

An Audit of

Community Service Contracts at Selected Health and Human Service Agencies

June 2002

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Key Points of Report

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Overall Conclusion

The Department of Mental Health and Mental Retardation (MHMR) and the Department of Human Services (DHS) do not adequately establish and monitor their community service contracts to ensure that client services result in appropriate outcomes and that funds are properly managed. As a result, MHMR and DHS may be unaware of providers that are providing substandard services and have weak fiscal operations.

Additionally, the Health and Human Services Commission (HHSC) has not fully complied with Texas Government Code, Section 2155.144, which requires HHSC to develop contract management processes for health and human service agencies. While MHMR and DHS need to take appropriate action to improve their contract administration, some of the weaknesses identified at MHMR and DHS can be addressed through HHSC's compliance with this statute.

The Interagency Council on Early Childhood Intervention (ECI) has generally adequate procedures to establish and monitor client service contracts.

Key Facts and Findings

- MHMR appropriately identified that it could recoup \$2.4 million at 27 community mental health and mental retardation centers (community MHMR centers) because these centers were not meeting contractual performance targets during the last three quarters of fiscal year 2001. MHMR took no action to recoup these funds. However, MHMR recouped approximately \$700,000 from the first quarter of fiscal year 2001.
- MHMR should strengthen its administration of community MHMR center contracts by establishing contract provisions that adequately address client outcomes. Furthermore, MHMR should improve its contract monitoring to ensure that services result in appropriate outcomes and funds are spent appropriately.
- MHMR needs to continue to closely monitor the financial health of community MHMR centers involved in the NorthSTAR managed care program.
- DHS should improve its contract administration to focus on outcomes of community care services. While DHS' community care contracts contain output and efficiency measures, they lack provisions to assess client outcomes. Additionally, DHS' monitoring of community care contracts does not adequately assess contractor performance.
- DHS needs to strengthen its fiscal oversight of the Star+Plus managed care program to ensure that program funds are used in the most efficient and effective manner.

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The Department of Mental Health and Mental Retardation (MHMR) and the Department of Human Services (DHS) do not adequately establish and monitor their community service contracts to ensure that client services result in appropriate outcomes and that funds are properly managed. As we previously reported in October 1994 and February 1996, contract administration still focuses on compliance with federal and state standards and regulations, which do not adequately address client outcomes. Fiscal monitoring procedures have improved since 1996, but further improvements are still needed.

Additionally, the Health and Human Services Commission (HHSC) has not fully complied with Texas Government Code, Section 2155.144, which requires HHSC to develop contract management processes for health and human service agencies. While MHMR and DHS need to take appropriate action to improve their contract administration, some of the weaknesses identified at MHMR and DHS can be addressed through HHSC's compliance with this statute.

The Interagency Council on Early Childhood Intervention (ECI) has generally adequate procedures to establish and monitor client service contracts.

MHMR Should Strengthen Its Administration Of Community MHMR Center Contracts To Ensure That Services Result In Appropriate Outcomes And Funds Are Spent Appropriately

MHMR's procedures for establishing and monitoring client service contracts do not provide reasonable assurance that contractors provide agreed-upon services at contractually specified prices.

MHMR appropriately identified that it could recoup \$2.4 million at 27 community mental health and mental retardation centers (community MHMR centers) because these centers were not meeting contractual performance targets during the last three quarters of fiscal year 2001. MHMR took no action to recoup these funds. However, MHMR recouped approximately \$700,000 from the first quarter of fiscal year 2001.

Additionally, the performance measures in MHMR's contracts with community MHMR centers do not fully gauge the effectiveness and efficiency of the community MHMR centers' operations. Contractual performance measures focus on client head count, which may cause community MHMR centers to strive to deliver services to more people at the expense of providing quality services. Coupled with the fact that MHMR's Client Assignment and Registration (CARE) system does not track the amount, duration, or scope of actual services provided, this means that MHMR may be unaware of instances in which community MHMR centers are providing substandard services. It also means that MHMR may be making improper decisions in its contract administration function.

MHMR's procedures for establishing and monitoring client service contracts do not provide reasonable assurance that contractors spend funds in accordance with state and federal requirements. These weaknesses increase the risk that MHMR will not identify and correct problems in a timely manner in service delivery and fiscal operations at the community MHMR centers with which it contracts. For example, MHMR did not adequately monitor information regarding community MHMR center expenditures of New Generation Medication funds in two cases:

- An independent audit report for fiscal year 2001 revealed improper use of more than \$1 million in New Generation Medication funds at the Denton County Community MHMR Center. MHMR

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agreed to allow this center to pay back the money over three years in quarterly payments with no interest.

- Independent auditors identified improper accounting for New Generation Medication funds in fiscal years 2000 and 2001 at the Harris County Community MHMR Center. However, MHMR has not followed up to determine whether this center misspent these funds.

MHMR may be unaware of weak fiscal operations at high-risk community MHMR centers. For example, MHMR has not conducted an on-site monitoring visit at the largest community MHMR center in the state, the Harris County Community MHMR Center, since 1998. When we conducted an on-site visit at this center, we found that the center did not accurately record payments to its subcontractors for 23 percent of transactions we tested. The errors totaled approximately \$43,200.

In fiscal year 2001, the 42 community MHMR centers received more than \$475 million of MHMR's \$1.7 billion appropriated budget. In addition to that amount, more than \$40 million went to NorthSTAR, a managed care pilot program for which community MHMR centers are the largest providers. During fiscal year 2001, independent audit reports specified that two out of the five community MHMR centers participating in NorthSTAR were in jeopardy of going out of business. MHMR needs to continue to closely monitor the financial health of community MHMR centers involved in the NorthSTAR managed care program.

DHS Should Improve Its Contract Administration To Focus On Outcomes of Community Care Services And Fiscal Operations Of The Star+Plus Managed Care Program

DHS' procedures for establishing and monitoring client service contracts do not provide reasonable assurance that contractors provide agreed-upon services at contractually specified prices.

DHS' contracts with community care providers contain performance measure provisions that focus on outputs, efficiencies, and processes. However, the contracts do not contain outcome performance measure provisions by which to assess the benefits clients receive from the providers' services. In addition, the contracts do not require providers to report performance measure information to DHS. DHS only reviews performance measure information when it conducts on-site monitoring visits.

The effect of these weaknesses can leave DHS unaware of providers that are providing substandard services and that have weak fiscal operations. In response to complaints rather than reported performance measure information, DHS initiated an investigation into a provider's fiscal activities and an alleged case of abuse and neglect in March 2002. It is significant that DHS had not conducted a monitoring visit at that provider since November 1999.

DHS' contract monitoring continues to focus on how providers spend funds and providers' compliance with federal and state standards and regulations. However, DHS' monitoring-risk-assessment process lacks specificity, and the monitoring process does not adequately assess providers' performance. In addition, communication among DHS' various units involved in monitoring is inadequate, and DHS lacks appropriate follow-up procedures to ensure

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that issues identified during monitoring visits are resolved.

DHS particularly needs to strengthen its fiscal oversight of the Star+Plus managed care program. For example, DHS should:

- Strengthen its monitoring of health maintenance organizations' (HMO) financial data and ensure that it recoups portions of the HMOs' profits to which the State is entitled. DHS did not recover \$18,279 from one HMO for the period ending August 31, 1999.
- Improve its efforts to ensure that Star+Plus HMOs pay providers in a timely manner.
- Improve its methodology for calculating the Star+Plus capitation rate.

In fiscal year 2001, more than 2,600 providers received approximately \$1 billion from DHS for community care services. In addition to that amount, more than \$230 million went to the Star+Plus program.

HHSC Has Not Fully Complied With Requirements To Develop Contract Management Processes

HHSC has not fully complied with Texas Government Code, Section 2155.144, which requires it to develop purchasing guidelines and contract management processes for health and human service agencies. HHSC has not developed a statewide risk analysis procedure, a contract management handbook, or a central contract management database required by the Texas Government Code. While MHMR and DHS need to take appropriate action to improve their contract administration, some of the weaknesses identified at MHMR and

DHS can be addressed through HHSC's compliance with this statute.

Texas Government Code, Section 2155.144, does not have a specific time frame for the implementation of its requirements (although it does require HHSC to prepare an annual report on agencies' compliance with HHSC's purchasing guidelines and contract management processes by December 15 of each year). To partially address these requirements, HHSC:

- Adopted rules in December 2000 to govern purchases of goods and services by health and human service agencies.
- Prepared an annual report in February 2002 that assesses the compliance of each health and human service agency and its rules governing purchases of goods and services.

ECI Has Generally Adequate Procedures To Establish And Monitor Client Service Contracts

ECI has generally ensured that its client service providers deliver agreed-upon services by (1) establishing a contract that clearly defines services and prices and (2) focusing its monitoring on how funds are spent, service outcomes, and compliance with contract provisions.

Summary of Management Responses

The agencies generally agree with our recommendations. Management responses from all four agencies are included immediately following each recommendation in the report.

Executive Summary

Summary of Objective, Scope, and Methodology

The objectives of this audit were to:

- Determine whether the procedures MHMR, DHS , and ECI use to establish and monitor purchased client service contracts provide reasonable assurance that:
 - Contractors provide agreed-upon services at contractually specified prices.
 - Contractors spend funds in accordance with state and federal requirements.
- Determine the status of HHSC’s compliance with statutes requiring it to develop purchasing guidelines and contract management processes for health and human service agencies.

The scope of this audit included community service contracts at MHMR, DHS, and ECI for fiscal years 2001 and 2002. Appendix 2 of this report provides an overview of the contract management processes at each of these agencies.

Our audit methodology consisted of reviewing applicable laws, policies, and procedures; conducting site visits at selected community care providers; analyzing operational data and relevant reports and documentation; and testing selected contract files and records.

Section 1:

MHMR Should Strengthen Its Administration of Community MHMR Center Contracts To Adequately Ensure That Services Result In Appropriate Outcomes And Funds Are Spent Appropriately

Although the Department of Mental Health and Mental Retardation (MHMR) has

Services Community MHMR Centers Provide Through Contracts with MHMR

- 24-hour emergency screening and rapid crisis stabilization services
- Community-based crisis residential services or hospitalization
- Community-based assessments, including the development of interdisciplinary treatment plans and diagnosis and evaluation services
- Family support services, including respite care
- Case management services
- Medication-related services, including medication clinics, laboratory monitoring, medication education, mental health maintenance education, and the provision of medication
- Psychosocial rehabilitation programs, including social support activities, independent living skills, and vocational training

Source: Department of Mental Health and Mental Retardation

improved its contract monitoring since we reviewed MHMR's contract administration in 1996, weaknesses in contract monitoring still remain. (See Appendix 3 for a map of MHMR's contract management process for community mental health and mental retardation center [community MHMR center] contracts.) These weaknesses increase the risk that MHMR will not identify and correct problems in service delivery and fiscal operations at the community MHMR centers with which it contracts.

