



*Committee Report, Vol. 16 , No.3*

**Community-based Behavioral Health:  
Funds, Efficiency, and Oversight**

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**Legislative Audit Office**

*April 2010*

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*Prepared by*  
**Don Arp, Jr.**  
**Clarence Mabin**



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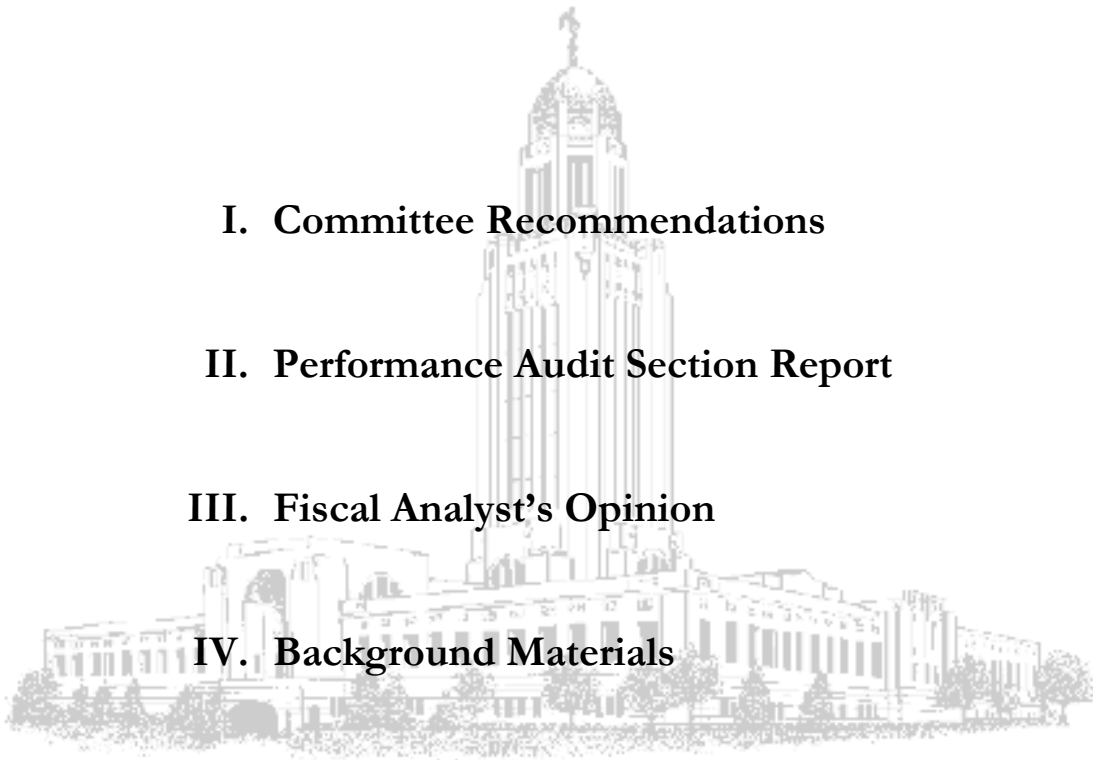
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*I. Committee Recommendations*





# **Audit Summary and Committee Recommendations**

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## **Audit Summary**

With the passage of the Nebraska Behavioral Health Services Act (LB 1083) in 2004, the Legislature undertook statewide behavioral health reform, which emphasized community-based services. The Act provides the structure for the administration and provision of community-based behavioral health services in Nebraska, including the promulgation of rules and regulations, authority to set service rates, and requirements for audits and oversight. The Act authorizes several entities to play roles in the provision of community-based behavioral health services, including the Department of Health and Human Services Division of Behavioral Health (Division), regional governing boards in six regions across the state, regional staff, and service providers.

This performance audit examined whether: (1) funds intended to pay for community-based behavioral health services differentiated from funds intended to pay for administrative costs; (2) administrative responsibilities between the Division and the regions are clear and efficient; and (3) oversight mechanisms are adequate. Audit staff identified a number of concerns, many of which are described as part of the following recommendations from the Legislative Performance Audit Committee.

## **Committee Recommendations**

The Committee is extremely concerned about the audit findings, which it believes demonstrate serious failings in the Department's implementation of the 2004 Nebraska Behavioral Health Services Act (LB 1083). Six years after enactment of LB 1083, the Department has failed to develop a statewide comprehensive plan for behavioral health services, which would provide the behavioral health regions and others with needed guidance about the goals for behavioral health reform in the state. In addition, the Department has failed to promulgate regulations as required. Under LB 1083, the behavioral health regions are required to follow the Department's regulations as part of the balance between the Department's broader authority over behavioral health compared to each region's narrower responsibility for the services within its boundaries. The absence of regulations undermines the Department's role in this regard.

The Committee is equally disturbed by some smaller, yet significant, findings. For example, the agency's attempt to justify a previous Director's bypassing statutory controls on competitive bidding by

citing the agency's broad authority to "integrate and coordinate the public behavioral health system" strains reason. Under this interpretation, a Director could avoid *any* statutory requirement by claiming it was necessary for the integration and coordination of the system.

Similarly, the Director's response to inconsistencies in policies relating to audits of behavioral health services that are purchased by the behavioral health regions reflects a lack of concern for the oversight that the Department should be providing. Audit staff found that two regions were permitted to use an error rate *double* that being used by other regions, and that another region's policies contained no sanction provision for violation of the policies. In response, the Director claimed that "the audits met minimum standards yet we do not require uniformity." This contradictory statement makes no sense and fails to explain why fundamental procedures, such a single allowable error rate and the presence of sanctions, would not be considered "minimum standards."

Also of concern to the Committee are the number of instances in which the agency's written response to the draft audit report provided information that was either contradictory to what audit staff had been told during the audit or was entirely new. It causes additional work for both the agency and the audit staff that could have been avoided if the full and correct information had been provided during the data gathering phase of the audit.

The Committee concludes that the audit identifies significant problems and that the agency's response to the audit findings is insufficient, in some cases failing to take the identified problem seriously. The Committee makes the following specific recommendations.

**Recommendation 1:**

The Committee will ask the Auditor of Public Accounts to conduct an audit of, at a minimum, whether the Department and regions are maintaining the appropriate separation between funds designated for services and those designated for administration. The Auditor may also wish to consider whether the Department has established appropriate internal controls over the funds that flow to the regions.

**Recommendation 2:**

The Committee will forward its concerns about the need for DHHS to develop a comprehensive strategic plan for behavioral health services to the Legislature's Health and Human Services Committee for follow-up.

**Recommendation 3:**

The Committee has begun a preaudit inquiry into the timeliness of regulation promulgation by state agencies, including DHHS.

**Discussion:** The Administrative Procedure Act, which governs the regulation promulgation process, contains no deadline for completion of regulations that are required by statute. Consequently, six years after enactment of LB 1083, the Committee finds itself in the frustrating position of being unable to find the Department in violation of any statute although the Committee fully believes that the lengthy delay has undermined the legislature’s intention that regulations be in place to facilitate LB 1083’s implementation.

In his written response to the draft audit report, the Director noted that the development of the LB 1083 regulations has been coordinated with related regulations and that the draft regulations have been revised five times to incorporate stakeholder input. The Committee appreciates that efficiencies may be gained by such coordination and that input prior to initial of the formal rulemaking process may be beneficial for complex regulations. However, such efforts *must be balanced* with the reality that regulations cannot serve their intended purpose if they are not promulgated within a reasonable period of time after a statute’s enactment. The Committee believes that six years after enactment is unreasonable.

**Recommendation 4:**

The Committee directs the audit staff to follow-up and report back to the Committee on when the draft regulations implementing LB 1083 are scheduled for public hearing, which the Director suggested would happen in “early 2010.”

**Recommendation 5:**

The Committee believes that services provided by regions when competitive bidding fails to produce a qualified bidder should subsequently be put out for competitive bid and will draft legislation for the 2011 legislative session to accomplish that.

**Recommendation 6:**

The Committee directs audit staff to follow-up to determine whether all of the financial and program audits required of the regions take place this year as the Department indicates will happen, in contrast to inconsistencies in completing audits in the past. If the Department finds in the future that it is unable to conduct all of these audits due to staffing concerns, as it reports has happened in the past, the Committee recommends that the Department notify the Committee immediately.

**Recommendation 7:**

The Committee recommends that the Department revise the minimum standards for audits of services purchased by behavioral health regions to include a single allowable error rate and a sanction policy for noncompliance. The Committee requests that the Department provide a copy of the revised standards to the Committee with the implementation plan due following the release of this report.

**Recommendation 8:**

The Committee recommends that the Division review the behavioral health regions' policies for all types of audits and ensure that those policies comply with minimum standards established by the Division.

**Audit Section Findings**

**Section II: Separation of Administrative and Service Funds**

**Finding #1:** DHHS and the regional authorities differentiate in budget proposals and year-end accounting reports the funds spent on administrative costs from the funds spent for services.

**Finding #2:** Although regions do not require service providers to account separately for funds spent on administrative costs and service costs, larger providers in three regions do report separate figures.

**Discussion:** Assessing whether expenditures are being properly recorded as administrative or services is a financial audit function, which the Performance Audit Section is not authorized to undertake.

**Section III: Clarity and Efficiency of Administrative Responsibilities**

**Finding #3:** Statute clearly delineates that the regions have some autonomy with regard to the services provided within their boundaries, but they must operate within a framework established by the Division.

**Finding #4:** Clarity of the responsibilities between the Division and the regions is likely harmed by the weaknesses in the Division's planning efforts identified by Behavioral Health Oversight Commission (BHOC) and the absence of updated regulations.

**Discussion:** Comprehensive planning for the delivery of an appropriate array of services across the state was a critical element of LB 1083's vision for shifting behavioral health care to community-

based services. Similarly, properly promulgated regulations would provide uniform definitions and processes for the regions to follow.

**Finding #5:** The responsibilities of the Division and regions with regard to the selection of service providers are efficient to the extent that the Division has appropriate processes in place.

**Finding #6:** The Division acknowledged one instance in which the Director deviated from the competitive bidding requirements due to a provider withdrawing mid-contract. This is a deviation that the Nebraska Behavioral Health Services Act does not appear to allow.

**Discussion:** Division representatives told us that they did not intend to deviate from the competitive bidding requirements in the future.

**Finding #7:** The Division's interpretation of the statute that allows regions to provide services in the absence of qualified bidders has created an extension of the grandfather clause because once a region begins providing a service, it never has to reopen the service to competitive bidding.

**Discussion:** This is a policy issue for the Committee's consideration.

#### **Section IV: Oversight**

##### *CPA Audits*

**Finding #8:** The regions complied with the requirements to have yearly financial audits.

**Finding #9:** The Division takes several steps to ensure audits of the regions are scheduled, conducted, and reviewed.

**Finding #10:** The Division was not compliant with the contractual requirement to audit regionally provided services on a yearly basis. One of the six regions had no services purchased audits between 2005 and 2008.

**Finding #11:** This noncompliance also raises questions about the effectiveness of the Division's review and monitoring of the audit timeline submitted with regional budget plans.

**Discussion:** Division representatives told us they do not have enough staff to conduct all of the required audits. As the state is facing a significant budget deficit in the current biennium, this problem may get worse.

**Finding #12:** Some regions' policies for conducting services purchased audits varied inappropriately from the Division's policies.

**Discussion:** It is within the Division's authority to ensure that the region's audit policies conform to minimum standards established by the Division.

*Program Fidelity Audits*

**Finding #13:** The Division is substantially compliant with the requirement to conduct timely program fidelity audits of regionally-provided services.

**Finding #14:** All six regions had adequate procedures for program fidelity audits.

*Consumer Input*

**Finding #15:** The Division conducts several consumer outreach activities, including an annual survey that suggests consumers are generally satisfied with the services they received.

