Program Evaluation: Purchasing of Mental Health Treatment Services in the Department of Mental Health

Prepared for the Committee on Legislative Research
by the Oversight Division

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April, 2000

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April, 2000

Members of the General Assembly:

The Joint Committee on Legislative Research adopted a resolution in June, 1999, directing the Oversight Division to perform a program evaluation of the Purchasing of Mental Health Treatment Services in the Department of Mental Health which included the examination of records and procedures to determine and evaluate program performance in accordance with program objectives, responsibilities, and duties as set forth by statute or regulation.

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

Respectfully,

Representative Robert M. Clayton III
Chairman

EXECUTIVE SUMMARY

The Missouri Department of Mental Health is charged with the prevention of mental disorders, developmental disabilities and substance abuse; the treatment, habilitation, and rehabilitation of Missourians with those conditions; and the improvement of public understanding and attitudes about mental disorder, developmental disabilities and substance abuse. In these efforts, the Department employs approximately 10,500 staff located within 27 community facilities and one administrative office and maintains 4,000 contracts with outside entities to provide treatment services. In terms of personnel, the Department of Mental Health is the largest state department in Missouri. The Department spends approximately $236,451,516 for their own staff costs and $256,459,030 in contracted services to treat approximately 125,000 clients. Average per capita spending on mental health, drug and alcohol treatment in Missouri is $117.81. The Oversight Division was directed to perform a program evaluation of the Department's contracting for mental health treatment services.

In reviewing DMH's provider contracts, Oversight determined DMH does not routinely rebid contracts to ensure the best services are obtained at the lowest costs. Oversight also noted that not all vendors are allowed to provide treatment services which they are capable of providing. In a sample of contract files, the average length of contracts with providers was 6.4 years. Some contracts had been in effect for 10 to 14 years. The DMH is not statutorily required to rebid contracts and it is their policy to renew the provider contracts unless the provider no longer meets certification requirements. Oversight recommends the DMH consider rebidding the contracts on a periodic basis to ensure the best providers are providing the necessary services at the lowest cost to the state. In addition, the Department should encourage broad participation in the service delivery system.

Oversight noted that funding mental health treatment services does not appear to be allocated equitably across the state. The DMH's current approach for distributing funding is based largely on historic funding levels. These funding levels evolved as various behavioral health programs and services were implemented over time. The funding amounts per region of the state do not coincide with population levels or any other variable. Oversight suggests the DMH maintain client data, which would support decisions for equitable allocation of funding per division. Funding should be based on per capita information by service area or assessed needs in the area and not on traditional or historical funding levels. Funds could also be prioritized based on clients who are most at risk if they do not receive services.

Oversight suggested several areas in which the DMH could strengthen monitoring of the contracted service providers. Billing audits are not performed as a standard practice on contracted providers of mental retardation and developmentally disabled services. Such audits should be done on an annual basis to limit the risk of overpayments to vendors. DMH also does not perform audits of purchase of service vendors on a rotating basis because of a lack of audit staff. Of the 16 audit positions documented in the April 1999 organizational chart for the Audit Services Section, five positions were vacant.

When audits are performed and adjustments made, they are not always followed up on for recoupment.

The DMH contracted for a functional analysis of the central office staff in 1997 at a cost of $69,000. Recommendations received from the review in 1997 have yet to be implemented, although the Department is working on some of them. The major recommendations focused on enhancing the internal infrastructure and management systems to serve as a foundation for other changes, including staffing issues.

The DMH is not on target for implementation of a managed care model of mental health service delivery. DMH stated in their own strategic plan dated August 1, 1996, their goal was to implement managed care for priority populations by July 1, 1998. They are projected to be five years beyond that date.

Oversight did not examine departmental financial statements and accordingly does not express an opinion on them. We acknowledge the cooperation and assistance of Department of Mental Health staff during the evaluation process.

Jeanne Jarrett, CPA
Director, Oversight Division

Chapter 1 - Introduction

Purpose

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

The Committee on Legislative Research directed the Oversight Division to perform a program evaluation and expenditure review of the Purchasing of Treatment Services in the Department of Mental Health for the purpose of providing information to the General Assembly regarding proposed legislation and appropriation bills.

Background

Though its functions date back to 1847, the Missouri Department of Mental Health (DMH) was first established as a cabinet-level state agency by the Omnibus State Government Reorganization Act on July 1, 1974. State law provides three principal missions for the department:

1) the prevention of mental disorders, developmental disabilities, and substance abuse;

2) the treatment, habilitation, and rehabilitation of Missourians with those conditions; and

3) the improvement of public understanding and attitudes about mental disorder, developmental disabilities, and substance abuse.

The Department's approximately 10,500 employees, located within 27 community facilities and one administrative office, and employees of numerous contract agencies, provide services to individuals in the least-restrictive environments possible.

Each year the department provides services to more than 125,000 Missourians through the Division of Comprehensive Psychiatric Services, the Division of Mental Retardation and Developmental Disabilities and the Division of Alcohol and Drug Abuse.

The department makes services available through state-operated facilities and contract agreements. The state-operated facilities include eight psychiatric hospitals, two children's facilities, six long-term habilitation centers, and 11 regional centers for persons with developmental disabilities.

Technical and administrative support for the division is provided through the department's Office of Administration, Office of Consumer Affairs, Office of Departmental Affairs, Office of Human Resources, Office of Information Systems, and Office of Public Affairs.

The Division of Alcohol and Drug Abuse

The Division of Alcohol and Drug Abuse serves approximately 35,000 individuals with substance abuse problems each year through community based treatment programs. According to the DMH, alcohol and other drug abuse affects more that 342,000 Missourians directly as substance abusers.

Division services are delivered through a network of contract providers coordinated by regional offices. The Division also promotes prevention programs that help to stop the cycle of abuse among young people within their communities. The Division supports community prevention initiatives by making available resources and personnel on the regional level.

The Division of Comprehensive Psychiatric Services

The Division of Comprehensive Psychiatric Services operates 16 facilities and supports more than 400 community mental health programs. According to the Division, one in four families in Missouri is affected by mental illness. While many persons with mental illnesses seek and obtain treatment from private health-care providers, more than 50,000 people each year turn to the Department of Mental Health's Division of Comprehensive Psychiatric Services.

The goals of the Division include:

a) accessible community-based services,
b) quality residential services,
c) available and affordable housing, and
d) family-focused children's services.

The Division of Mental Retardation and Developmental Disabilities

A developmental disability is a long-term condition, occurring before age 22, that delays/limits mental or physical development and interferes with basic life activities.

According to the Division of Mental Retardation and Developmental Disabilities, an estimated 25,000 Missourians with such developmental disabilities as mental retardation, cerebral palsy, and autism receive services from the division each year. Many of these individuals, because of their disabilities, face barriers to the basic opportunities of education, employment, and community life. The Division is committed to helping people with developmental disabilities live as independently and productively as possible in a safe and healthy environment.

1998 Consumer Satisfaction Report

In April 1998, the DMH conducted a consumer satisfaction survey for the Divisions of Comprehensive Psychiatric Services and Alcohol and Drug Abuse. The survey asked for demographic information from each consumer as well as input from the consumer and family concerning satisfaction to eight service related questions and eight quality of life questions. The survey specified how the delivery system was operating and identified ways in which it could by improved. The survey was also designed to offer quality improvement processes at the provider level by allowing each provider to compare themselves to other providers offering similar arrays of services.

The Division of Mental Retardation and Developmental Disabilities performed a separate satisfaction survey with the aid of the Missouri Institute of Mental Health.

The DMH contracted with the University of Missouri - Kansas City, Institute for Human Development to compile the responses to the survey and draft the report. The results from the survey and the Division of Mental Retardation and Developmental Disabilities survey were presented in a report dated March 1999. DMH's intention was to use the results to make changes in the delivery of services.

Overall, 79.6 percent of the 5,091 people who completed the Consumer Satisfaction Survey reported that they were satisfied or very satisfied with the services they received from the DMH. Specifically, the results of the survey indicated 79.9 percent of the clients served by the Division of Comprehensive Psychiatric Services were "satisfied" or "very satisfied" with the services they received. Satisfaction ratings for the Division of Alcohol and Drug Abuse was 79.2 percent.

Within the Division of Mental Retardation and Developmental Disabilities, 89 percent of clients ranked the services received were "good" or better.

The highest satisfaction was with how staff respected the ethnic and cultural background of those they served. The lowest satisfaction was with the service being provided in a timely manner.

There were differences in satisfaction along demographic lines. Females were more satisfied with services than males. Whites had the highest level of satisfaction with services of any racial or ethnic group. Some of the lowest ratings were found among African Americans for confidentiality, or lack thereof, and how staff respected their culture. The youngest consumers, up to 18 years of age, were the least satisfied with the services.

