Oversight Division

Committee On Legislative Research

PROGRAM EVALUATION

Department of Mental Health
Review of Contract and Bid Procedures and Accountability

Program Evaluation
Department of Mental Health
Review of Contract and Bid Procedures and Accountability

Prepared for the Committee on Legislative Research
by the Oversight Division

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Members of the General Assembly:

The Joint Committee on Legislative Research adopted a resolution in May, 2002, directing the Oversight Division to perform a program evaluation of 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,

Representative Rod Jetton
Chairman

EXECUTIVE SUMMARY

The Department of Mental Health (DMH or Department) was established as a cabinet-level state agency on July 1, 1974. The Department serves Missourians with mental disorders, developmental disabilities, and substance abuse; by treating, habilitating, and rehabilitating persons with those conditions; and by educating the public about mental health. The Department was appropriated approximately seven percent (7%) of the total state operating funds for fiscal year 2003 and has the largest workforce in state government.

Each year DMH provides services to more than 140,000 Missourians and their families through the Division of Alcohol and Drug Abuse (ADA), the Division of Comprehensive Psychiatric Services (CPS), and the Division of Mental Retardation and Developmental Disabilities (MRDD). DMH makes services available through state-operated facilities and contract providers. Each of the twenty-eight facilities has the delegation of authority to procure commodities/professional services under $25,000.

Each of the three divisions (ADA, CPS and MRDD) has its own types of service contracts, some of which are competitively bid and some of which are exempt from competitive bidding requirements. The Office of Administration, Division of Purchasing and Materials Management (OA-DPMM) delegates authority to the DMH to handle their own procurement practices for service contracts under the Special Delegation of Authority (SDA), previously referred to as the Contract Delegation of Authority (CDA). There was an average of 2,966 vendors with over four thousand (4,000) Purchase of Service (POS) and Community Placement (CPP) contracts each year administered by the DMH procurement and contracts area for FY 1998 to FY 2002. Approximately two-thirds of the contracts are for the Division of Mental Retardation and Developmental Disabilities services. In FY 2002, ADA's budget was $71 million while CPS and MRDD's budgets were $322 million and $267 million, respectively.

Oversight selected a sample of sixty contract providers and reviewed actual contract bid files for these providers. The sample included files from the three divisions as well as administrative files. Oversight notes that two original CSTAR bid files for contracts procured in 1991 for ADA providers could not be located. Since these files could not be located, Oversight could not determine if these two active contracts were properly bid. Oversight recommends DMH maintain bid files. Also, Oversight notes that DMH does not use any type of numbering system to determine how many renewals, amendments, and/or project requests were performed on their contracts. Oversight's review revealed that some of the bid files for contracts contained items or areas that were unclear. Oversight recommends DMH number all amendments, renewals and project requests. A listing of all the renewals, amendments and project requests should also be placed in the front of the folder stating the number of the item, and a short description of what the purpose is for the renewal, amendment or project request. Oversight recommends that DMH consider, as a matter of good business practice, to periodically re-bid their contracts. This would allow an opportunity for new providers to bid for services and give providers with current contracts the chance to change contract provisions.

Oversight selected a sample of Purchase of Service (POS) providers and reviewed actual invoices for these providers. These POS providers can bill for the allowable services performed at any time during the current state fiscal year. For example, if a provider performs services in July of a given year, that provider may delay billing DMH until June of the next year (same fiscal year). Oversight recommends DMH periodically review billings for POS providers who bill for services performed beyond a reasonable time frame and consider implementing a policy where services performed more than three months prior would require additional documentation or approval before DMH would pay for such services. Also, Oversight notes POS providers usually bill the specific allowable service performed and itemize it by the individual patient or client that receives the treatment. However, Oversight found one provider who was allowed to "estimate" the billable services provided under a non-specific client ID at the end of the fiscal year and consequently be paid based on these estimates. As it turned out, the provider had over-billed the estimate by nearly $95,000 and therefore developed a credit in the amount of the over-billing, that ultimately was used by DMH against a later invoice. Oversight recommends that DMH not allow estimates of services provided and require contract service providers bill for only client-specific itemized services. In addition, Oversight notes POS providers are allowed to bill client-specific services to "Client" or "Dummy". Oversight recommends DMH limit the use of the non-specific billing names used by service providers.

Oversight reviewed the review processes for ADA, CPS and MRDD providers and how providers are licenced and certified. The ADA Billing Review Unit gives providers advance notice of which files will be reviewed prior to their arrival. Oversight recommends that since advance notice of audit files to be reviewed allows the provider time to change, update, and/or correct a file, the ADA Billing Review Unit should not notify providers of specific case files prior to their arrival. If file location is a concern, the Unit could request additional audit files be made available than needed and once on site, select a sample from those files for review. Also, Oversight obtained a listing of the internal audit reports issued for the evaluation period and selected a small sample for review. Oversight's review revealed DMH Audit Services staff is decreasing while the need for audit services remains unchanged. The staff is also required to perform numerous other projects, reducing the resources available for audits. Oversight recommends DMH consider increasing the audit staff and reducing the number of extra activities required to be performed by the staff of Audit Services.

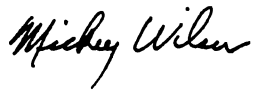
Oversight notes that prior to October, 31, 2001, the Licensure and Certification Unit did not have documentation in the provider files supporting the extended certification status of providers who had certification surveys completed but were working on Plans of Correction at the time the certification expired. Also, Oversight notes DMH needs improvement to prevent Community Placement payments continuing after the death of the client. Oversight recommends DMH programming staff create a program to run the death certificate information against the payment records of all identified deceased clients on a periodic basis.

Oversight notes DMH made a significant change in the implementation schedule for the Customer Information Management, Outcomes and Reporting (CIMOR) system, a multi-year project designed by DMH to replace the current DMH information systems. The contract with

iServ was cancelled for breach of contract. Rose International is now contracted to complete the project. In the future, Oversight recommends a risk analysis be performed by the Office of Information Technology.

In addition, Oversight notes that DMH has not implemented Oversight's prior audit recommendations relating to professional signatures on intake assessments and annual evaluations, rebidding ADA provider contracts, and performing MRDD billing reviews.

The Oversight Division did not audit departmental financial statements and accordingly, does not express an opinion on them. The Oversight Division wishes to thank the Department of Mental Health staff for their cooperation and assistance during the evaluation.



