REPORT OF

THE

STATE AUDITOR

Residential Treatment Center Rate Setting and Monitoring

PERFORMANCE AUDIT
JANUARY 2002

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STATE OF COLORADO

Joanne Hill, CPA
Acting State Auditor

OFFICE OF THE STATE AUDITOR
(303) 866-2051
FAX(303)866-2060

Legislative Services Building
200 East 14th Avenue
Denver, Colorado 80203-2211

January 9, 2002

Members of the Legislative Audit Committee:

This report contains the results of the performance audit of Residential Treatment Center Rate Setting and Monitoring. The audit was conducted pursuant to Section 2-3-103, C.R.S., which authorizes the State Auditor to conduct audits of all departments, institutions, and agencies of state government. The report presents our findings, conclusions, and recommendations, and the responses of the Department of Human Services and the Department of Health Care Policy and Financing.

Joanne Hill

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STATE OF COLORADO
OFFICE OF THE STATE AUDITOR **REPORT SUMMARY**
JOANNE HILL, CPA
Acting State Auditor

Residential Treatment Center Rate Setting and Monitoring Performance Audit - January 2002

Authority, Purpose, Scope

This performance audit was conducted pursuant to Section 2-3-103, C.R.S., which authorizes the Office of the State Auditor to conduct performance audits of all departments, institutions, and agencies of state government. The audit focused on the methods used by the Department of Human Services, including its Division of Child Welfare and Division of Youth Corrections, and the counties to set reimbursement rates for residential treatment centers. The audit also examined how various Department of Human Services entities and the counties monitor these residential treatment centers to ensure that adequate services are provided. To accomplish our audit objectives, we interviewed representatives from county departments of social services, the Division of Youth Corrections, the Division of Child Welfare, the Children's Mental Health and Rehabilitation Division, the Division of Child Care, the Office of the Attorney General's Medicaid Fraud Unit, the Department of Health Care Policy and Financing, and individual residential treatment center providers. In addition, we analyzed data provided by these entities and reviewed a sample of youth files at eight residential treatment centers and state-operated commitment facilities. The audit work, performed from May to November 2001, was conducted in accordance with generally accepted governmental auditing standards.

We gratefully acknowledge the assistance and cooperation extended by management and staff at the Department of Human Services, the Office of the Attorney General, the Department of Health Care Policy and Financing and individual county departments of social services. We also acknowledge the input of representatives of residential treatment centers.

Overview

Residential treatment centers (RTCs) offer 24-hour care and mental health services to youth up to age 21 who are determined to be mentally ill. Youth may be placed in an RTC either by the Division of Youth Corrections (DYC) or county departments of social services. During the first six months of Fiscal Year 2001, counties had about 1,340 youth in RTCs each month while DYC had about 251 youth. For youth discharged from DYC during Fiscal Year 2001, the average length of stay in an RTC was about seven months. Similar data are not available regarding youth placed by counties due to problems with the Colorado Trails system. RTCs represent the most expensive out-of-home placement option, costing an average of $53,527 per youth per year for room and board and mental health treatment services. This increases to an average of $67,107 per youth per year for those RTCs that also have an approved on-grounds school.

For further information on this report, contact the Office of the State Auditor at (303) 866-2051.

Funding for RTCs comes from a combination of state funds, county funds, and federal funds. The rate paid to RTC providers comprises three components. Mental health treatment services represent the largest portion of the rate. Mental health services are funded through Medicaid. RTCs receive a flat daily rate based on the youth's Level of Care (A, B, or C). Most youth are assigned to Level B. In Fiscal Year 2001 Level B treatment rates, the standard for RTCs, varied from $33,310 per year to $47,684 per year depending on the facility. The second portion of the rate covers room and board expenses. Room and board rates are set through competitive bidding by DYC and negotiation by the counties. Room and board expenses are paid using state and county funds and range from $6,672 per year to $22,287 per year depending on the facility, the youth, and whether DYC or a county places the youth. Approximately 38 RTCs have approved on-ground schools enabling them to also receive reimbursement from the Colorado Department of Education and local school districts. In Fiscal Year 2001 per pupil operating revenue (PPOR) and excess cost payments varied from $6,329 to $18,199 on an annual basis.

Develop Statewide Cost Information and Improve the Cost Reporting System

We reviewed cost information and analyzed rate setting data. We were unable to conclude on the reasonableness of the existing RTC rates because of the following problems:

- **Lack of Statewide Expenditure Information.** The fragmented rate-setting process makes it difficult to obtain an accurate accounting of residential treatment center expenditures. For example, an RTC provider can receive a different reimbursement rate for youth placed by DYC versus those placed by a county. Providers may also receive different rates from different counties. In addition, the counties are not required to tell the Department how much they pay each provider. As a result, the Department reported that it does not know the overall amount spent on residential treatment services. Identifying actual statewide mental health treatment costs is particularly important because Medicaid-funded mental health services are an entitlement for mentally ill youth in the custody of DYC or the counties. For example, if counties exceed their block allocation because more youth require residential treatment services, counties must find additional funds to pay the Medicaid match. Currently, the State lacks a computer database that contains statewide expenditure information related to RTCs. The Department is in the process of implementing a new case management system, known as Colorado Trails, that is designed to contain consolidated information on all youth in the child welfare and DYC systems. The Department needs to ensure that Trails has the capability to track and produce statewide expenditure information. The implementation of the Trails system has been seriously delayed. On the basis of information received from the Department it appears that it will be Fiscal Year 2003 before Trails will be able to produce reliable cost information.

- **Unreliable Cost Reports.** RTC rules require RTC providers to submit three cost reports each year: (1) an actual cost report completed by the provider, detailing how much it spent on residential treatment services; (2) an independently verified audit report of the provider's actual costs; and (3) a prospective cost report detailing how much money the provider believes it will take to operate its program during the upcoming year. Properly completed, cost reports provide valuable information to the State on the funding needed to serve mentally ill youth. Our review indicates that the cost reports are not reliable. We found that some providers change the formulas in the electronic spreadsheet and that providers have different interpretations of what information is required, requested, or permissible. This makes the reliability of the information in the cost reports questionable.

Establish Controls Over Medicaid Claim Payments

We compared billing and payment information in the Medicaid Management Information System (MMIS) with room and board payments for all youth receiving residential treatment services in August 2000 to determine if RTC providers accurately submitted Medicaid claims for allowable costs. Of the 1,497 claims reviewed, we found at least one error in 30 percent of them, totaling over $98,000 in erroneous payments. Annualized, this could amount to over a million dollars in inaccurate payments. Our findings indicate the need for basic edit checks in the MMIS system. In addition to more system edits, we found a need to conduct claims reviews.

Ensure the Provision of Treatment Services

As part of our audit work, we reviewed a sample of randomly selected youth treatment files at eight different RTCs. Eighty percent of the files we reviewed lacked complete documentation to show that all mental health treatment services as outlined in the treatment plan were actually provided to the youth. In addition, we found that for the most part treatment plans do not appear to be tailored to the youth's individual needs. For example, in 60 percent of the files we reviewed we were unable to determine if the treatment goals addressed the identified needs of the youth. Representatives of several state entities informed us that they were aware that Colorado RTC providers may fail to furnish all mental health treatment services. The failure to consistently provide treatment services could constitute Medicaid fraud. The Department needs to take immediate action to ensure that services are provided and properly documented.

Streamline Oversight of RTCs

The Department devotes significant resources to monitoring residential treatment centers. Consistent in-depth monitoring of RTC facilities is critical for ensuring the provision of services and the safety of the youth. However, the Department's current monitoring efforts are fragmented and unduly burdensome,

involving five separate Divisions within the Department. We believe that monitoring could be streamlined to allow for more attention on enforcement and correction of deficiencies. The Department has taken some initial steps to coordinate monitoring. For example, the Department now conducts some joint monitoring visits of RTC providers. We attended one joint monitoring visit involving 12 employees from four Department entities. The representatives appeared familiar with each other's standards. To make better use of its resources, the Department could combine the various monitoring standards to develop a set of core standards for all 24-hour providers. This would provide the Department with the opportunity to cross-train all monitoring units and reduce duplication within the Department. Another option is to further consolidate the monitoring of all 24-hour providers. It is our understanding that some consolidation has already taken place.

Our recommendations and the responses of the Departments of Human Services and Health Care Policy and Financing can be found in the Recommendation Locator on pages 5 through 8.

