million in state appropriations for roughly 500 full time employees. These six were bid out during the fall of 1996, with privatization expected to occur in the spring of 1997. Oversight's audit concentrated on examining the privatization process, bidding procedures and monitoring of contracts.

The audit attempts to answer questions regarding the contracting of services, such as, "Were the requests for proposal (RFP) written in such a way as to obtain the best deal for the state?" and questions regarding the administration of the resulting contracts, such as, "Has the Department of Mental Health effectively monitored the administrative agents?"

The audit report includes detailed findings and recommendations for changes in management practices and procedures. The Department of Mental Health's official responses to the findings and recommendations are incorporated into the report. Our audit was performed in accordance with generally accepted government auditing standards as they relate to program and performance audits. We did not examine departmental financial statements and do not express an opinion on them.

We wish to acknowledge the cooperation and assistance of staff of the Department of Mental Health during the audit process.


Jeanne A. Jarrett, CPA, CGFM
Director, Oversight Division

Introduction

The Joint Committee on Legislative Research directed the Oversight Division to perform a program audit to evaluate the function of the administrative agents within the Department of Mental Health. The state of Missouri has twenty-five administrative agents, providing services to mentally ill persons. This audit informs the General Assembly of the efficiency of the privatization process, monitoring of the administrative agents by the Department of Mental Health, and the sufficiency of the request for proposal to yield the best possible bids.

Background

The Department of Mental Health is required by section 632.035, RSMo, to divide the state into regions. The state is divided into twenty-five service areas. Each area includes an administrative agent to act as a service provider. The administrative agents make assessments of and provide services to adults with severe and persistent mental illness and children with severe emotional disturbances, including persons released from state operated inpatient facilities. Six of the administrative agents are state community mental health centers, and nineteen of the administrative agents are private community mental health centers. Beginning in the 1980s, the outpatient units of state-operated hospitals were separated from inpatient programs to create distinct organizations charged with the responsibility for community-based services in the service area as the Division of Comprehensive Psychiatric Services' (CPS) administrative agent.

The fiscal year 1997 appropriation for the state community mental health centers is approximately \$34 million. The six state community mental health centers include Central Kansas City Mental Health Services, Southwest Missouri Mental Health Center, Heart of Missouri Mental Health Services, Park Hills Mental Health Services, Great Rivers Mental Health Services, and St. Louis Mental Health Center.

The fiscal year 1997 appropriation for the private community mental health centers is approximately \$106 million, which does not include federal Medicaid billed directly to the Department of Social Services. The nineteen private community mental health centers include Family Guidance Center, Swope Parkway Health Center, Research Mental Health Services,

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Comprehensive Mental Health Services, Tri-County Mental Health Services, West Central Missouri Mental Health Center, Ozark Center, Burrell Center, Family Mental Health Center, North Central Missouri Mental Health Center, Mark Twain Area Counseling Center, Arthur Center, Crider Center, Ozark Area Care and Counseling, Service Area 19 Board, Bootheel Counseling Services, Community Counseling Center, Comtrea Community Treatment, and Hopewell Center.

The Oversight Division noted the Southwest Missouri Mental Health Center (SWMMHC) served the least number of clients at the highest per client cost as compared to the other five state mental health centers. However, SWMMHC's average unit cost for services was the lowest for the six state centers. In 1991 Nevada State Hospital closed, and SWMMHC began operating. Therefore, SWMMHC provides residential services, while the other state centers primarily provide outpatient services only. SWMMHC is serving a smaller number of clients at a higher per client cost, since residential services cost more than outpatient services. SWMMHC's lower unit cost results from more intensive and continuous services to their clients.

The Department of Mental Health issued a request for proposal in April, 1996, to privatize the six state community mental health centers. The department has been considering privatization of the state community mental health centers for several years. Some of the reasons offered by the department for privatization included providing continuity of care for clients, stability for clients during the transition to managed care, rapid decision-making, restructuring of staff and services, an incentive structure that rewards efficiency and innovation, contracting options with insurance and managed care entities, and accountability and comparability in performance of all community mental health centers. On November 13, 1996, the Department of Mental Health announced the award of a privatization contract for Central Kansas City Mental Health Services. The contract was awarded to Truman Medical Center, in cooperation with Swope Parkway Health Center. On November 27, 1996, the department announced BJC Health System was selected to manage Great Rivers Mental Health Services, St. Louis Mental Health Center and Park Hills Mental Health Services. The University of Missouri will operate Heart of Missouri Mental Health Services. Operations by Truman Medical Center, BJC Health System and the University of Missouri are scheduled to begin in the spring of 1997.

