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Examination of the Commission on Mental Health Services' Financial Operations Under Court-Ordered Receivership Revealed Ineffective Management Accountability and Inadequate Financial Controls

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EXECUTIVE SUMMARY

PURPOSE

Pursuant to Public Law 93-198, Section 455, the District of Columbia Auditor conducted a review of the Commission on Mental Health Services' (CMHS) financial operations while under Court-ordered receivership. The review included an examination of the cost of care for consumers residing in mental health community residential facilities (MHCRFs). The results of this examination will be used as a basis for examining the Department of Mental Health's current operations.

CONCLUSION

The Auditor's review of CMHS' accounts receivables for a seven-year period beginning with fiscal year 1995 through 2001 revealed that CMHS had large receivables for the cost of services rendered to mental health consumers that it was unable to collect from Medicaid, Medicare, and other federal benefits programs. The Auditor found that disorganized program, procurement, and finance operations, among other factors, undermined CMHS' Medicaid revenue maximization efforts. Because of longstanding, deep-seated mismanagement of functions integral to a successful Medicaid revenue maximization effort, CMHS spent millions of dollars in appropriated funds for reimbursable services that it could not recover. At the completion of audit fieldwork, $153 million owed to CMHS in Medicaid, Medicare, and other federal benefits reimbursements were written-off because CMHS could not provide adequate evidence to justify and support these reimbursements.

At a cost of approximately $9 million, CMHS management improperly allowed five vendors to provide case management services to mental health consumers without valid written contracts between fiscal years 1998 and 2001, through June 2001. The Auditor found that CMHS failed to plan in advance for the procurement of services, previously provided under contracts, through a competitive process. In addition to intensive case management services provided without written contracts, the Auditor noted instances in which vendors provided other services to CMHS consumers in the absence of the award of a valid written contract. According to a review of payment data, approximately $16 million were paid to vendors between fiscal years 1999 and 2001, as of June 30, 2001, in the absence of a contract. The Auditor also found that CMHS paid an additional $6.5 million in sole source emergency contracts for residential services and treatment provided to the District's child and youth mental health consumers residing in facilities outside the District of Columbia.

The Auditor found that CMHS was billed and paid approximately $6 million during the three-year audit period for intensive case management services that were not supported by adequate documentation, if any at all. Consumer files reviewed by the audit team did not contain adequate written documentation authorizing the specific level of services for which vendors billed.

The Auditor determined that CMHS' costs of vendor provided care to approximately 751 consumers served in MHCRFs during the audit period averaged approximately $37,546 per client. In addition to the costs of vendor provided services, CMHS also incurred administrative costs to provide care to consumers residing in MHCRFs. When these administrative costs are added to the vendor cost of care estimate, the per year cost of care for consumers residing in MHCRFs increased to approximately $59,000 per consumer. CMHS also paid substantial costs to provide residential, educational, and related services to children and youth residing in facilities outside the District at an average cost of approximately $53,586 per child per year.

The Auditor's review indicated that the responsibility to deliver mental health services and supports to District mental health consumers was not discharged in an effective, efficient, or economical manner while under Court-ordered receivership.

MAJOR FINDINGS

1. CMHS was unable to collect approximately $153 million in reimbursements from Medicaid, Medicare, and other federal benefit programs.

2. Deficiencies were found in CMHS' management of accounts receivable.

3. CMHS paid $9 million for services provided by vendors without valid written contracts.

4. $16 million in other services were provided without benefit of a contract.

5. CMHS awarded an additional $6.5 million in sole source emergency contracts for residential services and treatment for the District's child and youth mental health consumers.

6. CMHS was billed approximately $6 million during the three-year audit period for intensive case management services that were not supported by adequate documentation.

7. CMHS' costs of vendor provided care to consumers served in MHCRFs averaged approximately $37,546 per consumer for fiscal years 1998 through 2000.

8. Administrative costs increased the total estimated program costs for CMHS consumers residing in MHCRFs to approximately $60,000 per consumer per year.

9. CMHS incurred costs totaling $6.6 million for consumers in supported independent living arrangements.

10. The District housed and educated an average of approximately 180 children and youth in out-of-state facilities at an average cost of approximately $53,586 per child per year.

11. There is a wide disparity in the rates paid to providers that house District child and youth mental health consumers.

MAJOR RECOMMENDATIONS

1. The Director and Chief Financial Officer of DMH immediately implement stronger internal controls over the review, recording, and write-off of accounts receivables including the establishment of an effective methodology to age accounts receivables.

2. The Director and Chief Financial Officer of DMH immediately evaluate systems for the collection of encounter and per diem data that support a successful claims reimbursement process. DMH must also enhance staff training on data collection.

3. The Chief Financial Officer of DMH must develop realistic projections for third-party billings representing Medicaid, Medicare and federal benefits.

4. The Director of DMH must discontinue the practice of authorizing the delivery of services without competition or written contracts, and immediately solicit and award contracts on a competitive basis in a manner that complies with District contracting and procurement laws and regulations.

5. The Director of DMH immediately establish adequate contractor monitoring policies, procedures, and recordkeeping requirements ensuring the delivery of services to consumers. All services, whether intensive or regular, must be supported with proper authorizing documentation.

6. The Director of DMH must explore the possibility of establishing facilities within the District of Columbia to provide mental health care and related services to District children and youth mental health consumers.

7. The Director of DMH immediately negotiate contracts with vendors who provide services to the District's children and youth mental health population. These contracts should be awarded on a competitive basis in compliance with District contracting and procurement laws and regulations.

PURPOSE

Pursuant to Public Law 93-198, Section 455, the District of Columbia Auditor conducted a review of the Commission on Mental Health Services' (CMHS) financial operations while under Court-ordered receivership. The review included an examination of the cost of care for consumers residing in mental health community residential facilities (MHCRFs). The results of this examination will be used as a basis for examining the Department of Mental Health's current operations.

OBJECTIVES, SCOPE, AND METHODOLOGY

The objectives of this examination were to determine:

1. the per person cost of care for mental health consumers housed in MHCRFs;

2. the dollar amount and source of funds used to support the cost of care for consumers housed in MHCRFs;

3. the District's cost of providing care and services to emotionally disturbed children and youth referred for residential placement; and

4. whether CMHS' financial and procurement operations complied with District laws, regulations, and guidelines.

The review focused on fiscal years 1998 through 2000. In some cases the audit period was extended to include fiscal year 2001.

To accomplish the objectives, the Auditor reviewed CMHS' financial records and budget information; relevant program information from selected contract files, including accompanying documentation and related correspondence, and Medicaid cost reports. The Auditor also reviewed the Dixon Decree, the Court order governing the treatment and care of persons with mental illness, and information regarding the placement of CMHS (currently the Department of Mental Health) under receivership on June 13, 1997. Additionally, the Auditor reviewed the Service Development Plan, which was designed to address outstanding problems concerning Dixon class members, but was never fully implemented.[1]

[1]The Service Development Plan described the services available, including treatment, residential services, rehabilitation, support, and service program for people who were identified as mentally ill and homeless, and established rates for consumers receiving services through CMHS.

The Auditor interviewed key officials of CMHS, including financial staff within the agency's Office of the Chief Financial Officer (CFO) and program staff within the Community Services Administration. Additionally, discussions were held with CMHS service providers to obtain information necessary to assess their role in delivering outpatient services to persons with mental illness residing in MHCRFs, and to review consumer financial information.

BACKGROUND

The Commission on Mental Health Services (CMHS), formerly under receivership and now the Department of Mental Health, was created October 1, 1987, in accordance with D.C. Code, Section 32-621 et seq., to coincide with the transfer of St. Elizabeths Hospital from the authority of the federal government to the District government. CMHS is the primary District government entity authorized to provide mental health services within the District of Columbia.[2]

Dixon v. Weinberger

In 1974, a class action lawsuit was filed in the U.S. District Court for the District of Columbia on behalf of mentally ill persons institutionalized at St. Elizabeths Hospital. The plaintiffs contended that their statutory rights to appropriate treatment in alternative care facilities were being violated through their long-term institutionalization at the hospital. A ruling known as the Dixon Decree followed, affirming the statutory right of persons who suffer from mental illness to receive appropriate [Auditor's Emphasis], community-based treatment and services by the least restrictive means.[3] This decision and several subsequent orders, along with federal legislation enacted in 1984, required the District government to:

> "Develop and provide an array of community-based services to accommodate the responsible placement [Auditor's Emphasis] of Dixon class members who remain at St. Elizabeths Hospital and to remediate serious problems faced

[2]Pursuant to D.C. Law 14-56, the Department of Mental Health Establishment Amendment Act of 2001, the Department of Mental Health (DMH) is now the exclusive agency authorized to license and regulate all services and support for the mentally ill. Given that CMHS was the name of the responsible organization during the audit period, this report will refer to the department as CMHS rather than DMH.

[3]In William Dixon et al., Plaintiffs, v. Caspar Weinberger, et al., the court found, among other things, that the 1964 Hospitalization of the Mentally Ill Act requires that patients confined in St. Elizabeths Hospital pursuant to the 1964 Act receive suitable care and treatment under the least restrictive conditions where appropriate and be placed in proper facilities that are the least restrictive alternative to the hospital, [Auditor's Emphasis] as it is presently constituted; such alternatives include but are not limited to nursing homes, foster homes, personal care homes, and half-way houses.

by class members who are already in the community but who remain at risk of (re)hospitalization and/or are homeless."