**Finding #16:** The Division responds to recommendations from different consumer groups.

*Data Reporting and Analysis*

**Finding #17:** The Division is compliant with a requirement that it collect and report on the status of people in need of and receiving behavioral health services.

**Finding #18:** Division staff do not analyze program fidelity audit information to note trends in identified weaknesses for either specific providers or groups of providers.

**Finding #19:** The Division's lack of formal data analysis was noted as an area of concern in a 2007 review by the federal Center for Substance Abuse Treatment.

**Finding #20:** By not compiling consumer feedback from the helpline, the Division is missing an opportunity to increase consumer involvement in the behavioral health system.

**Discussion:** According to Division representatives, they review data from program fidelity audits and consumer outreach activities to identify immediate problems but do not compile and analyze the information to identify patterns or trends that develop over time.

**Finding #21:** There are adequate mechanisms in existence to oversee the behavioral health delivery system; however some are not functioning as well as they should be. This is particularly concerning since the Behavioral Health Oversight Commission (BHOC), which had the broadest oversight responsibility, has been eliminated.







*II. Performance Audit Section Report*



*Legislative Audit Office Draft Report*  
**Community-based Behavioral Health:  
Funds, Efficiency, and Oversight**

*November 2009*

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# INTRODUCTION

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In June 2009, the Legislative Performance Audit Committee directed the Legislative Performance Audit Section to conduct a performance audit of the Department of Health and Human Services Division of Behavioral Health's (Division) administration of the behavioral health system and answer the following questions:

1. How are funds that are intended to pay for community-based behavioral health services differentiated from funds intended to pay for administrative costs?
2. Are the administrative responsibilities of the Department of Health and Human Services and the regional administrations, in regards to community-based behavioral health, clear and efficient?
3. What oversight mechanisms exist in the community behavioral health system and are these mechanisms adequate to ensure proper functioning of the system?

Section I of this report provides an overview of Nebraska's behavioral health system. Sections II through IV answer the specific questions posed for this audit. Section V contains our findings and recommendations.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

In conducting this analysis, we reviewed the Nebraska Behavioral Health Services Act, rules and regulations, and Division policies and internal documents. We also interviewed Division staff. The Division provided the financial data cited in this report. Audit staff did not independently verify the financial data.

We appreciate the cooperation and assistance of Division staff during the audit.





## SECTION I: Behavioral Health Services in Nebraska

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In this section we give a brief background of Nebraska's behavioral health system, including statutory responsibilities of each entity involved.

### Nebraska's Community Behavioral Health System

Nebraska's behavioral health system was established in 1974, with elements of centralization and local control designed to meet the service needs of Nebraska citizens. The current system is comprised of the Division, groups of counties that make up regional behavioral health authorities (regions), and behavioral health service providers, which can be regions or private contractors.<sup>1</sup>

A major restructuring of the state's behavioral health system occurred in 2004, with the Legislature's passage of LB 1083, the Nebraska Behavioral Health Services Act. The Act sought to address an over-reliance on the state's regional centers, and move toward community based services. The Behavioral Health Oversight Commission (BHOC) noted in its 2008 report that, "Consistent with advances in research and treatment, evolving best practices, the legal and civil rights of those with mental illness or other disability as established in the U.S. Supreme Court Olmstead decision, and the advocacy of consumers, families, and professionals alike, LB 1083 envisioned and mandated the provision of services closer to home, family, and support services and in the least restrictive setting."

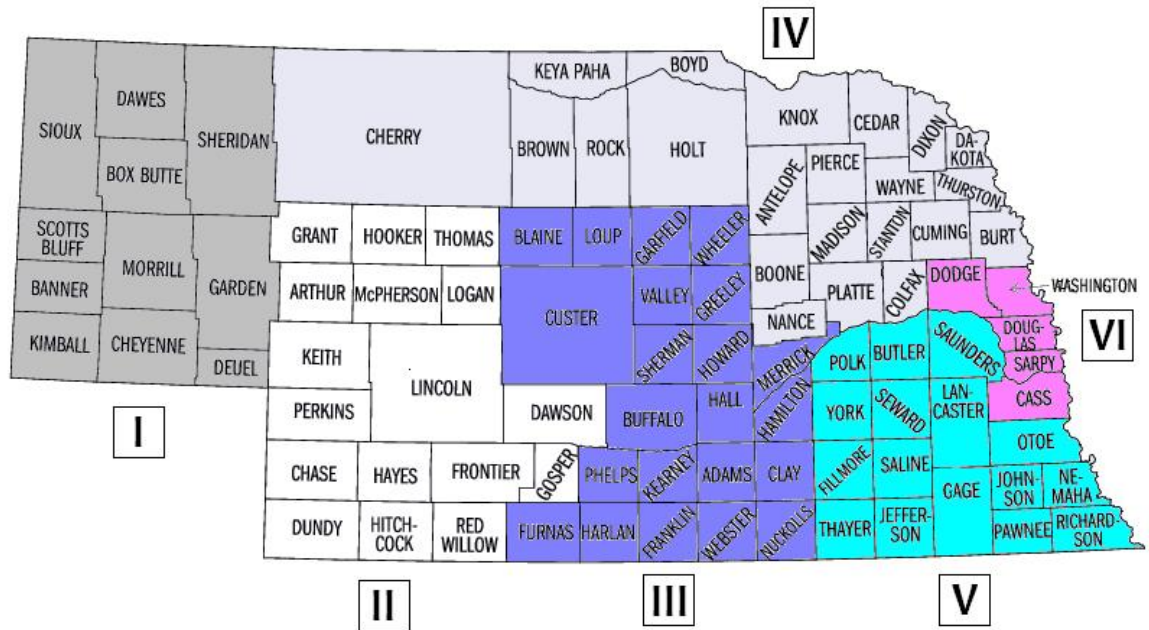
#### *The Division*

By law, the Division must direct the administration and coordination of the behavioral health system. The Division does so by overseeing the regions, including approving regional budgets and auditing regions' behavioral health programs and services.<sup>2</sup> Additionally, the Division sets the reimbursement rates for services and consumer fees, and is required to conduct statewide planning to ensure that an appropriate array of community-based behavioral health services are provided.<sup>3</sup> The Division is also responsible for adopting the rules and regulations to carry out the Act, which the regions must follow.<sup>4</sup>

To facilitate consumer feedback and provide state oversight, the Director of Behavioral Health must appoint a chief clinical officer and establish an Office of Consumer Affairs.<sup>5</sup> We will discuss the Division's oversight activities in Section IV of this report.

## The Regions

The state is divided into six behavioral health regions, as shown below. Acting under the Interlocal Cooperation Act, the counties in each region are required to establish a behavioral health authority.<sup>6</sup> One county board member from each county in a region serves on the regional governing board. The counties must provide a portion of the funding for the operation of their region's behavioral health authority and for the provision of behavioral health services in the region.<sup>7</sup>



## Regional Governing Boards and Authorities

Each regional governing board oversees a regional behavioral health authority and is required to appoint a regional administrator to administer and manage the region.<sup>8</sup> Each region is responsible for the development and coordination of publicly-funded behavioral health services within its service area. In doing so, it must ensure that these actions follow the rules and regulations established by the Division.<sup>9</sup>

Each region must:

- submit budgets to the Division for approval;
- plan to ensure that an appropriate array of community-based behavioral health services are provided in the regions;
- coordinate and conduct audits of programs and services;

- provide annual reports and other reports required by the Division;
- initiate and oversee contracts for behavioral health services;
- encourage consumer involvement “in all aspects of service planning and delivery within the region;” and
- coordinate its activities with the Division’s Office of Consumer Affairs.<sup>10</sup>

In addition to their statutory responsibilities, the regions sign contracts with the Division that provide further details about the regions’ responsibilities in financial processes, oversight and other areas.

The regions are allowed to provide services under certain circumstances, which we discuss in more detail in Section III of this report.<sup>11</sup>

#### *Private Contractors*

Additionally, regions enter into contracts with individual private contractors. The same rules and regulations that apply to the regions also apply to service providers.<sup>12</sup> The Division requires certain elements to be included in the contracts between the regions and service providers, including the submission of budget plans, participation in reporting and recordkeeping, and participation in oversight activities such as audits of programs and services.<sup>13</sup>

## Notes

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<sup>1</sup> The Nebraska Comprehensive Community Mental Health Act was enacted in 1974 with LB 302.

<sup>2</sup> Neb. Rev. Stat. § 71-806(1).

<sup>3</sup> Neb. Rev. Stat. § 71-806(1).

<sup>4</sup> Neb. Rev. Stat. § 71-806(2).

<sup>5</sup> Neb. Rev. Stat. § 71-805(1-2).

<sup>6</sup> Neb. Rev. Stat. § 71-808(1).

<sup>7</sup> Neb. Rev. Stat. § 71-808(3). Counties in each region consult with their regional governing board to determine the amount of funding to be provided by each county.

<sup>8</sup> Neb. Rev. Stat. § 71-808(1 and 2).

<sup>9</sup> Neb. Rev. Stat. § 71-809(1).

<sup>10</sup> Neb. Rev. Stat. §§ 71-809(1) and 71-808(2).

<sup>11</sup> Neb. Rev. Stat. § 71-809(2).

<sup>12</sup> The introductory language of 204 NAC Ch. 4 states: “The requirements under this chapter apply to Regional Governing Boards (hereafter referred to as ‘region’) as well as an organization or individual (hereafter referred to as ‘provider’) receiving community mental health funds directly from the Department or from the Department through a Regional Governing Board.”

<sup>13</sup> FY2008-2009 Contract, Section IV: Contractor Duties and Responsibilities (Subsections A and F) and Section IX: Audits, Services Purchased and Program Fidelity Verification Requirements.



## **SECTION II: Behavioral Health Administrative Costs**

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In this section we describe how funds that are intended to pay for community-based behavioral health services are differentiated from funds intended to pay for administrative costs associated with providing those services.

The Department of Health and Human Services Division of Behavioral Health (Division), regions, and providers all have administrative duties and accompanying costs. Following is a discussion of how the entities account for their administrative costs.

### **The Division**

The Division maintains separate budgets for state-level behavioral health administrative funds and funds it provides to the regions. For FY2008-09, the Division spent \$2.1 million (consisting of both state and federal funds) to administer Nebraska's behavioral health system.<sup>1</sup> According to Division staff, the administrative costs constitute approximately 1.2 percent of total behavioral health system expenditures.<sup>2</sup>

### **The Regions**

The regions receive funding for administrative and service-provision costs from the Division and from the counties that make up each region. For FY2008-09, the Division distributed \$87.3 million to the regions.<sup>3</sup>

By law, each county must contribute to the regional authority one dollar for every three dollars appropriated from the General Fund. In FY2008-09, the regions received approximately \$117 million from these sources, almost \$5 million of which was used for administrative expenses. Division staff noted that most regions use county matching funds to pay for their administration costs.<sup>4</sup>

Rules and regulations require the regions to submit yearly budget plans,<sup>5</sup> which include estimated expenditures for mental health services, substance abuse services, and administration.<sup>6</sup> After the fiscal year has ended, regions are required to submit reports of their actual expenditures to the Division.<sup>7</sup> Division staff said that they compare the reports of actual expenditures when they review the regions' budget estimates for the upcoming fiscal year.<sup>8</sup>

For FY2008-09, the regions spent between 3.0 and 11.5 percent of their total revenue for administrative expenses (shown in Table 1).

**Table 1: Actual Regional Administrative Expenditures for FY2008-09**

<b>Region</b>	<b>Actual Administrative Totals</b>	<b>Actual Revenue (state, local, and other fund sources)</b>	<b>Percentage of Funds Used Specifically for Administration*</b>
1	\$691,918	\$6,010,114	11.5%
2	\$356,880	\$7,084,505	5.0%
3	\$592,747	\$19,159,500	3.0%
4	\$537,794	\$15,440,723	3.5%
5	\$1,431,018	\$29,324,749	4.9%
6	\$1,269,503	\$40,073,688	3.2%
<b>Total</b>	<b>\$4,879,860</b>	<b>\$117,093,279</b>	---

Table prepared by the Legislative Audit Office using data provided by the Division of Behavioral Health.

