PERFORMANCE AUDIT

DIVISION OF COMPREHENSIVE PSYCHIATRIC SERVICES
CONTRACTS FOR SERVICES

From The Office Of State Auditor
Claire McCaskill

Contract providers for services to department clients need to report incidents to the department. Additionally, although audits have been effective, the audit section needs to exercise independence in audit selection.

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DIVISION OF COMPREHENSIVE PSYCHIATRIC SERVICES
CONTRACTS FOR SERVICES

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The Division of Comprehensive Psychiatric Services contracts with 30 private contractors to provide outpatient and community living services to about 57,500 Missouri residents with mental illness. This report focuses on the division's oversight of private contractors to ensure the contractors ensure the safety and welfare of their clients, and provide required services. Specifically, our objectives were to determine (1) the extent contractors were reporting to the division incidents of client abuse and neglect, (2) if the division has implemented effective monitoring procedures over contractor provided services and related charges, and (3) if contractors were selected based on a competitive bid procedure supported by a request for proposal process.

State laws prescribe the division's clients are entitled to safe housing, free from verbal and physical abuse, and contractors are required to report to the division incidents of abuse and neglect. State law also requires certain action from division officials who receive information alleging a person, because of mental disorder, presents a likelihood of serious harm to himself or others. These actions include investigating the incident and evaluating the allegations, as well as the reliability and credibility of all information sources.

We found (1) division regulations do not require contractors to document and report all incidents and allegations effecting clients safety and welfare, (2) although periodic audits of the contractors help ensure contractors provided required services, improved audit procedures could provide a broader scope of review and better identify the need for expanded audits, and (3) the division has complied with state law regarding the selection of contract providers.

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We conducted our audit in accordance with applicable standards contained in *Government Auditing Standards,* issued by the Comptroller General of the United States, and included such tests of the procedures and records as were considered appropriate under the circumstances. Appendix I, page 16, contains our scope and methodology.

Claire McCaskill
State Auditor

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RESULTS AND RECOMMENDATIONS

1. Better Oversight of Contract Providers of Care for Residents with Mental Illness Is Needed

Division of Comprehensive Psychiatric Services (the division) officials interpreted their regulations to not require contractors to report incidents of clients physically abusing other clients. The regulations were silent on this issue. Contractors are required to report incidents of contractor staff physically abusing division clients or one client sexually abusing another client. In addition, contractors are not required to report incidents of medication errors or suicide attempts unless these incidents involve allegations of abuse or neglect. Review of 8 contractors' records for the period July 1, 2001, through June 30, 2002, showed these contractors reported 385 incidents including client assaults, client suicides, and medication errors. Although the contractors internally documented another 140 similar incidents, division regulations did not require the contractors to report these incidents. Division officials rely on contractors' judgment on whether client assaults and suicide attempts are serious enough to report to the division. Not all contractors are documenting client incidents and, as a result, the division will not have the information needed to ensure clients' safety and welfare or compliance with state laws. State laws prescribe each client is entitled to safe housing, free from verbal and physical abuse. The law does not differentiate between clients who are abused by contractor staff or other clients.

The division contracts for services to provide care and treatment for clients

During fiscal year 2002, the division spent over $82 million in state funds among 30 private contractors and their affiliates to treat and care for over 53,000 clients. The division contracts with private residential care facilities to provide supervised living arrangements for an additional 4,500 clients with chronic mental illness. According to division personnel, private contractors reduce the state's reliance on state hospitals for care and enhance community involvement in clients' care. Therefore, division officials believe they successfully provided services to the community and increased public awareness of mental health issues, while relieving the state of becoming the sole resource and caretaker of persons with mental illnesses.[1] The division's contractors offer a continuum of therapeutic and treatment services for state residents diagnosed with mental illness. Allowed by statute, these service providers are considered the gatekeepers of Missouri's mental health delivery system.[2]

Contractors are not required to report to division officials all alleged incidents related to client abuse and neglect.

State law provides certain rights for clients and when allegations need to be investigated:

> Section 630.115.1, RSMo 2000 prescribes each client shall be entitled to certain rights without limitation, including (1) humane care and treatment with dignity; (2) medical care and treatment in accordance with the highest standards accepted in medical practice to the extent facilities, equipment and

[1] See Appendix II, page 18, for additional background information.
[2] Section 632.050, RSMo 2000

personnel are available; (3) safe and sanitary housing; and (4) freedom from verbal and physical abuse.

Section 632.300.1, RSMo 2000 requires mental health coordinators conduct an investigation when they receive information alleging a person, as a result of a mental disorder, presents a likelihood of serious harm to himself or others. These coordinators should evaluate the (1) allegations and data developed by the investigation, and (2) credibility and reliability of all sources of information.

The division's regulations require contractor employees to immediately make a verbal or written complaint if they have reasonable cause a client suffered physical, sexual, verbal abuse or neglect while under the care of a residential facility, day program or specialized service. These entities must be licensed, certified or funded by the division. The regulations do not differentiate between client-on-client or employee-on-client incidents.

Division officials interpreted the regulation to only require contractors to report if clients are physically or verbally abused by contractor staff. Officials said contractors are not required to report incidents involving one client physically or verbally abusing another client, unless the abuse is serious enough to warrant an investigation by the contractor. The division, however, has not issued any guidelines or directives to define incidents considered serious client-on-client abuse.

Contractors did not report all incidents affecting clients' safety

Division records showed 30 contractors submitted 826 incident reports involving client abuse and neglect during state fiscal year 2002. We selected 8 of the 30 contractors responsible for 385 of the 826 incident reports and determined their incident reporting procedures. The contractors' records (maintained for their own purposes) showed 6 of 8 contractors did not report an additional 140 incidents to the division because they did not deem the incidents serious enough to conduct an investigation or they were medication errors which contractors were not reporting as a practice. These incidents were not required to be reported under current interpretation of division regulations. Table 1.1 shows the types of incidents not reported to the division.

Table 1.1: Incidents Documented by Contractors but Not Reported

Contractor	Suicide Attempts	Medication Errors	Assaults and Injuries	Elopements[1]	Deaths	Other[2]
1	1	13	34	3	1	23
2	0	0	3	0	0	3
3	0	2	0	0	0	0
4	0	1	3	0	0	2
5	0	3	1	0	0	0
6	3	1	9	2	5	27
Totals	4	20	50	5	6	55

[1] Elopement is defined by the division as unauthorized absence of a client from a 24-hour oversight facility, residential setting or day program; or an unexplained absence that causes or raises concern for a client's well-being.
[2] Includes incidents documented by contractors but do not fit within the noted classifications.