In fiscal year 2001, the 42 community MHMR centers received more than \$475 million of MHMR's \$1.7 billion appropriated budget. Texas Health and Safety Code, Section 534.054, requires MHMR to award contracts to a local mental health or mental retardation authority in each service area. MHMR also is required to give preference to community MHMR centers located in each service area. As a result, MHMR is precluded from using competitive procurement procedures to select service providers and the majority of community MHMR centers have had contracts with MHMR for many years. This increases the need for effective contract monitoring of community MHMR centers.

Section 1-A:

MHMR Has Not Consistently Recouped Funds From Community MHMR Centers That Do Not Meet Contractual Performance Targets, Nor Has It Sanctioned Community MHMR Centers That Routinely Submit Inaccurate Client Data Or That Do Not Submit Required Reports On Time

MHMR appropriately identified that it could recoup \$2.4 million at 27 community MHMR centers because these centers were not meeting contractual performance targets during the last three quarters of fiscal year 2001. MHMR took no action to recoup these funds. However, MHMR recouped approximately \$700,000 from the first quarter of fiscal year 2001.

As Table 1 shows, the three community MHMR centers that we reviewed met between 70 and 82 percent of their output measures or service targets and between 57 and 90 percent of their outcome measure targets in fiscal year 2001.

Table 1

Performance Measures Data for Three Community MHMR Centers We Reviewed		
Community MHMR Center	Percent of Output Targets Met in Fiscal Year 2001	Percent of Outcome Targets Met in Fiscal Year 2001
Bluebonnet Trails Community MHMR Center	82%	90%
MHMR Authority of Harris County	73%	*90%
MHMR of Tarrant County	70%	57%
* MHMR Authority of Harris County did not report outcome measures for the first three quarters of fiscal year 2001. This figure is based on fourth quarter outcomes.		

Source: Texas Department of Mental Health and Mental Retardation

In addition, MHMR has not imposed sanctions on community MHMR centers that fail to submit timely and accurate information. Specifically:

- MHMR has not consistently imposed sanctions on community MHMR centers that routinely submit inaccurate client service data to the Client Assignment and Registration (CARE) system. As of the end of the first quarter of fiscal year 2002, only 5 out of 42 community MHMR centers met data accuracy standards for reporting in the previous three quarters.
- MHMR has not imposed sanctions on community MHMR centers that repeatedly miss deadlines for submitting quarterly and annual reports. Each community MHMR center submits at least 2 different quarterly reports and 13 different annual reports to MHMR. During fiscal year 2001, community MHMR centers submitted 29 percent of these reports after the deadline stipulated in the contract.

Recommendation:

MHMR should enforce contractual provisions by recouping funds from and imposing sanctions on community MHMR centers that do not meet contractual performance targets or do not submit timely and accurate information.

Management's Response:

- *TDMHMR agrees that we have not consistently recouped funds from community MHMR centers. The performance contract language does not mandate recoupment but provides for the ability to consider extenuating circumstances. In FY 2001, approximately 75% of the recoupment was due from Centers which were in the top 20 in terms of financial risk as of the second quarter with almost 50% coming from 2 small centers in the top 5 in terms of financial risk. It was determined that recoupment would have further*

contributed to the financial risk for these Centers and thus overall recoupment was suspended. During FY 2001, interventions were performed with several of these twenty Centers in the high risk category, including technical assistance, plans of correction, on-site reviews, and monthly financial evaluation.

- *TDMHMR resumed recoupment in the 1st quarter of 2002 and has sent notices of recoupment for the 2nd quarter of 2002. The Department will continue to monitor the impact of recoupment on the overall financial viability of the centers and to take intervention steps as necessary to improve performance.*
- *TDMHMR has stepped up enforcement of its contract with the community MHMR centers. A penalty of \$5,000 per quarter is assessed for submission of inaccurate data.*
- *TDMHMR's policy is to issue a penalty for the late submission of required documentation unless the community MHMR center contacts the Department in advance of the due date with legitimate extenuating circumstances.*

Section 1-B:

MHMR's Performance Measurement System Does Not Adequately Assess Client Outcomes

Generally, MHMR's performance contract with community MHMR centers contains all provisions required by statute. The contract states the responsibilities of both parties and clearly defines services and prices and the minimum acceptable performance against a number of output and outcome targets. However, the performance measures in MHMR's contracts with community MHMR centers do not fully gauge the effectiveness and efficiency of the community MHMR centers' operations.

Executive management at the three community MHMR centers we reviewed stated that they do not have adequate opportunities to provide feedback to make the performance measures more meaningful. They agreed that the current measures are limited in the following ways:

- The current performance measures stress client head count over quality or appropriate depth of treatment. By focusing on head count, community MHMR centers may strive to deliver services to more people at the expense of providing quality services.
- The current performance measures do not measure all community MHMR center services such as crisis and hotline services and respite care services. This can lead to the reduction or omission of services. (However, we noted that MHMR monitors crisis and hotline services with an annual survey.)

MHMR is currently in the process of reviewing its mental health performance measures for community MHMR center contracts. The community MHMR centers also recognize that MHMR created its Performance Contract Committee to provide a vehicle for community MHMR centers to offer feedback during the contract establishment and renewal process.

MHMR’s contracts with community MHMR centers do not contain clearly defined outcome measures for mental retardation (MR) services.

MHMR’s contracts with community MHMR centers clearly state that local authorities shall meet or exceed 18 service targets and 16 mental health outcome targets that are defined in attachments to the contract. (*Service targets* are the numbers of persons being served.) The attachments do not define outcome measures for mental retardation services such as service coordination, vocational training, or daily living skills.

Quality Assurance and Improvement System (QAIS)

QAIS was designed to be a framework by which community MHMR centers measure the success of their mental retardation services. It is based on a national accreditation program used by The Council on Quality and Leadership in Supports for People with Disabilities. Personal outcome measures are the core of QAIS and the tools used to ensure that centers focus on quality improvement and measurement that emphasize responsiveness to individual needs. The results are based on client interviews.

Source: Department of Mental Health and Mental Retardation

MHMR’s contracts require local authorities to conduct an annual QAIS self-assessment (see text box). MHMR conducts on-site reviews to validate the self-reported data and there is a performance target related to the accuracy of QAIS data. However, MHMR has not defined targets for the outcome measures defined within QAIS. Furthermore, sample sizes may not be adequate to draw valid conclusions and there is no trend analysis of results. The only way that MHMR holds community MHMR centers accountable for outcomes is through a requirement to implement a quality improvement plan.

MHMR does not use most of the mental health outcome measures to assess risk related to its contracts with community MHMR centers.

As already noted, MHMR’s contracts with community MHMR centers require these centers to meet or exceed 16 mental health outcome targets. However, MHMR does not use 13 out of the 16 mental health outcome targets to assess risk related to its contracts with the centers (see Table 2). According to management, two of the measures are not useful for risk assessment, one is used for other contract oversight functions, and six of the measures are addressed during on-site monitoring visits. Texas Administrative Code, Title 25, Section 417.61, requires MHMR to use performance outcomes to assess risk among the community MHMR centers.

Table 2
MHMR does not use most of the mental health outcome targets to assess risk related to its contracts with community MHMR centers.

Mental Health Outcome Targets in Community MHMR Center Contracts	Used by MHMR for Risk Assessment? (Y/N)
Adult Services – percent of adult clients receiving full mental health assessment in last 12 months	Y
Child & Adolescent Services – Parent Measure – Percent Satisfied	N
Child & Adolescent Services – Child Measure – Percent Satisfied	N
Child & Adolescent Services – Collateral Measure – Percent Satisfied	N
Child & Adolescent Services – Behavioral Functioning – Percent Stabilized or Improved	N
Child & Adolescent Services – School Functioning – Percent Improved	N
Child & Adolescent Services – Juvenile Justice Involvement – Percent Improved	N

Mental Health Outcome Targets in Community MHMR Center Contracts	Used by MHMR for Risk Assessment? (Y/N)
Per capita admissions to state facilities	N
Average length of stay in community for persons receiving case management services who are readmitted to a state facility	N
Percentage of persons discharged from state facilities with a community support plan.	N
Percentage of persons receiving In-Home & Family Support admitted to a state facility within two years.	N
Readmissions	N
Utilization of State Facility Beds – Bed Days	N
Utilization of State Facility Beds – FYTD Cost	Y
Follow-up (face-to-face visit) within 7 days of release	Y
Community Tenure (days)	N

Source: Department of Mental Health and Mental Retardation

Recommendations:

MHMR should:

- Review all contractual performance measures to determine whether all current measures are necessary and whether other measures would provide useful information.
- Define outcome measures for mental retardation services and include these measures in all contracts with community MHMR centers. While QAIS provides a starting point for the definition of outcome measures, performance measures should be considered to address outcomes of service coordination, vocational training, daily living skills, and other mental retardation services. For example, the percentage of clients who are satisfied with services or the percentage of clients who are satisfied with their personal life situations. MHMR should then set specific targets for outcome measures of mental retardation services and take appropriate action with community MHMR centers that do not perform at targeted levels.
- Reassess the QAIS process to establish targets for the defined outcome measures, establish adequate sample sizes to draw valid conclusions, conduct trend analysis of results, and hold community MHMR centers accountable for outcomes through the use of sanctions.
- Calculate, report, and use all performance measures defined in MHMR contracts with community MHMR centers to assess risk related to its contracts with the centers.

Management's Response:

- *TDMHMR agrees that the agency's current performance and contract measures do not adequately address client outcomes in all areas. For the FY 03 Performance Contract, the Department has reviewed community services measures and made alterations based on an evaluation of their usefulness. Through the Benefit Design for Mental Health Services initiative, the Department is developing measures to assess outcomes for individuals with mental illness.*
- *TDMHMR agrees that the Performance Contract outcome measures for mental retardation services should be re-evaluated. Existing measures for mental retardation services will be reviewed and measures to address service coordination, vocational training, and daily living skills, and will be incorporated into CMHMRC contracts. Management agrees that CMHMRCs should be held accountable for the outcome of service delivery and will review and improve its process for accomplishing this, including the use of sanctions for not achieving outcomes.*
- *TDMHMR agrees to assess the QAIS process to determine the appropriateness of establishing targets or thresholds for the personal outcome measures and/or supports and methods for conducting valid trend analysis of results. Management will evaluate the use of sampling methodology.*
- *TDMHMR has found that not all performance measures in the contract apply to a risk assessment process. During the development of the risk assessment process, the agency evaluated all measures to determine their usefulness as risk indicators. Only indicators that contributed to assessing risk were included. Other measures serve other purposes. Management agrees to review the performance measures and ensure the usefulness of each measure for either risk assessment or other management purposes such as policy/program evaluation and quality improvement efforts.*

Section 1-C:

MHMR's Automated CARE System Does Not Provide Complete And Accurate Client Data On Which To Assess Risk at Community MHMR Centers

MHMR primarily assesses service risk at community MHMR centers by using its Client Assignment and Registration (CARE) system. However, the CARE system

tracks the number of clients served and the category of service. It does not track detailed information on the amount, duration, or scope of actual services provided. In addition, MHMR does not adequately ensure that data in the CARE system is accurate. This means that MHMR may be unaware of instances in which community MHMR centers are providing substandard services. It also means that MHMR may be making improper decisions in its contract administration function.