\*Administrative includes both coordination costs and administration costs under the “System Coordination” section of the budget form.

### **Private Service Providers**

Like the regions, each private service provider submits a budget plan with its contract, including estimated expenditures for mental health services, substance abuse services, and administration.<sup>9</sup> Private providers apply for reimbursement from the regions after they have provided a service.<sup>10</sup>

According to Division staff, providers’ administrative costs typically run between 15 and 20 percent, although some organizations, such as hospitals, have administrative costs that are often more than 20 percent for their total expenditures.<sup>11</sup> Audit staff did not verify these percentages.

A survey of regional administrators found that although the regional budget plan guidelines do not require providers to report administrative costs separately, some providers do. Three of the six regions noted that larger providers gave separate figures for administrative and services costs, both in budgets and in year-end actuals. The other three regions said that their providers do not. All six regions noted that because most providers are small enterprises and are paid on a unit cost or fee-for-service basis, they cannot provide separate figures like the larger providers.

**FINDING: DHHS and the regional authorities differentiate in budget proposals and year-end accounting reports the funds spent on administrative costs from the funds spent for services.**

**FINDING: Although regions do not require service providers to separately account for funds spent on administrative costs and service costs, larger providers in three regions do report separate figures.**

## Notes

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<sup>1</sup> Budget Status Report from the Nebraska Information System as of June 30, 2009 for Agency 25, Program 268. E-mail from Sue Adams, October 14, 2009.

<sup>2</sup> Meeting with Scot Adams, Vicki Maca, Susan Adams, and Karen Harker, June 18, 2009.

<sup>3</sup> Budget Status Report from the Nebraska Information System as of June 30, 2009 for Agency 25, Program 38.

<sup>4</sup> Meeting with Scot Adams, Vicki Maca, Susan Adams, and Karen Harker, June 18, 2009.

<sup>5</sup> 203 NAC Ch. 4-003.

<sup>6</sup> Behavioral Health Division form 10a.

<sup>7</sup> FY2008-2009 Contract, Section IV: Contractor Duties and Responsibilities (Subsection F).

<sup>8</sup> Telephone conversation with Susan Adams, September 11, 2009.

<sup>9</sup> FY2008-2009 Contract, Section IV: Contractor Duties and Responsibilities (Subsection A).

<sup>10</sup> Telephone conversation with Susan Adams, September 11, 2009.

<sup>11</sup> Meeting with Scot Adams, Vicki Maca, Susan Adams, and Karen Harker, June 18, 2009 and telephone conversation with Susan Adams, September 11, 2009.





## SECTION III: Administrative Responsibilities

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In this section, we discuss whether the administrative responsibilities of the Department of Health and Human Services Division of Behavioral Health (Division) and the regional administrations, in regards to community-based behavioral health, are clear and efficient.

### Administrative Structure

By law, the Division is the “chief behavioral health authority” for Nebraska, responsible for the overall administration of the public behavioral health system, including coordinating and overseeing the work of the regions.<sup>1</sup> The Division must approve or disapprove regional budgets and plans and audit the regional authorities and all behavioral health programs and services.<sup>2</sup> Further, the Division is required to adopt and promulgate rules and regulations to carry out the Act and to conduct strategic planning plan for the delivery of behavior health services.<sup>3</sup> In short, the Division is responsible for ensuring that the necessary types of services are available throughout the state.

In contrast, each region is responsible for coordinating and overseeing the network of community-based service providers within its geographic boundaries, thus executing a critical role in serving its residents. The legislative history for LB 1083 reflects the Legislature’s intention that the regions exercise local control within the framework set out by the Division. For example, Senator Jim Jensen, Chair of the Health and Human Services Committee and introducer of LB 1083, stated:

We don’t want to tell communities what to do. They need to decide for themselves what is best for their community. Then the state has the overall plan.<sup>4</sup>

However, regions do not have unlimited control over the services provided within their boundaries. They must follow the provisions of the Act, the rules and regulations promulgated by DHHS, and the requirements of contracts they sign with the Division.

### Clarity of Authority

We found that the responsibilities of the Division and regions seemed clear, at least in statute. To determine whether they were clear in practice, we asked Division representatives and regional administrators whether their responsibilities under the Act (as described above) were clear to them. The Division representatives and some regional administrators told us there were times when their responsi-

bilities were not clear; however, they provided no specific examples of problems they had encountered. From our own analysis we identified two practical problems that are likely to contribute to confusion about responsibilities.

**FINDING: Statute clearly delineates that the regions have some autonomy with regard to the services provided within their boundaries, but they must also operate within a framework established by the Division.**

*Inadequate Comprehensive Planning*

By law, the Division is responsible for the “comprehensive statewide planning for the provision of an appropriate array of community-based behavioral health services and continuum of care.”<sup>5</sup> In 2008 and 2009, the Behavioral Health Oversight Commission (BHOC), created by the Legislature to help oversee implementation of LB 1083, called into question the extent of the Division’s planning. BHOC found that “many of the goals and responsibilities as set out in LB 1083 have not been accomplished,” noting that many of the 108 deliverables identified in DHHS’ “LB1083 Behavioral Health Implementation Plan” remained “incomplete and/or unaddressed altogether.” Some of these issues, according to BHOC, include:

- a plan for integrating the administration of behavioral health programs;
- a comprehensive statewide plan for behavioral health services;
- services that are research based, focus on recovery, and include peer support;
- a quality improvement plan; and
- a methodology for measuring consumer, process, and system outcomes.<sup>6</sup>

To address these shortcomings, BHOC recommended that the Division adopt a strategic vision for behavioral health that would lead to the “establishment of trusting and effective partnerships with key stakeholders in the system.” BHOC said such planning was “imperative.” Division staff confirmed that the Division has not completed comprehensive statewide planning and coordination for community-based behavioral health services.<sup>7</sup>

Through our survey, we found that some regional administrators believe that the lack of a comprehensive statewide plan for the provision of services created some instances of confusion between the Division and the regions. According to one of the regional representa-

tives, the absence of the plan “creates a void in vision, direction and leadership.”<sup>8</sup>

### *Regulations Not Promulgated*

An issue closely related to inadequate comprehensive planning is the lack of updated rules and regulations. As of the writing of this report, the promulgation of rules and regulations to implement the reforms of LB 1083 has not been completed—five years after passage of the bill. Although the Division and regions provided no examples of problems arising from this issue, updated rules and regulations with accurate statutory citations seems to us to be a resource that could add increased clarity to operating the community-based behavioral health system.

**FINDING: Clarity of the responsibilities between the Division and the regions is likely harmed by the weaknesses in the Division planning efforts identified by BHOC and the absence of updated regulations.**

### **System Efficiency**

The behavioral health system’s most important goal is the provision of services to those who need them. Therefore, to determine the efficiency of the system, we examined whether the Division has in place the required processes for the selection of service providers (we did not assess the efficiency of the delivery of individual services). To conduct this analysis, we reviewed relevant portions of the Act, rules and regulations, the regions’ processes for contracting with service providers, and the circumstances in which regions may provide services without conducting a competitive bidding process.

### *Service Provision*

As mentioned earlier in this report, the regions must provide an appropriate array of services, either through private providers or themselves. When not providing a service itself, a region must conduct a competitive bidding process to select the service provider(s).

### Bidding Procedures

Pursuant to a section of the Act often referred to as the “grandfather clause,” a region can provide a service, without first conducting a competitive bidding process, if it provided the service on July 1, 2004.<sup>9</sup> Currently, although private contractors provide most of the services in the system, all six regions provide some services under the grandfather clause.<sup>10</sup>

For services not covered by the grandfather clause, regions must conduct a competitive bidding process. Bidders participating in the process are assessed by region staff, as part of the request for proposal (RFP), to determine if they meet the “enrollment of providers” requirements set by the Division.<sup>11</sup> These requirements are: demonstration of capacity, state certification or national accreditation, an on-site visit, and primary source verification.<sup>12</sup>

If a provider meets the bidding requirements and is accepted by the region, it must sign a contract, agreeing to participate in required financial processes and other oversight activities. The provider then carries out a service and applies for reimbursement from the region.

**FINDING: The responsibilities of the Division and regions with regard to the selection of service providers are efficient to the extent that the Division has appropriate processes in place.**

#### Director’s “Exemption”

Division staff noted that the Division Director once allowed a deviation from the competitive bidding procedures (they termed it a “waiver”) when a provider unexpectedly withdrew from an active contract.<sup>13</sup> The Director believed this was necessary because the community could not do without the particular service for the time it would take to conduct the bidding process.<sup>14</sup>

Nothing in the plain language of the Act authorizes such a waiver. Although the currently promulgated rules and regulations make provision for a waiver, such action pertains only to certain chapters of that title of the administrative code, none of which address the actual bidding process.<sup>15</sup> Use of the waiver in this instance seems unsupported by statute. Division staff, including the Director, said that they are not inclined to grant a waiver in an instance such as this again.

**FINDING: The Division acknowledged one instance in which the Director deviated from the competitive bidding requirements due to a provider withdrawing mid-contract. This is a deviation that the Nebraska Behavioral Health Services Act does not appear to allow.**

#### Failure to Find a Provider

In addition to providing services under the grandfather clause, a region may provide a service if the bidding process does not identify a qualified bidder and the Division director authorizes the region to provide the service.<sup>16</sup> According to Division representatives, when a region is authorized to provide a service because there was no qualified bidder, it does not need to open that service for bidding again.<sup>17</sup>

We found that the Act itself and the legislative history of LB 1083 are both silent on whether the Legislature intended for regions to indefinitely provide a service under these circumstances, as they are allowed to do for grandfathered services.

**FINDING: The Division’s interpretation of the statute that allows regions to provide services in the absence of qualified bidders has created an extension of the grandfather clause because once a region begins providing a service, it never has to reopen the service to competitive bidding.**

## Notes

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<sup>1</sup> Neb. Rev. Stat. § 71-806 (1).

<sup>2</sup> Neb. Rev. Stat. § 71-806 (1) (d) and (i).

<sup>3</sup> Neb. Rev. Stat. § 71-806 (1) (c) and (2).

<sup>4</sup> Legislative History, LB 1083 (2004), remarks by Sen. Jim Jensen, March 17, 2004, pg. 11633.

<sup>5</sup> Neb. Rev. Stat. § 71-806 (1) (c).

<sup>6</sup> Behavioral Health Oversight Commission Final Report, June 22, 2009, pg. 7.

<sup>7</sup> and telephone conversation with Sue Adams, September 10, 2009.

<sup>8</sup> Written statements from regional administrators.

<sup>9</sup> Neb. Rev. Stat. § 71-809 (2). The Division used the Budget Planning Document, which describes services provided by each region, submitted by the regions during the fiscal year previous to the July 1, 2004, as the baseline of services provided by the regions prior to the implementation of LB 1083 (Meeting with Scot Adams, Vicki Maca, and Sue Adams, October 6, 2008).

<sup>10</sup> Budget Plan documents from all six regions provided by the Division.

<sup>11</sup> Neb. Rev. Stat. § 71-809 (2) (a-c)

<sup>12</sup> Network Management Review document. Demonstration of Capacity: Examines necessary facility licenses, professional licenses, insurance, fiscal viability, Medicaid enrollment (if services are eligible), and program plans for services provided in network. Program plans must contain: entry and discharge criteria; assessment procedures; discuss how consumer input is completed; staffing; and quality improvement processes. State certification or national accreditation: New providers must apply for State Certification or State Certification through National Accreditation. On-site visit: Verifies information used to demonstrate capacity, examines clinical record keeping practices, and conducts a data audit to verify information reported to the Division. For providers without national accreditation, a quality assurance review is also necessary. Primary source verification: All documents used to meet requirements are compiled and verified by network management.

