
Audit of the Big Island Pilot Project on Mental Health Services

A Report to the
Governor
and the
Legislature of
the State of
Hawaii

Report No. 98-1
January 1998

THE AUDITOR
STATE OF HAWAII

OVERVIEW

THE AUDITOR
STATE OF HAWAII

Audit of the Big Island Pilot Project on Mental Health Services

Summary

The Hawaii State Legislature requested the Office of the Auditor to conduct a financial and management audit of the Big Island Pilot Project on Mental Health Services through House Concurrent Resolution 250, H.D. 1, 1997 Regular Session. The audit was requested because of concerns raised about the cost, quality, and availability of mental health services to 1500 children and youth under the Department of Health's contract with Kapi'olani HealthHawaii for the Big Island Pilot Project. Concerns were also raised about whether the project was meeting the requirements of the *Felix v. Waihee* consent decree. The pilot project entailed contracting with a nonprofit organization to authorize services and secure and pay service coordinators and providers.

We found that the Child and Adolescent Mental Health Division of the Department of Health failed to manage the \$8.8 million contract to ensure that services were provided professionally and cost effectively. Critical contract terms were not enforced and public funds were needlessly paid out of the state treasury. The division overpaid Kapi'olani HealthHawaii between \$2.3 and \$3.5 million for services not rendered. The \$3 million emergency appropriation was not necessary. The division has not ensured that Kapi'olani HealthHawaii's management controls over services are sufficient. As a result, there are no assurances that services are provided by qualified personnel or that the services are effective.

In addition, the division has disregarded its fiscal responsibilities by making payments without proper support. It has allowed Kapi'olani HealthHawaii to pay providers for services that had not been previously authorized and to pay providers \$385,000 without required documentation. Finally, coordination among entities responsible for determining eligibility and providing services to children has been lacking, but efforts to improve have begun.

Recommendations and Response

We recommend that the director of health ensure that the Child and Adolescent Mental Health Division is staffed appropriately to manage and enforce its contract with Kapi'olani HealthHawaii. The division should enforce the terms of its contract so that only authorized services are provided, the required quality assurance activities are performed, and payments are made only for services actually rendered. The division should stop advancing moneys without adequate



support. We also recommend that the governor, the superintendent of education, and the director of health continue efforts to work together on the pilot project. In addition, the director of health should consider utilizing Family Guidance Center staff to provide services.

The department feels that some of our recommendations merit consideration, but that our report does not acknowledge the “significant efforts” of its division and its contractor nor the many activities of its liaison and the 1997 quality assurance initiatives of its contractor.

The department attributes its overestimation of its budget needs to the limited start-up period of the project. But its discussion of the 71 percent ratio of services rendered to services authorized does not respond to the point we make—that, for FY1996-97, the department overpaid Kapi’olani HealthHawaii.

The department agrees that the division’s current organizational structure does not allow for optimum contract monitoring efforts. It has recently recruited a contracts supervisor but we believe that problems will persist if the department continues to view its role as that of a “contract monitor” instead of a “contract manager.” Public funds must be managed to ensure that desired results are achieved. Contractors entrusted with public funds should also be managed, not monitored, for the same reason.

Marion M. Higa
State Auditor
State of Hawaii

Office of the Auditor
465 South King Street, Room 500
Honolulu, Hawaii 96813
(808) 587-0800
FAX (808) 587-0830

Audit of the Big Island Pilot Project on Mental Health Services

A Report to the
Governor
and the
Legislature of
the State of
Hawaii

Submitted by

THE AUDITOR
STATE OF HAWAII

Report No. 98-1
January 1998

Foreword

The Hawaii State Legislature requested the Office of the Auditor to conduct a financial and management audit of the Big Island Pilot Project on Mental Health Services through House Concurrent Resolution 250, H.D. 1, 1997 Regular Session. The audit was requested because of concerns raised about the cost, quality, and availability of mental health services provided to children and youth under the Big Island Pilot Project. Concerns were also raised about whether the project was meeting the requirements of the *Felix v. Waihee* consent decree.

We wish to express our appreciation for the cooperation and assistance extended to us by staff of the Department of Health and of Kapi'olani HealthHawaii.

Marion M. Higa
State Auditor

Table of Contents

Chapter 1 Introduction

The Felix v. Waihee Consent Decree	1
The Big Island Pilot Project	3
Contract Management Problems Are Not New	9
Objectives of the Audit	10
Scope and Methodology	10

Chapter 2 The Child and Adolescent Mental Health Division Fails to Adequately Manage the Big Island Pilot Project

Summary of Findings	13
The Child and Adolescent Mental Health Division Has Been Derelict In Its Management of the Contract With Kapi'olani HealthHawaii	14
The Division Has Not Enforced Quality Assurance Requirements for Services	17
The Division Has Disregarded Its Fiscal Responsibilities	22
Hasty Project Implementation Caused Service Delays .	26
Conclusion	29
Recommendations	29

Appendixes

Appendix A Hawaii Child and Adolescent Service System Program Principles	31
Appendix B Sub-Contracted Agency Providers (As of July 9, 1997)	33
Appendix C Glossary	35

Notes	39
-------------	----

Response of the Affected Agency	41
---------------------------------------	----

Exhibits

Exhibit 1.1	Felix v. Waihee Referral Process, Big Island Pilot Project	4
Exhibit 1.2	Roles and Responsibilities in the Pilot Project, October 1, 1996 to June 30, 1997	7
Exhibit 1.3	Funding for the Big Island Pilot Project, FY1996-97 and FY1997-98	9
Exhibit 2.1	Child and Adolescent Mental Health Division Organizational Chart	16
Exhibit 2.2	Payments to Kapi'olani.....	24

Chapter 1

Introduction

This is a report of our audit of the Big Island Pilot Project on Mental Health Services. The pilot project provides mental health services to children on the Big Island under a Department of Health contract with Kapi'olani HealthHawaii. The Legislature requested the Office of the Auditor to conduct a financial and management audit of the pilot project through House Concurrent Resolution 250, House Draft 1, of the 1997 legislative session. The audit was requested because of concerns raised about the cost, quality, and availability of mental health services provided to children and youth under this pilot project. Concerns were also raised about whether the project was meeting the requirements of the *Felix v. Waihee* consent decree.

The Department of Health's Child and Adolescent Mental Health Division has historically provided preventive, diagnostic, and rehabilitative mental health services to Hawaii's children and youth. Additional service requirements were placed upon the department and division as a result of the *Felix v. Waihee* consent decree.

The Felix v. Waihee Consent Decree

The *Felix v. Waihee* Consent Decree settled a lawsuit filed in 1993 against the State for failure to provide adequate mental health services to children and adolescents. The Big Island Pilot Project was developed as part of the State's compliance with this decree.

History of the consent decree

The consent decree resulted from a 1993 suit brought by Jennifer Felix against then Governor John Waihee, the superintendent of education, and the director of health (defendants) for failing to provide adequate mental health services as part of her educational program. On March 8, 1994, the case became a class action suit on behalf of all youth in Hawaii, ranging from birth to age 20, who had disabilities and were eligible for and in need of educational and mental health services (plaintiff class).

On May 24, 1994, the federal court concluded that the defendants had failed to provide services necessary to comply with the Individuals with Disabilities Education Act (IDEA) and Section 504 of the Rehabilitation Act of 1973. The plaintiff class and the State reached a settlement and jointly drafted the *Felix v. Waihee* consent decree. In October 1994, the court approved the consent decree, which sets out the settlement's terms and conditions, and the State developed an implementation plan.

In March 1996, the special master appointed by the federal district court found that the State had not sufficiently complied with its obligations under the consent decree and implementation plan. Deadlines in the implementation plan had not been met. The State then presented a revised plan that was accepted by the court in July 1996. The revised plan included three pilot projects, one of which was the Big Island Pilot Project.

Requirements of the consent decree

The *Felix v. Waihee* consent decree requires a statewide system of care for all eligible children and adolescents up to age 20. It requires the State to aggressively seek out members of the plaintiff class in need of services, create partnerships, and provide timely and adequate intervention and delivery of culturally relevant services in home-, school-, and community-based settings. The State must implement a fully operational system by June 30, 2000.

The consent decree required a “Felix Court Monitor” to oversee the State’s efforts to satisfy the terms of the decree and subsequent implementation plan. The monitor must report on the State’s implementation process and make recommendations to the court concerning enforcement of compliance. The consent decree also requires the Department of Education (DOE) and the Department of Health (DOH) to use a technical assistance panel comprised of experts in special education, mental health, system reform, and other areas. The panel is to assist the departments in designing the new system of care and in implementing a plan. The implementation plan, under the two departments, establishes a Complaints Resolution Office to address and resolve educational and service delivery issues for the plaintiff class.

The consent decree and implementation plan more specifically require that:

- The State create a system of services, programs and placements following the principles of the Child and Adolescent Service System Program.
- The quantity and quality of services, programs, and placements for the plaintiff class shall not fall below the level for which state appropriations had been made on May 2, 1994.
- The new system of care be family and child centered and provided in the least restrictive setting.
- Persons directly in contact with children and families should have training, encouragement, and access to resources to meet the children’s needs.

- Care coordinators will be assigned to each child and family.
- Transition from the old system of care and implementation of the new system will occur simultaneously.

Departmental roles and processes

The consent decree requires that, at a minimum, the Department of Education provide all educational services for the plaintiff class. It also requires that the Department of Health provide all mental health services to enable the plaintiff class to benefit from those educational services.

The process of determining eligibility for services is delineated in the implementation plan. Exhibit 1.1 charts this process for the Big Island Pilot Project. According to the plan, any person can refer a child suspected of having an educational or mental health disability for an evaluation at any time. This person must submit a request for evaluation to the public school that the child attends or would attend if enrolled.

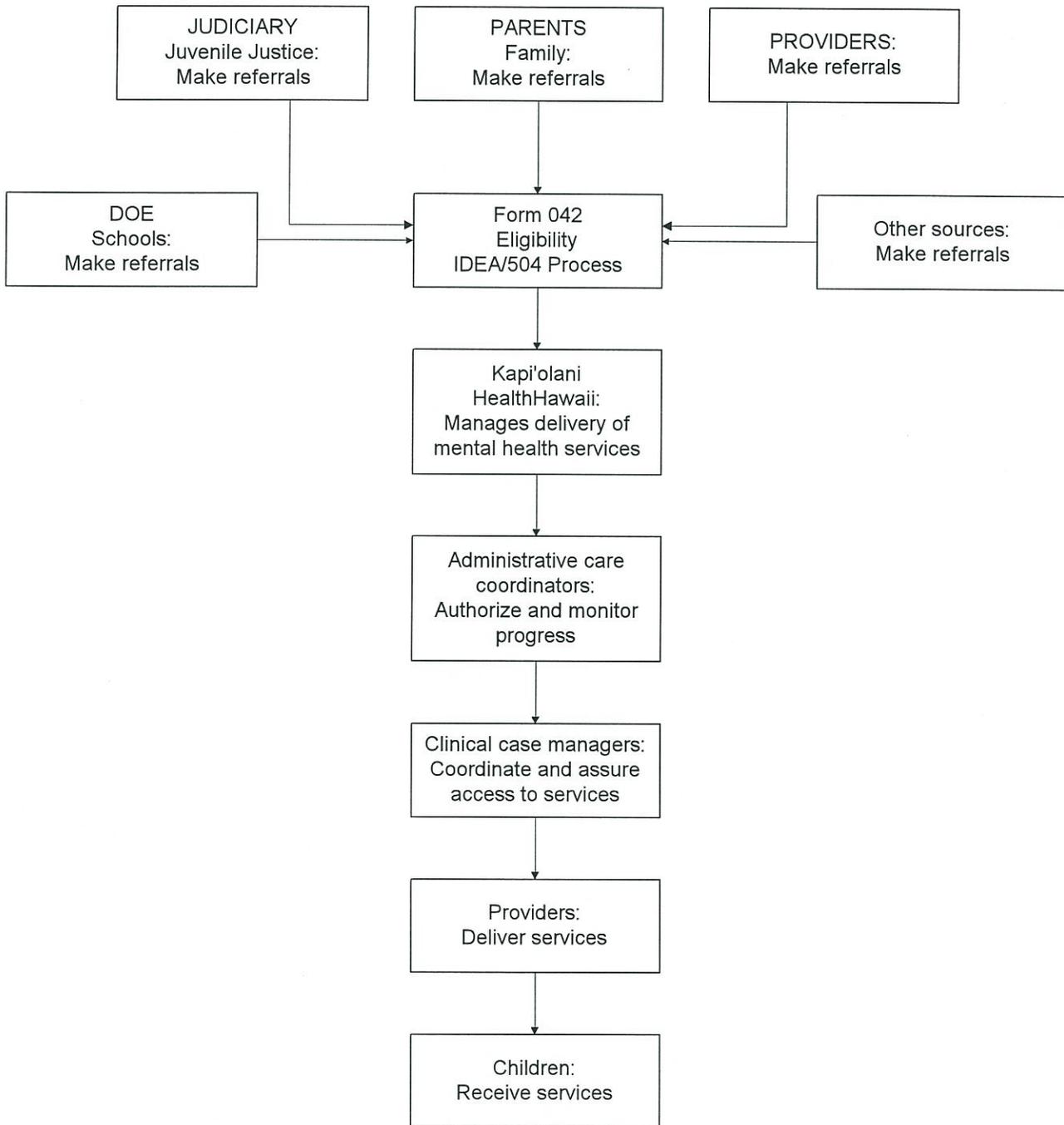
The school then screens the child to determine eligibility for services. The school collects data on the child's educational performance, developmental indicators, and emotional/behavioral characteristics. Educational and mental health professionals examine the collected data to determine the child's eligibility for services. The appropriate departments evaluate the child accordingly. The Department of Education's diagnostic teams evaluate and recommend educational programs or services. Either the Department of Health staff or a contracted private mental health provider evaluates the child's mental health status.