Source: SAO analysis

Specific incidents impacting client safety not reported to the division included:

- Client attempted suicide resulting in hospitalization
- Client threatened neighbor with steak knife
- Client allegedly physically assaulted and raped another client

See Appendix IV, page 24, for additional examples of incidents not reported.

Incidents involving client safety were documented by contractors but not reported to the division. We provided division officials a list of the incident reports, and they told us the incidents did not meet the criteria for reporting as established by 9 CSR 10-5.200 of abuse and neglect. However, one regional official said incidents involving suicide attempts should have been reported to the division. Also, our analysis of the division's incident and investigation tracking system showed similar incidents were reported to the division and the division deemed the incidents warranted investigation.

Reporting clients' assaults, suicides and medication errors is discretionary

Division officials have abdicated their responsibilities for ensuring proper client care by not requiring oversight of incidents between clients and by allowing contractors to determine an incident's significance. Contractors are not required to report (1) clients assaulting other clients, contractor staff or the general public, (2) attempted suicides, or (3) medication errors unless the incidents are the result of suspected abuse or neglect by contractor staff.

The division's written contracts state:

> "The contractor shall report serious incidents such as deaths, injuries that would prompt an investigation by the director of the facility or program, elopements, or other incidents that may be sensitive or that would prompt an internal investigation, such as client suicide attempt, physical abuse which caused serious injury, rape or other sexual assault, or fire."

Accordingly, if contractors do not deem an incident involving a suicide attempt, physical abuse, or rape as serious enough to warrant an internal investigation, they do not have to report the incident to the division.

A contractor provided us with the following information based on discussions held with a division official in August 2002:

> "From that point forward only completed suicides, completed homicides, suspected abuse and/or neglect cases and suspected misappropriations of client funds are being sent to DMH" (Department of Mental Health).

Some contractors do not document incidents

Division officials said although contractors are not required to report all incidents, division on-site monitoring procedures and a 24-hour consumer hotline help ensure client safety. Nevertheless, the division's on-site monitoring visits only occur once a year. Division regulations do not require contractors, who provide residential care to 4,500 division clients, to document client injuries or unusual incidents in the client's file. Two of five residential care contractors we visited do not document or report incidents of client assaults; opting to resolve the problems in-house. Because the division only requires contractors to report serious instances of abuse and allows contractors to determine how serious the abuse is, it does not know if clients are living in facilities where they are subject to repeated assaults, or know if the clients are free from physical and verbal abuse.

Medication errors go unreported

State statutes require each client receive medical care and treatment with the highest standards accepted in medical practice. This care is offered to the extent facilities, equipment and personnel are available. Twenty of the 140 occurrences of abuse and neglect that were not reported to the division between July 1, 2001, and June 30, 2002, were medication errors.[3] We discussed the medication error reporting issue with a Division of Senior Services[4] residential care facility examiner who was at one of our selected audit sites. The examiner said residential care facilities do not document all medication errors based on her review of client files during her investigations. Without complete reporting, the exact number of medication errors is unknown.

Medication errors are a measure of quality of care

Our analysis of the 20 unreported medication errors disclosed 3 medication errors involved giving clients medications intended for other clients. In addition, one medication error resulted in a client being admitted to a hospital for 2 days. Documents obtained from the facility's internal investigation of the incident showed the contractor employee who administered the wrong medication did not disclose the error; instead, recorded the client receiving the proper medication. Requiring contractors to submit incident reports involving medication errors would

[3] A medication error is defined as any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient, or consumer.
[4] Part of the Department of Health and Senior Services.

provide the division information to evaluate the care given to clients and allow the division to perform focused follow-up monitoring visits.

Conclusion

State laws require division clients receive safe housing, free from physical and verbal abuse. The division, however, does not require contractors to report incidents of physical abuse when it only involves one client assaulting another client, or medication errors.

Recommendation

We recommend the Director, Department of Mental Health:

1.1 Amend division regulations to require contractors to document and report to the division incidents involving client assaults, injuries, and medication errors.

Department of Mental Health Comments

We concur with the recommendation but wish to note that:

1. *Division contracts already require contractors to document and report serious incidents whether those incidents involve interactions between staff and consumers, or between consumers.*

2. *In the spring of 2002, the Department revised the DMH Incident and Investigation Tracking System (iiTS) to accommodate more detailed reporting of serious incidents, including non-abuse and neglect medications errors and injuries that require medical intervention greater than first aid.*

   The revised iiTS protocol is being piloted by fourteen providers prior to Department implementation statewide. The timeline for statewide implementation is Fall 2003, at which time the Department's new information system (CIMOR) is scheduled to go on-line.

   To support compliance with the new reporting requirements, the Department will promulgate a rule and make contract amendments.

3. *The Division believes that the information and data presented in the audit report may be misleading. A total of 826 incidents were reported to the Division by thirty (30) of its contract providers. The auditors selected eight (8) of the thirty (30) contract providers responsible for submitting 385 (46.6%) of the incident reports for review. Additionally, the contractors were asked to submit all of their internal documents to the auditors, whether or not they met the reporting criteria. In total, the auditors reviewed 525 incident reports, of which 140 were not reported to DMH.*

The Division was not provided with all of the additional documentation submitted by the contractors. The Division was asked to comment on fourteen (14) of the contractors' internal documents. Of the 14, the Division found that 3 (21%) were not Division clients. A list of the additional reports was subsequently provided to Division officials upon request. Our review of the list revealed that an additional eight (1.5%) clearly met the Division requirements and should have been reported and an additional seven (1.3%) appear to have been serious enough to be reported under the revised iiTS protocol currently being piloted, assuming that the incidents involved Division clients.

Of the eight incidents which met reporting criteria, six were deaths. None of these individuals lived in supervised settings and only one death was of a nature that would have required an investigation. The audit did result in the identification of a program error in the Departments' back-up quality control system for death reviews. All Missouri deaths recorded in the Department of Health database are routinely run against the department's census, thereby allowing the Department and each Division to identify any unreported deaths. The above deaths were not located in this search and a programming error was identified. This is now being corrected.

State Auditor's Comments

The division allows the contractor to decide what is or is not a serious incident and, consequently, the need to report to the division. The examples we cited in the report clearly show incidents that the contractors chose not to report that should have been reported.

We acknowledged in the report that contractors currently were not required to report the incidents we were citing, but still the incidents were serious enough to install better procedures to ensure such incidents are reported in the future. The 3 clients the division identified as not being division clients were not included in our report for the same reason. The 14 reports referred to were reports that the division received from contractors, but were not posted to the incident and investigation tracking system.