CMHS was required to perform the following under the Dixon Decree:

- provide upgraded crisis and intervention services;
- provide residential and support services for the mentally ill homeless;
- expand private provider housing;
- establish community outreach units; and
- establish a model residential service for the elderly outside of nursing homes.

In 1997, the Court conducted a follow-up review of the District's compliance with the Dixon Decree. The Court found that the District government had failed to comply with the Dixon Decree and, as a consequence, appointed a Receiver in October 1997 to oversee the Commission and implement the Dixon Decree and related court orders. The first Receiver resigned in March 2000, and was replaced by a Transitional Receiver in April 2000. The Transitional Receiver was charged with developing an integrated, comprehensive, cost-effective community-based plan for the provision of mental health services in the District. Further, the Transitional Receiver was to develop a plan to return control of the daily operations of the Commission back to the District government.

CMHS Consumer Population and Residential Placement Options

During fiscal years 1998 through 2000, CMHS' consumer population consisted of approximately 10,000 mentally ill persons, of which approximately 1,727 were children and youth. The breakdown of the consumer population, source of funds supporting their care, and their placement during the audit period is presented in Table I below.

Table I

CMHS' Average Consumer Population, Funding Source, and Placement: Fiscal Years 1998 Through 2000

Placement Category	Funding	Number of Consumers
Hospital Inpatients	Medicaid	750
Mental Health Community Residential Facilities	Local Funds/Medicaid	750
Community Mental Health Centers Region I/II Outpatients	Local Funds/Medicaid	3,697
Community Mental Health Centers Region III/IV Outpatients	Local Funds/Medicaid	2,399
Mobile Community Outreach Treatment Team (MCOTT) Outpatients	Local Funds	200
Homeless	Local Funds	111
Children and Youth	Local Funds/Medicaid	1,727
Total		**9,634**

Source: Office of the Receiver for CMHS

CMHS places consumers in residential facilities based upon needs identified in their Individual Treatment Plan (ITP), including, among other factors, whether the consumer has been institutionalized for an extended period of time or is an outpatient prone to periodic short-term hospitalization. During the audit period, support, case management, and treatment services deemed necessary to sustain consumers' health, safety, and well-being in the least restrictive placement in the community was determined by CMHS/Contract Referring Staff (also known as the Treatment Team), Medical Review Committee (MRC), and the Placement Worker.[4]

Five levels of community-based living arrangements are available to mental health consumers. The five levels of community-based living arrangements are: (1) Independent Living (IL); (2) Supported Independent Living (SIL); (3) Supported Residence (SR) facilities; (4) Supported

[4]The CMHS/Contract Referring Staff Treatment Team and the patient/consumer/family (or significant others) determine the patient's/consumer's readiness and preferences for outplacement to a community based residential facility. If the patient/consumer is found appropriate for placement in a community based facility, a referral package containing a medical certification and psychiatric assessment is sent to the Medical Review Committee (MRC). The MRC will then: (1) assess whether the patient/consumer is "clinically ready" for a community based facility; (2) determine whether the consumer's needs can be reasonably accommodated within a community based facility; and (3) make a determination as to the type of facility in which the consumer should be housed. After approval by the MRC, the placement worker will work in conjunction with the consumer and family members in finding an appropriate community based residential facility.

Rehabilitative Residence (SRR) facilities; and (5) Intensive Residence (IR) facilities. The definition and requirements for each of these living arrangements are presented in Appendix I.

By definition, a MHCRF is a licensed, publicly or privately owned residence that houses individuals 18 years or older with a principal diagnosis of mental illness who require 24-hour on-site supervision, personal assistance, lodging and meals. MHCRFs are required to provide a specific level of care in a safe, hygienic, protective/sheltered, home-like living arrangement for one or more individuals who are not related by blood or marriage to the residence director. The Office of the District of Columbia Auditor's July 17, 2001, report entitled, "Health and Safety of the District's Mentally Ill Jeopardized by Program Deficiencies and Inadequate Oversight," revealed that some District mental health consumers were residing in MHCRFs that, for multiple reasons, were unsafe, unsanitary and, in some instances, did not meet the medical or mental health needs of residents.

CMHS used 147 MHCRFs to house approximately 751 consumers with a diagnosis of mental illness during fiscal year 2000.

CMHS' Budget

CMHS was allocated a gross budget of approximately $180 million during fiscal year 1998, approximately $198 million in fiscal year 1999, and approximately $207 million in fiscal year 2000 to provide services to the District's mental health consumer population.[5] In fiscal year 2001, CMHS received $210.6 million in funding, and in fiscal year 2002, the newly created DMH received $227.6 million, an increase of approximately $17 million over the fiscal year 2001 funding level. Table II presents CMHS's operating budget for fiscal years 1998 through 2002.

[5]The private funds received by CMHS included funds from charitable contributions and fees.

TABLE II

CMHS Operating Budget
Fiscal Years 1998-2002

Budget Category	FY 1998 Actual	FY 1999 Actual	FY 2000 Actual	FY 2001 Approved	FY 2002 Approved
Local	$81,025,000	$105,369,000	$129,177,000	$125,408,000	$142,280,000
Federal	69,112,000	64,738,000	60,064,000	66,801,000	66,925,000
Private	30,571,000	26,414,000	17,456,000	18,325,000	18,329,000
Other	-0-	22,000	16,000	35,000	35,000
Intra-District	-0-	1,157,000	2,343	-0-	-0-
Total	**$180,708,000**	**$197,700,000**	**$206,715,343**	**$210,569,000**	**$227,569,000**

Source: FY 2000 and 2001 Proposed Operating Budget and Financial Plan dated June 9, 2000

Transition from the Commission on Mental Health Services to the Department of Mental Health

The Transitional Receivership was phased out and the Department of Mental Health (DMH) was established under the authority of the Mayor of the District of Columbia in May 2001. The Director of DMH has overall responsibility for the day-to-day operations of the department. The newly established DMH is responsible for:

(1) developing an integrated system of care for adults in conjunction with other District agencies, including but not limited to, addiction treatment and prevention, criminal justice, education, health, housing, income maintenance, and vocational rehabilitation;

(2) developing a system of care for children, youth, and their families that is integrated to the maximum practicable extent with other public systems in the District, including, but not limited to, addiction treatment and prevention, child welfare, criminal justice, developmental services, education, health, housing, income maintenance, juvenile justice, and vocational rehabilitation;

(3) ensuring that persons with mental illness and children or youth with mental health problems are treated in the most integrated setting that can be accommodated, consistent with individual needs and public safety;

(4) fostering the development of high quality, comprehensive, cost effective, and culturally competent mental health services and mental health supports, based on recognized local needs, especially for persons with serious mental illness and children or youth with serious emotional disturbances;

(5) promoting mental health and public awareness of mental health issues;

(6) ensuring that services provided to mental health consumers meet standards established by the DMH pursuant to District regulations for the operation of mental health services and mental health supports;

(7) developing and implementing strategies to eliminate barriers and improve access to mental health services and mental health supports for consumers of mental health services; and

(8) ensuring the participation of consumers, families, employees, providers, and advocates of mental health services and mental health supports in the planning, delivery, monitoring, and evaluation of these services and supports.

FINDINGS

CMHS WAS UNABLE TO COLLECT APPROXIMATELY $153 MILLION IN REIMBURSEMENTS FROM MEDICAID, MEDICARE, AND OTHER FEDERAL BENEFIT PROGRAMS

Medicaid is the largest program that finances the delivery of medical and health related services to certain low-income and needy individuals in the United States. Established in 1965 as part of Title XIX of the Social Security Act, the Medicaid program is jointly funded by the federal government and state governments, including the Government of the District of Columbia. Federal Financial Participation (FFP), which is the federal government's share of state and local governments' Medicaid program costs, generally falls under two categories: (1) administration, and (2) medical assistance. State and local governments are usually reimbursed at a fixed FFP rate of 50% for administrative costs incurred in carrying out functions such as Medicaid outreach, follow-up, and eligibility determination. Costs for medical assistance such as medical and mental health related services are reimbursed at varying FFP percentage rates, limited to a minimum of 50% and a maximum of 83%, with poorer state and local governments receiving a higher percentage and wealthier ones receiving a lower reimbursement percentage rate. During fiscal years 2001 and 2002, the FFP rate of reimbursement to the District of Columbia was 50% for administrative costs and 70% for medical assistance costs.

During the period under review, the Commission on Mental Health Services was responsible for ensuring that all mental health and related services were provided in a manner that appropriately met a consumer's needs as specified in the consumer's individual treatment plan. Further, the CMHS receiver and other accountable CMHS managers were responsible for undertaking additional efforts to ensure reimbursement from Medicaid for expenditures incurred in providing Medicaid eligible mental health and related services. For instance, mental health and related service providers were to ensure the preparation of adequately detailed documentation to justify and support third-party reimbursement for services actually delivered to CMHS consumers. The success of CMHS' Medicaid reimbursement recovery efforts (also known as Medicaid revenue maximization efforts) relied heavily on effective communications, cooperation, and coordination of efforts between CMHS' procurement, finance and program managers, and the overall direction and oversight of the CMHS receiver. However, the audit revealed this effort was ineffectively managed as a result, in part, of a poor system of accountability, coordination, and cooperation, as well as inadequate management direction and oversight provided by the transitional receiver. The Auditor found that

ineffective, narrowly focused management interests along with disorganized program, procurement, and finance operations, among other factors, undermined CMHS' Medicaid revenue maximization efforts. Because of longstanding, deep-seated mismanagement of functions integral to a successful Medicaid revenue maximization effort, CMHS spent millions of dollars in appropriated funds for Medicaid eligible services that it ultimately could not recover.