If the evaluation(s) indicate that the child needs education and/or mental health services, the DOE forms a committee of school personnel, parents, and mental health service providers to produce a plan to provide the needed educational and mental health services. This plan is known as the individualized education program (IEP) for children eligible under the IDEA statutes, and a modification plan (MP) for children eligible under Section 504 of the Rehabilitation Act. Once finalized, the IEP or MP must be followed. Failure to follow the plan's provision of required services violates federal and state statutes.

The Big Island Pilot Project

The Big Island Pilot Project changed the Department of Health's delivery of children's mental health services. Prior to the pilot project, the department provided direct mental health services to children through its Child and Adolescent Mental Health Division, or through contracted private providers. The pilot project, however, entailed contracting with Kapi'olani HealthHawaii, a nonprofit health care corporation, to manage the delivery of those services to eligible children on the Big Island. This

Exhibit 1.1
Felix v. Waihee Referral Process, Big Island Pilot Project



meant authorizing services and securing and paying sub-contractors. The pilot project is touted as one that “redefines the role of government, the community and mental health providers in treating children and youth in the Felix plaintiff class.”¹ After reviewing three proposals, the division entered into a contract with Kapi’olani for nine months, from October 1, 1996 to June 30, 1997.

The pilot project serves four groups of children:

- (1) Children who are Felix class members: youth ages 3 to 21 eligible under IDEA or section 504 of the Rehabilitation Act and in need of mental health services to benefit from their education.
- (2) Children who are Department of Education referrals: youth ages 3 to 21 who require a clinical mental health evaluation to determine eligibility for IDEA or section 504 of the Rehabilitation Act.
- (3) Youth with life-threatening psychiatric emergencies: youth who are in imminent danger of harming themselves or others due to emotional disturbance.
- (4) Children with presumptive eligibility: youth who are imminently likely to become eligible for the Felix class unless they receive immediate mental health intervention.

The objectives of the project are to:

1. Formally establish the demonstration of a private healthcare organization that manages the delivery of mental health services to children and adolescents in the County of Hawaii.
2. Ensure that the demonstration project meets the terms of the Felix Implementation Plan for creating a new system of care.
3. Determine the potential of replicating a private healthcare entity in other jurisdictions.²

The contract between the division and Kapi’olani HealthHawaii provided for two types of allowable costs—service and administrative costs. Of the \$8.8 million to be paid to Kapi’olani, \$7.4 million was to be for service costs, and \$1.4 million was to be for administrative costs. The division was to make three quarterly payments to Kapi’olani. The second and third payments were to be made after the division reviewed monthly reports on types and costs of services provided, administrative costs, statistical data, and other administrative data.

Kapi'olani HealthHawaii provided services to about 140 eligible children beginning on October 1, 1996. The State projected that 150 children would be initially eligible, and 400 to 500 would become eligible by June 1997. However, the actual number of eligible children exceeded the estimated number. By December 1996, about 1,000 eligible children had been identified, and by June 1997, more than 1,500. In order to provide services to children on the entire island, Kapi'olani set up two offices. The Hilo office serves children on the east side of the island, and the Waimea office serves children on the west side.

Project roles and responsibilities

The demonstration project is primarily administered by Kapi'olani HealthHawaii; DOH's role is limited to decree compliance and contract oversight. Exhibit 1.2 charts the roles and responsibilities of the various parties in the project: the Department of Health, the Child and Adolescent Mental Health Division, and Kapi'olani HealthHawaii.

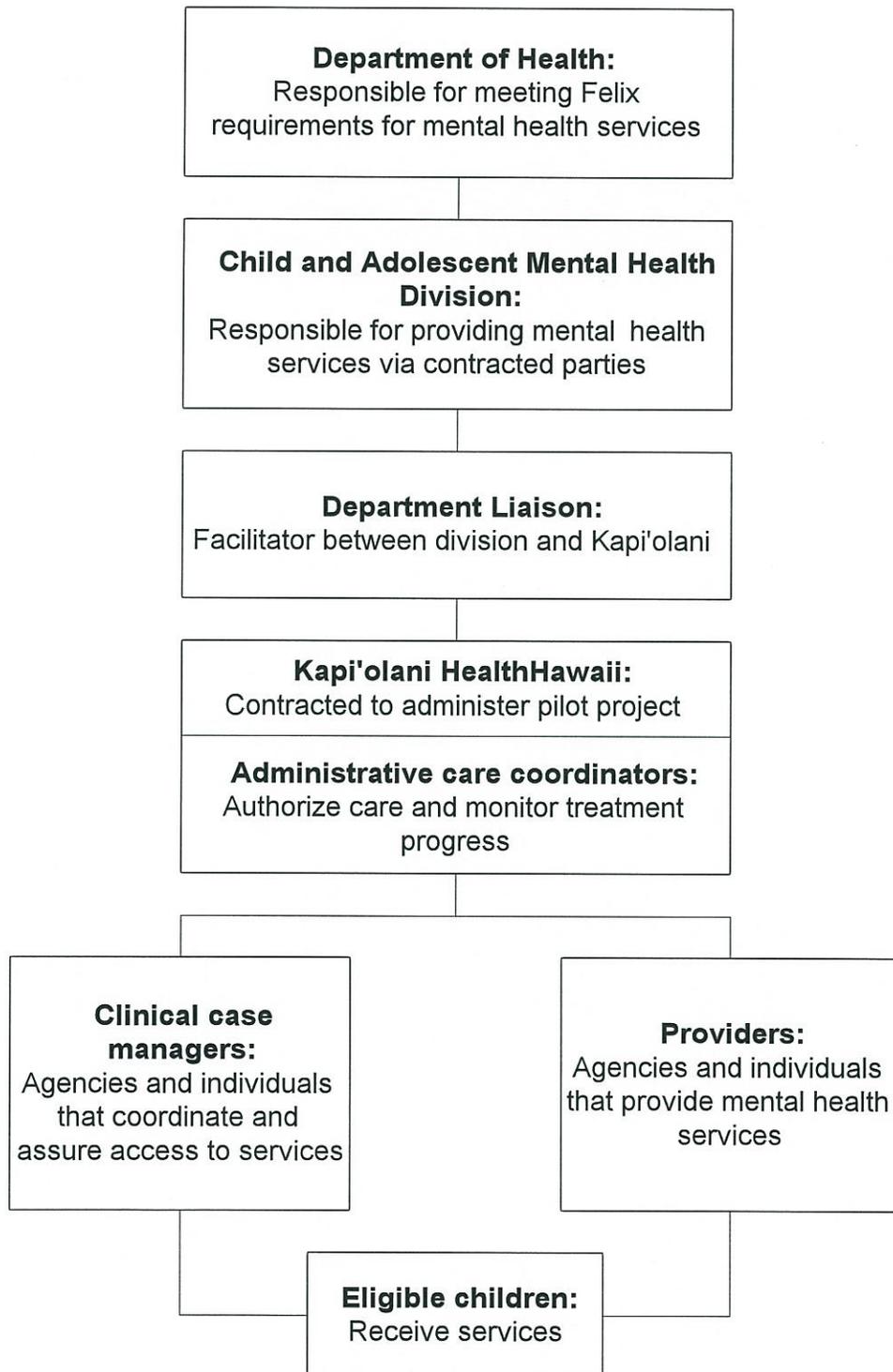
The contract requires Kapi'olani to provide a number of services that were previously provided by the division. These services include:

- receiving referrals and registering eligible children in a management information system;
- facilitating evaluation of children;
- contracting with private providers for child mental health services;
- authorizing services for children;
- paying claims from providers; and
- completing quality management reviews of case managers and service providers.

Kapi'olani's staff who manage the pilot project include an executive director, quality management director, fiscal manager, and clinical director. The executive director oversees the project. The quality management director oversees activities such as credentialing providers and reviewing services provided. The fiscal manager processes payments for administration and services. The clinical director ensures that the services provided meet clinical standards.

Kapi'olani also employs administrative care coordinators who authorize care and monitor treatment progress. They authorize services and care by case managers and service providers. They communicate with clinical

Exhibit 1.2
Roles and Responsibilities in the Pilot Project
October 1, 1996 to June 30, 1997



case managers and other providers regarding each child's needs, plan for care, and response to care. The contract with Kapi'olani limits an administrative care coordinator's case load to 100 children.

Kapi'olani sub-contracts with service providers who include clinical psychologists, psychiatrists, licensed clinical social workers, clinical case managers, and therapeutic aides. Psychiatrists, clinical psychologists and licensed clinical social workers perform mental health assessments and provide mental health therapy and other services. Service providers by types and costs for the period through June 1997 are as follows:

Types of service	Cost description	Percentage of authorized total costs
Psychological evaluations and family therapy	<ul style="list-style-type: none"> ● Psychiatrists and psychologists: costs range from \$75 to \$100 per hour ● Licensed clinical social workers: costs range from \$50 to \$100 per hour 	<ul style="list-style-type: none"> ● 5%- Psychological evaluations ● 16%-Family therapy
Clinical case management: coordinating and assuring access to services	Reimbursed at \$175 per child per month	10%
Therapeutic aide services: 1:1 child supervision and support	Reimbursed at \$25 per hour	23%
Residential, inpatient and other treatments	Varies by service	46%
Total		100%

Contracted agencies and individuals provide the foregoing array of services. The agencies under contract to Kapi'olani are listed in Appendix B.

Project funding

Funding for the pilot project is provided in the DOH's Child and Adolescent Mental Health budget program, HTH 460, that also includes funding for other division activities. The project is funded entirely with general fund appropriations, about \$8.8 million for FY1996-97. This amount includes \$2.9 million appropriated specifically for the project by the 1996 Legislature, \$2.9 million from the division's operating budget, and about \$3 million from an emergency appropriation of the 1997 Legislature. Exhibit 1.3 presents the project funding for FY1996-97 and FY1997-98.

Exhibit 1.3 Funding for the Big Island Pilot Project FY1996-97 and FY1997-98

Source	FY1996-97	FY1997-98
Existing department budget	\$ 2,931,170	\$ 588,450
Specific appropriation	2,881,920	8,781,440
Emergency appropriation	2,968,350	0
Total	<u>\$ 8,781,440</u>	<u>\$ 9,369,890</u>

The \$9.4 million funding for FY1997-98 continues the \$8.8 million level received in FY1996-97, plus \$600,000 transferred from other division funds.

Contract Management Problems Are Not New

Two State Auditor reports and two public accounting financial audit reports over the past five years testify to the department's poor contract management.