Mickey Wilson, CPA
Director

Chapter One - Introduction

Purpose

The General Assembly has provided by law that the Committee on Legislative Research may have access to and obtain information concerning the needs, organization, functioning, efficiency and financial status of any department of state government or of any institution that is supported in whole or in part by revenues of the state of Missouri. The General Assembly has further provided by law for the organization of an Oversight Division of the Committee on Legislative Research and, upon adoption of a resolution by the General Assembly or by the Committee on Legislative Research, for the Oversight Division to make investigations into legislative and governmental institutions of this state to aid the General Assembly.

The Joint Committee on Legislative Research directed the Oversight Division to perform a program evaluation of the Department of Mental Health's contract and bid procedures and accountability, for the purpose of providing information to the General Assembly regarding proposed legislation and appropriation bills.

Background

The Missouri Department of Mental Health (DMH or Department) was established as a cabinet-level state agency on July 1, 1974. The Department serves Missourians with mental disorders, developmental disabilities, and substance abuse; by treating, habilitating, and rehabilitating persons with those conditions; and by educating the public about mental health. DMH relies on funding recommendations by the Governor and approval by the Missouri General Assembly. The Department was appropriated approximately seven percent (7%) of the total state operating funds for fiscal year 2003.

DMH's major goal is to help provide a higher quality of life and increased independence for the people it serves by providing treatment and family support services. One important step toward this goal is to combat the stigma of mental health problems through public exposure of the facts about mental illness, developmental disabilities, and substance abuse. The Department of Mental Health aims to help end discrimination against people with disabilities and to provide hope to those suffering with mental illness.

DMH has the largest workforce in state government. The Department's 10,500 full-time employees, located within 32 community facilities and one administrative office, and employees of numerous contract agencies, provide appropriate services to individuals in the least-restrictive environments possible.

ADA makes treatment services available by contracting with community-based agencies. Individuals seeking help are admitted based on severity of need. They are charged for the cost of their care on a sliding scale according to income. Major programs include the Comprehensive Substance Treatment and Rehabilitation Program (CSTAR), General Treatment Services, Substance Abuse Traffic Offenders Program (SATOP), and Compulsive Gambling.

ADA offers prevention and treatment services through community contracted providers and through Department of Mental Health facilities. DMH has a Special Delegation of Authority (SDA) to enter into contracts for ADA. The contracts for services under ADA are competitively bid. The DMH has the authority to do its own bidding, but must follow Chapter 34, RSMo requirements. ADA has a separate Expenditure Registration (ER) approved by OA-DPMM for the CSTAR program which justifies fixed pricing for the contracts instead of the lowest and best. ADA also has a separate ER for SATOP since it is based upon statute and a judge determines where an offender goes for the weekend intervention program. The ER provides justification for the non-competitive nature of the bids for CSTAR and SATOP.

The Division's budget for FY 2002 was $71,429,011. Of the budgeted amount, funding for treatment services is 74%, prevention services 14%, SATOP 5%, Compulsive Gambling 1% and administration 6%. A large portion of the ADA budget is from Federal Funds (49%). State funding sources include General Revenue 39%, Health Initiative Fund 9%, Mental Health Earnings Fund 2%, and Compulsive Gambling Treatment 1%. Approximately 32,000 Missourians seek treatment from the ADA annually.

Division of Comprehensive Psychiatric Services

The Division of Comprehensive Psychiatric Services (CPS) is responsible for assuring the availability of prevention, evaluation, treatment and rehabilitation services for individuals and families requiring public mental health services. The goal of CPS is to give priority to people with serious mental illness, individuals in acute crisis, individuals who are homeless and mentally ill, those committed for treatment by the courts system, and children with severe emotional disturbances.

CPS is authorized and charged by Section 632.020, RSMo with the responsibility of "insuring that Division prevention, evaluation, treatment and rehabilitation services are accessible whenever possible."

CPS provides an array of services, including evaluation, day treatment, outpatient care, psychiatric rehabilitation, housing, crisis services, and hospitalization as well as evaluation and treatment of persons committed by court order. Eligibility for these services is determined through regional administrative agents designated by the Division. Administrative agents are given a great deal of autonomy and authority in the way they provide services. ER0198 was

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obtained to allow administrative agents for CPS to make purchases without first going through OA-DPMM.

Providing intermediate and long-term care on a regional basis, CPS has three state psychiatric hospitals, St. Louis, St. Joseph and Fulton, as well as one mental health center located in Farmington which also services sexual offenders. There are four mental health centers located in St. Louis, Kansas City, Eldorado Springs and Columbia that provide acute psychiatric care and emergency psychiatric services to persons with mental illness. In addition, CPS operates an acute children's psychiatric hospital in St. Louis and one residential facility in Cape Girardeau.

CPS divides Missouri into 25 service areas. Each service area has a service provider designated as the division's administrative agent. These administrative agents are responsible for the assessment and services to persons in their assigned areas and for providing follow-up services for persons released from state-operated inpatient services. Children and youth are provided services in much the same way through contracts with administrative agents and state-operated children's hospitals. Persons in supported community living programs receive support through case management and community psychiatric rehabilitation programs provided by administrative agents.

Through the purchase-of-service (POS) mechanism, contracted arrangements are made with local community health centers and providers to provide screening, evaluation, psychotherapy, and medication services.

The appropriation for the CPS for FY 2002 was $321,748,632, with over 5,146 FTE. The same division had an appropriation the following year (FY 2003) of $303,383,789 with over 4,976 FTE. During Fiscal Year 2001, the division reported providing services to 11,146 youths and 53,742 adults. A total of 64,425 clients is projected to be served in FY 2003.

Division of Mental Retardation and Developmental Disabilities

The Division of Mental Retardation and Developmental Disabilities (MRDD) serves persons who have been diagnosed with mental retardation, cerebral palsy, epilepsy, head injury, autism, or a learning disability related to a brain dysfunction. These mental or physical impairments must be manifested before the age of twenty-two, be likely to continue indefinitely and result in substantial functional limitations. The Division's primary mission is to help improve the lives of persons with developmental disabilities through programs and services which enable those persons to live independently and productively, given their individual needs and capabilities.

MRDD operates seventeen facilities that provide or purchase specialized services. Eleven regional centers form the framework for the system, backed by six habilitation centers, which provide residential care and habilitation services for more severely disabled persons.

The regional centers, the primary points of entry into the system, provide assessment and case management services, which include coordination of each client's individualized habilitation plan. A regional center may refer a client to a habilitation center. Habilitation centers primarily serve individuals who are severely disabled, behaviorally disordered, court-committed, or medically fragile. All habilitation centers are Medicaid certified.