<sup>13</sup> Meeting with Scot Adams, Vicki Maca, and Sue Adams, October 6, 2008; E-mail from Sue Adams, December 8, 2008, with answers approved by Scot Adams.

<sup>14</sup> Meeting with Scot Adams, Vicki Maca, and Sue Adams, October 6, 2008.

<sup>15</sup> NAC Title 204, Chap. 2.

<sup>16</sup> Neb. Rev. Stat. § 71-809 (2) (a-c).

<sup>17</sup> E-mail from Sue Adams, December 8, 2008, with answers approved by Scot Adams.



## SECTION IV: Behavioral Health Oversight Mechanisms

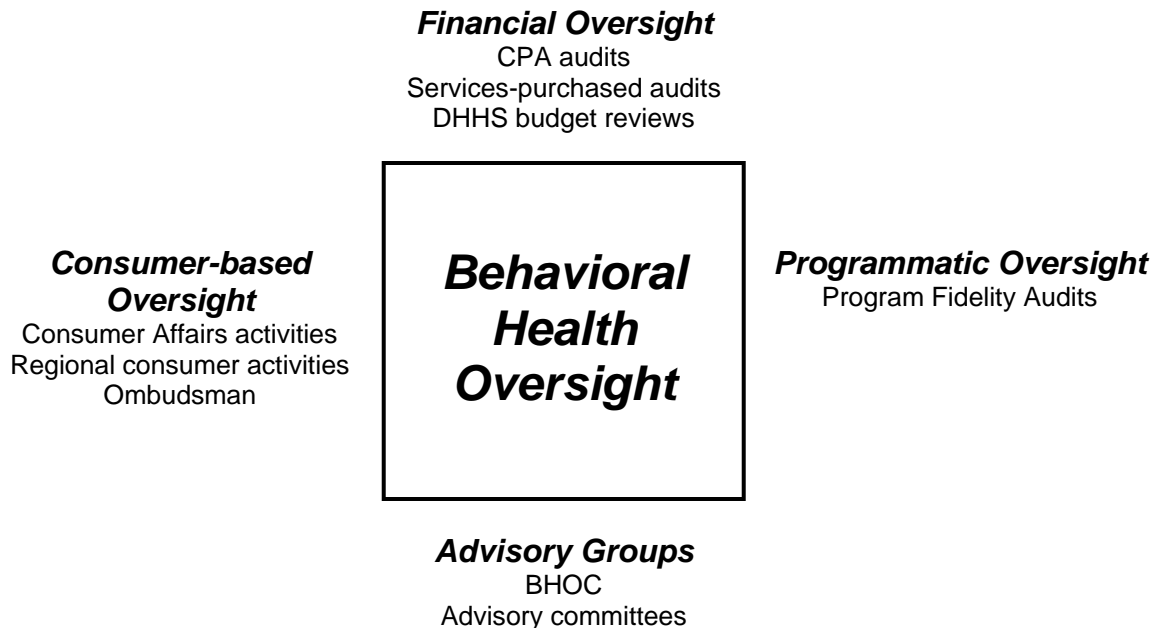
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In this section, we discuss the oversight mechanisms that exist in the community behavioral health system and whether these mechanisms are adequate to ensure proper functioning of the system.

### The Oversight Environment

There are several oversight mechanisms in place at various levels of the behavioral health system and that are executed by the Division, the regions, or independent contractors. These mechanisms include:

- financial oversight (CPA audits and services purchased audits);
- programmatic oversight (reviews of budget plans, program fidelity audits, audits from other entities such as the Legislature or accreditation organizations);
- consumer-based activities such as conferences and helplines; and
- input from advisory groups.



## Financial Oversight

### *Budget Reviews*

As part of its oversight responsibilities, the Division must review and approve regional budgets.<sup>1</sup> Division staff use budget plans submitted by the regions to examine, among other items, the spectrum of services provided and estimated administrative costs. Division staff also compare the list of services provided to a master list of services to ensure that the provisions of the so-called “grandfather clause” are followed by regions that are providing services themselves. Division staff noted that they work closely with regional staff during budget submission and that it is routine for them to ask for more information from the regions regarding budget issues.<sup>2</sup> Staff also said that they ask the regions to either submit more information or re-submit budget plans to address issues.<sup>3</sup>

### *CPA Audits*

Each region and private service provider must have an independent, annual financial audit conducted by a certified public accountant.<sup>4</sup>

We found that all regions complied with the requirement to have yearly financial audits. None of the audits reviewed identified any issues that rose to the level of “material” significance. We did not determine whether each private service provider also had a financial audit.

The Division takes several steps to ensure audits of the regions are scheduled, conducted, and reviewed. Regions submit an audit timeline with their budget plans indicating when audits will occur, which Division staff said they check against incoming audits. Once completed, the regions send audit reports to the Division. According to the Division, staff review the audit reports, noting any deficiencies on a cover sheet that must also be signed by the reviewer.<sup>5</sup>

**FINDING: The regions complied with the requirements to have yearly financial audits.**

**FINDING: The Division takes several steps to ensure audits of the regions are scheduled, conducted, and reviewed.**

### *Services-purchased Audits*

Services-purchased audits, required annually for each service, assess whether providers actually delivered the services they billed to the Division or the regions. Division staff audit region-provided services; region staff audit subcontractor-provided services. We reviewed the



audits conducted by the Division, but lacked the time to examine the audits done by region staff of subcontractors.

Similar to the CPA audits, the Division requires regions to submit a timeline for completion and reviews the report once completed. When we reviewed the services-purchased audits performed by Division staff from 2002 to 2008, we found that the Division conducted nine reviews of five regions' services during that time. Contrary to contract, no region's services were audited yearly.<sup>6</sup> Division staff explained that Division understaffing has meant fewer audits.<sup>7</sup> Division staff could not offer a clear explanation of why Region 3 did not have a services-purchased audit by the Division from 2005-2008, although staff reiterated that personnel levels were an issue starting in 2006.<sup>8</sup> This noncompliance also raises questions about the Division's review and monitoring of the audit timeline submitted with regional budget plans.

**FINDING: The Division was not compliant with the contractual requirement to audit regionally provided services on a yearly basis. One of the six regions had no services purchased audits between 2005 and 2008.**

**FINDING: This noncompliance also raises questions about the effectiveness of the Division's review and monitoring of the audit timeline submitted with regional budget plans.**

The Division's and the regions' written procedures for reporting audit results are similar, however variations exist. Variations found included a region with no sanctions policy and two regions that allow a ten percent error rate in services-purchased audits, rather than the five percent rate set by contract. The contract requires reviewers to evaluate at least two percent of purchased services. If the error rate exceeds five percent, reviewers must increase the sample size to five percent.

**FINDING: Some regions' policies for conducting services purchased audits varied inappropriately from the Division's policies.**

### **Programmatic Oversight**

In addition to oversight of behavioral health services expenditures, the Division and regions exercise oversight by tracking the use of broad categories of services. Further, the Division and regions conduct program fidelity audits that assess whether services sufficiently meet the needs of consumers.

*Information Systems and Reporting*

By law, the Division must maintain an information system for “all persons receiving state-funded behavioral health services.”<sup>9</sup> Data required to be collected by the system includes the number of persons:

- receiving regional center services;
- ordered by a mental health board to receive inpatient or outpatient treatment and receiving regional center services;
- voluntarily admitted to a regional center and receiving regional center services;
- waiting to receive regional center services;
- waiting to be transferred from a regional center to community-based services or other regional center services;
- admitted to behavioral health crisis centers.<sup>10</sup>

Currently, the Division contracts with Magellan Behavioral Health for what it calls a “management information system” for community-based services.<sup>11</sup> Providers enter information directly into the Web-based application. The Division, regions, and providers can access the reports developed by the information system.<sup>12</sup> The Division also uses Magellan to track services for consumers at the Lincoln Regional Center, but, according to Division staff, this is not at the level of specificity required by statute.<sup>13</sup> According to Division staff, to comply with statute in this regard, the regional centers generate their own weekly data reports that are then sent to the Division.<sup>14</sup> All of these sources of data are used to develop reports to the Legislature and the Governor, as required by law.<sup>15</sup>

**FINDING: The Division is compliant with a requirement that it collect and report on the status of people in need of and receiving behavioral health services.**

#### *Program Fidelity Audits*

A program fidelity audit reviews program plans and delivered services. The audits assess whether service providers have processes to ensure consistency in service quality and compliance with applicable grant requirements, and with state and federal laws and regulations.<sup>16</sup> Contracts require audit teams – comprised of HHS and, or, region staff members – to review provider records, including clinical records, and “other programmatic and clinical details of the service.” The reviewers must examine “sufficient” clinical records and other documentation to verify that the service provider complied with at least 95 percent of state standards, the minimum benchmark set by the Division for program fidelity audits.<sup>17 18</sup>

The Division and the regions must complete program fidelity audits at least once every three years for each service offered by a pro-

vider.<sup>19</sup> If a region provides the services, Division staff conducts the audit; if the region subcontracts for services, region staff conducts the audit and submits the results to the Division.<sup>20</sup>

Although the Division has done program fidelity audits since 2002, timeframe requirements were not placed in contracts until 2006 after a review of auditing procedures by a DHHS workgroup.<sup>21</sup> Prior to 2006, the only major requirement in audit guidelines stated that the regions could not conduct program fidelity audits on themselves, but instead had to use a neutral entity, with some regions using peer reviewers from a state behavioral health group.<sup>22</sup> Now, programs must be reviewed at least once every three years.<sup>23</sup>

According to the Division, between 2006 and 2009, only one program was not audited.<sup>24</sup> Division staff noted that a lack of personnel has limited completion of program fidelity audits in the past.<sup>25</sup> However, staff also noted that the Division “demonstrates growth” and improvement in this area while operating within its appropriations.<sup>26</sup>

**FINDING: The Division is substantially compliant with the requirement to conduct timely program fidelity audits of regionally-provided services.**

In conducting program fidelity audits Division staff uses a workbook outlining standards, definitions and audit procedures. Contract requires each region to develop written procedures and formats for reporting results of their audits of subcontractors.<sup>27</sup> All six had minimal but adequate written procedures — from one sentence to three sentences of instruction.

**FINDING: All six regions had adequate procedures for program fidelity audits.**

Regions submit their program fidelity audit reports to the Division for review. Division staff stated they review these audits primarily to correct any issues identified in the audits.<sup>28</sup> Division representatives told us they do not analyze the information to discern trends in identified weaknesses among providers.<sup>29</sup>

**FINDING: Division staff do not analyze program fidelity audit information to note trends in identified weaknesses for either specific providers or groups of providers.**

The federal Center for Substance Abuse and Treatment, in a 2007 review to determine federal block grant compliance, also identified this lack of formal analysis. In their subsequent report, the reviewers emphasized the importance of data analysis and concluded that Nebraska had “no systematic process for analyzing and reporting data

for decision-making” and “no formal plan exists for improving analytical and management capacity for data usage.”<sup>30</sup> The reviewers wrote that “data appear to be underutilized due to limited personnel resources” in the Division.<sup>31</sup>

**FINDING: The Division’s lack of formal data analysis was noted as an area of concern in a 2007 review by the federal Center for Substance Abuse Treatment.**

### **Consumer-based Activities**

In addition to audits and other reviews, consumer input provides another level of oversight of the community-based behavioral health system. Consumers, as the direct recipients of services, have a singular role in the assessment of those services.