Our Report No. 95-29, *Audit of State Contracting for Professional and Technical Services*, concluded that the Child and Adolescent Mental Health Division's "poor administrative controls, failure to monitor contractor performance or evaluate contract outcomes, and failure to comply with statutory reporting requirements seriously undermine the division's ability to manage resources in the public's best interests."³ Our

Report No. 92-30, *Financial Audit of the Department of Health*, found that the department's contracting practices failed to assure that services are provided to the public in a manner that safeguards the interests of the department, the service providers, and the recipients of services.

Financial audit reports of the department prepared by the certified public accounting firm of Grant Thornton LLP, for FY1993-94 and FY1994-95, noted deficiencies in the department's contract monitoring activities. In both reports the CPA firm recommended that the department perform and document monitoring in a timely manner to ensure that programs are functioning as required.

Objectives of the Audit

1. Determine how the roles and responsibilities of the Department of Health, Department of Education and other entities are established in the Big Island Pilot Project on Mental Health Services to meet the requirements of the *Felix v. Waihee* consent decree.
2. Assess whether the Department of Health is managing the contract with Kapi'olani HealthHawaii to ensure that required services are provided in a cost-effective manner.
3. Make recommendations as appropriate.

Scope and Methodology

We reviewed the *Felix v. Waihee* consent decree, the implementation plan, and other federal and state statutes and rules. We reviewed the contract between Kapi'olani HealthHawaii and the Child and Adolescent Mental Health Division of the Department of Health, the memoranda of agreement between Kapi'olani HealthHawaii and other organizations, and documents from the Felix Complaints Resolution Office.

We reviewed documents from the Child and Adolescent Mental Health Division of the Department of Health, including organizational charts and functional statements, policies and procedures, position descriptions, memoranda, and monitoring reports. We reviewed documents from Kapi'olani HealthHawaii including monthly reports, policies and procedures, and its quality management plan.

We interviewed Department of Education Big Island district staff, the Felix monitor, and staff of the Felix technical assistance panel. We interviewed staff of the Child and Adolescent Mental Health Division, Kapi'olani HealthHawaii, the Big Island district health office, and the Big Island Family Guidance Center of the Department of Health. We interviewed representatives from Children's Community Councils on the

Big Island. We reviewed files, expenditure records, and other reports at the Child and Adolescent Mental Health Division, and at Kapi'olani HealthHawaii's offices at Waimea and Hilo on the Big Island and in Honolulu. We reviewed the operations of the Big Island Pilot Project on Mental Health Services for the period of October 1, 1996 through the present.

Our work was performed from May 1997 through December 1997 in accordance with generally accepted government auditing standards.

Chapter 2

The Child and Adolescent Mental Health Division Fails to Adequately Manage the Big Island Pilot Project

This chapter presents the findings and recommendations of our audit of the Big Island Pilot Project. During the contract period, the number of children reportedly needing services exploded from the original estimate of 400 in October 1996 to more than 1,500 by June 1997. The Child and Adolescent Mental Health Division's decision to contract for the administration and delivery of services to this Big Island population thus increased the contracted responsibilities and the division's oversight duty. The division failed in its duty to manage the contract to ensure that services were provided professionally and cost effectively.

Summary of Findings

1. The Child and Adolescent Mental Health Division of the Department of Health has been derelict in its responsibilities to manage its contract with Kapi'olani HealthHawaii. Critical contract terms have not been enforced and public funds were needlessly paid out of the state treasury.
2. The division has not ensured that Kapi'olani HealthHawaii's management controls over services are sufficient. There are no assurances that services are provided by qualified personnel or that the services are effective.
3. The division has disregarded its fiscal responsibilities by making payments without proper support and not ensuring that Kapi'olani HealthHawaii follows fiscal requirements. The division paid Kapi'olani HealthHawaii at least \$2.3 million more than Kapi'olani expended during the contract period.
4. Coordination among responsible entities has been lacking, causing delays in providing services. Efforts to improve and address problems in delivering services have begun.

The Child and Adolescent Mental Health Division Has Been Derelict In Its Management of the Contract With Kapi'olani HealthHawaii

The division has not met its statutory and contractual requirements

The Child and Adolescent Mental Health Division is responsible for enforcing the terms of its contract with Kapi'olani HealthHawaii (Kapi'olani). It also is responsible for adequately defining the roles of division staff who manage the contract to ensure accountability and proper oversight. The division has been derelict in carrying out these responsibilities. As a result, there is no assurance that required services are provided in a cost-effective manner.

Section 334-8, Hawaii Revised Statutes, states that the Director of Health "shall establish standards and review procedures to assure that recipients of state funding provide the services and facilities necessary to accomplish the purposes for which the funds are provided." The standards are set in the contract with Kapi'olani. The contract also requires the division to perform reviews for such assurances which include site visits, fiscal reviews, and comprehensive evaluations in several performance areas. The division has failed to meet its statutory and contractual responsibilities in these regards.

Division staff ostensibly are responsible for managing the contract. Contract management responsibilities fall under three areas: clinical quality management, contract management, and fiscal monitoring. Clinical quality management staff ensure that clinical services meet local and national standards and requirements. The contract management section formulates, initiates, and oversees the work of contracted agencies. Fiscal monitoring staff evaluate the appropriateness of expenditures.

Divisional contract management staff failed to perform site visits, fiscal reviews, and performance evaluations during the contract period (October 1, 1996 to June 30, 1997). Instead, contract management primarily was done through visits to the Big Island by the division's contract liaison who described his role as that of a "troubleshooter to address problems as they arise, and as a facilitator to work with people in addressing the problems." Since division contract management staff conducted no site visits or evaluations during the contract period, the division had no basis to determine whether contract goals were being met nor whether the contract should be extended. Failure to conduct fiscal reviews left the division with no assurance that the moneys paid to Kapi'olani were needed or expended properly.

Site visits were late and perfunctory

Division contract management section and quality management staff visited the Big Island sites as was contractually required. However, the visits were late and cursory. Two divisional contract management section

staff visited the Big Island on July 16, 1997—two weeks after the contract end date. They visited Kapi’olani’s Hilo office in the morning and its Waimea office in the afternoon. We observed the staff’s site visit at the Waimea office where about half of Kapi’olani’s 1,585 case files are maintained. The staff spent only 45 minutes at the Waimea office, reviewed no files, and performed no substantive tests to confirm verbal information from the Kapi’olani staff.

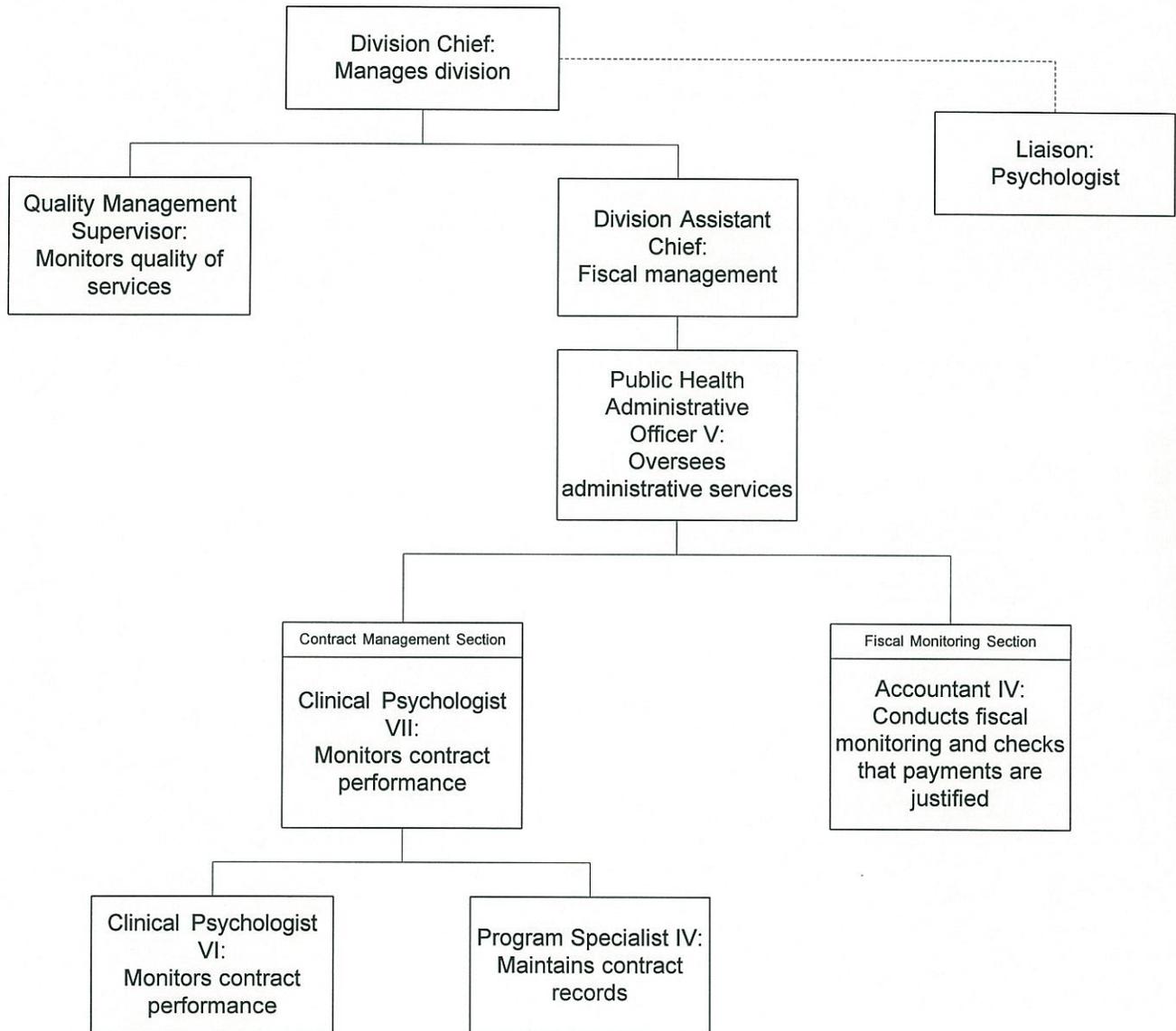
A site review conducted by the division’s quality management supervisor was equally cursory. During the visit to the Hilo office on July 9, 1997, the division supervisor reviewed only ten client files to ensure that services met required standards. This is not a “comprehensive evaluation” as required by the contract. Neither site visit provided the department with a substantive evaluation of contract performance. Neither provided the department with the timely information needed to determine whether the contract should be renewed.

Accountability is weak

The division should be responsible for adequately defining the roles of key personnel, granting them sufficient authority to carry out their functions, and holding them accountable for their performance. The division has failed to define these roles. It exercises little accountability and oversight in managing its contract with Kapi’olani HealthHawaii.

Exhibit 2.1 presents the division’s personnel organization for contract management which implies that certain positions provide the department with sufficient accountability and oversight. The contract management section which is responsible for contract compliance and recordkeeping consists of a clinical psychologist VI and a program specialist IV who report to a clinical psychologist VII. An accountant IV is responsible for justifying payments for services in the fiscal section. A public health administrative officer V oversees the work of the two sections and reports to the division’s assistant chief, who in turn reports to the division chief. A quality management supervisor reports directly to the division chief. The liaison, during the contract period, is a psychologist who does not appear on the division organizational chart, but reports directly to the division chief. He calls himself a liaison between the division and Kapi’olani. This organizational structure does not accurately reflect the level of authority and accountability assumed and delegated to the division.

Exhibit 2.1
Child and Adolescent Mental Health Division Organizational Chart*



*Only positions relevant to management of the contract are shown.

Despite the structure, when asked about their duties the staff were confused and deferred accountability. For example, the assistant chief stated that the program specialist IV was responsible for contract compliance. The program specialist IV, however, asserted that the psychologist VII or the liaison was responsible, while the psychologist VII deferred that responsibility to the liaison. The liaison, in turn, said that he had not accepted that responsibility and that the psychologist VII was responsible.

The liaison “position” is occupied by an employee of the University of Hawaii, under contract to the department to perform services at the Hawaii State Hospital. His contract does not identify any responsibility to act on behalf of the Child and Adolescent Mental Health Division. This helps to explain the liaison’s weakened accountability to the division and lack of authority to enforce the Kapi’olani contract.

In addition, positions are filled by individuals who may not have suitable backgrounds for contract management. Two persons with doctoral degrees in psychology conducted the review of contract compliance and have many contract oversight responsibilities. Yet, their job descriptions do not require extensive education or experience in contract management.