The programs and services offered by MRDD include community-based services and consumer and family directed supports including: Missouri's Consumer and Family Directed Supports, the Home and Community-Based Waiver program, the Sara Jian Lopez Medicaid Wavier, the Family Stipend and Loan Program, the Certification and Quality Enhancement program, the Missouri Alliance for Individuals with Developmental Disabilities, First Steps Program, and Choices for Families.

MRDD is delegated authority by OA-DPMM to establish contracts for the purchase of consumer services under ER0199. Qualified vendors who accept all of the stipulations of the agreement, are contracted with and their name goes into a pool of potential service providers that the consumer may choose from. MRDD contracts are not competitively bid.

MRDD serves approximately 27,460 persons annually. Many of these individuals because of their disabilities, face barriers to the basic opportunities of education, employment and community life. The Division employs 4,897 full time equivalent employees who are committed to helping people with developmental disabilities live as independently and productively as possible. The total budget for FY 2002 was $276,111,678. For FY 2003, MRDD projects 27,597 individuals will be served by their division.

Objectives

The program evaluation of DMH included the inspection of records for the purpose of providing information to the General Assembly for their consideration in proposing legislation and reviewing appropriation bills. The objectives of the Oversight Division's evaluation of DMH included:

- Reviewing the DMH policies and procedures for bids and contracts for goods and services.
- Determining whether DMH contracts are adequate to ensure DMH's needs and goals are met.
- Determining whether DMH is following state purchasing guidelines for the procurement of treatment services for clients;
- Verifying DMH compliance with the various state laws and regulations concerning the procurement of goods.
- Reviewing the procedures for ensuring accountability of contracts.

Scope/Methodology

The scope of the evaluation included the time period from July 1, 1997 to June 30, 2002. The scope was not limited to specific fiscal years, although for most analysis, data from fiscal years 2000 through 2002 was utilized.

The methodology used by the Oversight Division for the evaluation included reviewing statutes, rules and regulations, organizational charts, and selected DMH contract and bid files; interviewing DMH personnel; examining financial records and supporting documentation; and testing samples of transactions to the extent necessary to fulfill review objectives. Also, the State Auditor's Office audit reports and past Oversight reports were reviewed.

Chapter Two - Comments

Bid Files for Contracts

Chapter 34, RSMo states all purchases in excess of $3,000 shall be based on competitive bids, unless otherwise exempted. Oversight selected a sample of sixty contract providers and reviewed actual contract bid files for these providers. The sample included files from the three divisions as well as administrative files. The files were reviewed for appropriate documentation, contract dates, signatures, authority, amendments, services defined, unit price and sub-contractors.

Comment #1 Two original CSTAR bid files for contracts procured in 1991 for ADA providers could not be located.

In 1991, ADA procured its own contracts. This responsibility was shifted to the Contracts Section in 1998. The Contracts Section provided the requested bid files for Oversight's review or requested the bid files from ADA. ADA personnel could not locate the original bid files for two CSTAR providers, procured in 1991.

According to the RFP for one of the CSTAR providers, 15 services were to be provided. Each CSTAR provider has a Purchase of Service Catalog. The Purchase of Service Catalog is a report which shows all services a provider is authorized to provide. According to the August 25, 2002 catalog, the provider was authorized to provide approximately 51 different services. All but three of these services were added by contract amendment. DMH has spent $6,572,000 on the provider's contract for the CSTAR portion of services provided for the five years ended June 30, 2002.

According to the RFP for another provider, 14 services were to be provided. According to the August 25, 2002 Purchase of Service Catalog, the provider was authorized to provide approximately 68 services. All but 33 of these services were added by contract amendment. DMH has spent $4,227,000 on the provider's contract for the CSTAR portion of services for the five years ended June 30,2002.

Since these files could not be located, Oversight could not determine if the contracts were properly bid.

Oversight recommends DMH maintain bid files.

Comment #2 DMH does not use any type of numbering system to determine how many renewals, amendments, and/or project requests were performed on their contracts.

DMH does not use any type of numbering system to determine how many renewals, amendments, and/or project requests were performed on their contracts. Oversight's review revealed that some of the bid files for contracts contained items or areas that were unclear.

A contract with a private university was to provide medical direction for Hawthorne Children's Psychiatric Hospital (HCPH) by supplying a board-certified psychiatrist to serve as Medical Director. This contract was accepted by DMH on February 9, 1993. On March 29, 1993, additional revisions were added to the original contract. Included in this was an attached Purchase of Service Contract Amendment that added Malcolm Bliss Mental Health Center. The contract with Malcolm Bliss was renewed several times; however, the date of the original contract is unclear in all renewals. The assumption could be made that the "date of the contract" would be the "original", as in the date the first contract was signed with the private university. However, the date used was July 1, 1994. This portion is either not in the file reviewed or the date is incorrect on this amendment. On July 1, 1997, another amendment was added including the St. Louis Metropolitan Psychiatric Center. This contract was also renewed several times. The amendment adding the St. Louis Metropolitan Psychiatric Hospital states that the "contract" was entered into on July, 1995 (no day given). However, the original contract date was February 9, 1993. The original contract date varies from each amendment and adds to the confusion. It should also be noted that none of the amendments and/or renewals is numbered which makes it difficult to determine how many amendments there were and what was contained in those amendments. As of June 30, 2002, DMH has paid $4.4 million on this contract.

A contract with a public university on behalf of the Missouri Institute of Mental Health was for the contractor's performance of DMH project requests, as needed. To date, approximately thirteen "as needed" projects were performed at a total cost of $621,791. Each year the contract was renewed, the "Project Request" number either reverted back to Project Request No. 1 or it continued forward from the previous request. Due to the way the project request numbering is done, the total number of project requests to the original contract is difficult to determine.

Oversight notes that there is no time limit to these contracts or any other contracts reviewed. According to DMH, contracts can be renewed for indefinite periods of time. (See the Oversight recommendation to periodically rebid DMH contracts below.)

In addition, six contract amendments belonging to other providers were found in the contract file of one provider. A numbering system would aid in the accountability of amendments, renewals and/or project requests. Oversight was unable to determine how many amendments had been approved.

In 2002, DMH revised their contract amendment process. The "Contract Amendment/Renewal" is now sent to the provider of the service stating that the contract is extended through the appropriate fiscal year date. However, these renewals are also not numbered. DMH has an average of 2,966 vendors with over four thousand contracts.