Moreover, CMHS' failure to successfully claim Medicaid reimbursement of eligible costs was exacerbated by ineffective internal practices, including a flawed data collection model, lack of written contracts with vendors providing Medicaid reimbursable services to mental health consumers, inadequately articulated policies and procedures, and few or no technical and analytical tools with which to successfully manage its Medicaid revenue maximization responsibilities.[6]

A review of CMHS' accounts receivable for a seven-year period from fiscal year 1995 through 2001 revealed that CMHS had large receivables for the cost of services rendered to mental health consumers that it was unable to collect from Medicaid, Medicare, and other federal benefits programs. In this instance, accounts receivable can be defined as money owed by Medicaid, Medicare, and federal benefits programs for goods or services delivered to mental health consumers.[7]

Officials within CMHS and the Office of the Chief Financial Officer (CFO) decided to "downgrade the revenue projections for federal billings" for fiscal year 2001 and 2002. In other words, $153 million owed to CMHS in Medicaid, Medicare and other federal benefits reimbursements were written-off, or no longer pursued, because CMHS could not provide adequate evidence to justify and support these reimbursements. However, downgrading the revenue projections did not solve the more deeply rooted administrative, procurement and management problems that crippled CMHS' ability to obtain reimbursements from third parties.

The lack of adequate supporting documentation and problems with matching consumer eligibility data in the Department of Human Services' automated consumer eligibility determination system (ACEDS) and the Department of Health's Medicaid Management Information System (MMIS) contributed to CMHS' inability to successfully obtain reimbursement from Medicaid, Medicare, and other benefit programs. More specifically, service providers failed to collect,

[6] In addition to Medicaid, significant problems existed regarding reimbursements for CMHS' other third party revenues, Medicare and Federal Benefits. The Auditor notes, however, that any analysis of these programs, as well as Medicaid, was made difficult because CMHS officials were not forthcoming with detailed information regarding these entitlement programs.

[7] In accordance with Generally Accepted Auditing Standards (GAAS), accounts receivables are defined as "The entity's claims against customers that have arisen from the sale of goods or services in the normal course of business."

document, and maintain the proper encounter data to enable CMHS to seek reimbursement from third parties such as Medicaid for expenses incurred in providing eligible services to mental health consumers. As a result, reimbursable expenditures for mental health services that were initially paid with local appropriated revenue could not be recovered and used to support other critical CMHS operations and programs.

According to a CMHS interim CFO, Medicaid eligibility problems are longstanding, dating back at least 7 years or more. The Auditor's review of CMHS' Medicaid Adjustment Reports dated September 1996 through 1998 reflected substantial reductions in amounts for which CMHS sought reimbursement. For example, the Medicaid Adjustment Report as of September 30, 1996, reflected adjustments, or decreases, totaling millions of dollars including, but not limited to: (1) a $4 million decrease for services rendered that lacked supporting documentation; (2) a $3.3 million decrease for unsupported telephone costs; (3) a $29 million downward adjustment for Medicaid inpatient routine hospital service charges to agree with the intermediary's records; and (4) a $12 million reduction for interim payments made to CMHS by the health department's Medical Assistance Administration (MAA) that could not be sufficiently justified or supported by adequate documentation.

Further, a reduction of $86 million was recorded against CMHS' accounts receivable balance for Medicaid at the close of fiscal year 2001. The reduction represented that portion of the accounts receivable balance that CMHS determined it could not collect. In addition to Medicaid, CMHS reduced by $11 million the receivables balance for federal benefits, and approximately $57 million as an allowance against the receivables balance for Medicare. Again, these adjustments reflected CMHS' inability to obtain reimbursement for mental health service expenditures primarily resulting from its failure to adequately document services delivered and maintain the proper encounter data needed to support claims for reimbursement. This is a common deficiency in other District government agencies responsible for ensuring the delivery of Medicaid eligible services.

Table II presents a summary of CMHS' accounts receivable activity for Medicaid, Medicare and other third-party receivables through September 30, 2001, and amounts that CMHS believed it could not recover.

TABLE II

CMHS' Accounts Receivable For Medicaid, Federal Benefits, and Medicare As of September 30, 2001

Receivable Type	Revenue Beginning Balance	Fiscal Year 1999 Collections	Fiscal Year 2000 Collections	Fiscal Year 2001 Collections	Net Accounts Receivables	Reserve/ Disallowance	Accounts Receivables Ending Balance
Medicaid (Closing Adj)	$251,476,271	($27,977,367)	($20,516,520)	($19,651,850) ($27,126,243)*	$156,204,292	$85,712,306	$70,491,986
Federal Benefits	43,202,115	(13,574,947)	(6,104,112)	(3,724,200)	19,798,856	10,995,990	8,802,866
Medicare	101,804,564	(3,394,703)	(4,182,079)	(-0-**)	94,227,782	56,955,592	37,272,190
Totals	**$396,482,950**	**($44,947,017)**	**($30,802,711)**	**($23,376,050)**	**$270,230,930**	**$153,663,888**	**$116,567,042**

Source: CMHS's Interim CFO

* The Medicaid receivable was reduced by $27 million in a closing adjustment processed by the District CFO's OFOS.

* *There were no collections recorded for Medicare in fiscal year 2001.

Deficiencies Were Found In CMHS' Management of Accounts Receivable

The Auditor found deficiencies in CMHS policies and procedures governing the recording, collection, and write-off of account receivables. Based on the audit team's review of CMHS operations pertaining to Medicaid and other third party billings, accounts receivable were not properly reviewed, monitored, or aged. The Auditor requested, but CMHS could not provide, copies of any analyses or detailed reviews of CMHS' Medicaid eligible or other reimbursable costs. For example, had Medicaid eligible expenditures been properly and regularly monitored, reviewed, and analyzed in detail, CMHS officials would have been better equipped to: (1) timely determine the overall collectibility of accounts receivable; (2) accurately determine CMHS' financial position at critical points in a fiscal year; and (3) make appropriate and timely adjustments to its operations to reflect its financial position. Further, if CMHS management had established a properly functioning system of internal monitoring and analysis, the existence of accounts receivable balances as much as 180 days old or older should have been more timely identified and disclosed.[8] The disclosure of this information should have led to the timely recognition that there was a substantial problem with Medicaid, Medicare, and other third-party collections, and management should have immediately

[8] Accounts receivables that are 180 days old or older generally represent those accounts that may not be collectible. Aging accounts receivable involves an analysis of each individual account to determine the amounts not past due, moderately past due, and considerably past due. Classification of amounts by age (length of time uncollected) is important because experience indicates that the older an account, the higher the probability of uncollectibility.

developed an effective strategy to address this crippling financial problem. That did not occur throughout the period of the CMHS receivership.

Looking forward, routine monitoring and the dedication of comprehensive, competent efforts to improve the management of the Medicaid, Medicare, and other third-party reimbursement efforts can substantially improve the timely collection of money owed for mental health services rendered. The longer money owed remains outstanding the harder it becomes to collect.

RECOMMENDATIONS

1. The Director and Chief Financial Officer of DMH immediately implement stronger internal controls over the review, recording, and write-off of accounts receivables including the establishment of an effective methodology to age accounts receivable.

2. The Director and Chief Financial Officer of DMH immediately evaluate systems for the collection of encounter and per diem data that support a successful claims reimbursement process. DMH must also enhance staff training on data collection.

3. The Chief Financial Officer of DMH must develop realistic projections for third-party billings representing Medicaid, Medicare, and federal benefits.

CMHS PAID $9 MILLION FOR SERVICES PROVIDED BY VENDORS WITHOUT VALID WRITTEN CONTRACTS

At a cost of approximately $9 million, CMHS management improperly allowed five vendors to provide case management services to mental health consumers without valid written contracts between fiscal years 1998 and 2001, through June 2001. The vendors were Anchor Mental Health, Community Connections, Coates and Lane, Green Door, and Lutheran Social Services. The Auditor found that these vendors rendered services without contracts to CMHS consumers during a period in which CMHS was under the management control of a Court-appointed receiver. Further, these vendors were paid inappropriately through direct payment vouchers for miscellaneous services instead of the District's normal contract payment process.

In the absence of adequate systems of financial management, procurement, and programmatic accountability, the Court appointed receiver inappropriately permitted vendors to provide services without contracts. Services rendered through a properly developed and executed written contract

would have set forth the scope of work, performance standards and measures, service rates, reporting requirements, requirements governing the documentation of services delivered to each consumer, procedures governing verification of services billed, and invoice and payment policies and procedures. Within the poorly managed and regulated environment that prevailed during and subsequent to the receivership, the authorization, documentation and payment of services billed by vendors was not effectively controlled or monitored, and CMHS officials were not held to any discernible standards of accountability for their chronic failure to do so. Vendors' invoices were often paid without adequate supporting documentation or verification that the services billed were actually rendered. In some cases, services billed were not ordered by consumers' ITP. In other instances, vendors charged for services, such as case management, that could not be verified in the consumer's case file either because the services were not provided, the case worker failed to prepare a written record of services provided, or the vendor failed or refused to make its records available to authorized CMHS staff for review and verification.