RECOMMENDATION LOCATOR

Rec. No.	Page No.	Recommendation Summary	Agency Addressed	Agency Response	Implementation Date
1	24	Adapt computerized systems, such as Colorado Trails, MMIS, and CFMS, as a means of identifying the actual cost of providing residential treatment services. Ensure that the systems include consistent expenditure information and produce reports that can detail statewide expenditures.	Department of Human Services	Agree	No later than July 1, 2003
2	27	Identify and utilize information on the actual cost of providing room and board and mental health treatment services to youth in residential treatment centers.	Department of Human Services	Agree	No later than July 1, 2003
3	28	Identify the actual Medicaid cost of providing residential treatment services by periodically analyzing RTC billing and payment information in the Medicaid Management Information System.	Department of Human Services	Agree	No later than July 1, 2002
4	30	Ensure that room and board increases sought by providers are allowable under the RTC rules' definition of room and board. Do not pay consortia an extra fee for services that should be provided under the RTC rules' definition of treatment.	Department of Human Services	Agree	No later than October 1, 2002

RECOMMENDATION LOCATOR

Rec. No.	Page No.	Recommendation Summary	Agency Addressed	Agency Response	Implementation Date
5	31	Consult with all counties and RTCs to ensure that RTC services remain available to youth from all counties statewide.	Department of Human Services	Agree	No later than July 1, 2003
6	35	Implement procedures to ensure that only allowable costs for RTC services are paid by verifying the accuracy of RTC provider billing and payment information through periodic audits.	Department of Human Services	Agree	No later than July 1, 2003
7	35	Implement procedures to ensure that only allowable costs for RTC services are paid by verifying the accuracy of RTC provider billing and payment information through periodic audits, requiring additional MMIS payment edits, and seeking to recover overpaid amounts.	Department of Health Care Policy and Financing	Agree	October 2002
8	38	Establish a formal treatment rate appeal process for residential treatment centers.	Department of Human Services	Agree	No later than January 1, 2003
9	41	Establish mental health treatment standards which include the type and frequency of services required to be provided.	Department of Human Services	Agree	No later than October 1, 2003

RECOMMENDATION LOCATOR

Rec. No.	Page No.	Recommendation Summary	Agency Addressed	Agency Response	Implementation Date
10	44	Ensure that residential treatment centers meet established requirements for treatment plans and service documentation. Verify the provision of treatment services through treatment file reviews. Establish and use penalties/sanctions against providers who consistently fail to provide treatment services.	Department of Human Services	Agree	No later than July 1, 2003
11	47	Work with residential treatment center providers and other interested parties to develop specific outcome measures. Develop a system for monitoring the progress of youth by tracking the outcome measures.	Department of Human Services	Agree	No later than July 1, 2003
12	48	Develop a cost-effective peer review process that ensures the need for residential treatment center services.	Department of Human Services	Agree	No later than April 1, 2002
13	50	Include appropriate enforcement actions including financial and nonfinancial sanctions in its contracts with providers and use those sanctions when providers fail to correct violations in a timely manner.	Department of Human Services	Agree	No later than July 1, 2002
14	53	Streamline monitoring efforts by identifying core monitoring standards, cross-training staff on those standards and eliminating duplication.	Department of Human Services	Agree	No later than July 1, 2003

RECOMMENDATION LOCATOR

Rec. No.	Page No.	Recommendation Summary	Agency Addressed	Agency Response	Implementation Date
15	54	Establish requirements for case workers and client managers to regularly meet alone with youth. Train case workers and client managers in the evaluation of treatment plans and plan compliance. Develop procedures to require supervisors to evaluate compliance with standards by case workers and client managers.	Department of Human Services	Agree	No later than July 1, 2003
16	57	Amend current requirements for monitoring youth placed at out-of-state providers.	Department of Human Services	Agree	No later than December 1, 2002

Background

Each year the Department of Human Services (Department), through its Division of Youth Corrections (DYC) and Division of Child Welfare (DCW), oversees the out-of-home placement of thousands of youth. In Fiscal Year 2001, DYC placed about 871 youth in community residential placements. The Division of Child Welfare works with the individual counties in a state-funded, county-administered child welfare system. For the first six months of Fiscal Year 2001, the Division placed about 7,883 youth each month.

Out-of-home placement provides 24-hour care for youth who either have been committed following adjudication under the Colorado Children's Code or through a court order are under the control of individual county departments of social services. The type of out-of-home placement varies in the restrictiveness of the setting and the types of treatment provided. The following describes each of the major types of out-of-home placement:

- **Relative or Kinship Care**—A home-based setting that counties use to place youth with a willing relative or other person who has been reviewed for child protection purposes and with whom a family-like relationship exits. For the first six months of Fiscal Year 2001, an average of 1,296 youth under the supervision of the counties received this type of care each month.

- **Family Foster/Proctor Home**—This is a home-based setting that provides 24-hour family care for youth not related to the head of household. Youth placed in this setting should be able to function in a family setting, attend community schools, and live in the community without danger to themselves or others. County departments of social services administer family foster homes. During the first six months of Fiscal Year 2001, about 4,195 youth were in family foster homes each month. DYC places a small number of youth in proctor homes, which are similar to a family foster care setting.

- **Residential Child Care Facility (RCCF)**—These facilities serve youth with more severe family, emotional, or behavioral problems who cannot function in a less restrictive setting. An RCCF provides 24-hour group care and treatment for five or more youth. RCCFs operate under private, public, or nonprofit sponsorship. County placements in RCCFs averaged 299 each month for the first six months of Fiscal Year 2001. DYC contracted for 171 RCCF beds each day during Fiscal Year 2001.

- **Residential Treatment Center (RTC)**—A facility meeting the licensing requirements of a residential child care facility (RCCF) that has also been certified by the Division of Mental Health Services. These facilities provide Medicaid-reimbursed mental health services to youth diagnosed with a mental health issue who also need to reside in a more restrictive setting. RTCs operate under private or nonprofit sponsorship. For the first six months of Fiscal Year 2001, counties had about 1,340 youth in RTCs each month. At the same time, DYC had about 251 youth in RTC beds each day.

The Division of Youth Corrections Places Committed Youth

The Division of Youth Corrections provides programs to assess, treat, and supervise delinquent youth ages 10 to 21 who are committed following adjudication under the Colorado Children's Code. The Division also provides supervision and residential services to youth who are detained awaiting adjudication. Delinquent youth may be committed to DYC if they are adjudicated for crimes carried out prior to their eighteenth birthday and may remain under Division jurisdiction until age 21. The Division provides supervision, residential treatment, and transitional services to committed youth until their parole is complete and they return to society. The following chart shows population trends and Division expenditures for the past five years.

Division of Youth Corrections Population and Expenditures
Fiscal Years 1998 Through 2002

Average Daily Population (ADP)	Fiscal Year 1998 (Actual)	Fiscal Year 1999 (Actual)	Fiscal Year 2000 (Actual)	Fiscal Year 2001 (Actual)	Fiscal Year 2002 (est.)	Percentage Increase Fiscal Years 1998-2002
Detention[1]	591.8	602.4	589.1	582.5	574.2	-3.0%
Committed	973.5	1,112.2	1,198.3	1,252.9	1,354.2	39.1%
Parole	255.0	366.1	601.7	720.6	787.9	209.0%
Total ADP	1,820.3	2,080.7	2,389.1	2,556.0	2,716.3	49.2%
Total Expenditures (In Millions)[2]	$79.4	$89.1	$96.8	$105.4	$115.3	45.2%
Yearly Cost per Average Daily Population	$43,619	$42,822	$40,517	$41,236	$42,447	-2.9%

Source: Department of Human Services Fiscal Year 2003 Budget Request. Fiscal Year 2002 Long Bill.

[1] Committed youth awaiting placement in detention are reflected in detention figures through Fiscal Year 2001.

[2] This number represents DYC's total expenditures minus SB91-94.

The Division's responsibilities include providing youth with a safe, stable environment and appropriate treatment services including, when appropriate, mental health treatment services. During the first 30 days of DYC commitment, each youth receives an extensive assessment to identify individualized treatment and educational needs and to develop a treatment plan containing goals and time frames. A growing number of youth committed to DYC enter the system with significant mental health issues. The following table details the number of new committed youth and their associated mental health needs for Fiscal Years 2000 and 2001.