Oversight recommends DMH number all amendments, renewals and project requests. A listing of all the renewals, amendments and project requests should also be placed in the front of the folder stating the number of the item, and a short description of what the purpose is for the renewal, amendment or project request.

If services are added to a contract, Oversight recommends they be supported by a contract amendment. Also, DMH

should consider rebidding contracts rather than adding services.

Oversight notes that DMH is not statutorily required to re-bid contracts and it is DMH's current policy to renew the provider contracts unless the provider no longer meets certification requirements. However, Oversight recommends that DMH consider, as a matter of good business practice, to periodically re-bid their contracts. This would allow an opportunity for new providers to bid for services and give providers with current contracts the chance to change contract provisions.

Billing Issues

Purchase of Service (POS) providers directly bill DMH for the services they provide to eligible patients. DMH routinely conducts annual reviews of ADA and CPS POS providers. Oversight selected a sample of providers and reviewed actual invoices for these providers.

Comment #3 DMH service providers can bill for services provided at any time during the current fiscal year.

These POS providers can bill for the allowable services performed at any time during the current state fiscal year. For example, if a provider performs services in July of a given year, that provider may delay billing DMH until June of the next year (same fiscal year).

DMH's system requires services billed by the providers be itemized by client, by service and by date. As long as there is not an identical service performed for the same patient on the same day, providers can bill DMH for services for any period within the current fiscal year. These items are listed separately, by month the services were performed, on the invoice, but reimbursement by DMH is not impacted or scrutinized if any aged services are billed.

In the small sampling of invoices from FY 2002 that Oversight reviewed, a particular provider in St. Louis billed in June, 2002 for services dating back to September, 2001. Allowing providers to bill for services performed

potentially up to eleven months ago seems to encourage the delay in inputting information into the POS system. Obviously, for sound business practices regarding cash flow and budgeting, providers should not delay in billing DMH for services performed. Oversight assumes it would be beneficial to DMH if service providers billed for services in a timely manner.

Oversight recommends DMH periodically review billings for POS providers who bill for services performed beyond a reasonable time frame. For example, DMH should consider implementing a policy where services performed more than three months prior should require additional documentation or approval before DMH would pay for such services.

Comment #4 DMH providers are allowed to estimate services provided.

POS providers usually bill the specific allowable service performed and itemize it by the individual patient or client that receives the treatment. The providers are allowed to bill for services performed at any time during the current state fiscal year. However, the invoices must be entered into the system and allocated down to the individual client, by the fiscal year end cut-off date, which is in the middle of July. In mid-July, DMH closes out the previous fiscal year and opens reporting and billing for the new fiscal year.

For FY 2001, a large provider of CPS services apparently did not believe they would be able to input all of their unbilled services into the DMH system by the fiscal year end cut-off date. Therefore, the provider requested and was granted special permission by DMH to "estimate" the billable services provided under a non-specific client ID at the end of the fiscal year and consequently be paid $279,781 in FY 2001 based on these estimates. The provider agreed to provide client specific service billings for the period estimated, as available, to reconcile against the estimate and DMH records.

As it turned out, the provider had over-billed the estimate in July by nearly $95,000 under the non-client specific ID

and therefore developed a credit in the amount of the over-billing, that ultimately was used by DMH against the August invoice.

Service providers can bill for services at any point in a fiscal year and are required to input services performed into the DMH billing system by individual patient or client name. The system will reject if the same services are keyed in for the same patient on the same day. Therefore, providers can bill for services performed in July or August at any point until the end of the fiscal year in which the services were performed and any provider allowed to use a non-client specific ID would not be subject to the system check.

Since the provider overestimated their billing services for FY 2001, DMH allowed them roughly $95,000 of state money free for over a month. The estimates were utilized in mid-July and the corresponding credits were not determined and recovered by DMH until September (for the August billings). This allowed the provider to retain the allocated funds for services in FY 2001 and not have them lapse by having the payments occur in FY 2002.

Oversight recommends that DMH not allow estimates of services provided and require contract service providers bill for only client-specific itemized services.

Comment #5 POS providers are allowed to bill client-specific services to "Client" or "Dummy".

Some contract service providers bill services to a feigned patient named, "Client" or "Dummy". Examples of services billed on behalf of these fictitious clients from the small sample that Oversight reviewed include:

- Peer support billed for $6,874;
- Day care for the homeless billed for $16,594;
- Quality of care initiative billed for $3,750 and $9,626; and
- Access/crisis intervention billed by a large provider for $134,936.

These billed services were paid by DMH just as any other client service would be paid.

DMH's system requires services billed by the providers be itemized by client, by service and by date. Therefore, all services that are billed through the POS system must utilize a specific client and their corresponding identification number in order for DMH to pay for the services. Providers have utilized the feigned clients as a way to bill for services that are not easily attributed to individual and specific patients.

"Client" and "Dummy" have been used by providers to bill services for administrative expenses, group therapies and group education sessions. DMH states that a few clinical services may also be included in the "Client" billings, such as a person being evaluated by the provider (a billable service), but who is not enrolled in services (entered into the system as a patient for billing purposes). As far as Oversight could determine, any provider could potentially bill for services using "Client" or "Dummy".

By using the generic patient name of "Client" and "Dummy", DMH allows service providers to group services that should perhaps be billed to specific clients. Some of the services that were billed under "Client" or "Dummy" seem to be very client specific and probably should have been billed to an actual patient or client. In addition, the services billed through these non-client specific accounts are not reviewed by DMH before they are paid. DMH stated that they periodically look at the facilities' billings and inquire if it doesn't look right.

DMH stated that generally all Administrative Agents bill and are paid for services that are not specifically identified with an active client. The amount of services billed under non-client specific case numbers for FY 2003 was $19 million which included over $8 million spent for crisis services.

Oversight recommends DMH limit the use of the non-specific billing names used by service providers. If the

service can be identified to specific clients, then those clients' names should be used for the billings. Oversight also recommends DMH create more detailed generic names to use in discerning invoices when the service provided does not lend itself to being billed to a specific client.

DMH Contract/Billing Review Process

DMH has contract and billing review teams and established procedures to ensure provider compliance with DMH policies and provider contracts. Oversight reviewed the review processes for ADA, CPS and MRDD providers and how providers are licenced and certified. Also, Oversight obtained a listing of the internal audit reports issued for the evaluation period and selected a small sample for review.

Comment #6 ADA Billing Review Unit gives providers advance notice of files to be reviewed prior to their arrival.

The ADA Billing Review Unit gives providers advance notice of which files will be reviewed prior to their arrival for a review to expedite the ADA review. Sometimes files are with caseworkers or in satellite offices in other cities.