#### *Office of Consumer Affairs*

Recognizing the important role consumers could play in their treatment, the 2004 reform legislation increased consumer involvement in the behavioral health system.<sup>32</sup> The Legislature created the Office of Consumer Affairs (Office) within the Division and gave it the mission of planning, facilitating, and strengthening consumer involvement in behavioral health issues.<sup>33</sup> The Office has four staff members, including a Program Administrator, who must be a current or former consumer of behavioral health services.<sup>34</sup>

Office staff conduct several activities designed to inform and respond to behavioral health services consumers.<sup>35</sup> These activities include organizing an annual conference for consumers, administering e-mail listservs for consumers and providers, conducting a yearly consumer satisfaction survey, and operating a consumer helpline.<sup>36</sup> Division staff noted that more than 100 consumers attend the annual conference and that the helpline typically receives between 300 and 700 phone calls each year.<sup>37</sup>

Each year the Office conducts a survey of “persons receiving mental health and/or substance abuse services” in the behavioral health system.<sup>38</sup> The survey asks consumers, both adults and children/adolescents (parents or guardians often responding), to report on their satisfaction with several factors, including service access, quality and appropriateness of service, outcomes, participation in treatment planning, and general satisfaction. In 2008, the survey had a 31% response rate for adults and a 42% response rate overall.<sup>39</sup> In the survey, consumers gave generally positive reviews of the system. Adults responding to the 2008 survey reported 72.0-81.9% satisfaction with various services offered and outcomes. Responding

youth and their parents reported 58.4-82.0% satisfaction with various services offered and outcomes.<sup>40</sup>

**FINDING: The Division conducts several consumer outreach activities, including an annual survey that suggests consumers are generally satisfied with the services they received.**

Although the Division conducts several outreach activities with consumers, it is missing opportunities to take advantage of some of the sources of data available to it. For example, Division staff acknowledged that they do formally compile information from consumers at the annual conference, but not from the consumer helpline.<sup>41</sup> Not compiling this data is missing an opportunity to maximize consumer involvement in the system.

**FINDING: By not compiling consumer feedback from the helpline, the Division is missing an opportunity to increase consumer involvement in the behavioral health system.**

#### *Consumer Input at the Regional Level*

In addition to the state-level Consumer Affairs Office, the Division requires each region to have a designated consumer specialist on staff to deal with consumer issues on the local level.<sup>42</sup> Regional consumer specialists also field consumer calls regarding services concerns and can often guide consumers through their local behavioral health system more easily than the state-level employees.<sup>43</sup> The regional specialists and Office staff communicate regularly to discuss consumer issues.

Regions are also required to have grievance procedures in place as part of their accreditation process. Currently, according to Division staff, all regions are accredited and have met the requirement. As the Division is not accredited, it is not required to have grievance procedures; however, Division staff said that there has been a call for state-level grievance procedures, which would address concerns about services provided by the regions.<sup>44</sup>

#### *Office of the Public Counsel (Ombudsman)*

In 2008, the Legislature gave the Office of the Public Counsel (Ombudsman) the authority to investigate complaints from consumers of services provided by both the regions and private providers. The investigatory authority granted applied only to consumers who were patients of a state regional center within the prior 12 months.<sup>45</sup>

The legislation also created the position of deputy public counsel for institutions, which has purview over state regional centers, the Bea-

trice State Development Center and the state veterans' facilities. During floor debate, Sen. Mike Flood said the extended authority would give the Ombudsman the ability to determine if a patient had received the appropriate care from one end of the services continuum to the other.<sup>46</sup>

## **Advisory Resources**

### *Behavioral Health Oversight Commission*

The Legislature established the Behavioral Health Oversight Commission (BHOC) with the passage of LB 1083 (2004).<sup>47</sup> Until July 2008, the BHOC reported to the Legislature; after that date, it reported to the Director of Behavioral Health until it sunset on June 30, 2009.<sup>48</sup>

BHOC was required to oversee and support implementation of LB 1083 by providing advice and assistance to the Division relating to the implementation of the Act. In addition, BHOC promoted the interests of consumers and their families, and was required to provide reports and engage in other activities as directed by the Division.<sup>49</sup>

As mentioned earlier in this report, in June 2008, BHOC published a report that noted the accomplishments of recent behavioral health reform efforts, but also contained findings and recommendations for future efforts. In its report, BHOC found that “many of the goals and responsibilities as set out in LB 1083 have not been accomplished.”<sup>50</sup> In June 2009, BHOC released its final report, which reiterated many of the issues noted in its 2008 report and called for the adoption of a statewide strategic plan for behavioral health.<sup>51</sup>

### **FINDING: BHOC found that “many of the goals and responsibilities as set out in LB 1083 have not been accomplished.”**

With the elimination of BHOC in June 2009, there is no central entity providing a check on the high-level progress of the Division toward implementing the goals of LB 1083. As noted in a previous performance audit report, with the sunset of BHOC, there is no designated entity to review service reduction or discontinuation notices made by the Division.<sup>52</sup>

### *Specialized Advisory Committees*

LB 1083 also established two specialized behavioral health-related advisory committees: the State Advisory Committee on Mental Health Services and the State Advisory Committee on Substance

Abuse Services.<sup>53</sup> Members of both committees are appointed by the governor.

By law, the committees hold regular meetings and are charged with, among other duties, providing advice and assistance to the Division and promoting the interests of behavioral health consumers and their families. They are also required to provide reports and engage in other activities as directed by the Division.<sup>54</sup> Thus the committees, part of a behavioral health system designed to be responsive to individual consumers statewide, have a vital oversight role in that system.

Committee members develop recommendations during quarterly meetings attended by Division staff. The meeting agendas and minutes, posted on the DHHS Web site, typically identify any new recommendations as well as the Division's response to recommendations from prior meetings.<sup>55</sup> Generally, the Division responds to both committees' new recommendations at the following meeting.

**FINDING: There are adequate mechanisms in existence to oversee the behavioral health delivery system; however some are not functioning as well as they should be. This is particularly concerning since the Behavioral Health Oversight Commission, which had the broadest oversight responsibility, has been eliminated.**

## Notes

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<sup>1</sup> Neb. Rev. Stat. § 71-806 (1) (d).

<sup>2</sup> Meeting with Scot Adams, Sue Adams, Willard Bouwens, and Bob Zagozda, August 28, 2008.

<sup>3</sup> Meeting with Scot Adams, Sue Adams, Willard Bouwens, and Bob Zagozda, August 28, 2008.

<sup>4</sup> NAC Title 204, Chapter 4, 004 and NAC Title 203, Chapter 4, 006; Contract Number DHHSBH-09-REGION 1.

<sup>5</sup> Written communication from Sue Adams, October 29, 2009.

<sup>6</sup> Our review included both standard services purchased audits and those performed as part of the Division's Professional Partner Program for regional youth wraparound services.

<sup>7</sup> Telephone conversation with Sue Adams, September 30, 2009.

<sup>8</sup> Written communication No. 2 from Sue Adams, October 27, 2009; written communication from Sue Adams, October 28, 2009.

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- <sup>9</sup> Neb. Rev. Stat. §71-810 (7).
- <sup>10</sup> Neb. Rev. Stat. §71-810 (7) (a-h).
- <sup>11</sup> Written communication from Sue Adams, October 30, 2009.
- <sup>12</sup> Written communication from Sue Adams, October 30, 2009.
- <sup>13</sup> Written communication from Sue Adams, October 30, 2009.
- <sup>14</sup> Written communication from Sue Adams, October 30, 2009.
- <sup>15</sup> Written communication from Sue Adams, October 30, 2009; Neb. Rev. Stat. §71-810 (7) (h).
- <sup>16</sup> Nebraska Behavioral Health System Audit Orientation Workbook.
- <sup>17</sup> Regional Contract for Behavioral Health and Network Management Services, pg. 12. (Each region has the same components in its contract, including audit requirements, but the contracts are separate documents.)
- <sup>18</sup> Nebraska Behavioral Health System Audit Orientation Workbook.
- <sup>19</sup> Nebraska Behavioral Health System Audit Orientation Workbook.
- <sup>20</sup> Regional Contract for Behavioral Health and Network Management Services, pg. 11. The contract allows regions to have approved “neutral” parties conduct these audits instead of DHHS.
- <sup>21</sup> Written communication from Sue Adams, October 27, 2009.
- <sup>22</sup> Meeting with Scot Adams, Vicki Maca, Sue Adams, and Bob Zagozda, April 2, 2009; Written communication from Sue Adams, October 27, 2009.
- <sup>23</sup> Nebraska Behavioral Health System Audit Orientation Workbook.
- <sup>24</sup> Written communication from Sue Adams, October 27, 2009.
- <sup>25</sup> Meeting with Scot Adams, Vicki Maca, Sue Adams, and Bob Zagozda, April 2, 2009.
- <sup>26</sup> Written communication from Sue Adams, October 27, 2009.
- <sup>27</sup> In a meeting with Scot Adams, Vicki Maca, Sue Adams, and Bob Zagozda, April 2, 2009, we were told that if a region changes or revises its audit procedures, regional staff are required to report this to DHHS when they submit their annual budget plan.
- <sup>28</sup> Meeting with Scot Adams and Sue Adams, May 6, 2009.
- <sup>29</sup> Meeting with Scot Adams and Sue Adams, May 6, 2009.
- <sup>30</sup> Technical Review Report: Performance Partnership Grant Core Technical Review, September 28, 2007, Division of State and Community Assistance Center for Substance Abuse Treatment, pgs. 3-4.
- <sup>31</sup> Technical Review Report: Performance Partnership Grant Core Technical Review, September 28, 2007, Division of State and Community Assistance Center for Substance Abuse Treatment, pg. 21.
- <sup>32</sup> Neb. Rev. Stat. §71-803 (3) (d).
- <sup>33</sup> <http://www.dhhs.ne.gov/beh/mh/mhadvo.htm>
- <sup>34</sup> Neb. Rev. Stat. §71-805(1-2).
- <sup>35</sup> <http://www.dhhs.ne.gov/beh/mh/mhadvo.htm>
- <sup>36</sup> Meeting with Scot Adams and Sue Adams, May 6, 2009.
- <sup>37</sup> Meeting with Scot Adams and Sue Adams, May 6, 2009.
- <sup>38</sup> Nebraska 2008 Behavioral Health Consumer Surveys Summary of Results, pg 1.
- <sup>39</sup> Nebraska 2008 Behavioral Health Consumer Surveys Summary of Results, pg 6.
- <sup>40</sup> Nebraska 2008 Behavioral Health Consumer Surveys Summary of Results, pg 7.
- <sup>41</sup> Meeting with Scot Adams and Sue Adams, May 6, 2009.
- <sup>42</sup> FY09 Regional Budget Plan Guidelines for Behavioral Health Services, pg. 13. The Division required each region to “identify the individual with responsibility for Regional Consumer and Family Systems Coordination” in its 2009 Budget Plan. The Uniform Application FY 2008—State Implementation Report, Community Mental Health Services Block Grant states that the regional consumer specialists were first required in 2007.
- <sup>43</sup> Meeting with Scot Adams and Sue Adams, May 6, 2009.
- <sup>44</sup> Meeting with Scot Adams and Sue Adams, May 6, 2009.
- <sup>45</sup> Legislative History, LB 467 (2008), remarks by Sen. Mike Flood, January 17, 2008, pg. 46.
- <sup>46</sup> *Ibid.*, pg. 37.
- <sup>47</sup> Neb. Rev. Stat. § 71-818.
- <sup>48</sup> LB 928 (2008)
- <sup>49</sup> Behavioral Health Oversight Commission of the Legislature Final Report - June 2008, pg. 1.
- <sup>50</sup> Behavioral Health Oversight Commission, Final Report, June 2008.
- <sup>51</sup> Behavioral Health Oversight Commission, Final Report draft, June 22, 2009.
- <sup>52</sup> Department of Health and Human Services: Statutory Compliance in Closing the Lincoln Regional Center Community Transition, released \_\_\_\_\_.



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<sup>53</sup> Neb. Rev. Stat. §71-814 and §71-815. Neb. Rev. Stat. §71-816(3-4) also establishes the State Committee on Problem Gambling.

<sup>54</sup> Neb. Rev. Stat. §71-814(2) and 71-815(2).