Objectives

The objectives of the audit included informing the General Assembly of the efficiency of operating state versus private community mental health centers, monitoring of the administrative agents by the Department of Mental Health, and the sufficiency of the request for proposal to yield the best possible bids. The focus of the Oversight Division's audit centered on five main objectives to determine if:

- ▶ costs and level of services provided by private facilities are competitive with state facilities;
- ▶ DMH monitoring and billing procedures are adequate;
- ▶ assessment and evaluation of clients is efficient and effective;
- ▶ bidding specifications were sufficient to yield the best possible bids; and
- ▶ contracts with administrative agents are adequate.

Scope

The scope of the audit concentrated on the mental health services provided by the administrative agents. The main areas considered in the audit included unit cost reports, monitoring reports, intake assessments, annual evaluations, certifications, request for proposal, and contracts. The Oversight Division utilized the most current information available at the time of audit fieldwork.

Methodology

The Oversight Division conducted the audit in accordance with Government Auditing Standards issued by the Comptroller General of the United States as those standards relate to performance audits. The methodology used by the Oversight Division included analyzing samples of transactions and evaluating management controls to the extent necessary to fulfill our audit objectives.

Our efforts centered on the following procedures:

- ▶ comparing unit cost reports between private and state centers;
- ▶ evaluating DMH's monitoring and billing procedures;
- ▶ reviewing DMH's assessment and evaluation of clients;
- ▶ discussing with DMH personnel the operations of administrative agents;
- ▶ visiting administrative agents;
- ▶ reviewing the request for proposal for privatization of the state mental health centers; and
- ▶ examining the contracts between DMH and the administrative agents.

Findings

Recommendations

Agency Responses

FINDING #1:	The request for proposal (RFP) to privatize mental health centers included provisions which did not allow management flexibility by the contractor and thus may have discouraged potential bidders.
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The evaluation criteria of the RFP was based 50% on financial elements, stability, organizational experience, reliability, and organizational philosophy and methodology; 30% on personnel benefits and expertise of the offeror's personnel; and 20% on the additional services value. The criteria for personnel benefits included, but was not limited to, retaining employment of state agency personnel for a minimum of twelve months after the last day of state operation, permitting termination with cause; assuming the lease on existing state operated facilities; requiring the contractor to offer a retirement plan to the state personnel, similar to the plan offered to the contractor's other personnel with similar benefits to those of the state; requiring the contractor to provide health benefits and pay for at least 75% of the benefits; and paying for professional training.

The original RFP indicated the Southwest Missouri Mental Health Center (SWMMHC) generates approximately \$1.2 million in annual revenues. The monthly payroll and fringe benefits were shown as \$125,000. This computed to \$1.5 million in annual payroll and fringe benefit expenses. The

payroll expenses alone would have resulted in SWMMHC losing approximately \$300,000 annually. DMH did not receive any bids on the SWMMHC.

Based on phone calls to potential bidders, reasons for not bidding on SWMMHC included the following:

- ▶ RFP lacks financial information to project costs;
- ▶ SWMMHC runs a deficit;
- ▶ RFP provides limited flexibility to change staffing or supervisors;
- ▶ personnel costs exceed available resources;
- ▶ bidders could not obtain reliable unit cost information;
- ▶ SWMMHC is financially unfeasible;
- ▶ bidders were not allowed to cut costs, even though SWMMHC is losing money;
- ▶ state provides no guarantee of return on investment because state reimbursements are subject to legislative funding; and
- ▶ financial risk is difficult to assess.

Amendment #1 to the original RFP indicated that revised versions of the profiles of the mental health centers were available upon request. The revised profile for SWMMHC included additional revenue sources, lower payroll expenses and non-payroll expenses, resulting in potential revenues over expenditures of approximately \$221,000. However, based on the above comments from potential bidders, they may not have requested and received copies of the revised profile.

RECOMMENDATION TO FINDING #1

The Oversight Division recommends the SWMMHC RFP be rewritten and bid again to allow potential contractors more flexibility and control over the finances of the mental health center, with any revisions to the financial profile included in all amendments.

Agency Response to Finding #1

The Department does not concur that the lack of bidders for SWMMHC was solely the result of the financial responsibilities associated with employment guarantees and employee benefits, interpreted by the audit as lack of flexibility for the contractor. Since the provisions of the RFP resulted in successful privatization efforts for five of the six centers that were bid, the

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reimbursements. The state mental health centers collect revenues for services from third parties, such as private insurance and clients, which are deposited into the General Revenue Fund. Based on fiscal year 1996 projections included in the individual mental health center profiles in the request for proposal, the following third party revenues were projected by DMH for each center:

Heart of Missouri Mental Health Services	\$ 129,000
Central Kansas City Mental Health Services	350,000
Great Rivers Mental Health Services	410,000
St. Louis Mental Health Center	1,297,000
Park Hills Mental Health Services	<u>23,000</u>
Total	<u>\$2,209,000</u>

Upon privatization of these centers, the private facilities will retain these revenues. Therefore, a loss of state General Revenue will result upon privatization.