The Consumer Satisfaction Survey Report suggests that overall, the clients are satisfied with the services provided by the DMH.

Objectives

The program evaluation of the Purchasing of Treatment Services in the Department of Mental Health included the inspection of records for the purpose of providing information to the General Assembly for their consideration of proposed legislation and appropriation bills. The Oversight Division's evaluation focused on the objectives as noted below:

- Reviewing eligibility criteria for clients in the three divisions of the Department and the interaction between the Department and other state agencies and the federal government;

- Reviewing the fee structure in place to compensate the contracted service providers of treatment services for Department clients and the allocation of Department funds;

- Determining whether the Department is following state purchasing guidelines for the procurement of treatment services for clients;
- Determining whether the Department appropriately provided earmarked funds to the contracted providers for increasing direct care workers salaries;

- Reviewing the status of the Department's transition to a managed care model of mental health service delivery;

- Reviewing the procedures for ensuring that client and client family complaints are being resolved;

- Determining whether the Department is maintaining adequate records to determine if the treatment services are improving the lives of their clients; and

- Reviewing specific concerns from members of the General Assembly and other interested parties and stakeholders.

Scope/Methodology

Our evaluation included interviewing Department personnel, reviewing selected policies and procedures of the Department, interviewing Departmental employees, reviewing supporting documentation, reviewing selected contracts and financial reports, reviewing information provided from interested parties, and reviewing compliance with certain statutes relating to the procurement of treatment services.

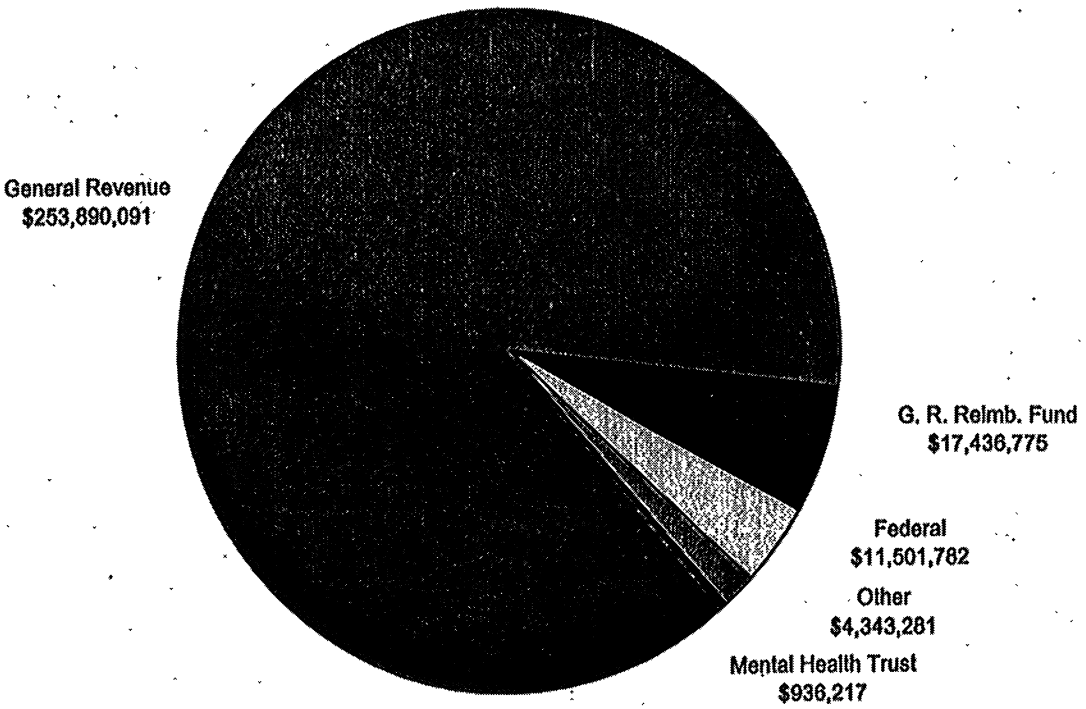
Our scope was not limited to any specific fiscal year.

Chapter 2 - Charts

Our report includes charts of various financial and statistical information. These charts include the sources and uses of funding for the Department for the last three fiscal years. We have also provided a chart comparing the number of full-time employees (FTE) in the Department to the number of employees in all other state departments for appropriation year 1998. We have provided a chart comparing the total appropriations for the Department to the other state departments for appropriation year 1998. In addition, we have prepared three tables that compare mental health expenditures per capita of Missouri and the surrounding states. All of the above charts and tables can be found immediately following this section.

Division of Comprehensive Psychiatric Services

Sources of Funding Fiscal Year 1999



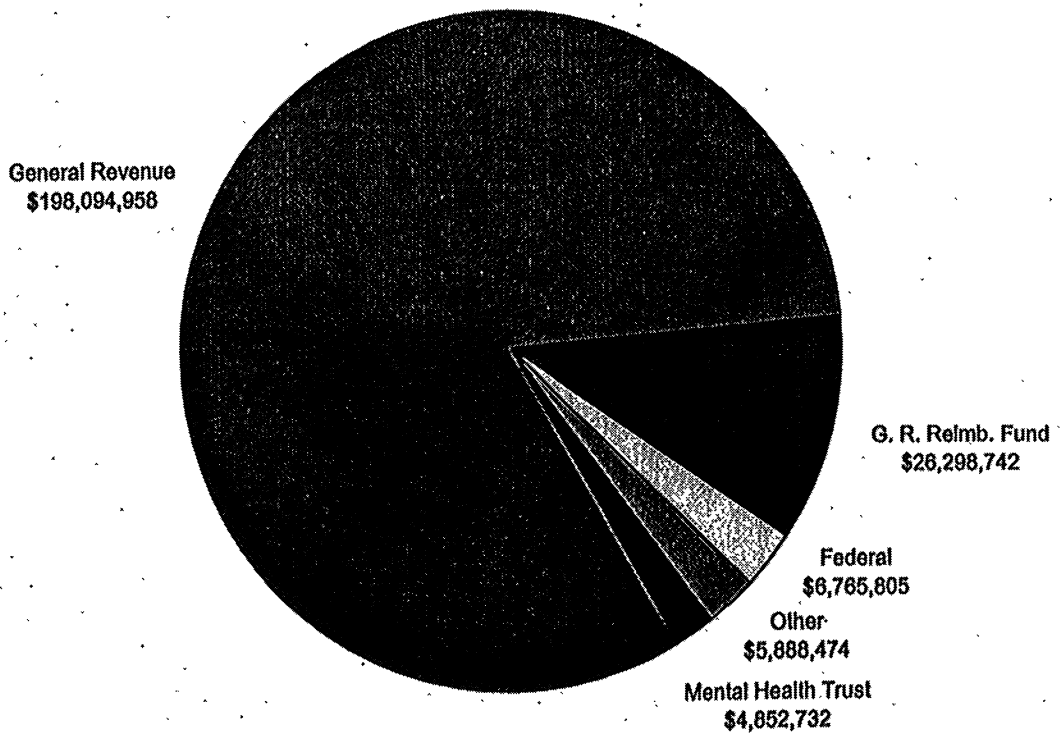
Total Funding = $288,108,146

Source: Department of Mental Health

Note: Other generally includes Health Initiatives Fund, Mental Health Earnings Fund and Mental Health Interagency Payments Fund

Division of Mental Retardation and Developmental Disabilities

Sources of Funding
Fiscal Year 1999



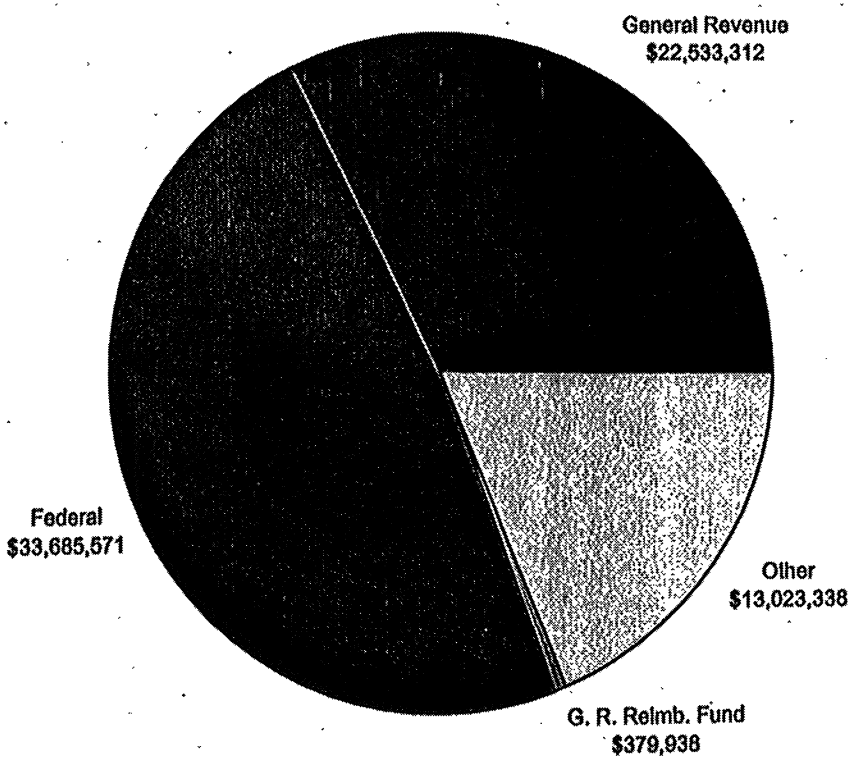
Total Funding = $241,900,711

Source: Department of Mental Health

Note: Other generally includes Family Support Loan Program Fund and Mental Health Interagency Payments Fund