2. Improvements in the Division's Quality Control Procedures Would Help Ensure Contractors' Billings Are Accurate

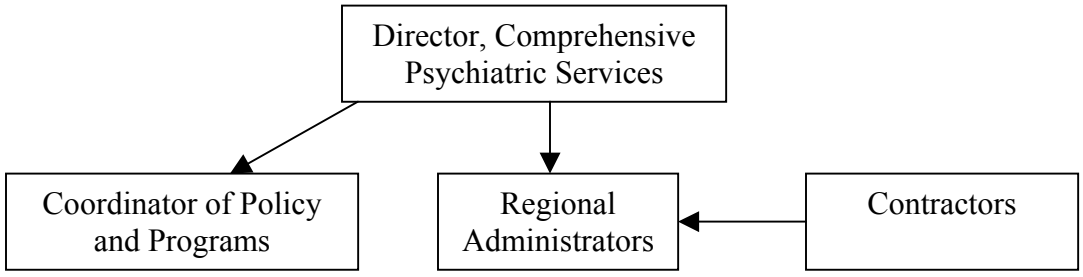
The division's quality control section does not have the appropriate authority to effectively conduct audits of contractor billings. The division's procedures provide for expanding audits of contractors if error rates exceed pre-established thresholds. According to a quality control section official, the decision to expand audits is not automatic and is based on the (1) contractor's history, (2) amount the thresholds were exceeded, and (3) subjective judgment of the division's five regional administrators who do not supervise the audit section. Thus, the audit function is not independent. As a result, only 1 of 26 contractors audited during the period July 1, 2001, through March 31, 2002, received an expanded audit, although division records showed 19 additional contractors' error rates exceeded the established thresholds. During the above period, the division audited approximately $700,600 in contractor claims and disallowed $75,303 due to errors, such as failing to document services provided, or for the incorrect service billings.[5] Additionally, statistical sampling techniques would enhance the quality control section's ability to estimate magnitude of potential error and help select contractors for audit. The completed audits were effective and helped ensure contractors submitted accurate bills and maintained supportable evidence of services provided.

The division audits contractor billings for client services

The audit function is not independent

As defined by state regulation 9 CSR 10-7.090(5) the division is required to "establish a formal, accountable relationship with any contractor or affiliate who provides direct service, but is not an employee of the organization." To meet this requirement, the division established a quality control section to review contractor billings for client services for claim accuracy and adequate support for reimbursement submitted by contractors. Figure 2.1 illustrates the organizational alignment of the quality control function in relation to the five regional administrators.

Figure 2.1: Organizational Alignment



As shown, the regional administrators and the Coordinator of Policy and Programs (quality control section) report directly to the division director. The regional administrators do not have supervisory or line authority over the quality control section. Thus, the quality control section is

[5] Includes the Comprehensive Psychiatric Rehabilitation (CPR), Purchase of Service (POS), and Targeted Case Management (TCM) billing categories. See Appendix VI, page 27, for definition of each billing category.

organizationally aligned to be an independent entity with an independent voice for the division director. But in practice, the quality control section does not operate independently when considering the need for expanded audits of contractors not meeting division standards for accurate billings. Instead, the quality control section must obtain approval from the regional administrators to conduct expanded audits. Our audit disclosed this practice could have resulted in fewer expanded audits and potential disallowances.

The quality control section selects a sample of claims and audits for accuracy and adequacy of supporting documentation for services provided from four contractor billing categories (1) CPR, (2) POS, (3) TCM, and (4) Community Support Services (CAPS).[6]

The division's Provider Monitoring Guide established the following percentage thresholds to indicate the possibility of significant risks for improper bills and to help determine whether expanded audits are warranted.

- 15 percent or more of the contractor's number of paid claims are disallowed.
- 10 percent or more of the total amount paid to the contractor is disallowed.
- Performance patterns for a specific staff person or a specific service that are significantly higher than the noted agency thresholds of 15 percent and 10 percent.
- A demonstrated pattern of violation of Medicaid or department requirements not specifically addressed by routine monitoring.

The above error rate thresholds are only used in part to determine if expanded audits are to be conducted. The Provider Monitoring Guide also states: "The regional manager (administrator), in conjunction with the division director, shall determine whether to proceed with additional monitoring" and "upon approval by the regional manager and director, expanded or focused monitoring shall be initiated."

Billing audit results showed several contractors had significant error rates

Analysis of the division's audit reports for 26 contractors[7] showed among the 3 billing categories CPR, POS, and TCM, the errors found in contractor billing claims ranged between 0 and 53 percent. Moreover, the associated monetary error rates in billable client services ranged between 0 and 37 percent. The CAPS category showed percentage of errors in claims ranging between 0 and 86 percent, and the associated monetary error rates ranged between 0 and 42 percent. Table 2.1 shows the number and percentage of contractors by billing type for two expanded audit threshold criteria.

[6] See Appendix VI, page 27, for definition of the CAPS billing category.
[7] Audits of the other four contractors were in progress as we did our fieldwork and were not included in the scope of the audit.

Table 2.1: Contractor Threshold Exceptions by Billing Type

Billing Type	15 Percent or More Disallowed Paid Claims		10 Percent or More Disallowed Dollars Paid	
	Number	Percentage	Number	Percentage
POS	12	46	15	58
TCM	6	23	8	31
CPR	1	4	2	8

Source: SAO analysis of the division's audit reports

Based on division records, over 75 percent of the disallowable billings were due to (1) inadequate or lack of support documentation for services billed or (2) wrong services being billed. Other disallowances identified were for duplicate or overlapping services, and use of incorrect billing codes. The total disallowances and recoveries from the division's billing audits of the 26 contractors resulted in $75,303 (10.7 percent of the $700,600 of sampled invoices).

The division audits included contractor billings among each of the division's five regions. Table 2.2 shows that several contractors exceeded the division's error rate threshold levels within each region.

Table 2.2: Total Contractors Exceeding Audit Threshold Percentages

Region	Total Billing Audits Conducted	Contractors Exceeding Thresholds	Number of Claims Disallowed*	Amount Disallowed
Central	4	4	217	$ 11,366
Eastern	4	4	389	$ 31,980
Northwest	8	6	231	$ 16,168
Southeast	6	4	125	$ 8,581
Southwest	4	2	126	$ 7,208
Total	26	20	1,088	$ 75,303

*Includes CAPS, CPR, POS, and TCM billing categories for both youth and adult clients.
Source: SAO analysis of the division's audit reports

Division auditors only expanded 1 billing audit although records show 20 of the 26 (77 percent) contractors exceeded the division's threshold error rates in 1 or more of the billing categories audited. The audit was expanded because the contractor historically exceeded thresholds by significant margins on multiple sample types.

