Study on the Privatization of the Child and Adolescent Mental Health Program

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

Report No. 99-12
March 1999

THE AUDITOR
STATE OF HAWAII

OVERVIEW

Study on the Privatization of the Child and Adolescent Mental Health Program

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Summary

The Child and Adolescent Mental Health Division of the Department of Health is responsible for providing, and coordinating the effective and efficient delivery of, mental health services to children and youth up to age 17. The division is heavily involved in the State's efforts to comply with the 1994 *Felix v. Waihee* consent decree. This federal court decree required the State to create a "system of care" of educational and mental health services for eligible children and adolescents, consisting of programs, services, and placements and an organizational and managerial infrastructure capable of supporting the system.

From FY1992-93 to FY1996-97, total appropriations for the Child and Adolescent Mental Health Division more than tripled, from over $17 million to over $57 million.

The state General Appropriations Act of 1997 and Supplemental Appropriations Act of 1998 directed the State Auditor to conduct a study on the privatization of the child and adolescent mental health program. In this study, we used the definition of privatization set forth by the U.S. General Accounting Office, that is, any process aimed at shifting functions and responsibilities, in whole or in part, from the government to the private sector.

With much of the State's child and adolescent mental health program being implemented through private organizations, we concluded that the program is highly privatized. The Child and Adolescent Mental Health Division administered over 50 contracts with 26 private and other public providers of services, totaling nearly $30 million—about 50 percent of its total appropriations for FY1996-97. The division's response to the *Felix* decree includes three demonstration projects: the Big Island Pilot Project; the Hawaii Ohana Project; and the Model School Complex (Mokihana Project). These projects have offered varying systems of care to children and adolescents through contracts and subcontracts with private providers. The Big Island Pilot Project contract was recently terminated.

We found that the Child and Adolescent Mental Health Division needs to manage privatized services more effectively. The division has begun restructuring the way it delivers services. To implement the new system, which emphasizes public-private partnerships, the division has decentralized administrative tasks, developed policies and procedures and a contract manual, provided training for staff, and redescribed staff positions. However, consent decree compliance will need continued attention. The division does not yet provide quality assurance or regularly assess the system's programs and services for effectiveness. Staff need additional training and the division's Child and Adolescent Mental Health Management Information System (CAMHMIS) may not meet its needs.

We also found that the inability of the Child and Adolescent Mental Health Division to effectively manage its contracts with private providers is an ongoing problem. Poor contract management controls leave no assurances that quality services are delivered effectively and efficiently by outside providers. The division's new performance-based method of contracting requires increased oversight for which the division is not adequately prepared. The division may not be able to compel contractor performance because it did not finalize clinical treatment standards before issuing its FY1997-98 request for proposals for contracted services. On-site monitoring of all contracts is not conducted regularly, and private providers are not giving the division the information necessary to assess whether services are required or provided.

Also, the division has been remiss in managing the Big Island Pilot Project, Hawaii Ohana Project, and Mokihana Project, raising additional doubts about the division's ability to provide services effectively and efficiently through privatization. Working relationships were unclear, payments were made without proper support, reporting requirements were not enforced, and the division arbitrarily set a contract amount.

Finally, we found that the division has been unable to analyze and control the cost of private provider contract services. An in-house analysis was never conducted to determine the cost-effectiveness of privatization. Also, the division has been unable to project accurately the number of children and adolescents who will require services. Without accurate information, the division cannot determine the costs and benefits of privatization.

Recommendations and Response

We recommended that the director of health ensure that the chief of the Child and Adolescent Mental Health Division takes the steps necessary to ensure effective privatization. Key elements should include a comprehensive evaluation system for quality assurance; additional staff training; and an interagency management information system. The division should also ensure that service authorization requests are valid and that authorized services are actually delivered; finalize clinical standards for assessing the quality of services; coordinate monitoring activities; and require sufficient information from providers.

The division should strengthen its oversight of the Hawaii Ohana and Mokihana projects by clarifying management responsibilities and working relationships. The division should also conduct an analysis of in-house costs to determine if its contracted services are cost-effective, and should improve its method of projecting the population to accurately determine its funding needs.

In its response, the Department of Health primarily provided comments on our findings and on recent reform efforts of the department and the Child and Adolescent Mental Health Division. We are encouraged by some of the efforts that the department reports are underway.

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

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Foreword

This is a report of our study on the privatization of the child and adolescent mental health program in the Department of Health. The study was conducted in response to a directive in Section 57 of Act 328, Session Laws of Hawaii 1997, as amended by Section 57 of Act 116, Session Laws of Hawaii 1998.

We wish to acknowledge the assistance given to us by officials and staff of the Department of Health and others who provided information during the course of the study.

Marion M. Higa
State Auditor

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Chapter 1

Introduction

The Legislature, through a budget proviso in Section 57 of Act 328, Session Laws of Hawaii 1997, amended by Section 57 of Act 116, Session Laws of Hawaii 1998, directed the State Auditor to conduct a study on the privatization of the child and adolescent mental health program. The proviso requires that the study include, but not be limited to, an analysis of current operating procedures, current program effectiveness, cost benefits of privatization, and the effectiveness of privatization.

Background

For many years, Hawaii's public mental health delivery system has been viewed as seriously deficient. In 1994, a class-action lawsuit, *Felix v. Waihee*, forced the State to examine the way in which it delivered services to children and youth. The Department of Health and the Hawaii State Legislature have recently been examining alternative methods of delivering services, which include privatization.

The Child and Adolescent Mental Health Program

The State's child and adolescent mental health program is administered primarily through the Department of Health. Under Chapter 321, Part XV, Hawaii Revised Statutes (HRS), the department's responsibilities include providing preventative, diagnostic, and treatment services for those who are emotionally disturbed, and treatment and rehabilitation services for those who are mentally ill. The services are to be delivered as soon as possible after the need is established.

The law also requires the department to provide all eligible children and youth between birth and age 17 with the mental health services necessary to ensure their proper and full development. Furthermore, the department is responsible for coordinating the implementation of any judgment or settlement in a legal action involving the delivery of children's mental health services.

Section 321-172, HRS, creates a children's mental health services branch in the department to coordinate the effective and efficient delivery of mental health services to children and youth, including services provided by private nonprofit agencies under contract to the department. The branch is also responsible for developing and implementing centralized and highly specialized programs for this target population. In 1989, a reorganization raised the children's mental health services branch to division status.

In May 1994, the U.S. District Court for Hawaii concluded that the State had failed to provide required and necessary educational and mental health services to qualified handicapped children in Hawaii. In October 1994, the court issued the *Felix v. Waihee* consent decree. The decree specifically names the Department of Health as one of the responsible agencies.

The Child and Adolescent Mental Health Division works to ensure the provision of evaluation, treatment, and care coordination services to the following groups:

- certified members of the *Felix v. Waihee* class of plaintiffs;
- youth between the ages of 3 and 21 who the Department of Education is assessing for eligibility for the *Felix* class and require a clinical mental health evaluation;
- youth with life-threatening psychiatric emergencies who are in imminent danger of harming themselves or others; and
- youth who without direct and immediate mental health intervention are imminently likely to become eligible for the *Felix* class.