The evaluation criteria also did not include comparison of unit costs of the provision of services which would be vital financial information to consider. The Oversight Division compared the unaudited unit cost reports of the state centers to the audited unit cost reports of the private centers for fiscal year 1995. Based on total costs for all services divided by total units served included in the unit cost reports, the average unit cost for state centers was \$29.45, and the average unit cost for private centers was \$16.40. DMH personnel stated a reason for unit cost differences could include the failure of state centers to adequately log units of service, causing an understatement of the number of units delivered and resulting in an inflated cost per unit. The state centers do not have to bill the Department of Mental Health to receive their appropriation. However, private centers are required to bill DMH for services provided in order to receive their state allocation. The \$16.40 average unit cost for private centers is not necessarily reflective of the average reimbursement rate paid by DMH to the existing private centers. However, it would indicate a potential for savings in reimbursement rates to private centers if rates were competitively bid. In addition, DMH was unable to provide Oversight with average reimbursement rates which will be paid to the five new administrative agents because they were still "negotiating" the rates with the selected contractors.

RECOMMENDATION TO FINDING #2

The Oversight Division recommends the Department of Mental Health develop evaluation criteria which considers any additional services value, third party reimbursements and a comparison of unit costs of providing services. DMH should competitively bid the mental health services contracts again at the end of the award period, which could result in potential financial benefits to the state.

Agency Response to Finding #2

The Department does not concur with this finding or recommendation.

The Department believes that the criteria used to evaluate the bids appropriately balanced the financial interests of the State with consideration and emphasis on criteria that would promote service quality and continuity, including factors designed to promote the retention of staff with experience in serving public section clients. Particularly in the human services, clients are not well-served if decisions are purely financial, and ignore other qualitative features that may result in better outcomes.

- ▶ *The evaluation criteria did include an objectively scored financial consideration.*
- ▶ *For accuracy and objectivity, it should be noted that the objectively scored additional service values did influence the awarding of the bids for Heart of Missouri Mental Health Service, Great Rivers Mental Health Services, St. Louis Mental Health Center, and Park Hills Mental Health Services.*
- ▶ *The Department has openly acknowledged that revenues from third party payors for these centers will no longer be deposited to General Revenue. Actual Fiscal Year 1996 collections deposited to General Revenue by the affected agencies were as follows:*

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Great Rivers MHS	\$62,842
St. Louis MHC	\$75,820
Heart of Mo MHS	\$66,796
Central KC MHS	\$236,311
Park Hills MHS	<u>\$28,041</u>
	\$469,810

The larger third party reimbursement projections referred to in this finding were based on these agencies being able to expand their services as private agencies to populations not targeted by the state. It should also be noted that privatization of these centers resulted in reducing the state workforce by more than 500 employees, resulting in lower long term salary, benefit and retirement costs for the state.

- ▶ *The audit teams method of calculating an average unit cost results in a meaningless figure that is not valid as a measure of costs or efficiency and should not be used for comparison among agencies. Dividing all units (quarter hour, hour, half-day, daily, injections/medications, etc.) into the total allocations, as the audit team did, distorts cost by failing to consider issues of client mix, pro bono or unbilled services, and geographic variations in salaries and other costs.*

The recommendation that the contracts should be bid again "at the end of the award period" shows a lack of understanding of the privatization process. Once a center has been privatized, it cannot be rebid because the staff are no longer employees of the state. There is nothing further to privatize.

Oversight Division's Comment to Finding #2

The Oversight Division understands that after the first year of private operation the staff are no longer employees of the state. However, DMH will retain contracts for services paid by the state, which could be competitively bid.

FINDING #3: The Department of Mental Health has not analyzed their staffing levels in the regional and central offices to determine if changes are needed after the privatization of the state mental health centers.

Upon privatization of the mental health centers, changes could occur in the method of billing for services reimbursable by the state and Medicaid and reporting requirements. In addition, monitoring functions could require enhancement. A total of approximately 500 regional full-time equivalent employees will transfer from the five state mental health centers to the private centers. Some of the central office DMH employees performing duties related to the mental health centers also have other responsibilities not related to the mental health centers. However, DMH has not completed a formal analysis of workload changes anticipated after privatization. The Office of Administration, Division of Personnel, could be involved in or conduct this analysis. Such an analysis could provide management with vital information which could be used to make decisions regarding departmental operations.

RECOMMENDATION TO FINDING #3

The Oversight Division recommends the Department of Mental Health or the Office of Administration, Division of Personnel, analyze the expected changes in the workload of the central and regional office staff to determine if staffing level changes are necessary. If it is determined that staffing levels should be adjusted, DMH should request changes through the appropriation process.