More expanded audits could be done

Division officials said the other 19 contractors did not have an expanded audit due to several factors, including: type and volume of billing error, consistency of error, past contractor performance, the contractor's willingness to work with the division on corrective measures, and the division's available resources.

Division officials also said they do not want to immediately conduct an expanded audit every time a provider exceeds a threshold by a few percentage points. We were not able to review

which factors played a role in the division's decisions not to expand audits for the other 19 contractors because division auditors did not document these decisions.

Statistical sampling methodology could be an effective tool for identifying contractors for expanded audits

Division auditors reviewed an average 2 percent of the total claims submitted for payment[8] among 3 billing categories for all contractors. The division selects a number of clients based on "client months" and their associated claims to determine contractors' error rates, and as shown above, disallows the sampled claims found in error. Although the sample sizes used are sufficient, the method of selecting the sample items is not random because all claims do not have the same opportunity to be selected. A division official said the process the division uses to select clients and their claims is not statistically valid and therefore cannot be used to extrapolate audit results to the total universe. Accordingly, the audits can result in error rates that are not representative of the actual error rate in the total client and claim population. For example, although the client sample had a 20 percent error rate, the error rate for the total population of clients may have been a lower or higher percentage. As a result, using error rates based on sample items that were not selected on a random basis may not have been a reliable indicator of a contractor's overall error rate and is not reliable for determining which audits should be expanded.

Division auditors could use random selection techniques to better target contractors who have the highest potential amounts of disallowances and for whom expanded audits should be initiated. Our analysis shows using random selection techniques should not require an increase in the number of claims reviewed. The Office of Inspector General, U.S. Department of Human Services, uses random selection techniques to audit states' Medicaid expenditures. In a 2002 report, the Office of Inspector General identified overpayments by one state of about $711,323 from a universe of $2,037,530 in total payments based on a sample size of less than 1 percent, or 206 of 98,225 claims. Accordingly, the division could use random selection techniques without impacting the sample sizes previously used.

Division plans to conduct fewer billing audits

Prior to state fiscal year 2003, the division conducted contractor billing audits every 6 months. In response to our inquiries, the director of the quality control section, one regional administrator and a department central office manager stated the 6-month audits were sufficient to ensure proper coverage and generally mitigated the lack of expanded audits and statistical precision. Due to budget cuts, however, billing audits will be conducted every 12 months. A regional administrator stated that as such, it is important that decisions to conduct or not to conduct expanded audits be based on objective and supportable error rate thresholds rather than the judgment of regional administrators. Implementing statistically valid sampling procedures would provide the division a broader based scope of review of contractor billings for client services. Such procedures can also provide a more reliable and valid indication of potential problem contractors.

[8] The 2 percent includes billing categories POS, TCM, and CPR. CAPS consists of a 100 percent review.

Conclusion

The division has implemented a quality control process that has helped ensure contractors provide services for which they were reimbursed, and the division's clients have received quality care. The quality control section does not operate independently when considering the need for expanded audits of contractors not meeting division standards for accurate billings. Recent budget decisions have forced the division to perform contractor audits every 12 months rather than every 6 months. Accordingly, it is important the division use statistically valid sampling and testing procedures to review contractors' claims and base the decision to perform expanded audits on the results of objective error rates.

Recommendations

We recommend the Director, Department of Mental Health:

2.1 Ensure the quality control section has the proper authority and exercises the authority to independently select and audit contractors.

2.2 Amend the division's audit manual to require expanded audits when contractor error rates exceed specified thresholds.

2.3 Use statistical sampling methodology as one tool for identifying contractors for expanded audits.

Department of Mental Health Comments

2.1 The Division concurs that the quality control section should have and exercise the authority to select contractors for expanded audits. As a result of Divisional re-organization, the Regional management system is being discontinued and operational functions previously delegated to the Regions will be managed from Central Office, effective August 2003. This provides the Division the opportunity to develop new protocols for expanded audits and to ensure standardized application.

2.2 The Division does not concur that expanded audits should be required to be conducted automatically when error rate thresholds are exceeded.

The Division's audit process is two-fold: (1) Fiscal, that is to ensure that purchased services were provided; and (2) Quality Improvement regarding clinical documentation. Therefore, the Division identifies disallowances and imposes financial penalties on providers for a wide variety of reasons, ranging from no evidence a paid service was ever delivered, to a progress note missing a staff signature.

The Division currently requires a Plan of Correction be developed by providers who exceed thresholds as a first step to addressing problems identified during the audit process. The Plan of Correction can be flexible, targeted to address specific problem area(s) identified by the audit, and is monitored for compliance by audit staff. The

Division believes that in most cases this process is sufficient to address problems identified in an audit.

In addition, while error rates should be a significant factor in the decision of when to expand an audit, other factors should also be taken into account as well, including: the past history of the provider in exceeding error rate thresholds; the providers prior responsiveness to correcting identified problems through the Plan of Correction process; the amount by which a threshold is exceeded; and the specific reasons for exceeding a given threshold.

While the Division's monitoring guide allows for expanded audits as a tool, the Division believes that in practice expanded audits should be used after attempts have been made to correct identified problems through a Plan of Correction.

2.3 *The Division partly concurs with this recommendation. The Division believes we already employ a random selection process in which all claims have an equal chance of being selected, and as such error rates are statistically valid. However, the Division intends to further analyze the impact of the recommendation by the state auditor to create audit samples from individual claims with respect to manpower issues and take appropriate action.*

ADDITIONAL COMMENTS

State Regulations Provide for Non-Competitive Procedures to Purchase Services for Division Clients

The division currently contracts with 30 not-for-profit entities to provide a comprehensive array of services to clients including mental health evaluation and assessment services, individual and group therapies, and medical services. State laws (34.100 and 630.405, RSMo 2000) authorize the division to purchase services for its clients from providers directly rather than going through the Office of Administration. State regulation (9 CSR 25-2.105) provides that the division may designate entities, to provide psychiatric services, and noncompetitive negotiation procedures shall be used when the division designates an affiliated community service provider. The regulation further states that the division shall contract with affiliated community service providers, after negotiating terms, for a 1-year period with option for renewal at the division's discretion.