CARE System

Community MHMR centers report information to the MHMR using MHMR's Client Assignment and Registration (CARE) system. The CARE system was developed in the 1980s and is the official client database used by all of MHMR's components and the community MHMR centers. (See Appendix 3).

Source: Texas Department of Mental Health and Mental Retardation

We reported in April 2002¹ that MHMR:

- Does not have documented policies and procedures for entering data into the CARE system.
- Does not adequately control the community MHMR centers' access to the CARE system.
- Performs limited validation of client data information in the CARE system.

Additionally, MHMR does not adjust its risk assessment of community MHMR centers after it identifies inaccuracies in CARE data.

During our review of three community MHMR centers, we noted that these centers generally had adequate controls over their internal automated systems. However, they had some weaknesses related to a lack of cross-training, lack of operating manuals, and weak data input controls. Because of these weaknesses, we identified the following errors at two of the community MHMR centers:

- Forty-seven percent of the case files we tested at the MHMR Authority of Harris County lacked sufficient documentation to support the information in the CARE system. Additionally, 21 percent of the client information we tested in the MHMR Authority of Harris County database did not match information in the CARE system.
- Twenty-two percent of the case files we tested at the MHMR of Tarrant County lacked sufficient supporting documentation to support information in the CARE system.

We found an error rate of 1.7 percent at the third center. In April 2002, we reported error rates ranging from 0.0 percent to 8.5 percent when we tested the accuracy of CARE information at five other community MHMR centers.

Recommendations:

MHMR should:

- Consider tracking within the CARE system detailed information on the amount, duration, and scope of actual services provided.
- Adjust the risk assessment process for community MHMR centers after identifying inaccuracies in CARE data.
- Monitor community MHMR centers to determine that they have sufficient controls over their automated systems, including adequate cross-training, operating manuals, and data input controls.

¹ The State Auditor's Office reviewed the CARE system in 2001 (see *A Financial Review of The Department of Mental Health and Mental Retardation*, SAO Report No. 02-033, April 2002).

Management's Response:

- *The Department concurs with the general finding that the current method of reporting client data is less than adequate in providing complete and accurate information regarding the services provided by the community MHMR centers. The CARE system was originally developed in the 1980's as a system for tracking the continuity of care of individuals moving between state facilities and community based services. The primary purpose of CARE was to track enrollment in services, not to track the units of service actually provided. This continues to be the primary capability of CARE.*

The Department agrees that there is a need to capture data on the amount, duration and scope of services provided. The Department has an initiative underway to develop the infrastructure and reassign the resources to utilize encounter level data in the management and evaluation of contracted services.

- *TDMHMR agrees that it has not adjusted its risk assessment process for community MHMR centers after inaccuracies in CARE data have been identified. Management agrees to establish thresholds and procedures for when the correction of inaccuracies in CARE data will be conducted.*
- *Each of the individuals who have been authorized by the Department to have access to the CARE system has signed a security authorization form which sets out the instructions for access to that system. A similar process is used for access to the Health and Human Services Consolidated Network. The Department will continue to work with the Information Managers Consortium of the Texas Council of Community MHMR Centers to assure that community center employees are trained on the proper use of CARE, including the access to the system. The Department's Information Services Security unit is also developing a new application for annual reaffirmation of the security and privacy agreements, which should further strengthen the controls.*

The policies and procedures developed and processes implemented by community MHMR centers to ensure control over access to CARE will also be reviewed as part of the Local Authority Certification process currently under development by the Department and scheduled to begin in FY 2003.

Section 1-D:

MHMR Does Not Adequately Consider Community MHMR Centers' Independent Audit Reports When Assessing Financial Risk at These Centers

Due to timing considerations, MHMR appropriately relies on unaudited data to assess the financial position of community MHMR centers. However, when independent audit reports become available, MHMR does not revise its risk assessment. In some cases, the relative financial risk of individual community MHMR centers changed because of their fiscal year 2001 audited data. For example, one community MHMR center was the lowest risk center based on unaudited data; however, it moved up 22 places to a moderately high risk center based on audited data. This could lead to inefficient and ineffective allocation of resources because MHMR on-site monitoring visits could focus on relatively low-risk community MHMR centers.

In addition, MHMR has not consistently followed up on issues identified by independent auditors who review community MHMR center financial statements. For example, MHMR did not adequately monitor information regarding community MHMR centers' expenditures of New Generation Medication funds in the following two cases:

- An independent audit report revealed improper use of New Generation Medication funds at the Denton County MHMR Center. The independent auditors identified that this center spent more than \$1 million in New Generation Medication funds for purposes other than New Generation Medication. MHMR's contract with the center states that these funds should be used solely for New Generation Medication and that unspent or misspent funds should be returned to MHMR unless MHMR adjusts the allocation of New Generation Medication funds. MHMR agreed to allow this center to pay back the money over three years in quarterly payments. However, handling the situation in this manner was comparable to making an interest-free loan of state funds to the community MHMR center.

New Generation Medication

New Generation Medications are a specific set of drugs prescribed to individuals who suffer from schizophrenia, bipolar disorders, and major depressive disorders. Riders in the General Appropriations Act require MHMR to follow established guidelines for the use of New Generation Medication funds.

In fiscal year 2001, MHMR allocated approximately \$44.6 million in New Generation Medication funds to community MHMR centers serving approximately 21,000 clients.

Source: Texas Department of Mental Health and Mental Retardation

- Independent auditors identified improper accounting for New Generation Medication funds in fiscal years 2000 and 2001 at the MHMR Authority of Harris County. However, MHMR has not followed up to determine whether the center misspent the funds.

Recommendations:

MHMR should:

- Adequately incorporate independent audit reports into its assessment of risk at community MHMR centers. MHMR should update its risk assessment when independent audit reports become available and consistently follow up on all issues identified by independent auditors.
- Monitor community MHMR centers' expenditures for New Generation Medication and ensure that these funds are spent as the Legislature intends. When appropriate, MHMR should utilize its authority to adjust the allocation of New Generation Medication funds or require the local authority to return unspent New Generation Medication funds if MHMR determines that the local authority may not spend all of its allocated funds.

Management's Response:

- *TDMHMR believes that risk assessment should derive from both audited and unaudited financial information. Since audited reports are only submitted annually (due February 1), the Department requires CMHMRCs to submit financial statements quarterly, which although unaudited, provide key up-to-date financial data on the centers' financial condition. TDMHMR then computes quarterly risk ratios and assessments to determine trends in performance and appropriate level of intervention and follow up.*
TDMHMR has assessed the difference between the FY01 audited and 4th Quarter FY01 unaudited financial statements submitted for FY01 and determined that the overall risk rating, which includes financial and non-financial risk indicators, has not substantially changed.
- *The Department agrees that New Generation Medication funds should be spent only for New Generation Medications. Denton County MHMR Center represents an example of the difficulties that the Department faces with respect to high-risk centers. TDMHMR became aware of the high financial risk of Denton County MHMR Center in May of 2000 and requested a financial stability plan at that time. Throughout FY 2001, TDMHMR engaged in a variety of interventions with Denton County MHMR management to develop a strategy for ensuring the financial viability of the center while reinforcing accountability to the Department for the appropriate use of state funds. The three year pay back plan was implemented as part of the agreement of the center to engage in an intensive oversight process that involved close monitoring of financial and service delivery performance.*
- *Since annual audit reports are due February 1st, TDMHMR had not, at the time of the auditors' visit, completed review of the annual audit reports for determination of any findings. TDMHMR routinely verifies the implementation of corrective action by a center for any significant findings noted in independent auditors' reports. Specifically, the Department conducted an on-site visit to the MHMRA of Harris County to validate the expenditure of \$6,151,314 for new generation medications during FY02. As a part of the review, the Department tested client services documents to ensure proper use of new generation medication money.*
- *During FY 2002, TDMHMR Quality Management conducted a focused review of CMHMRCs to determine the accuracy of data submitted about New Generation Medications in order to ensure that the funds are expended as intended by the Legislature. Analysis of the results is underway. Plans of improvement will be required to address problems that are identified.*

Section 1-E:

MHMR Has Not Conducted An Adequate Number Of On-Site Monitoring Visits At High-Risk Community MHMR Centers

MHMR conducted on-site financial monitoring visits at only 2 of the 13 highest risk community MHMR centers (see Table 3) and only 4 of the 42 community MHMR centers with which it contracted in fiscal year 2001. Furthermore, only 2 other high-

risk community MHMR centers identified as high risk in fiscal year 2001 had received an on-site financial monitoring visit during fiscal years 1998, 1999, or 2000. This means that MHMR may be unaware of weak fiscal operations at high-risk community MHMR centers. During fiscal years 1998 through 2001, MHMR conducted a total of 24 on-site financial monitoring visits at 17 community MHMR centers.

Table 3

On-Site Visits to Higher Risk Community MHMR Centers						
Community MHMR Centers Identified by MHMR as Higher Risk as of the 4th Quarter of Fiscal Year 2001	FY01 Financial Monitoring Visit	FY00 Financial Monitoring Visit	FY99 Financial Monitoring Visit	FY98 Financial Monitoring Visit	FY01 Quality Management Review	FY01 QAIS Review
Life Management Center		✓		✓		✓
Johnson-Ellis-Navarro		✓				✓
Tropical Texas	✓	✓		✓		✓
Border Region					✓	✓
Austin-Travis County						✓
Dallas MetroCare Services*						
Tarrant County						✓
Brazos Valley						✓
Texoma						✓
Sabine Valley						
Lubbock						
ACCESS						
Denton County	✓					✓

* Although a formal financial monitoring visit was not conducted in fiscal year 2001 at Dallas MetroCare Services, other on-site monitoring did occur.

Source: Department of Mental Health and Mental Retardation

MHMR conducted an on-site quality management visit at 1 of the 13 highest-risk centers in fiscal year 2001. A total of six on-site quality management visits were conducted in fiscal year 2001 and two of those were at the same centers that received on-site financial monitoring visits. Additionally, QAIS reviews were conducted at 9 of the 13 highest-risk centers in fiscal year 2001, but as noted in Section 1-B, these were limited reviews to validate self-reported client survey information.

MHMR has not conducted an on-site monitoring visit at the largest community MHMR center in the state, the MHMR Authority of Harris County, since 1998. When we conducted our own on-site review at this center, we identified the following issues:

- As noted in Section 1-C, we identified a 47 percent error rate in the accuracy of client service data that this center submitted to the CARE system.