Agency Response to Finding #3

The Department concurs with the recommendation, and is already conducting a functional analysis of all aspects of its central office to determine what functions and staffing needs are projected in the context of managed care.

FINDING #4: The Department of Mental Health does not utilize audited unit cost reports submitted by administrative agents (AAs) to compare the efficiency of AAs, adjust reimbursement rates or reconcile units paid by DMH.

Unit cost reports include for each service total costs per service, total units of service, and cost per unit of service. The AAs contract with independent auditors to audit the unit cost reports required by DMH. Contracts between the AAs and DMH require the AAs to maintain auditable records, including "... the specific number and type of service units provided."

DMH personnel prepare a report of unit cost information from the audited unit cost reports and DMH records of amounts paid per unit. However, this report does not appear to be utilized by the Division of Comprehensive Psychiatric Services to compare unit costs among AAs or to adjust amounts reimbursed by DMH to the AAs. The unit costs reports could have been used by DMH in determining cost effectiveness of privatizing the state mental health centers.

DMH internal auditors review the unit cost reports, but do not follow through on differences between audited units and DMH paid units. DMH internal audit personnel send letters to AAs regarding the differences, but the letters state that no action is required of the AAs. Oversight Division auditors examined the audit checklists prepared by DMH internal auditors for 18 audit reports for fiscal years ending June 30, 1995, and December 31, 1995. Three checklists indicated less units per the audited unit cost report than the units for which DMH paid the AAs. In addition, one audited unit cost report did not include targeted case management units. In all four cases, the letter from DMH to the AAs indicated that no action was required of the AAs by DMH.

In addition, the allocation of indirect costs by the AAs is not done consistently, resulting in difficulty in comparing unit cost reports between AAs. The methodology for the allocation is done at the discretion of each AA.

RECOMMENDATION TO FINDING #4

The Oversight Division recommends DMH utilize the audited unit cost reports by comparing unit costs among AAs to determine efficient uses of AA resources and to determine if DMH reimbursement rates accurately reflect costs of providing services. Oversight also recommends DMH and AAs reconcile units in the audited unit cost reports and DMH paid units to ensure that the number of paid units were actually delivered to clients. In addition, allocations of indirect costs in the unit cost reports should be done consistently for all AAs to improve comparability of unit costs.

Agency Response to Finding #4

The Department does not concur with this finding. The Department has used the audited unit cost reports to adjust reimbursement rates and reconcile units paid by the Department. Other methods and data are used to assess the efficiency of administrative agents.

- ▶ *The audited unit cost reports were used to establish the current POS flat rates. The weighted average audited unit cost was calculated for each service using data from the audited unit cost reports. The weighted average audited unit costs were then used to establish flat rates for services across all POS providers.*
- ▶ *Each year since the flat rates were established, CPS has requested funds to adjust these rates to account for inflationary increases in the cost of providing these services. The General Assembly has not appropriated funds for this purpose. As a result, the flat rates have not been adjusted.*
- ▶ *This finding suggests that although DMH identifies discrepancies between audited units provided and DMH paid units, DMH does not take action to recoup overpayments. This is not accurate. DMH internal audit staff did identify five (5) services out of five-hundred-fifty (550) that were overpaid in the eighteen (18) unit cost reports reviewed by staff from the Oversight Division. No recoupment was sought in these cases because, although the reports indicated that DMH overpaid a specific provider for a specific service, the reports also indicated that DMH underpaid the provider for other services, i.e., there were also additional units of service in other service*

categories that the provider could have billed DMH for that more than offset overpayments to the provider. When this situation is documented, recoupment would not result in the actual repayment of funds, and is, therefore, not sought.

- ▶ *The internal audit staff review of unit cost reports may result in an audit of the provider, or other follow up such as increased monitoring, if the audited unit cost report raises concerns regarding possible overpayments or other financial irregularities.*
- ▶ *Other financial analysis methods were used in relationship to decisions about privatization including individualized pro forma budgets and projections to assess feasibility and financial implications of privatization on the centers and for the Department.*

Because audited unit cost data by itself is insufficient to compare efficiency of DMH providers, the Department is developing comprehensive outcomes data to link with costs data in order to compare provider cost effectiveness. It is important to note that risk rating and client mix are further refinements to the data necessary to make valid and reliable comparisons among providers. The Department already has in place effective tools for reconciling units and collecting overpayments.

FINDING #5: DMH is not performing cost-benefit analyses on all programs as required by state law.

