Assessment of the State's Efforts Related to the *Felix* Consent Decree

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

Report No. 98-20
December 1998

THE AUDITOR
STATE OF HAWAII

Office of the Auditor

The missions of the Office of the Auditor are assigned by the Hawaii State Constitution (Article VII, Section 10). The primary mission is to conduct post audits of the transactions, accounts, programs, and performance of public agencies. A supplemental mission is to conduct such other investigations and prepare such additional reports as may be directed by the Legislature.

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1. *Financial audits* attest to the fairness of the financial statements of agencies. They examine the adequacy of the financial records and accounting and internal controls, and they determine the legality and propriety of expenditures.

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THE AUDITOR
STATE OF HAWAII
Kekuanao'a Building
465 S. King Street, Room 500
Honolulu, Hawaii 96813

OVERVIEW

Assessment of the State's Efforts Related to the Felix *Consent Decree*

Report No. 98-20, December 1998

Summary

By legislative request, the Office of the Auditor conducted an assessment of the State's efforts to comply with the *Felix* consent decree. The decree is the outcome of a 1993 lawsuit in U.S. District Court that alleged that "qualified handicapped children" were not receiving mental health services necessary to enable them to benefit from their education. The State waived all rights to appeal and agreed to fully implement a system of care by June 30, 2000. The State agreed to the consent decree to preserve its autonomy and maintain control in the design and implementation of a system of care.

The scope of our work focused on the Departments of Education and Health, the two state agencies named in the consent decree. We also reviewed the operational manager position created in 1997 within the Office of the Governor to resolve problems of interdepartmental conflict and lack of coordination. We also reviewed the roles of other state agencies and entities involved with the decree. We found that the State failed several times to ensure that requirements of the *Felix* consent decree were clear and compliance has become a moving target. A primary problem is the State's failure to develop a working definition of the *Felix* class. Staff from the Departments of Education and Health interpret *Felix* differently. This leads to difficulties in consistently identifying which children should be served and whether children receiving *Felix* services are actually eligible for those services.

We also found that the State does not clearly and accurately identify funding related to the consent decree partly because affected agencies disagree on who makes up the *Felix* class and how to report *Felix*-related expenditures. This is complicated by the inconsistent reporting requirements established by the federal court monitor. The lack of complete and accurate cost figures prevents the Department of Budget and Finance from ensuring that public funds are expended effectively.

Finally, we found that the lack of effective leadership is a major cause of the State's continued failure to efficiently and effectively address the terms of the decree. Despite improvements in some areas, there are still delays in mental health evaluations, excessive paperwork, an insufficient care coordination policy, no coordinated management information system, and poor monitoring of service quality. Despite the creation of the operational manager position, the State's efforts are uncoordinated and poorly implemented. For the State to regain and maintain control over the system of care, the *Felix* operational manager and her office must have the authoritative direction for all state agencies involved with the decree.

Recommendations and Response

We recommend that the governor ensure that the *Felix* operational management team aggressively pursues clarification of (a) the working definition for the *Felix* class and (b) the maintenance of effort requirement. We also recommend that the governor

and the Board of Education report all funding for *Felix* services with the same definitions of budget and expenditure terms between departments from one year to the next. Additionally, we recommend that the governor ensure that the *Felix* operational manager and team carries out its role of ensuring that quality services are provided consistently and in a coordinated and timely manner.

Furthermore, we recommend that the *Felix* operational manager ensure the systematic pursuit of federal Medicaid/QUEST funding for *Felix* services provided to eligible children. Also, the Department of Health should establish uniform payment schedules for mental health services.

The *Felix* operational manager submitted an "integrated response" for most of the affected agencies. The response contends that our assessment shows a lack of understanding about the State's specific compliance requirements, that the assessment fails to distinguish between impediments that can be addressed versus those over which the agencies have no control, and that the State has had much "catching up" to do.

In specific comments the response states that the working definition of the *Felix* class is clear; that there is no basis for concluding that the Comprehensive Student Support System (CSSS) of the Department of Education may potentially expand the *Felix* class; and that the identification of *Felix* funding is not an issue with the court monitor. Additional comments concerning remedial actions, and updated statistical information that pertains primarily to our comments on the Department of Health, were also submitted.

We note that the response contains no further clarification on the working definition of the *Felix* class and does not address the definitional concerns voiced by agency staff.

With respect to the relationship between the *Felix* implementation plan and CSSS, we point to the fact that CSSS is for *all* students and that *Felix* students should not be considered as separate from special and regular education students. Having already made CSSS a part of the *Felix* implementation plan, the departments may have committed the State to an expansion of the *Felix* class.

The response misses our point with respect to identification of *Felix* funding. Regardless of the maintenance of effort requirement, there is a fundamental need for oversight bodies such as the Legislature and the Department of Budget and Finance to know how much has been spent for the consent decree and how much will be needed in the future.

Finally, we note that the Department of the Attorney General reported that it was "inadvertently" omitted from the Felix operational manager's integrated response and elected not to submit a separate response.

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

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Submitted by

THE AUDITOR
STATE OF HAWAII

Report No. 98-20
December 1998

Foreword

This report was prepared by special request of the Legislature which directed the State Auditor to conduct a comprehensive assessment of the State's current efforts and all expenditures related to the *Felix v. Waihee* consent decree.

We wish to express our appreciation for the cooperation extended to us by the officials and staff of the Office of the Governor, Department of the Attorney General, Department of Education, and the Department of Health. We would also like to thank the staff of other departments and entities we contacted during the course of the audit.

Marion M. Higa
State Auditor

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Chapter 1
Introduction

The Legislature, by special request of the President of the Senate and the Speaker of the House, directed the State Auditor to conduct a comprehensive assessment of the state's current efforts and all expenditures related to the *Felix v. Waihee* consent decree (consent decree). The request notes the perception that the "Legislature will provide without challenge, whatever funds the plaintiffs and program staff request."[1] This perception has led to related concerns — that the dollars appropriated for services are funding another bureaucracy, there are fewer services provided to *Felix* class students than prior to the decree, and resources allocated for services and support personnel are not reaching the school level.

Furthermore, the Legislature has had difficulty obtaining information on the number of *Felix* class students served. Although both the Department of Education and the Department of Health agreed that 4,106 students were in the *Felix* class as of January 1998, the two departments are still debating the accuracy of this number.

Background

The *Felix* consent decree is the outcome of a 1993 lawsuit filed against the State in U.S. District Court on behalf of seven children, their parents (guardians), and mental health advocates. The lawsuit alleged that qualified handicapped children were not receiving necessary educational and mental health services and that the State was in violation of two federal laws—the Individuals with Disabilities Education Act (IDEA) and Section 504 of the Rehabilitation Act of 1973.

First enacted by Congress in 1975 as the Education for All Handicapped Children Act, the Individuals with Disabilities Education Act requires states to provide children with disabilities a "free and appropriate public education" that emphasizes special education and related services to meet their unique needs. Section 504 of the Rehabilitation Act of 1973 stipulates that a qualified person with a disability cannot be excluded from any program receiving federal financial assistance. Section 504 applies to children in regular and special education programs that receive federal funding.

Felix *consent decree concerns are not new*

The issues raised in the lawsuit were not new. Section 321-174, Hawaii Revised Statutes (HRS), requires the Departments of Education and Health to execute a memorandum of agreement (MOA) delineating the programs and responsibilities for coordinating mental health services for

children. However, our 1993 report, *A Study on the Memorandum of Agreement for Coordinating Mental Health Services to Children*, Report No. 93-1, found that the MOA was ineffective. Our report noted that the Department of Education and Department of Health had failed to define their respective responsibilities to serve children with mental health needs. Further, the necessary collaboration between the departments was non-existent. The lack of collaboration resulted in unanswered questions in such areas as clients to be served, referrals, financial assessments, data collection and monitoring, confidentiality, and treatment facilities. We stated that agreement on who is to be served was "obviously the most important issue."[2]

We also noted federal concern about the State's handling of mental health services for children and youth. In 1990, the U.S. Department of Education stated that the state Department of Education must provide or purchase mental health services for special education students when the Department of Health cannot do so. The federal special education law was also amended to permit interested parties to file suit in federal court when states or local school districts fail to provide the required services.

During a 1991 site visit, the U.S. Department of Education found that Hawaii's education department was not complying with the federal law because mental health services were not always provided to meet the needs of special education students. The education department stated that mental health services were simply not available in some schools and some teachers stopped trying to obtain such services because the Department of Health would not provide them. The federal agency reaffirmed the requirement that the Department of Education provide or purchase the mental health services that the Department of Health could not provide.

In addition, the Department of Health was not in compliance with federal law. The U.S. Department of Justice found that the department's child and adolescent residential treatment programs did not meet the requirements of the U.S. Civil Rights of Institutionalized Persons Act. The justice department continues to monitor these programs to track the State's progress in implementing the terms of an agreement covering their services.

Consent decree issued

In May 1994, the U.S. District Court concluded that the State had "systematically failed to provide required and necessary educational and mental health services to qualified handicapped children of the State of Hawaii in violation of the Individuals with Disabilities Education Act and the Rehabilitation Act of 1973."[3] The State did not appeal because the attorneys representing the State from the Department of the Attorney General believed that an appeal would have been unsuccessful.

The State admitted in pretrial statements that all members of the plaintiff class had not been identified, assessed, or provided timely mental health services to enable them to benefit from their education. The State further admitted that services needed by the plaintiff class, such as inpatient, residential, and other community-based programs, were unavailable in the community or the state.[4] The attorney general recommended entering into a consent decree to preserve some measure of state control rather than risk a federal court order placing the entire system in receivership and the loss of all autonomy.

In October 1994, the federal court issued the consent decree. The State waived all rights to appeal and agreed to fully implement a system of care by June 30, 2000. This system of care is to consist of adequate programs, placements, and services for the plaintiff class. In addition, the State agreed to follow the principles of the Hawaii Child and Adolescent Service System Program. The program consists of requirements developed by the National Institute for Mental Health for community-based services for children and youth with emotional problems. Implementation of these requirements is intended to assure that provisions of the Individuals with Disabilities Education Act and Section 504 are met by the State. A more detailed history of the *Felix* consent decree is contained in Appendix A and a glossary of terms is provided in Appendix B.

Departments of Education and Health are principal state agencies involved

The *Felix* consent decree specifically names the Department of Education and the Department of Health as responsible agencies, but stresses the importance of creating partnerships with other state agencies that provide services for the *Felix* class. These agencies include the Department of Human Services, the Department of Accounting and General Services, and the Judiciary's Family Court.

The Department of Education is required to provide educational services to children. Section 302A-1102, HRS, delineates the department's responsibility to serve as the central agency for the administration of statewide educational policy, interpretation, and development of standards for compliance with state and federal laws. Additionally, Section 302A-436, HRS, requires the department to assist children who need special services by overseeing the development of special facilities and addressing their instructional, therapeutic, and training needs. Furthermore, the department has the ultimate responsibility of meeting the requirements of federal laws affecting students with special needs.

The Department of Health, under Section 302A-442, HRS, is responsible, within funds available, for the provision of occupational therapy, physical therapy, school health, mental health, and psychological and medical services for children attending public schools. This section requires the department to work in cooperation with the Department of Education.

The Department of Health is also required, under Section 321-171, HRS, to provide the following mental health services to children and youth: (a) preventive health services; (b) diagnostic and treatment services for the emotionally disturbed; and (c) treatment and rehabilitative services for the mentally ill. These services are to be provided at the earliest possible moment after the need for such services is established. Section 321-171, as amended in 1996, charges the department with the responsibility for the coordination necessary to fulfill the terms of the *Felix* consent decree. In accordance with Section 321-172, HRS, the department, through its Child and Adolescent Mental Health Division, is responsible for meeting its statutory and consent decree responsibilities.

Other state agencies provide **Felix** *related services*

The Department of Human Services, the Department of Accounting and General Services, and the Judiciary's Family Court also provide services to *Felix* class children. The consent decree requires interagency collaboration to ensure that all needed services are provided.

The Department of Human Services provides placement and other services for children in need of foster care and child protective services. The department also provides health care for indigent children, care and custody services for adolescent law violators, and welfare assistance to families. Each of these activities may involve *Felix* class students. The department also cooperates with other agencies to maximize federal funds that may help offset the cost of the *Felix* consent decree.

The Family Court provides intake and probation services to juvenile offenders who may be members of the *Felix* class. As necessary, Family Court intake and probation officers refer children under their care for *Felix* eligibility determination and participate in the Individualized Education Plan meetings and service planning. The Department of Accounting and General Services provides transportation services for school children who may be of the *Felix* class.

The State was required to develop a plan to implement the decree

Under the consent decree, the State submitted an implementation plan to the federal court outlining specific tasks and timelines to develop a system of care. The final version of the implementation plan was approved in October 1995. Several entities, specified in the consent decree, provide oversight to ensure that the State completes implementation tasks by specified deadlines.

The consent decree designates a court-appointed special master to determine whether the State is in compliance with the consent decree. He is also required to resolve disputes between parties and to determine how much the State must pay for the services provided by court appointed individuals. Ultimately, the special master is responsible for determining whether the State is in compliance with the consent decree.

The decree also requires the appointment of a court monitor and a technical assistance panel. The monitor's responsibilities include issuing progress reports, making recommendations to the court concerning enforcement of compliance, and addressing complaints and concerns. The Technical Assistance Panel, which consists of the monitor and two other members, provides the education and health departments and other support agencies with assistance in the design of the system of care and the formulation of the implementation plan. Panel members also conduct studies and work as consultants to the state departments and entities created under the decree.

The court monitor and the Technical Assistance Panel are part of the *Felix* Monitoring Project, a nonprofit organization incorporated in November 1995 in accordance with the consent decree. The project provides the infrastructure to monitor and assist in the State's implementation of the consent decree. The decree specifies that the State must pay for all expenses of the project, including funds for administrative support staff. Project members are authorized to hire consultants with specialized knowledge to assist in such areas as training and evaluation. The project also contracts for professional services to conduct case studies that examine whether *Felix* class members have received appropriate services in a timely manner, to assess residential facilities, and to provide technical assistance and other services to further the implementation of the consent decree.

The State's non-compliance necessitates plan revisions

Less than a year after approval of the implementation plan, the State had already failed to meet a number of deadlines specified in the October 1995 plan, and acknowledged that it was not in compliance. During the March 27, 1996 status conference, the special master found the State in non-compliance and required it to submit revisions to the implementation plan. A modified plan that included 17 specific operational plans and revised deadlines was filed in court on August 2, 1996. The operational plans include the development of an interagency management information system, formulation of policies on coordination of care and service planning, and items addressing training concerns. Several offices under the Office of the Governor were also formed to address such specific issues as complaints, training, and community input.

The *Felix* Complaints Resolution Office, created in October 1996, serves as an interagency resource to independently investigate complaints pertaining to educational and mental health service issues on behalf of the *Felix* class. Complaints resolution staff decide on the veracity of complaints, offer technical assistance, and recommend corrective actions. This process is a less formal alternative to due process hearings and other dispute resolution methods. In 1997, a total of 324 complaints were filed with the office.

The *Felix* Staff/Service Development Institute was planned and funded by the Departments of Education and Health. The institute's purpose is to increase knowledge and skills of agency staff, families, and other stakeholders regarding the service needs of children and youth requiring special education and related mental health services. It has completed training sessions and initiatives in such areas as system of care, identification and determination of eligibility, and service planning. The institute began operating in May 1997, but was not fully staffed until November 1997.

The Community Children's Council Office disseminates information and provides technical assistance to 16 local Community Children's Councils and the State Children's Council. The Community Children's Councils elicit community input into the development of the system of care. The State Children's Council, a representative body of the Community Children's Councils, is responsible for integrating community councils' recommendations into a statewide plan.

These three entities are overseen by the *Felix* operational manager who is administratively attached to the Office of the Governor and reports to the governor's chief of staff and the chair of the Board of Education. The position was mandated by the court to overcome coordination difficulties between state agencies. A historical lack of coordination between the Departments of Education and Health prompted the court to rule that the State should delegate the authority to "direct, promulgate, and effectuate policies, goals, objectives, tasks, and timelines contained in the consent Decree, the Modified Implementation Plan and any subsequent Court Orders prescribed by the Court"[5] to the *Felix* operational manager.

The current manager is responsible for the "planning, direction, and administration of the state's activities to ensure compliance with the Consent Decree entered into in the *Felix v. Waihee* case, and resolves problems which arise in fulfilling the State's obligations under the Decree."[6] The superintendent of education, director of health, and directors of all other departments are required to provide their full cooperation to the operational manager.

The operational manager heads bimonthly meetings of the Operational Management Team whose membership consists of the director of health, superintendent of education, selected education and health department staff, deputy attorneys general, and various other personnel involved in implementing the consent decree. A summary of agencies and individuals who are involved with the consent decree is shown in Exhibit 1.1.

Exhibit 1.1
Agencies and Individuals Involved with the *Felix* Consent Decree

	ORGANIZATIONAL HIERARCHY	*FELIX*-RELATED RESPONSIBILITIES
FEDERAL AUTHORITY	FEDERAL COURT	Enforces consent decree
	— Special Master	Resolves disputes between parties
	—— Court Monitor	Provides status reports, recommendations
	—— Technical Assistance Panel	Consults for implementation plan
PUBLIC INVOLVEMENT	PLAINTIFFS' ATTORNEYS	Provides legal representation for plaintiffs
	STATE CHILDREN'S COUNCIL	Represents all Community Children's Councils
	— Community Children's Councils	Provides community input / feedback
STATE IMPLEMENTATION	EXECUTIVE BRANCH – GOVERNOR	Supervises state executive and administrative entities
	— *Felix* Operational Manager	Directs and administers state *Felix* efforts
	—— Complaints Resolution Office	Receives *Felix*-related complaints
	—— Community Children's Council Office	Serves as liaison to Community Children's Councils
	—— *Felix* Development Institute	Provides training/development to staff & families
	— Dept. of the Attorney General	Provides legal representation for the State
	— Dept. of Accounting & General Services	Provides transportation services
	— Dept. of Human Services	Provides foster care, child protection, services for indigent families
	— Dept. of Health	Provides statewide mental health evaluation & services
	—— Child & Adolescent Mental Health Division	Oversees child/adolescent mental health services
	——— Family Guidance Centers	Coordinates contracted mental health services
	———— Contracted Private Providers	Provides direct mental health evaluation & services
	BOARD OF EDUCATION	Monitors DOE performance
	— Dept. of Education	Provides educational and related services
	—— Office of Accountability & School Instruction	Oversees all DOE instructional and support services
	——— Student Support Services Group	Oversees DOE-wide student support and spec. ed. services
	———— Student Support Section	Oversees Comprehensive Student Support System
	———— Special Education Section	Coordinates DOE *Felix* efforts
	—— District Superintendents	Oversees all district activities
	——— District Ed. Specialists - Spec. Education	Oversees special education in district
	——— District Ed. Specialists - Spec. Services	Oversees district evaluation services
	———— Diagnostic Teams	Provides direct comprehensive evaluative services
	——— Principals	Oversees all school activities
	———— School Staff	Provides direct educational services
	JUDICIARY	Administers Family Court
	— Family Court	Provides intake and probation services

State's progress continues to be slow

Despite the appointment of the *Felix* operational manager, the State has not made much progress in meeting the requirements of the consent decree. In January 1998, the court noted the State's failure to meet deadlines and seriously questioned whether the requirements of the consent decree could be fulfilled by the June 30, 2000 deadline. The State concurred that it was not fully in compliance with the implementation plan and proceeded to make revisions. The court required the State to make additional revisions, which the State submitted in April 1998.