CMHS' acquisition of the services in this manner violated D.C. Code, Section 2-301.05 (d)(1), which provides:

> "No District official or District employee subject to this chapter shall authorize any payment for the value of goods and services received without benefit of a valid written contract, except that this subsection shall not apply to a payment required by a court order or a final decision of the Contract Appeals Board."

Additionally, D.C. Code, Sections 2-301.05(d)(2) and (3), provide the following:

> "After April 12, 1997, no District employee shall enter into an oral agreement with a vendor to provide goods or services to the District government without a valid written contract. Any violation of this paragraph shall be cause for termination of employment of District employee.
>
> Any vendor who, after April 12, 1997, enters into an oral agreement with a District employee to provide goods or services to the District government without a valid written contract shall not be paid. If the oral agreement was entered into by a District employee at the direction of a supervisor, the supervisor shall be terminated. The Mayor shall submit a report to the Council at least 4 times a year on the number of persons cited or terminated under this provision..."

Although the Court-appointed receiver was technically not a District employee, the court should have required and ensured compliance with all District laws and regulations in the obligation and expenditure of District funds.

According to Resource Management Guidance No. 96-02, issued by the District's Chief Financial Officer (CFO) on September 20, 1996, "All expenditures, with the exception of the items listed below, shall first be obligated in the District's financial management system before being vouchered and paid."[9] The CMHS Receiver and accountable CMHS program managers failed to comply with Guidance No. 96-02, or any other formal procurement process. Instead, these officials improperly obligated the District financially to pay for services invoiced by vendors that were not subjected to any discernible scrutiny or measures of accountability. Mismanagement of the procurement and delivery of mental health services and supports in this manner placed District financial resources at risk of loss and mental health consumers at substantial risk of harm.

The Auditor found that the CMHS receivership failed to develop and implement a plan for the competitive procurement of services provided under contracts that expired during the audit period. Instead, accountable CMHS officials allowed contracts to expire but permitted the continuation of services, over a long period of time, without successfully carrying out a competitive procurement process. CMHS officials failed to award valid contracts and failed to ensure the proper encumbrance of funds to cover the projected cost of services required under such contracts.

In accordance with 27 DCMR, Section 1210, Procurement Planning:

> "Agencies shall perform procurement planning and conduct market surveys to promote and provide for full and open competition with due regard to the nature of the supplies and services to be acquired."

In addition, 27 DCMR Sections 1210.5 and 1210.6 state:

> "Procurement planning shall begin as soon as the agency need is identified, preferably well in advance of the fiscal year in which the contract award is necessary. In developing the plan, the planner may form a team consisting of all those who will be responsible for significant aspects of the procurement, such as contracting, fiscal, legal, and technical personnel and, when applicable, the Minority Business Opportunity Commission.

[9]The District's current financial management system is entitled the System of Accounting and Reporting (SOAR).

> In order to facilitate attainment of the procurement objectives, each plan shall identify milestones at which decisions should be made. The plan shall address all the technical, business, management, and other significant considerations that will control the acquisition."

The value of case management services charged to CMHS during fiscal years 1998 through 2001 totaled $9 million. Table III presents a list of vendors providing case management services without contracts to CMHS' mental health consumer population and the amounts paid to each vendor.

TABLE III

Case Management Services Without Contracts
Fiscal Years 1998 - 2001

Provider	Services Rendered	Amount
Anchor Mental Health	Case Management Services	$1,157,634
Community Connections	Case Management Services	$2,421,834
Coates and Lane	Case Management Services	$1,000,026
Green Door	Case Management Services	$1,812,678
Lutheran Social Services	Case Management Services	$2,656,000
Total		**$9,048,172**

Source: CMHS Office of Contracts and Procurement

As justification for continuing services on a sole source, non-contractual basis at non-competitive rates, Receiver's Order No. 2001-64, signed by the Transitional Receiver, dated February 22, 2001, stated, in relevant part, the following: "The Commission on Mental Health Services (CMHS) is required to provide a wide variety of services to its consumers as required under the Dixon Court Order. In an effort to meet this obligation the Commission found it necessary to authorize the continuation of services provided by several contractors and/or vendors who did not have current obligations (contract/purchase orders) in place. These services are considered [sic] vital and necessary in accomplishing the mission and goals of CMHS." The Receiver's Order condoned noncompliance with District government procurement policies and procedures which resulted from internal management failures. Further, Receiver's Order 2001-64 undermined adherence to sound financial management principles, and resulted in the inefficient and uneconomical expenditure of scarce District funds.

The CMHS Transitional Receiver and accountable CMHS managers failed to timely recognize, or ignored, the agency's need for the continuation of contractor provided case management and other services well in advance of the expiration of contracts, and failed to develop and implement a procurement plan to award competitively priced contracts to meet its case management and related needs. As a consequence of management's failure to ensure the timely award of competitive contracts for these services, the quality and quantity of services delivered to CMHS consumers may have been jeopardized. For example, a written contract should have outlined the exact services to be delivered, the cost of each service delivered, and the manner in which service delivery to a consumer was to be authorized, provided, and documented. Additionally, a competitively awarded contract should have included the number of consumers to be served by the contractor, performance standards, and measures that would be used to evaluate a contractor's performance.

According to a CMHS acting contracting officer, numerous amendments to the original solicitation for these services resulted in its cancellation. Another solicitation was issued in fiscal year 1999, but in May 2000 it was also canceled by CMHS officials as a result of deficiencies in the Request for Proposals (RFP). The deficiencies in the RFP included CMHS' failure to: (1) document the minimum number of contacts the contractor was required to have with each consumer; (2) state the number of contracts that were to be awarded; and (3) include provisions that the contractor must become Medicaid certified and bill at a Medicaid fixed minimum rate.

$16 Million In Other Services Were Provided Without Benefit of a Contract

In addition to case management services provided without written contracts, the Auditor noted instances in which vendors provided other services to CMHS consumers in the absence of valid written contracts. According to a review of contract information and discussions with CMHS contract and procurement officials, $16 million were paid to vendors between fiscal years 1999 and 2001, as of June 30, 2001, in the absence of a contract. Table IV presents other services provided by vendors to CMHS consumers without the benefit of a contract during the audit period.

TABLE IV

Other Services Provided to CMHS Without Benefit of a Contract
Fiscal Years 1999 -2001 as of June 30, 2001

Provider	Services Provided	FY 1999	FY 2000	FY 2001 As of June 30, 2001	Total
HBOC ADP/Business	ADP Services, consumer billing	$6,084,839	$6,400,210	$1,763,497	$14,248,546
National Health Care	Health Care Services for the hearing impaired	549,848	533,472	180,367	1,263,687
Braton Botech	Neurology support services	101,326	145,809	38,874	286,009
Fonar	Neurology, MRI services	58,400	58,000	6,800	123,200
Washington Imaging	MRI scan interpretation services	7,100	6,600	1,550	15,250
Total		**$6,801,513**	**$7,144,091**	**$1,991,088**	**$15,936,692**

Source: CMHS Accounts Payable Division

Based on the Auditor's review of contracting and procurement information, it appears that CMHS engaged in a longstanding practice of permitting vendors to provide a variety of medical, mental health, case management, and other services on a sole source, non-contractual basis at non-competitive rates. Despite its receivership status, this practice violated the District government's procurement laws and regulations which require the use of a competitive process in the procurement of goods and services paid with taxpayer funds, and the award of written agreements signed by an authorized District contracting officer and the contractor.

CMHS Awarded An Additional $6.5 Million in Sole Source Emergency Contracts For Residential Services and Treatment For the District's Child And Youth Mental Health Consumers

At the end of fiscal year 2000, approximately $6.5 million in contracts covering residential and treatment services for the District's child and youth mental health consumers expired. The contracts were in their final year of a five-year contract period. Accountable CMHS officials had not issued a solicitation to obtain bids from prospective contractors to continue the services provided under the previous contracts. As a result of CMHS officials' failure to perform the tasks necessary to ensure the timely completion of a procurement process leading to the award of competitive contracts for these services, sole source emergency contracts were made with 18 vendors at a cost

of approximately $6.5 million to continue the delivery of services to approximately 1,727 children and youth for a one-year period from October 1, 2000, through September 30, 2001. Table V presents the sole source emergency contracts awarded and the amount of each contract award.