Percentage of Newly Committed Youth With Mental Health Needs
Fiscal Years 2000 and 2001

	Fiscal Year 2000	Fiscal Year 2001	Percent Increase
Total Youth[1]	848	766	-9.6 %
Total Youth with "Matched" CCAR Scores[2]	779	709	--
Group A - None to Slight (Percent)	267 (34%)	113 (16%)	-57.7 %
Group B - Moderate (Percent)	475 (61%)	552 (78%)	16.2%
Group C - Severe (Percent)	37 (5%)	44 (6%)	18.9%

Source: Division of Youth Corrections.

[1] Total youth reflects the number of new commitments to DYC during the fiscal year, as published in the DYC Management Reference Manual for Fiscal Year 2001.

[2] Reflects the number of youth for which valid Colorado Client Assessment Record (CCAR) data could be matched with the client served file. In some cases critical elements used to create groupings A, B, and C were missing for a particular youth and therefore, not included here.

As detailed in the table, in Fiscal Year 2000, 512 (66 percent) of DYC's newly committed youth were assessed in Groups B or C with moderate to severe mental health issues. This increased to 596 (84 percent) of the newly committed youth in Fiscal Year 2001.

The Division uses a combination of state-operated facilities and private contract providers to meet the needs of its committed youth including those requiring mental health services. State-operated facilities provide 337 commitment beds of which 60 beds are used for youth needing significant mental health services but who also require a secure environment. These 60 beds are located at Lookout Mountain Youth Services Center. DYC calculated the average cost to serve a youth in any state-operated facility as $59,061 per year in Fiscal Year 2001. This number includes all personnel, operating, educational, and contract costs associated with a youth's treatment. During Fiscal Year 2001 the total cost for the 60 beds at Lookout Mountain was approximately $3.5 million. In addition, the Division reported spending at least another $1.7 million for other mental health services at its state-operated commitment facilities.

The Division also purchases beds at residential treatment centers (RTCs) to serve some of its committed youth. In Fiscal Year 2001 the average reimbursement rate per youth paid by DYC to an RTC was $54,064 per year. The rate paid by DYC does not include educational costs. In Fiscal Year 2001, DYC contracted for approximately 251 beds at 23 RTCs, which totaled $13.6 million in Medicaid treatment and room and board expenditures.

Counties Also Use Residential Treatment Centers

The Department of Human Services, through its Division of Child Welfare operates a state-funded county-administered child welfare system. Child welfare consists of a group of services intended to protect youth from harm and to assist families in caring for their youth. These services help to meet the needs of youth who are placed or are at risk of being placed out-of-home for reasons of protection or community safety. In general, the Division of Child Welfare helps youth in three program areas:

- **Youth in Conflict**—This program area includes youth, usually between the ages of 10 and 18, whose behavior is beyond the control of their parents. The services provided to this group are intended to alleviate conflicts between youth/community when the conflict impacts youth, family, or community well-being; protect the youth and the community; reestablish family stability; or assist youth to emancipate successfully.

- **Children in Need of Protection**—This is the largest of the three program areas and includes youth of all ages whose physical, mental, or emotional well-being has been harmed or is likely to be harmed due to abuse or neglect. Services should provide for the youth's safety, enhance family functioning, and address the youth's need for permanence.

- **Children in Need of Specialized Services**—This program area includes youth in need of subsidized adoption or Medicaid-only services or those in placement for whom family reunification is not the goal.

The State provides money to cover the cost of services that it requires the counties to provide. Through Senate Bill 97-218, counties receive a capped allocation of funding to provide child welfare services. Services provided through the block funding include but are not limited to out-of-home placement including Medicaid treatment, subsidized adoptions, subsidized adoption case services payments, child welfare-related child care, and burials. The allocation also includes that portion of county administration related to child welfare, both administration and direct services. County departments can use this

allocation to provide child welfare services without categorical restriction. The following chart details the appropriations for child welfare services and out-of-home placement for the last four fiscal years.

Overall Child Welfare Services Expenditures and Out-of-Home Placement Expenditures Fiscal Years 1999 Through 2002

	Fiscal Year 1999 (actual)	Fiscal Year 2000 (actual)	Fiscal Year 2001 (actual)	Fiscal Year 2002 (est.)
Child Welfare Services	$212,901,385	$252,676,112	$272,524,706	$278,179,829
Out-of-Home Placement*	$122,880,129	$135,941,374	Not Available	Not Available

Source: Department of Human Services Fiscal Year 2002 and Fiscal Year 2003 Budget Requests. Fiscal Year 2002 Long Bill.

* Out-of-Home Placement includes all types of out-of-home placement and not just residential treatment centers.

Counties use out-of-home placement to provide 24-hour temporary or long term care for youth who are removed from their homes by county departments of social services or the courts due to abuse/neglect, parental conflict issues, or delinquent behavior. Youth need to meet Colorado's out-of-home placement criteria, and the county department must determine that the child cannot safely be served in their own home in order for placement to occur. The placement must reflect the least restrictive setting that also meets the needs of the youth. For those youth determined to be delinquent, the courts make placement decisions. In Fiscal Year 2000, on average, 8,000 youth were in out-of-home placement each month with 1,256 (16 percent) in RTCs. For the first six months of Fiscal Year 2001, the average number of youth in out-of-home placement was 7,883 with 1,340 (17 percent) in RTCs. Counties, through Senate Bill 97-218, have the authority to negotiate rates, services, and expected outcomes with providers. For RTCs, the counties pay the provider both a room and board rate as well as a treatment rate to cover the cost of mental health services. The counties use their capped allocations to cover these RTC placement costs and receive Medicaid reimbursement for the treatment portion of the rate. In Fiscal Year 2001, 3,711 youth entered RTCs and the counties spent $55.6 million for Medicaid services.

Residential Treatment Centers Offer Mental Health Services

Residential treatment centers (RTCs) are residential child care facilities (RCCFs) that are certified to provide mental health treatment to youth placed in them. Youth residing in an RTC have been diagnosed with a mental illness and found to be in need of mental health treatment services. RTC providers receive Medicaid reimbursement depending upon the specific needs of the youth. The State of Colorado utilizes a three-tiered Level of Care system to identify the amount of Medicaid reimbursement for each youth. The State uses the Colorado Client Assessment Record (CCAR), a mental health diagnostic tool, to determine a youth's Level of Care. Both the counties and the Division of Youth Corrections access RTCs to provide 24-hour care and mental health treatment to a portion of their youth populations.

Residential treatment centers tend to be the most expensive out-of-home option because these facilities provide not only 24-hour care but also a significant amount of mental health treatment services. Each RTC provider receives a set treatment reimbursement rate for each Level of Care. The providers also receive a separate room and board payment that varies depending on whether the youth is placed by a county or DYC. Senate Bill 97-218 provides counties with the authority to negotiate room and board rates, services, and expected outcomes on per provider basis. Our audit work indicates that the counties use a Division of Child Welfare-established base anchor rate as a reference point for negotiating with providers. Since it is a state agency, DYC follows the State's competitive procurement law when setting the RTC room and board rates. DYC also uses sole source contracts to obtain RTC providers in areas with less competition or to serve particularly difficult youth.

RTCs vary in their level of security as well as in the mental health treatment services they offer. For example, some RTCs offer treatment for specialized populations, such as sex offenders, while others offer a broad spectrum of treatment services. Residential treatment centers vary by the population served, with some focusing on young children while others serve teenagers, and by treatment setting. Some RTCs exist mainly as wilderness programs while others provide a more group home atmosphere, and some operate in a more traditional dormitory or campus setting. During the course of our audit we identified 74 RTC providers with a total capacity of 2,117 beds. RTC providers reported approximately 1,402 (66 percent) of the beds are for boys with the remaining 715 (34 percent) for girls. At the same time, information received from the Division of Child Welfare noted that at least 200 youth were on waiting lists for RTC beds.

Audit Scope

This audit reviewed the methods used by the Department of Human Services, the Division of Youth Corrections, and the counties to set the rates for RTC providers. The audit also examined how various Department of Human Services entities and the counties monitor residential treatment center providers to ensure the provision of services and the safety of the youth. Our examination included a determination of which state entities monitor RTCs and the specific issues reviewed. Through a case review of a sample of youth treatment files, we attempted to identify if the RTC providers offer all services identified in the treatment plan and in the frequencies required.

Cost of Care

Chapter 1

Overview

Residential treatment centers (RTCs) offer 24-hour care and mental health services to youth up to age 21 who are determined to be mentally ill. Because of the intensive mental health services they offer, RTCs represent the most expensive out-of-home placement option for DYC and the counties. In recent years, there has been a significant amount of controversy surrounding RTC rates. RTC providers complain that rates are too low. Faced with significant budgetary constraints, DYC and the counties are concerned about rapidly escalating costs.