As authorized by state regulations, the division has renewed 28 of the 30 service provider contracts non-competitively since 1988. The division did not renew one contract in 1997 due to nonperformance issues. At that time the division issued a request for proposal and awarded the contract to a new contractor based on competitive bid. The division did not renew another contract in 2000 also due to nonperformance issues. The division awarded the contract to an existing contractor within that service area. Division officials said the division has received little interest by potential contractors to bid for the comprehensive level of services the winning bidders are required to provide, especially within the current established rate structures. Division officials said the division has continued to renew contracts with current contractors due to their strong value of continuity of service delivery for the divisions' clients, who often require lifelong service and support. In addition, they said the division's current contracting methodology allows focus on quality of client care services and a comprehensive range of services while encouraging cooperative rather than competitive relationships among providers. According to division officials, the ability to renew contracts non-competitively to qualified contractors has helped minimize the number of disruptions to client care services and provided positive therapeutic results for client care.

APPENDIX I

OBJECTIVES, SCOPE AND METHODOLOGY

Objectives

The objectives of this audit were to determine (1) the extent contractors were reporting to the division incidents of client abuse and neglect, (2) if the division has implemented effective monitoring procedures over contractor provided services and related charges, and (3) if contractors were selected based on a competitive bid procedure supported by a request for proposal process.

Scope and Methodology

The scope of review was limited to the 12-month period July 1, 2001, thru June 30, 2002.

To develop information on the effectiveness of the division's oversight of contractors, affiliates and residential care facilities, we reviewed state laws and regulations that govern the operations of the division including:

- a review of the department's contracts with the contractors to ensure they were established in accordance with state laws/regulations, and

- verification of the department's authorization from the Office of Administration to contract directly with the contractors and residential care facilities.

Additionally, we reviewed the division's methods for monitoring division policy and contract compliance including a review of:

- performance measures regarding structured client support programs,

- the division's billing audit and certification review procedures, and

- the Secretary of State's registration records and annual report filings for each contractor and a sample of residential care facilities to ensure all were registered in good standing.

We also:

- toured selected contractor facilities in the division's northwest and eastern regions and a sample of residential care facilities in the northwest region, and

- conducted limited criminal background checks on a random sample of contractor case managers.

To further develop information on the effectiveness of the division's oversight of contractors who provide service to individuals with mental illness, we interviewed contractor officials to

determine their policies and procedures for obtaining, reviewing, archiving, and reporting client incidents and client grievances. To test the effectiveness of these procedures we analyzed 385 incident reports documented by contractors from two of the division's five regions (northwest and eastern). We obtained incident reports from:

- BJC Behavioral Health Community Services, St. Louis
- Comprehensive Mental Health Services, Kansas City
- Family Guidance Center, St. Joseph
- North Central Missouri Mental Health Center, Trenton
- Pathways Community Behavioral Healthcare, Inc., Warrensburg
- Swope Parkway Health Center, Kansas City
- Tri-County Mental Health Services, Kansas City
- Truman Medical Center Behavioral Health, Kansas City

Research Mental Health Services, a contractor in the northwest region, could not provide the necessary documentation to be included in the incident reporting analysis. We also obtained a copy of the Incident Investigation and Tracking database from the Department of Mental Health headquarters for comparison between the reporting processes. We researched inconsistencies within reporting and investigation procedures among the division regional offices.

Our analyses focused on the northwest and eastern regions because they receive combined about $46 million of the $82 million funding from this program (due to the client population), serve both rural and urban client populations, and have both large and small client caseloads.

APPENDIX II

BACKGROUND

The Department of Mental Health - Division of Comprehensive Psychiatric Services (division) provides assistance to over 57,000 persons with mental illness. The division has established regional offices in Columbia, Kansas City, Poplar Bluff, Springfield, and St. Louis to administer the division's mental health programs. Within these regional offices there are 25 service areas, which are administered by 30 contractors and/or affiliates. The contractors are paid by the division to provide an array of mental health services and are the designated entry/exit points to the state's mental health delivery system. For those clients who require assisted living services, the state also contracts with residential care facilities to provide safe, sanitary, and supervised living arrangements.

Contracts established between the division and the contractors stipulate the authority, responsibility, and accountability for providing specific services within each of the 25 service areas. The contract methodology focuses on a comprehensive range and quality of services, and cooperative rather than competitive relationships among service providers. Contract requirements state that contractors must be licensed and/or certified by the Department of Mental Health in order to provide certain services and programs. Some of the services provided by contractors include:

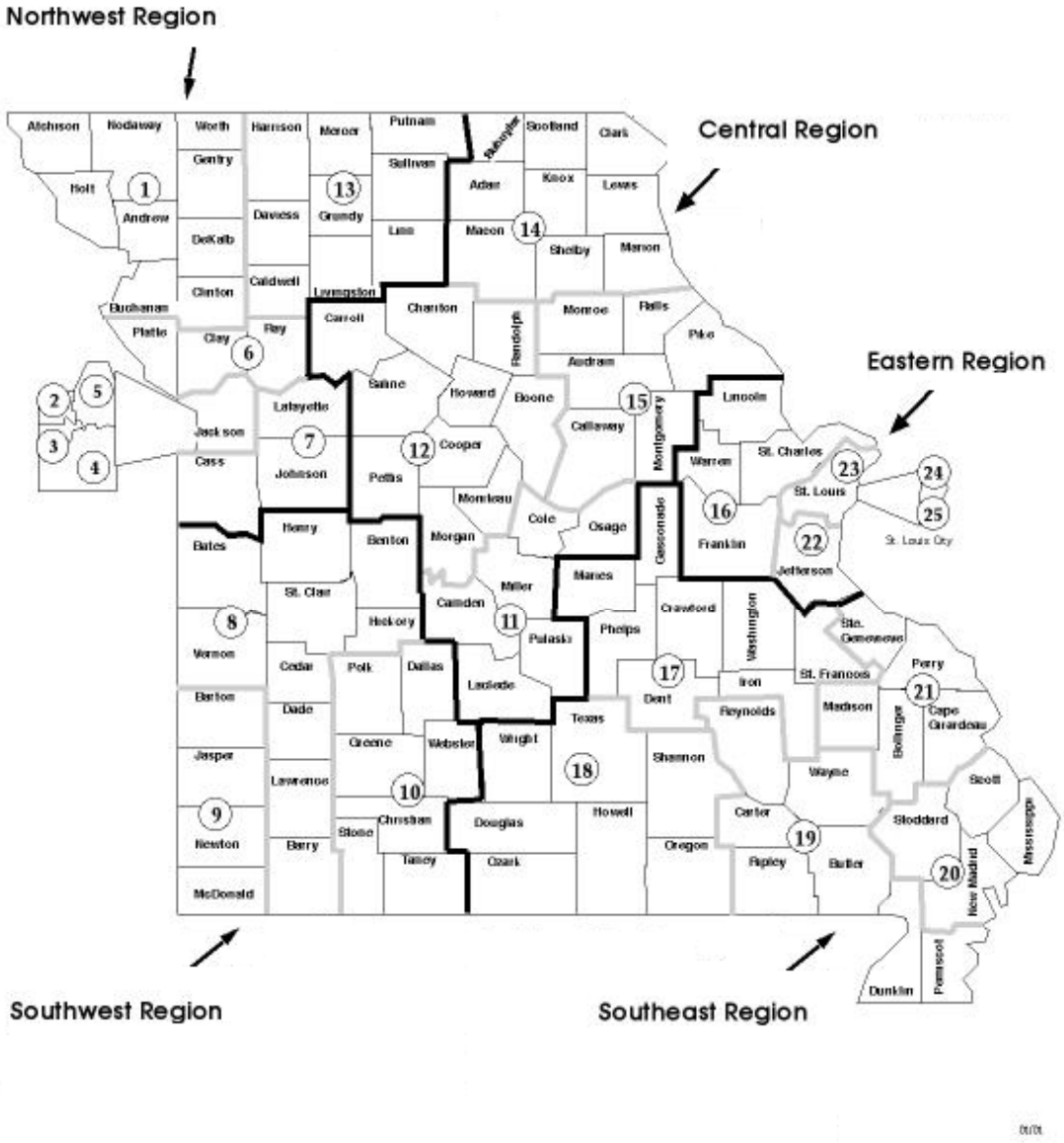
- Mental health evaluation and assessment
- Individual and group therapies
- Day treatment
- Medical services
- Administrative coordination
- Information and education services
- Access or provision to inpatient care on both a scheduled and 24- hour-a-day basis
- Follow-up services to individuals discharged from state-operated facilities
- Case management and community psychiatric rehabilitation for individuals in the supported community living programs