TABLE V

CMHS Sole Source Emergency Contracts Awarded as of Fiscal Year 2001

Contractor	Service Provided	Award Date	Expiration Date	Contract Amount
Devereux Florida	Residential Services	10/1/00	9/30/01	$1,404,066
Cumberland Hospital	Residential Services	10/1/00	9/30/01	334,050
Devereux Brandywine	Residential Services	10/1/00	9/30/01	227,059
National Children's Center	Residential Services	10/1/00	9/30/01	53,827
2nd Breath/Pheasant Run	Residential Services	10/1/00	9/30/01	219,199
MD School for the Blind	Residential Services	10/1/00	9/30/01	407,375
Devereux-Kanner	Residential Services	10/1/00	9/30/01	386,745
Georgia Jr. Republic	Residential Treatment	10/1/00	9/30/01	123,237
Abraxas Foundation	Residential Services	10/1/00	9/30/01	921,380
Episcopal Center	Residential Services	10/1/00	9/30/01	99,731
Barry Robinson	Residential Services	10/1/00	9/30/01	104,869
Devereux Georgia	Residential Services	10/1/00	9/30/01	702,188
Crystal Spring School	Residential Services	10/1/00	9/30/01	116,645
Pines Treatment Center	Residential Services	10/1/00	9/30/01	620,829
Kidspeace/Wiley House	Residential Services	10/1/00	9/30/01	303,306
National Children's Rehab	Residential Services	10/1/00	9/30/01	309,600
Kolbourne Schools	Residential Services	10/1/00	9/30/01	104,037
Grafton School	Residential Services	10/1/00	9/30/01	51,983
Totals				**$6,490,126**

Source: CMHS Office of Contracts and Procurement

According to contracting and procurement officials, CMHS entered into these sole source arrangements as a temporary measure in order to facilitate the continuation of services while providing additional time to procure the services in accordance with District procurement regulations set forth in 27 DCMR, Section 1905, Human Care Agreements. This is but another example of the Court-appointed receivership's failure to properly and adequately plan for the continuation of critical services to a vulnerable consumer population of District residents. A CMHS acting director of contracts and procurement indicated that the contracts covering residential and related services for children and youth would be awarded by the end of fiscal year 2001. At the time of our field work, DMA officials had not awarded new contracts for these services.

RECOMMENDATION

The Director of DMH must discontinue the practice of authorizing the delivery of services without competition or written contracts, and immediately solicit and award contracts on a competitive basis in a manner that complies with District contracting and procurement laws and regulations.

CMHS WAS BILLED APPROXIMATELY $6 MILLION DURING THE THREE-YEAR AUDIT PERIOD FOR INTENSIVE CASE MANAGEMENT SERVICES THAT WERE NOT SUPPORTED BY ADEQUATE DOCUMENTATION

According to the Auditor's review of consumer data and vendor billing information, CMHS was billed and paid approximately $6 million during the three-year audit period for intensive case management services that were not supported by adequate documentation, if any at all. The Auditor selected a sample of 75 consumers, 10% of the population residing in MHCRFs, and conducted site visits to either the vendor's offices or CMHS' Community Mental Health Centers in Regions I/II and III/IV. The audit team found that the consumers' files did not contain adequate written documentation authorizing the specific level of services for which vendors billed. In other words, there was no documentation in files that prescribed the delivery of intensive case management services to consumers in the sample.[10] The results of the Auditor's examination were that:

[10]Intensive case management services "Involves the provision of a more frequent and time intensive service to a less cooperative, more unstable or less skillful group of consumers than is typical in standard case management. More time is expended in relationship building; assertive outreach may be more frequently required; a focus on meeting basic subsistence needs such as housing and food; greater assistance in community skill development; and the involvement of a multi disciplinary team is essential. Consumers are seen as frequently as needed; they are typically seen face-to-face at least two times per week. Intensive case management targets seriously and persistently mentally ill consumers who: (1) do not participate in services, despite assertive case management, or (2) they have had multiple psychiatric hospitalizations or long-term hospitalization in the past year.

- specific orders for intensive case management services could not be found in any of the 75 consumer files for which the vendor billed CMHS;

- of the 75 files reviewed, 46, or 62%, contained information in the consumers' treatment plan that discussed some services but did not contain specific orders for intensive case management services that vendors' invoices claimed were provided to these mental health consumers;

- 29, or 38%, of the 75 files contained notations in the file or an individual treatment plan indicating the goals and objectives to be achieved by the consumer, but failed to document the specific authorization of the delivery of intensive case management services.

According to CMHS officials in the Community Services Administration, the treatment plan was the authorizing document for mental health and related services to be provided to consumers. CMHS officials stated that the treatment plan, which is signed by a doctor (psychiatrist), as well as the case manager, supervisor, and consumer, should have specifically described the services that vendors were authorized to provide to the consumer. Contrary to this procedure, the treatment plans in the Auditor's sample failed to state the specific services the consumer was to receive and did not specifically authorize the delivery of intensive case management services. For example, of the 75 consumer files reviewed, approximately 52 contained documentation prescribing a short term goal of having the consumer meet with the case manager weekly to discuss psychiatric concerns and any medication issues. However, this did not translate into intensive case management services, although vendors billed CMHS for intensive case management services provided to the 75 consumers in the Auditor's sample. CMHS officials indicated that this situation was being evaluated. Further, the Auditor noted that the greatest percentage of intensive case management services were provided to mental health consumers residing in supported independent living (SIL) facilities, numbering approximately 436, who were deemed capable of living independently in the community with minimal supervision and mental health services. These consumers, while requiring some case management services, may not have required intensive case management services based on their diagnosis. A requirement to provide intensive case management services to consumers residing in supported independent living facilities suggests that these consumers were improperly placed in living arrangements inappropriate to their mental health and related needs or that vendors were improperly providing services or claiming to have provided this particular service to these consumers.

Table VI presents the services that were provided to CMHS consumers during fiscal years 1998 through 2000 that were not supported by a physician's order or other specific written directive authorizing the provision of intensive case management services billed by vendors and paid by CMHS.

TABLE VI

Intensive Services Not Supported by a Physician's Order or Other Directive: Fiscal Years 1998 through 2000

Intensive Case Management	Number of Consumers	Cost of Service Per Contact	Annual Total
SIL Consumers	436	$25	$3,978,500
SR Consumers	5	25	45,625
SRR Consumers	253	25	2,308,625
IR Consumers	6	25	54,750
Total*	**700**		**$6,387,500**

Source: CMHS Office of Financial Services
*Based on 365 days

The Auditor held discussions with CMHS officials regarding the lack of supporting documentation for intensive case management services billed by vendors. CMHS officials indicated that intensive case management and other intensive services were necessary in order for its consumers to remain in the community. They further noted that the provision of intensive case management services represented the CMHS receivers' compliance with the Dixon Decree which requires the placement of mental health consumers in the least restrictive environment. Notwithstanding, the Auditor notes that the Decree requires the responsible placement of mental health consumers and that there should have been documentation justifying a vendor's delivery of intensive case management services and all other services to CMHS consumers. At the time these services were billed, there was an overwhelming likelihood that CMHS program and financial managers did not adequately scrutinize invoices or verify the legitimacy of services billed to exclude inappropriate charges.

Vendors billed, and CMHS, paid for intensive case management services for the same consumers throughout the three-year audit period. There was no evidence that CMHS consumers receiving intensive case management services improved over the period, thus requiring less intensive services as time progressed.

RECOMMENDATION

The Director of DMH immediately establish adequate contractor monitoring policies, procedures, and recordkeeping requirements ensuring the delivery of services to consumers. All services, whether intensive or regular, must be supported with proper authorizing documentation.

CMHS' COSTS OF VENDOR PROVIDED CARE TO CONSUMERS SERVED IN MHCRFs AVERAGED APPROXIMATELY $37,546 PER CONSUMER FOR FISCAL YEARS 1998 THROUGH 2000

CMHS' costs of vendor provided care to approximately 751 consumers served in MHCRFs during the three-year audit period averaged approximately $37,546 per consumer. According to information provided to the Auditor, approximately 751 of the 10,000 CMHS consumers, or 7.5%, resided in MHCRFs. As previously noted, CMHS used approximately 147 MHCRFs classified as SR, SRR, and IR facilities to provide residential services for these 751 consumers at an overall cost of approximately $85 million during the three-year audit period. In fiscal year 1998, CMHS served approximately 746 consumers and spent approximately $27.3 million for an average cost of $36,545 per consumer. In fiscal year 1999, CMHS served approximately 749 consumers and spent approximately $27.5 million for an average cost of $36,694 per consumer; and in fiscal year 2000, CMHS served approximately 758 consumers and spent approximately $30 million for an average cost of approximately $39,368 per consumer.

According to CMHS officials, the level of support and rehabilitative services should have been directly tied to the type of residential placement for the consumer. For example, all consumers residing in an MHCRF received residential services and meals, however, consumers placed in an SRR MHCRF were also to be provided rehabilitative care, and consumers placed in an IR MHCRF were to be provided with intensive services such as specialized psychiatric, behavioral, or other services. The per diem cost ranged from a low of $59 per day for consumers placed in SRs to approximately $167 per day for consumers placed in IR facilities offering the highest level of specialized care and intensive services.

CMHS' costs of vendor provided services to consumers in MHCRFs during fiscal years 1998 through 2000 are presented in Table VII.