The Division Has Not Enforced Quality Assurance Requirements for Services

Kapi’olani was under contract to ensure the timely and effective provision of services. For this purpose, it was required to establish a number of quality assurance controls over its sub-contractors who provided those services. The division did not enforce this requirement. The division should have enforced this requirement both to meet the needs of children and to meet the requirements of the *Felix v. Waihee* consent decree.

The division’s liaison did not ensure that Kapi’olani established proper controls and allowed Kapi’olani to neglect its oversight responsibilities for its sub-contracted providers. Providers did not follow the timeliness and reporting requirements for their services. Many providers’ credentials were not checked, and Kapi’olani has delayed its quality management activities.

Service authorization requirements are not enforced

For each case, Kapi’olani requires service providers to describe the services to be provided, obtain prior authorization from Kapi’olani to provide those services, and then provide the services. Kapi’olani has allowed providers to bypass requirements that ensure only clinically appropriate services are provided. Without this assurance, services provided may not be necessary nor appropriate.

Kapi'olani requires clinical case managers and providers to submit a service plan (for case management services) or treatment plan (for therapy and other services) to Kapi'olani's administrative care coordinators prior to providing services. These services are authorized by the administrative care coordinator for a specified period. During that time, the clinical case manager or provider is supposed to send regular reports on services provided to Kapi'olani's administrative care coordinators.

Authorizations and submittals are management controls to ensure that the services are necessary and appropriate. Kapi'olani did not exercise these controls and the division did not enforce its own contract with Kapi'olani to carry out this standard practice. Many providers did not receive authorization before providing services and did not provide reports on the services provided. As a result, there is little assurance that: a) services to children and families were appropriate and, b) services were in fact provided.

Kapi'olani has authorized services after they were provided and has authorized services without essential prior information such as service plans. In over half of the 80 cases we sampled, Kapi'olani authorized services without the required service or treatment plans. An April 1997 report from Kapi'olani noted that services are routinely retroactively authorized. The report stated that in February 1997, Kapi'olani retroactively authorized over \$350,000 in services that had been provided in prior months.

The division does not ensure submittals of required information

The division's contract requires Kapi'olani to ensure that services are timely and effective. However, Kapi'olani received little information about the timeliness and effectiveness of services provided by its sub-contractors and the division did not require Kapi'olani to correct this deficiency.

Kapi'olani requires clinical case managers to submit monthly reports that contain information on services provided and on progress. Our review of 80 files found that 40 percent lacked the required monthly reports. Without these reports, Kapi'olani's administrative care coordinators did not know if services were provided and thus could not determine if children receiving these services were making progress. The division's failure to ensure submission of required reports has allowed improprieties to go undetected.

In one case, a child had run away and required monthly reports had not been submitted by the case manager but the case manager was still being paid. In another instance, children did not receive services for a six-week period because the case manager took leave without finding a replacement

provider. Kapi'olani staff were unaware of the problem until the school principal called to report the lack of services for the children. Kapi'olani did not penalize the provider agency for this contract lapse.

The division does not know the quality of services being delivered

The division's contract with Kapi'olani requires timely quality management reviews to ensure that services are provided in a timely and effective manner. The reviews are of Kapi'olani's internal management and of its sub-contractors. The division allowed Kapi'olani to postpone many of these reviews and thus not meet its own contract requirements. Lacking these reviews, Kapi'olani could not attest to the quality of services during much of the contract period.

Kapi'olani began most of its quality management reviews only after its quality management director arrived in April 1997, six months after the start of the pilot project. Once the director began conducting quality management reviews of case managers and service providers, the director found deficiencies in the quality of services.

In one quarterly review of one out of 14 contracted agencies during the contract period, the director found major deficiencies in the contractor's clinical records. A majority of those records reviewed lacked the appropriate diagnoses for the children's symptoms. Half of the records lacked documentation of clinical supervision. Kapi'olani's review of treatment plans found a significant percentage of the treatment plans lacked required components—for example, treatment codes and diagnostic scores. In addition, only 24 percent of a sample of evaluations received from sub-contractors during May and June 1997 contained a complete Child and Adolescent Functional Assessment Scale (CAFAS), a required clinical measure. If Kapi'olani does not use this measure consistently, it cannot effectively track clinical progress.

A June 1997 quality management review conducted by Kapi'olani's Honolulu staff found that the lack of clinical evaluations in records made it difficult to assess whether the diagnosis, treatment plan, level of professional assigned, and response to treatment were appropriate. The Honolulu staff found that 23 of 36 treatment plans reviewed included psychiatric interventions that were inappropriate for the children's diagnoses. They also found that 25 of 36 records did not mention the children's responses to treatment. The reviewers noted that these deficiencies would make it difficult to track the children's treatment progress over time. Even though the 14 contracted agencies and numerous providers are costing the State \$7.4 million, the division cannot say that the minimum quality of services is being provided, due to Kapi'olani's lack of timely and comprehensive reviews.

Division does not ensure the professional competency of providers

The division's contract requires Kapi'olani to check the credentials of sub-contracted providers. However, the division has not ensured that providers meet standard qualifications and that credentials are checked. Kapi'olani established standard requirements for some providers, including psychologists, psychiatrists, and supervisors in sub-contracted agencies, but not for all providers. Other providers including clinical case managers and therapeutic aides were not required to meet standard qualifications nor were their credentials checked. Kapi'olani allowed its five contracted case management agencies to set their own minimum qualifications and job descriptions and to keep their own records of staff qualifications for their non-supervisory providers. Kapi'olani checked the qualifications of non-supervisory providers only during quality management site visits. Due to concerns about the quality of providers, the division should enforce this contractual requirement for credential checks, and set minimum professional requirements for *all* providers.

The case management agencies, allowed by Kapi'olani to set their own minimum professional requirements, did not even meet their self-established standards. Kapi'olani's staff visited two agencies in June 1997 and found that staff at one agency did not meet standards, and that there was no documentation of clinical supervision at the other agency. The qualifications and supervision of the other case management agencies are unknown as Kapi'olani has not completed these required site visits.

Clinical case managers coordinate care and ensure access to needed services. Therapeutic aides provide supervision and support to children. Without reviewing their credentials, Kapi'olani cannot verify that these providers are qualified. Without clinical supervision documentation, Kapi'olani cannot verify that case managers and therapeutic aides are adequately supervised. The division in turn has not enforced its contract requirements of Kapi'olani, as evidenced by the foregoing limited or no reviews of providers.

Professional qualifications of case managers and therapeutic aides have been questioned by community members, staff of the Department of Health, Department of Education, and Kapi'olani HealthHawaii, and others. For example, one school principal expressed concern about the training and competence of clinical case managers. The principal said, "Case managers assigned to cases literally tell us they are busy, don't think it is their job to call people or follow-up on cases, or they sit in on IEP's not knowing what to say, do, or suggest." Others expressed concerns about the level of supervision and training of the therapeutic aides, and the quality of their services.

Others have raised concerns about the detrimental behavior of clinical case managers assigned to court cases. An attorney general staff member noted inappropriate actions of clinical case managers in court cases such

as consulting with opposing parties, distributing reports without prior approval from the Department of Health, and appearing in court without authorization. A Department of Health staff member and a family court judge noted that case managers were not well prepared for court hearings. Case managers need to be well prepared and qualified for court cases due to the case complexity and intensity. The division needs to act on the serious lack of professional behavior and actions among Kapi'olani's sub-contracted case managers. Ultimately, it is the State that is liable for derelict duty and services.

Evaluations did not meet statutory deadlines

Evaluation deadlines are specified in federal and state statutes. Mental health evaluations for eligible children under IDEA are required no later than 100 days between the evaluation request and the eligibility determination or supplemental evaluation. Under state regulations for section 504 of the 1973 Rehabilitation Act, evaluations are required within 45 days of referral and eligibility determinations are required within 90 days of referral. These deadlines apply both to Kapi'olani, which arranges for the evaluation, and the Department of Education, which determines eligibility. These determinations require expeditious psychological assessments of the children to meet these deadlines. However, the division has done little to ensure that Kapi'olani is expeditious. In fact, Kapi'olani is chronically late in its evaluations.

We reviewed 80 case files and found that Kapi'olani's late evaluations to the Department of Education were caused by the tardiness of its providers. Sixty-one percent of cases we sampled that were subject to the statutory deadlines were late. During March 1997, 100 evaluations were past due. When Kapi'olani reviewed evaluations submitted in May and June 1997, it found that 48 percent of the evaluations were late. The percentage of late evaluations is decreasing. By June, the number of late evaluations had decreased to 39 of 129 (30 percent).

To address deadline problems, Kapi'olani staff typically and repeatedly call providers to remind them of their late evaluations. Kapi'olani also sends letters to providers reminding them of the deadline requirements. However, these actions fall short of Kapi'olani's guidelines to suspend further referrals to providers until their timeliness problems are addressed.

The division did not ensure that Kapi'olani followed its guidelines to meet the deadlines. The guidelines specify the deadline for evaluations and require action if providers do not meet the deadline. Providers who do not meet deadlines should not receive further referrals until problems are resolved.

Problems are not addressed

The Child and Adolescent Mental Health Division's liaison frequently visited the Big Island office, met with staff, and generally observed activities. The liaison reported some of these problems to the division chief and Kapi'olani staff. On December 20, 1996, the liaison informed the executive director of the pilot project through the division chief about Kapi'olani's failure to meet evaluation deadlines. Four months later the liaison sent another letter to the project executive director pointing out Kapi'olani's lack of action. May 19, 1997, the liaison informed the division chief about Kapi'olani's non-compliance with service reporting requirements. On June 18, 1997, in another letter to the Kapi'olani executive director, the liaison relayed concerns about the negative conduct of Kapi'olani's subcontractors in juvenile court and said that the division had cited this problem on three prior occasions.

We found no evidence that the division took any corrective actions with Kapi'olani as a result of these communications. It did not impose penalties nor withhold payments to Kapi'olani. The division's contract monitoring visit to Kapi'olani in July confirmed Kapi'olani's inactions. The division has not imposed sanctions, fines, or taken any other steps to cause Kapi'olani to address these deficiencies.

Contract requirement for a management information system not met

The division failed to enforce another contract requirement, that of Kapi'olani's maintaining a management information system to provide critical information on services provided and expenditures. The system was not in place during the contract and was still not in place at the end of the contract period. Kapi'olani's existing system provided data on services authorized but not on services actually provided. This lack of information on what actually transpired severely hampers the division's ability to assess the service outcomes and actual costs of the project. The division has taken no action on Kapi'olani to remedy this outstanding and significant contract term.

The Division Has Disregarded Its Fiscal Responsibilities

The division did not follow fiscally responsible practices. It failed to ensure that the moneys paid to Kapi'olani were warranted and that Kapi'olani followed contractual fiscal requirements. The division overpaid Kapi'olani between \$2.3 and \$3.5 million, and Kapi'olani made payments to providers that were unrelated to services rendered.

The division made payments without proper support

The division followed the compensation and payment schedule and made quarterly advance payments as provided in the contract. However, the contract also requires Kapi'olani to submit monthly program reports on the types and costs of services provided, administrative costs, and other statistical and administrative data. The division should have reviewed the

reports to determine whether services and costs were appropriate and allowable before advancing the next payment. It did not receive this level of reporting yet continued to advance quarterly payments to Kapi'olani.

Kapi'olani's monthly reports to the division summarized the services authorized, but did not provide information on actual services provided and actual expenditures. Services are normally authorized up to three months in advance and typically exceed actual services provided. This difference is due to no-shows and other reasons. According to division staff, about 70 percent of services authorized are typically delivered. Data from Kapi'olani's August 4, 1997 report on the contract period showed that 58 percent of services authorized from October 1996 through June 1997 were actually delivered. Kapi'olani's reports to the division on services authorized painted an inflated picture of the amount of funds actually expended or needed. However, the division made payments based on the inflated amounts. From an August 1997 report to the division, it appears the division's payments to Kapi'olani exceeded Kapi'olani's expenditures for services during the contract period by more than \$3.5 million.