Section 630.415, RSMo 1995, states "Through monitoring of the contracts under department rules and under the contract terms, the department shall require evidence that the services funded by the state are cost-and-benefit effective." Section 632.010 states the functions of Division of Comprehensive Psychiatric Services (CPS) should include "Evaluation, or the requirement of the evaluation, including the collection of appropriate and necessary information, of division programs to determine their cost-and-benefit effectiveness." These sections have been in effect since 1980.

House Bill 562 in 1995, section 630.461, RSMo Cumulative Supp. 1996, created the Review Committee for Purchasing to recommend changes in the Department of Mental Health's purchasing system. The committee's report, dated December, 1995, recommended that by 7-1-96 DMH develop an outcomes-based evaluation system and implement reporting and accounting

procedures to allow for cost comparison analysis. DMH replied in a report dated July 10, 1996, that reports would be required effective 8-1-96 for community psychiatric rehabilitation programs.

Outcome measures for supported housing were compiled from January, 1993, through April, 1996. Measures included housing status, employment status and hospitalizations of clients. These measures were discontinued because community psychiatric rehabilitation (CPR) measures began. Based on a review of supported housing measures, they did not consider costs.

Process and outcome measures were collected by the Missouri Institute for Mental Health and Department of Mental Health and were included in two reports dated July, 1996. The reports are studies of client outcomes for adult and child comprehensive psychiatric services and include measures regarding access to services, appropriateness of services, timeliness of services, consumer satisfaction, consumer functioning and consumer self-support. The reports do not include cost information.

Therefore, the current outcome measures collected by DMH do not consider the costs associated with those measures and therefore do not meet the statutory requirements of determination of cost and benefit effectiveness.

RECOMMENDATION TO FINDING #5

The Oversight Division recommends DMH collect outcome measures for all CPS programs and consider the costs associated with the outcome measures in order to fulfill the requirements of sections 630.415 and 632.010, RSMo 1995.

Agency Response to Finding #5

The Department does not concur with this finding, but concurs with the recommendation.

The Department continually develops new tools and methods for assessing cost-effectiveness to improve upon our existing systems for evaluation of cost-effectiveness. As the technology and standards for performance measurement change in the mental health field, the Department has a commitment to integrate these new tools for use in supporting policy, programming, and budget decision-making.

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- ▶ *There are many examples of studies conducted by the Division of Comprehensive Psychiatric Services over the years that have compared the cost/benefit of services, including, for example:*
 - ▶ *a demonstration program in Kansas City to determine the cost effectiveness of providing aggressive case management that later served as the model for the Community Psychiatric Rehabilitation program which has resulted in decreased use of expensive inpatient hospital resources.*
 - ▶ *the Children and Youth Inpatient Diversion project that demonstrated that an array of community-based alternatives to inpatient care developed with redirected inpatient funds can effectively serve children at no additional cost to the Department.*
- ▶ *These studies (as well as many examples not listed) clearly demonstrate that the Department has complied with state statutes requiring DMH to assess cost/benefit effectiveness.*
- ▶ *The development of outcome data in the Supported Housing and CPR programs will enable us to move our cost-benefit analyses of these programs to a new level. The data being collected on CPR clients includes, among other things, housing status, employment status, level of functioning, and client satisfaction data, as well as data regarding hospitalizations. This data, when adjusted for client mix and combined with existing cost data, will provide the basis for state-of-the art cost benefit analysis across programs.*
- ▶ *The MIMH studies referenced were designed to provide baseline data for further outcomes studies that would be program and provider specific. They looked at system wide measures. While it is true that they did not include a review of cost information, they were not intended or designed to produce that level of analysis.*
- ▶ *It is not true that "the current outcome measures collected by DMH do not consider the costs associated with those measures." Both earlier studies, and the current CPR outcomes project, were designed to assess both outcomes and costs.*

The Department is fully complying with statutory requirements consistent with the state of performance measurement technology in mental health services in terms of outcomes and cost data. The Department is committed to continual development and improvement in this area as technology improves.

Oversight Division's Comment to Finding #5

Based on previous comments from DMH, the demonstration program in Kansas City was conducted in fiscal year 1990, and the Children and Youth Inpatient Diversion project resulted in a redirection of funds in January, 1989, and October, 1991. Statutory intent appears to be that all CPS programs should be evaluated for cost and benefit effectiveness on an ongoing basis.

FINDING #6: Billing error rates of community mental health centers ranged from 3% to 66%.
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Contracts between DMH and the mental health centers state, "The Department reserves the right to make invoice corrections and/or changes with appropriate notification to the contractor." Monitoring of mental health centers by DMH revealed recurring billing errors. The error rates ranged from 3% to 66% for the samples of client information selected by DMH.