The court, however, found the proposed changes to the modified implementation plan were inadequate and unacceptable. In response to the court monitor's suggested new deadline for plan revisions, the State is currently undertaking "Strategic Planning for *Felix* Refinement." Concurrently, the plaintiffs' attorneys are gathering evidence for a contempt hearing to resolve outstanding compliance issues.

Big Island project mirrors problems of consent decree implementation

We described problems with one of the operational plans of the implementation plan, the Big Island Demonstration Project, in a report issued earlier this year. The report, *Audit of the Big Island Pilot Project on Mental Health Services,* Report No. 98-1, reviewed the Department of Health's Child and Adolescent Mental Health Division's management of its contract for mental health services on the Big Island. The report noted that the division was derelict in its management of the contract with Kapi'olani HealthHawaii and did not ensure that Kapi'olani had sufficient management controls. The report further noted that the division had disregarded fiscal responsibilities and that coordination among responsible agencies was lacking. This resulted in delays in the provision of services to children in need. These issues increased legislative concerns over the State's response to the consent decree.

Objectives of the Assessment

1. Describe the history of the *Felix* consent decree.

2. Assess the implementation efforts within and between state agencies related to the decree.

3. Review and assess appropriations and expenditures related to the decree.

4. Make recommendations as appropriate.

Scope and Methodology

We reviewed the State's efforts to meet the requirements of the consent decree and determined whether services are being provided to *Felix* class children and adolescents in an efficient manner. We focused on the state agencies named in the consent decree, the Department of Education and the Department of Health. We examined the appropriation and expenditure levels of the consent decree and followed up on significant relevant findings and recommendations of prior reports. The scope of our review was from FY1993-94 to the present. We conducted fieldwork on Oahu, Maui, Kauai, Molokai and the Big Island.

We reviewed pertinent federal laws, applicable state statutes and rules, the *Felix* consent decree, the implementation plan and modified implementation plan, the monitor's reports, supplemental court orders and documents, and relevant literature. Additionally, we reviewed legislative testimony, memoranda, letters, financial reports and other documents. We also conducted interviews with representatives of the Department of the Attorney General, the Office of the Governor, the Department of Human Services, the Department of Accounting and General Services, Family Court, and other agencies involved in the consent decree.

We interviewed personnel from various levels of the Departments of Education and Health, including district administrators, district superintendents, district program specialists, district diagnostic team members, program administrators, program officers, branch chiefs, principals, special education teachers, and school level counselors as well as other personnel involved in the consent decree. We conducted site visits, interviews, and file reviews at 18 schools statewide.

The selection of our site visits was based on two factors. We selected a complex of schools (high school, middle/intermediate school, and elementary school) from each island based on whether or not it had implemented the Comprehensive Student Support System. According to the court monitor and operational management staff, schools that have embraced this system should have an easier time implementing the requirements of the *Felix* consent decree. For comparison purposes, we selected schools that have not implemented the Comprehensive Student Support System, but otherwise had similar characteristics (e.g., location and enrollment).

We selected files at each of the sites utilizing information provided to us by the Department of Health's management information system. For each of the schools selected, we randomly selected samples based on a 95 percent confidence level, plus or minus a standard deviation of four.

We interviewed and reviewed the expenditures of the court monitor, the *Felix* operational manager and her staff, representatives of the 16

Community Children's Councils statewide, the Community Children's Council Office, *Felix* Complaints Resolution Office, and *Felix* Staff/ Service Development Institute. We also contacted and interviewed advocacy groups and plaintiffs' attorneys, federal offices, and other states' school districts.

Our work was performed from December 1997 to April 1998 in accordance with generally accepted government auditing standards.

Chapter 2

The State Continues to Face Difficulties In Implementing the *Felix* Consent Decree

This chapter presents the findings and recommendations of our assessment of the State's current efforts and all expenditures related to the *Felix* consent decree. We focused on the state agencies named in the consent decree, the Department of Education and the Department of Health. In 1994, the State was found liable for failing to provide educationally-related mental health services required by federal law. The State's efforts to provide those services have been costly and may have exacerbated current problems or created new ones.

Current efforts lack clarity and focus and meeting the requirements of the consent decree continues to be elusive. The most basic question of which children are eligible under the consent decree has not been definitively answered. Until the State finds a clarity of means, resources, and purposes, it cannot be assured of compliance. An inefficient and ineffective system of care, a complex accountability structure, and the absence of overall leadership, continue to hamper efforts to achieve compliance.

Summary of Findings

1. The State's failure to ensure that the *Felix* consent decree requirements are clear makes the goal of compliance a moving target.

2. The State does not clearly and accurately identify funding related to the consent decree.

3. The State's efforts to comply with the *Felix* consent decree are characterized by a lack of leadership, which results in inefficient delivery of educationally-related mental health services.

Compliance is a Moving Target

The State's primary motivation for entering into the *Felix* consent decree was to preserve its autonomy and as much control as possible in designing and implementing a system of care to meet the educational and mental health needs of qualified handicapped children by the court ordered date of June 30, 2000. The October 1994 consent decree mandated that the State design and implement a system of care to provide services for the *Felix* class. The State was also required to maintain specific levels of service and spending. While the decree

provided the State with some latitude to reach compliance, subsequent actions by the State have actually resulted in a greater loss of control.

The State has been unable to complete the tasks specified in the original implementation plan, resulting in modifications to the plan and additional requirements.

Opportunities to clarify the decree requirements have not been aggressively pursued. As a result, the State lacks a clear "working" definition of the *Felix* class, and is unable to ensure that every eligible child and youth of the *Felix* class will be identified and served.

The lack of a working definition may result in an expanded *Felix* class. In January 1998 the Departments of Education and Health estimated the number of *Felix* class students to be 4,106. However, it has been suggested that special education students cannot be considered separately from *Felix* class children, in which case the number of students would total approximately 18,000.

State efforts to clarify who belongs in the *Felix* class have been further complicated by including the Department of Education's Comprehensive Student Support System in the implementation plan. This has expanded the jurisdiction of the court, increased the requirements on the State, and potentially expanded the plaintiff class. If including the Comprehensive Student Support System in the State's response to *Felix* is interpreted to mean all students in public schools are within the *Felix* class, the total count would rise to approximately 191,000 students.

The State missed opportunities to clarify requirements and meet the terms of the decree

In the four years since the consent decree was issued, the State has failed to capitalize on several opportunities to clarify its requirements. The original *Felix* implementation plan was the State's first opportunity to clearly identify what needed to be done to be in compliance. The implementation plan was developed by the Department of Education and the Department of Health, the two primary agencies responsible for the development of the system of care. The Department of Education had been designated by the then governor as the lead agency for development of the plan. However, after the court and its representatives rejected the initial plan developed by the department, the current governor designated the Department of Health as the lead agency to revise the proposed plan.

Despite some reservations from the parties involved in the lawsuit, the revised proposal developed by the Department of Health was approved as the implementation plan in October 1995. The plan was written in general terms and largely focused on system level problems identified by the court. By design, the plan provided the State with latitude on how to develop a family-centered system of educationally and locally-based mental health services to realize the objectives and satisfy the

requirements of the consent decree. However, the State was unable to effectively utilize the latitude given. In less than one year after the plan was approved, tasks specified in the plan were left uncompleted and deadlines were unmet.

Failing to complete tasks and meet the original deadlines, the State was given another opportunity to clarify the requirements of the original implementation plan. The court allowed the State to revise the plan to eliminate unnecessary tasks and to revise or add other tasks. A modification to the implementation plan was filed in court in August 1996. This modified plan established new timelines and organized tasks into 17 operational plans. Despite the modifications the State continued to miss deadlines and failed to complete tasks. As a result, the State has been presented with another opportunity to clarify the requirements of the consent decree through a revision to the modified implementation plan. The plan is currently in draft form and is being reviewed in preparation for submission to the court.

Exhibit 2.1 documents the evolution of the implementation plan, its subsequent revisions, and the reasons for the revisions. In its third attempt at clarification, the State should ensure that it is clear on who makes up the *Felix* class.

The State has failed to develop a working definition of the Felix *class*

The State has also failed to develop a working definition of the *Felix* class. The current legal definition defines the *Felix* class as: "all children and adolescents with disabilities residing in Hawaii, from birth to 20 years of age, who are eligible for and in need of education and mental health services."[1] However, in an effort to implement a system of eligibility, screening, evaluating, and providing services to children, the State failed to develop a working definition that can be consistently interpreted by staff who work with the *Felix* class. Staff from the Department of Education and Department of Health have different interpretations of the *Felix* class. This confusion has led to difficulties in consistently identifying which children the system should serve and determining whether children receiving *Felix* services are actually eligible for those services.

The *Felix* consent decree requires the Department of Health and the Department of Education to actively seek out children who may fall into the *Felix* class. The State developed an identification, screening and evaluation system that allows any person to refer a child with a need for services, including mental health services. This process is intentionally ambiguous. It allows for the identification and assessment of any or all students potentially eligible for services under the Individuals with Disabilities Education Act (IDEA) and/or Section 504. Eligibility requirements under both acts are broader than those for the *Felix* class.

Exhibit 2.1
Major Events In the Implementation of the *Felix* Consent Decree

EVENT	DATE	DESCRIPTION
Felix v. Waihee complaint filed	May 4, 1993	
Settlement and consent decree approved	October 25, 1994	Decree includes requirement of the State to develop an implementation plan within 7 months and fully implement the requirements of the decree by June 30, 2000.
First draft of implementation plan rejected	April 1995	DOE was solely responsible for the draft. The court monitor and two technical assistance panel members rejected the plan because it was not representative of the concerns of the panel, families, advocates, mental health and educational professionals.
Implementation plan approved	October 1995	DOH takes lead and develops the implementation plan. The approved plan articulated strategies and tasks in order to effectively serve children with special needs.
Stipulation modifying implementation plan filed	August 1996	The State admits to not meeting deadlines established in implementation plan. The special master finds that the State has not sufficiently complied with the consent decree and implementation plan. The State develops a revised plan that establishes and organizes tasks into operational plans.
Status conference order issued	February 2, 1998	In a January 1998 status conference, the State admits that it has not fully complied with requirements. The court mandates a revision of existing plans and deadlines.
Revised Plan	April 1998	The State submits a revised plan after receiving an extension to the initial February 27, 1998 deadline. Plaintiffs' attorneys found that parts of the plan were inadequate and revisions were not in a form that could be accepted or recommended.

DOE: Department of Education
DOH: Department of Health

The Individuals with Disabilities Education Act ensures that states provide children with disabilities a "free and appropriate education" that emphasizes special education and related services.

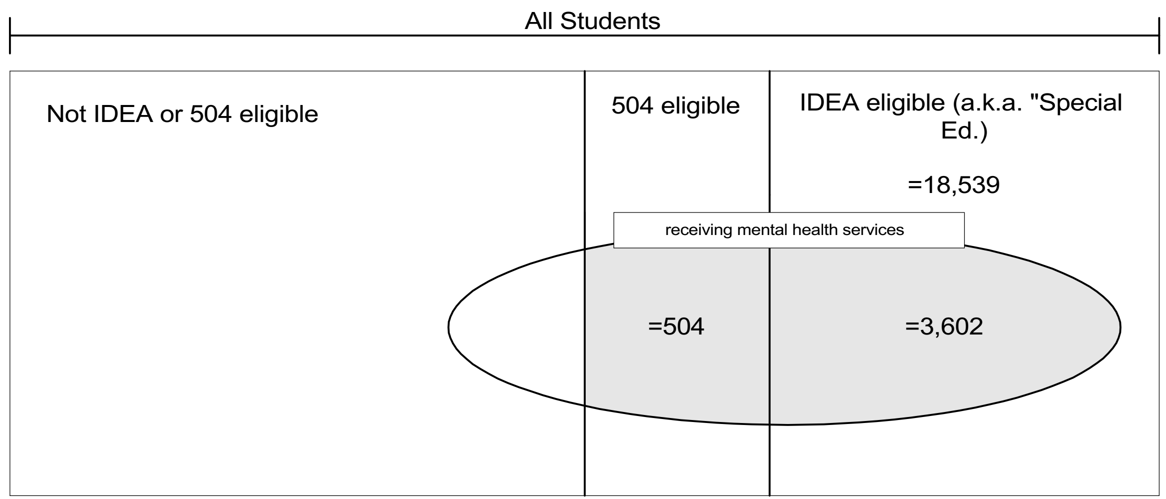
This includes students with the following disabling conditions: autism, deaf-blindness, deafness, emotional impairment, hearing loss, learning impairment, mental retardation, orthopedic impairment, other health impairment, speech or language impairment or both, traumatic brain injury, severe multiple impairments, specific learning disabilities, or visual impairment.

Section 504 provides that a qualified person with a disability cannot be excluded from any program receiving federal financial assistance.

This covers a much broader category of students who may have a physical or mental impairment. Physical or mental impairment includes, but is not limited to the following: infectious diseases such as HIV or AIDS, tuberculosis, Hepatitis B; medical conditions such as juvenile rheumatoid arthritis, chronic asthma, severe allergies, epilepsy, heart disease, and cancer; drug addiction; alcohol addiction; attention deficit disorder or attention deficit with hyperactivity disorder; and mental or psychological disorders such as depression, school phobia, and post-traumatic stress disorder.

Therefore, some students receiving services under IDEA or Section 504 are not included in the *Felix* class. Exhibit 2.2 shows the relationship between the *Felix* class and other students eligible under the Individuals with Disabilities Education Act and Section 504.

Exhibit 2.2
***Felix* Class Students as Compared to Other Students Eligible for Services Under IDEA or Section 504**



Source: Department of Education, Special Education Section

Officials at the Department of Education and the Department of Health agree that a student has to be eligible under the Individuals with Disabilities Education Act or Section 504 ***and*** in need of education and mental health services to be classified as a *Felix* child. However, the agreement has not been translated into action because a clear working definition is still lacking.

District and school staff in the education department and division and branch level staff in the health department are confused as to who should be considered a *Felix* child. In our interviews with education department personnel at the district and school level, 48 percent (38 out of 78) felt that the definition of the *Felix* class is unclear, vague, or ambiguous. Approximately 37 percent (9 out of 24) of the Department of Health staff interviewed felt that there was some confusion about which children were in the *Felix* class. Exhibit 2.3 lists some of the responses we obtained from the interviews.

A large part of this confusion stems from the inclusion of students who are "presumed eligible" as part of the *Felix* class. The Department of Health presumes that every student referred for assessment is eligible for *Felix* services. The Department of Education, however, does not presume eligibility. Instead, it waits for certification under either the Individuals with Disabilities Education Act or Section 504 before classifying a student as a "*Felix*" child. This makes it difficult for the two departments to agree on how many children actually constitute the *Felix* class.

In January 1998, the two departments agreed to report that there were 4,106 *Felix* class students. Despite this agreement, the Department of Health still maintains its position on presumptive eligibility and reports the number of *Felix* students as approximately 7,300 students. The Department of Health feels that students who *may* be eligible for *Felix* should be counted because it is responsible for paying for those evaluations. Therefore, the departments are still in disagreement about who truly makes up the *Felix* class.

Including the Comprehensive Student Support System further complicates compliance efforts

The State's efforts to obtain clarity on the requirements of the decree are further complicated by inclusion of the Department of Education's new educational reform effort, the Comprehensive Student Support System, in the implementation plan. The Comprehensive Student Support System is a school reform initiative developed by the education department prior to the *Felix* consent decree, with a mission to "provide *all students* with a support system so they can be productive and responsible citizens" (emphasis added). The support system is intended to focus on ways to improve and strengthen three principal components of a school—instruction, management, and student support. Under the system, an "umbrella" is created that provides a more caring environment where *all*

Exhibit 2.3
Sample of Interview Responses Regarding Definition of *Felix* Class Children

"Difficult to say exactly what makes one a *Felix* student."

"No...there is confusion out in the field. The focus was on mental health services for IDEA and 504 kids, but now it is viewed as everyone."

"*Felix* class includes all students."

"Clear in court documents, but vague in practice (due to the inclusion of unidentifed and unserved)."

"During implementation of the decree the definition has expanded and become ambiguous."

"There is really no sense in having criteria at all -- the state might as well just write a blank check and hand it to the providers."

"The door has been opened very wide."

"It seems like 80 percent of (the school) is *Felix*."

"The definition is very broad. Many students fit under the definition."

"Any child with a need is essentially eligible."

"The decree has led to a broad interpretation of the student's needs to include the parents' needs."

"The mandate under IDEA and 504 are clear, but the local interpretation of that mandate has made the definition of the *Felix* class totally unclear."

students—whether regular or special education—are supported in a manner conducive to learning. In theory, adopting the Comprehensive Student Support System would allow the State to address the needs of *Felix* class students as a normal part of the services provided to all students and eliminate the need to continue with the consent decree.

The Comprehensive Student Support System was viewed as complementary to other care coordination and coordinated service planning efforts in the implementation plan. The Comprehensive Student Support System was also viewed as a discrete phase in the development of a service delivery system for the *Felix* class. However, because the Comprehensive Student Support System is intended for *all* students, including the initiative in the implementation plan may extend the court's jurisdiction to all school students.