<sup>55</sup> Section staff reviewed the meeting minutes from both committees for the last two years. For the State Advisory Committee on Mental Health Services, we reviewed the meeting minutes from Aug. 7, 2007, to Nov. 4, 2008. The minutes were unavailable for the meetings of Feb. 6, 2007, May 1, 2007, Feb. 5, 2009 and May 7, 2009. For the State Advisory Committee on Substance Abuse Services, we reviewed the meeting minutes from Feb. 21, 2007, to Jan. 13, 2009.



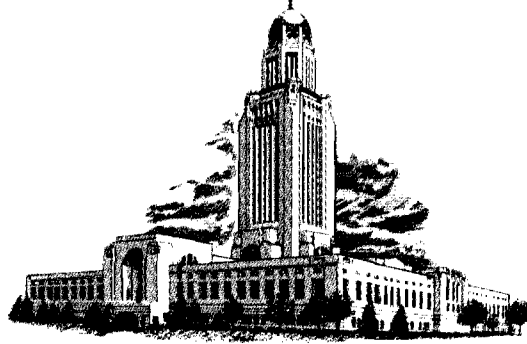


***III. Fiscal Analyst's Opinion***



# State of Nebraska

LEGISLATIVE COUNCIL



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LEGISLATIVE AUDIT

Legislative Fiscal Office  
PO Box 94604, State Capitol  
Lincoln, NE 68509-4604

## MEMO

TO: Martha Carter

FROM: Michael Calvert and Sandy Sostad

RE: Performance Audit – Community-based Behavioral Health

DATE: November 23, 2009

This memo is in response to your request of November 2 asking for our opinion as to whether the recommendations from the performance audit on “Community-based Behavioral Health: Funds, Efficiency and Oversight” can be implemented with existing appropriations.

It appears to us that all of the recommendations can be implemented with existing staff and resources of the Department of Health and Human Services or the Auditor of Public Accounts.





*IV. Background Materials*





## **BACKGROUND MATERIALS**

The “background materials” provided here are materials (in addition to the Section’s report) that were available to the Committee when it issued the findings and recommendations contained in Part III of this report. They include:

- the Section’s draft findings and recommendations (provided for context);
- the agency’s response to a draft of the Section’s report;
- the Legislative Auditor’s summary of the agency’s response.



## Section V: Findings and Recommendations

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### Section II: Separation of Administrative and Service Funds

**Finding #1:** DHHS and the regional authorities differentiate in budget proposals and year-end accounting reports the funds spent on administrative costs from the funds spent for services.

**Finding #2:** Although regions do not require service providers to account separately for funds spent on administrative costs and service costs, larger providers in three regions do report separate figures.

**Discussion:** Assessing whether expenditures are being properly recorded as administrative or services is a financial audit function, which the Performance Audit Section is not authorized to undertake.

**Recommendation:** The Committee may wish to consider asking the Auditor of Public Accounts to assess whether the Division's and regions' expenditures for administration and delivery of services are being recorded appropriately.

### Section III: Clarity and Efficiency of Administrative Responsibilities

**Finding #3:** Statute clearly delineates that the regions have some autonomy with regard to the services provided within their boundaries, but they must operate within a framework established by the Division.

**Finding #4:** Clarity of the responsibilities between the Division and the regions is likely harmed by the weaknesses in the Division's planning efforts identified by BHOC and the absence of updated regulations.

**Discussion:** Comprehensive planning for the delivery of an appropriate array of services across the state was a critical element of LB 1083's vision for shifting behavioral health care to community-based services. Similarly, properly promulgated regulations would provide uniform definitions and processes for the regions to follow.

**Recommendation:** The Performance Audit Committee may wish to establish statutory deadlines for the Division's completion of the comprehensive planning process and the updating of the regulations implementing LB 1083.

**Finding #5:** The responsibilities of the Division and regions with regard to the selection of service providers are efficient to the extent that the Division has appropriate processes in place.

**Finding #6:** The Division acknowledged one instance in which the Director deviated from the competitive bidding requirements due to a provider withdrawing mid-contract. This is a deviation that the Nebraska Behavioral Health Services Act does not appear to allow.

**Discussion:** Division representatives told us that they did not intend to deviate from the competitive bidding requirements in the future.

**Recommendation:** If a future need for such deviations arises, the Committee may wish to introduce legislation to allow them, for emergencies or other designated situations.

**Finding #7:** The Division's interpretation of the statute that allows regions to provide services in the absence of qualified bidders has created an extension of the grandfather clause because once a region begins providing a service, it never has to reopen the service to competitive bidding.

**Discussion:** This is a policy issue for the Committee's consideration.

**Recommendation:** If the Committee believes that services provided by region when competitive bidding fails to produce a qualified bidder should at some future point be put out for competitive bid, it may wish to introduce legislation to accomplish that.

#### **Section IV: Oversight**

##### *CPA Audits*

**Finding #8:** The regions complied with the requirements to have yearly financial audits.

**Finding #9:** The Division takes several steps to ensure audits of the regions are scheduled, conducted, and reviewed.

**Recommendation:** None.

*Services Purchased Audits*

**Finding #10:** The Division was not compliant with the contractual requirement to audit regionally provided services on a yearly basis. One of the six regions had no services purchased audits between 2005 and 2008.

**Finding #11:** This noncompliance also raises questions about the effectiveness of the Division's review and monitoring of the audit timeline submitted with regional budget plans.

**Discussion:** Division representatives told us they do not have enough staff to conduct all of the required audits. As the state is facing a significant budget deficit in the current biennium, this problem may get worse.

**Recommendation:** If the Division cannot complete all of the required services purchase audits, the Division should develop a plan that ensures some services in all regions are audited regularly.

**Finding #12:** Some regions' policies for conducting services purchased audits varied inappropriately from the Division's policies.

**Discussion:** It is within the Division's authority to ensure that the region's audit policies conform to minimum standards established by the Division.

**Recommendation:** The Division should immediately review the region's audit policies for all types of required audits and require regions to comply the Division's standards.

*Program Fidelity Audits*

**Finding #13:** The Division is substantially compliant with the requirement to conduct timely program fidelity audits of regionally-provided services.

**Finding #14:** All six regions had adequate procedures for program fidelity audits.

**Recommendation:** None.

### *Consumer Input*

**Finding #15:** The Division conducts several consumer outreach activities, including an annual survey that suggests consumers are generally satisfied with the services they received.

**Finding #16:** The Division responds to recommendations from different consumer groups.

### *Data Reporting and Analysis*

**Finding #17:** The Division is compliant with a requirement that it collect and report on the status of people in need of and receiving behavioral health services.

**Finding #18:** Division staff do not analyze program fidelity audit information to note trends in identified weaknesses for either specific providers or groups of providers.

**Finding #19:** The Division's lack of formal data analysis was noted as an area of concern in a 2007 review by the federal Center for Substance Abuse Treatment.

**Finding #20:** By not compiling consumer feedback from the helpline, the Division is missing an opportunity to increase consumer involvement in the behavioral health system.

**Discussion:** According to Division representatives, they review data from program fidelity audits and consumer outreach activities to identify immediate problems but do not compile and analyze the information to identify patterns or trends that develop over time.

**Recommendation:** The Division should develop a plan for increasing its analysis of audit results and consumer input. If such analysis cannot be conducted on all data every year, the Division should ensure that each type of data is analyzed at least every other year.

### *Oversight Generally*

**Finding #21:** There are adequate mechanisms in existence to oversee the behavioral health delivery system; however some are not functioning as well as they should be. This is particularly concerning since the Behavioral Health Oversight

Commission, which had the broadest oversight responsibility, has been eliminated.

**Recommendation:** The Division should make additional efforts to ensure that the existing oversight mechanisms under its authority are used to their fullest extent.

**Recommendation:** The Committee may wish to consider having audit staff conduct intensive followup for a period of time to ensure that improvements in the oversight system occur.





December 3, 2009

RECEIVED

Martha Carter, Legislative Auditor  
Legislative Audit and Research  
State Capitol, Room 1201  
Lincoln, NE 68509

DEC 03 2009

LEGISLATIVE AUDIT

Dear Ms. Carter:

Thank you for your recent report, "Community-based Behavioral Health: Funds, Efficiency, and Oversight," dated November 2, 2009.

I write to provide the Division of Behavioral Health (DBH) response. I will make some general comments then respond to the findings and recommendations. First, I appreciate the positive nature of this Report.

Second, the creation of multiple entities (regions and the DBH) allows each entity to address needs of the local consumers, while also taking into account the level of professional staff available since that factor and others differ across the state. Nebraska's behavioral health system continues to evolve over time as does any large system that strives to improve services to individuals. Thus, the goal is to achieve reasonable assurance of accountability, efficiency and oversight. These regional differences may account for the multiple responses that were provided to an inquiry from the LPAC, but does not by itself indicate system weakness or lack of oversight, though such multiplicity almost always makes management more complex.

Third, I would note that while the title of the draft report suggests a review of the entire community-based system, the report touches only upon the regions and DBH. The 2010 appropriation to DBH is approximately \$170 million. Program 038, Aid, is approximately \$100 million. Of this, approximately \$75 million is with the regions. The remainder (25%) is spent on other community-based services, which is not addressed in your report.

My response focuses on the Findings and Recommendations listed on page 27 of the draft report. I make no comment on 21 of the 32 Findings and Recommendations.

With regard to Finding 2, all agencies which receive an independent financial audit will separate out administrative costs from program costs for that agency according to generally accepted accounting principles. Thus, it is not accurate to note that these are not identified. Each agency and each region has this information, and while it may not be aggregated, there is not a business reason to do so.

With regard to Finding 4, I take exception to use of the phrase, "likely harmed." The report provides no basis for such a conclusion. It provides evidence of the variety with which each region approaches the issues. It should be noted that systems planning has been ongoing

and abundant during recent years. I would direct the reader to the DBH web site for documents in this category. In particular, I would urge attention to the annual Mental Health Block Grant application which provides a rich assortment of detail concerning the strengths, weakness, opportunities and threats facing the system while also focusing attention onto 17 specific goal areas, which reflect growth, change and accomplishment. Regions have taken this information and do have strategic plans which address the unique needs of the consumers in their region.

Further, DBH has had a contract with the University of Nebraska to facilitate a statewide strategic planning process since November, 2008. Additional considerations have caused the delay of this process, but not to the harm of the system. Some of these considerations have included an offer from the private sector to conduct a strategic planning process, national healthcare reform debate, and the downturn of the economy in the nation and Nebraska.

DBH has coordinated its efforts with the Division of Medicaid and Long-Term Care (DMLTC) so that DBH and DMLTC regulations are considered jointly for the public to focus its attention to the relationship between both sets. The regulations in DBH have been revised five times to address issues raised by stakeholders and further meetings continue to coordinate with the DMLTC regulations to provide consistency across the agency. This is significant work that has taken considerable time and received much public input. We continue to receive input as late as last week.

With regard to the Recommendations associated with Findings 3 and 4, we expect the revised rules and regulations to be completed in early 2010.

With regard to Finding 6, as I was not the director during this time period, I cannot speak to what circumstances or considerations led to the deviation from the competitive bidding requirements. DHHS could not find a prohibition in statute for the Director's actions. Sections 71-805, 71-806 and 204 NAC Chapter 2 grants the Director broad accountability to "integrate and coordinate the public behavioral health system." While it was an unusual action, it appears to have best served the system's emergency needs in that particular area at that time. If current law doesn't allow for handling such emergencies, the law could be revised.

With regard to Finding 10 & 11, I would like to note that all FY 2010 audits have been scheduled with regions. Staff reductions during prior years did hamper the DBH capacity to perform all of its assigned functions, notably, 5 (all managers) of 27 positions (including support positions) were eliminated between 2005 and 2008, exactly the period of behavioral health reform implementation. At the same time, funding to regions increased by nearly 50%. Workloads and resource trends were in opposition to one another. Recent reorganizations have helped. Present budget reductions increase the need for DBH to give priority to all functions expected of it, focusing attention onto the most important areas.