Division of Alcohol and Drug Abuse

Sources of Funding
Fiscal Year 1999



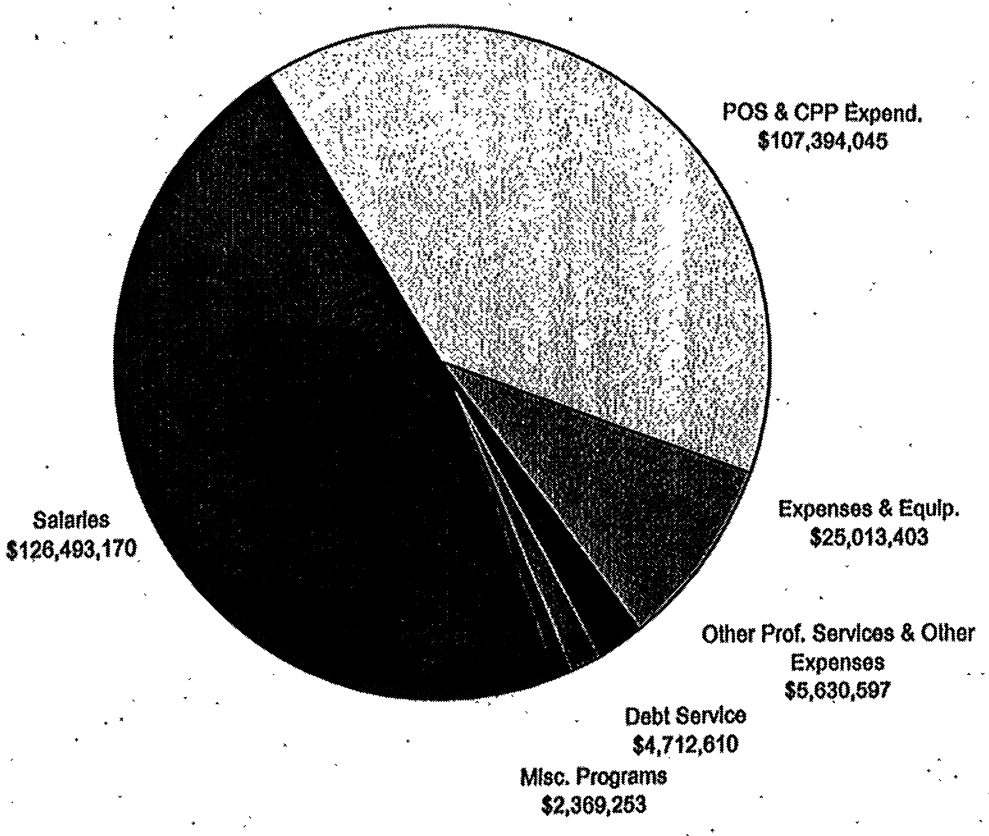
Total Funding = $69,622,159

Source: Department of Mental Health

Note: Other generally includes Health Initiatives Fund, Mental Health Earnings Fund and Compulsive Gamblers Fund

Division of Comprehensive Psychiatric Services

Expenditures Fiscal Year 1999



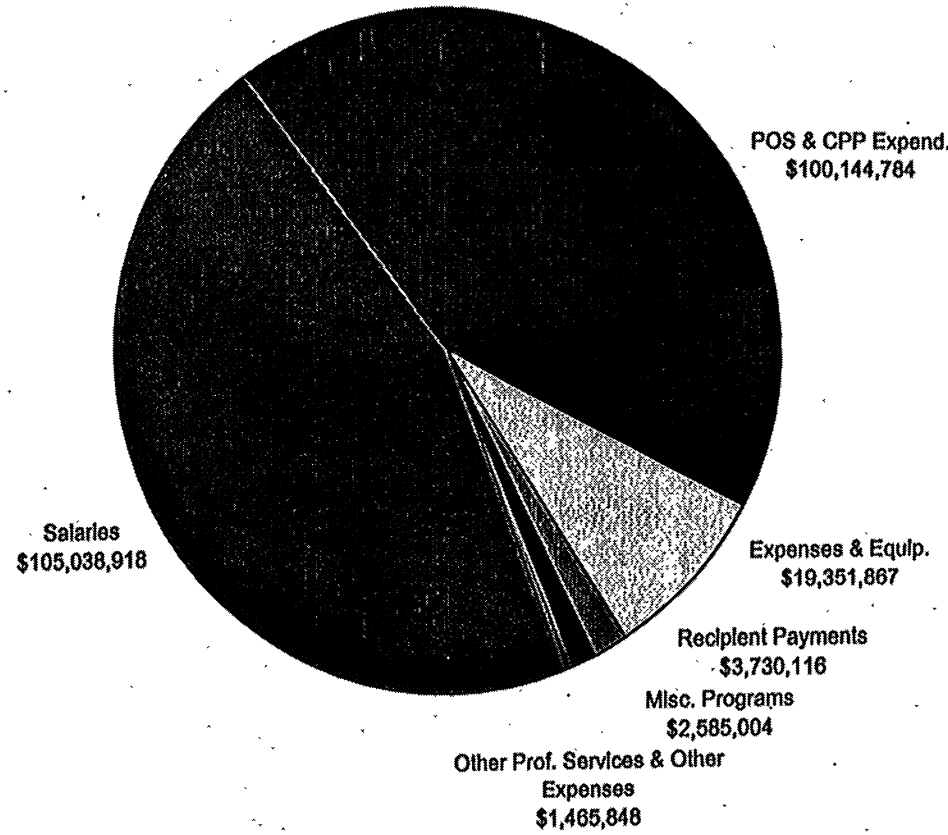
Total Expenditures = $271,613,078

Note: POS represents Purchase of Services, CPP represents Community Placement Program

Source: SAM Report No. 23021 for Org. 69000

Division of Mental Retardation and Developmental Disabilities

Expenditures Fiscal Year 1999



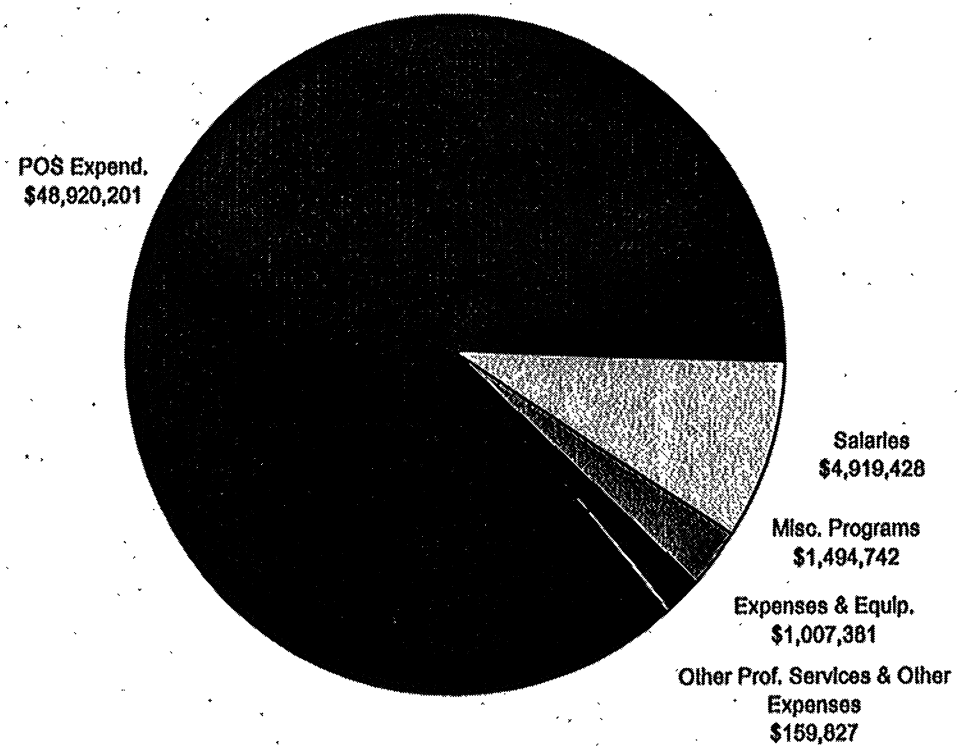
Total Expenditures = $232,316,537

Note: POS represents Purchase of Services, CPP represents Community Placement Program