The Comprehensive Student Support System encompasses more than *Felix* issues

In July 1996, the State, plaintiffs, and the court monitor agreed to a modification of the *Felix* implementation plan that included the addition of the Model School Complex demonstration project to "help the (State) implement the statewide system of care required by the consent decree."[2] But at the time the Model School Complex was still a demonstration project to test the Comprehensive Student Support System. The system's effectiveness was not yet proved before its implementation plan was submitted to the court in October 1997. But the State is now obligated, per the court monitor, to implement the Comprehensive Student Support System statewide by June 30, 2000.

While the Comprehensive Student Support System includes many of the principles required by the consent decree, its scope is not limited to the *Felix* class alone. The intent of the system is to integrate all school activities into one "caring community."

The Comprehensive Student Support System implementation plan does not differentiate mental health disabilities from any other disability, nor is it limited to serving only *Felix* class students. Rather, its mission is to "provide *all students* with a support system so they can be productive and responsible citizens"[3] (emphasis added). The underlying concept for the Comprehensive Student Support System is supported by many district and school level staff in the Department of Education. They believe it will lead to improved services for all students. Some education department staff believe that the system could help prevent students from becoming *Felix* class students by focusing on early intervention and prevention. However, others such as a special education administrator claimed that it is not possible to "prevent" most of the clinically identified mental and emotional disabilities characteristic of *Felix* class members.

Although one staff suggested that the system is intended to specifically address the consent decree, most stated that the Comprehensive Student Support System integrates all school services under an "umbrella" and creates a more caring environment where all students—in regular or special education—are supported.

Those involved with *Felix* also want input into the system for school-wide reform

Incorporation of the Comprehensive Student Support System into the *Felix* implementation plan has resulted in the expectation that parties involved with the consent decree also have input into the development of the entire system. Although the Comprehensive Student Support System is now a part of the *Felix* implementation plan, the system was created before its incorporation into the implementation plan and is intended for purposes beyond helping the *Felix* class. A number of the *Felix*-related parties have criticized the Department of Education for not consulting them about the Comprehensive Student Support System. For example, the State Children's Council complained of the late invitation from the department to participate in the design process. Also, Community Children's Council members feel that the department has not collaborated with the council in designing the system. Furthermore, members of the *Felix* operational manager's office commented that the lack of input by others outside the education department is a "bone of contention."

However, involving the *Felix*-related parties in the Comprehensive Student Support System would not limit them to *Felix* class issues. They would also shape educational policies affecting regular education and non-*Felix* special education students. Implementing the system statewide for all students could give the federal court, the plaintiffs, the court monitor, and other non-Department of Education parties significant control over the direction of the entire public school system.

The lack of clarity on who makes up the *Felix* class has not only led to the expansion of the court's jurisdiction but has also made it difficult to determine how much should be spent to maintain the level of spending required by the consent decree. The decree requires the State to maintain the levels of service and spending that existed on May 2, 1994—i.e., the "maintenance of effort" level. But what comprised this baseline is not clear. The court monitor maintains that he cannot recommend a level of spending until all *Felix* class children are identified first. And, until the definition of the *Felix* class is no longer a bone of contention, the State will be unsure of how much it needs to spend to be in compliance.

The State Does Not Clearly and Accurately Identify Funding Related to the Consent Decree

The State cannot clearly and accurately identify funding and expenditures related to the *Felix* consent decree because affected state agencies do not agree on who makes up the *Felix* class and also how *Felix*-related expenditures should be reported. This situation is complicated by inconsistent reporting requirements established by the court monitor. Thus, while the State reportedly spent almost $270 million during FY1997-98 on *Felix*-related programs and services, it is unable to determine the true costs to comply with the decree. As a result, it is difficult for the State to gauge the extent to which its efforts are in compliance with the decree. The State has also failed to effectively pursue reimbursements that would help offset the costs of compliance.

The departments do not provide the Department of Budget and Finance with accurate cost figures

The lack of complete and accurate cost figures prevents the Department of Budget and Finance from executing its responsibility to ensure the effective expenditure of public funds. Section 26-8, HRS, provides that the Department of Budget and Finance "shall undertake the preparation and execution of the executive budget..." and "...to assist each department in achieving the most effective expenditure of all public funds..." Although both the education and health departments provide the Department of Budget and Finance with some cost figures, budget and finance department staff have expressed concern about the reliability of the reported *Felix*-related expenditure information. In addition, budget and finance department staff are not clear on what services are appropriately charged, the actual number of children being served, and the total and projected costs related to the *Felix* consent decree.

Furthermore, budget and finance staff note that the departments appear to have the perception that labeling budget requests as part of the *Felix* class will guarantee that the requests will be funded. This makes the Department of Budget and Finance's task of reviewing the departments' budget requests difficult because it has to determine whether a *Felix*-labeled request is truly mandated by the court or not. Although the department has repeatedly tried, it has not received a clear and consistent response from either the education or health department on who makes up the target *Felix* group and the level of funding needed to ensure compliance with the consent decree.

The Department of Budget and Finance's efforts are further hampered because it does not presently track *Felix*-related expenditures by other state agencies. We attempted to identify the costs incurred by agencies other than the education and health departments, but found that only estimates were available. These estimates, together with the questionable funding information provided by the education and health departments, reinforce the fact that the true cost of the *Felix* consent decree is unknown.

The Department of Education's identification of *Felix*-related expenditures is unreliable

The Department of Education's practice for reporting *Felix*-related expenditures results in over-inflated and unreliable figures. The overstatement is partly due to the department's method for estimating *Felix*-related costs and partly due to the court monitor's reporting instructions to the department. These factors make it difficult to verify the accuracy of what the department reports as *Felix*-related.

For example, the Department of Education estimates that it spent a total of $167.7 million ($136.5 million in general funds and $31.2 in federal funds) for the *Felix* consent decree in FY1996-97. However, we found that the methodology used to develop these estimates results in unreliable estimates. With the assistance of a consultant working with the court monitor, the department developed different percentages to determine how much of the programs and expenditures should be included in setting the maintenance of effort baseline. For general schoolwide and preventive programs the estimated percentage of *Felix* students in the total school population—1.5 percent—is used as the maintenance of effort baseline. For early intervention, at-risk, and special education programs, the percentage of students in need of mental health services—estimated at 15 percent—is used as the basis for determining the contribution to the baseline. However, there is also a "miscellaneous" category where expenditures are based on "either actual dollar expenditures, actual percent of staff working with class members, or unique programs targeting specific at-risk groups in differential ways." This results in a wide variation of costs related to *Felix*.

Contributing to the unreliability of the estimates is the court monitor's requirement that all expenditures for a program be reported even when *Felix* students comprise a portion of students served by a program, and the expenditure percentages are calculated with different assumptions as described above. As a result, the amount actually reported by the education department is misleading. We examined the maintenance of effort baseline for each program as reported by the Department of Education. As we show in Exhibit 2.4, for FY1996-97, only $33.4 million (20 percent) of the $167.7 million reported as *Felix*-related expenditures were used for providing services to the *Felix* class.

Even $33.4 million is an inflated number. For example, including the entire A+ after-school program in the baseline is faulty. Calling the $11.1 million spent on the A+ program *Felix*-related, as though every child in the program has been so identified as a *Felix* child, is erroneous and misleading.

Exhibit 2.4
Department of Education
Felix-Related Maintenance of Effort Expenditures for FY1996-97

EDN	PROGRAM DESCRIPTION	BASELINE %	MOE EXPENDITURES	FELIX EXPENDITURES
100	English for Second Language Learners	15.0%	$7,952,781	$1,192,917
100	Comprehensive School Alienation Program	15.0%	6,820,340	1,023,051
100	Counseling	15.0%	17,551,340	2,632,701
100	After School Instruction Program	15.0%	1,701,920	255,288
100	Special Education Summer School	15.0%	1,792,090	268,814
100	At-Risk Program - Storefront School	15.0%	193,425	29,014
100	At-Risk Program - Olomana Youth Center	90.0%	473,150	425,835
100	At-Risk Program - Maui Alternative Center	15.0%	128,280	19,242
100	At-Risk Program - Molokai Alternative Center	15.0%	39,347	5,902
100	At-Risk Program - Kauai Alternative Center	15.0%	55,949	8,392
100	At-Risk Program - Kona Ho'oponopono	15.0%	108,519	16,278
100	At-Risk Program - Hilo High Alternative Program	15.0%	95,590	14,339
100	At-Risk Program - Hawaii Alternative Center	15.0%	197,364	29,605
100	At-Risk Program - Hon./Leeward Alt. Learning Center	15.0%	464,199	69,630
100	At-Risk Program - Olomana School	90.0%	910,894	819,805
100	Educl Innov. - Momilani At-Risk	1.5%	6,219	93
100	Lions Quest	15.0%	79,757	11,964
100	Comprehensive Positive Peer Prevention	15.0%	40,864	6,129
100	Comprehensive Elementary Counseling Project	5.0%	374,000	18,700
100	Special Needs Schools	1.5%	2,931,079	43,966
100	Special Education in Regular Schools	15.0%	57,213,603	8,582,040
100	Invidualized Education Program Plan	15.0%	193,448	29,017
100	Attorney and Related Fees	75.0%	137,607	103,205
100	Stwde Ctr for Students with Hearing & Vision Impair.	15.0%	1,539,819	230,973
100	Pohukaina School	5.0%	322,945	16,147
100	Jefferson Orthopedic Unit	5.0%	269,657	13,483
100	Contracted Special Education Services	75.0%	1,041,132	780,849
100	Transition Services	15.0%	1,156,439	173,466
100	Occupational Skills Learning Center	15.0%	104,998	15,750
100	Home/Hospital Instruction	50.0%	903,104	451,552

Exhibit 2.4 Continued

EDN	PROGRAM DESCRIPTION	BASELINE %	MOE EXPENDITURES	FELIX EXPENDITURES
100	Maui Pregnant Teen Center	50.0%	70,518	35,260
100	Pregnant/Parenting Program	50.0%	767,603	383,802
100	Resource for New Facilities - Special Education	15.0%	125,946	18,892
100	In School Suspension	15.0%	218,488	32,774
100	Families for Real	50.0%	178,142	89,071
100	Parent Community Networking Centers	1.5%	2,371,675	35,575
100	Special Education Handicap Title IVB	15.0%	5,694,199	854,130
100	ESEA (Elementary and Secondary Education Act)	1.5%	18,277,654	274,165
100	Comprehensive Dropout Prevention	15.0%	103,657	15,549
100	Maui Hui Malama	50.0%	102,099	51,050
100	Hale O Ulu	15.0%	225,286	33,793
100	School for Neglected and Delinquent Children	90.0%	57,131	51,418
100	Vocational Education	12.0%	2,727,862	327,344
100	Drug Free Schools and Community	1.5%	1,838,541	27,578
100	Preschool Incentive Grant	15.0%	748,528	112,278
100	Native Hawaiian Special Education Project	15.0%	883,352	132,503
100	Even Start Project	1.5%	484,755	7,271
100	Hawaii Deaf-Blind Program	50.0%	17,584	8,792
100	Transition Services for Youth with Disabilities	15.0%	380,860	57,129
200	Institutes and Workshops	10.0%	288,773	28,877
200	District Diagnostic Services	15.0%	14,320,887	2,148,133
200	Contracted Diagnostic Services	15.0%	346,893	52,034
200	Summer Recall Services	15.0%	591,306	88,696
200	Training Teachers for the Disabled	15.0%	108,501	16,275
200	Special Education	15.0%	528,106	79,216
300	District Administration - Honolulu	15.0%	330,945	49,642
500	After School A+ Program	100.0%	11,100,603	11,100,603
500	Families for Real - DOH	50.0%	6,923	3,462
	TOTAL		$167,696,676	$33,403,459

The Department of Health does not report all of its funding for *Felix*

In contrast with the Department of Education, the Department of Health is reluctant to identify the amount of funding related to the *Felix* consent decree. The health department's reluctance is attributed to the fear that programs only indirectly related to *Felix* may use the identification as a means to protect their funding. Under the terms of the decree, funding for *Felix*-related programs are protected by maintenance of effort requirements. Thus programs identified as *Felix*-related can use the designation to keep funding levels, they believe, while other programs may suffer because they lack the consent decree's maintenance of effort protection. The department's reluctance to identify programs as *Felix*-related has been an attempt to slow the expansion of the *Felix* class and the growth in obligations that the *Felix* consent decree places upon the State.

With this concern in mind, the Department of Health provided funding information to us with the following disclaimer: "All amounts shown do not imply that total amounts appropriated/expended for all program areas are *Felix*-related." Thus although we present in Exhibit 2.5 all programs and funding identified by the health department as *Felix*-related for FY1996-97, the exhibit may not accurately report expenditures. Reported expenditures totaled more than $77.2 million in FY1996-97.

The inclusion of the Healthy Start Program as a *Felix* expense exemplifies the health department's concern about the expansion of the *Felix* class. In April 1998, the court monitor ruled that the Family Health Services Division's Healthy Start Program should be included in the maintenance of effort baseline. The purpose of the program is to conduct hospital-based screenings of infants born into high risk families where severe social challenges place the infant at-risk for emotional or behavioral problems, language and social delays, and/or abuse and neglect.

The court monitor has stated that "the State has an obligation not only to serve *Felix* class members, but to identify, locate and evaluate new children who may be class members or at risk of becoming class members." During FY1996-97, general fund expenditures for the Healthy Start Program exceeded $7.1 million. Adding the entire amount for this at-risk program to the *Felix* baseline emphasizes the need to clarify both the definition of the *Felix* class and what constitutes funding for the class. Suddenly the expenditures for this program were deemed *Felix*-related because it serves at-risk children.

If the State must also consider other at-risk children as part of the *Felix* class, then the cost of the decree will continue to grow. In addition, there has been little effort to determine how the State will fund the consent

Exhibit 2.5
Department of Health
Maintenance of Effort Expenditures for FY1996-97
General Funds Only

HTH	ORG.CODE	DESCRIPTION	EXPENDITURES
460	HE	Central Oahu Child and Adolescent Mental Health Services	$1,027,083
460	HH	Diamond Head Child and Adolescent Mental Health Services	1,481,966
460	HI	Kalihi Palama Child and Adolescent Mental Health Services	1,176,284
460	HJ	Leeward Oahu Child and Adolescent Mental Health Services	616,277
460	HK	Windward Oahu Child and Adolescent Mental Health Services	1,510,491
460	HL	Hawaii County Child and Adolescent Mental Health Services	9,326,075
460	HM	Maui County Child and Adolescent Mental Health Services	1,153,278
460	HN	Kauai County Child and Adolescent Mental Health Services	937,360
460	HO	Other Services Including Purchase of Service/Grant-In-Aid	11,821,764
460	HS	Clinical and Consulting Services	206,276
460	HT	Centralized Treatment Services	15,980,289
495	HC	Office of Cluster	260,741
495	HF	Child and Adolescent Mental Health Division Admin.	3,079,831
501	CM	Purchase of Service	3,799,540
501	CN	State Title XIX Match	9,772,162
501	CQ	Central Intake	616,964
501	CU	Community Service for the Developmentally Disabled Branch Admin	391,118
501	CV	Family Support Services	430,254
501	VAR	Placement and Continuing Services Section	1,668,678
501	JU	Behavioral Intervention	245,186
530	CC	Children with Special Health Needs Branch	1,301,317
530	CG	Zero to Three	1,597,153
530	CH	Preschool Developmental Screening	31,033
530	CJ	Maternal and Infant Care	1,094,174
530	CO	Infant and Child Development	974,050
530	CT	Healthy Start	6,746,929
		TOTAL	$77,246,273

decree as the requirements become more encompassing. Although there have been efforts to collect federal fund reimbursements to offset the cost of the decree, obstacles prevent the State from maximizing its efforts.

Other agencies can provide only estimates at best

The State's efforts to comply with the *Felix* consent decree are not fully reported because agencies other than the education and health departments do not track *Felix*-related costs. The State is required to track only the funding for *Felix* in those departments that were named in the lawsuit—the Department of Health and the Department of Education. However, other agencies, such as the Department of Human Services, Department of Accounting and General Services, the Judiciary, and the Office of the Governor also serve the *Felix* class. We contacted these agencies as part of our effort to determine the total cost of the *Felix* consent decree to the State. At best, only estimates were available and, in the case of the Department of Human Services, we could not obtain any estimates. That department stated that it has not received any specific appropriations for the consent decree. Furthermore, the department lacks any mechanism to track the *Felix* population it serves and concluded that it was impossible to determine the cost of serving this group.

While other agencies also expressed difficulty in providing cost information, they did develop some estimates. The Department of Accounting and General Services provides transportation services for *Felix* class students. For FY1995-96 and FY1996-97 (estimates for FY1994-95 were unavailable), the Department of Accounting and General Services estimated that it spent a total of $230,340 in *Felix*-related costs including bus maintenance, drivers' salaries, and fuel costs. However, in providing this estimate, the department cautioned that it was difficult to come up with this estimate because its buses carry both *Felix* and non-*Felix* students. The large majority of special education students are transported by private bus companies under contract to the Department of Accounting and General Services. These bus contracts totaled approximately $8 million in School Year 1997-98. These buses also carry both *Felix* and non-*Felix* students in their curb-to-curb service.

The Judiciary also expressed concern that it was difficult to estimate how much it expends for the *Felix* class, noting that the figures provided are likely to be inaccurate. From FY1994-95 to FY1996-97, the total cost was estimated at $610,402 for services provided by Family Court.

Two positions in the Office of the Governor provide technical assistance to the *Felix* consent decree. They participate in evaluation of *Felix*-related programs and attend meetings. The time these individuals spent on *Felix*-related tasks for FY1996-97 was valued at $52,370.

None of the aforementioned departments have requested or received appropriations specifically related to the *Felix* consent decree. Furthermore, because they do not track this population separately, estimating the true cost of *Felix* is an extremely difficult task.

The State is unable to determine whether maintenance of effort requirements are being met

The State cannot determine whether it is complying with the maintenance of effort requirements of the *Felix* consent decree because no base compliance figure has been established. The decree specifically states "the quantity and quality of services, programs, and placements for the Plaintiff Class shall not fall below that for which appropriations had been made or provided on May 2, 1994."[4] To comply with this directive, the Department of Education and the Department of Health compiled a list of programs and funds that provided services to the *Felix* class on that date. However, the actual amount for the baseline has not been established.

Despite the designation of May 2, 1994 as the baseline date and a listing of programs that make up the baseline, the court monitor has refused to rule on whether the State is in compliance with the maintenance of effort requirement. The court monitor issued a memorandum in April 1996 stating that there is no absolute minimum baseline for funding, and that a maintenance of effort baseline will not be established until all members of the *Felix* class have been identified and a process for identifying potential members of the *Felix* class has been developed. The monitor's refusal to rule on the baseline raises the issue of whether the State can ever achieve full compliance. In theory, the monitor could require, without end, that programs be added or spending levels increased, effectively preventing the State from reaching compliance.