- This center did not accurately record payments to its subcontractors for 23 percent of transactions we tested. The errors totaled approximately \$43,200.
- This center did not comply with 5 out of 37 general contract provisions we tested. For example, the center did not comply with provisions requiring it to review and assess the effectiveness of the local authority's plan for reducing the number of confirmed incidents of abuse and neglect.

Recommendation:

MHMR should ensure that it conducts an adequate number of on-site monitoring visits of high-risk community MHMR centers. As part of this process, MHMR should consider the length of time between monitoring visits. For example, visits could be required once every three years.

Management's Response:

TDMHMR management uses progressive levels of intervention for monitoring and oversight including regular or periodic communication, reviews of detailed reports, training or technical assistance, and on-site reviews.

Many of the high-risk centers cited in the report had already been identified and some had been visited during the previous year. These high risk centers had submitted plans of improvement related to targeted risk areas and were being monitored as frequently as monthly.

TDMHMR continues to closely monitor those centers identified as high risk. Of the 13 centers identified for FY 01, 8 remain on the list for FY02. All of those 8 centers are currently receiving some sort of monitoring activity. During FY02, TDMHMR has conducted 5 onsite integrated (financial and programmatic) onsite reviews, 2 onsite "focused" reviews, and is engaged in 11 plans of improvement processes with CMHMRCs during the current fiscal year.

TDMHMR has established an integrated monitoring team that meets quarterly to evaluate financial, program and additional information related to CMHMRCs in order to better assess and respond to high risk issues.

TDMHMR will continue to review and assess the current methods for deployment of resources for onsite visits to ensure that all processes are efficient and effective and will make changes to improve processes and increase the frequency of reviews.

Section 1-F:

MHMR Needs To Continue To Closely Monitor the Financial Health of Community MHMR Centers Involved in the NorthSTAR Managed Care Program

The unique contractual relationship between MHMR and the 5 community MHMR centers involved in NorthSTAR demonstrates why MHMR needs to carefully review

community MHMR centers' independent audit reports and consider this information in its risk assessment. To deliver mental retardation services, community MHMR centers contract directly with MHMR as required by statute. However, the community MHMR centers involved in NorthSTAR sign a contract with a Behavioral Health Organization (BHO) to deliver mental health services. If a community MHMR center experiences financial problems operating under the managed care environment, this can affect the financial solvency of the community MHMR center as a whole. While this would not create difficulties for the BHO (because it could simply contract with another provider), MHMR is required by statute to continue contracting with that community MHMR center for mental retardation services. Therefore, it is critical that MHMR carefully monitor the financial health of the community MHMR centers that participate in the NorthSTAR managed care pilot program.

NorthSTAR Managed Care Program

NorthSTAR is a managed care pilot project created by MHMR, the Commission on Alcohol and Drug Abuse, and the Health and Human Services Commission. More than \$40 million went to NorthStar from MHMR in fiscal year 2001.

NorthSTAR integrates the publicly funded systems of mental health and chemical dependency services and was implemented in Dallas and contiguous counties in July 1999. Initially, MHMR contracted with two Behavioral Health Organizations (BHO). Since October 2000, MHMR has contracted with one BHO. The BHO contracts with direct health service providers, including community MHMR centers, to provide services.

Source: Department of Mental Health and Mental Retardation

Independent audit reports for fiscal year 2001 specified that two of the five community MHMR centers participating in NorthSTAR, Dallas Metrocare Services and Johnson-Ellis-Navarro MHMR Services, were in jeopardy of going out of business. These two community MHMR centers were not recording an allowance for bad receivables, even though they were aware that the BHO was not paying some of their claims. According to independent audit reports, total receivables at the end of fiscal year 2001 were approximately \$5.6 million for Dallas Metrocare Services and approximately \$0.4 million for Johnson-Ellis-Navarro MHMR Services. In January 2002, MHMR took over management of Dallas MetroCare Services, in part because of this center's relatively large accumulation of bad receivables.

Independent auditors also reported that Johnson-Ellis-Navarro MHMR Services did not account for its managed care business in a separate enterprise fund. By not accounting for managed care funds separately, this center increased the risk that it would use non-managed care funds to subsidize managed care. In fact, this community MHMR center and two other NorthSTAR community MHMR centers (Dallas MetroCare Services and LifePath Systems) used state mental health and mental retardation funds to subsidize managed care mental health services until the BHO paid their claims.

MHMR Is Not Using Encounter Data When It Sets Rates For The NorthSTAR Managed Care Program

Managed Care Encounter Data

Encounter data is the record of services provided to clients. It is the same data that the NorthSTAR Behavioral Health Organization uses to evaluate its payments to health care providers.

Source: Department of Mental Health and Mental Retardation

MHMR does not currently use encounter data when setting rates for the NorthSTAR managed care program. MHMR has begun to collect encounter data for program evaluation. However, it cannot use this information for rate-setting purposes until the Health and Human Services Commission certifies the data in accordance with Texas Government Code, Chapter 533. The requirement to certify encounter data was

added to the Texas Government Code through House Bill 1591 (77th Legislature).

MHMR relies on one rate-setting methodology to establish the capitation rates it pays to the NorthSTAR BHO. While that methodology is valid, MHMR does not have alternative, reliable data to ensure the cost-effective provision of quality health care under the NorthSTAR program.

Recommendations:

MHMR should:

- Continue to closely monitor the financial health of community MHMR centers that are involved in the NorthSTAR program.
- Closely monitor NorthSTAR community MHMR centers to ensure that these centers do not use funds they receive for providing mental retardation services (through contracts with MHMR) to subsidize the mental health services they provide (through contracts with the NorthSTAR BHO).
- Work with the Health and Human Services Commission to pursue the certification of encounter data for NorthSTAR rate-setting purposes.

Management's Response:

- *TDMHMR agrees that close financial monitoring of NorthSTAR Community Centers is necessary. Those Centers identified as high financial risks are required to submit monthly financial statements and other pertinent data such as aged accounts receivables and payables so that their financial condition can be adequately assessed.*
- *The Department will continue to monitor the delivery of Mental Retardation Services at the centers participating in the NorthSTAR program to ensure the adequacy of services.*
- *77(R) HB 1591 directs the Health and Human Services Commission to obtain external certification of the accuracy of encounter data that will be used for rate setting. NorthSTAR encounter data is intended to be used for rate setting. The Commission is in the process of hiring an External Quality Review Organization (EQRO) to support Texas Medicaid Managed Care. The contract includes certification of encounter data as an EQRO function. The NorthSTAR Data Warehouse will be among the first encounter data sets evaluated for certification.*

Section 2:

DHS Should Strengthen Its Contract Administration to Focus on Outcomes of Community-Based Services and Fiscal Operations of the Star+Plus Managed Care Program

Community Care Services

The goal of the Community Care Program is to provide in-home and community-based services to functionally impaired people who are elderly or have disabilities, allowing them to remain in their own homes or communities. Certain services are available to functionally impaired children who have an established medical need. There are 15 different services that are alternatives to institutionalization.

Source: Department of Human Services

The Department of Human Services' (DHS) procedures for establishing and monitoring client service contracts do not provide reasonable assurance that contractors provide agreed-upon services at contractually specified prices. DHS' contracts with community care providers do not contain outcome performance measure provisions by which to assess the benefits clients receive from the providers' services.

As the number of clients served through DHS' community-based programs continues to increase, monitoring of client outcomes will continue to be critical. According to DHS, the percentage of long-term care clients served through DHS' community-based programs increased for the fifth year in a row during fiscal year 2001. The percentage of long-term care clients served through these programs consistently exceeded targeted levels by 2 percent or more in every fiscal year except fiscal year 1998.

Provider monitoring still focuses on compliance with federal and state standards and regulations (as we reported in October 1994 and February 1996). Fiscal monitoring procedures have improved since 1996 but improvements are still needed. DHS also needs to strengthen its fiscal oversight of the Star+Plus managed care program. (See Appendix 4 for a map of the DHS contract management process for community care contracts.)

In fiscal year 2001, more than 2,600 providers received approximately \$1 billion from DHS for community care services. Approximately 85 percent of those expenditures were for the two programs we tested: Community-Based Alternatives and Primary Home Care. In addition to that amount, more than \$230 million went to the Star+Plus program.

Section 2-A:

While DHS' Community Care Contracts Contain Output And Efficiency Measures, They Lack Provisions To Assess Client Outcomes

DHS' contracts with community care providers contain performance measure provisions that focus on outputs, efficiencies, and processes. However, the contracts do not contain outcome performance measure provisions by which to assess the benefits clients receive from the providers' services. In addition, the contracts do not require providers to report performance measure information to DHS. DHS only reviews performance measure information when it conducts on-site monitoring visits.

The effect of these missing provisions can leave DHS unaware of providers that are providing substandard services and that have weak fiscal operations. For example, in

response to complaints, rather than reported performance measure information, DHS initiated an investigation into a provider's fiscal activities and a case of alleged abuse and neglect in March 2002. Yet, DHS had not conducted a monitoring visit at that provider since November 1999.

Contract provisions do not adequately address the benefits clients receive from community care services.

As we reported in October 1998 (see *An Audit Report on Home and Community-Based Services at the Department of Health and the Department of Human Services*, SAO Report No. 99-005, October 1998), DHS' compliance standards continue to focus on how services are delivered, rather than on the benefits clients receive from the services. Output and efficiency performance measures such as the timeliness of service delivery and the existence of service breaks are clearly defined in DHS' Community-Based Alternative and Primary Home Care provider manuals. (These manuals are incorporated by reference in the contract provisions.) Providers must maintain at least 90 percent compliance with the defined output and efficiency measures. However, there are no outcome measures with which providers must comply. Examples of outcome measures could include the percentage of individual care plans that are followed or the percentage of clients who are satisfied with services.

In addition, DHS does not require providers to report output and efficiency performance measures information. The only time DHS gathers this information is when it conducts on-site monitoring visits, and according to management, each provider is supposed to receive an on-site monitoring visit no less than once every 24 months.

Financial and compliance contract provisions are adequate.

While DHS needs to strengthen contract provisions regarding provider performance, we found that contract financial and compliance provisions are adequate. For example, there are contract provisions that:

- Define the specific responsibilities and duties of each party to the contract.
- Ensure that information the provider is required to submit is accurate and timely.
- Ensure public safety, fraud prevention, and minimum liability and exposure for the State.
- Define sanctions and other penalties for non-performance on the part of the provider.

Recommendations:

DHS should:

- Define outcome measures to assess client service benefits and include these measures in all contracts with community care providers. For example, the

percentage of individual care plans that are followed or the percentage of clients who are satisfied with services.

- Require providers to report performance measures information on a regular basis, monthly or quarterly reporting.

Management's Response:

Community Care will develop and implement outcome measures to assess client service benefits and include the measures in contracts with community care providers. Community Care will research the feasibility of requiring that providers report performance measures on a regular basis. Implementation of these recommendations will likely require rule changes. These recommendations will be implemented by December 2003.