Division chief overrode fiscal controls

The division's fiscal section attempted to withhold payments in the absence of actual cost data but was overruled by the division chief. In December 1996, the fiscal section questioned Kapi'olani's second quarterly advance due to a lack of monthly reports from the prior quarter and decided not to process the payment until this problem was resolved. The division chief was informed of this in the program specialist IV's memo dated December 17, 1996. On December 18, 1996, the program specialist IV informed the public health administrative officer, who approves payment, that the division chief wanted the invoice paid. The division then made all scheduled payments although they were unrelated to services performed and reports had not been submitted.

Emergency appropriation was not warranted

The division's request for an emergency appropriation of \$2,968,350 for the pilot project was not necessary. Payments to Kapi'olani were based on a percentage of the contractual budget, not on services performed. The contract amount was for \$5.8 million, of which a third was payable each quarter. The last payment to Kapi'olani was the emergency appropriation by the 1997 Legislature. Kapi'olani ultimately received \$8.78 million. Exhibit 2.2 presents the contract payment history.

**Exhibit 2.2
Payments to Kapi'olani**

Date of Payment	Expected Administrative Costs	Expected Service Costs	Total Payment
October 1996	\$ 223,002	\$ 1,714,695	\$ 1,937,697
December 1996	223,002	1,714,695	1,937,697
March 1997	223,002	1,714,695	1,937,697
May 1997	686,164	2,282,186	2,968,350
Total	\$ 1,355,170	\$ 7,426,271	\$ 8,781,441

Including the emergency appropriation, the division paid Kapi'olani \$7,426,271 for provider services and \$1,355,170 for administrative costs. However, Kapi'olani's August 4, 1997 cost report showed that it, in turn, had paid sub-contracted providers only \$3,903,867 as of June 30, 1997. With actual, not authorized expenditure data from Kapi'olani, the division could have avoided overpayment. Based on the August 4, 1997 expenditure report, the division's payment of \$7.4 million for services exceeded Kapi'olani's \$3.9 million payments for services by more than \$3.5 million.

Late expenditure report should be scrutinized

The division recently received another expenditure report for the contract period. Dated November 25, 1997, this report claims that Kapi'olani actually spent \$5,099,560 for services—\$1,195,693 more than the August 4, 1997 report. The report also shows that Kapi'olani spent \$1,369,810 for administrative costs, which exceeded the budgeted amount. Neither of these expenditure reports have been audited or verified by the division staff. The lateness of the second report and the disparate service and administrative cost information should cause the division to carefully scrutinize the expenditure reports.

The division continued to allow Kapi'olani to provide services without a contract

The division allowed Kapi'olani to continue providing services for more than three months without a contract. It did not renew the contract with Kapi'olani until October 9, 1997, retroactive to July 1, 1997 through June 30, 1998. Kapi'olani continued to operate and pay for pilot project expenses by using the division's overpayment for the prior year. Further, the division did not reduce the 1997-1998 contract amount by the overpayment amount. In fact, it continued its practice of making quarterly payments without receiving the required reports.

Providing professional services without a contract does not protect the interests of the State or Kapi'olani. Properly executed contracts are essential to ensure that (1) the type and scope of services to be provided have been agreed upon, (2) the services are those for which the Legislature appropriated moneys, and (3) the roles and responsibilities of the department and service providers are clearly delineated to avoid confusion or misunderstandings. Without the benefit of a contract, there is no assurance that services being provided are those that are necessary or those intended by the Legislature.

The division failed to ensure project fiscal controls

The division's original contract required Kapi'olani to establish fiscal controls for provider payments, of which collecting encounter data of services rendered to justify payments is an example. The division was derelict in assuring that Kapi'olani established and used such controls. We found that Kapi'olani:

- paid providers for unauthorized services;
- paid providers amounts that were unrelated to services provided; and
- paid providers over \$385,000 without adequate supporting documentation.

Standard fiscal controls require services to be authorized prior to being delivered and documents be provided that support requests for payment of services. Kapi'olani's administrative care coordinators supposedly authorize all services before providers deliver services. Providers must submit adequate documentation such as encounter data with their invoices to show that they actually performed the services.

Kapi'olani is contractually required to collect service encounter data to support invoices. Service encounter data are typically in the form of clinical notes, i.e. notes that document professional treatment. According to the consultant hired by Kapi'olani to review its clinical and fiscal processes, submitting clinical notes with invoices is industry standard for this type of program. Normally, invoices are sent back if not supported by clinical notes. However, Kapi'olani did not require providers to submit clinical notes with invoices.

During our testing of service costs, we found instances where Kapi'olani intentionally paid sub-contractors without required documentation. Kapi'olani's fiscal manager explained that providers pressured Kapi'olani to by-pass its requirements and allow payment. Kapi'olani's June 30, 1997 cost report showed more than \$385,000 in such payments to providers. The division's contract management role to ensure substantiated spending of state moneys was notably absent.

The division did not enforce required provider audits

The division's contract required Kapi'olani to perform quarterly audits of its providers to verify that billed services were actually performed. However, Kapi'olani audited only one agency during the entire contract period and the audited agency lacked documentation to support its payment claims. Over 25 percent of the files reviewed lacked sufficient justification for the services billed. Kapi'olani's Honolulu office also conducted a site visit of this agency and found that 64 percent of client records reviewed had "no clinical progress notes and/or contact log entries to document that services were rendered as billed."

The division should be concerned about the absence of Kapi'olani's quarterly audit program and the high probability of abuse based on this absence. If Kapi'olani's audit found lack of documentation and possibly abuse, the probability of similar conditions among other unaudited providers is high. Without systematic checks and negative consequences for non-compliance, providers will not be motivated to meet requirements.

The division is culpable

The division is ultimately responsible and culpable for fiscal management deficiencies. The division seems to condone Kapi'olani's lax controls over payments. In one case, a provider wrote directly to the division about its cash-flow problems in paying its bills. Kapi'olani then paid the provider, even though the provider did not submit evidence that services were authorized or provided. The division chief was aware of the payments but took no serious steps to remedy the provider's and Kapi'olani's problems. In a letter to the provider, the division stated that Kapi'olani's payment "went far beyond normal contractual responsibility." However, the division made no request for supporting evidence of services rendered, a revised business plan for the provider's cash flow problem, or technical assistance for either Kapi'olani or the provider. The division's lack of fiscal responsibility for public funds is blameworthy.

Hasty Project Implementation Caused Service Delays

The *Felix v. Waihee* consent decree requires collaboration of all agencies involved in meeting the needs of eligible children. The Department of Education and Department of Health are the primary agencies involved in this collaborative process. The Department of Education receives referrals and coordinates determination of eligibility for services. The Department of Health arranges for mental health evaluations and for mental health services. Other involved agencies include the Judiciary and Department of Human Services as required. However, the Child and Adolescent Mental Health Division quickly conceived and implemented the pilot project without adequately coordinating with the other agencies. As a result, coordination problems have affected and delayed services.

The division's inadequate planning also resulted in underutilized staff of the division's own Family Guidance Center. While these problems are being addressed, better planning and coordination initially would have minimized them.

Coordination problems among agencies delay services

Kapi'olani must coordinate its services with the Department of Education to determine and meet the needs of eligible children. Initial problems in coordinating services are still being resolved but have resulted in some delayed services.

One problem relates to the privacy and appropriateness of mental health evaluations. The Department of Education does not accept evaluations that contain sensitive information or recommendations for educational interventions. Sensitive information—for example, reports of physical or sexual abuse—is protected and not for school staff review. Recommendations for educational interventions are not within the scope and purpose of the mental health evaluations and therefore not accepted by DOE. Recommendations for mental health interventions are appropriate.

These problems with content of evaluations have caused delays because DOE district staff review all evaluations before sending them to the appropriate schools. Content issues with Kapi'olani had to be resolved first. The evaluations have reportedly improved because Kapi'olani's clinical director has asked providers to revise their evaluations. However, these efforts to improve evaluations have resulted in some missed statutory deadlines.

Another coordination issue was confusion regarding the start date for referrals which also resulted in evaluation delays. The DOE and Kapi'olani used different start dates. In counting the 100-day limit for cases under the Individuals with Disabilities Act (IDEA), Kapi'olani used the date of referral from the department, but the department used the date of referral to the school. The problem was resolved after identifying the misunderstanding and agreeing on a common start date.

Kapi'olani also differed with the DOE on the content of individual education plans (IEPs) prepared by DOE. Some IEPs specified mental health service providers by name. Kapi'olani objected because the IEPs are legal documents, and problems in delivering services could arise if the specified provider is not available.

Coordination improvements are being made

Kapi'olani, the Department of Education, and other agencies have increased communication to improve coordination. DOE district staff began meeting with Kapi'olani administrative care coordinators in June

1997 to educate them on guidelines related to children in the plaintiff class. The administrative care coordinators have also contacted school counselors and principals to improve communication.

Departments have also formed committees to facilitate coordination between agencies. The director of health has met with top management from his department, the Department of Education, and Kapi'olani HealthHawaii. Also, a proactive inter-agency committee, a Big Island interagency team, and a Big Island interagency team sub-committee were recently established. These interagency groups include members from all agencies involved with children in the plaintiff class, including: the Departments of Education, Health, and Human Services; the Judiciary, and Kapi'olani HealthHawaii.

The Big Island interagency team discusses system of care issues and complex or intensive cases. The proactive interagency committee also discusses individual cases to find appropriate interventions. The Big Island interagency team sub-committee has the sole purpose of creating an interagency care coordination working agreement, and guidelines to address service planning.

***Family Guidance Center
staff are underutilized***

The division implemented the pilot project without utilizing the Family Guidance Center staff on the Big Island. The division did not involve the center's staff during project planning and gave them minimum responsibilities under the new system. Consequently, staff are underutilized.

The division dramatically changed the role of the Family Guidance Center when it implemented the pilot project. Prior to the project, the center's staff were case managers for children. They obtained assessments, arranged for services, and handled family interactions. Under the pilot project, the staff do not see clients nor do they coordinate care. Their new responsibilities are at school campuses helping to screen children for eligibility.

A memorandum of agreement between the Family Guidance Center and Kapi'olani HealthHawaii lists the center staff's responsibilities, but some of the responsibilities are repetitive or unnecessary. The center staff report that they do not even perform some of those responsibilities. For example, the agreement says that the staff forward information to Kapi'olani following screening meetings and assist in collecting background information for evaluations. However, school personnel perform these functions. The agreement also states that the center staff will help Kapi'olani by providing feedback from Community Children's Councils and by gathering consumer satisfaction survey information. However, the Family Guidance Center staff report that Kapi'olani has not requested their assistance in these duties.

We observed four of the six Family Guidance Center staff after the beginning of the school year in September. We found that their assigned work does not utilize all of their time. Some staff were occupied for only half of their work periods. They mainly participate in screening meetings to determine eligibility and provide assistance to Community Children's Councils. One staff primarily attends Family Court hearings.

The division is underutilizing staff who have the skills and ability to contribute to the project. Demands for services and the population of eligible children have increased. The Department of Health should look into the possibility of utilizing these staff to provide services, either on the Big Island or on other islands.

Conclusion

The number of children needing services is expected to grow. One mental health agency estimates as many as 39,000 children statewide may need services. The cost of providing these services is already staggering. The State can ill afford services to be provided without controls in place to ensure that quality services are provided in a cost-effective manner.

The division has failed to manage the contract for the pilot project. It has disregarded its fiscal responsibilities and its responsibilities to the children who need services. Furthermore, the division has not improved on its history of derelict contract management. Drastic steps need to be taken to improve the division's contract management practices—particularly with respect to its management of the Big Island Pilot Project.

Recommendations

1. The Director of the Department of Health should ensure that the Child and Adolescent Mental Health Division is staffed appropriately to manage and enforce its contract with Kapi'olani HealthHawaii. In doing so the director should consider:
 - a. The changing responsibilities of the division, particularly with respect to contract management and the *Felix v. Waihee* consent decree;
 - b. The education, skills, and work experience needed to effectively manage contracts; and
 - c. A structure that provides accountability in the division.
2. The Child and Adolescent Mental Health Division should enforce the terms of its contract with Kapi'olani HealthHawaii to ensure that:

- a. authorized services are provided;
 - b. the required quality assurance activities are performed; and
 - c. payments are made only for services actually rendered.
3. The division should cease the practice of advancing moneys without adequate support.
 4. The governor, the superintendent of education, and the director of health should continue efforts to coordinate and work together on the Big Island Pilot Project.
 5. The director of health should look at the possibility of utilizing Family Guidance Center staff as providers of services.