Not only has the court monitor made it difficult to gauge compliance, but he has also made it difficult for the State to obtain an accurate picture on how much it is spending for the consent decree. He allows the Department of Education and the Department of Health to report inconsistent information on the quarterly maintenance of effort reports. The health department reports only general funds, while the education department reports all sources of funding. The court monitor confirmed that he authorized the Department of Health to report only general funds because it presented a convincing argument to do so. The health department maintained that it did not want to be liable for federal funds because if the funds were not received, the department would be in non-compliance with the maintenance of effort requirement. However, the Department of Education voluntarily reports all sources of funding, including federal and special funding. Furthermore, the education department has elected to calculate what percentage of each program actually serves *Felix*. The health department provided only estimates and even those only after we repeatedly requested the information.

The Department of Health also reports only total funding for *Felix*-related programs. Unlike the Department of Education, the Department of Health does not identify the percentage of *Felix*-related funding in each program. This leads to problems in identifying actual cost.

Cost figures lacking in efforts to maximize federal funding

Given the escalating cost of the *Felix* consent decree, the maximization of federal fund reimbursements would be helpful. However, the Department of Education and the Department of Health cannot even project how much they could collect in federal funds to help offset the cost of the decree. Although some efforts have been made in collecting reimbursements for training costs related to *Felix* under Title IV-E (approximately $2.8 million over the past three years), reimbursement efforts for Title XIX (i.e., Medicaid and QUEST) have been lax.

From the earliest stages of implementation, maximization of federal fund reimbursements was identified as a way to offset the cost of the decree. Reports by the court monitor and the Technical Assistance Panel in late 1994 emphasized the need to maximize federal fund reimbursements to help support the decree's implementation. The implementation plan itself includes the maximization of federal fund reimbursements among its proposed goals and places responsibility with the Department of Education, the Department of Health, and the Technical Assistance Panel.

Title XIX was targeted by the panel as a particularly promising source of *Felix*-related federal fund reimbursements. While some financial support has been obtained, federal fund reimbursements to offset the cost of the decree are far from maximized. Obstacles blocking the utilization of Medicaid funds have not been addressed and have affected the State's ability to tap that source.

Medicaid and QUEST reimbursements have not been adequately pursued

Although approximately $3.2 million in Medicaid reimbursements have been secured on behalf of the *Felix* class since FY1994-95, maximization of this funding source has been impeded by long standing obstacles that the Department of Health has failed to address. Medicaid provides matching funds to states for health care including mental health services to eligible low-income recipients. In Hawaii, Medicaid is administered by the Med-Quest Division of the Department of Human Services and is monitored by the federal Health Care Financing Administration (HCFA).

Some of the covered Medicaid services are mental health services the State provides under the *Felix* decree, and some members of the *Felix* class are eligible for assistance through either fee-for-service Medicaid or

QUEST, the state's managed care demonstration project. Medicaid or QUEST funding can be used to help offset the cost of the decree to the extent they overlap with *Felix* services and individuals.

The State has had some success in utilizing Medicaid reimbursements for certain segments of the *Felix* population. Forty-four *Felix* class members were in out-of-state residential placements as of April 1998 at a cost of approximately $1.8 million. Medicaid pays for the cost of the mainland placement and transportation. In addition, Medicaid reimbursements are used to support early intervention services for infants and toddlers which are required under Part C of the re-authorized Individuals with Disabilities Education Act and the consent decree.

Other than these attempts, Medicaid and QUEST reimbursements for the majority of the *Felix* class have not been systematically or effectively pursued. Obstacles preventing optimal utilization of these funds on behalf of *Felix* class members have been apparent for some time. However, the Department of Health, through its Child and Adolescent Mental Health Division, has failed to take the steps necessary to address these obstacles. These steps include:

- maintenance of accurate data on who within the *Felix* class is covered under Medicaid;
- development of service definitions that are comparable to Medicaid definitions of covered services;
- development of a fee schedule comparable to the fee schedule used for Medicaid and QUEST purposes;
- establishment of general Medicaid standards of good practice, service delivery, and fiscal compliance; and
- development of specific agreements regarding how Medicaid is to be billed and by whom.

These barriers prevent the health department from utilizing Medicaid and QUEST resources to support the provision of mental health services to *Felix* class members.

The Department of Health has failed to address obstacles to utilization of Medicaid and QUEST funding

Previous attempts to obtain Medicaid and QUEST benefits for *Felix* class children through several different mechanisms have failed because obstacles that were previously identified were not removed. In late 1994, the Department of Human Services' Med-QUEST Division agreed to transfer the responsibility for providing mental health services to seriously

emotionally disturbed children to the Department of Health's Child and Adolescent Mental Health Division. Under this arrangement, the Child and Adolescent Mental Health Division's general fund appropriations were used to obtain the federal Medicaid matching funds. The division would receive capitated payments for the services it provided for any seriously emotionally disabled child who was eligible for QUEST. This arrangement prevented the State from financing duplicative efforts in two departments.

To receive QUEST payments, the State must meet Medicaid requirements. The division, through its eight Family Guidance Centers located throughout the State, was responsible for ensuring that these requirements were met. However, in 1996 most of the centers failed to meet federal Medicaid requirements for quality assurance. Therefore, in September 1997, this arrangement was terminated.

Furthermore, the Child and Adolescent Mental Health Division has failed to pursue the Med-QUEST Division's offer to provide QUEST reimbursements for mental health services rendered by private providers under contract to the Child and Adolescent Mental Health Division. In March 1997, the Med-QUEST Division instructed the QUEST plans to reimburse all private providers contracted under the Child and Adolescent Mental Health Division for any mental health assessments performed for QUEST eligible children. However, the plans did not receive any request for reimbursement from the division's private providers during the four-month period this arrangement was in effect.

Both departments state that this arrangement failed because the Child and Adolescent Mental Health Division: 1) lacked accurate data on QUEST eligibility of its client population which made it impossible to monitor providers' efforts to bill QUEST; 2) lacked provisions in its contracts to require providers to bill Medicaid or QUEST; and 3) paid more for the assessments than either Medicaid or QUEST, creating a disincentive for providers to bill QUEST.

Efforts to maintain Medicaid and QUEST eligibility data are inadequate

Since at least December 1996, the Department of Health's Child and Adolescent Mental Health Division had been aware that Medicaid and QUEST eligibility data in its management information system was inaccurate or incomplete, contributing to the division's inability to capitalize on Medicaid and QUEST benefits available to *Felix* class students. Not until April 1998 did the division make an effort to correct the deficiencies. The division attempted to match its data with the Department of Human Services' Med-QUEST data to determine eligibility of *Felix* class members and found approximately 2,200 *Felix* class members who are eligible for Medicaid or QUEST benefits.

While the data match is a positive first step, it also points to weaknesses in the division's approach to this issue. For instance, the results of the data match highlight the inadequacy of past efforts by the Child and Adolescent Mental Health Division to capture and maintain Medicaid and QUEST eligibility information. Prior to the data match, the division had identified only 473 *Felix* class students as eligible for either Medicaid or QUEST benefits. Furthermore, the data match provides only a temporary solution to the problem of inaccurate Medicaid and QUEST eligibility data. Because eligibility status can change from month to month, the division will need to update its Medicaid and QUEST eligibility data regularly to ensure appropriate utilization of benefits. The division has no plan for obtaining and maintaining such data.

Standard fee schedule comparable to Medicaid standards is still nonexistent

A Child and Adolescent Mental Health Division fee schedule that corresponds to Medicaid standards, including comparable service definitions, billing codes, and reimbursement rates is still nonexistent. Definitions utilized by the division do not match Medicaid definitions for similar services. Despite the fact that the division's current contracts require providers to charge the State rates that do not exceed "usual and customary" reimbursements for Hawaii, rates actually paid by the division continue to exceed Medicaid reimbursement rates. As Exhibit 2.6 demonstrates, the division's payment rates are also markedly higher than the rates paid by other state agencies for the same or more extensive services. For example, a private provider charges $100 a day for a child placed by the Office of Youth Services for group home services while it charges $260 a day for a child placed by the Child and Adolescent Mental Health Division. The reason for the discrepancy is that the division bases payment on costs identified by the provider whereas other agencies tell providers what they are willing to pay.

The lack of common definitions and billing codes makes it difficult for the Child and Adolescent Mental Health Division to bill Medicaid or QUEST for covered services. Moreover, as past experience demonstrates, the vast differences in the division's and Medicaid rates would likely discourage providers from billing Medicaid or QUEST even if common definitions and billing codes were developed. These coordination issues are typical of the types of problems that hamper the State's effort to provide the quality of services necessary to comply with the terms of the consent decree.

Exhibit 2.6
Comparison of Medicaid, DHS, & CAMHD Payment Rates

Service Description	Medicaid usual and customary reimbursement	DHS/OYS payment rate	CAMHD payment rate
Acute Inpatient			
Kahi Mohala	$ 549.99/day	n/a	$ 670.00/day
Queens	411.09/day	n/a	581.00/day
Castle (thru 3/98)	452.09/day	n/a	550.00/day
Mental Health Assessment	316.00/encounter	n/a	676.00/encounter*
Intensive Case Management	53.20/hr	n/a	88.00/hr*
Psychological Testing	74.31/hr	$ 128.13/hr	157.00/hr*
Psychiatric Diagnostic Evaluation	90.00/hr	128.13/hr	190.00/hr*
Medication Monitoring	12.70/encounter	n/a	184.00/hr*
Partial Hospitalization	45.00/day	n/a	296.00/day*
Emergency Shelter			
Maui Youth & Family Services	n/a	75-100/day	275.00/day
Group Home			
Hale Kipa	n/a	100.00/day	260.00/day
Hale Opio	n/a	137.00/day	298.00/day
Maui Farms	n/a	137.00/day	200.00/day
Maui Youth & Family Services	n/a	137.00/day	313.00/day

Sources: (1) American Medical Association, *Physician's Current Procedural Terminology,* 1998; (2) Med-Quest Division, On-Line Customary File; (3) CAMHD *Clinical Service Array Treatment Standards*, July 1997; (4) CAMHD, Unit Cost Summary Sheet, March 1998; (5) OYS, *RFP Service Specifications*, November, 1996; DHS, (6) *Purchase of Service Directory for fiscal biennium 1997-1999*.

*Where CAMHD payment rates varied widely by service provider, the maximum payment offered by CAMHD is noted.

DHS - Department of Human Services
OYS - Office of Youth Services
CAMHD - Child and Adolescent Mental Heath Division, Department of Health

Lack of Effective Leadership Continues to Hamper State Efforts to Comply with *Felix* Consent Decree

While there has been improvement in a number of areas, the State continues to experience difficulty in its efforts to comply with the *Felix* consent decree. An analysis of the problems indicates that the State lacks the leadership necessary to organize, direct, and coordinate *Felix*-related activities. This is at the root of the State's continued failure to efficiently and effectively comply with the terms of the decree.

The problems facing the State from the consent decree are not new. The State documented preexisting problems with the mental health services program in the original *Felix* implementation plan. The plan stated that "children and adolescents with disabilities residing in Hawaii, from birth to 20 years of age, who are eligible for and in need of education and mental health services under the Individuals with Disabilities Education Act and

Section 504 have not been adequately served because programs, services, and placements are either unavailable, inadequate, or inappropriate . . ."[5] Prior to the decree, children who were potentially eligible for services faced delays, waiting lists, suppression of referrals, and general confusion among service providers.

As illustrated in Exhibit 2.7, some improvements in the delivery of mental health services have occurred since the consent decree. However, significant improvement is still needed in a number of areas. Inefficient and ineffective practices continue both within and between the Department of Education and Department of Health, despite the creation of the *Felix* operational manager position.

Exhibit 2.7
State Efforts That Have Improved Since *Felix* and Areas Still Needing Improvement

Improved	Needs Improvement
• More children identified • Less confusion about where to make referrals • Greater amount and types of services available to children	• Mental health evaluation delays • Evaluation paperwork burden • Insufficient care coordination policy • No coordinated information system • Poor monitoring of service quality

The new system of care has improved somewhat under Felix

The State made some improvements to the mental health system and special education delivery system. For example, the court has acknowledged that more children have been identified as eligible for services. Prior to the decree, the number of children certified for special education was only 4.74 percent of the public school population, well below the 8 percent national average. For the 1998-99 school year, the Department of Education projects that 9 percent of the student population will be enrolled in special education.

In addition, there is less confusion about where to make referrals. The State has improved the evaluation process by designating a single entity to accept and process new referrals. Without this entity, the previous evaluation process was confusing and disorganized.

The new evaluation process has improved access for families and has increased parental involvement. Currently, all referrals for mental health evaluations are initiated through the schools. The principal designates the referrals activities coordinator to coordinate all referral activities. This individual convenes other school staff, staff from other agencies, and parents to form the student support team. That team assesses the needs of the child and determines whether further evaluation is necessary. District level diagnostic teams receive requests for evaluations and test children for special education certification. Once the evaluations are

completed and a child is found eligible for special education services, the diagnostic teams, Department of Health staff, school staff, parents, and any other concerned parties participate in the individualized educational plan meeting to outline the types of services to be provided to the child.

In addition, the amount and types of services available under the consent decree has increased. In 1994, many children were not being referred due to the lack of available services. Three years later, the Department of Health changed its delivery system from providing direct services to contracting for services from private providers. The department established a delivery system that includes an array of 21 different services.

At the school level, staff report an increase in service availability. It should be noted, however, that the court monitor is concerned that the State has yet to develop adequate services to reduce the number of out-of-state placements and has stated that it is too early to determine if the current system is sufficient.

The State's system of providing mental health services still needs improvement

Despite the improvements to the mental health service delivery system and reported increase in moneys expended on the consent decree to over $200 million per year since 1994, the system continues to be inefficient and ineffective. Evaluations essential to the identification of *Felix* class students are not conducted on a timely basis, the paperwork burden is excessive, case coordination is insufficient, and service quality is poorly monitored.

Evaluations continue to be late

Prior to the consent decree, children and families failed to receive the timely and adequate services to which they were entitled. Although the State has established a single point of entry for referrals, the lack of timely services continues to be an issue largely because evaluations for special education and mental health assessments are delayed.

The Department of Education completed 8,887 evaluations during FY 1996-97. However, 3,078 of these (34.6 percent) were not completed by the 100 day deadline. The department reported that 1,190 (13.4 percent) were late due to delays in receiving non-departmental evaluation reports such as mental health evaluations. The department maintains that it lacks the ability to control the processing time for non-departmental reports. However, the department failed to mention that a number of special education evaluations were late because of its own delays. Department of Education staff who compile this information confirmed that 1,222 evaluations (13.8 percent) labeled "late for no reason" were attributed to the education department.

The situation worsened during FY1997-98. The court, noting the increase in late evaluations, has recently disallowed requests for extensions, except in cases where parents request the extension. This makes any late evaluation not requested by a parent a violation of the court order. The *Felix* operational manager is responsible for ensuring that the State's activities are administered to comply with the consent decree and should be able to both monitor and require that evaluations are completed within the prescribed 100 day processing period.

Mental health evaluations have additional interagency procedures

Ineffective leadership has also resulted in the failure to address interagency coordination problems that hinder efforts to comply with the consent decree. Interagency procedures and a considerable amount of paperwork contribute to the delays in conducting mental health evaluations. These delays ultimately threaten the timely provision of appropriate services to children with mental health needs.

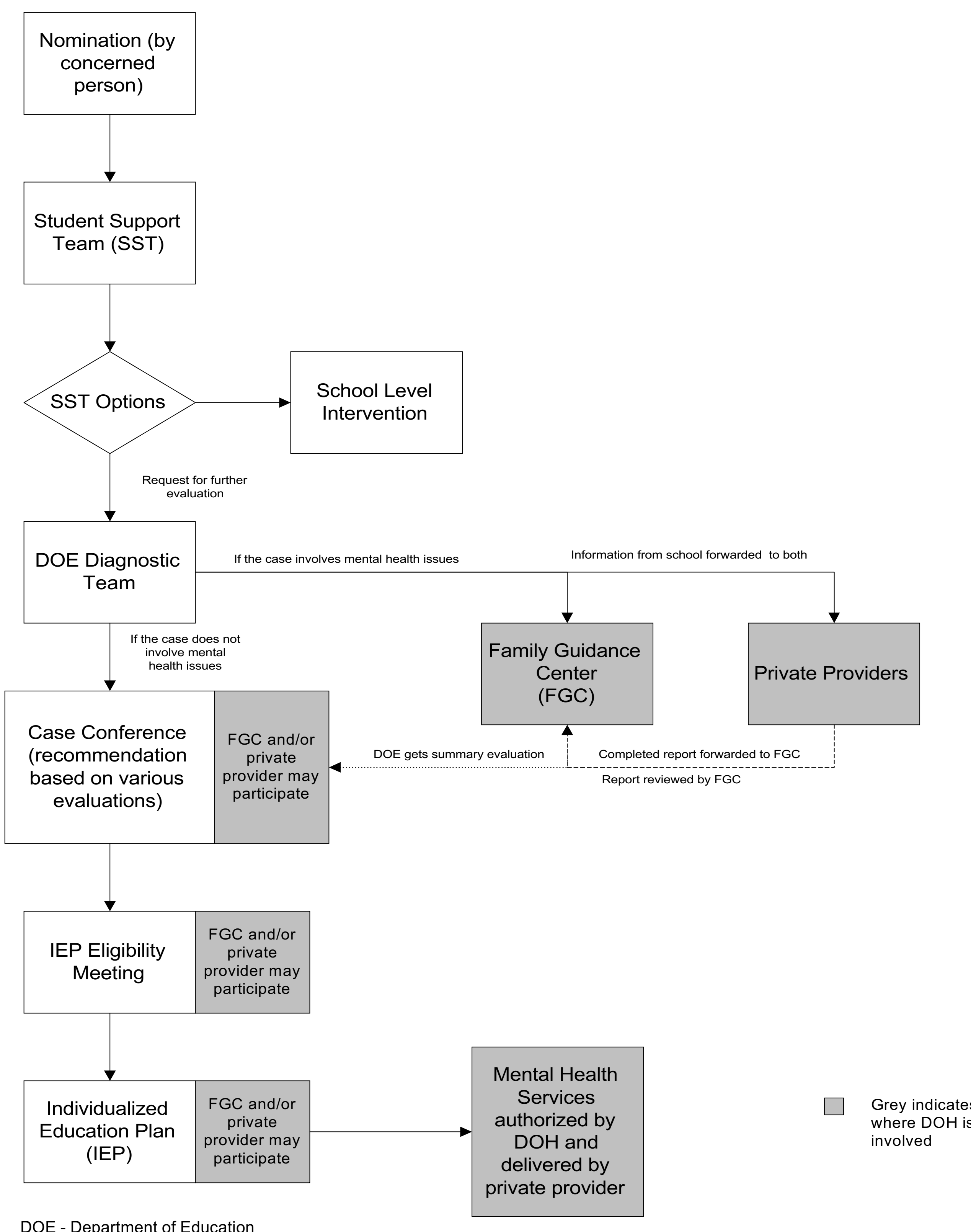
To determine eligibility for special education, the Department of Education's diagnostic teams must: (1) conduct a battery of special education evaluations to assess the student's academic, intellectual, social, and speech/language abilities; (2) meet as a group to discuss the child's case and develop recommendations; and (3) appear at individualized education plan conferences to discuss recommendations. When a mental health evaluation is requested, the team must initiate and coordinate the mental health evaluation with the Department of Health. The Department of Health's Family Guidance Centers authorize the provision of services and private providers perform the mental health evaluations. Once the private provider completes the evaluation, the evaluation is sent to the Family Guidance Center for review. Only after the center completes its review does the diagnostic team receive the report. Exhibit 2.8 depicts the general identification, screening, and evaluation process.