Section 2-B:

DHS' Monitoring of Community Care Contracts Does Not Adequately Assess Contractor Performance

Although DHS has strengthened its monitoring of community care providers since 1998, improvement is still needed.² DHS' contract monitoring continues to focus on how providers spend funds and providers' compliance with federal and state standards and regulations. However, DHS' monitoring-risk-assessment process lacks specificity, and the monitoring process does not adequately assess provider performance. In addition, communication among DHS' various units involved in monitoring is inadequate, and DHS lacks appropriate follow-up procedures to ensure that issues identified during monitoring visits are resolved.

DHS' monitoring-risk-assessment process lacks the specificity needed to properly focus DHS resources.

DHS has documented the general direction for the provider risk assessment it uses to plan fiscal and program contract monitoring; however, DHS has not developed specific risk assessment procedures. For example, DHS' risk assessment process:

- Does not describe which types of contracts may be the highest risk contracts.
- Does not define contract dollar amount thresholds to consider during the risk assessment.
- Does not define what constitutes high staff turnover (one indicator of risk) at a provider.

DHS relies on the skills, knowledge, and abilities of individual contract managers to implement its general risk assessment process. Yet, there may be a lack of risk assessment training for new contract managers. In addition, DHS does not require

² See *An Audit Report on Home and Community-Based Services at the Department of Health and the Department of Human Services*, SAO Report No. 99-005, October 1998.

contract managers to document their risk assessments, which makes it difficult to verify that the risk assessments are conducted in an adequate fashion.

Because DHS' risk assessment process lacks specificity, there may be inconsistencies in the manner in which contract managers in different regions perform risk assessments. Although the contract managers we interviewed indicated that they used multiple factors to conduct risk assessments, it appears that the dollar amount of the contract drives the selection of providers for monitoring visits.

Additionally, there are inefficiencies and duplication in the compilation of data that can be used for risk assessment. For example, DHS' Central Contract Register is not integrated into DHS' contract monitoring responsibilities (see Appendix 4). The Central Contract Register is a database of providers that is maintained by DHS as a log of all contracts. The Central Contract Register contains provider information, such as the amount of each contract. However, the information in the Central Contract Register is duplicated in DHS' Claims Management System. Regional offices enter data into the Central Contract Register, and monthly reports from this system are distributed to DHS managers. However, regional contract managers do not use information from the Central Contract Register to conduct risk assessment or to perform other monitoring tasks.

DHS' monitoring process does not adequately assess provider performance.

DHS Efforts to Capture and Review Provider Performance Information

- The Claims Management System captures information on providers, contracts, rates, budgets, authorized services, and claims for services. The State Auditor's Office conducted limited testing of payments from the Claims Management System in 2001 and reported exceptions on the timeliness of claim submission and allowability of expenditures. (See *An Audit Report on Medicaid Long-Term Care Claims Data at the Department of Human Services*, SAO Report No. 02-018, January 2002.)
- The Community Care Contracting & Policy Section now has access to information in the licensing tracking system, which contains information on provider licensing activity such as penalties.
- The Sanctions and Review Committee captures information on providers' sanction histories.

(See Appendix 4 for an understanding of how the systems fit into DHS' contract management process.)

Source: Department of Human Services

Although DHS has made progress in capturing and reviewing provider performance information (see textbox), it still does not have complete and comprehensive information on which to evaluate a provider's history and past performance. Without this information, there is a risk that low-performing providers will continue to provide substandard services.

As discussed in Section 2-A, DHS does not have specific standards that address client outcomes or quality of services. The program-specific provider manuals adequately define methods, tools, and information such as customer satisfaction surveys and complaint and licensure information that DHS could use to assess the performance of community care providers. However, not all of these tools are required and they focus primarily on the individual client or transaction level.

The content of the guides DHS uses to monitor providers demonstrates a lack of focus on client outcomes and quality of services. For example:

- The guide DHS uses to monitor Community-Based Alternative providers specifies eleven standards that focus on the delivery of service and the timeliness of delivery. The guide does not contain standards that refer to

outcomes for clients or the quality of service. There is an underlying assumption that, if the service was delivered, the client benefited.

- The guide DHS uses to monitor Primary Home Care providers specifies five standards that predominantly address outputs and processes such as delivery of services and timeliness of service delivery.

In addition, providers themselves have inconsistent and incomplete methods for evaluating their success. Providers we visited measured their success in the following ways:

- One provider's executive director relies predominantly on financial information (percentage of service versus revenue generated) and output information (breaks in service, number of authorized hours, number of service hours) to determine success. The executive director made reference to only one outcome measure: seeing that the clients get better with treatment. The provider does not use client surveys or comparable tools.
- One provider's administrator asserted that the provider's best indication of the success is the number of complaints it receives.
- One provider has an advisory board that evaluates its performance. Minutes of the board meetings indicate that there is discussion of issues relating to service quality, including adequacy of service time frames, processes for ordering supplies, low attendant salaries, and consumer complaints. Provider management reviews customer satisfaction surveys and statistical reports that focus on the number of visits and the number of clients.

Communication among parties involved in monitoring at DHS remains largely informal.

DHS has not established or required clear lines of communication among all parties involved in monitoring. These parties include contract managers, case managers, internal audit staff, and licensing staff. Additionally, contract managers are not required to document key communication with providers. Although DHS has some policies and procedures for communication between regional contract managers and its central office, there is still a lack of formal communication between all parties who play a role in monitoring.

The weaknesses in communication can lead to inconsistencies in the monitoring of providers. One provider administrator we interviewed asserted that the rules that licensure and contract monitoring staff use are inconsistent and that the rules are applied differently among regions. The administrator also asserted that contract managers interpret policy differently.

Without clear communication processes, the assessment of a provider's performance may be incomplete or inaccurate. Although there are criteria to monitor the provider's performance in the guides for Community-Based Alternative and Primary Home Care provider monitoring, multiple parties gather this information.

DHS does not have documented requirements to follow up on the results of monitoring reviews.

As a result, DHS does not consistently follow up on its monitoring visits. For example, DHS did not follow up on two of the four monitoring reviews that we tested:

- According to DHS, one provider did not require a follow-up review because the review in November 1999 was a “courtesy review.” However, the provider had a compliance rate of 80 percent, which is below the minimum compliance level of 90 percent, for the Community-Based Alternative program. In March 2002, DHS placed the provider on vendor hold as it conducted an investigation into the provider’s fiscal activities and a case of alleged abuse and neglect.
- One provider did not receive a follow-up review because of a regional decision to suspend follow-up reviews until all initial monitoring reviews were completed. The provider had a compliance rate of 81.5 percent, which is below the minimum compliance level of 90 percent, for the Primary Home Care program in the latest on-site monitoring visit.

DHS’ monitoring of provider expenditures is adequate.

DHS has documented fiscal monitoring procedures to ensure that providers spend funds appropriately. For example:

- DHS uses a *Fiscal Monitoring Guide* that provides adequate guidance for reviewing payments to providers.
- DHS requires providers to submit cost reports identifying actual allowable costs and other financial and statistical information. DHS’ Internal Audit Division performs desk reviews of all cost reports and field audits on a sample of cost reports to ensure that costs that providers submit are allowable.
- Contract managers have received additional training on fiscal analysis and are accountable for being familiar with the provider’s financial position. For example, contract managers are expected to be knowledgeable about providers’ expenditures, financial structure, business relationships with suppliers, and sub-contractors.

Recommendations:

DHS should:

- Define specific risk assessment procedures and guidelines for contract managers to follow. For example, DHS should define the types of contracts that are higher risk, contract-dollar-amount risk-assessment thresholds, and what constitutes high provider staff turnover. Specific risk assessment procedures should be required, and risk assessment procedures should be documented. In addition, DHS should provide proper training and oversight in the implementation of the specific risk assessment procedures.

- DHS should assess the duplication of data between the Central Contract Register and the Claims Management System and consider alternatives that would eliminate the duplication. DHS should assess ways to integrate the Central Contract Register into the risk assessment of contracts and other monitoring tasks.
- DHS should establish a comprehensive set of information to evaluate a provider's history and past performance. DHS should clearly define standards that relate to the quality of services and outcomes for clients, and it should monitor providers to ensure that they adhere to those standards.
- DHS should formalize communication among all parties involved in monitoring, including contract managers, case managers, internal audit staff, and licensing staff. To accomplish this, DHS should:
 - Require contract managers to document key communication with providers and other relevant parties.
 - Require communication between contract managers and internal audit staff regarding cost report audit findings.
 - Elaborate in its *Monitoring and Complaints Handbook* the importance of open communication between contract monitoring staff and providers.
- Document a requirement to conduct follow-up reviews for all monitoring visits and ensure that these follow-up reviews are conducted in a timely manner.

Management's Response:

Community Care will formalize the risk assessment process to include definitions, require documentation and provide training as recommended. Community Care will also assess ways to eliminate duplication between the Central Contract Register and the Claims Management System and to integrate information contained in the Central Contract Register into contract management activities. Community Care will establish a comprehensive set of standards to evaluate a provider's past contract performance. Furthermore, Community Care will revise monitoring review forms to ensure standards relate to quality of service and outcomes. Community Care will implement policies and procedures to require contract managers to document key communication with providers and other relevant parties and to encourage open communication between contract managers and audit staff regarding cost report audit findings. Community Care will also stress the importance of open communication between contract staff and providers in the next revision to the Monitoring and Complaints handbook. Community Care will implement procedures to require follow-up reviews and will also implement procedures for monitoring the timeliness of these follow-up reviews. Implementation of many of these recommendations will require rules changes. These recommendations will be implemented by December 2003.

Section 2-C:

DHS' Rate-Setting Process For Community Care Contracts Is Adequate

DHS has an adequate rate-setting process for calculating the unit rates for community care contracts. In addition, it has adequate controls over the provider-submitted annual cost reports that it uses to establish unit rates. The primary objective of the cost reporting process is to provide a basis for determining appropriate unit rates to pay providers. DHS' Automated Cost Report Evaluation System (ACRES) captures cost report data submitted by the providers and performs edits and other checks on the reports while compiling data to assist in rate-setting for the different community care programs (see Appendix 4). As stated previously, DHS' Internal Audit Division performs desk reviews of all cost reports and field audits on a sample of cost reports to ensure that costs providers submit are allowable.

Section 2-D:

There Are Weaknesses In DHS' Fiscal Oversight Of The Star+Plus Managed Care Program

Star+Plus Managed Care Program

Star+Plus is a Medicaid pilot project designed to integrate delivery of acute and long-term care services through a managed care system.

Medicaid clients in Harris County have been required to participate in Star+Plus since its inception in April 1998.

DHS contracts with two Health Maintenance Organizations for Star+Plus. The HMOs contract with direct health service providers to provide services.