The ADA Billing Review Unit does a review of all ADA providers annually. The objective of the review is to get all providers doing their billing correctly and to satisfy block grant requirements. On average, a sample of 200 Medicaid transactions and another 200 non-Medicaid transaction are reviewed. The Unit reviews the sample client's chart for documentation to support the amount paid to the provider. The providers are faxed a list of case files needed approximately one to two days in advance of the unit arriving on-site. If the Billing Unit finds errors such as billings without proper documentation, ADA will recoup the amount(s) in error.

Oversight recommends that since advance notice of audit files to be reviewed allows the provider time to change, update, and/or correct a file, the ADA Billing Review Unit should not notify providers of specific case files prior to their arrival. If file location is a concern, the Unit could request additional audit files be made available than needed

and once on site, select a sample from those files for review. This would increase the number of files a provider would need to review and prepare any updates, changes, or corrections to prior to the arrival of the Billing Review Unit personnel.

Comment #7 DMH Audit Services staff is decreasing while the need for audit services remains unchanged.

Oversight's review revealed DMH Audit Services staff is decreasing while the need for audit services remains unchanged. The staff is also required to perform numerous other projects, reducing the resources available for audits.

DMH Audit Services performs compliance and financial reviews of a specific service provider or of a facility at the request of management at the facility or at the Department Deputy Director level. DMH Audit Services does not perform audits of Purchase of Service (POS) providers on a rotating basis. Audit Services does not get involved with the routine monitoring within each division unless specifically requested to do so because of a lack of audit staff.

In addition, audit staff is required to perform other projects that are administrative functions/activities. Examples of these activities are serving on Department teams or groups, liaison hours for outside audits, and management/supervisory tasks.

DMH Audit Services staffing levels have decreased from 10 FTE in 1998 to 6 FTE as of November 15, 2002. The number of audits have decreased from 28 in FY 1998 to 16 audits in FY 2002. Twelve percent (12%) of the total staff hours in FY 2002 were spent on other activities and projects. On average fifty-four percent (54%) of the total activities performed by Audit Services from FY 1998 to FY 2002 was for other activities. Follow-up reviews to prior audit findings are generally not conducted due to the lack of resources.

In the small sample of audit reports reviewed by Oversight, Audit Services staff:

- Determined the accuracy of financial statements and billings (found overpayments)
- Compared revenue from Medicaid with the provider's actual costs;
- Matched client services needed per the Personal Plan of Care with the actual services provided;
- Reviewed compliance with contract provisions;
- Matched provider client names with the names in the DMH Client Information Management System (CIMS);
- Determined provider cost of services by multiplying the unit cost by the number of units provided;
- Reviewed client medicaid eligibility records maintained by the provider;
- Recalculated revenues/expenses or payroll/overtime, as needed;
- Determined degree of compliance with contract provisions and DMH policies;
- Determined adequacy of staffing levels and pay;
- Compared employees' time sheets with client time records;
- Reviewed internal controls for bank statements and blank checks; and
- Matched room and broad funding to actual expenses incurred.

The Audit Services review of providers assists with compliance and helps identify overpayments. When an overpayment is identified, the provider's account is credited for the amount of the overpayment. However, Audit Services does not verify amounts have been recouped nor do they perform follow-up procedures to ensure overpayments identified have been recouped.

Some contracts allow the provider to input the unit price and the number of units when submitting a bill to DMH. The only cap on spending for a provider in this case is the allocation limit. Overpayments routinely result when the provider bills for services that were not provided and then later discovers the error. The more common situation involves third party payments where the provider bills DMH, receives payment, and then later receives payment

from the other source. DMH depends on the provider to determine any overpayments and ask for the amount to be recouped the next month.

Oversight notes that there could be a possible decrease in compliance with DMH policies/procedures, and an increase in overpayments not recouped by DMH because of the staff reduction and increased duties in Audit Services.

Oversight recommends DMH consider increasing the audit staff and reducing the number of extra activities required to be performed by the staff of Audit Services. An increase in audit staff would increase the number of provider-based risk assessments performed annually and ensure that contracted providers are receiving a more appropriate level of audit coverage. Also, Audit Services should ensure that any amounts identified as overpayments during the audits are actually recouped.

Comment #8 Prior to October 31, 2001, DMH Licensure and Certification Unit did not have documentation in provider files supporting extended certification status.

Prior to October, 31, 2001, the Licensure and Certification Unit did not have documentation in the provider files supporting the extended certification status of providers who had certification surveys completed but were working on Plans of Correction at the time the certification expired. The Licensure and Certification Unit's practice was to informally extend a provider's certification. Once the Plans of Correction were submitted and accepted by the Unit, a new certification was issued.

According to 9 CSR 10-7.130(5)(A) "Temporary status shall be granted to an organization if the survey process has not been completed prior to the expiration of an existing process". Subsection (5)(C) provides that "Conditional status shall be granted to an organization which, upon a site survey by the Department, is found to have numerous or significant deficiencies with standards that may affect quality of care to individuals but there is reasonable expectation that the organization can achieve compliance within a stipulated time period".

Short-term cancellations of certification status would cause significant billing and continuity of care problems. Due to confusion over the issue of when and if extensions needed to be documented, a formal policy change was made by DMH. If certification extensions are not documented in the provider files, confusion over whether or not a provider is certified to provide services would occur. If a provider is not certified, any services rendered and paid would be unallowable if Federal matching monies were involved and require recouping.

Oversight recommends the DMH Licensure and Certification Unit document all extensions granted to providers who have had certification surveys completed and are in the process of correcting deficiencies at the time certifications expire. (Effective October 31, 2001, DMH issued new certification standards and began documenting certification extensions.) Oversight recommends DMH continue to document these extensions and implement procedures to ensure extensions are being issued according to the Core Certification Standards for Psychiatric and Substance Abuse Programs.

Oversight recommends the DMH Licensure and Certification Unit verify that each provider is registered with the Secretary of State, if required, and that all state taxes have been paid.

Comment #9 DMH needs improvement to prevent Community Placement payments continuing after the death of the client.

DMH receives a tape containing the death certificate information from the Department of Health each month. The procedure has been to run the tape against the client files and enter the date of death as the release date into the CTRAC system. Currently, no check is in place to prevent payments to providers on behalf of deceased clients.