The Oversight Division reviewed seven letters dated in July and August of 1996 summarizing the results of quarterly monitoring visits for fiscal years 1995 and 1996 which revealed the following billing problems, totalling approximately \$31,000:

- ▶ Missing progress notes, weekly summaries or individualized treatment plans (ITPs), and
- ▶ Discrepancies between the number of units billed and the number of units documented in the charts.

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In addition to quarterly monitoring, DMH's internal audit staff performs audits of mental health centers on an as needed basis. Problems discovered in seven audits for periods ranging from July 1, 1992, through April 30, 1995, totalling approximately \$21,000, included the following:

- ▶ Payments for the same service from multiple funding sources;
- ▶ Services paid for from incorrect funding sources;
- ▶ Payments for services in excess of what was actually provided;
- ▶ Failure to bill Medicare, Medicaid and private insurers; and
- ▶ Lack of documentation of the Standard Means Test and verification of financial data.

The billing errors require DMH to adjust subsequent invoices, resulting in additional paperwork by the department. Only overpayments detected by DMH are adjusted. Overbillings by mental health centers could result in DMH reimbursing services earlier in the year than necessary. The compounding effect of billing errors could result in an unrealistic estimate of the budgetary allocation of state funds for each mental health center.

RECOMMENDATION TO FINDING #6

DMH should recoup the overbillings within two months of discovery of the errors and enforce penalties for noncompliance in order to encourage compliance with DMH standards (see finding #7 regarding DMH charging interest). DMH should also consider ongoing training for the mental health centers regarding internal controls over billings.

Agency Response to Finding #6

The Department partially concurs with this finding and recommendation.

This finding illustrates that DMH monitoring and auditing procedures are effective in identifying billing errors. However, it is important to note that the letters reviewed by the Oversight Division audit team represented agencies that were selected as billing "outliers" for 1995 and 1996 through an automated algorithm analyzing amount and cost of services billed, and therefore do not provide a representative sample of the Department's providers.

To improve provider billing accuracy and documentation, the Department

has utilized a variety of methods including, but not limited to, policy modifications and clarification, provider training, provider technical assistance, and expanded monitoring. These tools have been effective in reducing error rates in most cases. The Department seeks recoupment of overpayments identified by monitors.

- ▶ *All providers are monitored on a quarterly basis.*
- ▶ *The Department is monitoring service delivery from 3 to 6 months after delivery.*
- ▶ *DMH has procedures for recoupment of both Medicaid and POS overpayments.*
- ▶ *Acceptable levels of billing errors have been established and performance that does not meet the standard result in additional actions and sanctions.*
- ▶ *The Department defines discovery of errors as the point in time when official written notification is made to the provider of a suspected overpayment. Date of discovery is extended by provider appeals until the point of written notification of final determination by the appropriate appeal authority.*

The Department considers three months a reasonable timeframe from discovery to recoupment in order to allow for appeals and statewide compilation of findings in a quarter to the state Medicaid agency.

DMH has provided statewide provider training related to its monitoring efforts and is available to conduct additional training upon the request of a provider or based on poor performance by a provider.

FINDING #7:	The Department of Mental Health is not complying with the statutes requiring interest to be charged on overpayments to mental health service contractors.
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The contracts with the administrative agents state under "Financial Requirements" that "All overpayments SHALL be collected in accordance with section 630.460, RSMo." Since 1984, section 630.460, RSMo, requires a service provider funded by DMH to reimburse the department for any

overpayment within forty-five days after the overpayment is discovered. If the department is not reimbursed within forty-five days, interest is to be charged at the rate of one and five-tenths percent per month (18% annually) from the date the overpayment is discovered. In 1996, SS For SCS For HB 1081 was signed into law and became effective August 28, 1996. This bill amended section 630.460 by allowing a provider to request a review of the overpayment with the department and reducing the interest rate to prime plus three percentage points.

The Department of Mental Health is not charging interest to the mental health centers for overpayments resulting from inaccurate billings by the mental health centers, which were discovered by DMH through quarterly monitoring. According to records maintained by DMH, overpayments from state funds not yet settled with contractors for calendar year 1995 and fiscal year 1996 total approximately \$50,000. The majority of these overpayments were discovered prior to the effective date of HB 1081 and should therefore have interest accrued at the rate of eighteen percent annually. The failure to charge interest on overpayments allows the mental health centers to receive interest-free advances from the Department of Mental Health.

RECOMMENDATION TO FINDING #7

The Oversight Division recommends DMH calculate and collect interest on overpayments in accordance with Section 630.460, RSMo. The collection of interest could increase contractors' incentives not to overbill DMH for services provided.

Agency Response to Finding #7

The Department does not concur with this finding, but concurs, and already complies with, this recommendation.