Part of the problem with this system is that once the request for evaluation is forwarded to the Family Guidance Center and private providers, the Department of Education's diagnostic teams lose control over the evaluation process. Although the Department of Education is required by its administrative rules to complete the entire evaluation process within 100 days, the Department of Health and its private providers have no such requirements in statute or rules. Therefore, the Department of Education and its diagnostic teams have little control over delays caused by late mental health evaluations.

The paperwork burden is heavy

The heavy volume of paperwork reduces the efficiency of the evaluation process. The Department of Education and the Department of Health

Exhibit 2.8
Identification, Screening, and Evaluation System after the *Felix* Consent Decree



DOE - Department of Education
DOH - Department of Health

each require extensive documentation, especially when a mental health assessment is involved. Exhibit 2.9 summarizes the forms used, their purported function, and the procedures involving the use of the forms. Exhibit 2.10 illustrates the paperwork flow.

The heavy volume of paperwork applies to all staff who process requests for evaluation. For school level personnel, the paperwork procedures have increased dramatically. As Exhibit 2.10 shows, parental consent is required at least three times.

Paperwork has become a burden especially for diagnostic teams, largely due to the need to coordinate mental health referrals. Under the current system, the diagnostic team is required to assemble information packets for the Department of Health—one for the Family Guidance Center and one for the private provider. This requirement is in addition to district reports and special education certification reports that the team is required to complete. For FY1996-97, the number of evaluations completed ranged from 254 to 1,662 (both special education and mental health).

Late evaluations may affect the State's ability to comply with the decree

Late evaluations may affect the ability of the State to attain total compliance with the consent decree. Both special education and mental health evaluations are used by the individual education plan team to determine the services that a child needs. If an assessment is late or incomplete, some services may still be provided in the interim. However, interim services may not be appropriate.

The Department of Education, under its policy of not extending evaluations beyond the 100 day deadline, has stated that if a mental health evaluation is late but the child otherwise qualifies for special education services, then an individual education plan will be created to provide those services that are not related to mental health. Once the mental health evaluation is completed, another meeting will be held to modify their individual education plan if necessary. In cases where a mental health problem is the only issue, the child has to wait until the evaluation is completed. The Department of Health has a policy allowing children being evaluated to receive some services.

While these procedures allow some children to receive services, there is a clear need to establish a more efficient system to ensure that evaluations are completed in a more timely manner to assure that the services provided are appropriate. This is key to ensuring that the State's system is in compliance with the consent decree.

Exhibit 2.9
Sample of Paperwork Involved In an Evaluation for IDEA Eligibility with a Mental Health Component for DOE Honolulu District and DOH Diamond Head Family Guidance Center

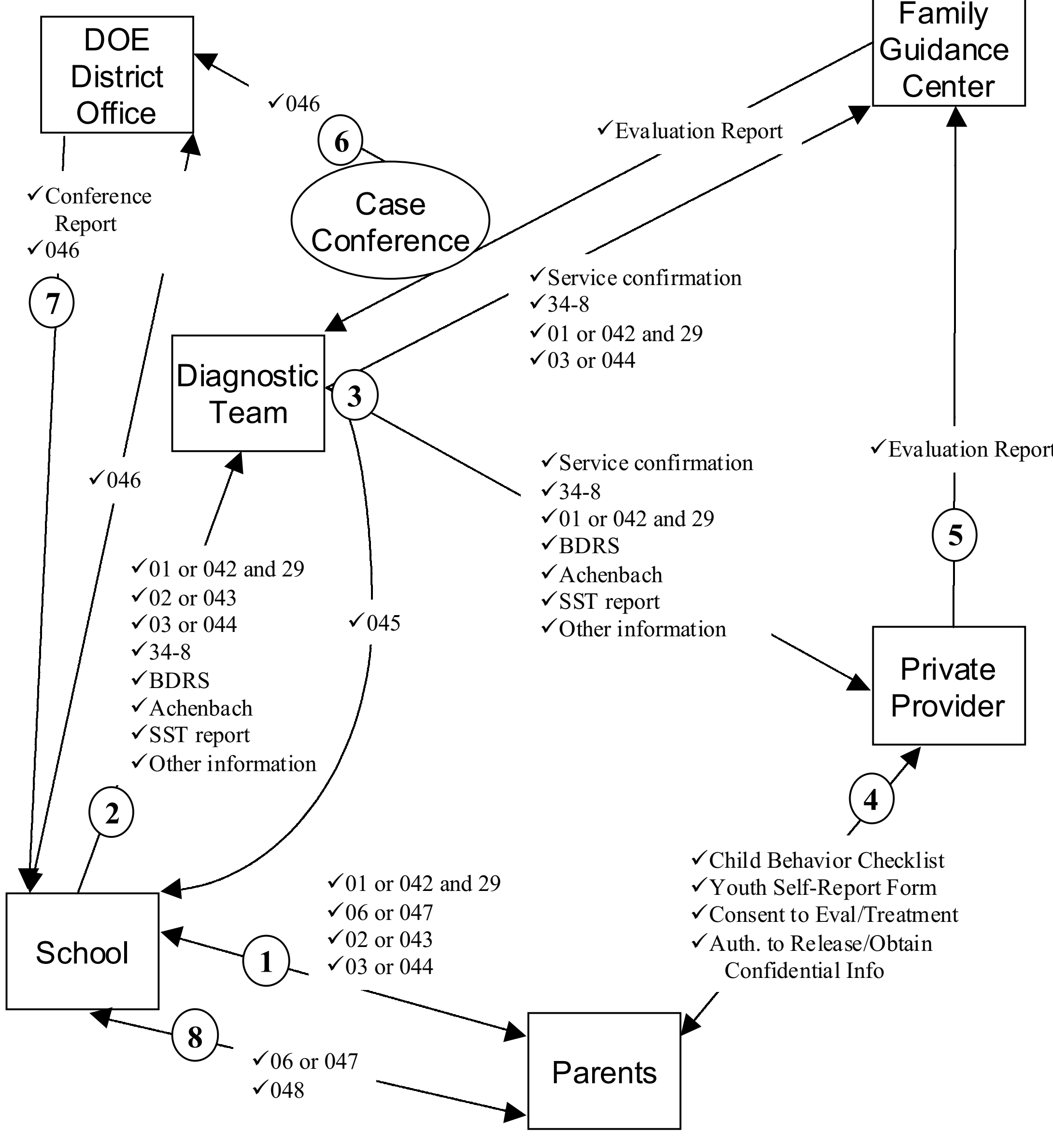
Guidance Center

Evaluation Stage	Form	Purpose	Procedure
Referral	01 or 042 and 29	Document request for evaluation/re-evaluation.	School gives copy to diagnostic team which makes copy for family guidance center (FGC) and provider
Data Collection	BDRS	Behavioral rating scale for mental health evaluations	School does assessment and sends to diag. team which sends copy to provider
	Achenbach	Behavioral rating scale for mental health evaluations	School does assessment and sends to diag. team which sends copy to provider
	SST Report	Document decision made by student support team (SST)	The report is the result of an SST meeting and is then sent to the diag. team who forwards it to the provider
Pre-Evaluation Notice and Consent	02 or 043	Notify parent of student support team's decision	Principal uses form to inform parents of SST decision; also sends copy to diag. team
	03 or 044	Obtain consent of parent for initial or re-evaluations	School gives copy to diag. team which sends copy to FGC
	34-8	Parental release of confidential information for mental health evaluation	School gives copy to diag. team which sends copy to FGC and provider
	045	Disposition of evaluation from diag. team to schools	After receiving documentation from the school, diag. team sends 045 to the school to show an evaluation is underway
Mental Health Forms	Service Confirmation	DOE procurement for mental health services	Diag. team completes and sends to FGC and provider to initiate evaluation
	Child Behavior Checklist	Parent form of the Achenbach	Provider gives to parent to complete
	Youth Self-Report Form	Information from adolescent for mental health evaluation	Provider gives to parent to have student complete
	Consent to Evaluation/ Treatment	Parental consent to a mental health evaluation	Provider gives to parent to complete
	Auth. to Release Information	Parental consent to release confidential information to provider for evaluation	Provider gives to parent to complete
Evaluation Results	Mental Health Eval. Report	Mental health portion added to diag. team report before case conference can be held	Provider reviews with parent and forwards to FGC which forwards to diag. team
	Conference Report	Document outcome of case conference	Outcome of the evaluation is sent to district education specialist who sends report to the school along with an 046
	046	Documents eligibility determination	District education specialist signs form and sends to principal who signs and sends to district superintendent for approval; form returned to the principal
	048	Documents meeting with parents regarding eligibility	Principal obtains parent signature at a conference for initial placement
Other Forms	06 or	Provide notice to parent to	Principal sends this form to parents 10 days

DOE - Department of Education
DOH - Department of Health

Exhibit 2.10
Honolulu District Paperwork routing for evaluations with a mental health component for Department of Education and Department of Health Diamond Head Family Guidance Center

1. Referral is made, student support team meeting, parent permission for evaluation
2. School information to diagnostic team
3. Diagnostic team begins evaluation; forwards information for mental health evaluation
4. Private provider obtains information from parents to conduct mental health evaluation
5. Mental health evaluation goes back to the diagnostic team through family guidance center
6. Case conference to discuss results of evaluations and determine eligibility
7. Results of evaluation get back to the school; principal and district must sign
8. Parent conference on outcome of evaluation; begin IEP



Agencies do not abide by coordination policy

The care coordination policy is unclear and confounds line staff. The implementation plan requires that each child be assigned a care coordinator. However the specific responsibilities of a care coordinator and who is to be designated a care coordinator are not clear.

The care coordinator is responsible for ensuring that the child's individual education plan is carried out as prescribed, a task that is particularly crucial when more than one agency is involved. The Department of Education, as the state agency designated by the Individuals with Disabilities Education Act as accountable for the assessment and service provision processes, is also the agency ultimately responsible for coordinating the care for children as prescribed in their individual education plans. This does not prevent other agencies or individuals from serving as the party responsible for coordinating care, particularly if it is more appropriate to do so. For example, a child with mental health needs might be better served if someone from the Department of Health's Family Guidance Center coordinated the care for this child. Despite this, some agencies' staff refuse to serve as care coordinators. In addition, the term care coordinator itself is not clear and subject to misinterpretation.

The *Felix* implementation plan states that "no matter how many agencies are involved, one person has to be accountable for insuring that each child and family get the services they need in a coordinated manner," and "clear policies and practices of care coordination must be established."[6] We found the policy on care coordination is not being followed. Staff we interviewed from the Departments of Education and Health were unclear on the term. Department of Health staff identify all employees involved with the service authorization process at the Family Guidance Centers as "care coordinators" whether or not they are the care coordinators who carry out the individual education plan.

The joint policy of the Departments of Education and Health states that choosing a care coordinator is a team decision based on factors which include family preference and knowledge of the child. In practice, care coordinators are usually special education teachers or Family Guidance Center workers. However, under this policy the care coordinator may also be a Family Court probation officer, Department of Human Services social worker, a private provider, a family member, or any other person deemed best suited for the task. While the departments of education and health claim that anyone can be the designated care coordinator, both Family Court and the Department of Human Services have written policies that their staff will not serve as care coordinators.

These types of problems exist because individual state agencies lack the authority to enforce their policies upon each other despite the existence of

the overarching *Felix* operational manager position. Furthermore, the policy is unclear and confounding to line staff. As a result, the goal of implementing a more efficient service provision process for children remains unfulfilled.

Agencies have not collaboratively developed an information system

The Department of Education and the Department of Health have failed to collaborate to develop an integrated management information system as required by the implementation plan. The plan calls for the establishment and maintenance of a *Felix* Information System to support the collection and analysis of data on the *Felix* class. Specifically, its features should include: the use of retrieval, sharing, and communications technology; the development and use of an interagency shared consent form; and the coordination of service planning, delivery, and evaluation opportunities.

These two agencies are merely enhancing their existing information systems. The Department of Health developed the Child and Adolescent Mental Health Management Information System (CAMHMIS) to track client registration, service authorizations, and billing information. This system allows the Department of Health to perform the basic functions of providing services, but the system lacks a component to adequately monitor and evaluate the timeliness of services being provided. However, the Department of Health reported that it is currently in the process of adding on such a module.

The Department of Education developed a *Felix* database that primarily tracks dates on forms used in the evaluation process for special education. This database allows personnel to gauge, to some degree, the progress of the evaluation and allows departmental staff to communicate through e-mail. This system was recently used to establish a link with the Attorney General's office and share information.

Both departments have decided to share information rather than develop an integrated system to meet the requirements of the implementation plan which includes ensuring that both departments use the same information. In order to do this, the Department of Health is developing a data warehouse to provide access to certain CAMHMIS data and Department of Education data. However, there is no assurance that the information stored in the Department of Health's data warehouse will be accurate or updated in a timely manner. For example, although there is an agreement on what information is to be collected, the departments vary on how often information is updated. The Department of Health updates the CAMHMIS information on a regular basis while the Department of Education updates its data less frequently. Furthermore, while the health department removes old or invalid information, the education department has no such controls.

Quality of services is not monitored

Services provided to children with mental health needs must meet a standard of quality. As one Family Guidance Center worker stated, it is possible that no services are better than very poor services that can harm children. To prevent this, the Department of Education and the Department of Health have a joint plan for assessing and improving quality.

However, most of the Department of Health's Family Guidance Center staff and the Department of Education's personnel we interviewed were concerned about the quality of services currently provided. For example, some reported that providers conducted inappropriate activities. The court monitor has also noted that the education and health departments have yet to develop an effective system for monitoring the quality of services. The monitor has emphasized the importance of assessing the quality of services and has identified it as a critical issue that needs to be addressed immediately.

With the exception of Kauai, the Department of Health contracts statewide with private providers to supply the mental health services outlined in individual education plans. While the Department of Education is held responsible for monitoring the quality of services "as they relate to education," it lacks authority to write the measures of quality into contracts and enforce the terms of those contracts. Although school personnel have numerous opportunities to monitor quality, they must ultimately rely on the Department of Health to be diligent in contract formation and management.

Department of Health personnel have not fully responded to this issue. Some staff in the departments told us that their heavy workloads prevent them from monitoring the quality of services. Other staff said that their focus is on making services available while quality is a secondary concern.

The State needs stronger leadership to ensure effective interagency coordination

The State needs more authoritative leadership if it hopes to achieve compliance. The continued lack of effective interagency coordination hampers the State's efforts to comply with the consent decree. The State has recently been threatened with contempt for failing to carry out its plans to comply with the consent decree. The aforementioned problems are some of the challenges that the State must address if it is to comply with the decree.

We contacted other states and federal agencies to inquire about the existence of a model system and to determine whether it would be better to have all educational and mental health services for students provided in

one agency, versus the dual system in Hawaii. We found that a "model" system does not exist and there is no research available to indicate that making the educational agency responsible for delivery of mental health services as well is more efficient or effective than dividing the responsibilities between an educational and a mental health agency.

However, we found that strong leadership is required when multiple agencies provide services, to ensure that the mental health system is coordinated and effective. An expert on child welfare consent decrees identified the importance of having a "czar" direct and coordinate the work of these agencies.

In May 1997, the federal court ordered the State to resolve this problem by creating an operational manager position. An interagency agreement, shown in Exhibit 2.11, executed by the governor's chief of staff, chair of the Board of Education, director of health, and the superintendent of education, set forth the responsibilities and authority of the operational manager's position. In July 1997, the State hired a *Felix* operational manager who is responsible for and has authority over the planning, direction, and administration of the State's activities to ensure compliance with the consent decree. More specifically, the operational manager is authorized to direct, promulgate, and effectuate policies, goals, objectives, tasks, and timelines contained in the consent decree, the modified implementation plan, and any subsequent court orders.

Despite the creation of this position, the State's efforts are uncoordinated and poorly implemented. The operational manager feels she lacks the power to compel action, particularly with the Department of Education which reports to the Board of Education and not the governor. Similarly, leaders in the Department of Education have expressed reservations about the operation manager's objectivity because the position is under the Office of the Governor where all departments other than the Department of Education are administered.

Despite these concerns and differing opinions, we believe that the responsibilities and authority of the *Felix* operational manager agreed upon by the Office of Governor, Board of Education, Department of Education and the Department of Health, are sufficient to direct the changes necessary to achieve compliance. Although the position is administratively attached to the Office of the Governor, the operational manager reports jointly to the governor's chief of staff and the chair of the Board of Education.

As long as the State fails to demonstrate an ability to coordinate its own activities, the federal court and court monitor will continue to fill the leadership void with detailed directives in their effort to ensure compliance. For the State to regain and maintain control over the system of care, the *Felix* operational manager and her office must have both the

Exhibit 2.11
Interagency Agreement on Responsibilities and Authority of the *Felix* Operational Manager

Responsibilities and Authority of the Felix Operational Manager

The **Felix** Operational Manager is responsible for the planning, direction, and administration of the state's activities to ensure compliance with the Consent Decree entered into in the Felix v. Waihee case, and resolves problems which arise in fulfilling the State's obligations under the Decree. As such, the Operational Manager thereby is authorized to direct, promulgate, and effectuate polices, goals, objectives, tasks, and timelines contained in the consent Decree, the Modified Implementation Plan, and any subsequent Court Orders prescribed by the Court.