All contracts are subject to noncompetitive negotiation with automatic annual renewal unless the division discovers performance or administrative issues which compromise client care.

Regions and Service Areas

The following map shows the division’s 5 regions and 25 service areas.

MISSOURI DEPARTMENT OF MENTAL HEALTH
Division of Comprehensive Psychiatric Services
Administrative Regions and Service Areas



APPENDIX II

Table II.1: Location and Service Area for Contractors/Affiliates[1]

Contractors and Affiliates	Location	Service Area
Family Guidance Center	St. Joseph	1
Truman Medical Center Behavioral Health	Kansas City	2
Swope Parkway Health Center	Kansas City	3
Research Mental Health Services	Lee's Summit	4
Comprehensive Mental Health Services	Independence	5
Tri County Mental Health Services	Kansas City	6
Pathways Community Behavioral Healthcare, Inc.	Warrensburg	7
Pathways Community Behavioral Healthcare, Inc. - (Affiliate)	Clinton	8
Clark Community Mental Health Center - (Affiliate)	Monett	8
Ozark Center	Joplin	9
Burrell Behavioral Health	Springfield	10
Pathways Community Behavioral Healthcare Inc.	Jefferson City	11
New Horizons Community Support Services - (Affiliate)	Jefferson City	11
University Behavioral Health Services	Columbia	12
New Horizons Community Support Services - (Affiliate)	Columbia	12
North Central Missouri Mental Health Center	Trenton	13
Mark Twain Area Counseling Center	Hannibal	14
Arthur Center	Mexico	15
Crider Center	Wentzville	16
BJC Behavioral Health Community Services	Farmington	17
Pathways Community Behavioral Healthcare - (Affiliate)	Rolla	17
Ozarks Medical Center	West Plains	18
Family Counseling Center	Kennett	19
Bootheel Counseling Services	Sikeston	20
Community Counseling Center	Cape Girardeau	21
Comtrea Community Treatment	Festus	22
BJC Behavioral Health Community Services	Bridgeton	23
BJC Behavioral Health Community Services	Kirkwood	23
Places for People, Inc. - (Affiliate)	St. Louis	23
Independence Center - (Affiliate)	St. Louis	23
ADAPT Institute of Missouri - (Affiliate)	St. Louis	23
Hopewell Center	St. Louis	24
BJC Behavioral Health Community Services	St. Louis	25
Places for People, Inc. - (Affiliate)	St. Louis	25
Independence Center - (Affiliate)	St. Louis	25
ADAPT Institute of Missouri - (Affiliate)	St. Louis	25

[1]Some contractors have multiple locations, but operate under one contractual agreement with the division.

Source: Division of Comprehensive Psychiatric Services records

APPENDIX III

STATUTES AND CODE OF STATE REGULATIONS

Section 630.115.1, RSMo 2000 prescribes each client shall be entitled to certain rights without limitation that include (1) humane care and treatment with dignity; (2) medical care and treatment in accordance with the highest standards accepted in medical practice to the extent that the facilities, equipment and personnel are available; (3) safe and sanitary housing; and (4) freedom from verbal and physical abuse.

Section 630.165.1, RSMo 2000 requires anyone: "physician, dentist, chiropractor, optometrist, podiatrist, intern, nurse, medical examiner, social worker, psychologist, minister, Christian Science practitioner, peace officer, pharmacist, physical therapist, facility administrator, nurse's aide or orderly in a residential facility, day program or specialized service operated, funded or licensed by the department or in a mental health facility or mental health program in which people may be admitted on a voluntary basis or are civilly detained pursuant to Section 632, RSMo, or employee of the department has reasonable cause to believe that a patient, resident or client of a facility, program or services has been abused or neglected, he shall immediately report or cause a report to be made to the department or the department of health, if such facility or program is licensed pursuant to chapter 197, RSMo."

Section 630.167, RSMo 2000 requires the department or its agents, contractors or vendors, or the Department of Health and Senior Services to investigate reports of abuse and neglect within 24 hours upon receipt of a report. If the investigation indicates possible abuse or neglect of a patient, resident or client, the investigator shall refer the complaint and the investigator's report to the department director for appropriate action. "Within 5 working days after a report required to be made pursuant to this section is received, the person making the report shall be notified in writing of its receipt and of the initiation of the investigation."

Section 630.168, RSMo 2000 requires the heads of facilities, programs or services to promptly notify and cooperate with local law enforcement authorities during conduct of an investigation of all alleged or suspected acts of client abuse resulting in physical injury or in cases of sexual abuse.

Section 632.005 (9), RSMo 2000 defines the division director as the Director, Division of Comprehensive Psychiatric Services of the Department of Mental Health, or his designee.