Source: SAM Report No. 23021 for Org. 74000

Division of Alcohol and Drug Abuse

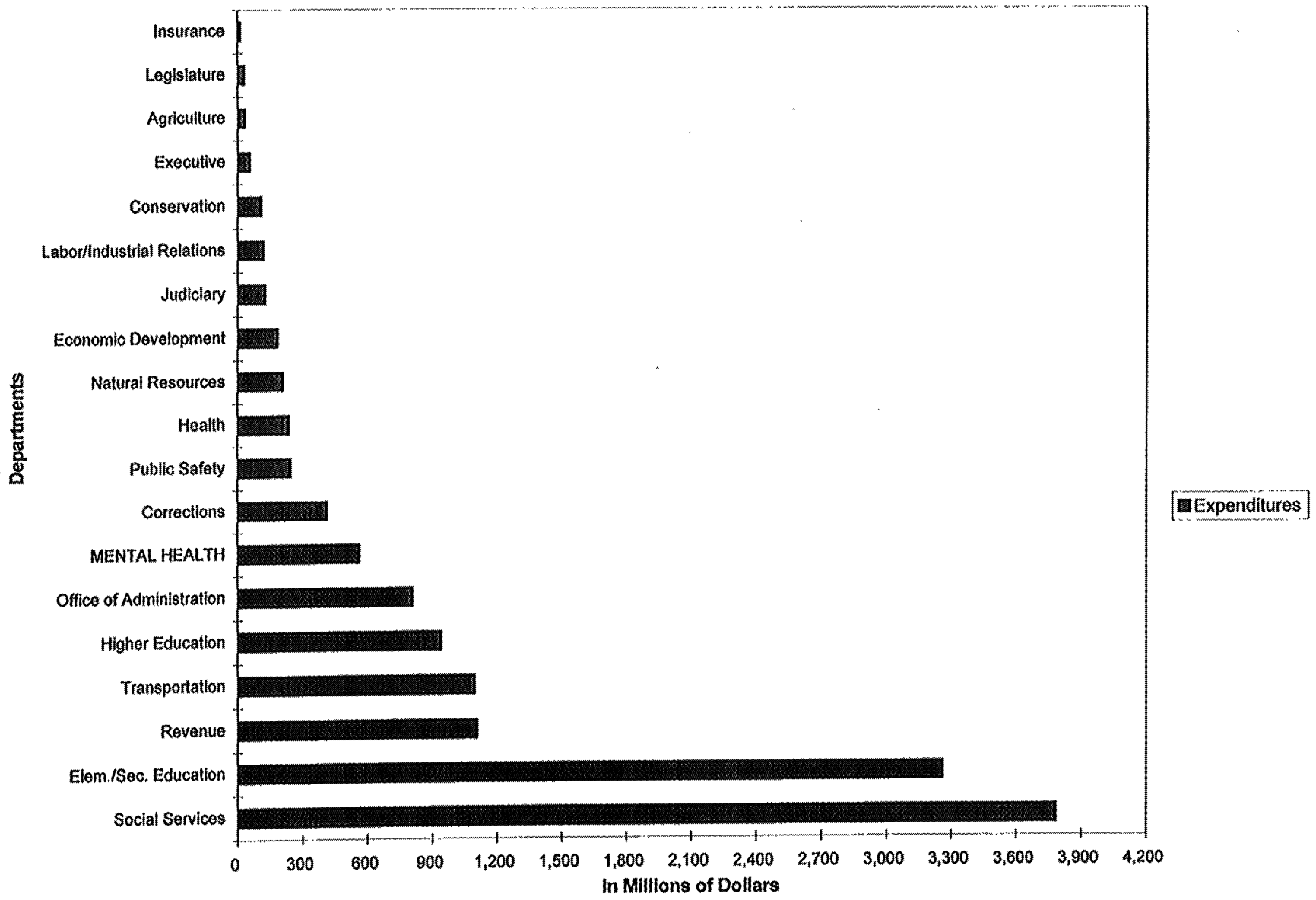
Expenditures
Fiscal Year 1999



Source: SAM Report No. 23021 for Org. 66000

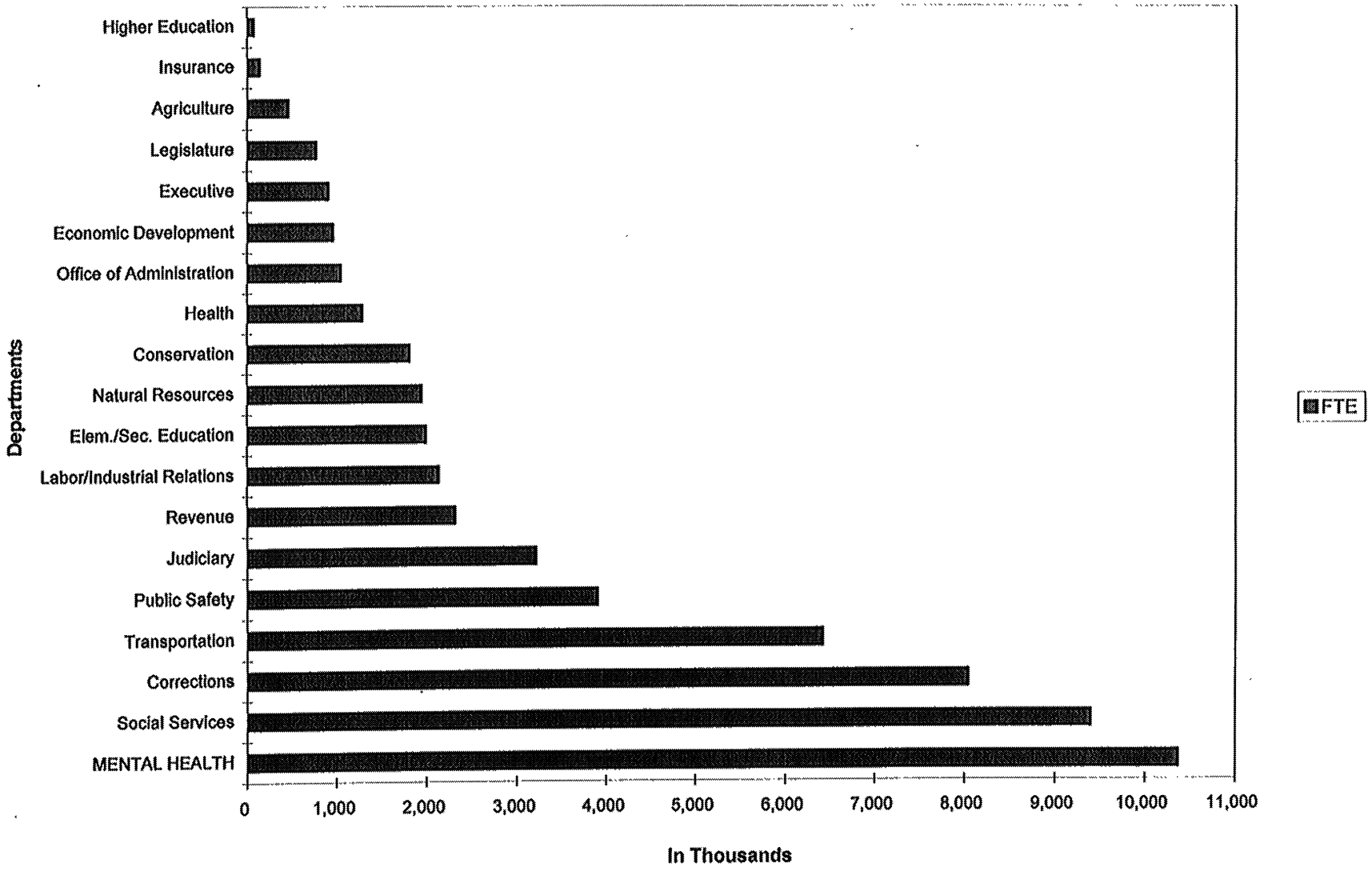
Total Expenditures = $56,501,579
Note: POS represents Purchase of Services

Chart of Expenditures by Department
All Funds
For Appropriation Year 1998



Source: State of Missouri Appropriation Activity Report for Appropriation Year 1998

Chart of FTE by Department
After Veto
For Fiscal Year 1998



Source: Annual Fiscal Review for Fiscal Year 1998

ADA Expenditures Reported for State-Supported Alcohol and Other Drug Abuse Services

State	Expenditures from all Sources (1)	Expenditures Per Capita (2)	National Rank (3)
Iowa	$ 46,279,950	$ 16.22	12
Illinois	$ 179,940,878	$ 15.12	14
Missouri	$ 55,734,389	$ 10.35	28
Nebraska	$ 15,237,995	$ 9.24	32
Kansas	$ 23,299,015	$ 9.07	34
Oklahoma	$ 25,708,898	$ 7.80	39
Arkansas	$ 16,425,607	$ 6.52	41
Tennessee	$ 28,812,283	$ 5.36	46
Total	$ 3,984,162,066	$ 14.96	

(1) Source: State Alcohol and Drug Abuse Profile FY 97, published by the National Association of State Alcohol and Drug Abuse Programs, August 1999.