Oversight requested a match be performed between the Community Placement client files and the death certificate information from the Department of Health, Vital Statistics for the period including January 1 through June 30, 2002. Where a hit was found, the deceased client payment

records were to be reviewed. A report was prepared by DMH with only payment amounts and deceased dates. Twenty-five payments were identified as occurring after the month of the client's date of death.

Seventeen of the twenty-five payments were selected for further review. Only two deceased clients' providers received overpayments during this sample. The payments will be recouped. Right now, DMH relies on case managers to review client files/billings and catch any overpayments, or the provider to realize that their billing includes a period of time the deceased client did not receive services and notify DMH of the overpayment.

Payments made more than one month after the death of a client should be reviewed for possible overpayments. Any erroneous payments must be recouped.

Oversight recommends DMH programming staff create a program to run the death certificate information against the payment records of all identified deceased clients on a periodic basis.

Comment #10 DMH made a significant change in the implementation schedule for CIMOR.

The Customer Information Management, Outcomes and Reporting (CIMOR) system is a multi-year project designed by DMH to replace the current DMH information systems. According to the CIMOR website, "CIMOR will be more than a processing system, it will allow DMH stakeholders better access to data with meaningful, accurate reports. It will provide data for performance measurement and practice guidelines. And, it will ensure better quality services for DMH customers. The system will also be accessible over DMH's private network."

The funding for this project is not guaranteed from one year to the next. According to the budget request for FY 2001, CIMOR costs $4.7 million without on-going maintenance costs. Some expenditures for this program have been extended to FY 2002. In FY 2002, an additional $5.9 million was approved for the deployment of a network

server and work station upgrades. In FY 2003, an additional $1.75 million in Federal earnings and $2.8 million redirected from the Office of Information Systems was approved for communication line charges, server computers, network capacity, workstations, equipment leases, and increased maintenance and communication line charges. In FY 2004, and annually thereafter, anticipated ongoing costs were expected to be $2.7 million or less. The original pilot was scheduled to start April 2002 and then to be phased in. However, the CIMOR Implementation Team made a significant change in the deployment schedule. The plan was changed to do a phased in rollout to different facilities and providers over an eight month period, from September 2002 to April 2003. This new plan was to bring all state and contract providers online at the same time, on July 1, 2003.

According to information on the CIMOR website, the primary reasons for the change in deployment were:

- The opportunity to procure state-of-the-art technology and additional technical capability;
- Additional resources will be available for the development of the project; and
- Implementing the system at the beginning of a fiscal year will simplify fiscal year reporting, and avoid duplication of accounting data.

Subsequent to our field audit investigation, in January, 2003, the contract with iServ for CIMOR development was cancelled with the help of the Office of Information Technology and the Office of Administration, Division of Purchasing. DMH is now contracting with Rose International to complete the project. The CIMOR implementation date has been moved from July 1 to October 1, 2003.

According to DMH, iServ, the original CIMOR vendor, expected the purchase of iServ by Qualifacts to provide them more resources with which to support CIMOR development. However, iServ was a very small company and DMH was willing to assume some risk in contracting

with them from the beginning. DMH believes iServ was spending more than DMH paid them for their CIMOR deliverables. The contract with iServ was cancelled for breach of contract. Basically, iServ was not delivering the required functionality on schedule. In addition, iServ demonstrated that they could not be counted on to complete the project within the budget. DMH forwarded the information regarding the contract with iServ to the Attorney General's Office to consider any recourse. It is possible that iServ has no remaining assets worth going after.

According to DMH, iServ was paid a total of $3,239,131 for FY 2001, FY 2002 and FY 2003. DMH estimates that roughly 50% of the project was complete at the time the contract was cancelled.

Oversight contacted the Attorney General's Office to follow up on any recourse available. The Attorney General Office stated that they are investigating the breach of contract and looking at possible actions.

Rose International is now contracted to complete the project. Rose agreed to complete the core of the application for the remaining amount on the iServ contract. Rose is the primary vendor on the statewide contract for software development, Missouri Contract Number C202001001. This contract was awarded by the Office of Information Technology and the Office of Administration, Division of Purchasing to support all types of software outsourcing services.

In the future, Oversight recommends a risk analysis be performed by the Office of Information Technology including any additional cost because of the change and a time line signifying if and when the system will be fully operational, due to the significant change in the implementation and deployment schedule of CIMOR and the risk of unguaranteed funding from one year to the next.

Prior Audit Findings

Comment #11 DMH has failed to implement recommendations made by Oversight.

DMH has not implemented Oversight's prior audit recommendations, as follows:

1.) DMH has not implemented Oversight's prior audit recommendation to adhere to the Code of State Regulations regarding required signatures on client assessments and annual evaluations. During the program evaluation of DMH Administrative Agents, dated May 1997, Oversight noted intake assessments from different Administrative Agents were not consistently signed by both a physician and/or psychologist and a qualified mental health professional in accordance with 9 CSR 30-4.034 (2)(A) and 9 CSR 10-7.030 (11)(B). DMH stated during Oversight's follow-up on this finding that DMH did not concur with this finding. DMH stated that their current practice is in compliance "with the intent" of the regulations. DMH's position is that acceptable documentation of physician involvement may be on other documents and therefore the physician's signature on the assessment itself is unnecessary.

The lack of signatures on intake assessments and annual evaluations may indicate required staff not being present during those assessments and evaluations, as required by state law.

Oversight again recommends DMH follow state regulations and require physicians and other mental health professionals sign intake assessments and annual evaluations as required by the Code of State Regulations.

2.) DMH has not implemented Oversight's prior audit recommendation to routinely rebid provider contracts for services. During the program evaluation of the Purchasing of Mental Health Treatment Services in DMH, dated April 2000, Oversight noted that DMH does not routinely rebid ADA contracts to ensure the best services are obtained at the lowest costs. In addition, not all providers are allowed to provide treatment services which they are capable of providing. The average length of contract reviewed by

Oversight was 6.4 years. Sixteen of the contracts reviewed had been in effect for at least ten years.

DMH stated during Oversight's follow-up on this finding that DMH has not rebid any ADA contracts because the provider agencies would bid rates much higher than are currently contracted.

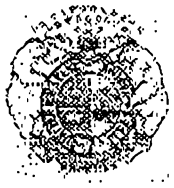
Oversight again recommends DMH periodically rebid ADA provider contracts to ensure the best services at the lowest costs available and to offer admission into the provider network for potential providers for ADA services.