- ▶ *DMH does assess interest on overpayments to mental health contractors. DMH provided letters as examples of notification to contractors indicating interest will be assessed if payment is not made within 45 days. Since the overwhelming majority of contractors settle the overpayments within the timeframe established by the statute, interest charges are rarely collected. However, when a contractor fails to make repayment, interest is charged and collected.*

- ▶ *During an effort to improve the timeliness of monitoring reports, there was a significant increase in the volume of monitoring conducted during the summer and fall of 1996. Due to the volume of monitoring conducted during this period, reports and recoupments are still in process. It is premature to conclude that interest on overpayments will not be charged on these findings.*
- ▶ *The Department defines discovery of errors as the point in time when official written notification is made to the provider of a suspected overpayment. Date of discovery is extended by provider appeals until the point of written notification of final determination by the appropriate appeal authority.*

The Department already complies with this recommendation.

Oversight Division's Comment to Finding #7

The examples of interest charged by DMH included in their letters were not included in the DMH records used as the basis for the finding. The overpayments included in the records from quarterly monitoring examined by Oversight did not include interest calculations.

FINDING #8:	The Department of Mental Health does not adhere to state regulations requiring both a physician and/or psychologist and qualified mental health professional to sign intake assessments and annual evaluations.
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The certification standards for mental health programs in the Code of State Regulations, 9 CSR 30-4.035 (17)(18), establish criteria for completion of intake assessments and annual evaluations. The regulations require the signatures of both a physician and/or psychiatrist and a qualified mental health professional to sign intake assessments and annual evaluations. The Provider Monitoring Guide, developed by the Division of Comprehensive Psychiatric Services (CPS), also addresses the issue of appropriate documentation.

A review of 23 intake assessments from three different administrative agents revealed that the assessments are not consistently being signed by both a physician and/or psychologist and a qualified mental health professional in accordance with state regulations. The Provider Monitoring Guide contains

conflicting information on the signature issue. Section 2 of the guide states that involvement by the physician and qualified mental health professional is to be documented by their signatures on the assessment and individualized treatment plan. Section 9 indicates that both signatures would not be necessary as long as there is other documentation that the required staff were involved in a "meaningful and substantive way". Lack of this involvement would result in the total payment being recouped by DMH. DMH intends to amend the Community Psychiatric Rehabilitation (CPR) recoupment rule in the Provider Monitoring Guide by allowing only partial recoupment, depending on the documented level of involvement by the physician and/or psychologist and qualified mental health professional.

Failure to adhere to the state regulations could result in inadequate intake assessments and evaluations, ultimately resulting in the provision of inappropriate services.

RECOMMENDATION TO FINDING #8

The Oversight Division recommends the Department of Mental Health adhere to the Code of State Regulations with regard to the required signatures or amend the regulations to reflect the current practice of accepting additional documentation and partial recoupment of payments. In addition, the Department of Mental Health should also amend its Provider Monitoring Guide to make it consistent with the regulations.

Agency Response to Finding #8

The Department does not concur with this finding.

- ▶ *The intent of this requirement is to assure that qualified staff have substantive involvement in, and contribution to, the assessment and treatment planning processes. The signature provides an easy way to document the appropriate involvement of these staff.*
- ▶ *Acceptable documentation may include the physician's signature on a service plan indicating the physician's involvement in the assessment, Individual Treatment Plan development, and eligibility determination processes; a narrative progress note by the treatment team leader describing the participation and contributions made by the physician; or a separate physician note or addendum in the*

medical record but separate from the assessment, describing the physician's role and involvement in the assessment and treatment planning processes. Since these alternative methods of documentation often provide more information about the role of the physician in these important processes than does a simple signature on the assessments, these methods are in full compliance with the standard.

- ▶ *In practice, as the result of provider education and sanctions, the Department's monitoring has found that agencies are now in full compliance with the regulation.*
- ▶ *While it is true that failure to comply with state regulations for the CPR Program "could" result in the provision of inappropriate services, the Department's program monitoring indicates that there is no evidence that the alternative methods of documentation used to assure compliance with the intent of this standard have in any way resulted in the provision of inappropriate services.*

The Department continues to require the involvement of both a physician and/or psychologist and a qualified mental health professional and promote substantive contributions of these professionals to the clinical process and outcomes.

<p>FINDING #9: The Department of Mental Health is not performing on-site certification surveys in a timely manner, resulting in administrative agents and affiliates operating as community psychiatric rehabilitation centers and outpatient mental health centers with expired certificates.</p>

Authority for certification of administrative agents and affiliates as community psychiatric rehabilitation centers (CPRC) and outpatient mental health centers is contained in the DMH Code of State Regulations, 9 CSR 30-4.031 and 9 CSR 30-4.020, respectively. Sections 630.005 and 630.655, RSMo 1995, also provide statutory authority for the provision of services. According to DMH licensure personnel, certification reviews are not always conducted on a timely basis.