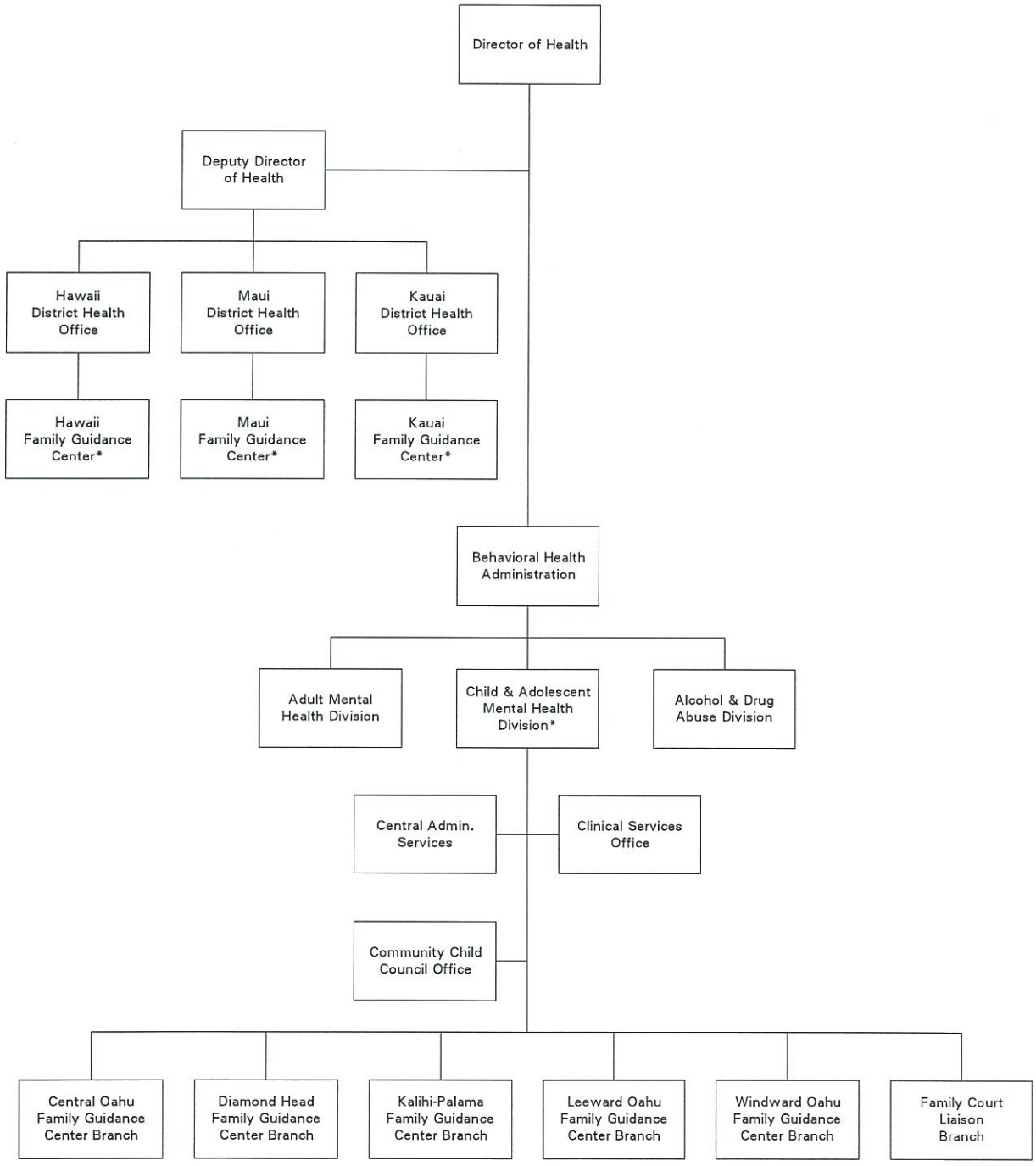
During June 1996, the Child and Adolescent Mental Health Division served 2,857 clients. During June 1997, the division served 5,795 clients.

The Child and Adolescent Mental Health Division is headed by a division chief and includes a central administrative services office, a clinical services office, a community child council office, a family court liaison branch, and five family guidance center branches on Oahu. A family guidance center branch also operates on each of the islands of Hawaii, Maui, and Kauai; each of these centers receives "administrative" supervision from a district health officer of the department and "technical" supervision on clinical matters from the division chief. Exhibit 1.1 shows the division's organization.

The division's budget consists of approximately 70 percent general funds and 30 percent federal, special, and other funds. From FY1992-93 to FY1996-97, the division's total appropriations more than tripled, from over $17 million to over $57 million (Exhibit 1.2).

As part of its total appropriations, the division has obtained emergency appropriations to cover projected shortfalls for the past four fiscal years. During the 1998 legislative session, an emergency appropriation of $9.7 million in general funds was made to cover the division's projected

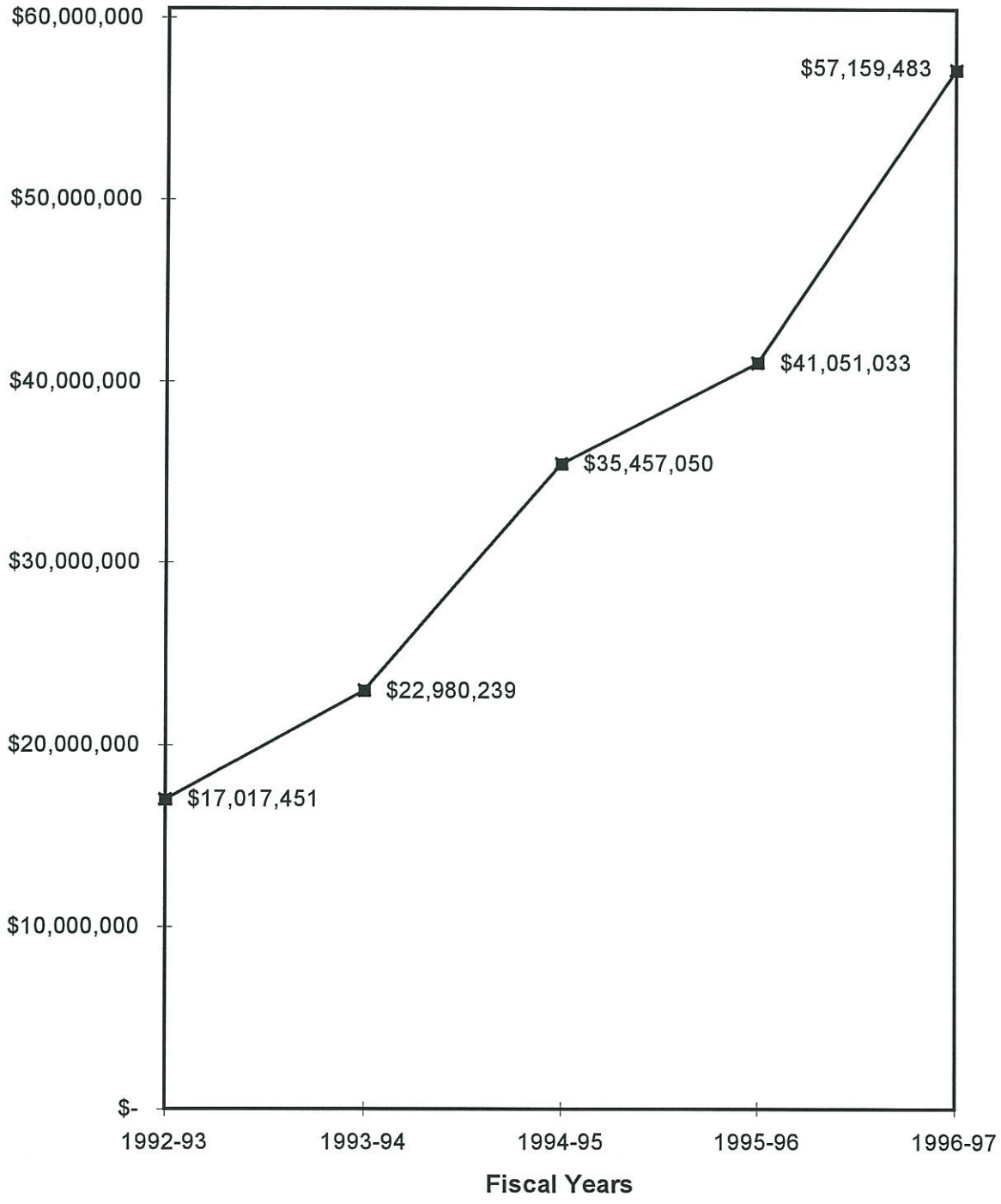
Exhibit 1.1
Organizational Chart of the Child and Adolescent Mental Health Division and Family Guidance Centers



*The chief of the Child and Adolescent Mental Health Division provides "technical supervision" on clinical matters to the Hawaii, Maui, and Kauai family guidance centers.

Source: Organizational charts of the Department of Health (July 1, 1996).

Exhibit 1.2
Child and Adolescent Mental Health Division Appropriations
FY1992-93 through FY1996-97



Source: Department of Health

shortfall for FY1997-98. The division also received emergency appropriations of $6.2 million for FY1994-95, $5.9 million for FY1995-96, and $9.2 million for FY1996-97 to cover anticipated shortfalls.

Privatization of services

For purposes of this study, we used the definition of privatization set forth by the U.S. General Accounting Office, that is, "any process aimed at shifting functions and responsibilities, in whole or in part, from the government to the private sector."[1] Many governments privatize services to reduce costs, solve labor problems, reduce implementation time, provide higher quality services, or provide services not otherwise available. State governments use various models of privatization, such as contracting out for services from the private sector, offering grants to the private sector, providing vouchers to clients to purchase services from private organizations, transferring ownership of assets to the private sector, and managing competition whereby government agencies submit bids to compete with private bidders.

Privatization of mental health services is growing rapidly in the nation. The most popular model is contracting for services, often with community-based organizations. This reflects a trend away from large, centralized health-service programs towards more personal, community-oriented programs.