With regard to Finding 12, we believe the audits met minimum standards yet we do not require uniformity. This is not to say that any one of these approaches is “inappropriate” or wrong. The majority of services audits are complete. Regions are in compliance. Nothing of substantial concern was reported.

With regard to Finding 18, we believe that DBH staff do compile and analyze program fidelity information to note trends. Conversations about program performance form the heart of working agendas for the Division Quality Improvement Team (DQIT), Magellan Quality Improvement Team (MQIT), and Statewide Quality Improvement Team (SQIT). These data improvement teams involve regions, providers, consumers, and Magellan. Minutes with analysis therein are available. These teams have been working since 2007 and earlier under various other names.

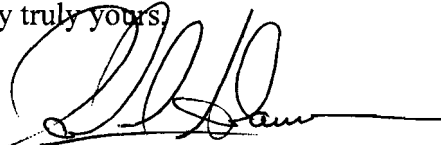
With regard to Finding 19, the 2007 Corrective Action Plan noted a multitude of actions that were the result of analysis in this area. The State is not now within a Corrective Action relationship with CSAT/SAMHSA. This Finding is dated.

With regard to Finding 20, we believe that DBH compiles consumer data from the annual conference. Phyllis McCaul has done this.

With regard to the Recommendation for these Findings, the DBH continues to increase still further the level of consumer involvement in these and other activities in the wake of the hiring of Carol Coussons de Reyes, the new Administrator for the Office of Consumer Affairs in May, 2009. DBH wishes to note that a Quality Improvement Team has been established within the past 2 years. Its activities relate to regions, Magellan, providers, consumers, regional centers, and the federal government. All quality processes are coordinated within this team. From these processes, we see improvements to data – its collection, analysis, and distribution - on an ongoing basis.

In conclusion, the Division appreciates the work of the audit team and its efforts over the past eight months. We believe the report is more complete with this response. We understand that in such a complex system, not all priorities will be shared and valued alike. The report serves as a basis for public discussion of the type of community based behavioral health system the citizens of Nebraska may want to develop and to fund in the future.

Very truly yours,



Scot L. Adams, Ph.D., Director  
Division of Behavioral Health  
Department of Health and Human Services



# Legislative Performance Audit

## Committee

### Committee Members:

Senator John Harms, Chair  
Senator Danielle Conrad, Vice Chair  
Speaker Mike Flood  
Senator Lavon Heidemann  
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Senator Dennis Utter  
Senator John Wightman

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Clarence Mabin, Analyst  
Dana McNeil, Analyst  
Stephanie Meese, Legal Counsel  
Sandy Harman, Committee Clerk

December 22, 2009

Mr. Scot Adams, Director  
Division of Behavioral Health  
Department of Health and Human Services  
P.O. Box 95026  
Lincoln, NE 68509-5026

Dear Mr. ~~Adams~~<sup>Scot</sup>:

Thank you for your written response to the draft report titled *Community-based Behavioral Health: Funds, Efficiency, and Oversight*. There are three topics addressed in your report that contain new or different information from what our staff were told during the audit. We will need additional information on these topics as explained below.

**Finding 4 and Discussion:** Clarity of the responsibilities between the Division and the regions is likely harmed by the weaknesses in the Division's planning efforts identified by BHOC and the absence of updated regulations. Comprehensive planning for the delivery of an appropriate array of services across the state was a critical element of LB 1083's vision for shifting behavioral health care to community-based services. Similarly, properly promulgated regulations would provide uniform definitions and processes for the regions to follow.

**Division Response (in part):** DBH has had a contract with the University of Nebraska to facilitate a statewide strategic planning process since November, 2008. Additional considerations have caused the delay of this process, but not to the harm of the system. Some of these considerations have included an offer from the private sector to conduct a strategic planning process, national healthcare reform debate, and the downturn of the economy in the nation and Nebraska.

**Audit staff comment:** We were not told about this contract during the course of the audit.

**Finding 18:** Division staff do not compile or analyze program fidelity audit information to note trends in identified weaknesses for either specific providers or groups of providers.

**Division Response:** We believe that DBH staff do compile and analyze program fidelity information to note trends. Conversations about program performance form the heart of working agendas for the Division Quality Improvement Team (DQIT), Magellan Quality Improvement Team (MQIT), and Statewide Quality Improvement Team (SQIT). These data improvement teams involve regions, providers, consumers, and Magellan. Minutes with analysis therein are available. These teams have been working since 2007 and earlier under various other names.

**Audit staff comment:** This response is different from what we were told during the audit, when DHHS representatives told us that they do not look for trends in the program fidelity data. At a May 6, 2009, meeting, DHHS staff said that they would use a program fidelity audit to see if a region was struggling. Audit staff asked if DHHS analyzed the results of the audits in any way, to which the Division director said that this is a regional function and should be done on that level as problems with providers would impact whether their contracts are renewed through the regions. Audit staff also asked if the audit information was used to look at whether a Region has a tendency to pick bad providers. Division staff said that they are concerned about outcomes—how many people have been helped, served—and not about the process.

**Finding 20 and Discussion:** By not compiling consumer feedback from the annual conference and helpline, the Division is missing an opportunity to maximize consumer involvement in the behavioral health system. According to Division representatives, they review data from program fidelity audits and consumer outreach activities to identify immediate problems but do not compile and analyze the information to identify patterns or trends that develop over time.

**Division Response:** We believe that DBH compiles consumer data from the annual conference. Phyllis McCaul has done this.

**Audit staff comment:** During a May 6, 2009 meeting, audit staff asked Division staff if they gather input from consumers at the conference and report on it in any way. The Division director said that attendees fill out written evaluation forms, but said there's no formal report on the conference. Division staff made no mention of any compilations done by Ms. McCaul.

#### **Additional Information Request**

In order for us to determine whether changes need to be made to the draft report, please provide us with:

- all materials produced out of the Division's contractual relationship with the University;
- minutes and any other documentation of the analyses conducted related to program fidelity audits; and
- Ms. McCaul's most recent compilations of consumer feedback.

Please also explain in your response why this information was not provided to us during the course of the audit.

We would appreciate receiving your response by January 8, 2009, if possible. If you have any questions, please contact me at 471-0072 or Don Arp at 471-0040.

Sincerely,

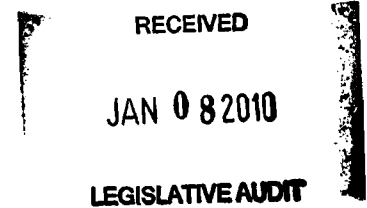


Martha Carter  
Legislative Auditor

cc: Performance Audit Committee members

January 6, 2010

Martha Carter, Legislative Auditor  
Legislative Audit and Research  
State Capitol, Room 1201  
Lincoln, Ne 68509



Dear Ms. Carter:

I write in response to your letter of December 22, 2009 seeking additional information on the Draft Report entitled, Community Based Behavioral Health: Funds, Efficiency and Oversight. Additional information that you requested is provided in attachments.

Your first topic involves planning efforts by the Division of Behavioral Health (DBH). The requested draft documents from the University concerning strategic planning are enclosed, as are other documents related to planning done by DBH, as Appendix A.

The topic of strategic planning was discussed with the Behavioral Health Oversight Commission and with regions during the past year. The issue also was discussed with the staff of the Legislative Performance Audit Committee (LPAC). We mentioned we had been preparing to engage overall strategic planning, though I do not recall if we discussed the relationship with the University specifically. We mentioned the original documents and plans from the implementation phase of LB 1083, which are still available on the DHHS web site. We also said that some of the regions have conducted their own strategic planning efforts. The DBH supports the regions' efforts to create plans that address their specific regional needs and resources. Thus, the Nebraska Behavioral Health System – the composite of the DBH, regions, network providers and consumers – has a wide variety of planning processes. Our discussions with LPAC staff were intended to illustrate that planning is conducted in many ways and levels.

My concern is that the word “harmed” seemed to have little solid basis, as no harm was identified.

The next topic in your letter involved the analysis of audit data. Additional information related to analysis of data is enclosed as Appendix B.

This issue may reflect a difference of understanding of the focus of audits specifically and the oversight function more generally. Audits are reviewed internally by staff. Significant information goes through the quality processes as noted in our response, such that the phrase “does not ... analyze...” seems to us to be inaccurate.

Martha Carter  
January 6, 2010  
Page 2

Additionally, I believe that I said the DBH is "...concerned about outcomes and LESS about the process," rather than "not" concerned as written in the draft report. I wish also to note that the examples I am cited as having said are not outcomes, but process objectives, and indicate that we did indeed talk about concern for process.

I thought it important to provide additional, specific, information to improve the Draft Report's accuracy.

Additional information in Appendix B complements that provided to LPAC staff during its interview process and nothing in this letter is intended to negate those comments.

I believe this issue highlights a fundamental dynamic at play. The interplay between the DBH and the regions is complex. At times we are a unified system, at other times we act competitively. Both relationships are appropriate depending on the specific situation and are sanctioned in statute. I believe the Draft Report presents an overly simplified approach to these dynamics, perhaps causing some misinterpretation of the issues noted herein.

The third topic you identify related to compilation of data from the annual consumer conference and helpline. Ms. McCaul's report is enclosed as Appendix C. I simply did not think of this report at the time of the interview. The larger topic at the time was whether or not consumers have input to the DBH as part of a balanced oversight and monitoring function described in LB 1083 and this had already been amply documented with your staff. In this light, the Finding was a surprise and caused me to review our files.

Thank you for your efforts to help us improve the publically-funded behavioral health system in Nebraska.

Very truly yours,

A handwritten signature in black ink, appearing to read "Scot L. Adams", written over a horizontal line.

Scot L. Adams, Ph.D., Director  
Division of Behavioral Health  
Department of Health and Human Services

Enclosures:



# LEGISLATIVE AUDITOR'S SUMMARY OF AGENCY RESPONSE

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This summary meets the statutory requirement that the Legislative Auditor “prepare a brief written summary of the response, including a description of any significant disagreements the agency has with the Section’s report or recommendations.”<sup>1</sup>

On December 3, 2009, the Director of the Department of Health and Human Service Division of Behavioral Health (Director) submitted the agency’s response to a draft of the Performance Audit Section’s audit report. The Director’s response disagreed with a number of findings and other statements contained in the draft report. The response also included new information that had not been provided during the data gathering portion of the audit as well as some information that directly contradicted what we were told during that time. Following receipt of the Director’s response, we requested additional information on some of the new items and received that information on January 8, 2010.

Before discussing the remaining substantive issues, we note for the Committee that receiving new or contradictory information in the agency’s response to a draft report decreases the efficiency of the audit process. It causes additional work for both the agency and the audit staff that could have been avoided if the full and correct information had been provided during the data gathering phase of the audit.

A detailed response to each of the Director’s concerns is attached to this response. What follows is a description of the substantive areas in which remain in disagreement with the Director.

## **Need for a Strategic Plan and Up-to-Date Regulations**

The draft report contained a finding that the absence of a statewide comprehensive strategic plan for service delivery and out-of-date regulations “likely harmed the clarity of responsibilities between the Division and the regions.” The Director disagreed with this finding, citing a lack of evidence to support it. However, the draft report cited (1) representatives of some behavioral health regions, one of whom suggested that the absence of a strategic plan “creates a void in vision, direction, and leadership” and (2) the final report of the Behavioral Health Oversight Commission, created by the Legislature to oversee implementation of LB 1083, which criticized the absence of a “comprehensive statewide plan for behavioral health services.”