Appendix A

Hawaii Child and Adolescent Service System Program Principles

1. The system of care will be child-centered and culturally sensitive, with the needs of the child determining the types and mix of services provided.
2. Access will be to a comprehensive array of services that addresses the child's physical, emotional, educational, recreational and developmental needs.
3. Family preservation and strengthening along with the promotion of physical and emotional well-being shall be the primary focus of the system of care.
4. Services will be provided within the least restrictive, most natural environment that is appropriate to individual needs.
5. Services which require the removal of a child from his/her home will be considered only when all other options have been exhausted, and services aimed at returning the child to his/her family or other permanent placement are an integral consideration at the time of removal.
6. The system of care will include effective mechanisms to ensure that services are delivered in a coordinated and therapeutic manner, and that each child can move throughout the system in accordance with his/her changing needs, regardless of points of entry.
7. Families or surrogate families will be full participants in all aspects of the planning and delivery of services.
8. As children reach maturity, they will be full participants in all aspects of the planning and delivery of services.
9. Early identification of social, emotional, physical and educational needs will be promoted in order to enhance the likelihood of successful early interventions and lessen the need for more intensive and restrictive services.
10. The rights of children will be protected and effective advocacy efforts for children will be promoted.

Appendix B
Sub-Contracted Agency Providers
(As of July 9, 1997)

Don Hashimoto and Group
E Ala 'Ike (Division of Rise Institute)
Hawaii Behavioral Health Services
Hawaii Center for Children
Hawaii Counseling Services
Island Counseling Affiliates
Kahi Mohala
Na Laukoa Program
Na Ohana Pulama (a program of Catholic Charities)
North Hawaii Alliance for Child and Family Therapy
Rise Institute
The Salvation Army
The Institute for Family Enrichment
West Hawaii Counseling Associates

Appendix C

Glossary

Administrative care coordinator

Staff of Kapi'olani HealthHawaii who initially evaluates a child's needs and refers the child for services; coordinates consumer needs with provider specialties; monitors consumer follow-through and treatment progress; reviews authorization of care; conducts crisis assessment; and handles emergency calls.

Authorization of services

Permission provided by Kapi'olani HealthHawaii to sub-contractors before they can deliver and bill for specified services.

Child and Adolescent Functional Assessment Scale (CAFAS)

A standardized measure of functional status that indicates the level of impairment in school/work, home, and community settings; behavior towards others; moods; substance use; thinking; and caregiver resources.

Child and Adolescent Service System Program (CASSP)

A set of principles required by the *Felix v. Waihee* consent decree to guide the system of care created by the defendants. See Appendix A for a list of these principles.

Community Children's Council

Community groups required by the implementation plan for the *Felix v. Waihee* consent decree to effect community participation. The functions of the council includes participation in needs assessment, service system planning, budget recommendations, and quality management activities.

Clinical case manager

A person sub-contracted by Kapi'olani HealthHawaii to provide services including ongoing monitoring and support, skill development, crisis resolution, and assistance in accessing needed community resources and supports.

Family Guidance Centers

Branches of the Child and Adolescent Mental Health Division with the functions of planning, organizing, implementing, and monitoring programs and activities to meet the mental health needs of children, adolescents and their families.

Felix court monitor

An individual appointed by the U.S. District Court to monitor defendants' efforts to implement the provisions of the *Felix v. Waihee* consent decree and implementation plan. The monitor also recommends improvements to the court's compliance enforcement activities.

Felix technical assistance panel

A panel of experts required by the U.S. District Court to assist the Department of Education and Department of Health in designing the system of care under the *Felix v. Waihee* consent decree, and in formulating the implementation plan.

Individualized education program (IEP)

A written statement for a child with a disability that is developed jointly by participants including (a) principal, vice-principal, or principal's designee; (b) child's teacher; (c) one or both of the child's parents; (d) the child, where appropriate; (e) other individuals, at the invitation of the parent or the department; and (f) a member of the diagnostic team and a person knowledgeable about placement options. The program includes the following components: (1) A statement of the child's present levels of educational performance; (2) A statement of annual goals, including short-term instructional objectives; (3) A statement of the specific special education and related services to be provided to the child, and the extent to which the child will be able to participate in regular education programs; (4) The projected dates for initiation of services and the anticipated duration of the services; (5) Appropriate objective criteria and evaluation procedures and schedules for determining, on at least an annual basis, whether the short-term instructional objectives are being achieved; and (6) A statement of the needed transition services beginning no later than age sixteen, or at a younger age, if determined appropriate.

Individuals with Disabilities Education Act (IDEA)

A federal act whose purpose is to (a) ensure that all children with disabilities have available to them a free appropriate public education that includes special education and related services to meet their unique needs; (b) ensure that the rights of children with disabilities and their parents are protected; (c) assist states and localities to provide for the education of all children with disabilities; and (d) assess and ensure the effectiveness of efforts to educate those children.

Mental health evaluation

A clinical evaluation to determine eligibility for mental health services that includes completion of a functional assessment scale, written narrative, recommendations regarding the nature and extent of services that may be appropriate, and other components.

Section 504 modification plan

A written plan developed by a section 504 team to meet the individual education needs of a qualified student with a disability. The plan includes the modifications or any related aids and services necessary to meet the individual educational needs of a qualified student with a disability under section 504 of the Rehabilitation Act of 1973. The section 504 team is a group of persons who are knowledgeable about a student, the meaning of the student's evaluation data, and the department's educational placement options. The team may consist of an administrator, counselor, teacher, parent, the student, if appropriate, or other persons knowledgeable about the student.

Section 504 of the Rehabilitation Act of 1973

A federal statute that protects all qualified students with disabilities from discrimination on the basis of disability. Subpart D of the section requires the provision of a free appropriate public education to all qualified students with disabilities whether or not they are eligible for special education and related services under the Individuals with Disabilities Education Act Amendments of 1991.

Service plan

A plan that is required before clinical case management services are authorized. The plan includes goals and objectives, diagnosis, symptoms, requested visits, and other information.

Therapeutic aide

Personnel sub-contracted by Kapi'olani HealthHawaii to provide one-to-one supervision and support to a child or adolescent with a serious emotional disorder to avert treatment in a residential or inpatient setting. Services may be provided in the home or school for a specified number of hours per day or round-the-clock for a defined length of time.

Treatment plan

A plan for providing treatment that is required before treatment is authorized in order to allow the administrative care coordinators to evaluate criteria in determining clinical necessity and authorization of visits; and provide a standard for quality assurance and consistency of treatment.

Notes

Chapter 1

1. Budget request justification for fiscal year 1997, Child and Adolescent Mental Health Division, December 1, 1995.
2. Jennifer Felix, et al. v. Benjamin J. Cayetano, et al.; Civil No. 93-00367 DAE; Stipulation modifying implementation plan dated October 31, 1995; Order; Exhibit C, Operational plan for the Big Island Demonstration Project; Honolulu, Hawaii; July 31, 1996.
3. Hawaii, The Auditor, *Audit of State Contracting for Professional and Technical Services*, Report No. 95-29, Honolulu, November 1995.

Response of the Affected Agency

Comments on Agency Response

We transmitted a draft of this report to the Department of Health on December 18, 1997. A copy of the transmittal letter to the Department of Health is included as Attachment 1. The response from the department is included as Attachment 2. The department's response included additional attachments that are available for public inspection at our office.

The department feels that some of our recommendations merit consideration, but that our report does not acknowledge the "significant efforts" of its division and its contractor nor the many activities of its liaison and the 1997 quality assurance initiatives of its contractor. It also defends its need for the emergency appropriation because it was based on the best available data.

The department's response includes a detailed 18 page discussion of our findings. Most of the discussion describes actions begun to correct the problems we noted or attempts to explain why we found what we did. The department states that Kapi'olani HealthHawaii takes exception to a statement in our report draft that "In another instance, children did not receive services for a six week period." The department's response claims the children did not receive services for about a four week period. We obtained our information directly from the files of the division's liaison, who wrote a detailed memorandum on this incident. We cannot confirm the information provided to the department by Kapi'olani HealthHawaii and will leave the report as drafted.

The department attributes its overestimation of its budget needs to the limited start-up period of the project. But its discussion of the 71 percent ratio of services rendered to services authorized does not respond to the point we make—that, for FY 1996-97, the department overpaid Kapi'olani HealthHawaii.

The department agrees that the division's current organizational structure does not allow for optimum contract monitoring efforts. It has recently recruited a contracts supervisor to oversee the division's monitoring functions. We believe that problems will persist if the department continues to view its role as that of a "contract monitor" instead of a "contract manager." Public funds must be managed to ensure that desired results are achieved. Contractors entrusted with public funds should also be managed, not monitored, for the same reason.

ATTACHMENT 1

STATE OF HAWAII
OFFICE OF THE AUDITOR
465 S. King Street, Room 500
Honolulu, Hawaii 96813-2917



MARION M. HIGA
State Auditor

(808) 587-0800
FAX: (808) 587-0830

December 18, 1997

COPY

The Honorable Lawrence H. Miike
Director of Health
Department of Health
Kinau Hale
1250 Punchbowl Street
Honolulu, Hawaii 96813

Dear Dr. Miike:

Enclosed for your information are three copies, numbered 6 to 8 of our draft report, *Audit of the Big Island Pilot Project on Mental Health Services*. We ask that you telephone us by Monday, December 22, 1997, on whether or not you intend to comment on our recommendations. If you wish your comments to be included in the report, please submit them no later than Monday, December 29, 1997.

The Governor and presiding officers of the two houses of the Legislature have also been provided copies of this draft report.

Since this report is not in final form and changes may be made to it, access to the report should be restricted to those assisting you in preparing your response. Public release of the report will be made solely by our office and only after the report is published in its final form.

Sincerely,

Marion M. Higa
State Auditor

Enclosures

BENJAMIN J. CAYETANO
GOVERNOR OF HAWAII



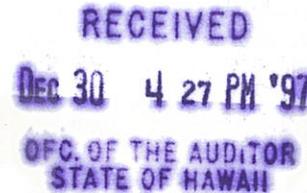
LAWRENCE MIIKE
DIRECTOR OF HEALTH

STATE OF HAWAII
DEPARTMENT OF HEALTH
P.O. BOX 3378
HONOLULU, HAWAII 96801

In reply, please refer to:
File: 44394

December 30, 1997

The Honorable Marion M. Higa
State Auditor
Office of the Auditor
465 S. King Street, Room 500
Honolulu, Hawaii 96813



Dear Ms. Higa:

Attached is the Department of Health's response to your draft report, *Audit of the Big Island Pilot Project on Mental Health Services*.

We would note that while some of the recommendations you have made merit consideration, your report does not acknowledge:

- Consideration of the significant efforts made by the Child and Adolescent Mental Health Division and its contractor, Kapi'olani HealthHawaii to implement this legislatively approved and Felix Consent Decree required demonstration project. The CAMHD's charge to build a system of care which was originally estimated to include 400 children and adolescents to a system which has been required to serve 1600 children and adolescents has not been without challenge given the need to build a viable service network capacity on the Big Island.
- Oversight by the CAMHD liaison to oversee the Big Island Pilot Project. His activities included BIPP interagency meetings with the Department of Education, CAMHD, Hawaii District Health Office, Department of Human Services, Family Court and DOH Director's office staff; twice monthly meetings between KHH and the DOE; monthly facilitation with KHH Administrative Care Coordinators; participation in the KHH/BIPP Island Community Policy Board; participation in the KHH Quality Management committee; consultation related to contract terms and supervision (as needed) of the Hawaii Family Guidance Center staff.

The Honorable Marion M. Higa
Page 2
December 30, 1997

- Quality Assurance demonstrated by the ongoing training efforts by the KHH to strengthen provider capability in the areas of strength based treatment planning (since January 1997), service authorization, and contract documentation and reporting requirements. Focused attention has resulted in strengths and accomplishments as noted in the November 1997 service testing by the Felix Court Monitor.
- Fiscal budget estimates that were based on best data available. The original service budget was based on a maximum need of 400 children. Although the project had a start up date of November 1, 1996, 754 children were enrolled in the same month. Funds to service this rapidly growing population for the rest of Fiscal Year 1997 had to be estimated with only two months of project data (December 1996) so that additional funding could be considered prior to the 1997 legislative session.