Prior to 1994, all youth requiring out-of-home placement were served either in foster care or residential child care facilities (RCCFs). Mental health treatment, if necessary, was provided on an outpatient basis through the Medicaid fee-for-service system. Providers received a low rate of reimbursement to cover room and board costs, making it increasingly difficult to place youth. Colorado, following a nationwide trend, developed a system to access federal Medicaid funding to pay the provider to offer mental health services. The intention was to improve the quality of care while also increasing the daily reimbursement. Accessing Medicaid allowed the State to considerably raise the reimbursement levels without significantly increasing the impact on the General Fund, since the federal government reimburses about one-half of the Medicaid cost. Currently youth in an RCCF or foster care requiring mental health services receive them on an outpatient basis through the Medicaid capitation program overseen by Mental Health Assessment and Service Agencies (MHASAs). The following chart details the Fiscal Year 2001 average daily cost for the various types of out-of-home placement if the youth also requires mental health treatment services:

Average Daily Cost for Out-of-Home Placement Plus Mental Health Treatment - Fiscal Year 2001

Type of Facility	Avg Daily Cost	Avg Yearly Cost
Foster Care plus MHASA	$58.63	$21,400
Residential Child Care Facility plus MHASA	$78.82	$28,769
Residential Treatment Center	$146.65	$53,527

Source: Information provided by the Division of Child Welfare, the Division of Youth Corrections, and the Division of Mental Health Services.

Note: The Average Yearly Cost is the overall average of rates paid by both DYC and the counties.

Funding Comes From Three Sources

Funding for residential treatment centers comes from the State's General Fund, the counties, and the federal government. There are three components to an RTC's rate:

- **Treatment.** This is the largest portion of the rate and represents reimbursement for the mental health treatment services provided to the youth. The State calculates daily treatment rates for each provider based on the State's Level of Care system. There are three levels, A, B, and C, with A being the least severe and C the most severe. Funding for treatment comes from Medicaid, with a 50 percent federal and 50 percent state/county split. Daily rates are the same regardless of whether the youth is placed by a county or by the Division of Youth Corrections. We found that for Fiscal Year 2001, Level B treatment rates, the standard rate for providers, varied from $33,310 per year to $47,684 per year, depending on the facility.

- **Room and Board.** This portion of the rate is covered entirely with state and county funds and includes reimbursable services such as food, shelter, and support staff. The daily rate for room and board represents a much smaller percentage of the total cost of an RTC placement. Unlike treatment rates that are set by the

RTC Administrator, room and board rates vary between DYC and the counties and within the counties themselves. DYC rates are set, for the most part, through a competitive bidding process. Under Senate Bill 97-218, counties have the authority to negotiate rates with each RTC provider. To assist the counties, the Division of Child Welfare sets a base anchor rate for each provider when they are first licensed that can be used in the negotiation process. Room and board rates range from $6,672 per year to $22,287 per year depending on the facility, the youth, and whether the youth is sent by DYC or the counties.

- **Education**. About 38 RTC facilities representing 1,344 beds for Colorado youth have approved on-grounds schools for their residents. This enables them to access per pupil operating revenue (PPOR) and excess cost funding from the Colorado Department of Education and the local school districts. The RTC receives the State's average PPOR for each Colorado youth as well as an excess cost payment for those Colorado youth designated as needing special education services. In Fiscal Year 2001, PPOR and excess cost reimbursements combined vary from $6,329 to $18,199 on an annual basis.

The following chart shows the range of reimbursement rates for Fiscal Year 2001:

Reimbursement Rates for Fiscal Year 2001

	DYC Annual Rates [1]	Child Welfare Annual Rates [2]
Level B Treatment	$33,310 to $47,684	$33,310 to $47,684
Room & Board	$8,344 to $22,287	$6,672 to $15,556
Education	$6,329 to $18,199	$6,329 to $18,199
Total	$41,942 to $81,052	$41,362 to $79,588

Source: Rate information provided by the RTC Administrator, the Division of Child Welfare, and the Division of Youth Corrections.

[1] Average length of stay for a DYC youth in an RTC is about seven months. Similar information does not exist for child welfare youth. Annual amounts are used to give perspective on what DYC and the counties pay assuming all RTCs' beds are always full.

[2] Daily room and board rates reflect the base anchor rate for each provider and not necessarily the rate paid by the counties.

Depending upon the provider, youth stay at an RTC anywhere from one month to over three years. For youth who were discharged from DYC during Fiscal Year 2001, the average length of stay in an RTC was about seven months. We could not obtain similar data from the Division of Child Welfare due to problems with the Colorado Trails system. Unquestionably, providing RTC services to these youth is expensive, at an average cost of $54,064 per year for committed youth under the supervision of the Division of Youth Corrections, and $52,990 per year for youth placed by the counties during Fiscal Year 2001. Providers offering an approved on-grounds school receive more reimbursement, about $68,313 per year for youth placed by DYC and $65,901 per year for youth placed by counties. These calculations represent the average payments, but the actual annual rates paid to individual providers vary greatly from about $41,362 per youth to $81,052 per youth depending on whether DYC or a county places the youth and if the RTC receives education funding.

Develop Statewide Cost Information

On average, the State pays $53,527 to provide room and board and treatment services to youth in residential treatment centers. However, we found that the per youth rates paid for room and board and treatment range from $41,362 to $66,872 per year depending on who places the youth and which provider is chosen. The State does not know if the rates paid are too low or too high for the services provided.

We found the cost report information submitted by RTC providers to be unreliable; therefore, we sought other methods to determine whether the amounts paid to RTC providers are reasonable. One method we hoped to utilize was to determine the actual amount the State pays for residential treatment services. However, we found that due to the fragmentation of the rate-setting process and the current lack of a statewide database with consolidated payment information, it is very difficult to obtain an accurate accounting of residential treatment service expenditures. For example, we asked the Department to provide us with information on the amount spent by counties to pay the room and board costs for youth in RTCs. Since counties have the authority to negotiate room and board rates on a per youth per provider basis, the Department told us we would have to contact the individual counties to obtain the actual rates paid for room and board. When we contacted the counties for this same information, they told us that it would be a time-consuming process requiring the review of each youth's case file and billing information. County representatives indicated that they did not have the staff or the time to complete our request. We did obtain each provider's base anchor room and board rate and have used that rate in our calculations.

Obtaining statewide actual payment information is particularly important on the treatment side. Medicaid-funded mental health treatment services are an entitlement for mentally ill youth under the custody of DYC or the counties. Payments for mental health treatment are shared, with the federal government paying 50 percent and state/county funds being used for the remaining 50 percent. However, the counties operate under a block funding system which provides them with a set amount of federal, state, and county funds that they can use to fund several child welfare programs. If they exceed the block allocation because more youth require mental health services and residential treatment, the counties must find additional county funds to pay the Medicaid match. Having actual statewide expenditure information could help the State better anticipate the overall Medicaid, state, and county funding needed. In addition, the State recently received the authority to allow counties and their local MHASAs to develop a plan to provide mental health services to youth in a residential treatment center through a capitated system overseen by the MHASA. Actual statewide expenditure information would provide the counties and the MHASAs with cost information that could be valuable when negotiating rates with RTCs.

In the absence of such statewide information, we used other means to determine if the State's RTC rates are reasonable. We compared the rates paid to Colorado RTC providers with rates paid by other states to similar providers. As might be expected, state-by-state comparisons in this area are limited because of different ways of placing and treating youth and different reimbursement systems. In lieu of systemwide cost comparisons, we asked a sample of states to provide us information on the rates they pay for youth needing 24-hour care as well as mental health services. We obtained information from five states: Arizona, California, Minnesota, Nebraska, and Virginia. The information received provides at least some indication that Colorado's rates may not be out of line. We found that:

- Nebraska uses two types of providers for residential treatment services. A treatment group home receives about $56,210 per year per child, while a residential treatment center gets $82,490 per year. However, Nebraska law requires a treatment group home to provide and document 21 hours of scheduled treatment services per week, while an RTC must provide 42 hours of scheduled treatment services per week. These scheduled treatment hours must include group and individual therapy by a licensed practitioner and a minimum of one hour of family intervention. These rates do not include educational costs.

- Arizona also uses two types of providers for residential treatment services: therapeutic group homes and residential treatment centers. The average daily rate for a therapeutic group home is $54,385 per year, while a residential treatment center receives an average of $71,540 per year. Rates are developed through negotiations using cost information. The quoted rates do not include the costs of education.