The Child and Adolescent Mental Health Division administered over 50 contracts with 26 private and other public providers of services, totaling nearly $30 million—about 50 percent of its total appropriations for FY1996-97. Individual contract amounts for FY1996-97 ranged from about $50,000 for individualized services to $5 million for residential treatment services. Six contracts were with the Department of Education and the University of Hawaii to provide a system of care, community-based prevention and intervention, and psychiatric training. Other contracted services include crisis mobile outreach (on-site mental health assessment and intervention, 365 days a year, 24 hours a day, for life-threatening emergencies), brief crisis counseling, emergency residential services, intensive clinical case management, and family treatment services. The division also contracts with out-of-state providers for residential services that it cannot provide in-state. Forty-three children and adolescents from Hawaii were placed in mainland facilities during FY1996-97. Contracts with out-of-state providers for FY1996-97 exceeded $2.5 million.

With so much of the division's program being implemented through private organizations, we believe it is accurate to say that the program is highly privatized.

Response to Felix v. Waihee *consent decree*

On May 24, 1994, the United States District Court for Hawaii found in *Felix v. Waihee* that the Departments of Education and Health 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 federal Individuals with Disabilities Education Act and the Rehabilitation Act of 1973. The court found that the departments were therefore liable to the plaintiffs as a matter of federal law. On October 25, 1994, a settlement was approved by the court.

The consent decree was designed to ensure that the plaintiff class has available to its members the "free appropriate education" they are entitled to under federal law. The decree defines the plaintiff class to include "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 but for whom programs, services, and placements are either unavailable, inadequate, or inappropriate."

The consent decree also requires an Implementation Plan for establishing a "system of care" which includes a continuum of services, placements, and programs following the principles of the Hawaii Child and Adolescent Service System Program (CASSP). The National Institute for Mental Health initiated CASSP in 1984 to provide funding for the development of community-based services for children and youths with emotional problems. Among other things, the consent decree emphasizes the "creation of partnerships" between the Department of Education and the Department of Health and other state and private agencies and individuals who provide related services.

The consent decree recognized that the process will involve complex and fundamental reforms and gave the State six years—the year 2000—to complete the Implementation Plan and make the new system of care fully operational. An Implementation Plan was prepared in accordance with the consent decree and approved by the court in October 1995.

In July 1996, the court approved modifications to the Implementation Plan establishing model programs to help implement the statewide system of care required by the consent decree. The programs established included three demonstration projects: the Big Island Pilot Project; the Hawaii Ohana Project; and the Model School Complex (Mokihana Project). The projects offered varying systems of care to children and adolescents through contracts and subcontracts with private providers. The Big Island Pilot Project contract was terminated after completion of our fieldwork.

Objectives of the Study

1. Describe and assess the recent efforts of the Child and Adolescent Mental Health Division to privatize its services.

2. Determine whether the division has management controls sufficient to ensure that its required services are delivered in a cost-effective manner.

3. Make recommendations as appropriate.

Scope and Methodology

This study focused on the current operations of the Child and Adolescent Mental Health Division and identified the extent of and justification for its move toward privatization. We examined the division's systems of accountability and management oversight with regard to its infrastructure to manage its privatized services. Specifically, we examined the three pilot projects and the division's purchase of services system. We analyzed the division's fiscal activities and examined the adequacy of its measures of cost-effectiveness. We also analyzed the division's system to determine its adequacy for forecasting anticipated costs.

We reviewed national studies on trends in privatization. We interviewed staff at the division's administrative office and selected family guidance centers. We also interviewed personnel from the Big Island Pilot Project, the Hawaii Ohana Project, and the Mokihana Project. We examined the division's mission statements, policies and procedures, expenditure information, plans, position descriptions, and purchase of services contract files.

Our work was performed from May 1997 through January 1999 in accordance with generally accepted government auditing standards.

Chapter 2

The Child and Adolescent Mental Health Division Needs to Manage Privatized Services More Effectively

Chapter 1 of this report showed that the child and adolescent mental health program in the Department of Health is now highly privatized. Chapter 2 presents our findings and recommendations on the effectiveness of this privatization. We concluded that the Child and Adolescent Mental Health Division needs to manage privatized services more effectively.

The Child and Adolescent Mental Health Division has begun to respond to the requirements of the *Felix v. Waihee* consent decree by developing a new system of care that emphasizes public-private partnerships and interagency coordination. The system of care must be fully implemented by June 2000.

To ensure that the deadline is met, the department needs to more fully address several compliance issues. Also, the division has continued to ineffectively manage its contracts. Thus, the division has no assurances that private providers are delivering the contracted services and no means of evaluating their quality.

Weaknesses in managing three demonstration projects—the Big Island Project, the Hawaii Ohana Project, and the Mokihana Project—undermine the division's privatization efforts. Finally, the division is unable to assess whether privatization is cost-effective and to accurately project client population.

Summary of Findings

1. The Child and Adolescent Mental Health Division is developing a new "system of care" required by the *Felix* v. *Waihee* consent decree. Privatization is a key component. However, the division needs to address several compliance issues.

2. Poor contract management controls leave the division with no assurances that quality services are delivered effectively and efficiently by outside providers.

3. The division has been remiss in managing the Big Island Pilot Project, Hawaii Ohana Project, and Mokihana Project. Working relationships

were unclear. Payments were made without proper support, reporting requirements were not enforced, and the division arbitrarily set a contract amount.

4. The division is not yet in a position to analyze and control its costs.

The Division Needs to Improve Its Privatized System of Care

The Child and Adolescent Mental Health Division has recently begun restructuring the way it delivers services in response to the 1994 *Felix v. Waihee* consent decree. To implement the new "system of care" required by the decree which emphasizes public-private partnerships, the division has decentralized administrative tasks, developed policies and procedures and a contract manual, provided training for staff, and redescribed staff positions. However, several compliance issues are unresolved. Staff need additional training and the division's management information system may not meet the needs of the system of care.

Consent decree emphasizes partnerships with private providers

The October 1994 *Felix* consent decree requires the State to create a "system of care" for eligible children and adolescents consisting of the following: (1) a system of programs, placements, and services, and (2) an organizational and managerial infrastructure capable of supporting the system and minimally ensuring that the requirements of the Individuals with Disabilities Education Act, Section 504 of the Rehabilitation Act of 1973, and the principles and standards of the decree are satisfied.

The system of care must satisfy ten principles including the following:

- prompt access to a continuum of programs, placements, and services that provides appropriate educational, related services or early intervention services;
- placement in the least restrictive, appropriate, and normal environment;
- programs and planning that anticipate special needs;
- a seamless delivery of services through integrated programs and planning; and
- integrated planning, financing, and service delivery for overlapping services to link related community service systems.

To meet the ten principles and standards, the decree emphasizes that the Department of Health needs to create partnerships with private agencies and individuals who provide related services to eligible children and adolescents.

The system of care must be fully implemented by June 30, 2000.

Division is working to implement the decree

The decree requires that the State's system of care ensures coordinated services provided by competent and adequately trained staff. The Department of Health must include quality assurance and monitoring to regularly evaluate the system's effectiveness. In addition, regular assessments of the system's programs and services must be made to determine whether they are effective.

The Child and Adolescent Mental Health Division has taken steps to meet the court-ordered requirements. The division has restructured its method of service delivery from fee-for-service contracting to performance-based, unit-cost contracting and prepared division staff for the transition to the new delivery system. Under performance based, unit-cost contracting, services are purchased in measurable units at a fixed rate per unit. According to the division, the change was needed to deal with the increase in clients, to oversee and be accountable for the services delivered, and to have the capabilities to expand with additional private sector providers.

Under the new service delivery method, the family guidance centers have been assigned a different role. Their priority under the *Felix* implementation plan is to coordinate and authorize care rather than provide clinical case management and direct services. Care coordination services help to ensure that necessary services are accessed in a timely and efficient manner. The division now contracts directly with private providers for emergency services, outpatient services, intensive support services, day services, community-based treatment homes, and residential treatment.

Administrative tasks are being decentralized

The consent decree required that services be delivered in community-based settings. In response, the division reorganized in July 1996 and decentralized administrative tasks. It assigned the eight family guidance centers the responsibility of providing high quality, culturally sensitive, and locally-based treatment services to eligible children and adolescents.

The Child and Adolescent Mental Health Division previously operated as a centralized mental health system. The family guidance centers, previously called Children's Teams, served primarily as the division's satellite offices. Decision making about clients occurred at the division level and the teams had virtually no input or accountability.

A 1996 reorganization of the division elevated the family guidance centers to branch status to enable them to become fully operational mental health centers equipped to serve geographic catchment areas parallel to the Department of Education's school districts. New staff were recruited, and each center hired a branch chief, a public health administrative officer, a mental health supervisor, and statistics clerks. The 1996 reorganization was expected to enable the centers to operate more autonomously and to be more responsive to local needs. The division has described the centers as the "linchpin" in the system.