(2) Estimated 1997 civilian population, US Census Bureau

(3) 47 states and D.C. reporting.

CPS Reported Per Capita Expenditures as Compared to Surrounding States and Nationwide

State	Expenditures per Capita	Rank
Kansas	$ 58.72	23
Missouri	$ 56.38	26
Illinois	$ 51.47	30
Oklahoma	$ 40.53	40
Nebraska	$ 38.79	42
Arkansas	$ 29.90	46
Iowa	$ 28.93	48
Tennessee	$ 22.91	51
National Median	$ 56.38	

Source: National Association of State Mental Health Program Directors Research Institute, Inc., August, 1999

MRDD Related Expenditures as Compared to Surrounding States and Nationwide

State	State-Federal 1998 Expenditures for ICF/MR & Waiver	Expenditures per Capita	Rank
Iowa	$ 229,216,766	$ 80.09	15
Kansas	$ 205,762,553	$ 78.27	16
Oklahoma	$ 225,741,918	$ 67.45	20
Nebraska	$ 110,123,864	$ 66.22	22
Illinois	$ 761,073,358	$ 63.19	24
Tennessee	$ 340,212,878	$ 62.64	25
Missouri	$ 277,813,193	$ 51.08	30
Arkansas	$ 125,989,736	$ 49.64	32
National	$ 16,932,609,200	$ 62.64	

Source: University of Minnesota - Residential Services for Persons with Developmental Disabilities: Status & Trends through 1998

Chapter 3 - Comments

Comment #1 Quarterly reports are not being prepared as requested by the Review Committee on Purchasing.

The Review Committee on Purchasing (RCP) was enacted by House Bill 562 in the 1995 legislative session. The Committee's purpose was to review the manner in which the Department of Mental Health (DMH) purchases services for persons with mental health disorders and substance abuse problems. The Committee was directed to recommend any changes that should be made in the Department's purchasing system. The Committee prepared a report dated December 1995 and had included specific recommendations to the department. The DMH was to develop an outcomes based evaluation system for the department, providers and other parties involved in the delivery of services. The Committee also required that the Mental Health Commission report on a quarterly basis the progress in moving the Department to the managed care model of mental health service delivery. The reports were to be made to the Governor, General Assembly, Commissioner of Administration, the DMH Director, and State Advisory Councils. Oversight reviewed the report from the Review Committee on Purchasing and the progress made by the DMH in implementing the recommendations from the Committee.

Although it appears that the Divisions of Alcohol and Drug Abuse and Comprehensive Psychiatric Services have started and have completed some outcomes based evaluations, the Department has not prepared quarterly progress reports on the transition to managed care. The Mental Health Commission had agreed to prepare the reports as recommended by the Committee.

Oversight asked the DMH to provide any progress reports from the Mental Health Commission and any documentation which would demonstrate the progress made to implement the recommendations of the RCP. The Mental Health Commission issued one progress report since the time they agreed to monitor the progress in changing the model of the delivery of mental health services. This page and a half report is dated July 11, 1996. There have been no more progress reports to date. The quarterly reports are necessary to ensure that all interested parties have the most current information available and can be involved in the decision making process as applicable.

RECOMMENDATION:

The Department should start preparing the quarterly reports, as promised by the Mental Health Commission, to ensure the Governor, General Assembly, and all interested parties have the information necessary to make decisions affecting the Department's clients.

Comment #2. Transition to managed care is not on the pace recommended by a statutory review panel.

Oversight also notes that the transition to a managed care model of mental health service delivery is not on the pace recommended by the Review Committee on Purchasing (See Comment #1). The main recommendation was that the DMH was to continue its current contracting procedures while moving swiftly to transition to a managed care system by October 1, 1997 or earlier if possible.

The DMH has made some strides in moving to the managed care model of services delivery. However, the pace at which this is being accomplished is slower than the pace recommended by the Committee. The Department stated in the Strategic Plan dated August 1, 1996, that its Strategic Plan for Managing Managed Care was to implement managed care technology (e.g., screening, assessment tools treatment protocols, outcome monitoring) for DMH priority populations by July 1, 1998.

Recently, the DMH has held meetings throughout the state asking for input from the vendors and the clients they serve. The DMH does not expect their new system of service delivery to be completed until July 1, 2003, well over 5 years behind the pace requested by the Committee.

Once the decision was made to transition to the managed care model of mental health service delivery, the Department should make the change as swiftly as possible in order to reduce the anxiety of their clients, employees, and all interested parties and to better plan the use of state resources.

RECOMMENDATION:

Since the Department has made the decision to move to a managed care model of service delivery, the Department should continue its efforts to move in that direction at a pace that best meets the needs of the Department's clients and stakeholders.

Comment #3 Funding mental health treatment services does not appear to be allocated equitably.

The Department's current approach for distributing funding is based largely on historic funding levels. These historic funding levels evolved as various behavioral health programs and services were implemented over time.

The funding by Division of Alcohol and Drug Abuse (ADA) service area, Division of Comprehensive Psychiatric Services (CPS) administrative agent service area, or Division of Mental Retardation and Developmental Disabilities (MRDD) region has remained fairly static, increasing by less than an average of one percent annually since Fiscal Year 1995. This is presented in table form below as Table 1A, 1B, and 1C:

TABLE 1A **Funding by Region - ADA Division**
Percentage of Total Funding Amounts for ADA

	FY95	FY96	FY97	FY98	FY99
Central	9%	8%	9%	10%	10%
Eastern	28%	34%	32%	32%	32%
Northern	12%	11%	12%	11%	11%
Southeast	13%	15%	13%	11%	12%
Southwest	12%	10%	11%	13%	13%
Western	26%	22%	23%	23%	22%
Totals	100%	100%	100%	100%	100%

Note: Approximately the same percentage of funding is received by each region each fiscal year.

Table 1 B **Funding by Administrative Agent - CPS Division**

		Percentage of Total Funding Amounts for CPS			
	AA	**FY97**	**FY98**	**FY99**	**FY2000**
Northwest	1	3%	3%	3%	3%
	2	9%	9%	8%	8%
	3	3%	3%	3%	3%
	4	3%	3%	3%	3%
	5	3%	3%	3%	3%
	6	3%	3%	3%	3%
	7	2%	2%	2%	2%
	13	1%	1%	1%	1%
Southwest	8	4%	4%	4%	4%
	9	5%	5%	5%	5%
	10	8%	8%	8%	8%
Central	11	4%	4%	4%	4%
	12	5%	5%	5%	5%
	14	2%	2%	2%	2%
	15	2%	2%	2%	2%
Southeast	17	4%	4%	4%	4%
	18	2%	2%	3%	3%
	19	3%	3%	3%	3%
	20	2%	2%	2%	2%
	21	3%	3%	3%	3%
Eastern	16	5%	5%	5%	5%
	22	2%	2%	2%	2%
	23 & 25	19%	19%	19%	19%
	24	3%	3%	3%	3%
Totals		100%	100%	100%	100%

Note: Approximately the same percentage of funding is received by each Administrative Agent each fiscal year.

Table 1C **Funding by Region - MRDD Division**

Percentage of Total Funding Amounts for MRDD Regional Centers

	FY95	FY96	FY97	FY98	FY99
Albany	5%	5%	5%	5%	5%
Central MO	9%	10%	10%	10%	10%
Hannibal	7%	7%	7%	7%	6%
Joplin	8%	7%	8%	7%	7%
Kansas City	17%	16%	16%	17%	17%
Kirksville	4%	4%	4%	4%	4%
Poplar Bluff	4%	4%	4%	4%	4%
Rolla	6%	6%	6%	6%	6%
Sikeston	4%	4%	4%	4%	4%
Springfield	8%	8%	8%	8%	8%
St. Louis	28%	29%	28%	28%	28%
Totals	100%	100%	100%	100%	100%

Note: Approximately the same percentage of funding is received by each region each fiscal year.