- California pays between about $17,500 per year and $76,000 per year not including education. California bases its rates on the hours of child care, social work, and mental health treatment provided as well as the education and experience of the staff. The more services provided and the more experienced the staff, the higher the rate.

- Virginia pays up to $107,675 per year, but that rate requires at least 3 individual and 21 group therapies per week.

- Minnesota negotiates rates based upon the line-item cost reports detailing direct program expenses and administrative costs. The average reimbursement rate is $63,875 per year not including education.

Of note here is that other states set standards for required treatment services and tie the rates to those standards. We believe that this could be beneficial for Colorado youth. Establishing treatment service requirements is discussed further in Chapter 2.

Another comparison that may show whether current rates are reasonable is the rate for serving youth in state-operated facilities. For Fiscal Year 2001 the Division of Youth Corrections reported that the average daily cost to serve a youth in a state-operated facility, both detention and commitment, was $59,060 per year. This includes all treatment, room and board, and education costs associated with the youth. Unlike rates paid to private RTCs, the state-operated facility rate does not include costs associated with the actual physical plant such as maintenance or depreciation. For the same time, the average daily rate paid to private RTC providers by DYC and educational entities was $68,313. RTCs with an approved school actually received about $9,253 more per year than it cost to keep a youth in a state-operated facility. However, as state facilities tend to serve more difficult youth, one would expect that they would be more expensive.

Trails Database Could Provide Needed Statewide Cost Information

The Department needs comprehensive cost information in order to identify how much is actually paid for residential treatment services. The Department is in the process of implementing a new automated case management system that will contain consolidated information on all youth in the child welfare and DYC systems. This Children, Youth, and Families database, known as Colorado Trails, has been under development for five years at a cost of over $47 million. Currently it is not fully operational and is experiencing substantial start-up problems including serious reporting capability limitations. Full implementation and operation of the Colorado Trails system is not expected until Fiscal

Year 2003. Although the system has been rolled out for all counties, current problems have led to counties' not inputting all information related to child welfare youth into the system. DYC is not scheduled to begin using the system until early 2002.

When fully operational, Colorado Trails is designed to contain a full case management file on all youth in out-of-home placement including those in residential treatment centers. This will allow for the collection of consolidated expenditure information as long as the system contains consistent data for all youth. This information should include each youth's Colorado Client Assessment Record score and the resulting Level of Care, the youth's assessed needs, the service history of the youth including those services provided while the youth remained at home, the out-of-home placement history of the youth including the individual providers, and both the treatment and room and board rates paid and the entity placing the youth in residential treatment. It is our understanding that currently the youth's Level of Care, which determines the Medicaid payment to the RTC, is not included in the Colorado Trails system. This is valuable information that should be at the Department's fingertips rather than in the youth's file at either the county or DYC region.

In addition, the Department needs to ensure that the Colorado Trails system has a report production capability that can produce statewide expenditure information. For example, as we previously discussed, when we sought the actual payments made to providers by counties for room and board services, neither the Department nor the counties could produce this information in a timely manner. Colorado Trails should contain this type of expenditure information. The Department should ensure that the system has the capability to produce a report detailing how much counties pay for room and board overall as well as what each county pays particular providers for each youth. This type of report will allow the Department to not only know the overall expenditures but also show which counties can negotiate better room and board rates. It would also offer an opportunity to compare the rates paid by counties with those obtained by DYC through the competitive bidding process. Similarly, the Department should ensure that the Trails system can produce comprehensive reports detailing the number of youth at each Level of Care including which providers tend to serve more Level C youth. Finally, the Department should consider developing a report that could calculate the average length of stay by provider and for youth assessed at the different Levels of Care. Such information could aid in the appropriation process by allowing the Department to know how long youth need to receive residential treatment services.

Without consolidated actual expenditure information, the State cannot identify trends or assess costs. Cost comparisons provide some evidence of reasonableness. However, actual expenditure data give the State a baseline to determine how much it costs to serve youth in residential treatment centers.

Recommendation No. 1:

The Department of Human Services needs to adapt computerized systems, such as Colorado Trails, the Medicaid Management Information System, and the County Financial Management System, as a means of identifying the actual cost of providing residential treatment services including:

a. Ensuring that the system includes consistent expenditure information such as the Level of Care and the placement history for the youth, including the room and board and treatment rates paid.

b. Ensuring that the system has the ability to produce reports that can detail statewide expenditures for both room and board and treatment as well as reports that can track youth at each Level of Care and the rates paid to individual providers.

Department of Human Services Response:

Agree. Estimated completion date: No later than July 1, 2003. The Department has already prioritized corrections, improvements, and modifications in the Trails system. Modifications in other systems will help accomplish the goal.

Improve Cost Reporting System

The State uses different methods for establishing the RTC treatment and room and board rates. When the State created the RTC system, it elected to base the treatment rate on the individual RTC providers prospective costs and available appropriations. On the other hand, DYC and the counties set the room and board rates through a competitive bidding and/or negotiation process. Currently, to aid in the rate-setting process, the State requires RTCs to submit three different cost reports each year. If properly completed, these cost reports can provide valuable information to the State on the funding needed to serve mentally ill youth. When reviewing the cost reports to determine the reasonableness of the current rates, we found that not only are they not being used by the State but that the reports contain unreliable information.

In the initial years of the RTC system, the State, through the Department of Human Services, fully reimbursed providers for treatment services on the basis of their reported prospective costs. In other words, the State paid providers on what they thought their costs would be. However, treatment cost projections submitted by providers escalated

rapidly and available appropriations fell short of projected costs. Although the State decided not to fully fund the prospective treatment costs, the RTC Administrator continued to use the submitted cost reports to set treatment rates. For three fiscal years beginning in Fiscal Year 1998, the Administrator averaged the reported prospective costs and used the average rate as the upper limit for the treatment rate. All providers whose prospective costs exceeded the upper limit received the upper limit as their treatment rate. For the remainder, whose reported costs were lower than the upper limit, the RTC Administrator calculated the standard deviation from the average. Depending on the standard deviation, these providers received either a percentage of their costs or their reported costs. For the last two fiscal years, providers have continued to submit the cost reports, but the State has not used them to adjust the treatment rate. Instead, the RTC Administrator has increased the previous year's treatment rate by a set percentage to represent a cost-of-living adjustment (COLA). Producing the cost reports and having the information in them audited is costly. Requiring residential treatment centers to submit the reports and then not using them is not in anyone's interest.

Although we have problems with the reliability of the cost report information, we note that the prospective costs reported by the RTC providers continue to far exceed the available appropriations. For example, in Fiscal Year 2002 our calculations based on the prospective cost reports available and the reported number of beds serving Colorado youth indicate that providers requested $94.9 million for mental health services while the approved appropriations totaled $73.6 million. This represents a difference of about $21.3 million between what providers say they need to cover their mental health treatment costs and what the State is able to pay.

RTC rules require each provider to submit three cost reports each year. These include (1) an actual cost report completed by the provider, detailing how much was spent on room and board and mental health treatment services; (2) an independently verified audit report of the provider's actual costs; and (3) a prospective cost report detailing how much money the provider believes it will take to operate its program during the upcoming year. These reports offer the Department of Human Services valuable information regarding the cost to provide room and board and mental health treatment services. However, we found the current cost reports are unreliable because:

- **Many cost reports are not audited.** RTC rules require a provider to submit an independent audit report of the previous year's actual costs. This represents an independently investigated and verified source of cost information. We found that in Fiscal Year 2001, 29 of 46 (63 percent) providers did not submit the required audited costs. In addition, RTC rules require the provider to submit a nonindependently verified actual cost report. In the very limited number of cases where providers submitted both of the required actual cost reports, we found that

the independently audited information did not always match the actual cost information reported by the provider. For example, one provider showed actual treatment costs of $175.62 per day, while the independently audited report detailed costs of $162.68 per day. This represents a difference of $4,723 per bed, or about $170,032 a year for the facility. This is only one example and does not necessarily reflect the information supplied by all providers.

- **Information in reports is not comparable.** Our analysis indicates that providers have different interpretations of what information is required, requested, or permissible. For example, we found that providers used different definitions of bed days when calculating their treatment rate, which makes it difficult to accurately compare treatment rates across providers. As a result, the reliability of the reported rates is questionable because not all providers divide their total costs by the total number of youth served.

- **Providers change the cost reports.** The Department sends the RTC providers an electronic version of the cost reports to complete. We found that some providers change the formulas in the spreadsheet. As a result, the information provided may be misleading. For example, at least one provider changed the spreadsheet calculation for the administrative cost allocations. This inflated the percentage of administrative costs allocated to treatment services, thereby increasing the overall treatment rate.