Draft policies and procedures are in place

To prepare the family guidance centers for the July 1, 1997 transition, the division drafted and implemented new policies and procedures to guide the centers in their new role in the increasingly privatized division. As of July 1997, the department had approved the following policies and procedures: support of contract monitoring by family guidance centers, clinical treatment standards, service procurement, care coordination, and accessing services from the division's contract providers. The following policies and procedures related to service procurement have been drafted but have not yet been approved as of completion of our fieldwork: use of flex funds, use of respite resources, and service authorization. Flex funds are specified amounts of money used for traditional and nontraditional services that augment mental health service delivery. Examples of flex fund services include psychotropic medication, interpreters, and special community programs.

The division has also developed a detailed service procurement manual for the family guidance centers and the division's contracted private providers. Policies and procedures for the division's service authorization process went into effect on July 1, 1997. The manual provides the following information:

- the division's service eligibility policy;
- definitions of the 23 available services and resources provided and types of treatment;
- prior authorization requirements;
- defined service units and the maximum units of services that can be authorized for restricted services; and
- criteria for service authorization, continuation of direct services, and discharge from level of care or transfer to another level of care to receive additional services.

In addition, the manual assigns each service an authorization code that is entered into the Child and Adolescent Mental Health Management Information System for billing purposes.

Staff have received training and new position descriptions

The division provided training for family guidance center and division staff in preparation for the July 1, 1997 transition. Family guidance center staff also received new position descriptions.

Service authorization and care coordination training began in March 1997. Except for the Hawaii Family Guidance Center on the Big Island, all family guidance center staff were required to attend two training sessions covering care coordination and service authorization. In June 1997, the division and family guidance centers received additional training on care coordination. Staff also attended sessions on service procurement and the service authorization module of the management information system.

Staff from the eight family guidance centers and the division also recently received training in the following: interagency case planning and care coordination; community team building; case management; understanding mental health needs in children; determining progress/outcomes in services to children; identifying and managing problem behaviors; and working with parents and foster families.

The division also trained contracted private providers about the new system. Providers attended two orientation and training meetings to discuss clinical treatment standards, service authorization and clinical review, contract monitoring, and data entry and billing procedures.

Staff positions previously dedicated to providing services were redescribed in the July 1997 restructuring. Social workers at the family guidance centers, whose duties had included providing direct and indirect "mental psychiatric social work services" to severely emotionally disturbed children and adolescents, have become mental health care coordinators. Psychologists at the centers, who had been providing diagnostic, treatment, rehabilitation, and emergency services to youth, also became care coordinators. With contracted private providers now responsible for providing direct services, the care coordinators are primarily concerned with authorizing, coordinating, and monitoring services.

Contract monitoring manual was developed

The consent decree required that the new system of care include monitoring processes for the Department of Health. In response, the division developed a contract monitoring manual that covers policies and

procedures for program monitoring; fiscal monitoring; payment; Chapter 103D, HRS (Hawaii Public Procurement Code); and administration. These policies and procedures took effect in the summer and fall of 1996. If followed, they are adequate to assess whether providers are in compliance with Chapter 103D, HRS, and with contract terms.

Consent decree compliance will need continued attention

To meet the requirements of the *Felix* decree, some issues will still need to be addressed. The division does not yet provide quality assurance or regularly assess the system's programs and services for effectiveness. Staff need additional training and the division needs to implement its Child and Adolescent Mental Health Management Information System.

Manual needs to ensure evaluation

The contract monitoring manual does not yet address the evaluation of services provided and the effectiveness of providers in delivering services. Consequently, the division is unable to effectively assess the quality of services provided by its private contractors.

Although the division has a policy to periodically monitor and evaluate programs to ensure that the division and the programs are fulfilling contractual agreements, that policy is inadequate. The division relies on contractor-set standards of performance that do not provide the division with enough information to determine contractor effectiveness. Effective contract monitoring requires well-written contracts with clear contractor performance expectations. Performance standards and expectations must be established by the division before issuing a request for proposals (RFP) and must not be set by bidders. However, the division's January 1997 RFP requested bidders to establish well-defined indicators of service quality for 21 services it contracts to private providers.

Following completion of our fieldwork, the division provided us with information indicating that service quality indicators have been developed for its FY1999-00 contracts.

Additional training is needed

Although division personnel have recently received training in service authorization and care coordination, they need additional training for their new roles. According to a key division official, training is an ongoing issue. She wants to make sure that the family guidance centers' care coordinators are not authorizing services without proper documentation. However, we found that some family guidance center staff are authorizing services without proper documentation.

The *Felix* Court Monitor's Office confirms the need for more assessment and service monitoring training for clinical staff. The office points out the need for the division to sort out issues of roles and responsibilities, both interdepartmental and intradepartmental. According to the office, the primary barrier to the division's success is the lack of adequately trained clinical staff who have skills in assessment and service monitoring. The division must take steps to ensure that the system is implemented with solid training.

Management information needs attention

The division has not adequately planned for an interagency computerized database and information system to support the system of care required by the consent decree. The division is currently implementing a Child and Adolescent Mental Health Management Information System (CAMHMIS) that may not meet its needs. With CAMHMIS, the division hopes to achieve a system that will allow it to track client registration, service authorizations, and fiscal data. However, we found that the division has little control over the costs, schedule, and results of CAMHMIS. The division has not developed a budget for the system, continues to make changes to the system based on its modified needs, and constantly revises the implementation schedule.

The division is unable to ensure that all children and adolescents identified as needing mental health services are receiving them. CAMHMIS does not accurately identify eligible clients because Department of Education information on eligible children and adolescents and CAMHMIS are not linked. The centers have encountered problems when clients are registered by the Department of Education but not in CAMHMIS. The centers have the time-consuming task of reconciling the information based on lists provided by the Department of Education. Following our fieldwork, the division reported that the information system will be linked to the Department of Education by December 1998.

The division has also not adequately planned for the inclusion of private providers in the system. CAMHMIS was originally planned for only eight providers; however, 35 providers are currently using the system. Furthermore, because many providers are unaccustomed to working with automated systems, the division must validate the data received from the providers. Without additional training or support from the division, private providers will continue to submit the following types of data errors: invalid service authorization code, total services units billed in excess of units authorized, unauthorized service code billed, and services provided prior to their authorization. The division has acknowledged that it has problems with its management information system.

The Division Continues to Manage Poorly Its Contracts With Private Providers

The division's inability to manage effectively its contracts with private providers is an ongoing problem. Deficiencies in the division's contract management controls leave the division with no assurances that services are delivered or that the provided services are adequate. Furthermore, the division's new performance-based method of contracting requires increased oversight for which the division is not adequately prepared.

The division has a history of poor contract management

Our previous reports and a Department of Health fact-finding report show the division's continuing deficiencies in contract management.

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

A 1994 fact-finding report prepared in response to a request by the deputy director of the Department of Health's Behavioral Health Administration uncovered major deficiencies in the division's procurement practices. The inquiry team found that the division had no policies and procedures and lacked controls over its procurement process. The team also found that the division parceled services into increments under $10,000 in violation of procurement laws. The division also allowed a contractor to work without an approved contract, resulting in the inability to pay the contractor's bill.

Our 1995 *Audit of State Contracting for Professional and Technical Services*, Report No. 95-29, found that the Child and Adolescent Mental Health Division had an inadequate internal control structure to manage its contracted services. Failing to exercise appropriate administrative controls over its contracts had put the State and providers at risk. Clear policies and procedures over authorization of payments to contractors were lacking, and monitoring and evaluation efforts were deficient.

Most recently, our *Audit of the Big Island Pilot Project on Mental Health Services*, Report No. 98-1, found that the division failed to manage its $8.8 million contract with Kapi'olani HealthHawaii to ensure that services were provided professionally and cost-effectively. Critical contract terms were not enforced and public funds were needlessly paid out of the state treasury.

New service approach requires increased oversight

Increased involvement of the private sector requires greater public oversight to ensure that the division's interests are being protected and accountability maintained.

A comprehensive monitoring system to provide adequate oversight has three components: contractor reports, inspections, and citizen/client complaints and surveys. Contractor reports should detail the work completed to date, compare the work with contract requirements and previous contract periods, forecast work for the entire contract period, and describe problems encountered. Inspections may include surprise visits but should not hinder the provision of services. Citizen/client complaints and surveys should be formally documented and should measure the degree of client satisfaction.

An effective evaluation system includes clear and reasonable performance standards. Performance standards are specific indicators of the level of contractor performance. There are several ways to measure whether performance standards are being met, one of which is using output measures. Examples of output measures include the number of street miles cleaned or patient satisfaction with nursing care.

Performance can also be measured by using efficiency or effectiveness measures. Efficiency measures demonstrate how inputs, such as the number of staff or the cost of a program, relate to outputs. Effectiveness measures assess the impact of the service on customers. Efficiency and effectiveness measures are usually better criteria than input or output measures for judging contractor performance.