We agree that the division's current organizational structure does not allow for optimum contract monitoring efforts. As such, we have recently recruited for a contracts supervisor to oversee the CAMHD monitoring functions. We are also reviewing and will propose a reorganizational change which will not only address contract monitoring but quality management functions for the CAMHD.

Thank you for the opportunity to comment. We do not dispute some of your conclusions, however, we request that your report also consider the enormity of effort in developing and implementing this demonstration project and the accomplishments made. We will be forwarding our response to the Governor and the Legislature. If you have any questions, please call me at 586-4410.

Very truly yours,



Lawrence Miike
Director of Health

Enclosures

The Child and Adolescent Mental Health Division Fails to Adequately Manage the Big Island Pilot Project (Legislative Auditor)

Auditor's finding. The division has not met its statutory and contractual requirements. (Page 14)

Auditor's Observations.

- CAMHD contract management staff failed to perform site visits, fiscal reviews and performance evaluations during the contract period.

CAMHD contract management staff did conduct their site visit on July 16, 1997, after the first contract period had passed.

- Contract management was primarily done through visits to the Big Island by the division's contract liaison.

The role of the division's contract liaison is described below. His role included that of contract consultant to Kapiolani HealthHawaii (KHH).

- Since division contract management staff conducted no site visits or evaluations during the contract period, the division had no basis to determine whether contract goals were being met nor whether the contract should be extended.

The frequency of the contract liaison's site visit and oversight of demo project activities speaks to ongoing monitoring, evaluation and dialogue.

Further Comments Regarding the role of the CAMHD contract liaison. Howard Weiner (clinical psychologist) served as the CAMHD BIPP liaison. The contract liaison's involvement in the BIPP began in June 1996. The liaison facilitated the review and analysis of responses received to the Big Island Demo Project Request for Proposals (RFP). Beginning in October 1996, this staff member was assigned by the CAMHD chief to serve as a liaison to the BIPP.

Dr. Weiner served as BIPP liaison from Oct. 1996 to July 1997. As BIPP liaison, Dr. Weiner's duties and activities included:

- CAMHD liaison at BIPP interagency meetings (meetings involved DOE district and state office staff, CAMHD/HI FGC staff, Hawaii District Health Office staff, Department of Human Services staff, Family Court staff, DOH Director's office staff and other state agency staff by request);
- supervision of Family Guidance Center (FGC) staff (when HI FGC chief's position was vacant);
- divisional consultant to KHH regarding contract terms;
- member of the KHH Quality Management (QM) Committee;
- twice monthly meeting (since December 1996) with KHH and Department of Education (DOE) executive staff to explore and resolve BIPP issues and problems (e.g., the IDEA/504 referral process and issues surrounding the delivery of mental health services to BIPP clients);
- telephone consultation regarding complaints received as to the delivery of services for individual cases or other issues related to terms of the BIPP/KHH contract;
- facilitator of monthly meetings called with KHH Administrative Care Coordinators (ACC) and FGC staff;
- member of the KHH/BIPP Island Community Policy Board;
- participant at all KHH/BIPP Provider Council meetings; and
- reviewer of all memorandum-of-agreements (MOA) between KHH and DOE, Community Children Councils (CCC) and the FGC.

The frequency and breadth of Dr. Weiner's involvement with all aspects of the KHH contract invokes a conclusion different from that reached by the Legislative Auditor. Closer examination of Dr. Weiner's activities would show instead that CAMHD staff and division chief had regular and specific involvement with all aspects of the BIPP. Dr. Weiner's background as the facilitator of the RFP process, clinician and mental health program administrator also qualifies him as a nearly ideal liaison with the BIPP.

Auditor's Finding. Site Visits were late and perfunctory (page 14).

Auditor's Observation.

- July 16, 1997 - Two contract management staff visited the Big Island. They visited Hilo in the morning and Waimea in the afternoon. The staff spent only 45 minutes at the Waimea office, reviewed no files and performed no substantive tests to confirm verbal information received from KHH staff.
- July 9, 1997 - QM supervisor visited Hilo office. Examined 10 client files. This is not the comprehensive evaluation required by the contract.
- Neither site visit provided the department with the comprehensive evaluation of the contract or with the timely information needed to determine whether the contract should be renewed.

The activities of the CAMHD BIPP liaison and the site visits serve to confirm the ongoing review of project activities.

Further Response. The contract management and QM reviews performed by CAMHD staff served to confirm or deny the on-going observations, consultation and dialogue performed by the BIPP liaison.

Auditor's Finding. Accountability is Weak (page 15).

Auditor's Observations.

- The division should be responsible for defining the roles of key personnel, granting them authority to carry out their functions and holding them accountable for their performance
- The liaison, during the contract period is a psychologist who does not appear on the division organizational chart but, reports directly to the division chief. This organizational structure does not accurately reflect the level of authority and accountability assumed and delegated to the division.

Accountability is weak
(cont'd.)

- The liaison position is occupied by an employee of the University of Hawaii, under contract to the department to perform services at the Hawaii State Hospital. His contract does not identify any responsibility to act on behalf of the CAMHD.

When Dr. Weiner was first assigned as BIPP liaison, he occupied the position of clinical psychologist VII, position number 40234, located in the Clinical Services Office. On January 16, 1997, Dr. Weiner assumed a competitively recruited position within the Department of Psychiatry, Division of Child & Adolescent Psychiatry housed at CAMHD.

This faculty position reported to the division chief. Subparagraphs 1.1 and 1.1 (1) thru (3) of the contract with the Dept. Of Psychiatry provide the division chief with all necessary authority to supervise Dr. Weiner. The Auditor is also incorrect in stating that this position had any connection to the Hawaii State Hospital.

- Two persons with doctoral degrees in psychology conducted the review of contract compliance and have many contract oversight responsibilities. Yet their job descriptions do not require extensive education or experience in contract management.

Clinical background was considered to be an asset with regards to review and analysis of the activities of KHH and their subcontractors.

Further Response. The DOH will propose a re-organization to implement a multi-disciplinary approach to contract monitoring. The division has recruited a contract supervisor to address and lead compliance, clinical and fiscal issues. This position will be filled on December 31, 1997. CAMHD also seeks to provide technical assistance to providers who are adjusting to performance based contracting.

The Division has not enforced Quality Assurance Requirements for Services

Auditor's Finding. Service authorization requirements are not enforced (page 17).

Auditor's Observations.

- KHH has allowed providers to bypass its requirements that ensure that only clinically appropriate services are provided. Without this assurance, services provided may not be necessary or appropriate.

Prior to the establishment of the BIPP, contracted mental health providers were not accountable for the submission of treatment plans for clients that they served. KHH is working with their ACCs to ensure compliance by their subcontractors with the development of appropriate treatment plans.

During the first contract period, it became apparent that some contracted mental health providers lacked the training and experience in developing good treatment plans. Strength based treatment planning is a new principle which the FCD requires the State to adopt within its new system of care. A schedule of training that KHH has launched since Jan. 1997 to bolster contract provider skills is attached.

- KHH contracted clinical case coordinators are supposed to send regular reports on services to KHH ACCs. KHH did not exercise these controls and the division did not enforce its own contract with KHH to carry out this standard practice.

KHH BIPP staff regularly monitor the performance of its contract providers with regards to its reporting requirements. Samples of its correspondance with providers on a variety of these issues are attached.

The CAMHD liaison functions and activities kept himself fully informed as to KHH's efforts.

Auditor's Finding. Service authorization requirements are not enforced (cont'd.)

- KHH has authorized services after they were provided and without service plans. In Feb. 1997 KHH retroactively authorized over \$350K that had been provided in previous months.

KHH has had daily experience with the lack of fiscal training and structures within contract provider agency with performance based contracting. KHH has initiated training activities and is working directly with providers who are exhibiting the most problem with performance based contracts and reporting requirements.

Corrective Actions Taken. KHH has identified two agencies who have had the most difficulty in meeting requirements for paying claims and which have had chronic cash flow problems. KHH has developed corrective action plans to assist them in meeting their administrative responsibilities.

Auditor's Finding. The Division does not ensure submittals of required information (page 18).

- KHH received little information about the timeliness and effectiveness of services provided by its subcontractors. The division did not require KHH to correct this deficiency.
- In one case, a child had run away and required monthly reports had not been submitted. Case manager was still being paid. In another instance, children did not receive services for a six week period.

KHH disputes the accuracy of this statement. KHH received a call on 5/5/97 indicating that the mental health worker had not seen the children for 2 weeks. KHH called Island Crisis Help (ICH) and were informed that the provider would return that day. On 5/7/97, the children has still not received services. KHH again notified ICH that coverage was needed. On 5/14/97, KHH was notified that ICH would no longer provide services to these children. Services were restored within 5 working days.

KHH Response. Once informed of the problem, KHH moved quickly to resume services and coverage, especially to high priority cases. KHH worked closely with school officials to resume services. ICH is an agency which ceased operations on 6/30/97. Prior to their closure, KHH established a five day response time for ICH to provide service to a child referred to their agency for services. If ICH was unable to provide services within this time frame, the case was returned to KHH.

As of July 1, 1997, KHH has established a policy for pulling cases in which agencies and/or individual providers are not providing care or responding within time frames set by KHH staff. In these instances, the case has been reassigned to another provider who is able to fulfill the terms of their contract. As of July 1997, there have been five such incidences. KHH has also begun requiring that providers have appropriate certifications and continuing education credits to qualify for future case referrals.

Auditor Finding. The division does not know the quality of services being delivered (page 19).

- Contract with KHH requires timely quality management reviews. The reviews are of KHH's internal management and of its subcontractors. Division allowed KHH to postpone many of these reviews. KHH cannot attest to the quality of services during much of the contract period.

It is notable that the FELIX Court Monitor conducted service tests on the Big Island in May and November 1997. The November 1997 testing concludes that "there are more services available" and that "children are being identified earlier with better results". Another finding notes that "training is occurring and is having an impact on practice". These results would indicate that the BIPP is having a positive impact on the care of children on the Big Island. A parent satisfaction survey conducted by KHH also notes a 80% satisfaction with the BIPP.

- KHH began most of its QM reviews after the QM director arrived in April 1997. Once QM started, deficiencies were found. In one quarterly review of one of the 14 contracted agencies, many deficiencies found in the clinical records.

Auditor Finding. The division does not know the quality of services being delivered (cont'd.)

- A majority lacked diagnosis. Half of the records lacked documentation of clinical supervision. A significant percentage of the treatment plans lacked required components. 24% of a sample of the evaluations contained a CAFAS. The rest did not.
- Honolulu staff found that 23 of 36 treatment plans included inappropriate psychiatric interventions. 25 of the 36 records also did not mention the children's response to treatment.

KHH has worked individually with its contract providers as to their reporting and documentation requirements. It is important to note for most providers, performance based contracting documentation and reporting requirements were new areas for them. KHH has identified this as a major challenge for which they have developed specific training activities (see previous listing of its training activities).

The auditor continually reports instances where contract providers utilized by KHH did not fully meet the terms of their contracts. Given the greater than anticipated number of requests for evaluations and services, it was necessary for KHH to utilize all available providers. It is important to note that even when utilizing all available providers, there was still inadequate capacity to immediately meet the demands for all requested services. KHH readily acknowledges that while these providers were available, some were definitely not fully prepared for the standards and requirements of performance based contracting. Given the priority for delivering services to children, KHH has worked hard during the first contract period to establish consistency and capacity within its contract provider network to address both administrative (prior authorization, documentation and reporting) and clinical service requirements.

Auditor's Finding. Division does not ensure the professional competency of providers (page 20).

- The division's contract requires KHH to check the credentials of sub-contracted providers. KHH established standard requirements for some providers (psychologist, psychiatrists and supervisors) but not for all providers.

Auditor's Finding. Division does not ensure the professional competency of providers (cont'd.)

- They have also allowed five contracted case management agencies to establish their own minimum qualifications, job descriptions and to keep their own records of staff qualifications. KHH checked the qualifications of non-supervisory providers only during QM site visits.

CAMHD is working with the KHH QM staff to shore up its credentialing process. Again, given the priority for bringing services to children, the division acknowledges that this area requires immediate attention.