Section 632.050, RSMo 2000 states the division shall identify community-based services in each geographic area as entry and exit points into and from the state mental health delivery system offering a continuum of comprehensive mental health services.

9 CSR 10-5.200 prescribes procedures for reporting and investigating complaints of abuse, neglect and misuse of client funds/property. Definitions are:

- Class I neglect--"failure of an employee to provide reasonable and necessary services to maintain the physical and mental health of any consumer when that failure presents

either imminent danger to the health, safety or welfare of a consumer, or a substantial probability that death or physical injury would result."

- Class II neglect--"failure of an employee to provide reasonable or necessary services to a consumer according to the individualized treatment or habilitation plan, if feasible, or according to acceptable standards of care. This includes action or behavior which may cause psychological harm to a consumer due to intimidating, causing fear or otherwise creating undue anxiety."

- Consumer--"individual (client, resident, patient) receiving services directly from any program or facility contracted, licensed, certified or funded by the department."

- Misuse of funds/property--"the misappropriation or conversion of a consumer's funds or property for another person's benefit."

- Physical abuse--"Purposefully beating, striking, wounding or injuring any consumer; or in any manner whatsoever mistreating or maltreating a consumer in a brutal or inhumane manner."

- Sexual abuse--"any touching of a consumer for sexual purpose or in a sexual manner."

- Verbal abuse--"using profanity or speaking in a demeaning, nontherapeutic, undignified, threatening or derogatory manner in a consumer's presence."

Additionally, according to state regulations:

- "Any employee who has reasonable cause to believe that a consumer has been subjected to physical, sexual or verbal abuse, misuse of funds/property, class I neglect, or class II neglect while under the care of a residential facility, day program or specialized service that is licensed, certified or funded by the department shall immediately make a verbal or written complaint."

- "A complaint shall be made to the head of the facility, day program or specialized service, and to the department's regional center, supported community living placement office or regional administrator office."

- "The head of the facility, day program or specialized service shall forward the complaint to the Division of Family Services if the alleged victim is under the age of eighteen (18); or the Division of Senior Services if the alleged victim is a resident, client of a facility licensed by the Division of Senior Services, or receiving services from an entity under contract with the Division of Senior Services."

- "Failure to report shall be cause for disciplinary action, criminal prosecution, or both."

APPENDIX III

The head of the residential facility, day program or specialized service that is licensed, certified or funded by the department is required to immediately report alleged sexual abuse, physical injuries caused by abuse and neglect and potential criminal misuse of property or funds to the local law enforcement official. Accordingly, the head of the facility or program and all employees of the facility, program or service shall fully cooperate with law enforcement authorities and with department employees or employees from other agencies authorized to investigate the complaint. Failure to cooperate may result in contract termination or dismissal of the employee.

"A board of inquiry, local investigator assigned by the division, or the department's central investigative unit shall gather facts and conduct an investigation regarding the alleged abuse or neglect. The investigation shall be conducted in accordance with the procedures and time frames established under the department's operating regulations. Upon completion of its investigation, the board of inquiry, local investigator or central investigative unit shall present its written findings of facts to the head of the supervising facility."

9 CSR 10-7.070(4)(D), requires "the program shall establish and implement policies defining the types of medication errors that must be reported to a licensed physician."

Department Operating Regulation 2.210 4(c), requires the regional administrator's office, regional center director's office or other department designee to initiate an investigation upon receiving a complaint. Investigations of class I neglect, physical abuse or sexual abuse shall be initiated immediately. Investigations of class II neglect, misuse of funds/property or verbal abuse shall be initiated within 24 hours. "The investigation report shall be completed within 30 working days of the filing of the complaint. A preliminary report shall be completed if the investigative report cannot be completed within 30 working days due to conditions beyond control of the investigative body (e.g. awaiting outside records such as an autopsy report). The preliminary report will contain the current findings, reason(s) for delay, and the expected completion date of the investigative report."

APPENDIX IV

EXAMPLES OF DOCUMENTED INCIDENTS NOT REQUIRED TO BE REPORTED TO THE DIVISION

Table IV.1: Incidents Not Reported

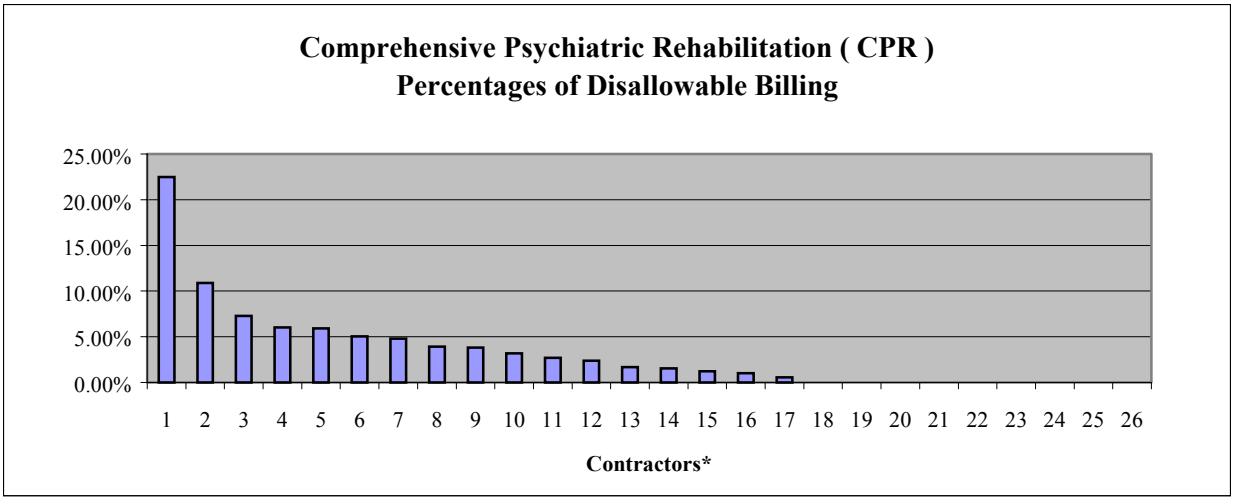
Date	Description
07/03/2001	Client acting inappropriate - EMT called - client hospitalized
07/03/2001	Client fell and taken to emergency room at hospital
07/09/2001	Client medication error
07/24/2001	Client fell and hit head - taken to hospital
08/15/2001	Client medication missing - not found
08/21/2001	Client committed suicide
08/29/2001	Client ticketed for animal cruelty
09/10/2001	Client given incorrect medication
09/13/2001	Client medication missing
09/24/2001	Client threatened to commit suicide
09/25/2001	Client complained of chest pain and sent to hospital
10/10/2001	Client given incorrect medication
10/15/2001	Client medication error - client hospitalized
10/18/2001	Client made suicidal gestures
10/24/2001	Client death - natural causes
10/29/2001	Client assaulted a relative resulting in the relative's death
10/31/2001	Client medication error
11/25/2001	Client death - natural causes
12/01/2001	Client elopement
12/08/2001	Client assaulted another client
01/06/2002	Client committed suicide
02/07/2002	Client in possession of illegal substance
02/11/2002	Client given incorrect medication
02/20/2002	Client made homicidal threat
03/04/2002	Client overdosed - suicidal gesture
03/21/2002	Client threatened to shoot/assault person and then threatened to commit suicide
03/24/2002	Client suicide attempt and admitted to hospital
04/05/2002	Client threatened to kill relative
04/27/2002	Alleged that staff sexually assaulted client
06/08/2002	Client hitting himself in the head with pipe
06/13/2002	Client made suicidal gestures and sent to hospital
06/28/2002	Client diagnosed with HIV threatens to bite other clients