TABLE VII

Costs to CMHS of Vendor Provided Services: Fiscal Years 1998 through 2000

CMHS COST COMPONENTS FISCAL YEARS 1998 THROUGH 2000								
Service Type	**Number of Consumers 1998**	**Cost per Consumer 1998**	**Number of Consumers 1999**	**Cost per Consumer 1999**	**Number of Consumers 2000**	**Cost per Consumer 2000**	**Overall Average Number of Consumers**	**Overall Average Costs**
Residential Services	746	$17,863,825	749	$18,064,718	758	$19,316,349	751	$18,414,964
Socialization		4,601,288		4,570,414		4,570,414		4,580,706
Day Treatment		343,743		350,141		350,141		348,008
Employment/ Training		2,625,441		2,670,014		2,670,014		2,655,156
Transportation		278,784		282,936		282,936		281,552
Medical Management		600,321		600,321		600,321		600,321
Therapy (respiratory, adjunctive, drama)		422,236		429,765		429,765		427,255
Psychiatric Services		365,186		359,568		1,465,237		729,997
Medical Services (radiology, medical lab)		162,398		156,132		156,132		158,221
Total		**$27,263,222**		**$27,484,009**		**$29,841,309**		**$28,196,180**
Average per person contract cost estimate	746	$36,545	749	$36,694	758	$39,368	751	$37,546

Source: CMHS Office of Contracts and Procurement

Administrative Costs Increased the Total Estimated Program Costs for CMHS Consumers Residing in MHCRFs To Approximately $60,000 Per Consumer Per Year

In addition to the costs of vendor services provided to consumers residing in MHCRFs, allocable administrative costs incurred by CMHS and other agencies, while not included in the Auditor's calculation of the costs of vendor provided care, increased the costs of providing care to CMHS consumers residing in MHCRFs. According to the Auditor's analysis, administrative costs associated with services provided by other agencies in support of CMHS' community-based mental health program were approximately $22,353 per consumer per year, and included services provided by:

1. the Department of Health, Medical Assistance Administration (MAA) - responsible for administering the District's Medical Assistance Program, Medical Charities Program, and other health care financing initiatives of the District;

2. the Department of Health, Licensing Regulation Administration (LRA) - responsible for licensing and monitoring all MHCRFs. LRA was directly responsible for inspecting, regulating and licensing all MHCRFs during the audit period; and

3. the Department of Consumer and Regulatory Affairs (DCRA), Fire Protection Division and Building and Land Regulation Administration - responsible for conducting annual fire inspections for all licensed MHCRFs. DCRA's responsibilities also include conducting one-time fire inspection of all facilities requiring a certificate of occupancy.

To capture these costs, the Auditor estimated that approximately 3 percent of CMHS' costs of vendor provided care were related to residential services provided to consumers residing in MHCRFs during fiscal years 1998 through 2000. This percentage was then applied to budgeted costs of outside agencies to capture their cost of providing services to the MHCRF population.

Table VIII presents the estimated administrative costs incurred by CMHS and other agencies to provide services for consumers residing in MHCRFs.

TABLE VIII

Total Estimated Program Costs for CMHS Consumers Residing in MHCRFs: Fiscal Years 1998 - 2000

MHCRFs and Other Administrative Costs	Number of Consumers	FY 1998	FY 1999	FY 2000	Average Total
MHCRFs Costs	**751**	**$27,263,222**	**$27,484,009**	**$29,841,309**	**$37,546**
Other Administrative Costs[11]					
MAA	751	$12,103,620	$12,103,620	$12,103,620	$16,117
LRA	751	126,480	126,480	126,480	168
DCRA	751	268,800	268,800	268,800	358
Other divisions within CMHS (Community Programs, Mental Health Administration, Office of Chief Financial Officer, Contracting)	751	4,288,170	4,288,170	4,288,170	5,710
Total		**$16,787,070**	**$16,787,070**	**$16,787,070**	**$22,353**
Total combined MHCRFs and Other Administrative Costs	**751**	**$44,050,292**	**$44,271,079**	**$46,628,379**	**$59,899**

Source: CMHS Office of Contracts and Procurement and Community Services Administration

In addition to the above noted agencies, there are other agencies which also provide some level of service that impact the consumer population residing in MHCRFs. Although not captured in the Auditor's estimate, the costs associated with these agencies can include, but are not limited to, services provided by:

1. the Office of the Corporation Counsel;
2. Metropolitan Police Department;
3. Public Defender Service;
4. the Department of Housing and Community Development; and
5. the Office of the Chief Medical Examiner, among others.

[11]The other administrative costs covered administrative, personnel, and other costs within CMHS and estimated costs associated with legal counsel, management and support costs, costs of the Chief Medical Examiner's office, and other agencies that may provide services and/or support to this consumer population.

CMHS Incurred Costs Totaling $6.6 Million for Consumers in Supported Independent Living Arrangements

Under the supported independent living (SIL) category, CMHS consumers live in the community, with case manager contact as necessary, and are provided numerous supports through an array of services provided by SIL counselors. Consumers are provided assistance with home management services such as solving living arrangement issues; life skills training, assistance with personal hygiene, grocery shopping, housekeeping, transportation, training, and community skills; assistance with food preparation and nutrition counseling; shopping for clothes; medication management; assistance with money management issues; and coordinating recreational activities. Approximately 389 CMHS consumers residing in approximately 131 SIL facilities were provided supports by vendors during fiscal years 1998 through 2000, including questionable intensive case management services. During the three-year audit period, costs incurred by CMHS for providing these services totaled approximately $6,558,287. The per diem rates established under SIL provider agreements averaged approximately $15.40 per consumer per day during the audit period. Based on the number of consumers receiving supports, the cost of care for consumers residing in SILs averaged approximately $5,619.79 per consumer/per year for fiscal years 1998 through 2000.

THE DISTRICT HOUSED AND EDUCATED AN AVERAGE OF APPROXIMATELY 180 CHILDREN AND YOUTH IN OUT-OF-STATE FACILITIES AT AN AVERAGE COST OF APPROXIMATELY $53,586 PER CHILD PER YEAR

During the audit period, the District provided residential and educational services for approximately 180 children and youth in out-of-state facilities, at an average cost of approximately $53,586 per child per year. Ninety-five percent (95%) of the District's children and youth mental health consumers referred for residential treatment services are placed in facilities outside of the District of Columbia. These consumers were placed in facilities in Georgia, Florida, Pennsylvania, Massachusetts, Virginia, Maryland, and Tennessee. The remaining 5% were housed at the Hurt Home and the Episcopal Center, the only community based residential treatment centers in the District of Columbia for seriously emotionally disturbed children 6 to 12 years of age. The Hurt Home is designed to house 48 residents, however, the population as of fiscal year 2001 was 24 residents. According to CMHS' Child and Youth Services Administration (CYSA) officials, the Hurt Home was under capacity because the facility was not licensed to accept any child older than 12 years of age.

Decisions to place children and youth in mental health residential facilities is made by CMHS' Child Youth Services Administration, Residential Placement Unit (RPU). A residential review committee (RRC) comprised of representatives from D.C. Public Schools (DCPS), St. Elizabeths Hospital, D.C. Superior Court, and Child and Youth Services (juvenile justice administration) receives all referrals for residential placement. The committee met weekly to hear cases and determine eligibility. Cases for residential placement were received from a number of sources including DCPS, the Department of Human Services' Family Services Administration and Youth Services Administration (YSA), D.C. Superior Court Social Services, and attorneys or private social service providers working through one of the above noted government agencies.

According to information provided by CMHS, the RPU is required to conduct annual Medicaid inspections of Medicaid certified residential facilities located within the boundaries of the District. For those facilities located outside the geographic boundaries of the District, CMHS relied on reports from case managers, through their daily and weekly interactions with officials at the residential facilities to monitor compliance with the terms of contracts.

Table IX presents the costs to provide mental health care for District children and youth in fiscal years 1998 through 2000.

TABLE IX

Costs to Provide Care and Services to District Children and Youth Placed in Residential Facilities: Fiscal Years 1998 through 2000

Component	FY 1998 Consumers	FY 1998 Costs	FY 1999 Consumers	FY 1999 Costs	FY 2000 Consumers	FY 2000 Costs	Average Cost
Residential	188	$6,850,879	178	$3,733,690	176	$4,381,730	$3,922,099
Educational				5,939,394		4,937,931	4,692,442
Total		**$6,850,879***		**$9,673,084**		**$9,319,661**	**$8,614,541**
Average cost residential	188	$36,441	178	$20,975	176	$24,896	$27,438
Average cost educational				$33,367		$28,056	$26,148
Total Average		**$36,441***		**$54,342**		**$52,952**	**$53,586**

Source: Residential Treatment Unit at CMHS

*According to CMHS officials, educational expenses totaled approximately $3.2 million in fiscal year 1998.

CMHS spent approximately $6,850,879 to provide residential and related services to 188 children and youth during fiscal year 1998 at an average cost-per-child of $36,441. The average cost included residential services, educational services, clothing allowance, emergency medical services, and travel.

In fiscal year 1999, CMHS entered into a memorandum of agreement with D.C. Public Schools (DCPS) requiring it to cover the education costs of the District's emotionally disturbed child and youth population. As a result, CMHS spent approximately $3,733,690 to provide residential and related services including clothing allowance, emergency medical services, and travel costs for 178 children and youth during fiscal year 1999. The average residential cost of care per child in fiscal year 1999 decreased to approximately $20,975. DCPS paid fiscal year 1999 educational costs totaling $5,939,394 for an average cost per child of $33,367, almost twice the per child cost of educational services paid by CMHS. The combined per child cost of residential and educational services totaled $54,342 per child during fiscal year 1999, an increase of $17,901.

In fiscal year 2000, DCPS and CMHS again worked together to manage the provision of residential, educational , and related services to District children and youth mental health consumers. In fiscal year 2000, spending for residential services for approximately 176 child and youth consumers totaled $4,381,730. The average cost per child was approximately $24,896, representing an increase of $3,920, or .04 percent, above fiscal year 1999. The average cost per child included residential services, clothing allowance, emergency medical services, and travel costs, all paid by CMHS. Educational costs of $4,937,931 were paid by DCPS at an average cost of $28,056 per child. The combined cost of care per child totaled approximately $52,952, a decrease of $1,390 from fiscal year 1999.