3.) DMH has not implemented Oversight's prior audit recommendation to perform billing audits at least once per year for the Division of Mental Retardation and Developmental Disabilities. During the program evaluation of the Purchasing of Mental Health Treatment Services in DMH, dated April 2000, Oversight noted that while ADA and CPS are performing billing audits at least annually, billing audits were not performed each year for contracted providers of MRDD services. MRDD offers mainly Medicaid related services and therefore, services are billed directly to the Department of Social Services, Division of Medical Services. MRDD performs certification reviews that can included the review of billings; however, this is not an integral part of the review. In addition, Oversight notes that the certification review is done every two years.

DMH stated during Oversight's follow-up on this finding that DMH has not implemented MRDD billing reviews as scheduled because of the budget situation. All monitoring has been put on hold due to the lack of resources.

Oversight again recommends DMH perform billing reviews on at least an annual basis. Without an annual billing audit, overpayments to vendors may go undetected for a longer period of time.

APPENDIX



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September 10, 2003

Mickey Wilson
Director, Oversight Division
Joint Committee on Legislative Research
State Capitol, Room 132
Jefferson City, MO 65101

Dear Mr. Wilson,

Thank you for the opportunity to respond to your report entitled, "Program Evaluation: DMH Review of Contract and Bid Procedures and Accountability."

Please find enclosed the Department of Mental Health's responses to the comments and recommendations included in your report.

If you have any questions, please contact Janet Gordon at 751-8067.

Sincerely,

Dorn Schuffman
Director
Department of Mental Health

Enclosure

cc: Janet Gordon

DMH Responses
Program Evaluation: DMH Review of Contract and Bid Procedures and Accountability
September 8, 2003

Comment #1 Two original CSTAR bid files for contracts procured in 1991 for ADA providers could not be located. Oversight recommends DMH maintain bid files.

DMH Response:
We concur. DMH currently maintains a log of each year's competitive Request for Proposals (RFPs). Bid files are logged, boxed and stored in accordance with their established retention schedule.

Comment #2 DMH does not use any type of numbering system to determine how many renewals, amendments, and/or projects requests were performed on their contracts.

Oversight's Recommendation #2-1: Oversight recommends DMH number all amendments, renewals and project requests. A listing of all the renewals, amendments and project requests should also be placed in the front of the folder stating the number of the item, and a short description of what the purpose is for the renewal, amendment or project request.

DMH Response:
The Department is planning to implement its new CIMOR Information System later in this fiscal year. Current models of CIMOR include a method to number contract amendments and renewals as well as enter notes and descriptions for each.

Oversight's Recommendation #2-2: If services are added to a contract, Oversight recommends they be supported by a contract amendment.

DMH Response:
We concur. Duly authorized amendments are necessary to change the terms and conditions of a contract.

Oversight's Recommendation #2-3: DMH should consider rebidding contracts rather than adding services.

DMH Response:
See response to Recommendation #2-4, below.

Oversight's Recommendation #2-4: Oversight recommends that DMH consider, as a matter of good business practice, to periodically re-bid their contracts. This would allow an opportunity for new providers to bid for services and give providers with current contracts the chance to change contract provisions.

DMH Response:
The Division of Comprehensive Psychiatric Services (CPS) and the Division of Mental Retardation and Developmental Disabilities (MR/DD) are exempt from competitive procurement when purchasing services and supports for individuals affected by long-term, serious disabilities and disorders. However, any qualified provider may obtain a contract to provide residential care to CPS and MR/DD consumers and other community services for MR/DD consumers, with consumers exercising the right to choose

among qualified providers. If CPS wishes to purchase other community services, it must use a competitive procurement process.

The Purchase of Service contracts of the Division of Alcohol and Drug Abuse are established by competitive procurement, and do not have a specified limit on the number of renewals. Contracts are typically renewed unless the provider has difficulty continuing to meet program monitoring, certification, and/or licensure standards.

Comment #3 DMH service providers can bill for services provided at anytime during the current fiscal year. Oversight recommends that DMH periodically review billings for POS providers who bill for services performed beyond a reasonable time frame. Oversight further recommends that DMH should consider implementing a policy where services performed more than three months prior should require additional documentation or approval before DMH would pay for such services.

DMH Response:
The department encourages all providers to input services provided as soon as possible However, for a number of reasons, we cannot require them to input within a specific timeframe. Providers are instructed to bill Medicaid and a client's private insurance first, prior to billing DMH. It is often weeks or even months before these claims are denied at which time the provider would submit the claim into the POS system. In most cases, there is no additional documentation that the provider could provide after three months. Also, due to staffing limitations, we do not have the staff necessary to review all billings that are not submitted within three months of the date service.

Comment #4 DMH providers are allowed to estimate services provided. Oversight recommends that DMH not allow estimates of services provided and require contract service providers bill for only client-specific itemized services.

DMH Response:
We concur; as noted in the audit this finding occurred only once and was allowed in order to assist a community provider who was experiencing computer related billing problems.

Comment #5 POS providers are allowed to bill client-specific services to "Client". Oversight recommends DMH limit the use of the non-specific billing names used by service providers. Oversight also recommends create more detailed generic names to use in discerning invoices when the service provided does not lend itself to being billed to a specific client.

DMH Response:
The new Consumer Information, Management, Outcomes Reporting (CIMOR) system will provide the Department with the ability to capture client specific information that has not been available previously. For example, DMH will be able to capture client specific information on individuals who are screened to determine eligibility for service but who are not subsequently enrolled in service. This will reduce some of the non-specific client identifiers currently being used. However, DMH will continue to use non-specific client identifiers in programs such as the ACCESS/Crisis Intervention system where, for example, the use of telephone hotline services cannot be tracked on a client-by-client basis.

Comment #6 ADA Billing Review Unit gives providers advance notice of files to be reviewed prior to their arrival. Oversight recommends that since advance notice of audit files to be reviewed allows the provider time to change, update, and/or correct a file, the ADA Billing Review Unit should not notify providers of specific case files prior to their arrival. If file location is a concern, the Unit could request additional audit files be made available than needed and once on site, select a sample from those files for review. This would increase the number of files a provider would need to review and prepare any updates, changes, or corrections to prior to the arrival of the Billing Review Unit personnel.

DMH Response:
The Division of Alcohol and Drug Abuse conducts billing reviews of each provider contract annually. Provider contracts may cross multiple sites in the state. Each site maintains their own client files. During FY2003 the Division conducted 152 billing reviews. These reviews are conducted by two staff.. Procedures allow providers to bring all files needed to a central location (usually administrative offices) for billing reviews. A list of files needed is submitted 1 to 2 working days prior to the review to allow providers time to bring the files to the central location. If a provider has only one site, they are faxed the list one day in advance. If a provider has multiple sites, the list is provided two days in advance. With limited state staff to do the reviews it would not be possible to complete adequate reviews at each site. We do not concur with Oversight's recommendation to not notify providers of specific case files prior to the arrival of personnel. However, we do concur with Oversight's recommendation to submit a larger list of client files to each provider.