The Operational Manager is administratively placed in the Office of the Governor and reports jointly to the Chief of Staff of the Governor's Office and to the Chair of the Board of Education. The Operational Manager receives the full cooperation of the Superintendent of the Department of Education, the Director of the Department of Health, and directors of all other Departments; and performs his/her responsibilities through consultation with the legislative and judicial branches of the state.

Charles Toguchi, Chief of Staff
Office of the Governor
MAY -7 1997
Date

Karen Knudsen, Chair
Board of Education
May 9, 1997
Date

Herman Aizawa, Superintendent
Department of Education
5/8/97
Date

Lawrence Miike, Director
Department of Health
May 7, 1997
Date

ability and the will to make informed and objective decisions that provide authoritative direction for all state agencies involved with the decree. If this is not the case, we find it difficult to justify an additional *Felix* office that is unable to fulfill its mission.

Conclusion

The State, in agreeing to create a system of care for the *Felix* class students, acknowledged that services being provided were inadequate and did not comply with federal requirements. However, in attempting to implement the terms of the consent decree, the State has been hampered by vague requirements, a lack of clear parameters, and ineffective leadership. As a result, there continues to be a lack of accountability and a failure to effectively address the needs of the *Felix* class students.

The State has also put itself in an awkward position. It may have to consider all 191,000 public school-aged children to be in the *Felix* class. The State does not know what the true costs of compliance are; permits one state agency to pay more for services provided to the *Felix* class than another state agency pays for the same services to a non-*Felix* child; fails to fully pursue reimbursements that can help offset costs; and continues to fall short in complying with the consent decree. More importantly, the needs of children are not being adequately met. The State needs to take firm and decisive steps to comply with the decree and serve the children of Hawaii.

Recommendations

1. The governor should ensure that the *Felix* operational management team aggressively pursues clarification of (a) the working definition for the *Felix* class and (b) the maintenance of effort requirement. After clarification is obtained, this information should be disseminated to staff, including Department of Education staff. The *Felix* operational management team should confirm that the clarified meanings of these basic terms are understood by all staff of the affected departments.

2. The governor and the Board of Education should report all funding for *Felix* services with the same definitions of budget and expenditure terms between departments and from one year to the next.

3. The governor needs to ensure the *Felix* operational management team, led by the *Felix* operational manager, carries out its role of ensuring that quality services are provided consistently and in a coordinated and timely manner.

4. The *Felix* operational manager should ensure that the Department of Health and the Department of Human Services' Med-QUEST Division work together to develop a plan for the Child and Adolescent Mental Health Division to access federal Medicaid/QUEST funding for services provided to eligible children.

5. The Department of Health's Child and Adolescent Mental Health Division should establish uniform payment schedules for mental health services.

6. The *Felix* Operational Management Team should ensure that reimbursement of federal funds is pursued in a systematic manner and report to the Legislature on the status of efforts to maximize federal fund reimbursements.

Appendix A
Chronology of Events and Background on the *Felix* Consent Decree

1973	Congress enacts Section 504 of the Rehabilitation Act, a Civil Rights Act that protects the rights of all disabled children. The section states that no individual with a disability can be denied access to any program or activity that receives federal funds. The law was amended in 1988.
1974	The Legislature establishes a program and branch for children's mental health in the Department of Health through Act 211. Legislation includes Section 321-174, HRS, requiring coordination of services with the Department of Education for identifying and referring for treatment children in need of mental health services.
1975	Congress enacts the Education for All Handicapped Children Act which provides access to education for disabled children. The title of the law was changed in 1990 to Individuals with Disabilities Education Act (IDEA). The act was re-authorized in 1997.
1977	The Departments of Education and Health develop an interagency agreement describing coordination of services.
1980	Section 321-174, HRS, was amended to **require** the Departments of Education and Health to develop a memorandum of agreement (MOA) describing responsibilities.
1982	Act 269, amended Section 301-27, HRS (now Section 302A-442) of the education laws to require the Department of Health, within funds available, to be responsible for a number of health services including mental health. It was also amended to require the Department of Health to cooperate with the Department of Education to implement these requirements.
1985	Hawaii Child and Adolescent Services System Program (CASSP) principles are adopted. A memorandum of agreement regarding coordination

	between the Department of Education and the Department of Health mandated under Section 321-174, HRS, is issued.
1991	The U.S. Department of Education finds that the state Department of Education is not in compliance with federal laws since mental health services were not always provided as needed. The Department of Education is instructed to provide or purchase the mental health services that the Department of Health could not provide. The U.S. Department of Justice finds that the State's child and adolescent residential treatment programs are not in compliance with federal laws.
1992	The Legislature passes HCR 433 and SCR 251, requesting the Auditor to assess the effectiveness of the memorandum of agreement between the Department of Education and the Department of Health, required under Section 321-174, HRS.
January 1993	The State Auditor issues Report No. 93-1, *A Study of the Memorandum of Agreement for Coordinating Mental Health Services to Children*. The report cites concerns about the coordination efforts between the education and health departments.
May 4, 1993	***Felix et al., v. Waihee et al.,*** A complaint is filed in U.S. District Court by seven parents on behalf of their children and 21 organizations statewide against the governor (in his official capacity), the director of health, and the superintendent of education (individually and in their official capacities). Trial date scheduled for January 1994 (later postponed).
Summer 1993	Informal Discovery -- circulation of settlement document. Parties consult expert witnesses: Dr. Ivor Groves for the plaintiffs (now court monitor and a member of Technical Assistance Panel); Dr. Judy Behar for the defendants (now member of Technical Assistance Panel).
November 1993	Settlement discussion called off and formal discovery begins.

December 29, 1993	Plaintiffs file motion for partial summary judgment and for preliminary injunction.
March 7, 1994	Defendants file motion to dismiss or for partial summary judgment.
May 24, 1994	Order of Judge Ezra granting in part and denying in part plaintiff's motion for summary judgment and granting in part and denying in part defendant's motion for dismissal or for summary judgment. The court finds the State liable as a matter of law and states that the defendants (State) have failed to provide services to the plaintiff class in violation of the Individuals with Disabilities Education Act (IDEA) and Rehabilitation Act of 1973, Section 504.
Summer 1994	Parties engage in discussion about "relief" and settlement of case.
July 1994	Joint motion for preliminary approval of settlement and consent decree filed.

October 25, 1994	Order of Judge Ezra granting joint motion for approval of settlement and consent decree, and appointment of special master.
	Terms of the consent decree include:
	• Parties stipulate to the jurisdiction of the federal court;
	• State waives its right to appeal the court's May 24, 1994 finding of liability;
	• State agrees to establish a system of care of programs, placements, services, and an organizational & managerial infrastructure to support it with:
	    • Adherence to requirements of Individuals with Disabilities Education Act, Section 504, and Hawaii's CASSP Principles;
	    • The Department of Education providing all educational services and the Department of Health providing all mental health services to members of the *Felix* class;
	    • Emphasis on the creation of partnerships (interagency, multi-agency, private and parents)

	and coordination of services between all responsible agencies; • Full implementation of consent decree by June 30, 2000; • Development of implementation plan within seven months; • Mr. Jeffrey Portnoy, Esq., appointed as special master; • Dr. Ivor Groves (plaintiffs' expert witness) designated as court monitor; • Establishes technical assistance panel and provides a means of funding for the *Felix* Monitoring Project; • Provides for (reasonable) plaintiffs' attorneys' fees; • Requires maintenance of services and programs measured by appropriations as of May 1994 -- known as the maintenance of effort (MOE) requirements.
March 1995	The State Auditor issues Report No. 95-10, *Follow-Up Report on a Study of the Memorandum of Agreement for Coordinating Mental Health Services to Children*. Finds 1985 agreement still not updated.
April 1995	First draft of the State implementation plan was rejected.
October 1995	Implementation plan approved by U.S. District Court and timelines established -- plan was dated October 31, 1995.
March 27, 1996	Status conference held. The State acknowledges that it has not complied with obligations of the consent decree and that deadlines have not been met.
June 13, 1996	March 27, 1996 status conference order issued, Requiring revisions to the implementation plan and Community Children's Councils access to $1,000 each along with a number of other mandates.
August 2, 1996	Stipulation modifying implementation plan dated October 31, 1995.
March 19, 1997	Status conference held. Parities agree that there are serious and legitimate concerns regarding state compliance.
May 1997	*Felix* Staff/Service Development Institute operational. (Not fully staffed until November 1997.)

	fully staffed until November 1997.)
June 11, 1997	March 19, 1997 status conference order issued requiring the establishment of the *Felix* operational manager position and a number of other corrective actions and mandates regarding: the Complaints Resolution Office; Identification, Evaluation and Screening; Community Children's Councils; Autism Training Plan; Training Plan; Staff Recruitment; Hearing procedures and the Comprehensive Student Support System.
July 16, 1997	Position of *Felix* operational manger filled by Linda Colburn.
January 1998	The State Auditor issues Report No. 98-1, *Audit of the Big Island Pilot Project on Mental Health*. The report finds problems with contract management and coordination of services.
January 27, 1998	Status conference held. Defendants once again state that they have not fully complied with requirements.
February 2, 1998	January 27, 1998 status conference order issued Mandating revision of existing plans and deadlines, adherence to future deadlines, Department of Education Management study ($98,400 transfer from Department of Education to *Felix* Monitoring Project) and corrective actions and recommendations for Identification, Evaluation and Screening (100 days deadlines for *Felix* class determination), funding Zero to Three Program, Medicaid reimbursements and other mandates.
April 1998	Proposed changes to the implementation plan are found inadequate. The court monitor suggests a new schedule ("Strategic Planning for *Felix* Refinement") to revise the plans.

Appendix B
Glossary of Terms Related to the *Felix* Consent Decree

Big Island Pilot Project
Pilot project which provides mental health services to children on the Big Island through a Department of Health contract with Kapi'olani HealthHawaii. Under the terms of the contract, Kapi'olani HealthHawaii manages delivery of mental health services to children by authorizing services and securing and paying subcontractors. The Department of Health's role is limited to overseeing compliance with the contract and with the *Felix* consent decree.

care coordinator
Individual acting as the single point of contact for families and service providers working with a child served by more than one state agency. The care coordinator provides ongoing assistance to facilitate coordinated development and implementation of all service plans and timely access to needed services.

Child and Adolescent Services System Program (CASSP) principles
A set of guiding principles for systems designed to provide comprehensive mental health services to severely emotionally disturbed children and adolescents. The principles were developed as part of a National Institute for Mental Health initiative known as the Child and Adolescent Services System Program. Among the program's principles are: (1) the system of care will be child-centered and culturally sensitive, (2) services will be provided within the least restrictive, most natural environment, (3) services will be delivered in a coordinated and therapeutic manner, and (4) early identification of needs will be promoted. The *Felix* consent decree requires that Hawaii's system of care be developed in accordance with the Child and Adolescent Services System Program principles.

"child with a disability," or "disabled child"
<u>(1) Under the Individuals with Disabilities Education Act</u>
A person between 3 and 20 years of age, determined to be eligible for special education and related services under the disabling conditions of: autism, deaf-blindness, deafness, emotional impairment, hard-of-hearing, learning impairment, mental retardation, orthopedic impairment, other health impairment, speech or language impairment, traumatic brain injury, severe multiple impairments, specific learning disabilities, or visual impairment, and who, by reason thereof, needs special education and related services.

<u>(2) Under Section 504 of the Rehabilitation Act of 1973</u>
A person having any physical or mental impairment that substantially limits one or more major life activities, having a record of such an impairment, or being regarded as having such an impairment. The definition of 'disabled' is broader under Section 504

than it is under the Individuals with Disabilities Education Act. Therefore, some children qualifying as disabled under Section 504 do not qualify as disabled under the Individuals with Disabilities Education Act.

Community Children's Council (CCC)
Councils established to provide a forum for community-based participation to meet local educational and mental health needs of children and for setting community priorities in resource development, planning, and quality management. Members may include parents, state agency staff, and private providers.

Comprehensive Student Support System (CSSS)
Comprehensive Student Support System was developed by the Hawaii State Department of Education in cooperation with other state agencies and encompasses three necessary interrelated components (instruction, management and student support) with the schools. The system realigns services of the Department of Education, Department of Health and other student- and family-serving agencies to provide all students with a comprehensive, coordinated and integrated system of support that encourages achievement and creates caring communities in schools.

coordinated service planning
A planning process to ensure that services are accessed and provided in a more coordinated manner. The process whereby representatives of all agencies and providers serving a child, family members of the child, and individuals chosen by the family work together to develop an integrated service plan for a child receiving services from more than one agency.

court monitor or monitor
Court appointed individual responsible for monitoring defendants' efforts to implement the decree, issuing semi-annual reports on defendants' progress, keeping parties apprised of implementation and compliance, and making recommendations to the Court concerning enforcement of compliance. Dr. Ivor Groves currently serves as monitor under the consent decree.

early intervention services
Services provided under public supervision and at no cost to families, designed to meet the special developmental needs of infants and toddlers, in conformity with an Individualized Family Support Plan. Early intervention services include family support, counseling and home visits; special instruction; speech pathology and audiology; occupational therapy; physical therapy; psychological services; case management services; medical services for diagnostic or evaluation purposes only; early identification screening and assessment services; and health services necessary to enable the infant or toddler to benefit from the other early intervention services.

Family Guidance Center (FGC)
Branches of the Child and Adolescent Mental Health Division responsible for planning, organizing, implementing, and monitoring programs and activities to meet the mental health needs of children, adolescents and their families.

"*Felix* class," "plaintiff class," or "class members"
All children and adolescents with disabilities residing in Hawaii, from birth to 20 years of age, who are eligible for and in need of education and mental health services.

***Felix* consent decree**
The consent decree document settling the lawsuit files in 1993. The decree was signed by Judge David A. Ezra on October 25, 1994. The decree sets forth the terms and conditions of the settlement of the law suit. The decree provides that the plaintiff class receive a free appropriate public education as required under the Individuals with Disabilities Education Act and Section 504 and requires the state to create a system of services, programs, and placements for the Plaintiff class.

***Felix* Operational Management Team (OMT)**
An executive body established by the implementation plan with the authority to manage and implement the policies developed in the plan and recommend changes in operations or management. Members of the OMT include the deputy director of Health for Behavioral Health, the assistant superintendent of Education for Instructional Services, the chief of the Child and Adolescent Mental Health Division and the Department of Education's administrator for the *Felix* consent decree. Deputy directors of other state agencies participate as required.

***Felix* operational manager**
Individual responsible for the planning, direction, and administration of the state's activities to ensure compliance with the *Felix* consent decree and for resolving problems which arise in fulfilling the state's obligations under the decree. The operational manager is authorized to direct, promulgate, and effectuate policies, goals, tasks and timelines contained in the consent decree, the Implementation Plan, and related Court Orders. The operational manager reports directly to the chief of staff of the governor and the chair of the Board of Education.

"free appropriate public education"
Special education and related services provided in the least restrictive environment, at public expense, under public supervision and direction, and at no cost to a parent, in conformity with an Individualized Education Program.

implementation plan
The plan of operation which describes the specific design of the new system of care required under the *Felix* consent decree and which includes a specific schedule with critical milestones for implementing the design.

Individuals with Disabilities Education Act (IDEA)
The Individuals with Disabilities Education Act, amendments of 1997. The Act: (1) ensures that children with disabilities have available to them a free appropriate public education that includes special education and related services; (2) ensures that the rights of children with disabilities and of their parents are protected; (3) provides assistance to states and localities for the education of all children with disabilities; (4) provides assistance to states for the provision of early intervention services to infants and toddlers with disabilities; (5) provides for technical assistance to the states; and, (6) provides for assessments of efforts to educate children with disabilities.

Individualized Education Program (IEP)
A written plan developed to meet the special education needs of a student qualified as disabled under the Individuals with Disabilities Education Act. The Individualized Education Program describes the specific special education and related services to be provided, the duration of service and objective criteria for determining whether stated instructional objectives are met.

Individualized Family Service Plan (IFSP)
A written plan for providing early intervention services to meet the needs of infants and toddlers with disabilities. The Individualized Family Service Plan describes the child's status, the outcomes to be achieved, and the early intervention services required to achieve those outcomes. Participants in development of the Individualized Family Service Plan must include one or both parents, the child's service coordinator, persons who conducted evaluations or assessments, and persons who will be providing services to the child (as appropriate).

"least restrictive environment"
The principle, articulated in the Individuals with Disabilities Education Act, that to the maximum extent appropriate, a child with a disability shall be educated in an environment as close as possible to the child's home and with children without disabilities. Furthermore, the removal of the child from the regular education environment shall occur only when the nature or severity of the disability is such that education in regular classes with supplementary aids and services cannot be achieved satisfactorily.

Maintenance of Effort (MOE)
Requirement under the *Felix* consent decree that the quantity and quality of services, programs, and placements for the plaintiff class shall not fall below that for which

appropriations had been made or provided on May 2, 1994. Appropriations as of this date constitute a funding floor for specified Department of Health and Department of Education programs.

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

Modification Plan (MP)
The Modification Plan describes the specific regular or adapted regular education and related services to be provided to a class member who does not require special education.

related service
Developmental, corrective and other supportive services as are required to assist a child with a disability to benefit from special education. Related services include speech pathology, audiology, psychological services, physical therapy, occupational therapy, recreation, including therapeutic recreation, early identification and assessment of disabilities in children, counseling services including rehabilitation counseling, medical services for diagnostic or evaluation purposes, school health services, social work services in schools, parent counseling and training, transportation, and may include other developmental, corrective, or supportive services if required to assist a child with a disability to benefit from special education.

Section 504 or 504
Section 504 of the Rehabilitation Act of 1973, a federal statute which 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.

special education
Specially designed instruction provided at no cost to parents to meet the unique needs of a child with a disability, including instruction conducted in the classroom, the home, in hospitals and institutions and in other setting, and instruction in physical education.

Student Support Team (SST)
A team of individuals including the student, family, school staff, and other professionals and personnel knowledgeable about the student or appropriate services. The team is responsible for assessing the student's strengths and needs, identifying appropriate services, and referring the student for evaluations as appropriate. Student

Support Teams are a key component of Comprehensive Student Support System initiative.