Division is still not effectively managing contracts

The division is unable to manage effectively its private provider contracts. There is no internal system to determine whether authorized services are actually being delivered or whether delivered services are adequate. Clinical standards for contractor performance are not finalized and on-site monitoring efforts are inadequate. Furthermore, information received from providers is insufficient and providers are exceeding their contracted allotments. The division has failed to protect public resources against fraud, waste, and inefficient use.

There is no assurance that services are delivered

Early indications are that some family guidance centers do not follow policies and procedures to ensure the delivery of authorized services by private providers. Family guidance center care coordinators are responsible for ensuring that clinically indicated services are delivered and coordinated. Care coordinators are required to contact the assigned contract clinician after the appointment date to verify that services were rendered. The coordinators are also required to confirm that services were provided by contacting client families to verify their satisfaction with the services provided.

Some care coordinators authorize services without following up with the provider or client's family. One care coordinator, while aware of this

responsibility, acknowledges that he has not done this yet. Our case file review at one family guidance center confirms that its care coordinators are not following division procedures. The 18 case files that we reviewed contained no evidence that a care coordinator from the center made any contact with the family or service provider to confirm service delivery.

We found indications that some private providers are not providing the services authorized. One center staff member stated that some private providers may not be providing necessary services for children who are classified high priority. The division chief stated that the division still does not have a clear picture of authorizations versus services actually delivered. One center reports that at least three clients have not received authorized services for family treatment from one of its providers.

There is no system to evaluate quality

The division is unable to determine whether contracted services are adequate and effective. The division's Quality Management Office has not fulfilled its responsibilities. The Quality Management Office is responsible for the development, implementation, and monitoring of a division-wide, structured system for continuous organizational improvement. The office oversees program and clinical service standards to ensure high quality, timely, and cost-effective treatment services; it also develops mechanisms to assess utilization of services and the extent to which they meet the needs of clients and their families.

The division's only mechanism for verifying the quality of contracted services is contact with client families via telephone or survey. Care coordinators are required to contact families to verify service satisfaction; however, as discussed above, there are indications that this is not being done. The division's care coordination procedure is too general to assess the quality. It only requests the care coordinator to conduct regular reviews of the effectiveness of services. Although the division has developed client satisfaction surveys, they are not yet standardized. The division is in the process of standardizing the surveys so that results among different providers can be compared.

Quality assurance deficiencies are not new. In 1996, the division lost its Medicaid QUEST capitated monthly payment agreement. Under the agreement, the division was paid a set amount per QUEST recipient receiving mental health services through the division. However, the division failed to meet the federal Health Care Financing Administration's 16 standards of quality. The interagency agreement between the Department of Human Services and the division was amended to allow centers that met the standards to continue capitated monthly payments for QUEST clients. All other centers would revert to a fee-for-service payment methodology. A new agreement was reached in early 1997 under which all centers except Kauai and Windward would be paid on a fee-for-service basis.

The division asserted that quality is important but acknowledged that it did not yet have sophisticated measures of effectiveness. The division's top priority was to ensure that clients had accessible services; poor services were viewed as better than no services. However, we believe that the division needs to more actively ensure quality.

Following our fieldwork, the division showed us that measures of effectiveness have been developed for its FY1999-00 contracts.

Clinical standards are pending

The division did not finalize clinical treatment standards before issuing its FY1997-98 RFP for contracted services. Without appropriately detailed performance expectations, the division may be unable to effectively compel and evaluate contractor performance.

The division should have finalized its clinical treatment standards prior to awarding any contracts. Standards serve as guidelines for private providers in the development and execution of mental health services to Hawaii's youth. Without the standards, the division has relied on its clinicians to establish standards according to federal regulations and guidelines and on unwritten standards considered common knowledge among those in the mental health clinical community. The division must finalize and implement its clinical standards to ensure that private providers are held accountable for the services they provide.

On-site monitoring is insufficient

The division is not conducting on-site monitoring regularly. The policies and procedures require annual fiscal monitoring of all contracts to ensure fiscal compliance and to evaluate the appropriateness of expenditures. However, the division has not monitored all FY1996-97 contracts for fiscal appropriateness.

Of the 14 contract files we reviewed for FY1996-97, the division monitored only five for fiscal compliance. The division found that two of the contractors were inappropriately charging expenditures to their contracts with the division. In one case, the contractor was required to reimburse the State for inappropriate payroll charges in excess of $9,500. The division found that another private provider was inappropriately charging expenditures for staff members to the division contract through the contract's petty cash fund. Without an on-site fiscal review of its contracted private providers, the division is unable to determine whether charges being made to its contracts are reasonable or appropriate.

Information from providers is inadequate

Private providers are not giving the information necessary to enable the centers to assess whether services are required or provided. As of July 1, 1997, all providers must submit monthly client reports, fiscal reports, and program performance reports and quarterly activity reports summarizing their major activities. The quarterly reports enable the division to review the progress of the services specified in the contracts. However, one center has encountered problems when private providers request the continuation or extension of service authorizations but do not give timely feedback regarding clients. The center reports that many providers simply call for an extension of services without submitting the required progress reports.

Without timely submittal of the required information, care coordinators are unable to authorize necessary services. According to the division's policies and procedures, care coordinators must receive a client's mental health evaluation conducted by a contract provider prior to authorizing services. However, centers reported delays in getting evaluations from providers and initiating services. Centers on the islands of Hawaii and Kauai have reported problems with receiving necessary information from private providers.

Poor Management of Demonstration Projects Further Undermines Privatization

The division had established three demonstration projects as model programs for the State's system of mental health care for children and adolescents. The division's failure to adequately manage the three demonstration projects raises additional doubts about the division's ability to provide services effectively and efficiently through privatization. The projects, which were established in the July 1996 modifications to the *Felix* implementation plan, were elements of the division's movement toward privatization. The Big Island Pilot Project, Mokihana Project, and Hawaii Ohana Project offered varying systems of care to children and adolescents through contracts with Kapi'olani HealthHawaii, the University of Hawaii, and the Department of Education and subcontracts with private providers. (The Big Island Pilot Project contract was terminated in October 1998.) The projects were jeopardized by the division's inability to develop clear working relationships and by other management weaknesses.

Description of demonstration projects

Big Island Pilot Project

The Big Island Pilot Project was established by the division to evaluate alternatives to the current system for providing child mental health services. A contract with Kapi'olani HealthHawaii, a nonprofit corporation, took effect on October 1, 1996. Under terms of the contract,

Kapi'olani HealthHawaii provided administrative services to the division and contracted with private providers for an array of direct services on the island of Hawaii. The project received about $8.8 million in general funds for FY1996-97. The contract with Kapi'olani HealthHawaii was extended through FY1997-98 for $9.4 million. As of June 1997, more than 1,500 children had been identified as eligible to receive services from Kapi'olani HealthHawaii.

The last contract with Kapi'olani HealthHawaii ran through June 30, 1999; however, the contract was prematurely terminated by mutual agreement in October 1998. Services have been transitioned to the model currently utilized by the rest of the State.

Hawaii Ohana Project

The Hawaii Ohana Project is designed to develop and demonstrate systems of care for children with serious emotional disturbances. It is funded through grants by the Center for Mental Health Services of the U.S. Department of Health and Human Services. It covers two of Hawaii's nine mental health catchment areas: Leeward Oahu and Waianae. The Department of Health receives the federal funds and contracts with the University of Hawaii to provide technical assistance, research expertise, human resources development, and program development to help implement the project. The university, under the terms of its contract with the department, develops subcontracts with private providers for family support services, administrative and fiscal services, therapeutic foster care services, and home-based crisis services.

Originally awarded at $18.3 million in federal funds for a five year period, the Hawaii Ohana Project received about $1.0 million for its first year (September 30, 1994 through August 31, 1995), $3.0 million for its second year, and $3.2 million for its third year. For its fourth year of grant funding (September 1, 1997 through August 31, 1998), the project received $3.5 million. It served 358 clients during FY1995-96.

Mokihana Project

The Mokihana Project, which began in November 1996, is a "geographically integrated" mental health delivery system operated by the Department of Education and the Department of Health on Kauai. The project provides a school-based system of mental health care through the Department of Education's Kauai District Office in cooperation with the Kauai Family Guidance Center. The Department of Education is responsible for providing emergency, outpatient, intensive support, and day-program mental health services to eligible children through subcontracts with private providers. The Kauai Family Guidance Center is responsible for authorizing all services on Kauai including those for the Mokihana Project. The project received $197,966 in general and special

funds for the contract period November 1, 1996 through June 30, 1997 and $1.0 million in general funds for FY1997-98. As of June 1, 1997, the Mokihana Project served 366 clients.

Working relationships have been unclear

Working relationships for the demonstration projects have been unclear.