Source: Department of Human Services

DHS needs to strengthen its fiscal oversight of the Star+Plus Medicaid pilot program to ensure that program funds are used in the most efficient and effective manner.

DHS does not adequately monitor the financial results of Star+Plus Health Maintenance Organizations (HMO) and has not recouped \$18,279 in excess HMO profits to which the State is entitled.

DHS requires each HMO to submit a quarterly financial statistical report that specifies revenue, expenses, and the profit allocated to the Star+Plus program. The financial statistical report includes useful financial information such as administrative costs and direct payments that the HMO makes

to the health care providers. However, DHS does not adequately ensure the accuracy of the financial statistical reports. DHS has not conducted independent audits of the HMOs' financial statistical reports since 1999. In addition, DHS has failed to recoup excess HMO profits to which the State is contractually entitled.

DHS contracted with two independent CPA firms to review the financial statistical reports covering the period from January 1, 1998, through August 31, 1999. These contracts called for the CPA firms to conduct specific agreed-upon procedures, which limited their work. The procedures included recalculating reported amounts in the financial statistical report, comparing financial statistical report amounts to the general ledger, and verifying a sample of expenses and payments by reviewing supporting documentation. The objective of the reviews was to assist DHS in its review of the financial statistical reports. However, the procedures did not include a test to determine whether the HMOs had received third-party reimbursements, such as worker compensation payments or payments from relatives. Additionally, the procedures did not include tests of the reasonableness of the HMOs' administrative cost allocation methodology.

One of the CPA firms identified \$73,118 in reported expenditures that were unsupported or inappropriately applied to the Star+Plus contract (this also means that the HMO's profits were understated by that amount). Because the HMO had a profit between three and seven percent (see Table 4), DHS was entitled to recoup 25 percent of the excess profit associated with the audit finding, or \$18,279.50. However, DHS has not recovered that amount. DHS recovered the appropriate amount of excess profit originally reported in the unaudited financial statement.

Accurate financial statistical reports are essential to ensuring that the State is collecting a percentage of excess profits that the HMOs may be making on the Star+Plus program. The contract between DHS and the HMOs includes a clause specifying that if the HMOs make a profit of more than 3 percent, they must share the excess profits with the State based on a tiered formula. Table 4 details the State's share of excess HMO profits from Star+Plus contracts.

Table 4

State Rebates on HMO Star+Plus Contracts		
HMO Profit from Star+Plus	HMO Share of Profit	State Share of Profit
0 to 3%	100%	0%
Over 3 to 7%	75%	25%
Over 7 to 10%	50%	50%
Over 10 to 15%	25%	75%
Over 15%	0%	100%

Source: Department of Human Services

DHS does not adequately monitor HMOs for compliance with prompt payment provisions of the Star+Plus contract.

DHS does not analyze or use information HMOs report regarding their compliance with state requirements to promptly pay or adjudicate claims made by health care providers. By contract, Star+Plus HMOs must adjudicate 90 percent of all claims within 30 days and 99 percent of all claims within 90 days. Instead of relying on information the HMOs report regarding compliance, DHS relies on complaints from providers to monitor HMO compliance with prompt payment provisions.

An independent CPA's review indicated that one HMO did not comply with prompt payment provisions in 1999. Additionally, the independent CPA reported that the HMO was not in compliance with state requirements to calculate and pay interest to providers that it did not pay promptly. We analyzed the information that same HMO provided to DHS. This information showed that for the quarter ending August 31, 2001, the HMO did not comply with the requirement to adjudicate 90 percent of all claims within 30 days; the HMO began complying with that requirement during the quarter ending November 30, 2001. DHS has taken no enforcement action against this HMO.

When an HMO does not promptly adjudicate claims, health care providers in the Star+Plus program may experience cash flow problems that ultimately put the continuity of client service at risk.

DHS has not used a competitive bid process to establish capitation rates since the initial procurement for the Star+Plus program in 1998.

Texas Government Code, Chapter 533, requires DHS to establish capitation rates for the Star+Plus program through a competitive bid process. (Capitation rates are rates DHS pays Star+Plus HMOs on a per client basis.) Texas Government Code also requires DHS to consider other factors that influence the potential for cost savings. Medicaid rules require DHS to establish capitation rates that will reduce costs or slow the rate of increased costs compared to what the State would otherwise have paid under unit-rate Medicaid contracts. Because DHS has not conducted a competitive bid process since 1998, it cannot ensure that it is paying the lowest rates possible for the Star+Plus program.

DHS does not currently use encounter data for setting the capitation rates for the Star+Plus program.

**Managed Care
Encounter Data**

Encounter data is the record of services provided to clients. It is the same data that Star+Plus HMOs use to evaluate their payments to health care providers.

Source: Department of Human Services

DHS has begun to collect encounter data for program evaluation.

However, it cannot use this information for rate-setting purposes until the Health and Human Services Commission certifies the data in accordance with Texas Government Code, Chapter 533. The requirement to certify encounter data was added to Texas Government Code through House Bill 1591 (77th Legislature).

DHS relies on one rate-setting methodology to establish the capitation rates it pays to Star+Plus HMOs. While that methodology is valid, DHS does not have alternative, reliable data to ensure the cost-effective provision of quality health care under the Star+Plus program. Separate reports from two independent reviewers and the Health and Human Services Commission

indicate that DHS should evaluate the feasibility of using encounter data as the basis for rate-setting.

Recommendations:

DHS should:

- Strengthen the auditing of Star+Plus HMOs' financial statistical reports by ensuring that an audit of each HMO's financial statistical report is completed at least every two years. Include tests in audit procedures to determine whether the HMOs received third-party reimbursements and tests of the reasonableness of the HMOs' administrative cost allocation methodologies.
- Ensure that DHS promptly recoups the portion of HMO excess profits to which the State is entitled.
- Strengthen reporting tools designed to detect HMO noncompliance with prompt payment requirements and proactively analyze the information. For example, review HMOs' patterns of denial and rejection of provider claims. In addition, take appropriate enforcement actions against HMOs that do not comply with prompt payment requirements.

- Consider using a competitive bid process for establishing capitation rates and consider other rate-setting factors that influence the potential for cost savings.
- Continue to work with the Health and Human Services Commission to pursue the certification of encounter data for rate-setting purposes.

Management's Response:

- *The managed care programs in Texas under the governing authority of the Texas Health and Human Services Commission (HHSC) – STAR, STAR+PLUS, and CHIP – have begun a cooperative effort with the Texas Department of Insurance (TDI) to provide on-site audits of the HMOs in these programs. HHSC and TDI are currently developing a memorandum of understanding (MOU) which will provide for the incorporation into TDI's audit program, the HHSC audit program, to ensure contract compliance. TDI will perform these on-site audits at least every two years. The HHSC audit program will include tests to assure the reasonableness of administrative cost allocation methodologies and testing for 3rd party reimbursement. In addition, the FSR is currently being redesigned. This redesign is intended to increase the ability of DHS (and HHSC) to monitor the financial operation of the STAR+PLUS HMOs on an interim basis during the contract periods.*
- *DHS will recover excess profit of \$18,279.50 from Americaid rising from a disallowance of \$73,118.00 by one of DHS's CPA firms. DHS has also recouped \$310,224.00 from Americaid following the end of the initial contract period. This recoupment was obtained through the contractual agreement DHS has with the HMOs regarding sharing of excess profits (HMO Blue did not meet the profit limit for the experience rebate to apply). DHS also undertook an audit of capitation payments made to the HMOs. Risk group assignment inaccuracies were identified which resulted in a recoupment from one HMO for \$210,120.45, and an additional payment to another HMO for \$868,231.41. The capitation audits are an ongoing process and will occur for each SFY of the program's operation.*
- *DHS has, and will continue, to work with both the HMOs and the providers through provider/HMO claims workgroup meetings to improve the claims payment efficiency of the HMOs. At the present time, the HMOs are in compliance with the contract requirements for claims payment. DHS has a monitoring system in place, which will allow for monitoring the frequency of denied claims. This system will be more closely scrutinized, in order to detect and correct any claims payment issues that arise in the future. DHS will pursue enforcement actions against HMOs as specified under Article XVI of the contract between the HMOs and DHS.*
- *HHSC is the administrative authority for the Medicaid managed care programs in Texas. This includes both the STAR and STAR+PLUS programs. As such, it is often the case that DHS STAR+PLUS is required to mirror many aspects of the STAR program in order to improve efficiency and reduce client and provider confusion. This cooperative effort also often includes the contract periods and contracting procedures. Due to the nature of the managed care program it is not feasible to rebid the contracts on a frequent*

basis. As the HMOs are providing a medical home for the DHS clients it would be difficult to have a primary care provider establish a relationship with an individual which would need to be broken on a frequent basis. In addition, the rates that are paid to the HMOs were established by past Fee for Service expenditures for the State. The State set the rate that they would pay and asked prospective HMOs if they would accept it. As such, the HMOs did not competitively "bid" for the contract on financial grounds. There is also a significant "start-up" cost that is entailed by HMOs that would be new entrants to the program. Such costs, and the inability to predict future membership, should be considered a significant hindrance to attracting potential HMOs as providers. DHS is considering the use of a Request For Information (RFI) that would allow the State to assess the potential for additional bidders in the advent of a reprocurement.

- The Health and Human Services Commission is currently procuring for the services of an External Quality Review Organization (EQRO) that will, among other requirements, be required to either certify or decertify the encounter data that the State receives from the HMOs. If certified, this data will be used, in conjunction with other methods, for future rate-setting purposes.

HHSC Has Not Fully Complied With Requirements To Develop Contract Management Processes

The Health and Human Services Commission (HHSC) has not fully complied with Texas Government Code, Section 2155.144, which requires HHSC to develop purchasing guidelines and contract management processes for health and human service agencies. HHSC has not developed a statewide risk analysis procedure, a contract management handbook, and a central contract management database, as required by Section 2155.144.

Texas Government Code, Section 2155.144, does not have a specific time frame for the requirements. However, this code section does require HHSC to prepare an annual report by December 15 of each year. Texas Government Code, Section 531.0055(c), directs HHSC to implement Section 2155.144 *after* implementation of other duties prescribed by statute. These duties include (1) supervising the administration and operation of the Medicaid program, (2) supervising information systems planning and management for health and human service agencies, (3) monitoring the use of all federal funds received by health and human service agencies, and (4) implementing Texas Integrated Enrollment Services.

To partially address requirements of Section 2155.144, HHSC:

- Adopted rules in December 2000 to govern purchases of goods and services by health and human service agencies.
- Prepared an annual report in February 2002 that assesses the compliance of each health and human service agency with the requirements imposed under this section.

Recommendation:

HHSC should work toward full compliance with Texas Government Code, Section 2155.144, by developing an action plan with clearly defined milestones for a statewide risk analysis procedure, a contract management handbook, and a central contract management database.