Oversight's review of the funding levels of all three divisions indicated each region of the state has historically received basically the same percentage of total funds. For instance, the Division of ADA funding in the northern part of Missouri has been between 11% and 12% of the total funding for the Division of ADA each fiscal year (See Table 1A above). As a result of historic level funding, allocation of funds vary across regions of the state and does not seem to be equitably divided as the following per capita tables demonstrate.

Dividing the population of a Division of ADA service region, Division of MRDD region or Division of CPS administrative agent service area by the funding allocated to that region will generate funding on a per capita basis (i.e. amount spent per citizen).

Based on the table information noted below, it appears that there is a funding inequity in all three divisions. For example, the Northern area of the state receives more funding per capita in terms of ADA and MRDD treatment monies than other areas of the state. Truman Medical Center (administrative area #2) receives substantially more CPS dollars per capita than any other administrative agent. Tables 2A, 2B, and 2C show that the per capita spending is not equal for any of the three divisions:

Table 2A — **ADA Division**

Per Capita Spending by Region (population/regional funding)

	FY95	FY96	FY97	FY98	FY99
Central	4.93	5.77	5.84	5.97	6.81
Eastern	4.55	6.91	5.93	5.76	6.36
Northern	*8.55*	*9.81*	*9.28*	*8.58*	*9.47*
Southeast	7.85	10.71**	8.69	7.41	8.63
Southwest	5.43	5.36	5.37	5.85	6.60
Western	7.88	8.28	7.92	7.70	8.13

** $10.71 in the Southeast region in FY96 was a one-time funding increase.

Table 2B — **CPS Division**

Per Capita Spending by Administrative Agent (population/ funding)

	AA	FY97	FY98	FY99	FY2000
Northwest	1	10.31	10.36	10.48	10.91
	*2	*45.08*	*45.16*	*46.58*	*47.02*
	3	12.78	12.83	13.94	14.36
	4	7.90	7.93	8.54	8.93
	5	12.45	12.49	12.94	13.42
	6	7.49	7.53	8.58	9.01
	7	5.74	5.78	8.68	9.11
	13	7.56	7.61	11.03	11.45
Southwest	8	13.93	13.96	15.73	16.14
	9	15.81	15.85	16.98	17.40
	10	12.52	12.57	13.35	13.76
Central	11	10.51	10.56	11.94	12.39
	12	10.53	10.58	10.92	11.35
	14	11.55	11.61	12.03	12.46
	15	13.03	13.08	13.54	13.96
Southeast	17	14.55	14.60	15.13	15.56
	18	12.10	12.16	15.16	15.58
	19	13.50	13.58	15.46	15.89
	20	12.24	12.30	14.00	14.43
	21	14.36	14.40	14.90	15.33
Eastern	16	6.77	6.80	6.44	6.87
	22	6.47	6.51	7.10	7.54
	23 & 25	9.28	9.42	10.09	10.53
	24	13.69	13.80	16.29	16.79

* AA #2 is Truman Medical Center in Kansas City, MO

Table 2C	MRDD Division				
Per Capita Spending by Regional Center (population/regional funding)					
	FY95	FY96	FY97	FY98	FY99
Albany	27.48	31.67	33.96	35.41	37.91
Central MO	22.90	29.29	29.38	32.30	34.68
Hannibal	*47.19*	*51.64*	*54.35*	*54.26*	*56.57*
Joplin	25.01	27.70	30.34	31.12	32.37
Kansas City	15.14	17.85	18.97	19.67	21.12
Kirksville	*29.89*	*34.68*	*37.43*	*38.35*	*41.56*
Poplar Bluff	22.22	25.18	27.17	28.11	29.91
Rolla	15.08	18.08	18.66	17.96	18.98
Sikeston	16.86	20.35	23.19	24.80	25.82
Springfield	16.22	19.68	20.78	21.31	22.78
St. Louis	15.40	18.98	19.54	20.04	21.21

With Division of ADA per capita rates, comparing the other regions' per capita rates to the Northern region per capita rate indicates that other regions of the state are receiving as little as 67 percent of the mental health funding available for citizens in the Northern region of the state, as noted in Table 3A below.

Table 3A Northern Region Per Capita Rates as Compared to Other Regions

	FY99 Per Capita Rates by Region	Other Region Funding as Compared to Northern Region Funding
Central	6.81	72%
Eastern	6.36	67%
Northern	*9.47*	
Southeast	8.63	91%
Southwest	6.60	70%
Western	8.13	86%

Note: Dividing the other regions' per capita rates by the Northern Region rate indicates other regions receive as little as 67 percent of what the Northern Region receives in mental health funding.

With Division of CPS per capita rates, comparing the administrative agents (AA) per capita rates to the Truman Medical Center rate (AA #2) indicates the other AA's receive as little as 14% of what the Truman Medical Center receives in mental health funding for CPS treatment services, as noted in Table 3B below.

Table 3B AA # 2 Per Capita Rates as Compared to Other AA's

	AA	FY99 Per Capita Rates by AA	Other AA Funding as Compared to Truman Medical Center (AA #2)
Northwest	1	10.48	22%
	2	*46.58*	
	3	13.94	30%
	4	8.54	18%
	5	12.94	28%
	6	8.58	18%
	7	8.68	19%
	13	11.03	24%
Southwest	8	15.73	34%
	9	16.98	36%
	10	13.35	29%
Central	11	11.94	26%
	12	10.92	23%
	14	12.03	26%
	15	13.54	29%
Southeast	17	15.13	32%
	18	15.16	33%
	19	15.46	33%
	20	14.00	30%
	21	14.90	32%
Eastern	**16**	**6.44**	**14%**
	22	7.10	15%
	23 & 25	10.09	22%
	24	16.29	35%

Note: Dividing the other AA's per capita rates by the Truman Medical Center rate (AA #2) indicates other AA's receive as little as 14% of what the Truman Medical Center receives in mental health funding (eg: AA #16).

Each administrative agent receives the same rate for unit of service for the core services delivered (ie: counseling, case management, etc). Although the Department maintains records based on national prevalence rates of mental illness to help determine the potential number of clients in the service delivery area, the Department does not allocate funding based on a needs assessment. This has resulted in the Division of CPS allocating resources on a historical/traditional basis.

With MRDD per capita rates, comparing the other regional centers' per capita rates to the Hannibal Regional Center or the Kirksville Regional Center per capita rate indicates the other regional centers are receiving as little as 34 percent and 46 percent, respectively, of the mental health funding available for clients served by the Hannibal or Kirksville Regional Centers, as noted in Table 3C below.

Table 3C Per Capita spending rates in MRDD Division

	FY99 Per Capita Rates by Regional Center	Other Region Funding as Compared to Hannibal Regional Center Funding	Other Region Funding as Compared to Kirksville Regional Center Funding
Albany	37.91	67%	91%
Central MO	34.68	61%	83%
Hannibal	*56.57*		136%
Joplin	32.37	57%	78%
Kansas City	21.12	37%	51%
Kirksville	*41.56*	73%	
Poplar Bluff	29.91	53%	72%
Rolla	18.98	**34%**	**46%**
Sikeston	25.82	46%	62%
Springfield	22.78	40%	55%
St. Louis	21.21	37%	51%

Note: Dividing the other regions' per capital rates by the Hannibal Regional Center rate and the Kirksville Regional rate indicates other regions receive as little as 34 percent and 46 percent respectively of what the Hannibal or Kirksville Regional Center receive in mental health funding (eg: Rolla).

In conclusion, client data should be maintained in order to determine an equitable allocation of funding for each division. Funding should be based on per capita information by service area or assessed needs in the area and not on traditional or historical funding levels.

The Department may want to prioritize its funding, especially non-Medicaid funds, on specific population types versus regional service areas. Populations could be prioritized based on a number of different variables. For example, priorities could be based on the income level of non-Medicaid-eligible clients. Under such an approach, the "working poor" who are not eligible for Medicaid could be a priority population for non-Medicaid monies and services. Another possible approach is to prioritize based on clients who are most at risk if they do not receive services.

RECOMMENDATION:

After funding priorities have been identified, the Department should revise its funding allocation formula to reflect these statewide funding goals. Any funding formula designed should contain some of the same theoretical formulas behind the capitated system used for Medicaid monies. Specifically, in addition to aligning allocations to specific funding goals, distribution should be based upon a general service area's population and the potential need for services in those areas based on data that reveals prevalence rates of persons needing service.