- Auditor cites inappropriate behavior of some case managers. The Auditor also cites an instance where an attorney general also noted inappropriate actions of some KHH case managers.

Effective July 1, 1997, KHH has agreed with the Family Court that if reports submitted in court do not meet a mutually agreed upon criteria, that there will be sanctions passed onto the agency/provider. Training was held on 12/19/97 with case managers regarding this criteria. A monthly review and training process for case managers have also been initiated.

Auditor's Finding. Evaluations did not meet statutory deadlines (page 21).

- Mental health evaluations for eligible children under IDEA are required no later than 100 days between the evaluation request and the eligibility determination or supplemental evaluation. 504 evaluations are required within 45 days of referral and eligibility determinations are due within 90 days of referrals. Eighty case files were reviewed. 61% of cases sampled were late because of the tardiness of the providers.

Auditor's Finding. Evaluations did not meet statutory deadlines (cont'd.)

- March 1997 - 100 evaluations late
- May/June 1997 - 48% were late
- June 1997 39 of 129 cases were late (30%)
- KHH staff repeatedly call providers to remind them of their late evaluations. However, KHH did not suspend further evaluations to providers until their timeliness problems are addressed.

KHH had been initially contracted to provide mental health services to a maximum of 400 kids. The provider network was not equipped to provide evaluations for 1,600 kids. Given the inadequate number of providers, if KHH had sanctioned providers for late evaluations, this would have further delayed evaluation and jeopardized the provision of care to kids. This was not a viable alternative. A listing of KHH contract providers is attached.

Auditor's Finding. Problems were not addressed (page 22).

- The CAMHD liaison frequently visited the Big Island office, met with staff, and generally observed activities. The liaison reported some of these problems to the division chief and KHH staff.
- Dec. 20, 1996 letter to KHH about evaluation deadlines. 4 months later - the same thing.
- May 19, 1997 division chief informed about non compliance with reporting requirements.
- June 18, 1997 letter to KHH executive director, relayed concerns about negative conduct of KHH subcontractors in juvenile court.

Auditor's Finding. Problems were not addressed (cont'd.)

- The division has not imposed sanctions, fines or taken any other steps to cause KHH to address these deficiencies.

Aside from the liaison's attempts to problem solve the issues and problems which arose during the first contract period, there were other forums of note. These forums included regular meetings of: the CCCs, the BIPP interagency meetings; the KHH QM committee; the meeting of DOE/KHH/DOH executive staff; the KHH/BIPP Island Community Policy Board and the KHH/BIPP Provider Council meetings.

Given the necessary amendment to the KHH contract and the significant challenge to service four times the projected number of clients, sanctions were not considered to be an effective means with which to resolve the issues and challenges before all parties.

Auditor's Finding. Contract requirement for a MIS system not met (page 22).

- KHH's existing system provided data on services authorized but not on services actually provided. Division has taken no action on KHH to remedy this outstanding and significant contract term.

A Lack of Historical Data. KHH's management information system (MIS) provides both clinical and financial functional and reporting needs. The data reported by KHH, and agreed to by CAMHD was based on authorized services rather than actual payments. Providing utilization and financial data based on paid claims would have significantly understated service outcomes and costs of the project due to the lag time in claims submissions, claims payment turnaround and providers getting accustomed to the new pre-authorization and claim payment processes. Providing utilization and financial data based on authorizations, though possibly overstating results, would provide a better indication of service outcomes and actual costs of the project. As historical data becomes available (industry expectations are 12-18 months of data history), a more reliable utilization percentage factor between actual payments and authorizations would be applied to the authorization figures to project actual costs.

Auditor Finding. The division made payments without proper support (page 22).

- The division should have reviewed the reports to determine whether services and costs were appropriate and allowable before advancing the next payment. It did not receive this level of reporting yet continued to advance quarterly payments to KHH.

Quarterly advances were specified in the contract. The division's payment schedule for the first contract period follows.

10/16/96 - \$1,937,697.00
12/18/96 - \$1,937,697.00
03-05/97 - \$1,743,926.00
05/29/97 - \$2,968,350.00

- KHH's reports to the division on services authorized painted an inflated picture of the amounts of funds actually expended or needed. From an August 1997 report to the division, it appears the division's payments to KHH exceeded expenditures for the contract period by more than \$3.5 million.

Given the lack of historical expenditure data, KHH and CAMHD utilized by mutual agreement, a projected final expenditure of 70%. Legislative requests for emergency appropriation and advances paid to KHH were based on this figure.

Overpayments by the Division. The overpayment of \$2.1 million to KHH was attributed to an over estimation of funds needed to service a rapidly growing enrollment of children after only two months of being in operation. Also, the advance payments to KHH were not adjusted for direct payments made by the State for inpatient and residential services. Realizing the original service budget of \$5.1 million was to serve a maximum enrollment of 400, and with enrollment at 754 in November 1996, KHH needed to project the additional funding requirement prior to the 1997 legislative session. Due to the startup of the project, both volumes of children as well as historical cost data was not available. KHH based its emergency funding request on information on hand as of December 1996 (2 months after start).

Auditor's Finding. Division Chief overrode fiscal controls (page 23).

- In Dec. 1996, the fiscal section questioned KHH's second quarterly advance due to a lack of monthly reports from the prior quarter and decided not to process the payment until the problem was resolved. On Dec.18, 1996, staff were informed that the division chief wanted the invoice paid.

True. Given the court's requirement that services to children are provided, the division chief placed greater priority on the provision of services to children over the absence of monthly reports by KHH. The division chief did not absolve KHH of this requirement but, instead allowed them to continue services and catch up with necessary reporting.

Auditor Finding. Emergency appropriation was not warranted (page 23).

- Emergency appropriation of \$2,968,350 was not necessary. Payment to KHH was based on a percentage of the contract amount and not on services performed.
- The division paid KHH \$7,426,271 for provider services. In its August 1997 expenditure report, KHH reported service expenditures of \$3,903,867 or an overpayment of nearly \$3.5 million.

Auditor Finding. Late expenditure report should be scrutinized (page 24).

- The division received an expenditure report dated November 25, 1997. This report claims that KHH expended \$5,099,560 for services - \$1,195,693 more than the August 1997 report. The lateness of the second report and the disparate service and administrative cost information should cause the division to carefully scrutinize the expenditure reports.

Auditor Finding. Late expenditure report should be scrutinized (cont'd.)

The CAMHD fiscal audit of KHH is scheduled for Jan. 8, 1997. These and other reports generated by KHH will be reviewed and analyzed by the CAMHD fiscal staff for accuracy.

The unaudited November 1997 expenditure report notes that the \$5,099,560 figure is equal to 71% of the authorized service level for FY 97 services. The division and KHH had projected that 70% of the authorized service level would actually be expended.

Auditor's Finding. The division continued to allow KHH to provide services without a contract (page 24).

- KHH continued in the second contract year for three months without a contract.

The May 8, 1997 minutes of the KHH/BIPP Community Policy Board meeting reflects an announcement by Howard Weiner, CAMHD liaison that the KHH contract would be renewed.

- KHH continued to operate and pay for project expenses by using the division's overpayment for the prior year.

KHH operated in the first three months of the second contract year with the understanding that its contract would be renewed after carryover balances and other issues were resolved. CAMHD withheld 10% of the last contract payment until final resolution.

- Division did not reduce the new contract amount by the overpayment amount. In fact, it continued its practice of making quarterly payments without receiving the required reports.

Auditor's Finding. The division continued to allow KHH to provide services without a contract (cont'd.)

Division did not make an advance for the first quarter until Oct. 24, 1997 or 2 weeks after the second contract was executed. As the second contract was retroactive to July 1, 1997, the division made its 2nd quarterly advance to KHH on December 5, 1997.

Auditor's Finding. The division failed to ensure project fiscal controls (page 25).

- The contract required KHH to establish fiscal controls for provider payments, of which collecting encounter data of services rendered to justify payments is an example.

KHH's payment policy for any vendor claim or invoice requires proper and adequate documentation to verify payment for services provided or goods received. KHH, in recognizing its obligations to increase access to services as well as provide fiscally responsible administrative and management services, made accommodations to its payment process to transition its cash-strapped providers while still maintaining appropriate levels of control and minimizing financial risks.

- The division was derelict in assuring that KHH established and used such controls.
- KHH intentionally paid sub contractors without the required documentation. KHH's June 30, 1997 showed more than \$385,000 in such payments.
- During our testing of service costs, we found instances where KHH intentionally paid sub-contractors without required documentation. KHH's fiscal manager explained that providers pressured KHH to by-pass its requirements and allow payment.

Auditor's Finding. The division failed to ensure project fiscal controls (cont'd.)

KHH reports that there were two agencies who have had difficulty in meeting requirements for payment of claims and who have cash flow problems. KHH developed corrective action plans to assist them with their financial difficulties and to promote their financial viability.

Further DOH Clarification and Response. The first plan involves an agency with monthly cash flow issues. The agency in questions was not able to operate within the contract's thirty day payment cycle. KHH agreed to shorten the payment cycle to 15 days for clean claims received from the agency. This was a time limited accommodation and facilitated the agency's establishment of a credit line. The agency is currently moving towards financial stability.

The second agency requested a large advance, which was denied. An agreement was reached which allowed for expedited payment of all "clean" invoices when all previous and outstanding documentation was submitted. The agreement also described a process to ensure that all future claims were appropriately documented.

KHH made payments to Island Crisis Help against unprocessed claims that were already "in-house". Payments were made up to 90% of dollars billed on unprocessed claims. The 10% was withheld to allow for denials on "un-clean" claims. The percentage payable would vary downward if the previous claim's processing run showed a higher percentage of denials than usual. Once the claims were processed, the "true" allowable and payable amount was compared to the previously paid amount. Any underpayment was paid at that time. Any overpayment was applied against future payments.

Auditor's Finding. The division did not enforce required provider audits (page 26).

- Contract required KHH to perform quarterly audits of its providers to verify that billed services were actually performed.
- KHH audited only one agency during the contract period. Over 25% of the files lacked sufficient justification for the services billed. 64% of the client records had no clinical progress notes and/or contract log entries to document that services were rendered as billed.

Auditor's Finding. The division did not enforce required provider audits (cont'd.)

- If KHH's audit found lack of documentation and possibly abuse, the probability of similar conditions among other unaudited providers is high. Without systematic checks and negative consequences for non-compliance, providers will not be motivated to meet requirements.

Auditor's Finding. Hasty Project Implementation Caused Service Delays (page 26).

- However, the division quickly conceived and implemented the pilot project without adequately coordinating with the other agencies. Coordination problems have affected and delayed services.

The Auditor is mistaken. Coordination between the DOH, DOE, DHS and the Family Court can be traced to minutes of meeting held on January 3, 1996. Orientation meetings specific to the BIPP were begun between DOE and DOH on February 21, 1997. Minutes of these (monthly at a minimum) meetings are available. This regularly scheduled meeting has since grown to involve affected district and state DOE, DOH, DHS and Family Court staff. This meeting was referred to earlier in this report as the BIPP interagency meetings.

Auditor's Finding. Coordination problems among agencies delay services (page 27).

- DOE does not accept evaluations that contain sensitive information or recommendations for educational interventions. Recommendations for educational interventions are not accepted, mental health recommendations are appropriate.

Auditor's Finding.
Coordination problems
among agencies delay
services (cont'd.).

- DOE and KHH use different start dates for evaluations and referral for services.
- The contents of IEPs were contentious. Some IEPs contained the name of specific providers. As IEPs are legal documents, there are problems if a specified provider is not available.

Regularly scheduled meetings such as the KHH/DOE/DOH executive staff meetings or the BIPP Interagency Meetings were routinely used to resolve these issues. The issues discussed and the solutions identified for these and other issues are cited in the minutes of these meetings.

Auditor's Finding. FGC staff
are underutilized (page 28).

- The division did not involve the center's staff during project planning and gave them minimum responsibilities under the new system. Consequently, staff are underutilized.

Given the limited amount of permanent staff positions available (six) and the FCD requirement that "at least one liaison from the Children's Team will be housed in each school complex to participate as member of multidisciplinary IEP or Section 504 Modification Plan teams", FGC staff were deployed to school complexes. The division is currently finalizing, in conjunction with these employees, an expansion of their position description to include responsibilities for participating in family court proceedings.