Requiring RTC providers to submit audited cost reports provides the Department of Human Services with the opportunity to gather important information about the actual cost of residential treatment services for both mental health treatment and room and board. If used properly, cost reports would give the Department information on overall RTC provider spending as well as actual costs that can be used when deciding on appropriation levels. They can also provide comparable information across providers, allowing the Department to evaluate the efficiency of programs. The counties and the Division of Youth Corrections could also benefit from actual cost information when setting room and board rates. Since room and board rates are set through either a competitive bidding or negotiation process, provider cost information gives the counties and the Division an important negotiation tool.

The Department needs to make important changes to the current cost reporting system including:

- **Modifying the Reporting Requirements.** Annual reporting requirements appear unnecessary. The Department could achieve its goals of understanding and budgeting for RTC costs if the providers submitted reports on a three- to five-year

cycle. Cost information is unlikely to substantially change from year to year. Periodic submittal allows the Department the opportunity to fully analyze the information and then make informed decisions about needed appropriations. It also saves the providers money. In the in-between years, the Department can continue to give providers a COLA.

- **Streamlining the Cost Reports.** The Department should eliminate the prospective cost reports and focus on obtaining independently verified audited actual costs of providing room and board and mental health treatment services. This information is more accurate and tells what it actually costs to serve these youth. In addition, the Department should finalize the written guidelines on allowable costs for RTC providers it has been developing over the last two years and resume the hands-on training in completing the cost reports. This would give the Department comparable information across providers by ensuring that providers have a clear understanding of what information is required, requested, and permissible.

- **Sharing the Data.** The RTC Administrator needs to share the cost reports and the resulting analysis with both the counties and the Division of Youth Corrections. This will aid them when negotiating or bidding for room and board services.

Recommendation No. 2:

The Department of Human Services should identify and utilize information on the actual cost of providing room and board and mental health treatment services to youth in residential treatment centers by:

a. Requiring RTC providers to on a periodic basis, submit independently verified actual cost reports.

b. Analyzing the information from audited cost reports as part of the budgeting process and comparing costs across providers.

c. Providing written guidelines and hands-on training to providers on how to properly complete the cost reports including definitions for calculating allowable costs.

d. Sharing cost information with the counties and the Division of Youth Corrections.

Department of Human Services Response:

Agree. Estimated Completion Date: No later than July 1, 2003. The Department will provide written guidelines and hands-on training to providers on how to properly complete cost reports. The Department will analyze cost information, generate cost information reports, and provide the information to appropriate entities including the Division of Youth Corrections and county departments.

Analyze MMIS Information

While awaiting the full implementation of Colorado Trails, the Department can access statewide Medicaid payment and billing information through the Medicaid Management Information System (MMIS). The Department can use this system to identify the actual treatment expenditures made by the State on behalf of youth in residential treatment centers.

The Department of Human Services received authority from the Department of Health Care Policy and Financing to oversee the Medicaid mental health programs, including RTCs. As a result, designated Human Services staff have access to MMIS and its billing and payment information. MMIS provides staff with the ability to create their own reports and perform analysis of the data. This includes the ability to obtain detailed individual claim data supporting summarized reports. However, it does not appear that the Department of Human Services accesses this information to specifically monitor claims submitted by RTC providers. Department of Human Services representatives noted that the Division of Child Welfare has only one FTE designated for the RTC program, and that person does not have the authority to check MMIS to analyze provider claims. However, MMIS contains the actual billing and payment information for each youth at an RTC. Therefore, it provides the Department with the ability not only to track monthly payments, including how many youth are billed at each Level of Care, but also to verify that providers are submitting accurate claims. The Department needs to download MMIS information on a routine basis to analyze costs and, as we discuss later in this chapter, ensure the accuracy of payments.

Recommendation No. 3:

The Department of Human Services should identify the actual Medicaid cost of providing residential treatment services by periodically analyzing RTC billing and payment information in the Medicaid Management Information System.

Department of Human Services Response:

Agree. Estimated Completion Date: No later than July 1, 2002. The Department currently analyzes MMIS information in determining county RTC utilization. The Department will prepare quarterly reports summarizing the results of the analysis.

Review Proposed Rate Increases

In recent months several RTC providers have notified counties that they are seeking increases in their daily room and board rate. Due to reporting problems with the Colorado Trails system, we were unable to determine all the providers who may be seeking room and board rate increases or whether the counties are paying them. We did contact Denver and Jefferson counties, which place a large number of youth in RTCs each month. They informed us that they had received notification from 16 RTCs requesting room and board rate increases between 2.5 percent and 121 percent. We have concerns that some of the notification letters cite increased costs that may not fall under the RTC rules' definition of room and board. For example, at least three letters specifically cited increased staff costs. However, most staff costs fall under the definition of treatment, not room and board, and are included in the daily treatment rate. Using room and board monies to cover costs related to mental health treatment would be considered a double payment. The Department needs to ensure that any room and board rate increases sought by the providers comply with the definition in the RTC rules.

In addition, groups of RTC providers have recently joined together to form two separate provider consortia. These consortia, each consisting of five providers, offer additional nontreatment-related services to those counties or groups of counties willing to pay an additional fee per day. This additional fee ranges from $15 to $40 per day per youth. Consortia representatives and participating counties contend that the consortia were established not only to generate more funding for the providers but also to improve outcomes for the youth. For the additional fee, the consortia offer extra nontreatment services such as immediate placement of youth without having to go through a waiting list, a limited no rejection policy guaranteeing the acceptance of most youth referred, and increased frequency of case management over that required by the RTC rules to ensure the provision of treatment services and quick resolution of problems. Consortia arrangements also involve a closer working relationship between the provider staff and the county case workers including regular problem-solving meetings. Consortia providers argue that these extra nontreatment services allow counties to more quickly place their most difficult youth and ensure the provision of proper treatment services allowing youth

to move to less secure providers more quickly. At the same time, county representatives informed us that the extra payment puts providers on notice that outcome expectations are higher.

While consortia may benefit participating counties, they may also negatively impact counties not willing or able to pay extra fees by limiting placement choices for their youth. At least one consortia provider noted his facility only takes youth from counties contracting with the consortia, although the provider used to take youth from all counties. The Department, individual counties, and RTC providers should work together to make sure that provider consortia do not restrict the market to such a degree that RTC services become unavailable to youth from nonparticipating counties.

In addition, we are concerned that some of the services provided by the consortia may represent basic case management services that are part of the treatment rate established by the RTC Administrator. For example, one service cited under the consortia agreements is more frequent reviews to ensure youth receive the proper services and problems are addressed in a timely manner. Another is consortia providers working together to ensure a smooth transition when the youth moves from one RTC to another. However, these are things that providers should already be doing. For example, RTC rules require documentation by a multi-disciplinary team at least every month of services, including a statement of progress toward established goals. Further, the rules mandate that providers develop an individual service plan which specifies all services necessary to meet the youth's needs and states that the plan shall be reviewed and revised if necessary at least monthly. Services detailed in the plan when indicated by the youth's needs include case management. Finally, the RTC rules note that providers must only transfer youth to another provider after adequate arrangements for care, including at least one planning conference with the new provider, have taken place. The Department needs to ensure that the counties are not paying extra for services that RTC providers should already be offering.

Recommendation No. 4:

The Department of Human Services needs to ensure that:

a. Room and board increases sought by providers are allowable under the definition of room and board in the RTC rules.

b. Counties do not pay consortia an extra fee for services that should be provided under the definition of treatment in the RTC rules.

Department of Human Services Response:

Agree. Estimated Completion Date: No later than October 1, 2002. An Agency letter will be published and distributed to counties and providers, requesting all proposed across-the-board increases for room and board be reviewed prior to rate negotiations. The Department will continue the practice of contract review by the Attorney General Office when the contract contains consortia fees to assure that Medicaid fraud does not occur.

Recommendation No. 5:

The Department of Human Services should consult with all counties and RTCs to enhance the availability of placements for all youth needing RTC services and should work to ensure that RTC services remain available to youth from all counties statewide.

Department of Human Services Response:

Agree. Estimated Completion Date: No later than July 1, 2003 The Department will work to develop additional provider resources, including placements for the very difficult-to-place children with multiple problems and issues.