There Is a Wide Disparity in The Rates Paid to Providers That House District Child and Youth Mental Health Consumers

The Auditor found a wide disparity in the rates paid by the District to 19 facilities that provided residential and other services to children and youth mental health consumers. Two facilities, Kidspeace and Second Breath, housed and provided services to only one District child each at rates in excess of $200,000 per year. The cost of intensive residential services provided by Kidspeace totaled approximately $275,155 annually for one child. The cost of residential care and medically related services provided to one child by Second Breath cost approximately $222,220 per year. According to the contract with Kidspeace, the higher cost is based on providing intensive therapy in a highly structured individualized setting. At Second Breath, in addition to intensive residential services, the cost also covered ventilator care for the consumer every day of the year. Table X presents the costs charged by contractors for providing services to the District's child and youth mental health consumers during fiscal year 2000.

TABLE X

CMHS Children and Youth Services Contract Costs
Fiscal Year 2000

CMHS Children & Youth Services FY 2000						
	Provider Name	**Contract Cost**	**Per Diem Res Rate**	**Per Diem Educ Rate**	**one to one**	**# Children**
1	Abraxas Foundation - Penn					
	Male Intensive	$ 921,380.25	$ 135.90	$ 43.20		10
	Female Intensive		$ 145.85	$ 43.20		1
	Male Drug Sellers		$ 135.90	$ 43.20		4
2	Barry Robinson Center (Medicaid)	$ 104,869.00	$ 250.00	$ 69.00		3
3	CPC College Meadows (Medicaid)	$ -	$ 250.00	$ 64.00		13
4	Crystal Springs School	$ 113,297.90	$ -	$ 298.46		1
	Regular Residential					
	Behavior Intensive		$ 345.36	$ -		0
5	Cumberland Hospital (Medicaid)	$ 338,145.00	$ 250.00	$ 65.00		4
6	Devereux - Brandywine (Medicaid)	$ 222,494.65	$ 188.50	$ 125.79		12
	Devereux - Florida (Medicaid)	$ 338,145.00	$ 250.00	$ 121.00		21
	Devereux - Georgia (Medicaid)	$ 989,650.00	$ 250.00	$ 77.30		21
	Devereux - Hurt Home (Medicaid)	$ 700,314.50	$ 250.00	$ 143.90		24
	Devereux - Kanner Ctr	$ 1,449,064.00	$ 132.00	$ 69.00	$ 15,120.00	5
7	Episcopal Center for Children	$ 366,745.00	$ 73.81	$ 151.55		2
	Speech & Language			$ 40.00		
8	George Jr. Republic					
	General Residential	$ 120,038.00	$ 94.20	$ 48.00		1
	Special Needs Services		$ 158.20	$ 48.00		1
9	Good Shepherd (Medicaid)	$ 22,392.28	$ 201.00	$ 61.34		1
	Speech & Language		$ 9.00	$ 82.00		
	Psychiatric Counseling		$ 36.00	$ -		
	Diagnostic Evaluation		$ -	$ 61.00		
10	Grafton School Inc	$ 140,223.74	$ 234.36	$ 113.05		1
	Occupational Therapy / HR			$ 62.80		1
	OT Consultation/ HR			$ 65.92		1
	Speech & Language/HR			$ 58.08		1
	Comm - Based Vocational Inst/HR			$ 14.36		1
11	Kidspeace (Wiley House)	$ 275,155.00				
	Regular Residential		$ 253.00	$ 145.50		1
	Intensive Residential		$ 318.00	$ 145.50		1
12	Kolburne School	$ 97,037.25	$ -	$ 256.65		1
13	Maryland School for the Blind	$ 405,740.00	$ -	$ 319.00		5
14	National Childrens Center DC (Medicaid)	$ 280,885.50	$ 273.99	$ 150.61		6
15	National Children Rehab (Medicaid)	$ 296,700.00	$ 250.00	$ 89.50		5
16	Pines Treatment (PHC) (Medicaid)	$ 385,720.24				
	Regular Residential		$ 250.00	$ 44.78		4
	Special Education		$ 250.00	$ 58.35		10
17	Value Mark Brenner	$ 31,112.40	$ 250.00	$ 25.00		1
18	Second Breath	$ 222,220.64	$ 555.24	$ 57.77		1
19	The Woods School	$ 1,498,330.00				
	Residential Level II		$ 172.00	$ 82.00		2
	Challenging Behaviors I		$ 234.00	$ 125.00		9
	Challenging Behaviors II		$ 210.00	$ 125.00		1
	Totals	**$9,319,660.35**	**$6,406.31**	**$3,593.81**	**$15,120.00**	**176**

Source: CMHS Residential Placement Unit

CMHS managers within the Child and Youth Residential Placement Division (CYRP) indicated that the placement of children in a facility is based largely on the required level of care and/or specialty needs. Specialty needs can include services related to children suffering from severe brain damage or those who are seriously incapacitated requiring the use of a ventilator. In further discussions with CYRP officials, the Auditor found that placements are also largely contingent upon the acceptance of a child by a residential provider. The Auditor found seven cases in which a residential provider refused to accept a child for placement after referral by CMHS' residential treatment unit. The reasons varied and included: (a) a determination that placement in the facility would not be suitable; (b) the child would not benefit from the program offered; and (c) the child's age.

RECOMMENDATIONS

1. The Director of DMH must explore the possibility of establishing facilities within the District of Columbia to provide mental health care and related services to District child and youth mental health consumers.

2. The Director of DMH immediately negotiate contracts with vendors who provide services to the District's child and youth mental health population. These contracts should be awarded on a competitive basis in compliance with District contracting and procurement laws and regulations.

CONCLUSION

The Auditor's review of CMHS' accounts receivables for a seven-year period beginning with fiscal year 1995 through 2001 revealed that CMHS had large receivables for the cost of services rendered to mental health consumers that it was unable to collect from Medicaid, Medicare, and other federal benefits programs. The Auditor found that disorganized program, procurement, and finance operations, among other factors, undermined CMHS' Medicaid revenue maximization efforts. Because of longstanding, deep-seated mismanagement of functions integral to a successful Medicaid revenue maximization effort, CMHS spent millions of dollars in appropriated funds for reimbursable services that it could not recover. At the completion of audit fieldwork, $153 million owed to CMHS in Medicaid, Medicare, and other federal benefits reimbursements were written-off because CMHS could not provide adequate evidence to justify and support these reimbursements.

At a cost of approximately $9 million, CMHS management improperly allowed five vendors to provide case management services to mental health consumers without valid written contracts between fiscal years 1998 and 2001, through June 2001. The Auditor found that CMHS failed to plan in advance for the procurement of services, previously provided under contracts, through a competitive process. In addition to intensive case management services provided without written contracts, the Auditor noted instances in which vendors provided other services to CMHS consumers in the absence of the award of a valid written contract. According to a review of payment data, approximately $16 million were paid to vendors between fiscal years 1999 and 2001, as of June 30, 2001, in the absence of a contract. The Auditor also found that CMHS paid an additional $6.5 million in sole source emergency contracts for residential services and treatment provided to the District's child and youth mental health consumers residing in facilities outside the District of Columbia.

The Auditor found that CMHS was billed and paid approximately $6 million during the three-year audit period for intensive case management services that were not supported by adequate documentation, if any at all. Consumer files reviewed by the audit team did not contain adequate written documentation authorizing the specific level of services for which vendors billed.

The Auditor determined that CMHS' costs of vendor provided care to approximately 751 consumers served in MHCRFs during the audit period averaged approximately $37,546 per client. In addition to the costs of vendor provided services, CMHS also incurred administrative costs to provide care to consumers residing in MHCRFs. When these administrative costs are added to the vendor cost of care estimate, the per year cost of care for consumers residing in MHCRFs increased to approximately $59,000 per consumer. CMHS also paid substantial costs to provide residential, educational, and related services to children and youth residing in facilities outside the District at an average cost of approximately $53,586 per child per year.

The Auditor's review indicated that the responsibility to deliver mental health services and supports to District mental health consumers was not discharged in an effective, efficient, or economical manner while under Court-ordered receivership.

Respectfully submitted,

Deborah K. Nichols
District of Columbia Auditor

APPENDIX I

1. **Independent Living (IL)** - An independent living arrangement means: living (1) alone, (2) with friends or relatives in private homes, (3) in an apartment, or (4) in a rooming house. It is a residential setting appropriate for a person who, either alone or with minimal assistance, is capable of performing activities of daily living, managing household affairs, functioning in the community and supporting themselves through public benefits and employment. Occasional medical, mental health care, and community support services may be needed. According to CMHS officials, CMHS case managers occasionally "drop-in" to visit clients in independent living arrangements. Independent living facilities:

   - are not required to be licensed;
   - are not monitored by the Department of Health or the Clinical Monitoring Evaluation Division (CMED) of CMHS;
   - are not required to obtain a certificate of occupancy if utilized by less than five unrelated persons; and
   - are not inspected by the Department of Consumer and Regulatory Affairs or the Fire Marshall unless they require a certificate of occupancy.