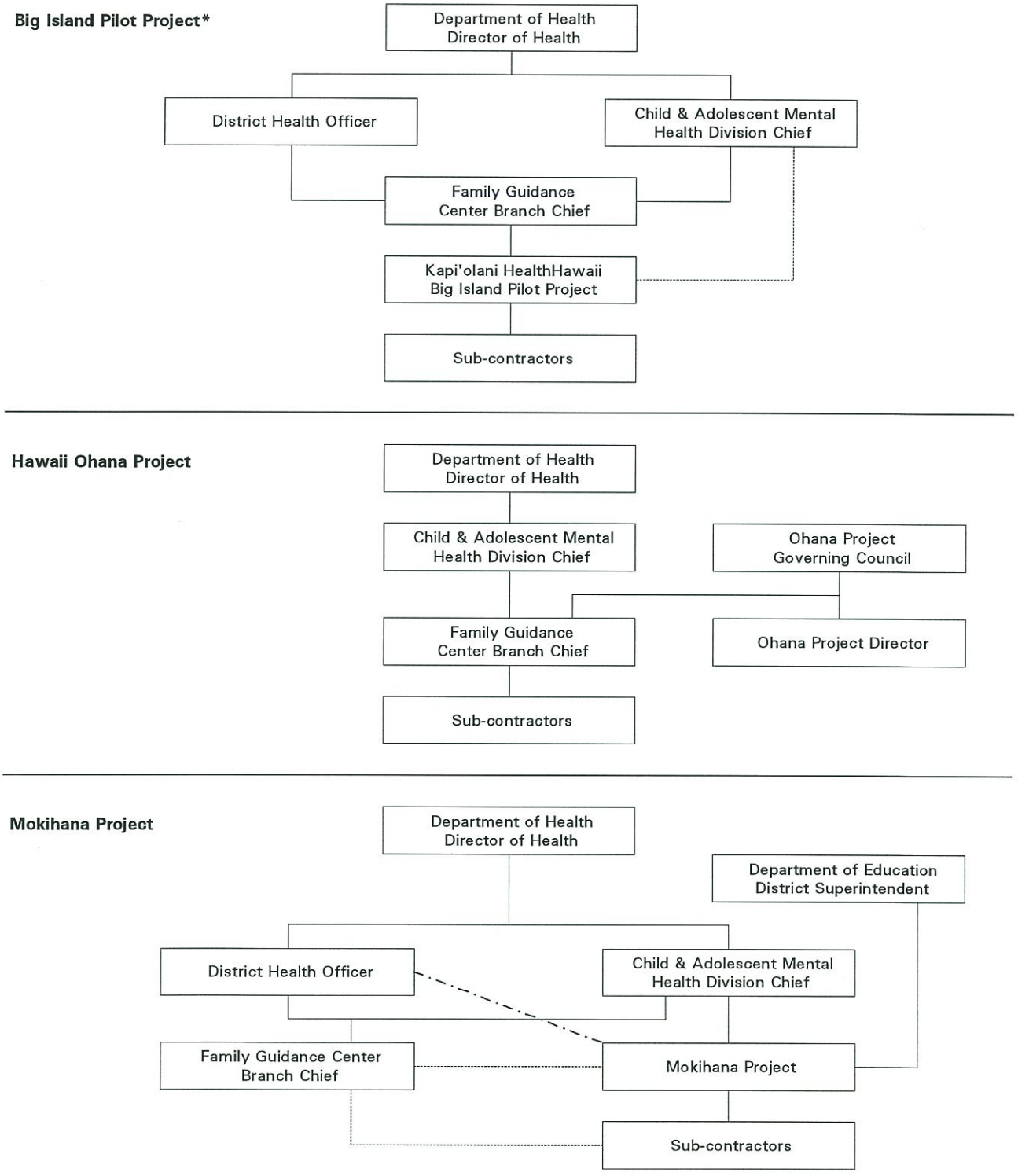
Exhibit 2.1 shows the organization of the projects.

The family guidance centers are trying to clarify their roles under the July 1, 1997 transition and the demonstration projects. Project administrators and the center chiefs are not sure about their management responsibilities. Prior to July 1, 1997, the Leeward Family Guidance Center had direct oversight of day-to-day operations of the private subcontractor of the Hawaii Ohana Project, and center staff and private provider staff worked side-by-side. Center staff took direction from the Hawaii Ohana Project administrator. With the transition, the center now has management oversight over the project's subcontractors. Furthermore, the project administrator no longer has authority over the center and is unclear about her and the center chief's management responsibilities. Instead, a Governing Council made up of representatives from the community, families, youth, the Child and Adolescent Mental Health Division, the Department of Education, the Family Court, and the Department of Human Services has oversight of the center and the Ohana Project Office.

The role of the Kauai District Health Office further complicates the organizational structure and responsibilities of the Family Guidance Center in the Mokihana Project. The District Health Office is still trying to resolve its relationship with the Mokihana Project; however, the division has asked the district health officer to monitor the project. The District Health Office also expressed concern that responsibility for the center and project are split between the center chief and project director, believing that one person should be ultimately responsible for both the center and the project because they are integrated. Mokihana staff include Kauai Family Guidance Center staff, Department of Education Kauai District Office staff, and Department of Education-contracted staff. Department of Education employees are responsible for authorizing services to subcontractors, but authorizations must first go through the center chief.

According to the division, the Hawaii Family Guidance Center chief's role, function, and relationship under the Big Island Pilot Project was continuously evolving and changing.

Exhibit 2.1
Organization of Big Island Pilot, Hawaii Ohana, and Mokihana Projects



*The Big Island Pilot Project contract was recently terminated.

Projects have had other management weaknesses

The demonstration projects have had other management problems. The division made payments without verifying expenditure data, failed to enforce reporting requirements, did not adequately monitor its providers, and arbitrarily set the contract amount for one of the projects.

Payments made to Mokihana Project without proper support

The division made payments to the Mokihana Project in excess of $190,000 without determining the appropriateness of reported expenditures. The contract between the division and the Department of Education requires the latter department to submit quarterly reports of expenditures incurred for services provided. Upon submittal of these reports and invoices for services provided, the division makes quarterly advance installment payments. However, we found no evidence that the Department of Education filed any quarterly reports for the contract period November 1, 1996 to June 30, 1997.

About six weeks *after* the 1996-97 contract period ended, the division detected that expenditure reports were missing. The division then wrote to the Mokihana Project director requesting data on contract expenditures through June 30, 1997. The amounts paid to each provider, their hourly rates, and copies of provider invoices were also requested. The division suggested September 26, 1997 as a tentative review date to determine the appropriateness of expenditures incurred during the previous contract year—three months after the close of the fiscal year.

Nonetheless, the division extended the Mokihana contract for another year without reviewing the FY1996-97 expenditure information it requested. Without any information on how the $190,000 in contract funds were used, the division signed a contract extending the Mokihana Project through FY1997-98 for $1.0 million. In addition, the $1.0 million contract amount was arbitrarily set based on the division's best guess of contract costs and its concept that the Department of Education is a "major provider." The division had no historic data on this project, but assumed it would provide services in excess of the $1.0 million.

Reporting requirements not enforced for Big Island Pilot Project

The division failed to ensure that Kapi'olani HealthHawaii submitted information required by the contract.

Kapi'olani HealthHawaii was required to submit monthly fiscal and program performance reports. The reports were to include the work accomplished, number of clients served, and services provided. Kapi'olani HealthHawaii was also required to submit monthly service reports with the following information: client name, diagnosis, insurance coverage, insurance billed, insurance paid, service provider, unit cost,

paid units of service, and authorized but unpaid services. However, the division failed to discover that Kapi'olani was not submitting all required information until it conducted an on-site monitoring visit two weeks after the original contract period ended.

The division must be more vigilant in enforcing all reporting requirements. Kapi'olani HealthHawaii failed to submit information on the paid units of service and authorized but yet to be paid services. Without this information, there was no way to determine if claims had been paid for individual clients except through a very detailed fiscal audit. The only information provided by Kapi'olani was an annual report of total provider payments from October 1996 to June 1997.

Kapi'olani was also required to submit monthly information on client insurance, including the amount billed, paid, and retained. However, the division discovered that Kapi'olani never included any insurance information in its monthly reports. Unless a detailed fiscal audit is conducted, the division is unable to determine if a client's insurance has been billed or if insurance claims were paid. Without monthly service reports, the division was unable to determine what kind of services an individual child received. Kapi'olani had provided information only on the services and funds authorized, but not on the services provided and paid for. According to the division, Kapi'olani had never met the requirements for monthly service reporting for individual children as outlined in the RFP.

In our *Audit of the Big Island Pilot Project on Mental Health Services,* Report No. 98-1, we found that the division continued to advance quarterly payments to Kapi'olani even though it did not receive the required reports. As a result, the audit found that the division's payments to Kapi'olani exceeded Kapi'olani's expenditures for services during the October 1996 to June 1997 contract period by between $2.3 and $3.5 million.