Source: SAO analysis of non-reported incidents received from contractors

APPENDIX V

BILLING AUDIT SUMMARY

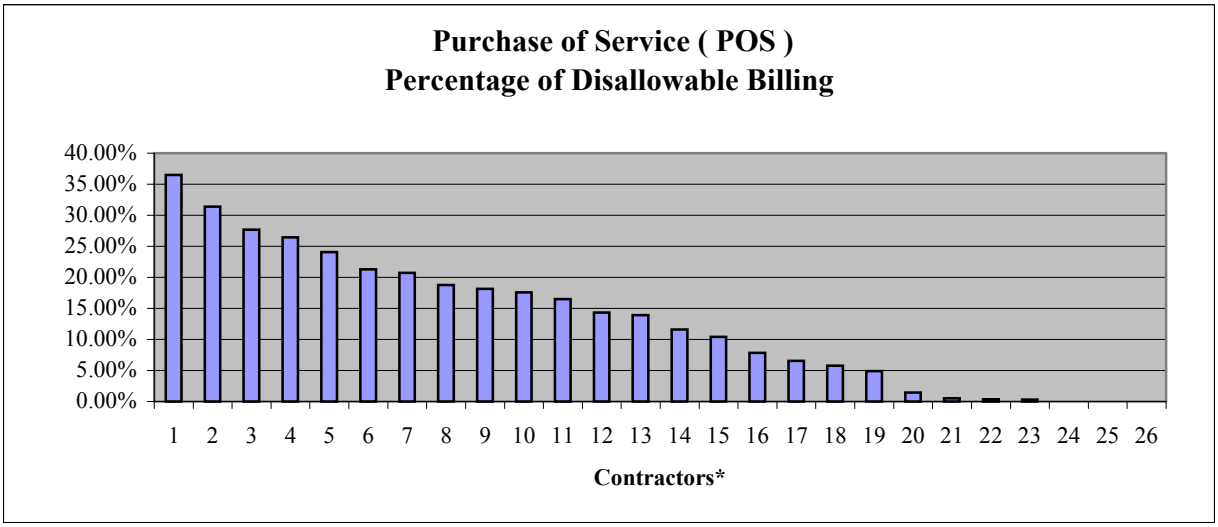
Figure 5.1: CPR Disallowable Billing Percentages Based on Division Billing Audits



Source: SAO analysis

*Contractors are identified numerically, but are not identical among each billing category graph.

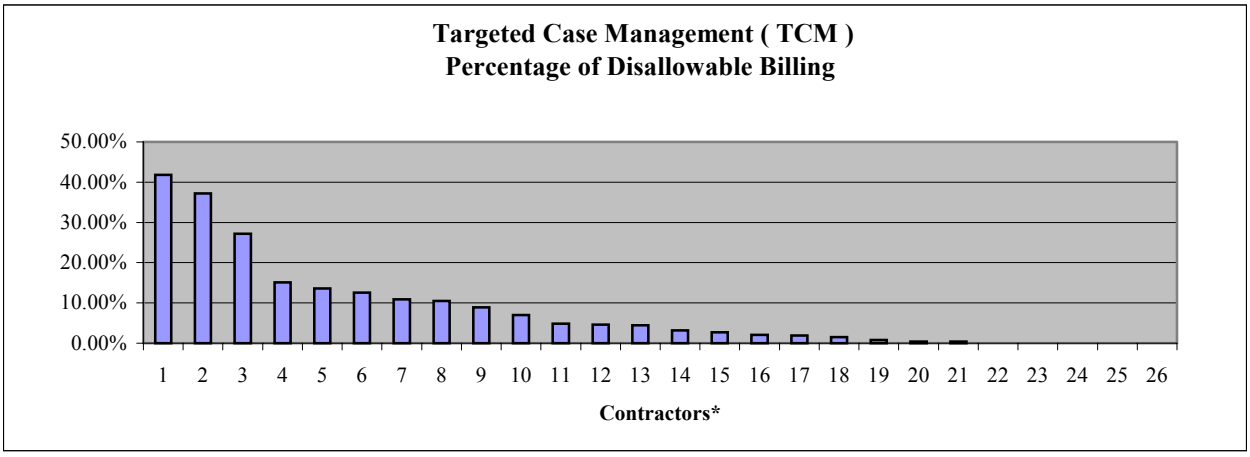
Figure 5.2: POS Disallowable Billing Percentages Based on Division Billing Audits



Source: SAO analysis

*Contractors are identified numerically, but are not identical among each billing category graph.

Figure 5.3: TCM Disallowable Billing Percentages Based on Division Billing Audits



Source: SAO analysis

*Contractors are identified numerically, but are not identical among each billing category graph.

APPENDIX VI

DIVISION DEFINITIONS

POS - Purchase of Service A basic billing system the Department of Mental Health uses to record services and generate invoices to various payers. It is the billing system for community based outpatient services delivered by providers, most of whom are administrative agents.

TCM - Targeted Case Management A specific Medicaid supported program that essentially consists of a single service (case management).

CPR - Community Psychiatric Rehabilitation A specific Medicaid supported program with a menu of about 10 services. It can be delivered to Medicaid clients and paid through the Medicaid billing system, or to non-Medicaid clients and billed through the POS system.

CAPS This term refers to a specific sample representing amounts billed over a cap for those charges. It applies only to one service in one program: Community Support services in the CPR program. It is the most frequently used service from the CPR menu, constituting about 70 percent of all payments.