Comment #4. Functional Analysis recommendations do not appear to be implemented on a timely basis.

In March, 1997, the Department of Mental Health (DMH) contracted with the National Community Mental Healthcare Council for technical assistance to undertake a "functional analysis" of the operations of the DMH Central Office. The goal was to ensure quality mental health, addictive disorder and developmental disabilities services while preparing for a managed care environment. The functional analysis report was issued September 30, 1997. The DMH paid the National Community Mental Healthcare Council $69,850 for their assistance in the analysis. The major recommendations focused on enhancing the internal infrastructure and management systems to serve as a foundation for other changes, including staffing issues. Some recommendations were outlined for short-term projects to increase efficiency and effectiveness during the time the Department was preparing for the managed care approach to service delivery.

Some of the highlights of the functional analysis are noted below:

- The functional analysis report noted that contracted providers enjoy a very favorable and sometimes protected relationship with the Department. The report notes that the Department maintains multiple payment systems for the convenience of providers and regularly works to obtain immediate payment for a small number of providers with limited cash reserves, even when the cash flow problem was not created by the Department. The functional analysis team was told contracted provider resistance was the main reason that claims processing (currently provided by DMH) would be difficult to contract out since many providers do not have the capability to interface with private-sector claims processing operations. The report recommended the DMH build more formal, business-like relationships with the contracted providers.

- The functional analysis report also revealed that the Department "was not found to be leanly staffed" and could reduce staffing by 5 to 10 percent through careful monitoring of attrition and implementation of other recommendations. The report noted that administrative staffing levels (which includes primarily clerks and related classifications) appear high since there is a ratio of 3 to 1 for staff to each support position.

In other words, for every three non-clerical staff positions, the Department employs a support person. The report recommended the Department increase the ratio to 4 staff for each clerical position.

- The report also noted that the current performance level of the Department's information systems is a significant barrier to staffing efficiencies, overall Department function and on-going positioning for managed care. The report cited that collecting information about performance may require data from two to three databases. Multiple, separate databases are maintained within the Offices and Divisions to track information not available from the Office of Information Systems computer system.. These separate databases require duplicated data entry and can result in different data in reports, creating a lack of confidence in any information from the Department. The functional analysis recommended investing in building an adequate information system.

Oversight notes that the Department obtained funding totaling $4,700,000 in Fiscal Year 2000 budget for improving the information systems; however, an appropriation request has been forwarded to re-appropriate the funds in the Fiscal Year 2001 departmental budget request in the event the contract is not complete. The Department has just recently issued a request for proposal (RFP) for the purchase, installation, and training for tracking software to capture client data. It appears this process could have been handled in a more timely manner.

RECOMMENDATION: Since the Department requested, participated in, and paid for the functional analysis of the central office, the Department should strive to fully implement all of the recommendations included in the Functional Analysis report on a timely basis in order to make the transition to the managed care model of service delivery as fluent as possible.

Comment #5. Audits of vendors are not performed on a periodic basis.

Monitoring staff within each division performs periodic billing reviews and contract compliance reviews for their divisions. However, DMH Audit Services (an internal audit function) does not perform audits of Purchase of Service (POS) providers on a rotating basis because of the lack of audit staff currently available, according to DMH officials. Oversight notes that of the 16 audit positions documented in the April 1999 organization chart for the Audit Services Section, five positions were vacant.

Each of the three Divisions have staff that conduct reviews of their POS providers on an ongoing basis and often make adjustments to the providers' invoices. Audit Services does not get involved unless specifically requested to do so by the division monitors or upon request by the regional manager of the divisions. Therefore, POS providers are reviewed by Audit Services only when a request is received after a problem has been identified.

In addition, audit findings concerning the overpayment of funds to a provider are forwarded to the Director of Administration for follow-up and recoupment of the overpayments. Audit Services does not verify amounts that have been recouped nor do they perform follow-up procedures to ensure the overpayments they identified have been recouped. Oversight noted one audit performed by the Audit Services Section revealed a $884 overpayment of non-Medicaid monies to a provider. The overpayment was referred to the Department's Accounting Section for collection. At that time, formal procedures were not in place for collecting overpayments from vendors. Formal procedures were established in March 1998. The overpayment was not pursued due to the length of time that had elapsed since the audit was issued (May 14, 1997).

DMH Audit Services should perform reviews of POS providers after completion of a vendor based risk assessment. This would allow them to concentrate their efforts on vendors which pose greater financial risk of over billings or contract non-compliance. In addition, Audit Services should follow-up on all audit findings to verify that all issues have been addressed and resolved.

RECOMMENDATION:

Audit Services Section should perform vendor based risk assessments to ensure that contracted providers are receiving an appropriated level of audit coverage. Also, the Audit Services Division should ensure that any amounts identified as over-paid to vendors during their audits are actually recouped.

Comment #6. Billing audits are not performed each year for contracted providers of mental retardation and developmentally disabled services.

All three divisions in the Department perform billing audits of vendors at various intervals throughout the year. The Division of Comprehensive Psychiatric Services performs billing audits twice per year. This Division determines which vendors to audit based on a statistical sampling method. In addition, the Division of Alcohol and Drug Abuse performs billing audits once per year. However, the Division of Mental Retardation and Developmental Disabilities is not specifically performing billing audits as a standard practice.

The Division of Mental Retardation and Developmental Disabilities offers mainly Medicaid related services and therefore, services are billed directly to the Department of Social Services - Division of Medical Services. The Division of Mental Retardation and Developmental Disabilities performs certification reviews that can include the review of billings; however, this is not an integral part of this review. In addition, Oversight notes that the certification review is done every two years.

The Division of Mental Retardation and Developmental Disabilities should perform billing audits on at least an annual basis. Without an annual billing audit, overpayments to vendors may go undetected for a longer period of time.

RECOMMENDATION:

The Division of Mental Retardation and Developmental Disabilities should perform billing audits at least once per year and model the sampling of the billings to be audited after the Division of Comprehensive Psychiatric Services procedures.

Comment #7. The Department is not in compliance with state bidding laws relating to certain contracts in the Division of Alcohol and Drug Abuse.

The Department of Mental Health (DMH) is not in compliance with Chapter 34 RSMo and the Special Delegation of Authority granted by the Office of Administration relating to certain contracts in the Division of Alcohol and Drug Abuse.

The Department has statutory authority to waive certain bidding requirements for the procurement of mental health services in the Division of Comprehensive Psychiatric Services and in the Division of Mental Retardation and Developmental Disabilities.

However, the procurement of Division of Alcohol and Drug Abuse services must follow Chapter 34 state procurement laws. The Department is awarding firm-fixed price contracts for alcohol and drug abuse treatment services. Services for the Substance Abuse Traffic Offenders Program (SATOP) and compulsive gambling programs are typically procured with firm fixed-price contracts. The potential vendors are asked to respond to a request for proposal (RFP) for treatment services for the price stated in the proposal. The vendors do not have to state a price that they require to provide the services. The price does not vary and is uniform throughout the state. The vendor's responses are evaluated by an independent review committee, and the committee determines the best provider of services for the area to be served.

Office of Administration - Division of Purchasing officials stated that this method of procurement fails to consider the main requirement of competitive bidding which is the lowest and best requirement. When the Department sets the price of the contract, the Department cannot ensure that it is receiving the services at the lowest cost by the best providers. The Office of Administration officials stated that the Department could possibly set price ceilings for the contracts and this would allow the Department to become compliant with the bidding laws.

The reason for the firm fixed-price contracts, according to Department officials, is that if the price is not fixed, the cost of the services will escalate. However, without a competitive bid process, the Department cannot ensure that it has received the best services at the lowest possible cost. If vendors could provide the same services at lower costs, more clients could be served.

RECOMMENDATION:

The Department should fully comply with current state bidding laws. The Department should discuss their options with the Office of Administration - Division of Purchasing and may wish to consider setting price ceilings for the services to be provided.

Comment #8. Some contracts have not been bid out for many years and not all potential providers can participate in the Department's provider network.

The Department of Mental Health (DMH) does not routinely rebid contracts to ensure the best services are obtained at the lowest costs. In addition, not all vendors are allowed to provide treatment services which they are capable of providing.

The DMH has approximately 4,000 contracts with outside entities to provide treatment services to the approximately 125,000 clients it serves each year. Oversight reviewed 60 contracts selected on a sample basis for analysis. Oversight noted the average length of the contracts reviewed was 6.4 years. Two contracts reviewed have been in effect for 14 years and fourteen of the contracts reviewed have been in effect for 10 years or longer. The DMH is not statutorily required to re-bid the contracts and it is their policy to renew the provider contracts unless the provider no longer meets certification requirements.