In addition to finding that the division had been derelict in its management of the contract with Kapi'olani, the audit found that the division had not enforced quality assurance requirements for services, had disregarded its fiscal responsibilities, and had implemented the project hastily without adequately coordinating with other agencies involved in meeting the needs of eligible children. As a result, coordination problems had delayed services. The audit concluded that drastic steps need to be taken to improve the division's contract management practices—particularly with respect to its management of the Big Island Pilot Project.

Ohana Project FY1996-97 contract not fiscally monitored

According to the division's contract monitoring manual, fiscal monitoring is the evaluation of the appropriateness of expenditures through either a

desk review or an on-site visit. The division has not conducted fiscal monitoring of the Ohana Project since contract year 1994-95. The division must conduct monitoring of all contracts annually. We found that the division failed to monitor the project fiscally to evaluate the appropriateness of expenditures. Although the then-division chief planned to monitor the project in early July 1996, a review of the project's files revealed that this was never done. The lack of adequate fiscal monitoring may result in the use of federal grant funds for expenditures inappropriate under terms of the grant.

Privatization Costs Are Not Well Analyzed and Controlled

The division has been unable to analyze and control the cost of private provider contract services. An in-house cost analysis was never conducted to determine the cost-effectiveness of privatization and the division has been unable to make accurate population projections. Without accurate information, the division cannot determine the costs and benefits of privatization.

Division failed to analyze in-house costs

Without an analysis of in-house costs of providing services, the division is unable to determine whether the performance-based contracted services will be cost-effective. The division never conducted a formal study of in-house costs prior to making the decision to contract with private providers to deliver services. Reliable and complete cost data on government activities are needed to ensure a sound competitive process and to assess overall performance. Reliable and complete data simplify decisions and make those decisions easier to implement.

To determine the total cost of providing a target service in-house, the division must identify the direct costs of providing the service and its proportional share of overhead costs or indirect costs. Direct costs include staff salaries, fringe benefits, supplies, and travel. Direct costs frequently overlooked include interest, pension, facility, and equipment costs. Indirect costs are expenses such as supplies, printing, rent, and utilities that benefit the target service.

Without an accurate assessment of in-house costs, the division has been unable to make informed decisions regarding privatization.

Division is unable to make accurate population projections

The division has been unable to accurately project the number of children and adolescents who will require services. In January 1997, the division projected the following increases in the number of children eligible for *Felix*-related mental health services per year:

- 174 verified Individual with Disabilities Education Act (IDEA) *Felix* children, excluding the island of Hawaii;
- 117 unverified IDEA *Felix* children, excluding the island of Hawaii;
- 1063 non-IDEA *Felix* children, excluding the island of Hawaii; and
- 763 additional *Felix* children on the island of Hawaii.

In January 1997, the division also projected that the number of children and youth in the *Felix* class would be 4,720 on July 1, 1997 and 6,837 on July 1, 1998. However, the division underprojected the *Felix* population by as much as 36 percent. On July 1, 1997, 7,390 children and youth were actually registered with the division—2,670 more than what was projected in January 1997. On July 1, 1998, there were 6,837 registered clients—1,105 more than the division's original estimate. Without accurate projections of the number of clients, the division is unable to accurately project its funding needs.

Conclusion

The Child and Adolescent Mental Health Division began restructuring to respond to the 1994 *Felix v. Waihee* consent decree. In order to fulfill the requirements of the decree and meet the needs of the State's target population, the division chose to increase the already substantial involvement of the private sector in delivering services. While this restructuring effort reveals that the division has begun to accept its responsibilities under the consent decree, its ability to effectively manage privatized services is unproven.

Results of privatization are questionable

The division cannot currently assess the costs, benefits, and effectiveness of privatization. The division's failure to manage its private provider contracts results in no assurances that authorized services are being delivered or that the services actually being delivered are adequate. Monitoring of contract providers and enforcement of reporting requirements are lax. Furthermore, without conducting an in-house cost analysis, the division is unable to determine whether privatizing services is cost-effective. Problems with the division's oversight of its contracts point to weaknesses in the State's system of care that could result in a failure to serve Hawaii's children and adolescents.

Recommendations

The director of health should ensure that the chief of the Child and Adolescent Mental Health Division takes the steps necessary to ensure effective privatization as follows:

1. The division should address all *Felix* compliance issues. Specifically, in implementing its new "system of care" the division should:

    a. integrate a comprehensive evaluation system for quality assurance in its contract monitoring manual;

    b. provide additional training for staff to prepare for a smooth transition; and

    c. prioritize the implementation of an interagency management information system.

2. The division should establish a comprehensive contract management process. Specifically, the division should:

    a. implement checks and balances to ensure that service authorization requests are valid and that authorized services are actually delivered;

    b. finalize clinical standards for assessing the quality of services;

    c. coordinate monitoring activities among the different sections within the division and the family guidance centers; and

    d. enforce accountability requirements for services by requiring sufficient information from providers.

3. The division should strengthen its oversight of the Hawaii Ohana and Mokihana projects by clarifying management responsibilities and working relationships.

4. The division should conduct an analysis of in-house costs to determine if its contracted services are cost-effective. The division should also improve its method of projecting population to accurately determine its funding needs.

Notes

Chapter 1

1. U.S., General Accounting Office, *Privatization: Lessons Learned by State and Local Governments*, GAO/GGD-97-48, March 1997, p. 1.

Response of the Affected Agency

Comments on Agency Response

We transmitted a draft of this report to the Department of Health on February 22, 1999. A copy of the transmittal letter is included as Attachment 1. The department's response is included as Attachment 2.

The department's response begins by questioning the timeliness of our report. In its response, the department points out that our office was initially to provide the study to the Legislature no later than 20 days prior to the 1998 regular session. However, the department failed to mention that the Legislature subsequently extended the due date to no later than 20 days prior to the 1999 Legislature. While our work was performed from May 1997 to January 1999, we reaffirm that our work was performed in accordance with generally accepted government auditing standards.

The department's response focuses primarily on the *findings* in our draft report and on recent reform efforts of the department and the Child and Adolescent Mental Health Division. The department's response agrees with the need to continually address compliance issues and integrate a comprehensive evaluation system. Also, the department acknowledges that it did not conduct a formal study of in-house costs prior to deciding to contract with private providers. The department indicates that reliable and complete cost data was not available at the time and the division's infrastructure was known to be inadequate, and therefore, such a study was not seen as valuable.

The department's response also says that it has made progress in various areas discussed in our report, including contract management and training. We appreciate the department's statement of its commitment in these areas.

The department says we were inaccurate to say that the monitoring of services over the past year has been insufficient. It is not clear which parts of our report the department is referring to. However, we note that our finding regarding insufficient on-site monitoring covers FY1996-97 contracts, not the past year. As our report points out, only about one-third of the FY1996-97 contracts we reviewed were monitored for fiscal compliance.

In addition, the department describes as inaccurate our finding that enforcement of reporting requirements is lax. However, the department's response on this point is vague, general, and unconvincing. The response focuses on plans for corrective action, the developing nature of the system, the dynamic process of quality improvement, and the importance of working in partnership with provider agencies.

The department also describes as incorrect our finding regarding division policies for service procurement, use of flex funds, and respite resources. We disagree. As of the end of our work, such policies for service authorization, use of flex funds, and use of respite resources were still in draft form and not officially approved.

Also, the department disagrees with our finding that there is confusion about the reporting relationships as related to the Ohana Project and notes that there is no confusion regarding the authority of the branch chief in relation to this federal grant. However, our report focused primarily on management responsibilities and working relationships.

The department describes as inaccurate our finding that quality assurance requirements were not maintained during the Big Island Pilot Project. However, our *Audit of the Big Island Pilot Project on Mental Health Services*, Report No. 98-1, found that the division did not enforce a contract requirement that the contractor establish quality assurance controls over the project's subcontractors. The division allowed the contractor to neglect its oversight responsibilities for its subcontracted providers. Providers did not follow the timeliness and reporting requirements for their services, many providers' credentials were not checked, and the contractor delayed its quality management activities.

Finally, we are encouraged by the department's response that a *Felix* management information system is being developed to integrate data from the Child and Adolescent Mental Health Division with Department of Education data. We are also encouraged by the department's response that it is in the process of implementing a benefits verification procedure, has begun tracking some outcome and quality data, has developed a statewide minimum data set of agreed-upon outcome measures, and has extensive staff training efforts in place.

We made some editorial changes to the draft report for purposes of clarification.