Establish Controls Over Claim Payments

In Fiscal Year 2001 the State paid residential treatment centers approximately $69.2 million for mental health services. Medicaid claims are paid through the State's Medicaid Management Information System (MMIS). The Department of Health Care Policy and Financing (HCPF), the Department of Human Services (DHS), and the State's fiscal agent, Affiliated Computer Systems Inc. (ACS), formerly known as Consultec, share the responsibility for ensuring that only accurate and allowable claims are paid.

During our audit we reviewed the claims submitted by RTC providers for treatment services provided to county-placed youth. As noted earlier, mental health treatment services are reimbursed on a flat daily rate. Due to the fact that Colorado Trails contains incomplete data, we had to use room and board payment data from the system that was in existence prior to Trails (the CWEST system). We compared the billing and payment information in MMIS with room and board records in CWEST to try to match room and board claims to mental health treatment claims for all youth receiving services in August

2000. Our review of 1,497 Medicaid claims indicated inadequate controls over the payment of these claims.

Medicaid Payments for RTC Claims Contain a Significant Number of Errors

Our audit focused on whether RTC providers accurately submitted Medicaid claims for allowable costs. Of the 1,497 claims reviewed, we found at least one error in 455 (30 percent) of them, totaling over $98,000 in erroneous payments for August 2000. Annualized, this could amount to over a million dollars in inaccurate payments.

We identified 147 claims for amounts that did not correspond to any of the established Level of Care rates for a particular provider. For example, one provider appears to consistently be charging about $6.00 more per day than the Level of Care B rate for 14 of the 17 youth it served in August 2000. For the days the 14 youth were served, we estimate the provider received about an extra $2,000. Dates of services for treatment claims did not match room and board dates in 211 claims. Thirty-four percent of those with dates of service that did not match resulted in apparent overbilling. Providers appeared to bill for treatment services for youth who, according to corresponding room and board payments, had not yet entered the RTC or had already left. We also found 108 claims submitted by providers that appear to be bills for the last day of service, which is specifically prohibited by Department of Human Services rules. Finally, we found numerous inconsistencies with the information internal to the youths' MMIS payment record. These included submitting two separate and different calculations of dates of service and improper account codes.

Inadequate controls over RTC Medicaid claim payments include the following:

- **Basic System Edits.** We found that basic edit checks are needed. For example, although RTCs are supposed to submit claims based on three Levels of Care, the MMIS system only contains the rate matching the highest and most expensive level—Level C. In other words, MMIS contains an upper payment limit but lacks controls over specific payment levels. As noted in our 2001 Medicaid Management Information System report, ACS, the State's fiscal agent, has had difficulty keeping up with edit change requests. We found that over two years ago HCPF submitted a Change Request Letter to ACS to input all three Level of Care rates. To date this has not been done.

  Second, although Division of Child Welfare representatives informed us that they believe MMIS should contain edits to ensure that dates of service are accurate,

this is not the case. ACS representatives indicated that they check to ensure that the youth is Medicaid-eligible, but that the MMIS system does not cross match the days of service or whether the youth is actually at the RTC with the Department of Human Services systems (Colorado Trails or CWEST).

- **Claims Review.** RTC claims are not routinely sampled to ensure accuracy. The Department of Health Care Policy and Financing (HCPF) has general procedures in place to review all Medicaid claims. Claims audits are conducted by Information Section and Program Integrity Unit staff. The Information Section staff conducts a quarterly audit of a sample of claims from all 13 Medicaid categories to ensure the accuracy of the system's payment process. RTCs are included in the criteria for the sample, but there is no guarantee that an RTC claim will actually be selected. In addition, the Information Section audit focuses on whether payments are made in accordance with the edits in the MMIS system. For RTCs, the check would be to ensure that the claim does not exceed the Level C rate, not whether the RTC provider submitted a claim for the proper rate. The Program Integrity Unit investigates allegations of improper billing but does very little related to RTC payments. Staff noted only one case in the last year involving an RTC and it was a placement rather than a billing issue.

  In addition to the oversight currently done by the Department of Health Care Policy and Financing, the Department of Human Services has access to the MMIS system and could check the accuracy of claims. However, the Division of Child Welfare staff noted that the one FTE designated for the RTC program is focused on other duties. The Division tracks the total Medicaid amount spent by each county for RTC placements. While these data can be used by counties to try to get a picture of their standing in terms of overall appropriated monies, they do not provide any information related to the accuracy of claims payments.

  As already noted, we identified errors in 30 percent of the claims we reviewed. We believe that the Department of Health Care Policy and Financing and the Department of Human Services need to perform more program-specific sample claims audits. We note that the MMIS system has the ability to produce RTC claims reports to include both summarized information and individual claim data for such an analysis.

- **Compliance With Approved Vendor List.** Finally, a good system of internal controls would include checks over vendors. Department of Human Services rules state that payments cannot be made to a provider unless that provider is listed on the Division of Child Welfare's approved vendor list. This is meant to ensure that only those providers who meet all state licensing requirements serve youth and

receive the corresponding state payments. We found two providers are currently receiving placements from the counties and submitting claims for Medicaid reimbursement, even though they are not on the approved vendor list. We asked Division staff to determine if these vendors were approved. They informed us that in these two cases the providers met all requirements and their absence from the vendor list was a documentation error. To date, however, the Department has not corrected its vendor list. Maintaining an accurate list and checking it prior to payment is important in expediting claims and ensuring accuracy.

We also spoke with the RTC Administrator about how the vendor list is amended and ACS notified of those providers who are no longer eligible for RTC placements. The Administrator stated that he verbally informed ACS about those providers that had closed but had not sent an official transmittal letter removing them from the MMIS system because those providers had outstanding Medicaid bills to be paid. The two departments need to develop payment cutoff points to ensure that these providers do not continue to bill ACS for mental health treatment services. The RTC Administrator also needs to ensure that the vendor list is updated to accurately reflect eligible providers and existing reimbursement rates.

In conclusion, our review indicates the possibility of over $98,000 in Medicaid overpayments during the month of August 2000 alone resulting from a lack of payment controls. The State has the responsibility for ensuring that only accurate and allowable Medicaid bills are paid. Although Medicaid-funded mental health treatment services are an entitlement, overpayments are inappropriate and impact county finances. Counties are responsible for using their own funds to pay the Medicaid match when the block funding has been exceeded. In addition, failing to audit the claims leaves open the potential for Medicaid fraud. The State, through the Department of Health Care Policy and Financing and/or the Department of Human Services, needs to conduct periodic audits of the MMIS billing and payment information related to RTC providers to ensure accurate payments. In addition, the Department of Health Care Policy and Financing should work with ACS to establish additional edits in the MMIS system that will help prevent inaccurate billings. In regard to the potential overpayments due to the lack of payment controls, HCPF needs to recover these overpayments.

The counties and DYC are in the best position to verify the accuracy of RTC provider billing and payment information. These entities authorized the placement of the youth and, therefore, know the authorized rate. They also have placed the youth and thus they know the providers and the true dates of service. In addition, DYC and the counties have both a financial and an operational need to verify RTC billing information. On the financial side, counties and DYC need to operate this program within authorized spending authority.

From the operational perspective, the counties and DYC must ensure that RTC providers charge for the youth's approved Level of Care.

In addition, HCPF could require ACS to cross-check payment claims with the room and board information in the Colorado Trails system. Division of Child Welfare representatives informed us that the room and board information in the Colorado Trails system should accurately reflect the placement of the youth and the days of service. Such cross-checking would prevent the payment of claims for last day of service and billing for days in which the youth was not in the RTC. However, this would involve allowing ACS access to the Colorado Trails system and a willingness by ACS to perform these checks prior to payment. ACS representatives informed us that they could perform such cross-checking but that it could lead to additional costs under the contract.

Recommendation No. 6:

The Department of Human Services should implement procedures to ensure that it pays only allowable costs for RTC services. This could be accomplished by verifying the accuracy of RTC provider billing and payment information through periodic audits.

Department of Human Services Response:

Agree. Estimated Completion Date: No later than July 1, 2003. Since counties and DYC already verify room and board payments, the Department will require providers to rout treatment invoices through the placing county or DYC to similarly verify Medicaid treatment payments for ACS.

Recommendation No. 7:

The Department of Health Care Policy and Financing should implement procedures to ensure that it pays only allowable costs for RTC services by:

a. Verifying the accuracy of RTC provider billing and payment information through periodic audits.

b. Requiring Affiliated Computer Systems, Inc., the State's fiscal agent, to include additional payment edits within the Medicaid Management Information System to ensure that the system has adequate controls to prevent inaccurate billing;

c. Seeking to recover overpaid amounts for the prior periods.