Comment # 7 DMH Audit Services staff is decreasing while the need for audit services remains unchanged. Oversight recommends DMH consider increasing the audit staff and reducing the number of extra activities required to be performed by the Audit Services staff. Also, Audit Services should ensure that any amounts identified as overpayments during the audits are actually recouped.

DMH Response:
Vacant auditor positions have not been filled over the last several years to aid in meeting budget shortfalls. The Department acknowledges the risks associated with a decreasing audit staff available to conduct provider fiscal audits and will take the recommendation to increase audit staff under advisement.

Most of the extra activities recommended by Oversight to be reduced are linked to identifying and assessing risks related to provider operations, Division programs, information systems, internal controls and general Department operations. Providing assistance to Department management in terms of identifying risks is one way of mitigating the risks associated with a small audit staff. We disagree with Oversight with reducing those activities which serve to identify and assess risks related to the operations of the Department. However, we will review these activities to identify any activities for which we might reduce or eliminate in the future.

Identified Medicaid and Purchase of Service overpayments are forwarded to the Office of Administration for recoupment in accordance with RSMo. 630.460. The Office of Administration tracks the actual recoupment of funds and shares this information with the Office of Audit Services.

Comment # 8 DMH Licensure and Certification Unit did not have documentation in provider files supporting extended certification status. Oversight notes that DMH began documenting extensions

effective October 31, 2001, and recommends DMH continue to document these extensions and implement procedures to ensure extensions are being issued according to the Core Certification Standards for Psychiatric and Substance Abuse Programs. Also, Oversight recommends the DMH Licensure and Certification Unit verify that each provider is registered with the Secretary of State, if required, and that all state taxes have been paid.

DMH Response:
In accordance with regulation and standard practice, the Department's Licensure and Certification Unit currently documents in providers' files any extensions granted for expired licenses/certificates in circumstances where a provider has complied with application requirements, but the Department is unable to perform an onsite survey prior to expiration. In those circumstances where an onsite survey is completed prior to the expiration of a license/certificate, documentation of a continuation of licensure/certification status is reflected in the provider file per a copied survey confirmation letter in the event that a new license/certificate is not issued prior to expiration date pending completion of final reports.

The DMH Licensure/Certification Unit currently verifies through onsite document inspection that organizations certified under regulations from the Divisions of Alcohol and Substance Abuse and Comprehensive Psychiatric Services are registered with the Secretary of State. The Department will seriously consider adding this requirement for organizations licensed solely by the Department or certified through MRDD Division Medicaid Waiver program as those regulations are opened for revision.

The Department concludes that verification of provider payment of state taxes might provide some limited information on the financial stability of providers, however current resource limitations prohibit implementation this recommendation at this time. This recommendation would most likely be feasible only with considerable automation.

Comment #9 DMH needs to improvement to prevent Community Placement payments continuing after the death of a client. Oversight recommends DMH programming staff create a program to run death certificate information against the payment records of all identified deceased clients on a periodic basis.

DMH Response:
The Department does not support the recommendation of the auditors.

- Although the Department does use the DHSS death certificate records as one source for increasing the accuracy of the DMH client database, the DHSS records have significant limitations. DHSS receives death certificate records at highly variable times; some as much as 6 to 8 months after time of death. We have some DMH records that reflect client death for which we've never received DHSS notice.
- Given current fiscal constraints, DMH does not have the capacity to make programming changes in current systems that would have marginal effects for a short period of time.
- The department uses a variety of methods to avoid or correct inappropriate billings. Overpayments are prevented or discovered by the involvement of state employee Case Managers through normal case work, as well as through reports or audits. Overpayments are subtracted from later payments to vendors. These discoveries may be after the fact, but this is more efficient than any reprogramming that would only prevent a few inappropriate payments. Such reprogramming would still be ineffective when the date of death is not available in the system.
- Some billing improvements will be made when DMH implements the Customer Information Management, Outcomes and Reporting (CIMOR) System, later in this fiscal year. CIMOR will

support an easy report of payments made for services after the date of death, once the date of death has been entered into the system.

Comment #10 DMH made a significant change in the implementation schedule for CIMOR. Oversight recommends a risk analysis be performed by the Office of Information Technology including any additional cost because of the change and a time line signifying if and when the system will be fully operational...

DMH Response:
Throughout this project, Risk Analysis and Project Oversight, as defined by OIT and the State IT Advisory Board, has been an integral part of the Project Management practice for CIMOR. DMH has assigned two Missouri-certified Project Managers to manage and oversee the CIMOR project from its beginning. This project has been the first in the State to apply the Project Oversight practice implemented by OIT. An independent vendor, contracted by OIT, has worked with our project manager and presented their results, monthly, to our internal CIMOR Oversight Team, to help us identify and respond to risks. A monthly report from the Oversight Vendor is provided to OIT.

In June of 2002 and again in January of 2003, when major decisions were made about the CIMOR project technology, vendor, and schedule, OIT and OA purchasing were involved at all stages.

The software development is now scheduled to be completed by November, 2003. CIMOR will be deployed between February, 2004 and July 1, 2004.

Three clarifications are needed related to the CIMOR budget:

- A statement about FY2003 appropriations in the second paragraph is misleading. The original plan, presented to and approved by the legislature during the FY02 budget session, called for $6.1 million in additional funding for CIMOR in FY03. The $1.75 million in new Federal earnings were appropriated to OIS for CIMOR, as stated. The Department identified $2.8 million in existing IT expenditures within the DMH facility budgets. DMH leadership proposed, and the legislature approved, the use of an inter-agency fund to charge the facilities for the IT services provided by OIS and to give OIS the authority to spend those dollars. There were no "new" dollars introduced to the DMH information technology budget through this move.

- The on-going costs of CIMOR, and all other DMH IT services, have been reduced significantly. The original CIMOR plan, presented to and approved by the legislature during the FY02 budget session, had called for an additional $2.7 million per year for a total DMH IT E&E budget of $9.0 million, all General Revenue, per year beginning in FY2004. The current DMH IT E&E budget totals $7.8 million, with only $5.8 million coming from GR.

- The total cost of the project is several million dollars below initial projections.