Management's Response:

HHSC agrees with the findings and recommendations, but notes that the agency has made progress toward implementation of the remaining portions of the statute despite the prioritization established in Section 531.0055(c). HHSC is in the process of employing a director of contract administration whose responsibilities will include completing the implementation of Section 2155.144. However, HHSC believes further coordination and clarification of its responsibilities must occur with respect to two of the outstanding tasks assigned under the statute.

For example, the Legislature enacted Senate Bill 311 last legislative session. The bill enacts Section 2262.051 to the Government Code. This section delegates to the Texas Building and Procurement Commission, the State Auditor's Office, the Comptroller of Public Accounts, and the Office of the Attorney General the responsibility to develop a contract management guide for use by state agencies. The guide must include information concerning the primary duties of a contract manager, model contract provisions, and instructions on various aspects of the competitive contracting process. The statute does not appear to exempt health and human service agencies from the duty to comply with the requirements of the published guide. Consequently, HHSC believes it may be necessary to obtain appropriate clarification concerning the duties of HHSC and health and human service agencies concerning the contract management handbook requirement under Section 2155.144.

HHSC also notes that the implementation of a centralized contract management database may require additional funding to fully and adequately implement. HHSC is researching, however, the availability of current resources (including the Health and Human Services Enterprise Administrative System now under development) to fulfill this requirement.

Section 4:

ECI Has Generally Adequate Procedures For Establishing And Monitoring Client Service Contracts

Services that Providers Deliver Through Contracts with ECI

Through contracts with ECI, service providers and community MHMR centers provide children under 3 years of age with services such as:

- Activities to promote motor and speech development
- Activities to help social and emotional development
- Activities to develop learning and eating skills
- Activities that support children so they can attend a child care setting or other community setting
- Education and counseling
- Coordination of needed social and health services
- Access to family support

Source: Interagency Council on Early Childhood Intervention

The Interagency Council on Early Childhood Intervention (ECI) has generally ensured that its client service providers deliver agreed-upon services by:

- Establishing contracts that clearly define agreed-upon services and prices.
- Focusing its monitoring on how funds are spent, service outcomes, and compliance with contract provisions.

Section 4-A:

Although ECI's Contracts Include Specific Provisions Regarding Agreed-Upon Services And Prices, They Lack Performance Targets

ECI's contracts with community MHMR centers and other client-service providers contain provisions that

clearly state the work required of the providers, the factors by which that work will be evaluated, spending restrictions, and potential sanctions for noncompliance. The contracts also include output and outcome measures by which ECI monitors contractor performance. In addition, ECI gathers performance information and communicates performance expectations to its providers.

While contracts contain provisions that help to ensure that providers deliver agreed-upon services, they do not include specific performance targets for each performance measure. For example, the only targets that ECI sets for contracts with community MHMR centers are (1) the number of children enrolled during the year and (2) the community MHMR center's budget. Community MHMR centers are required to report other outcome and output measures, such as the number of children reaching developmental proficiency and the number of eligible children receiving comprehensive services. However, ECI does not compare these measures to a target. Instead, ECI evaluates these measures by comparing each community MHMR center's results to the statewide average. By clearly communicating performance targets in its contracts, ECI could increase local accountability for delivery of quality services.

Recommendation:

ECI should clearly define targets for each contractual performance measure and compare reported measures to those targets.

Management's Response:

Management concurs. ECI will clearly define targets for each contractual performance measure included in contracts issued for FY 03 and thereafter and will compare reported measures to those targets.

Section 4-B:

ECI Adequately Focuses Its Contract Monitoring Efforts

ECI's monitoring of client-service contracts is generally adequate. For example:

- ECI has a well-documented risk assessment process.
- ECI uses various tools for fiscal monitoring including quarterly financial status reports, on-site financial reviews, and independent audit reports.
- ECI uses monthly and quarterly performance reports and on-site audits to monitor provider performance.

ECI sanctions poor-performing providers. For example, ECI terminated contracts with two providers in fiscal year 2001 because the providers were not performing at acceptable levels.

Although its monitoring of providers is generally adequate, ECI should strengthen its monitoring of community MHMR centers' automated information systems. During on-site visits we conducted at three community MHMR centers, we noted weaknesses in the centers' information systems in the areas of access controls, information system policies and procedures, and information system edit checks. For example, one center was not deleting terminated employees' user identification numbers and passwords.

At the time of our audit, ECI was in the process of implementing the Texas Kids Intervention Data System (T-KIDS), a new automated database of client service information to be used by all providers. Lacking this database, ECI's providers had developed their own systems to generate reports that ECI requires. These systems often lacked essential controls. For example, these systems sometimes consist of a spreadsheet on which information from the provider's main system is copied.

Despite these weaknesses in controls, it is important to note that we did not find significant problems regarding the integrity of service data collected by providers. None of the providers we reviewed had errors in more than 3.4 percent of their case files.

Recommendations:

ECI should:

- Continue to work toward implementing the T-KIDS automated database of client service information.
- Ensure that providers have adequate controls over automated systems and processes that capture and report client service data to ECI.

Management's Response:

Management concurs. ECI will continue to implement the T-KIDS automated database in keeping with pending Attorney General's Opinion Request No. 0535-JC.

In FY 03, ECI will work with local contractors to establish standards for ensuring security, privacy, and accuracy of data reported to ECI. Monitoring of these standards will begin in FY 04. ECI will work with MHMR to avoid duplication of monitoring efforts.

Objectives, Scope, and Methodology

Objectives

The objectives of this audit were to:

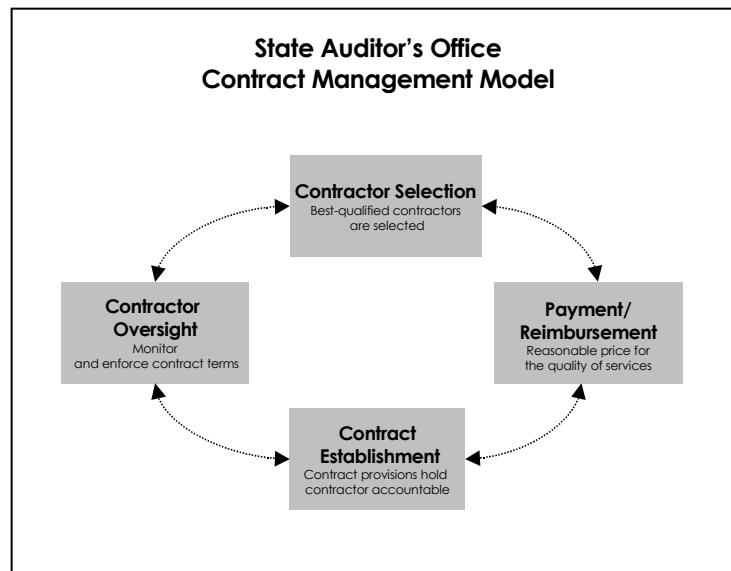
- Determine whether the procedures that the Department of Mental Health and Mental Retardation (MHMR), the Department of Human Services (DHS), and the Interagency Council on Early Childhood Intervention (ECI) use to establish and monitor purchased client-service contracts provide reasonable assurance that:
 - Contractors provide agreed-upon services at contractually specified prices.
 - Contractors spend funds in accordance with state and federal requirements.
- Determine the status of the Health and Human Service Commission's (HHSC) compliance with statutes requiring HHSC to develop purchasing guidelines and contract management processes for health and human service agencies.

Scope

The scope of this audit included community service contracts at MHMR, DHS, and ECI for fiscal years 2001 and 2002.

Methodology

We used the following contract management model as a guide for this audit.



Audit procedures included review of applicable laws, policies, and procedures; site visits to selected community care providers; analysis of operational data and relevant reports and documentation; and testing of elected contract files and records.

Information collected:

- Relevant statutes and rules (such as Texas Government Code, Chapter 533, and Sections 531.0055 and 2155.144; Texas Health and Safety Code, Section 534.054; and Texas Administrative Code, Title 25, Section 417.61)
- Uniform Grant Management Standards
- Agency Web sites
- Other states' Web sites
- Agency contracts with community care providers and supporting documentation
- Policy and procedure manuals and provider handbooks
- Interviews with agency management and staff and with regional staff
- Various management reports from the agencies
- Agency documents, memoranda, and publications
- Prior State Auditor's Office reports
- *Sunset Advisory Commission Report to 76th Legislature*, February 1999
- Independent audit reports of community care providers

Procedures and tests conducted:

- Mapping of key contract systems and processes for each agency
- Site visits to three community MHMR centers and four private community service providers
- Testing of expenditure and service documentation at selected providers
- Review and analysis of documentary evidence and results of interviews

Other Information

We conducted fieldwork from November 2001 to March 2002. The audit was conducted according to generally accepted government auditing standards.

The following members of the State Auditor's Office staff performed the audit work:

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- Fred Bednarski
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- David Dowden
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- Richard Perel, MPA
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- John Quintanilla, MBA
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- Leslie Ashton, CPA (Quality Control Reviewer)
- Joanna B. Peavy, CPA (Audit Manager)
- Frank N. Vito, CPA (Audit Director)

Contract Management Processes

The following table summarizes our assessment of contract management processes at the Department of Mental Health and Mental Retardation (MHMR), the Department of Human Services (DHS), and the Interagency Council on Early Childhood Intervention (ECI).

Assessment of Contract Management		
The contractor selection process should ensure that the best-qualified contractors are selected.		
MHMR	Weak	State requirements preclude MHMR from using competitive procurement procedures to select service providers. Texas Health and Safety Code, Section 534.054, requires MHMR to award contracts to a local mental health or mental retardation authority in each service area. MHMR also is required to give preference to community MHMR centers located in each service area. As a result, the majority of community MHMR centers have had contracts with MHMR for many years.
DHS	Not tested	A legal entity may apply to receive a contract if it meets the requirements of licensure and certification and agrees to the terms and conditions of the proposed DHS contract. Procurements are conducted so that they provide maximum open and free competition. DHS develops enrollment and procurement packages based on clear and accurate descriptions of the services to be purchased. The package includes all requirements the offeror must fulfill for its proposals and/or for enrollments to be evaluated. DHS can exempt a potential contractor if authorized by law, rule, or regulations and if certain other circumstances occur.
ECI	Not tested	Each year, local programs submit funding applications for the upcoming year's funding. The applications include detailed information including the local programs proposed budget, number of children to be served, hours of services to be provided by type of service, request for funding for new services, planned and delivered services for the prior year, and cost per child. ECI completes an in-depth review of the applications and determines whether it should establish or renew a contract with the local programs.
The payment/reimbursement methodology should ensure that the agency pays a reasonable price for the quality of services it desires.		
MHMR	Mixed	<p>The amount paid for services is strictly a function of the legislative appropriation process that allocates available funding to community MHMR centers. MHMR acknowledges that the methods by which funds are allocated to each community MHMR center are not reflective of regional conditions and/or needs. Therefore, the allocations require review and revamping. A "Benefit Design for Mental Health Services" initiative addresses this and other related contract issues.</p> <p>The rate setting methodology and data used for the NorthStar managed care contract are reasonable for the years ending June 30, 2000, and June 30, 2001. The Medicaid waiver, which was approved by the Health Care Financing Administration in September 1999, specifies the rate-setting methodology. MHMR does not currently use encounter data for setting rates for the NorthSTAR program.</p>

Assessment of Contract Management

The payment/reimbursement methodology should ensure that the agency pays a reasonable price for the quality of services it desires.