2. **Supported Independent Living (SIL)** - Supported independent living means living alone, or with one or more compatible persons in an apartment or house. Mentally ill persons residing in SILs receive assistance and training in daily living activities and home management and community skills which may be provided in or outside the residence on a scheduled basis as frequently as determined necessary by the resident's Individual Treatment Plan. Services such as case management, psychiatric rehabilitation, and vocational services are provided by professionals who do not live in the residence. According to CMHS officials, CMHS case managers occasionally "drop-in" to visit clients in supported independent living arrangements. There were 131 SIL facilities in operation during the audit period that housed clients receiving support from CMHS. Supported independent living facilities:

   - are not required to be licensed;
   - are not monitored by the Department of Health;
   - are not monitored by the Clinical Monitoring Evaluation Division (CMED) of CMHS, unless the facility is operated by a vendor under contract with CMHS;

- are not required to obtain a certificate of occupancy if utilized by less than five unrelated persons; and
- are not inspected by the Department of Consumer and Regulatory Affairs or the Fire Marshall unless they require a certificate of occupancy.

3. **Supported Residence (SR)** - A supported residence is a "homelike setting" where residential care is provided in an apartment, house, or other residential facility for six or fewer residents, including at least one adult who is responsible for providing 24-hour supervision and assistance with the tasks of daily living, supervision, meals, and lodging. It is appropriate for individuals whose mental and/or physical disabilities interfere only minimally with their functioning. There were 93 SR facilities that received funding through CMHS during the audit period. Supported residence facilities are required:

   - to be licensed by the Department of Health, Licensing Regulation Administration (DOH/LRA), under guidelines set forth in Sections 3 and 6 of the Health-Care and Community Residence Facility, Hospice and Health-Care Licensure Act of 1983, effective February 24, 1984 (D.C. Law 5-48; D.C. Code, Sections 44-502 through 505) and District of Columbia Municipal Regulations, Title 22, Chapter 31, Licensing of Health Care and Community Residence Facilities;[12]
   - to obtain a certificate of occupancy from the Department of Consumer and Regulatory Affairs (DCRA) as required by 14 DCMR Section 1401.1;
   - to be monitored by CMED; and
   - to be inspected annually for safety by the Fire Marshall or DCRA in accordance with the Omnibus Regulatory Reform Act of 1998 as required by 14 DCMR Section 901.1-901.5.

[12] DOH recently renamed LRA as Health Regulatory Affairs. Given that LRA was the designated name of the licensing authority at all times during the audit period, this report will continue to use LRA when referring to matters related thereto. More importantly, all licensing functions related to mental health CRFs have now been transferred to the newly created Department of Mental Health pursuant to D.C. Act 14-72 entitled "Department of Mental Health Establishment Temporary Amendment Act of 2001."

4. **Supported Rehabilitative Residence (SRR)** - A supported rehabilitative residence is an apartment, house, or other residential facility with six or fewer residents, including at least one adult living in the home who is responsible for providing 24-hour supervision and assistance with activities of daily living, personal supervision, meals, lodging and rehabilitative care. Rehabilitative care is coordinated under the direction of each client's CMHS treatment team. Specialized services are provided on a scheduled basis as determined by the consumer's ITP. There were 40 SRR facilities funded by CMHS during the audit period. Supported rehabilitative residential facilities are required:

   - to be licensed by the Department of Health's Licensing Regulation Administration pursuant to Sections 3 and 6 of the Health-Care and Community Residence Facility, Hospice and Health-Care Licensure Act of 1983, effective February 24, 1984 (D.C. Law 5-48; D.C. Code, Sections 44-502, 505) and District of Columbia Municipal Regulations, Title 22, Chapter 31, Licensing of Health Care and Community Residence Facilities;
   - to obtain a certificate of occupancy from DCRA as required by 14 DCMR Section 1401.1-1499.1;
   - to be monitored by CMED; and
   - to be inspected annually for safety by the Fire Inspector as required by 14 DCMR Section 901.

5. **Intensive Residence (IR)** - An intensive residence is a supportive residential facility with a high staff-to-patient ratio, usually with no fewer than 1 staff to 2 clients, operating 24 hours a day, with a one-to-one ratio in times of high activity, such as meal times. Specialized programming may be provided for clients with problems that limit the likelihood of progress to higher functional levels. Such programming may include medical, psychiatric, behavioral, social and/or recreational services. There were 14 IR facilities funded by CMHS during the audit period. Intensive residential facilities are required:

   - to be licensed by the Department of Health's Licensing Regulation Administration pursuant to Sections 3 and 6 of the Health-Care and Community Residence Facility, Hospice and Health-Care Licensure Act of 1983, effective February 24, 1984 (D.C.

Law 5-48; D.C. Code, Sections 44-502, 505) and District of Columbia Municipal Regulations, Title 22, Chapter 31, Licensing of Health Care and Community Residence Facilities;

- to obtain a certificate of occupancy from DCRA as required by 14 DCMR Section 1401.1;
- to be monitored by CMED; and
- to be inspected annually for safety by the Fire Inspector as required by 14 DCMR Section 901.

AGENCY COMMENTS

AGENCY COMMENTS

On March 27, 2003, the Office of the District of Columbia Auditor submitted this report in draft for review and comment to the Director of the Department of Mental Health. The report was also submitted to the District of Columbia Chief Financial Officer (CFO) for review and comment.

Written comments were received from the Director of the Department of Mental Health on April 15, 2003. Where appropriate, changes were made to the final report based upon the comments received from the Director of the Department of Mental Health. All written comments received by the Auditor are appended, in their entirety, to the final report.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF MENTAL HEALTH

Office of the Director

April 10, 2003

Deborah K. Nichols
District of Columbia Auditor
717 14th Street, N.W., Suite 900
Washington, D.C. 20005

Dear Ms. Nichols:

This is in response to your letter of March 27, 2003 forwarding for comment a copy of the draft report, "Review of the Commission on Mental Health Services' (CMHS) Financial Operations Under Court Ordered Receivership."

While I appreciate being given the opportunity to comment, I wish to advise you that CMHS was in federal court receivership during the time period covered by your report. The local government did not operate or control the agency. All management and fiscal control was vested in the United States District Court Receivers appointed in Dixon v. Williams, C.A. No. 74-0285 (DDC)(NHJ). For these reasons, you may wish to seek comments from those who had control over, and responsibility for, the CMHS' operations during the time period covered by the audit. Given the receivership, my comments will address the progress we have made in correcting the deficiencies that prompted your offices' investigation, and in creating new systems and procedures to ensure that any such problems do not reoccur. We concur with a number of findings and recommendations you have made and have already taken substantial steps to correct the reports cited in your report. For instance, when we discovered in mid-2001 that the CMHS' Medicaid and Medicare revenues had been grossly overstated, we reported the problem to the Council and took immediate action to change our billing operations and information systems. Today we operate our own billing offices, have trained all front desk and billing staff in new processes, and are procuring new practice systems for St Elizabeths and the Public Core Services Agency. For the first time, both operations will have functional information systems that can provide management data for clinical and business functions and can perform essential claims processing functions with proper state of the art audit functions built into the system.

We have expended substantial effort to maximize recoupment of federal revenue. . We have submitted Medicare cost reports for FY 1999 and FY2000 and Medicaid cost reports for FY2000 and FY2001. The Medicaid Assistance Administration (MAA) and its cost report audit firm have performed a detailed review in an effort to finally settle Medicaid cost reports previously submitted for FY1992 – FY1999. We expect to completely catch up in the next few months with all cost reports through FY2002.

In addition, we established internal controls over receivables including methodology to age accounts receivables. We have developed a model process for forecasting revenues accurately. The progress we have made is encouraging as demonstrated by the fact DMH closed it FY2002 with no audit adjustments proposed by the District's independent auditors and is on track to collect FY 2002 and FY 2003 receivables.

We would like to clarify one matter. Your report references placement of youth in residential treatment facilities when a valid contract does not exist. In many situations youth are court ordered into specific facilities right from the courtroom from both juvenile detention and abuse and neglect dockets. DMH does not have the authority to countermand that decision. Often the order is made to a facility outside the District. We are in the process of overhauling the entire Child and Youth system including the former RPU process in part to improve these processes and better protect children and in part to increase capacity for serving children in the District. We have developed a process whereby we can enter into provider agreements with facilities and certify them as eligible for Medicaid reimbursement. We will then place those facilities into a pool that Superior Court judges and others can make referrals to when issuing orders or making treatment decisions. We cannot require this for Judges but we can make a strong case for better service delivery.

As stated, we have already revamped the RPU process and have already diverted 125 children and youth from residential placement this fiscal year. We believe that if we provide more timely and practical evidence based alternatives for the Courts and other agencies we can correct most if not all of the problems that we have found which are quite similar in nature to your findings in the children's residential treatment system.

Finally, you indicated in a recent conversation with me that you are considering initiation of an audit of the accounts maintained by Dennis Jones during his tenure as the Transitional Receiver. Please note that we expect an independent audit will be initiated shortly and submitted to the federal court within the next several months. Assuming there is no impediment to sharing a copy of the resulting report with your office, we would be pleased to do so. In the meantime, if you intend to proceed with an audit of your own, I encourage you to communicate that intent directly to Mr. Jones.

Thank you again for your consideration. I am available to discuss these matters at your convenience.

Sincerely,

Martha B. Knisley
Director