Technical Assistance Panel (TAP)
A technical panel consisting of, at a minimum, Dr. Ivor Groves, Dr. Lenore Behar, and Dr. Judith Schrag, responsible for assisting the Department of Education and the Department of Health in designing the system of care and formulating the Implementation Plan required under the *Felix* consent decree.

Title IV-E or IV-E
Title IV-E of the Social Security Act which established "Federal Payments for Foster Care and Adoption Assistance", a federal program which provides assistance to states for supporting foster care programs and activities directed at preventing the need for foster care. The program provides federal matching funds for training and administrative activities related to foster care or the prevention of foster placement.

Title XIX or Medicaid
Title XIX of the Social Security Act which established "Grants to states for Medical Assistance Programs", a federal program, also known as Medicaid, which provides matching funds to states for the provision of health care to low-income individuals.

Notes

Chapter 1

1. Letter to Marion Higa, Auditor, from Norman Mizuguchi, President of the Senate and Joseph M. Souki, Speaker of the House, December 18, 1997.

2. Hawaii, The Auditor, *A Study on the Memorandum of Agreement for Coordination of Mental Health Services to Children,* Report No. 93-1, Honolulu, January 1993.

3. Order Granting Joint Motion for approval of settlement and Consent Decree and Appointing Special Master; Exhibit "A", at 3 and 4 of Exhibit A. *Felix et al., v. Waihee et al*., Civil No. 93-00367-DAE at 3-4, District of Hawaii, filed October 25, 1994.

4. *Defendants' Amended Pretrial Statement; Certificate of Services*, at 7, *Felix et al., v. Waihee, et al.,* Civil No. 93-00367-DAE, District of Hawaii, dated June 3, 1994.

5. Memorandum to Chief of Staff Charles Toguchi, Chair of the Board of Education Karen Knudsen and Superintendent of Education Herman Aizawa from Director of Health Lawrence Miike, Subject: Felix Operational Manager, May 12, 1997.

6. Ibid.

Chapter 2

1. Stipulation and order modifying consent decree at 1-2, *Felix et al., v. Waihee et al.* District of Hawaii, Civil No. 93-00367-DAE, filed January 12, 1998.

2. Stipulation modifying implementation plan dated October 31, 1995; order at 2, *Felix et al., v. Waihee et al*., District of Hawaii, Civil No. 93-00367-DAE, filed August 2, 1996.

3. Hawaii, Department of Education, *Comprehensive Student Support System: An Implementation Plan*, Honolulu, November 1997, p. 4.

4. *Felix et al., v. Waihee et al*., Civil No. 93-00367-DAE at 9, District of Hawaii, filed October 25, 1994.

5. Hawaii, Department of Education, *State of Hawaii Implementation Plan: Felix vs. Waihee Consent Decree, October 31, 1995*, Honolulu, November 1995, p. 11

6. Ibid., p. 2.

Responses of the Affected Agencies

Comments on Agency Responses

We transmitted drafts of this report to the *Felix* Operations Manager, Department of the Attorney General, Department of Education, and Department of Health on November 19, 1998. A copy of the transmittal letter to the *Felix* Operations Manager is included as Attachment 1. The *Felix* Operations Manager submitted an "integrated response" reflecting the leadership of the Department of Education, Department of Health, the *Felix* Operations Manager, and consultation with the Family Court and Department of Human Services. This response is included as Attachment 2. The Department of the Attorney General noted that it was "inadvertently" omitted from the integrated response and elected not to submit a separate response to our draft.

Overall, the integrated response contends that our assessment shows a lack of understanding about the State's specific compliance requirements for the *Felix* consent decree, IDEA, and Section 504. Further, the response contends that our assessment fails to distinguish between impediments that can be addressed versus those over which the agencies have no control. The response also stresses the fact that the State was not in compliance when the decree was agreed upon and has had much "catching up" to do.

In specific comments the integrated response contends that the working definition of the *Felix* class is clear. The response also states that there is no basis for concluding that the Comprehensive Student Support System may potentially expand the *Felix* class; and that there is no relationship between the system wide change activities provided by the Comprehensive Student Support System and the identification of a child as a *Felix* class member. The response further notes that identification of *Felix* funding is not an issue with the court monitor. Finally, a number of additional specific comments concerning remedial actions, and updated statistical information that pertains primarily to our findings about the Department of Health, were also submitted.

With respect to the broad comments in the integrated response, we note their defensive nature. The responding auditees, once again, have demonstrated a ready willingness to blame impediments beyond their control for their failures. We reiterate that the State entered into the consent decree and the implementing agencies have continually represented to the Legislature their ability to comply with the decree as long as the Legislature provided the resources. Now that they are being called to account for the effectiveness of their efforts and their expenditures, they appear unwilling to accept unflattering information. We stand by our evidence.

More specifically we note that the auditees provided no further evidence to demonstrate that a clear definition of the *Felix* class exists. The director of health, among others, informed us of repeated requests to the court monitor to clarify the definition of the *Felix* class. Also numerous staff in the field reported their confusion to us. The response does not clarify the definition — it merely cites updated statistics.

The contention in the response that the Comprehensive Student Support System has no relationship with the identification of a child as a *Felix* class member runs contrary to the fact that the support system is meant for *all* students, including those of the *Felix* class. The design of the system is rooted in the belief that *Felix* class students cannot be considered as separate from special and regular education students. Therefore making the Comprehensive Student Support System a part of the *Felix* implementation plan has a definite impact upon the *Felix* class and the State's obligations under the consent decree.

We note that whether the identification of *Felix* funding is an issue with the court monitor is not the point of our finding. Regardless of the maintenance of effort requirement, there is a fundamental need for oversight bodies such as the Legislature and the Department of Budget and Finance to know how much has been spent for the consent decree and how much will be needed in the future. We reiterate that the Department of Health did indeed present many obstacles to our access to fiscal information; we have an abundance of evidence to support this point. Moreover, the views of the Department of Education regarding the proposed joint budget are notably absent from the response.

Our usual practice is to publish the auditees' responses in their entirety unless they are lengthy. Although the present response is somewhat lengthy, we have included all of it here since it represents several agencies' comments. Much of it consists of unaudited information, events that occurred after our fieldwork was concluded, or material that proves rather than disproves one point — many activities may go on in the name of the *Felix* decree, but toward undetermined outcomes and levels of quality. Overall, however, the integrated response does not disprove our findings nor merit reconsideration of our recommendations. In fact, our recommendations went unchallenged.

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

November 19, 1998

COPY

Ms. Linda Colburn
Felix Operations Manager
Office of the Governor
State Capitol, 4th Floor
Honolulu, Hawaii 96813

Dear Ms. Colburn:

Enclosed for your information is a copy numbered 6 of our draft report, *Assessment of the State's Efforts Related to the* Felix *Consent Decree*. We ask that you telephone us by Monday, November 23, 1998, 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, November 30, 1998.

The Department of the Attorney General, Department of Education, Department of Health, 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

Marion M. Higa
State Auditor

Enclosures

EXECUTIVE CHAMBERS
HONOLULU

BENJAMIN J. CAYETANO

December 2, 1998

Ms. Marion M. Higa
State Auditor
State of Hawaii
Office of the Auditor
465 S. King Street, Room 500
Honolulu, HI 96813-2917

RECEIVED
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OFC. OF THE AUDITOR
STATE OF HAWAII

Dear Ms. Higa:

Thank you for the opportunity to clarify various aspects of the Draft 1998 "Assessment of the State's Efforts Related to the Felix Consent Decree." The following comments reflect the responses of the leadership of the Department of Education (DOE), Department of Health (DOH), and the Felix Operations Manager in consultation with the Family Court and the Department of Human Services (DHS).

As this integrated response addresses important aspects of what is clearly a very complex and dynamic compliance effort, we respectfully request that it be included with the publication of your final report in its entirety.

Three broad initial observations resulted from the departmental review of the document. These are:

(1) It appears that there may be a lack of understanding concerning the specific compliance requirements of the State, regarding Section 504 of the Rehabilitation Act, the Individuals with Disabilities Education Act (IDEA) and the Felix vs. Cayetano Consent Decree.

(2) In some areas it appears that the reviewer has been unable to make distinctions between system impediments over which the departments have no control and those areas where the departments can effectuate change. It is noted that the provision of special education and related services including mental health services is subject to policies and regulations enacted by the federal government.

(3) It's important to recognize that the State was out of compliance with federal law and regulation at the time that the State entered into the Felix vs. Cayetano Consent Decree. The commitments made by the parties at the time of entering into the agreement have necessitated an enormous amount of "catching up" which has had to be accomplished while the State has had to continue to provide services.

This document is structured to address specific statements presented in the draft report:

1. Statement Number One:

   ". . . collaboration between the Departments was 'non-existent'." (page 2, State Auditor's Draft Report)

Response:

The statement reflects conditions that led to the 1994 Settlement Agreement. Since that time, there has been marked increased collaboration between the DOH and DOE, as evidenced by Operational Management Team (OMT) meetings (which also involves representatives from DHS, Family Court and the State Children's Council). In addition, the Felix Operations Manager functions as the facilitator for coordinating the State's efforts in a collaborative manner, through multiple working groups/committees/meetings such as the Multi Agency Children Committee, Licensing Working Group, Aging Out Working Group, Autism Working Group, Felix Staff Services Development Institute Steering Committee, Quality Outcomes Working Group, Service Testing Working Group, Management Information System Working Group, Community Children's Council Informational Meetings, Integrated Budget Meetings, Maui Management Team Meetings, and Big Island Interagency Team Meetings. In addition, as other issues are identified, teams are assembled from the appropriate departments to problem-solve around specific issues.

2. Statement Number Two:

   ". . . the State lacks a clear "working" definition of the Felix class. (pages 12-19, State Auditor's Draft Report)

Response:

The State has a clear "working" definition of the Felix class which was provided in the "Stipulation and Order Modifying the Consent Decree", filed on January 12, 1998 which defines the Plaintiff class as "all children and adolescents with disabilities residing in Hawaii, from birth to 20 years

of age, who are eligible for and in need of education and mental health services."

Moreover, the State has an operational definition of the Felix class. The process includes the nomination, screening and evaluation process which was approved by the Office of Special Education Programs of the U.S. Office of Education (under the provisions of the IDEA). This is followed by a DOE multi-disciplinary Diagnostic Team, which involves the development of a mental health assessment completed by DOH contracted providers. The determination of eligibility for services is made by a team consisting of parents, DOE personnel and DOH personnel in accord with either Section 504 of the Rehabilitation Act or the IDEA. If special education and related mental health services are deemed necessary, then these services are provided by either a 504 Modification Plan (MP) or an Individual Education Plan (IEP).

The Felix class members are children who have been identified for Section 504 or special education services and are receiving mental health services as a related service. It is important that the relationship between 504 eligibility, IDEA eligibility, and Felix class membership be fully understood.

There are currently 20,592 children with identified disabilities being served in the special education programs in the state. These children were identified under the provisions of the federal IDEA. These are the IDEA eligible children who are currently being provided services:

Number	Category	Percent
2,748	children with mental retardation	13%
9,317	children with learning disabilities	45%
2,560	emotionally impaired children	12%
395	hearing impaired children	2%
2,586	speech-language impaired children	13%
975	early childhood learning impairment	5%
791	health impaired children	4%
190	children with autism	1%
1,030	other impairments	5%
20,592	Total	100%

As of this date, 4,857 or 24% of the IDEA eligible children are receiving related mental health services. An additional 1,266 children are currently receiving mental health services as a program modification under Section 504 of the Rehabilitation Act of 1973.

These 6,123 children are the Felix Class Children as defined as *"all children and adolescents with disabilities residing in Hawaii, from birth to 20 years of age, who are eligible for and in need of education and mental health services."*

It is additionally noted that another 1,828 children in the state have been referred by the DOE to the CAMHD for mental health assessment as part of the eligibility determination process.

It is important to keep in mind, that while the Consent Decree requires the Child and Adolescent Mental Health Division (CAMHD) of the DOH to provide the full range of mental health services to the 6,123 Felix Class Children, the Federal IDEA requires the DOE to provide the full range of educational services to all 20,592 children identified for special education services.

In addition, the Felix class also includes children in the DOH's Zero-to-Three (ZTT) Program. There is agreement as to who constitutes the Felix class for the ZTT Program. It is defined as those children who are "developmentally delayed", as evidenced in Ivor Groves' letter to Special Master, Mr. Jeffrey Portnoy, dated July 15, 1998, a copy of which is attached (Attachment "A").

3. Statement Number Three:
   "This makes it difficult for the two departments to agree on how many children actually constitute the Felix class." (page 16, State Auditor's Draft Report)

Response:

As this comment initially related to an issue regarding eligibility, and presumptive eligibility, it is important to recognize that neither Department currently uses a category called "presumptive eligibility." Although it is suggested that a disagreement in numbers also results from the lack of a clear description of the Felix Class and the perceived lack of collaboration between the departments, the reality is quite different.

First of all, the two departments have different service requirements. The DOE is required to provide services to all children found eligible for special education services under IDEA. The DOH provides related mental health services for these children requiring such services under the provisions of Section 504 of the Rehabilitation Act and IDEA.

Secondly, the numbers of actual children requiring services change from day to day as new children are identified, and it is determined that other children no longer require services.

4 Statement Number Four:

"The State's efforts to obtain clarity on the requirements of the decree are further complicated by inclusion of the DOE new educational reform effort, the Comprehensive student Support system, in the Implementation Plan." (pages 16-19, State Auditor's Draft Report)

Response:

The Comprehensive Student Support System (CSSS) of the DOE is essentially an organizational change within the Department of Education that improves access to services, coordinates the provision of services, and provides additional support personnel to schools to improve and facilitate the provision of services to all children. It has been incorporated as a system wide change process as part of the DOE response to the Felix Consent Decree.

There is no relationship between the system wide change activities provided by the CSSS and the identification of a child as a Felix Class Member. There is no basis for the concern expressed in the draft of the Auditor's Report. Implemention of CSSS will not expand the number of children included within the Felix class to 190,000, as stated by the Auditor.

5. Statement Number Five:

"The State is unable to determine whether maintenance of effort requirements are being met." (page 27, State Auditor's Draft Report)

Response:

The maintenance of effort (MOE) base is the funding and staffing levels as of May 2, 1994 for specified program areas. This base date was meant to assure that the state did not retreat in its commitment. Given the substantial increases in funding which have taken place, MOE is no longer a significant issue.

6. Statement Number Six:

". . . the Department of Health is reluctant to identify the amount of funding related to the Felix consent decree. The health department's reluctance is attributed to the fear that programs only indirectly related to Felix may use

the identification as a means to protect their funding." (page 24, State Auditor's Draft Report)

Response:

There is no issue of reluctance. As discussed in item #2, the DOH has implemented an operational process for identifying Felix class children. Once a child is screened, evaluated and assessed for mental health services, then funds are needed to provide those services to the child. The DOH can then accurately identify the funding related to services under the Felix Consent Decree. Additional costs are incurred in support systems, such as monitoring and training.

It is noted that the DOH did readily agree to provide information regarding general fund appropriations and expenditures related to the Felix Consent Decree. However, when asked to provide such information for non-general funds, the DOH stated that the Court Monitor required the department to report on only general funds and that such non-general fund information was not readily available. The department did subsequently complete spreadsheets reflecting non-general fund appropriations and expenditures. The department did not, however, differentiate between Felix and non-Felix amounts. Funds follow identification not visa-versa. While the department was not precluded from differentiating between Felix and non-Felix amounts, there is no relationship between identifying Felix funding and non-Felix funding under the obligations of the Consent Decree.

In an effort to clarify the Felix-related budget commitments, DOE and DOH are currently working on the development of an "integrated Felix budget" which will provide a more specific explanation of each department's Felix commitments, how the amounts are derived, and shows the complimentarity of services provided by the respective departments. This is intended to assist legislators and other policy makers in strengthening their understanding of the resources associated with the compliance activities.

7. Statement Number Seven:

". . . the Department of Health does not identify the percentage of Felix-related funding in each program. This leads to problems in identifying actual cost." (page 28, State Auditor's Draft Report)

Response:

The case is actually as follows. The DOH recognizes the Felix class as those children who require mental health services or who are

developmentally delayed and require early intervention services in order to benefit from their education.

Although the CAMHD is able to clearly identify which of their clients are Felix and which services are mental health, which of the services provided to ZTT and Infant and Toddler Developmental Program (ITDP) are not currently Felix related. CAMHD can produce the actual cost to providing services to Felix youth. This can be provided in a specific youth by youth count, or summarized in the average cost per youth. This data is routinely provided to leadership and the Court Monitor.

8. Statement Number Eight:
   "Medicaid & QUEST reimbursements have not be adequately pursued." (pages 28-32, State Auditor's Draft Report)

Response:
The DOH has been addressing these issues. Efforts to maximize federal revenues through the Medicaid/QUEST program have been ongoing since May 4, 1998, at which time CAMHD received a memorandum from Ms. Aileen Hiramatsu, Administrator, Department of Human Services (DHS) - Med-Quest Division (MQD), regarding a RFP for QUEST medical plans. Hence, an alternative was presented in which QUEST/Medicaid/Felix eligible children would be "carved-out" of MQD's program and provided with behavioral health services by CAMHD under a sub-capitated arrangement. As a result, the MQD requested a meeting with CAMHD and the Felix Operations Manager. In addition, a summary of all meetings is attached (Attachment "B") which evidences that reimbursement efforts for Medicaid & QUEST have not been "lax", as stated by the State Auditor. At this point in time, CAMHD is prepared to go forward with the QUEST carve-out plan. This is contingent on legislative funding of positions needed by CAMHD to support capacity needs for program implementation.

The DOH and MQD will continue to work together to maximize Title XIX funds through cooperative arrangements for providing and claiming federal reimbursements for services provided to QUEST eligible Felix children. In addition, the Felix OMT will continue to ensure that federal funds are maximized for both Title IV-E and XIX.

9. Statement Number Nine:

   ". . . the court monitor is concerned that the State has yet to develop adequate services to reduce the number of out-of-state placements and has stated that it is too early to determine if the current system is sufficient. (page 34, State Auditor's Draft Report)

Response:

The number of youth receiving services outside the state is actively being addressed. The departments are jointly developing a policy regarding out-of-state placements. This is not simply a CAMHD service capacity issue, but a systemic issue involving all child-servicing agencies. The decisions to send youth out of state are made by the IEP team (which consists of DOE, DOH, parent, providers and other resource persons) or Family Court judges. While we are quickly working to expand local residential capacity, we are also developing systemic policies to guide the process. These policies are currently being developed by a subgroup of OMT.