DHS	Mixed	DHS' rate-setting process for community care contracts is adequate. DHS has not used a competitive bid process to establish capitation rates for the Star+Plus managed care program since the initial procurement for this program in 1998. DHS does not currently use encounter data for setting the capitation rates for the Star+Plus program.
ECI	Not tested	As part of the review process, the cost per child (and other information) is compared across all local programs. Local programs with high (or low) indicators are reviewed to determine why they vary from the norm. Requests for new services are separated in the budget request so that they can be reviewed or denied on an individual request basis.

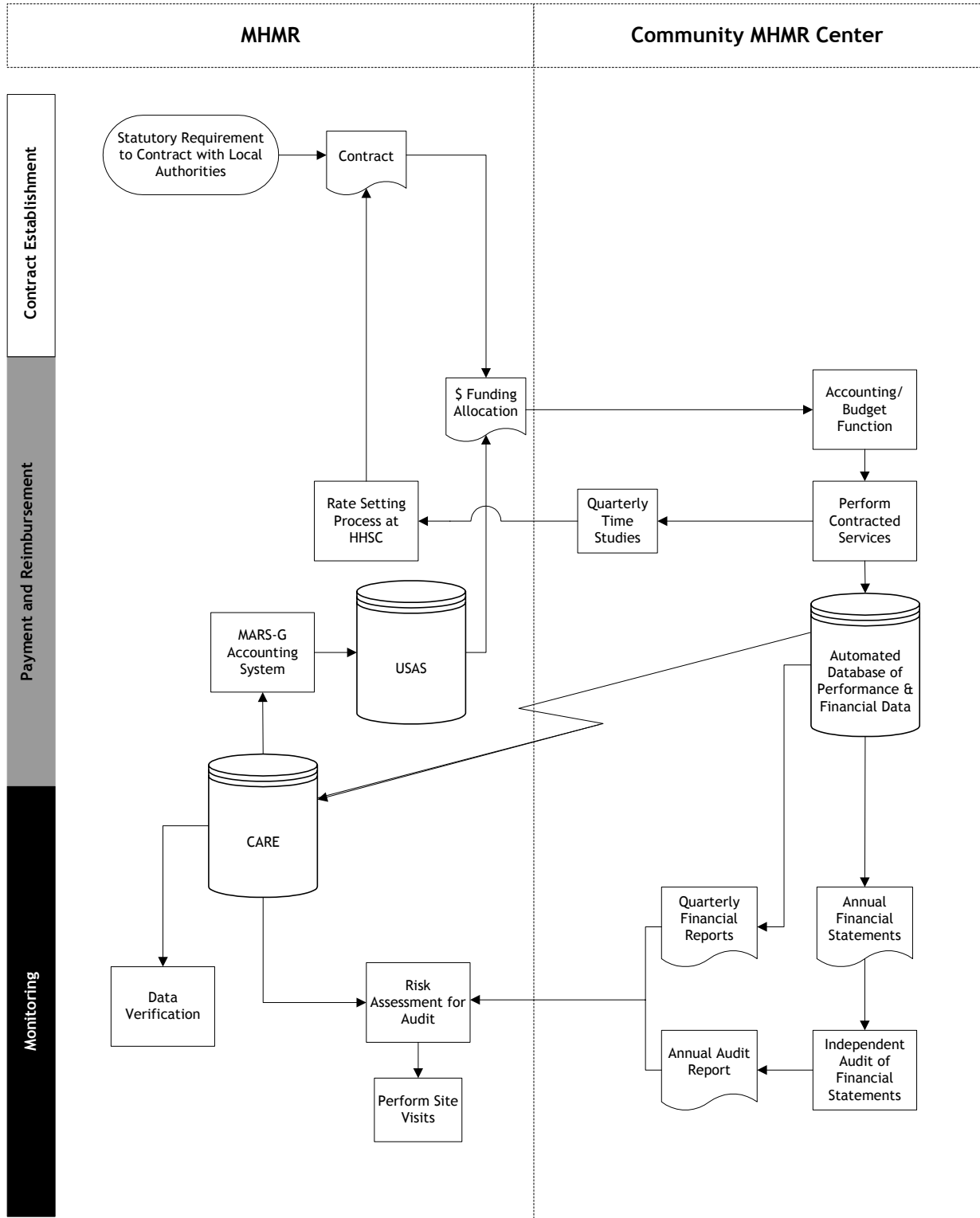
Contract establishment procedures should ensure that contract provisions are sufficient to hold contractors accountable.

MHMR	Mixed	Generally, MHMR's performance contract with community MHMR centers contains all provisions required by statute. The contract states the responsibilities of both parties and clearly defines services and prices and the minimum acceptable performance against a number of output and outcome targets. However, the performance measures in MHMR's contracts with community MHMR centers do not fully gauge the effectiveness and efficiency of the community MHMR centers' operations.
DHS	Mixed	While DHS' community care contracts contain output and efficiency measures, they lack provisions to assess client outcomes. Financial and compliance provisions are adequate.
ECI	Adequate	ECI's contracts include specific provisions regarding agreed-upon services and prices. However, they lack performance targets.

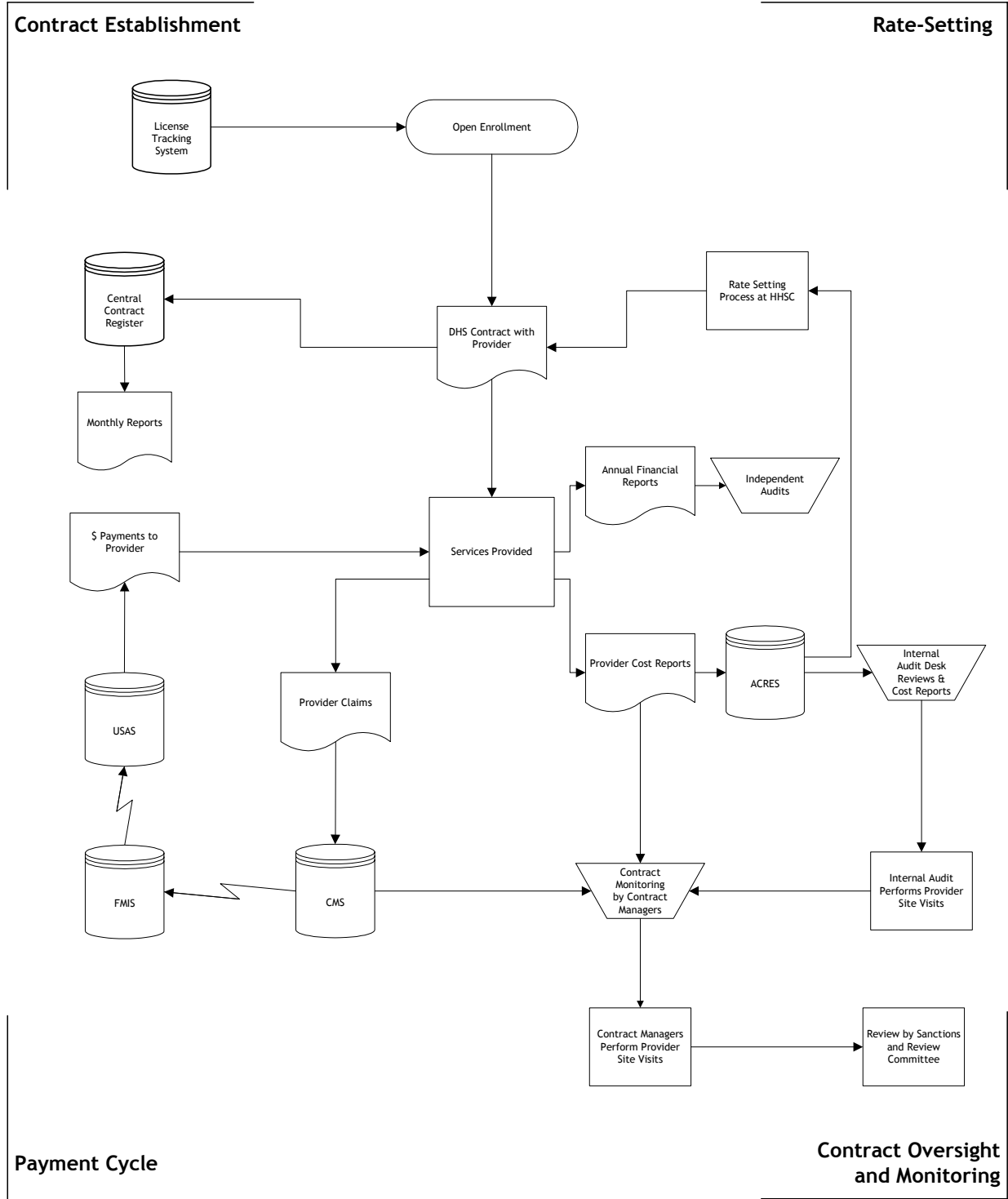
Contractor oversight should be sufficient to ensure the enforcement of contract provisions.

MHMR	Weak	MHMR's monitoring of community MHMR center contracts does not ensure that services result in appropriate outcomes and that funds are spent appropriately. MHMR has not consistently recouped funds from poor-performing community MHMR centers, nor has it sanctioned community MHMR centers that do not submit reports on time. MHMR's Client Assessment and Registration (CARE) system data is not complete and accurate. MHMR does not adequately consider community MHMR centers' independent audit reports when assessing financial risk at these centers nor does it conduct enough onsite monitoring visits at high-risk community MHMR centers.
DHS	Weak	DHS' monitoring of community care contracts does not adequately assess contractor performance. DHS' monitoring of provider expenditures is adequate. However, there are weaknesses in DHS' fiscal oversight of the Star+Plus managed care program.
ECI	Adequate	ECI adequately focuses its contract monitoring on how funds are spent, the outcomes of services, and compliance with contract provisions.

Contract Management Process Map for MHMR Contracts with Community MHMR Centers



Contract Management Process Map for DHS Contracts with Community Care Service Providers



Copies of this report have been distributed to the following:

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Department of Human Services

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Mr. James R. Hine, CPA, Commissioner

Department of Mental Health and Mental Retardation

Chair and Members of the Texas Board of Mental Health and Mental Retardation
Ms. Karen F. Hale, Commissioner

Health and Human Services Commission

Mr. Don Gilbert, Commissioner

Interagency Council on Early Childhood Intervention

Chair and Members of the Board
Ms. Mary Elder, Executive Director



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