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

February 22, 1999

COPY

The Honorable Bruce S. Anderson
Director of Health
Department of Health
Kinau Hale
1250 Punchbowl Street
Honolulu, Hawaii 96813

Dear Dr. Anderson:

Enclosed for your information are three copies, numbered 6 to 8 of our draft report, *Study on the Privatization of the Child and Adolescent Mental Health Program*. We ask that you telephone us by Wednesday, February 24, 1999, 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 Wednesday, March 3, 1999.

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

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

Sincerely,

Marion M. Higa
State Auditor

Enclosures

ATTACHMENT 2

BENJAMIN J. CAYETANO
GOVERNOR OF HAWAII

BRUCE S. ANDERSON, Ph.D., M.P.H.
DIRECTOR OF HEALTH

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

In reply, please refer to:
File:

March 3, 1999

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

Dear Ms. Higa,

Thank you for this opportunity to respond to the draft report entitled ***Study on the Privatization of the Child & Adolescent Mental Health Program***. While the Department appreciates the value that this report would have offered, the Department has concerns that this audit report does not conform to generally accepted government auditing standards on timeliness of reports. Initially, the Auditors Office was to complete and provide the study no later than twenty days prior to the convening of the 1998 regular session of the Legislature. According to the draft report, the Auditor's Office commenced work in May 1997 through January 1999, a period spanning twenty-one months.

During this time the Department had begun to undertake significant reforms in its child and adolescent mental health programs. Essentially, this report affirms that the Department is on target with its efforts to improve the service delivery system for child and adolescent mental health programs. Unfortunately, this report is crafted as a collage of findings spanning different time periods and previous audit reports, rather than a cohesive document with clear findings and recommendations. Given the progressive changes that have occurred within the Child & Adolescent Mental Health Division during this time period it is somewhat difficult to respond to the broad array of feedback.

Given the complexity of the issues related to the Felix Consent Decree and the magnitude of changes that were necessary within the Child & Adolescent Mental Health Division to work toward compliance, it is understandable that conducting this study was a tremendous and challenging undertaking for the Auditors' Office. However, given the Auditor's previous experience with auditing the Division, we are surprised that the feedback from the Auditor's Office was not more timely, precise and productive.

The Child & Adolescent Mental Health Division has implemented major management reforms in the last year and a half in order to aggressively pursue compliance with the Felix Consent Decree, and has made significant progress during this time. The Department agrees that compliance issues need to be continually addressed and as evidenced by the Felix Implementation Plans, there are specific benchmarks and timelines to support and guide our efforts. There are some specific findings and comments made in the report that would benefit from correction or clarification. These are described as follows:

Contract/Performance/Quality Management
The report identifies that the Division has demonstrated poor contract management with no assurance that quality services are delivered effectively and efficiently by outside providers. This is a definitive area where significant changes have occurred during the last 21 months. While this may have been a significant finding in May 1997, the Division has now implemented specific actions to address the issues raised.

The Division has clinical standards which have been accepted by the provider agencies and the communities that have been utilized for contract monitoring processes for fiscal years 1997-1998, and 1998-1999. Based on the piloting of these standards, CAMHD adopted a new set of standards that have been finalized and distributed with the Request for Proposals for services effective July 1, 1999. The contract monitoring process allows for the verification of service delivery by taking a sampling of accepted records and comparing with actual provider documentation. It is inaccurate for the Auditor to state that the monitoring of services over the past year has been insufficient.

Under the Felix Consent Decree there is a comprehensive monitoring system that extends beyond the monitoring of contracts. There are other levels of review, both internal and external. Internal reviews for quality include review of mental health assessments, treatment plans, treatment team and IEP meetings. External reviews for quality include Service Testing, development of care through the Community Children's Councils, Felix Technical Assistance Panel, and monitoring by the Felix Monitor's Office for compliance with the consent decree implementation plans.

In addition to monitoring, we are implementing a benefits verification procedure to include parents in verifying the service delivery as billed by providers.

We have begun tracking some outcome and quality data in accordance with the Felix Quality Outcomes Implementation Plan. The Division is a strong participant in service testing, the Court Monitor's methodology for assessing the effectiveness of the system in meeting the needs of the Felix youth. There are other checks and balances in place including the development of quantitative indicators by the Felix Monitor's Office, review of assessment

timelines, treatment plans as they pertain to the IEP process, and the Felix Complaints Resolution Office.

The Auditor's finding that enforcement of reporting requirements are lax is inaccurate. We have clear plans for corrective action. This is a developing system and both CAMHD and the provider network are working to meet full compliance. Quality improvement is an on-going and dynamic process. We **choose** to take remedial action and work in partnership with provider agencies to improve the quality of services rather than close down agencies.

CAMHD agrees that there is a need to integrate a comprehensive evaluation system. Along with the Felix Monitor's Office we have developed a statewide minimum data set of agreed upon outcome measures. We will be using this core data set of elements as part of the evaluation system.

Population Projections/Cost Analysis
The report states that Division has not accurately projected its population and has not accurately analyzed its cost. The initial population projections did not provide for growth. As a Division we were acutely aware of the increasing population. Government budgeting methods generally do not recognize this. The Division's current projections use a regression analysis to project population growth. CAMHD is now using current utilization data for cost projections.

It is correct that the Division did not conduct a formal study of in-house costs prior to making the decision to contract with private providers. Reliable and complete cost data was not available at the time, and the Division infrastructure was known to be inadequate; therefore, it was not seen as a valuable exercise.

Efforts are underway to transition lower intensity services to the school. However, the complexity of these issues require that this transition be carefully planned with a clear plan for oversight. The Division will evaluate in house costs as we move forward with the implementation of school based services.

Training
Another specific concern raised involved the training in skills assessment and service monitoring. The training needs of all mental health professionals in this system is widely known and accepted by stakeholders involved in the Consent Decree. For this reason, there is a jointly funded Felix Staff Services and Development Institute and objectives in the Felix Implementation Plan to coordinate, conduct, and monitor the effectiveness of all training related to Felix Consent Decree services. Much training has occurred in the last year in the

areas of assessment, case management/coordination, and direct treatment services. Extensive training efforts are in place for the next 18 months.

Information System Design
The findings related to the Child & Adolescent Management Information System (CAMHMIS) are perplexing. The Auditor seems to be confusing the CAMHMIS system and the Felix Interagency MIS that exist separate from one another. As it relates to CAMHMIS, the Department has submitted a biennium budget that includes a request to stabilize the MIS infrastructure. It is accurate that prior to May 1997, the Division did not have an information system. CAMHMIS has been established to meet the needs of the Division and consent decree. It is providing us with clear registration, demographic, and service data. The Felix MIS is a warehouse in development to integrate CAMHD data with DOE data. The Felix MIS is required by the Felix Implementation Plan for which the Departments of Health and Education are jointly responsible for and at this time we are on track.

CAMHD Operational Policies/Protocols
The report is incorrect as it relates to CAMHD policies regarding service procurement, use of flex funds, and respite. The Division has policies in place and are currently in use; however, as expected in a system undergoing rapid systems change, these policies are revised to reflect changes in policy directions.

Management of Pilot Projects
It is not accurate that there is confusion about the reporting relationships as it relates to the Hawaii Ohana Project. The Division Chief is clearly identified as the Principal Investigator (PI) of the Hawaii Ohana Project, and functions in such capacity. Although the Leeward Oahu Branch Chief participates in the interagency and community meetings, there is no confusion regarding the authority of the branch chief in relation to this federal grant.

The Mokihana Project is managed by the Kauai District Health Officer and Kauai District Superintendent. The CAMHD Chief participates in the management team meetings, and Mokihana reports service data on a monthly basis. The annual budget and quarterly disbursements of funds is clearly defined between the Departments of Health and Education.

The Child & Adolescent Mental Health Division agrees that a comprehensive fiscal audit of the Big Island Demonstration Project is warranted, and has required Kapiolani Health Hawaii to ensure that an audit will take place. It is not accurate that quality assurance requirements were not maintained during the project. There is clear evidence of a quality review process within KHH documentation with required corrective actions plans expected of provider agencies.

In closing, the Auditor's recognition that CAMHD is working to implement the necessary changes in order to accept the responsibilities under the Consent Decree is reassuring. The Department is appreciative of the Auditor's efforts in this study on the privatization of the child and adolescent mental health program.

The Felix Consent Decree and the issues related to compliance are very complex; and the availability of an external entity to critique us is welcomed as we believe recommendations resulting from an objective assessment of our performance will assist us in carrying out our mission. It is clear we are evolving in our system of care and will continuously refine our efforts for serving Felix class youth. The CAMHD has the capability to objectively assess the performance of its program as evidenced by the findings of this report and the fact that CAMHD had begun to undertake the major reforms prior to the issuance of this draft report. We have acted in good faith in providing services to Felix class youth and in complying with the consent decree.

Sincerely,

Bruce S. Anderson, Ph.D, M.P.H
Director of Health