10. Statement Number Ten:

    "Evaluations continue to be late." (pages 34-37, State Auditor's Draft Report)

Response:

Although the Departments were overdue on about 980 initial evaluations and reevaluations (to determine eligibility per Federal law which requires reevaluation of children every three years by the IEP team) as of January 1998, the DOE is managing to remain current on evaluations in most districts at this time. In addition, the DOH and DOE track the status of evaluations twice a month and takes immediate corrective action for outliers.

More specifically, Maui County DOE/DOH staff worked collaboratively to reduce the number of overdue evaluations and reevaluations from 750 as of 10/18/97 to "0" as of mid-November, 1998.

The data for November 18, 1998 indicated the following status:

District	Overdue Initial Evaluations	Overdue Re-evaluations
Honolulu	4	3
Central	0	0
Leeward	4	2
Windward	12	7
Kauai	0	0
Maui	0	0
Hawaii	8	14
Totals	28	26

11. Statement Number Eleven:
"Agencies do not abide by coordination policy." (pages 40-41, State Auditor's Draft report)

Response:
It appears that there may be some confusion on the legislatives auditor's part between the Felix requirement for each youth to have an IEP/MP care coordinator and the coordinating of services between the two departments. Both departments consistently comply with the Consent Decree requirement of each youth having a care coordinator. System issues are coordinated through the actions and activities of the OMT, the various task groups committees, and sub committees which review all aspects of the provision of services on a continuing basis.

12. Statement Number Twelve:
"Agencies have not collaboratively developed an information system." (page 41, State Auditor's Draft Report)

Response:
The DOH and DOE have been collaborating on an ongoing basis, through its Felix Management Information System Interagency Work Task Group, to develop an integrated management information system to meet the requirements of a Felix Implementation Plan. This task group has determined and documented the database elements that will support and ensure an effective care coordination effort. The technical elements, e.g., communications link, transmission protocol, and database technology, have been established.

The Attorney General's office is assisting the departments in determining the amount and extent of confidential information that can be shared by departments regarding Felix children. Receipt of the final AG opinion will allow the departments to complete the develoment of an integrated system as set forth in the Felix Implementation Plan.

An MIS component called *"100 Day Tracking"* was recently developed for the Child & Adolescent Mental Health Management Information System (CAMHMIS). This component tracks the various dates that a Felix child has been identified, referred from the DOE to the DOH, registered as a DOH client, assessed by the DOH, and officially identified for DOH services. The operational service/billing tracking module of CAMHMIS completes the capture of data necessary to adequately monitor and evaluate the timeliness of the services being provided.

The data captured from this process is sufficient to support case coordination. There is no provision for evaluation or coordinated service planning components in the present system. Without placing undue burden on the schools, the DOE will need a new data system to address those and other issues.

The DOH and DOE have selected technology that is flexible enough to meet the requirements of the Felix Implementation Plan. Timely updating of data will be based on operations policy and is not a technology constraint. The DOH and DOE will ensure that the information shared will be accurate and updated in a timely manner to meet the required objectives.

13. Statement Number Thirteen:
"Quality of services is not monitored." (page 42, State Auditor's Draft Report)

Response:
This is no longer the case. CAMHD provides at least once per year, and for most of the new agencies, much more frequent monitoring of each contract provider agency. CAMHD has clearly defined Clinical Treatment Standards to which each agency must adhere. These standards have been revised and enhanced even further in the next Request for Proposal for services as of July 1999. CAMHD has protocols and monitoring tools to guide the monitoring process. The DOH and DOE are also participating in collaboration with the Court Monitor to evaluate system compliance performance on an individual youth basis (i.e., service testing).

14. Statement Fourteen:
    "The State needs stronger leadership to ensure effective interagency collaboration. In May 1997, the federal court ordered the State to resolve this problem by creating an operational manager position." (pages 42-43, State Auditor's Draft Report)

Response:

The Director of the Health recommended to the Governor and the Board of Education, that an operations manager position be created. The Operation Manager serves as chair of the OMT and coordinates the various compliance activities and initiatives required for achieving compliance with the Consent Decree. The "Delegation of Authority" has been beneficial in precipitating departmental involvement in a more collaborative approach to systems change.

The recent leadership conference where department leadership reaffirmed their commitment to the compliance effort has also resulted in improved responsiveness by departmental representatives to compliance efforts.

15. Statement Fifteen
    "The State's noncompliance necessitates plan revisions." (page 5, State Auditor's Draft Report)

Response:

Pages 5 through 14 present information relating to the Felix Implementation Plan sequence which has taken place over the course of achieving compliance with the various provisions of Section 504 of the Rehabilitation Act, the IDEA and the Consent Decree. The first iteration was approved in October 1995. The plan identified 106 tasks that had to be completed. A review of this plan indicates that 82 or 77% of these tasks have been completed.

A revised Felix Implementation Plan was submitted to the Court and approved in August 1996. This plan was broken into specific Operational Tasks designed to enhance system capabilities to strengthen and develop the operational infrastructure of the departments to facilitate the achievement of system wide compliance with the Decree.

The third version is currently in the process of development. The task of this plan is system wide compliance with the decree within a 24 month time period.

Rather than documenting a failure or failures of the system, the movement from plan one to plan three exemplifies the evolutionary process of moving from the general identification of tasks to be accomplished to infrastructure development and on system wide actualization within a designated time frame.

16. Statement Sixteen

"Compliance is a Moving Target."(page 11, State Auditor's Draft Report)

Response:

Five tasks were identified by the Monitor on August 4, 1998, which had to be addressed for the State to be in compliance with the provisions of the Consent Decree. These were reiterated in the State DOE's response to the DOE Management and Accountability Study submitted on August 28, 1998, and referenced in the Technical Assistance Panel Agreements of September 30, 1998. These five tasks are:

1. The early identification of children with disabilities.
2. The timely evaluation of these children within each child's suspected area of disability.
3. The Comprehensive Service Plan development of an Individual 504 Modification Plan, Individual Education Plan (IEP), or a Coordinated Service Plan required to meet the identified needs of each child.
4. The provision of instructional and related services required to fully implement each child's individual service plan.
5. The outcome based assessment and monitoring of services to ensure the adequacy and quality of the services being provided.

The performance of these tasks will be monitored and assessed on a quantitative and qualitative basis. The quantitative basis for monitoring will be derived from the periodic reporting of student evaluation and determination of eligibility data, school staffing data, and other measures of student performance. The qualitative assessment will be derived from Felix Service Testing as overseen by the Court Monitor.

The above-mentioned clarifications respond to many of the issues raised in the draft report. We welcome the opportunity to provide any additional information that would be responsive to your concerns.

While we have much to accomplish before our compliance objectives are fully addressed, significant improvements are occurring daily which directly affect the quality of care available for Felix youngsters.

It is our belief that the progress resulting from our concerted focus on the needs of Felix youngsters will ultimately bring about systems and practice changes that will benefit all of Hawaii's children.

Sincerely yours,

Linda M. Colburn
Felix Consent Decree Operations Manager

Attachments

cc: Mr. Sam Callejo
Dr. Ivor Groves
Dr. Paul LeMahieu
Dr. Larry Miike

DIR
DD
BRIAN

Felix Monitoring Project, Inc.

for the Felix vs. Waihee Consent Decree

Ivor D. Groves, Ph.D.
Monitor

Lenore B. Behar, Ph.D.
Technical Assistance Panel

Judith Schrag, Ed.D.
Technical Assistance Panel

Juanita Iwamoto, MSW, MPH
Executive Director

July 15, 1998

'98 JUL 15 :41

Mr. Jeffrey Portnoy
Special Master
Cades, Schutte, Fleming & Wright
P.O. Box 939
Honolulu, Hawaii 96808

Re: Felix vs. Waihee Civil No. 93-00367 DAE

Dear Mr. Portnoy:

As a follow-up to my letter of June 24, 1998 to you, I have had discussions with Dr. Miike and his staff regarding the Department of Health's (DOH) concerns about the maintenance of effort issues related to early intervention (Zero-to-Three) outlined in his letter of June 5, 1998.

DOH has agreed to the dollar amount of $2,931,610 which presents 100% of the funding of the Zero-to-Three program and Infant Development programs in the baseline year of FY 1994. In addition DOH has committed that a waiting list will not be maintained for children who have a disability and require services from the Zero-to-Three program and the Infant Development program. If DOH maintains this position, then they will be in compliance with the commitment in the Felix Implementation Plan to not create a dual system of services within the IDEA program for children with disabilities.

The letters you have been receiving are also advocating that children who do not have delays or disabilities but are at risk because of environmental risk factors be included under the Felix Consent Decree. It is my interpretation that the class definition "all children and adolescents with disabilities residing in Hawaii, from birth to 20 years of age, who are eligible for and in need of education and mental health services" does not include children at risk except for childfind and assessment for disability.

The DOH has a draft plan pursuant to the Monitor's recommendations addressing the services for the Part C eligible children who have disabilities.

1314 South King Street
Suite 856
Honolulu, HI. 96814
Tel: (808) 594-0110
Fax: (808) 594-0116

ATTACHMENT "A"

If the DOH confirms that they are in agreement with the understandings as articulated in this letter, then the Zero-to-Three concerns currently at issue have been resolved.

I am hereby requesting that upon confirmation from the DOH, the court order that the recommendations of the Monitor be fully implemented.

Sincerely,

Ivor D. Groves, Ph.D.
Court Monitor

cc: Dr. Lawrence Miike

Quest Issues summarized in 1/98 Status Sheet (Attached).

May 4, 1998 - CAMHD received Aileen Hiramatsu's memo to Tina Donkervoet re RFP for Quest Medical Plans (see Attachment). The "carve-out" alternative was presented as an option for CAMHD to pursue. A meeting with CAMHD and the Felix Operations Manager was requested by MQD.

May 5, 1998 - Lenore Behar's "Review and Recommendations Related to Medical Assistance Funding for Treatment of Children and Adolescents with Mental Health Problems" report was submitted to Jeffrey Portnoy, Special Master. No. 4 recommendation was Sub-capitation/sub-contracting the Quest program to CAMHD.

May 8, 1998 - Meeting was held at MQD. CAMHD staff present at the meeting: Tina Donkervoet, Keith Fujio and Venus Dagdagan. Felix Operations Manager's Office representative present: Eric Rolseth. MQD staff present: Aileen Hiramatsu, Dr. Lynette Honbo and Alan Matsunami.

Aileen explained that MQD was releasing their medical RFP for the period beginning 7/1/99 at the end of 5/98. They said needed to know CAMHD's direction for Quest Felix kids since CAMHD's plans will affect the way they coordinate with their health plans --- and they needed to be clear with the plans. Internally, MQD expressed that the carve-out was the way to go and that borders will need to be defined. According to MQD, the issue of budget neutrality is still a problem. Also, if we enter into a carve-out, CAMHD would be treated like a regular Plan. They would also need assurances that we can meet MQD requirements particularly in the area of QA, reporting requirements and provider credentialing. Dr. Honbo, MQD Medical Director, advised CAMHD that if we cannot do a QA Plan, we should not go the carve-out route because it is a big responsibility to become a health plan.

Tina asked what MQD needed from CAMHD if we were to pursue the carve-out. Aileen explained that these were some of the issues that we need to think about: (1) We need to define what services we will pay for; (2) What line items will be carved-out? (3) How will our reporting system be? (Provider reporting needs to be consistent with the MQD system, following Medicaid procedure codes, etc. (4) How will clients enter and exit the system?

Dr. Honbo and Aileen expressed that it may be best for drugs and probably acute inpatient services to remain with the health plans instead of carving these out. Aileen and Dr. Honbo said that CAMHD would be exempt from HEDIS requirements but that they would expect us to meet all other requirements of a regular Plan.

As for HCFA, Aileen said that they will have another run with their discussions with HCFA to get them to agree to adjust the budget neutrality. MQD will use a different tactic with HCFA. There are some representatives at HCFA who know about IDEA/504

ATTACHMENT "B"

issues who could explain the Felix issue to the regular HCFA staff that MQD works with and this may help.

The 5/98 CAMHD/Quest data match was also discussed. There were about 2200 good matches and 2100 partial matches (mainly due to missing SSNs). Big Island clients were not included.

Venus asked MQD if there is still a chance beginning 9/1/97 for CAMHD to get back the SED Quest capitation contract. The contract went to KHH from 9/1/97. This was an area that Venus has tried to convince MQD to give us back the contract. The answer was "no." Reason: we couldn't give them QA assurances, which was why we lost capitation in all but 2 FGCs and eventually lost the contract.

May 21, 1998 - In an internal meeting with Keith, Rachael Guay and Venus — Tina announced her decision to carve-out Felix clients. Questions regarding excluded services (drugs and acute inpatient) were clarified with Aileen.

June 2, 1998 - Aileen faxed us her first CAMHD section draft in the MQD RFP. Back-and-forth on further clarifications on excluded services took place in 6/98 - 7/98.

July 9, 1998 - Meeting at MQD with Paula Yoshioka, Brian Furuto, Keith Fujio, Venus Dagdagan, AG's office: Russell Suzuki and Cindy Inouye; Chuck Duarte and Aileen Hiramatsu. Issue: strategy for DOH response to Lenore Behar's report.

Chuck Duarte explained the budget neutrality issue. The 1993 baseline did not include services for Felix: (1) Felix consent decree was not finalized in 1993; (2) services did not exist; (3) CAMHD did not bill Medicaid; and (4) kids were not identified ---- therefore, there was no historical data for HCFA to look at.

Chuck and Aileen announced that they will be meeting with HCFA in 8/98 to discuss the budget neutrality formula and try to negotiate a deal. Chuck told the group that they thought that HCFA may reconsider and will be open to renegotiation. Aileen requested for utilization data from CAMHD ASAP. If we choose to carve-out Felix kids who are Quest eligible, Aileen said they will need another waiver and in order to be able to draw down federal funds. budget neutrality needs to be adjusted.

July 13, 1998 - The MQD Medical RFP was released.

Week of August 17, 1998 - Chuck Duarte, MQD Administrator, Aileen Hiramatsu and Steve Kawada from MQD met with HCFA in Baltimore to discuss budget neutrality adjustment and the Felix issue. Prior to their departure, Venus provided Aileen with CAMHD drugs and acute hospitalization utilization data.

August 19, 1998 - First CAMHD Quest Planning meeting was held. The Quest RFP and the carve-out were discussed with CAMHD Central and FGC staff.

August 31, 1998 - The DOH Federal Maximization Response memo was submitted by Dr. Miike to Linda Colburn. The CAMHD carve-out direction was mentioned under Issue 4. The decision on the budget neutrality adjustment is beyond HCFA and is now an OMB decision to make.

August, 1998 - Venus requested Aileen for another system-to-system matching of clients since the first data match from April/May is no longer up-to-date (Quest new enrollment period started 7/1/98) and did not include Big Island clients. Aileen OK's and requested that we work with MQD Systems Officer Randy Chau.

Sept. 29, 1998 - Meeting was held at MQD with MQD Research Officer, Jim Cooper; Jim Efstation, Mary Brogan, Venus Dagdagan, Nona Meyers, Robert Lau, and Susan Nillias. This was preliminary meeting to discuss MQD reporting and MIS requirements for the carve-out per the MQD Health Plan Manual.

Oct. 21, 1998 - Meeting was held at MQD. This was the first CAMHD/MQD meeting after the Quest RFP came out. MQD staff present: Aileen Hiramatsu, Dr. Lynette Honbo, Dr. Wallace Chun (Psychiatric Consultant). Present from CAMHD: Keith Fujio, Jim Efstation, Venus Dagdagan, Alan Shimabukuro, and Nona Meyers.

It was clarified that the MQD contact for data match would be Randy Chau; MQD contact for encounter data and other reporting requirements for Quest carve-out would be Jim Cooper.

Aileen clarified that we do not have to submit a bid/proposal in order to do the carve-out under their RFP. They requested to see the CAMHD RFP (which was being drafted at that time). They said that we need to have a Quality Assurance Plan (QAP) that defines our standards, and if we accept the QAP of our providers, that becomes the standard CAMHD is held to. Aileen and Dr. Honbo will need to review CAMHD definitions of services; who provides the services; who trained these providers; who licensed them; what makes a service therapy? what portion is therapy v.s. R&B? what is our plan for getting providers to comply? Etc. Other specific issues about carve-out operation and what we need to be thinking about and planning for were discussed: communicating with the health plans; grievance and appeals; eligibility; Dr. Honbo's assistance with procedure codes; HCFA's thrust towards quality improvement v.s. quality assurance, etc. Aileen said that the sooner we get requirements to her for review, the better.

Venus asked if Residential Treatment will be included in the carve-out capitated rate. Aileen said yes, and this can be phased in or staggered and we must meet MQD standards.

Venus asked Aileen for an update on the budget neutrality issue. Response: HCFA is still discussing with the OMB. No budget neutrality adjustment has been allowed for any other state. A lot depends on what agreement MQD gets with HCFA. HCFA is

supportive and MQD expects a decision before 6/30/99. HCFA will need to review the first year's historical carve-out data. If the budget neutrality is not adjusted, we may take a hit in the first year. When Venus asked Aileen if MQD will still pursue the carve-out if the request for budget neutrality adjustment is not granted, Aileen said yes, however, CAMHD will have to be capped. Aileen couldn't give an amount but when we threw a $20+ million projected revenue amount, she said there was no way we can expect to get that much. If we get capped, that would mean that even if we billed for so much for a year, if the maximum allowable under the cap has been paid to us, MQD won't be able to pay us any more. But Aileen said that she thinks it's still worthwhile to pursue the carve-out even with a cap because we would be maximizing federal dollars for services whose funding underwriting generally now comes from state dollars. We agreed and Jim shared our general direction and effort at making the carve-out operational and
in the process, also strengthen CAMHD's overall QA and service planning and delivery. Aileen said that a letter will go out to HCFA by the following week. MQD will reject the terms and conditions because they feel that HCFA is responsible for not taking Felix into consideration. Our understanding was that the carve-out will proceed regardless of HCFA/OMB decision.

Oct./Nov., 1998 - CAMHD has been working on the Request for Approval to Establish Exempt Positions to Expedite the Implementation of the CAMHD Quest Carve-out. Draft to Tina and Russell Uchida week of 11/16/98.

Nov. 2, 1998 - CAMHD RFP was released. Carve-out is indicated in the RFP. MQD needs to review.

Nov. 13, 1998 - Carve-out briefing for key CAMHD staff.

Nov. 25, 1998 - CAMHD Quality Improvement Committee meeting scheduled.