The Department is not statutorily required to re-bid the provider contracts since they are basically exempt from Chapter 34 bidding laws for a majority of the contracts they enter. The DMH should, as a matter of good business practice, consider periodically rebidding the contracts to ensure the best providers are providing the necessary services at the lowest cost to the state. In addition, the DMH should encourage broad participation in the service delivery system in order to promote program diversity, creativity, and client choice.

RECOMMENDATION:

The Department should consider periodically rebidding the provider contracts to ensure that their clients are receiving the best services at the lowest costs available. In addition, the Department should ensure that all eligible providers are offered admission into the provider network encourage broad participation in the service delivery system in order to promote program diversity, creativity, and client choice.

APPENDIX

Agency Response

Department of Mental Health Response

To Legislative Oversight Division Recommendations

Program Evaluation: Purchasing of Mental Health Treatment Services in the Department of Mental Health

Recommendation #1: The Department should start preparing the quarterly reports, as promised by the Mental Health Commission, to ensure the Governor, General Assembly, and all interested parties have the information necessary to make decisions affecting the Department's clients.

Response

We believe that the quarterly reports recommended by the Purchasing Committee are no longer necessary given the public process used by the Department in its System Redesign initiative. This process has involved publication of a variety of documents for public comment, special briefings for legislators, and legislative participation in the System Redesign Steering Committee.

Recommendation #2: Since the Department has made the decision to move to a managed care model of service delivery, the Department should continue its efforts to move in that direction at a pace that best meets the needs of the Department's clients and stakeholders.

Response

The department will continue its efforts to improve the service delivery system for clients that best meet the needs of our client population and stakeholders. Based on reaction to the public discussion document, *MODMH Implementing Missouri's "Show Me System Redesign", June 10, 1999* there is considerable resistance and reservation in developing a service delivery system based solely on a managed care model.

Recommendation #3: After funding priorities have been identified, the Department should revise its funding allocation formula to reflect these statewide funding goals. Any funding formula designed should contain some of the same theoretical formulas behind the capitated system used for Medicaid monies. Specifically, in addition to aligning allocations to specific funding goals, distribution should be based upon a general service area's population and the potential need for services in those areas based on data that reveals prevalence rates of persons needing services.

Response
The Department concurs in general. Allocations should be aligned to specific funding goals and that distribution should be based upon the need for services in a service area as indicated by relevant data including prevalence rates. In the Division of Comprehensive Psychiatric Services (CPS), decisions regarding the allocation of new resources already take into consideration service needs. The Division of CPS continues to refine their approach to assessing service needs.

The Division of Alcohol and Drug Abuse (ADA) is developing allocation methods to be used for future funding received. Funds will not be allocated on populations, but will look at other factors that are predictors of substance abuse. The Division of ADA will determine a method for fund allocation by June 1, 2000.

The Division of Mental Retardation and Developmental Disabilities (MRDD) has recently restructured their allocation methodology for new funding to include population and waiting list data. The Division will also review historic funding to see if the regional amounts are appropriate for the clients served in those regions.

Recommendation #4: Since the Department requested, participated in, and paid for the functional analysis of the central office, the Department should strive to fully implement all of the recommendations included in the Functional Analysis report on a timely basis in order to make the transition to managed care model of service delivery as fluent as possible.

Response
In the Spring and Summer of 1997, the Department undertook a functional analysis of Central Office operations with the assistance of external consultants. The purpose of this analysis was to examine and propose ways to enhance Central Office efficiency, effectiveness, and productivity within the context of how any changes might best position DMH for a future role with managed behavioral healthcare. This analysis was to serve as a tool to assist Department leadership in targeting and directing activities supportive of its strategic planning effort begun in 1996.

A number of specific recommendations within the subsequent report of this activity outlined short and long-term projects believed to increase efficiency, effectiveness, and build capacity while the future managed care approaches were being developed. It was anticipated that additional planning for reorganization would need to take place once clarity around the eventual managed care system was determined.

In the summer of 1999, The Department completed development of a proposal for system redesign employing significant managed care technology. A public discussion document; *MODMH Implementing Missouri's "Show Me System Redesign", June 10, 1999,* was widely distributed for public comment. Public comment rendered significant resistance to the specific strategies related to managed care. The Department and designated stakeholders are currently exploring options and strategies to achieve service delivery goals other than those heavily related to manage care. It is unlikely that the Department will pursue the use of significantly managed care influenced model of care delivery.

The Functional Analysis has proven to be a useful tool to prompt significant improvements in the Central Office infrastructure in addition to its intended use of "managed care" preparation. As a tool, it offered analysis and recommendations for consideration by senior Department leadership. All recommendations were considered. Some recommendations were adopted and implemented in their entirety; while others were modified or rejected based on additional information or changing needs and strategies. A full report will be available following the Mental Health Commission meeting, February 10, 2000

Recommendation #5: Audit Services should perform vendor based risk assessments to ensure that contracted providers are receiving an appropriated level of audit coverage. Also, the Audit Services Division should ensure that any amounts identified as over-paid to vendors during their audits are actually recouped.

Response
The comment section noted that there were sixteen audit positions with five positions vacant. The Office of Audit Services has not had sixteen positions. Further, as of April 1999 there were only two funded vacancies.

We concur that the Department with the assistance of the Office of Audit Services should assess risks at the vendor level. We also agree that reviews of vendors should be performed where the greatest potential for over-billings or contract non-compliance exists. The Office of Audit Services will develop a plan in collaboration with the program divisions to ensure the contracted vendors receive the appropriate amount of audit attention from the Divisions and/or the Office of Audit Services.

We agree that the Office of Audit Services should ensure that overpayments identified are actually recouped by the DMH Office of Administration. The DMH Office of Administration currently produces a tracking sheet of overpayments. This information or some other method will be developed to ensure the Office of Audit Services knows the status of recoupments.

Recommendation #6: The Division of Mental Retardation and Developmental Disabilities (MRDD) should perform billing audits at least once per year and model the sampling of the billings to be audited after the Division of Comprehensive Psychiatric Services

Response

The Division of MRDD currently has approximately 3,000 contracts. Assuring a billing audit of each contract annually is but one method to ensure billing compliance. There is not sufficient staff to assure that each contract has a billing audit completed each year. Other procedures and safeguards are in place to assure that consumers receive appropriate services and funding is not mis-used. These procedures and safeguards include:

- **Pre-authorized services by a staff member, normally a casemanager. The provider cannot bill for more services than authorized;**
- **Regular visits with the consumer and provider to assure that service delivery is appropriate;**
- **Quality assurance teams and/or other individuals at the Regional Centers that review providers on a regular basis, examining among other issues billing procedures and services delivered.**

The Division staff will review the Oversight Committee's recommendations and determine if there are ways to further strengthen these processes without adding additional staff.

Recommendation #7

The Department should fully comply with current state bidding laws. The Department should discuss their options with the Office of Administration – Division of Purchasing and may wish to consider setting price ceilings for the services to be provided.

Response

In 1996, a provision of Chapter 34 was repealed which allowed the Commissioner of Administration to waive certain bidding requirements, specifically the use of fixed rate contracts for alcohol and drug abuse services. It was brought the Department's attention that we would be out of compliance on any contract that was re-bid using a firm-fixed price, not otherwise exempted. Since the Department became aware of this issue, we have worked to have corrective legislation introduced. This legislation has been filed again this legislative session. A determination has been made that existing contracts are not out of compliance since they were issued when the statute was in effect. We will modify our bidding procedures if we re-bid a contract not otherwise exempted and the corrective legislation does not pass.

Recommendation #8: The Department should periodically re-bid the provider contracts to ensure that their clients are receiving the best services at the lowest cost possible. In addition, the Department should ensure that all eligible providers are offered admission into the provider network to ensure clients have a variety of provider choices.

Response

The Division of Alcohol and Drug Abuse bids all substance abuse service contracts. All providers have an opportunity to participate for any new funds appropriated to the Division for program expansion.

We will consider periodically re-bidding the provider contracts in the Division of Comprehensive Psychiatric Services to ensure that clients are receiving the best services at the lowest costs available. We support re-bidding contracts when a provider fails to fulfill its contractual responsibilities as indicated by failure to meet certification, licensure, auditing, or other requirements.

The majority of MRDD providers are now in the Mental Retardation (MR) Medicaid Waiver program. Any willing provider that meets Medicaid requirements is allowed to enroll and provide services. Their rates are based on cost. Provider enrollment requirements are also established for non-Medicaid providers. MRDD consumers are given freedom of choice to select the provider that will best suit their needs.

The Department does support broader participation in the service delivery system to enhance consumer choice.