In addition, although we did not raise this issue in the draft report, the manner in which the Division closed the Lincoln Regional Center Community Transition Program (CTP) also demonstrates the lack of clarity caused by the absence of a comprehensive statewide strategic plan and current regulations. The Director has publicly stated that the closing of CTP was long envisioned by the Department as part of the LB 1083 implementation. Had a comprehensive statewide plan for services been in place, it presumably would have included the expected closing of this program, allowing consumers and providers to plan accordingly. In-

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<sup>1</sup> Neb. Rev. Stat. sec. 50-1210.

stead, the closing came as a surprise to many. In addition, had the regulations been updated, there might well have been less confusion about whether or not the treatment provided through CTP constituted a “service” and if it triggered a requirement for legislative notification.<sup>2</sup>

In his written response, the Director explains that the proposed regulations have been subject to considerable public input. Specifically, he states that:

DBH has coordinated its efforts with the Division of Medicaid and Long-Term Care (DMLTC) so that DBH and DMLTC regulations are considered jointly for the public to focus its attention to the relationship between both sets. The regulations in DBH have been revised five times to address issues raised by stakeholders and further meetings continue to coordinate with the DMLTC regulations to provide consistency across the agency.

Audit staff appreciate the importance of obtaining input in developing regulations but question whether the formal rulemaking process—which requires a public hearing and the Attorney General’s approval of an agency’s interpretation of the statutes—should be delayed almost six years beyond a statute’s enactment. The absence of official regulations for several years leaves those who must comply with the law without the detailed guidance regulations are intended to provide.

### **Director’s Discretion**

The draft report also contain a finding (#6) that in one instance a previous Director had essentially waived statutory competitive bidding requirements when a provider stopped providing services while still under contract. The report noted that such a deviation does not appear to be authorized under the Nebraska Behavioral Health Services Act. Audit staff recommended that if the Legislature wants the Director to make such exceptions in emergency cases, it should authorize it explicitly.

The Director disagreed with this finding, stating that “DHHS could not find a prohibition in statute for the Director's actions. Sections 71-805, 71-806 and 204 NAC Chapter 2 grants the Director broad accountability to “integrate and coordinate the public behavioral health system.””

We disagree with the Director’s interpretation that the broad authority to “integrate and coordinate the public behavioral health system” allows the director to bypass statutory controls on competitive bidding. Taken to the extreme, this interpretation would allow a Director to avoid *any* statutory requirement simply by claiming that the violation was necessary for the integration and coordination of the system. We stand by our recommendation that if the Legislature’s believes the Director should have such authority, it should adopt legislation to explicitly grant it.

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<sup>2</sup> Additional issues related to closure of the CTP program are discussed in the report “HHS Statutory Compliance in Closing the Lincoln Regional Center Community Transition Program.”

Attachment: Additional Information Relating to the Agency Response to the Draft Behavioral Health Audit Report

Line #	Draft Report Language	DHHS Response Letter	Audit Staff Response
1		Third, I would note that while the title of the draft report suggests a review of the entire community-based system, the report touches only upon the regions and DBH. The 2010 appropriation to DBH is approximately \$170 million. Program 03 8, Aid, is approximately \$100 million. Of this, approximately \$75 million is with the regions. The remainder (25%) is spent on other community-based services, which is not addressed in your report.	The title accurately reflects the review conducted, which was dictated by the concerns of the Committee relating to DHHS and the regions.
2	<b>Finding #2:</b> Although regions do not require service providers to account separately for funds spent on administrative costs and service costs, larger providers in three regions do report separate figures.	With regard to Finding 2, all agencies which receive an independent financial audit will separate out administrative costs from program costs for that agency according to generally accepted accounting principles. Thus, it is not accurate to note that these are not identified. Each agency and each region has this information, and while it may not be aggregated, there is not a business reason to do so.	This response directly contradicts what we were told by a representative of each region during the audit. A few regions told us that noted that larger providers make this distinction; however others noted there is no requirement in budget plan guidelines to differentiate between the administrative costs and service costs of the providers. And although DHHS believes there is no “business reason to do so,” aggregating information that allows for a comparison between budgeted administrative costs versus actual administrative costs over time could provide for the detection of improper administrative fees and provide a safeguard that money allocated for services is not being depleted by administrative costs.
	Finding 4 regarding strategic planning.	Further, DBH has had a contract with the University of Nebraska to facilitate a statewide strategic planning process since November, 2008. Additional considerations have caused the delay of this process, but not to the harm of the system. Some of these considerations have included an offer from the private sector to conduct a strategic planning process, national healthcare reform debate, and the downturn of the economy in the nation and Nebraska.	Department representatives did not mention this contract during the audit. After learning about it in the Division’s response to the draft audit report, we requested, and the Division provided, additional information it. We note that the contract simply provides for the University to facilitate “strategic planning meetings”; it contains no objective for development of a comprehensive strategic plan.

Line #	Draft Report Language	DHHS Response Letter	Audit Staff Response
	<p><b>Finding #10:</b> The Division was not compliant with the contractual requirement to audit regionally provided services on a yearly basis. One of the six regions had no services purchased audits between 2005 and 2008.</p> <p><b>Finding #11:</b> This noncompliance also raises questions about the effectiveness of the Division's review and monitoring of the audit timeline submitted with regional budget plans.</p>	<p>With regard to Finding 10 &amp; 11, I would like to note that all FY 2010 audits have been scheduled with regions. Staff reductions during prior years did hamper the DBH capacity to perform all of its assigned functions, notably, 5 (all managers) of 27 positions (including support positions) were eliminated between 2005 and 2008, exactly the period of behavioral health reform implementation. At the same time, funding to regions increased by nearly 50%. Workloads and resource trends were in opposition to one another. Recent reorganizations have helped. Present budget reductions increase the need for DBH to give priority to all functions expected of it, focusing attention onto the most important areas.</p>	<p>The Division's plan to accomplish of the statutorily required reviews in FY 2010, which we support, does not alter the fact that those requirements were not met in the past.</p>
	<p><b>Finding #12:</b> Some regions' policies for conducting services purchased audits varied inappropriately from the Division's policies.</p>	<p>With regard to Finding 12, we believe the audits met minimum standards yet we do not require uniformity. This is not to say that any one of these approaches is "inappropriate" or wrong. The majority of services audits are complete. Regions are in compliance. Nothing of substantial concern was reported.</p>	<p>The variation in audit standards reported in the draft report were allowing two regions to use an error rate that was <i>double</i> the rate used by the other four regions, and allowing one region to use a policy that contained no sanction policy. We continue to believe that these are, in fact, inappropriate variations and despite the Director's statement to the contrary, he provides no good reason why these elements should not be uniform.</p>
	<p><b>Finding #18:</b> Division staff do not compile or analyze program fidelity audit information to note trends in identified weaknesses for either specific providers or groups of providers.</p>	<p>With regard to Finding 18, we believe that DBH staff do compile and analyze program fidelity information to note trends. Conversations about program performance form the heart of working agendas for the Division Quality Improvement Team (DQIT), Magellan Quality Improvement Team (MQIT), and Statewide Quality Improvement Team (SQIT). These data improvement teams involve regions, providers, consumers, and Magellan. Minutes with analysis therein are available. These teams have been working since 2007 and earlier under various other names.</p>	<p>This response directly contradicts what DHHS representatives told us during the audit. At a May 6, 2009, meeting, DHHS staff told us that they would use a program fidelity audit to see if a region was struggling. Audit staff asked if DHHS analyzed the results of the audits in any way, to which the Division director said that this is a regional function and should be done on that level as problems with providers would impact whether their contracts are renewed through the regions. Audit staff also asked if the audit information was used to look at whether a Region has a tendency to pick bad providers. Division staff said that they are concerned about outcomes—how many people</p>

Line #	Draft Report Language	DHHS Response Letter	Audit Staff Response
			have been helped, served—and not about the process.
	<b>Finding #19:</b> The Division’s lack of formal data analysis was noted as an area of concern in a 2007 review by the federal Center for Substance Abuse Treatment.	With regard to Finding 19, the 2007 Corrective Action Plan noted a multitude of actions that were the result of analysis in this area. The State is not now within a Corrective Action relationship with CSATISAMHSA. This Finding is dated.	The report was cited to show a trend in DHHS practice.
	<b>Finding #20:</b> By not compiling consumer feedback from the annual conference and helpline, the Division is missing an opportunity to maximize consumer involvement in the behavioral health system.	With regard to Finding 20, we believe that DBH compiles consumer data from the annual conference. Phyllis McCaul has done this.	This response directly contradicts what DHHS representatives told us during the audit. During a May 6, 2009, meeting, audit staff asked Division staff if they gather input from consumers at the conference and report on it in any way. The Division director said that attendees fill out written evaluation forms, but said there’s no formal report on the conference. Division staff made no mention of any compilations done by Ms. McCaul.
	<b>Recommendation:</b> The Division should develop a plan for increasing its analysis of audit results and consumer input. If such analysis cannot be conducted on all data every year, the Division should ensure that each type of data is analyzed at least every other year.	With regard to the Recommendation for these Findings, the DBH continues to increase still further the level of consumer involvement in these and other activities in the wake of the hiring of Carol Coussons de Reyes, the new Administrator for the Office of Consumer Affairs in May, 2009. DBH wishes to note that a Quality Improvement Team has been established within the past 2 years. Its activities relate to regions, Magellan, providers, consumers, regional centers, and the federal government. All quality processes are coordinated within this team. From these processes, we see improvements to data - its collection, analysis, and distribution - on an ongoing basis.	Again, the audit response was the first mention of this quality improvement team.

Note: Concerns raised relative to findings 4 and 6 are addressed in the memo that accompanies this table.

# Performance Audit Committee Reports: 1994 to 2010

- Department of Health and Human Services: Statutory Compliance in Closing the Lincoln Regional Center Community Transition Program (November 2009)
- Department of Economic Development's Job Training Grant Program: Statutory Compliance (November 2009)
- The State Foster Care Review Board: Authority, Conflicts of Interest, and Management Practices (December 2008)
- Personal Services Contracts: An Examination of Compliance and Oversight (October 2008)
- The Nebraska Information Technology Commission: An Examination of Statutory Compliance and the Project Review Process (November 2007)
- The Nebraska Lottery's Implementation of LB 1039 (February 2007)
- The State Department of Education's Student-based Teacher-led Assessment and Reporting System (February 2007)
- The Lincoln Regional Center's Sex Offender Services Program (August 2006)
- The Public Employees Retirement Board and the Nebraska Public Employees Retirement Systems: An Examination of Compliance, PIONEER, and Management (August 2006)
- The Nebraska Medicaid Program's Collection of Improper Payments (May 2005)
- The Lincoln Regional Center's Billing Process (December 2004)
- Nebraska Board of Parole (September 2003)
- Nebraska Department of Environmental Quality: Administering the Livestock Waste Management Act (May 2003)
- HHSS Personal-Services Contracts (January 2003)
- Nebraska Habitat Fund (January 2002)
- State Board of Agriculture (State Fair Board) (December 2001)
- Nebraska Environmental Trust Board (October 2001)
- Nebraska Department of Roads: Use of Consultants for Preconstruction Engineering (June 2001)
- Department of Correctional Services, Inmate Welfare Fund (November 2000)
- Bureau of Animal Industry: An Evaluation of the State Veterinarian's Office (March 2000)
- Nebraska Ethanol Board (December 1999)
- State Foster Care Review Board: Compliance with Federal Case-Review Requirements (January 1999)
- Programs Designed to Increase The Number of Providers In Medically Underserved Areas of Nebraska (July 1998)
- Nebraska Department of Agriculture (June 1997)
- Board of Educational Lands and Funds (February 1997)
- Public Service Commission: History of Structure, Workload and Budget (April 1996)
- Public Employees Retirement Board and Nebraska Public Employees Retirement Systems: Review of Compliance-Control Procedures (March 1996)
- Leaking Underground Storage Tank Program (December 1995)
- School Weatherization Fund (September 1995)
- The Training Academy of the Nebraska State Patrol and the Nebraska Law Enforcement Training Center (September 1995)
- Nebraska Equal Opportunity Commission (January 1995)
- The Interstate Agricultural Grain Marketing Commission (February 1994)