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In September, 1996, the Oversight Division audit staff reviewed certification of administrative agents and affiliates as CPRCs and outpatient mental health centers. Of the twenty administrative agents which have community psychiatric rehabilitation (CPR) certificates, three have expired CPR certificates, and one is on probationary status. Of the twenty AAs which have outpatient certificates, one has an expired outpatient certificate, and one is on probationary status. Of the thirteen affiliates which have CPR certificates, three have expired CPR certificates, and of the five affiliates which have outpatient certificates, three have expired outpatient certificates. The expiration dates ranged from July, 1996, to September, 1996. Additionally, it was noted that CPR certificates for six administrative agents were slated to expire during October, 1996.

According to DMH personnel, if corrective action plans are needed, issuance of a new certificate could take, on average, ninety days. For example, for one administrative agent, copies of the new certificates, with issuance dates of July 15, 1996, were received by the audit team on October 16, 1996. DMH back dates the certificates in order to show continuing certification. The on-site certification survey revealed that the administrative agent had deficiencies which required a plan of correction. However, this plan was not approved until after October, 1996, resulting in the administrative agent operating approximately three months without proper certification. DMH licensure personnel indicated that it was departmental practice to assume that a provider was "deemed certified" until decertified, even if the certificate was expired.

Failure by the Department of Mental Health to conduct timely on-site certification surveys could potentially affect their ability to ensure the quality of services provided by the AAs and affiliates. In essence, providers are operating without proper certification, and DMH does not attempt to recoup any payments reimbursed during this time period.

RECOMMENDATION TO FINDING #9

The Oversight Division recommends the Department of Mental Health develop a tracking system to ensure that on-site certification surveys are conducted in a timely manner, resulting in uninterrupted certification of the administrative agents as community psychiatric rehabilitation centers and outpatient mental health centers.

Agency Response to Finding #9

The Department does not concur with this finding, but concurs, and already complies with, this recommendation.

- ▶ *Recertification procedures were initiated, and site visits conducted, prior to the expiration of the certificate for all CPR and Outpatient Programs requiring recertification in 1996. In all cases, site visits are completed prior to the expiration date. In some cases, the certification process extends beyond the expiration date of the certificate when a plan of correction has not been fully approved by the expiration date. Once a plan of correction fully approved, the program is recertified with an effective date consistent with the expiration date of the previous certificate.*
- ▶ *If for some reason, DMH is unable to schedule a site visit prior to the expiration of the certificate, the certification of the organization is extended until the survey is completed. These extensions of certification occur very rarely and when they do occur, they are documented formally, in writing, and are time limited.*
- ▶ *These procedures are consistent with accepted industry standards of practice for accreditation and regulatory organizations such as JCAHO, CARF, Medicare, and nursing home licensure agencies.*

DMH already has a tracking system to assure that on-site surveys are conducted in a timely manner, prior to the expiration of the certificate.

<p>FINDING #10: The Department of Mental Health did not ensure that Park Hills Mental Health Services had the proper certification or accreditation to be providing outpatient mental health services.</p>

The Code of State Regulations, 9 CSR 30.4-020, requires DMH to certify each agency's level of service. The regulations require DMH to certify an agency accredited by the Joint Commission on the Accreditation of Hospital Organizations (JCAHO).

Park Hills Mental Health Services was established in 1994 to provide outpatient services to the customers of St. Francois, Washington and Iron

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counties. Prior to 1994, Park Hills was part of Southeast Missouri Mental Health Center (SEMMHC). Oversight verified with JCAHO that SEMMHC was accredited in 1993 at which time the outpatient portion was also accredited. In addition, Oversight verified with JCAHO that SEMMHC was currently accredited, but that Park Hills was not, and as a separate entity it would need to be accredited separately. During the last on-site certification survey, DMH discovered that Park Hills did not have its own outpatient certification. In effect, Park Hills Mental Health Services has been providing outpatient services without proper certification or accreditation.

Three years ago when SEMMHC was accredited, the quality of outpatient services was acceptable for accreditation, but with the separation of Park Hills in 1994 there would be no means for ensuring the continuing quality of services without proper accreditation.

RECOMMENDATION TO FINDING #10

The Oversight Division recommends Park Hills Mental Health Services seek accreditation from the Joint Commission on the Accreditation of Hospital Organizations and certification by the Department of Mental Health in accordance with state regulations.

Agency Response to Finding #10

We concur that Park Hills MHS was not properly certified as an outpatient provider for a period of time. It is important to note, however, that throughout this period, Park Hills was certified by DMH as a CPR Program and that many of the CPR Program certification requirements parallel the Outpatient Program certification requirements. Park Hills is now in the process of becoming a certified outpatient provider consistent with state regulations.