Department of Health Care Policy and Financing Response:

a. Agree. The accuracy of payment will continue to be a part of the Claims Processing Assessment System (CPAS) reviews. However, as noted in the narrative, these reviews only assess whether the system paid the claim correctly according to the policy that is implemented within the system. It is the obligation of the provider to properly bill for the services rendered. The Program Integrity Unit within the Quality Assurance Section will conduct random sample monitoring to assess whether this is done correctly. This monitoring will commence in March 2002. Recommendations for a recovery plan will result from the sampling. The Department anticipates recovery on substantiated overpayments to begin August 2002, or within two months of being identified.

   Human Services staff continue to use the Executive Information System/Decision Support System to review claims for services. Through the use of this capability, staff would be able to compare claims data to the records at the RTC and the local agencies for appropriateness of billing and compare their list of valid RTC providers with the definition used by the Medicaid Management Information System to assure payments to only valid providers.

b. Agree. The Medicaid Management Information System change request to accommodate the three pricing levels was put in the queue on September 1999. There are policy decisions that need to be made about how to handle the problems identified in this audit. The design considerations include use of prior authorizations, coding of services, and other possible solutions. Once the policy decisions are made, the systems changes to implement the policies can be made within six months. Health Care Policy and Financing commits to working with Human Services staff to resolve the policy issues. It is anticipated that the systems changes will be in place by the end of October 2002.

c. Agree. The Department will pursue recoveries through the work done by Program Integrity (described in item a). Once identified and substantiated, the recovery process can begin within two months, though it may take longer than that to receive all the identified money. As Department of Human Services

identifies overpayments, financial transactions can be entered into the Medicaid Management Information System to make recoveries from providers from current payments. Other recovery methods will be explored with Human Services.

Establish a Formal Appeals Process

As noted earlier, for the past two fiscal years the RTC Administrator has increased mental health treatment rates through cost-of-living adjustments (COLAs). As part of our audit work, we compared treatment rate increases for the last several fiscal years. Our comparison showed some RTC providers had received increases in their treatment rates in excess of the established COLA.

Upon investigation, we found some RTC providers appealed their assigned mental health treatment rate and were granted a higher rate. RTC rules contain no provisions allowing for an appeal of the assigned treatment rate. However, we learned that RTC providers can use an informal appeal process based upon the nursing home provider appeal process.

In the absence of an established appeals process, it is unclear whether all RTC providers are aware of their right to appeal their initial treatment rate. While the Department's rate notification letter sent in past years has contained a statement regarding the right to appeal the assigned treatment rate, appeal language was not included in the Fiscal Year 2002 rate notification letter. In the past few years a small number of RTC providers took advantage of the right to appeal. However, we were unable to find any criteria to guide the appeal process.

The lack of an established appeal process appears to have contributed to limited existing documentation regarding rate appeals. The RTC Administrator did not know if documentation exists detailing all appeals. Apparently some providers sent a letter to the RTC Administrator, appealing their rate including justification for why they believed the treatment rate was inadequate. Other RTC providers may not have sent letters, but their rates were changed anyway. Some anomalies found during our rate comparison cannot be explained by the appeal documentation we received, raising possibilities that other providers appealed their rates. Limited documentation exists, but it appears that the RTC Administrator agreed to increase some treatment rates, while other appeals were decided by an administrative law judge. In addition, we contacted a representative of the Office of the Attorney General, whose Office apparently must sign off on any appeal. The representative remembered a few appeal cases involving RTC providers but could not

locate any corresponding documentation. For those appeals we could document, RTC providers received between $1,759 and $7,400 more per youth per year than what they would have received if they had not appealed their initial treatment rate. Those providers who appealed their initial rate serve between 10 and 22 youth each day.

We believe a formal appeals process is needed to ensure fairness and equity. The Department should amend the RTC rules to create a formal process for providers to appeal their assigned mental health treatment rate. The process could be patterned after the process for nursing homes. In addition, the Department should establish criteria to aid the RTC Administrator and providers in determining how to decide if an appeal for a rate increase is valid. The lack of written criteria limits independent review of decisions regarding rates. Once the process has been established, the Department needs to ensure that all RTC providers are aware of the ability to appeal their treatment rate and the criteria for doing so.

Recommendation No. 8:

Through regulation, the Department of Human Services should establish a formal treatment rate appeal process for residential treatment centers. Regulations should include:

a. Criteria for submitting an appeal.
b. Time frames for appeals and decisions.
c. Evaluation criteria.
d. Documentation of basis for decision.

Department of Human Services Response:

Agree. Estimated Completion Date: No later than January 1, 2003. The Department will develop a rate appeal process by working with the RTC workgroup (comprised of state, county, and provider staff). The work of the group related to the above recommendations will be implemented through a change to HCPF Staff Manual, Volume 8.

Service Delivery

Chapter 2

Establish Treatment Standards

As noted earlier, payments for mental health treatment services represent the largest portion of the rate paid to residential treatment center (RTC) providers. The State bases the treatment rate on a Level of Care system. The three levels of care are as follows:

- **Level A**—Youth in need of transitional and/or aftercare mental health services are assigned to Level A. Level A services are intended to help transition the youth to a less restrictive setting. Only youth who have previously received Level B or Level C services are eligible for Level A. The Level A reimbursement rate is 20 percent less than the standard Level B rate.

- **Level B**—Youth with moderate mental health needs are assigned to Level B. Level B represents the standard Level of Care. County and DYC representatives estimate that up to 90 percent of all youth placed in RTCs are assessed as needing B-level services.

- **Level C**—Youth with the most severe mental health problems are assigned to Level C. Providers receive a 20 percent higher rate than the standard Level B rate for these youth.

Department rules do not require that RTCs provide any minimum number or type of services at each Level of Care. As part of our audit work, we reviewed 48 randomly selected youth treatment files—six files at each of eight different RTC providers. Our examination included comparing provider-prepared individual treatment plans with mental health treatment services documented in the file.

We reviewed all case treatment information, including, but not limited to, daily progress notes, monthly progress summaries, group notes, and individual therapy notes. Eighty percent of the files we reviewed lacked complete documentation to show that all treatment services as outlined in the treatment plan were actually provided to the youth. In addition, we found no evidence that one youth who moved up to Level C received a greater number or different type of treatment services than he did when he was classified as Level B, even

though the provider received a 20 percent higher daily treatment rate for the youth at Level C. We are concerned that (1) the Department's expectations for mental health treatment services at each Level of Care are not clear, and (2) youth residing in RTCs may not be receiving the mental health services identified in their individual treatment plans. RTC rules require a written service plan for each youth, based on their assessed needs. The plan must contain concrete goals and objectives and list the type, frequency, and duration of all mental health services. In addition, providers must maintain an organized, written, and current record on each youth that includes all treatment entries. Documentation is discussed further in the next comment.

We obtained information from five states that place children in Colorado facilities. Three of those states tie reimbursement rates to the type and frequency of mental health services provided. For example, the State of Nebraska has two types of residential treatment providers. In that state, reimbursement is based on the number of scheduled treatment hours provided each week. A treatment group home receives $56,210 per year in return for giving youth 21 scheduled treatment hours per week. A residential treatment center's rate is about $82,490 per year and youth receive 42 scheduled treatment hours per week. In California the rate of reimbursement is directly related to the number of treatment services provided and the number and experience level of staff. Virginia also bases rates on the number of treatment services.

Colorado has an "all-inclusive" approach to treatment rates and services, much like an HMO concept. Providers are paid one rate for all needed mental health treatment services. This approach offers providers flexibility in maximizing resources available to serve troubled youth. However, this approach can also result in a lack of direction regarding the State's service delivery expectations. In addition, RTC providers complain that they are prohibited from accessing outside funding and mental health services needed for their most troubled youth. For example, RTC providers sought to work with the Mental Health Assessment and Service Agencies (MHASAs) to augment funding for about 50 youth receiving residential treatment services. These youth required constant one-to-one interaction to address specific behavioral issues. Providers used funding from the MHASAs to supplement the regular Medicaid treatment rate and to hire individuals to provide constant one-to-one interaction. However, due to the "all-inclusive" definition of treatment, the Office of the Attorney General's Medicaid Fraud Unit determined these augmented payments to be third-party or double payments for the same services and, therefore, Medicaid fraud. Changing to a system that requires either minimum services or a range of services for each Level of Care would allow for augmented payments when circumstances warrant additional treatment.

We believe that establishing treatment standards makes sense. We recognize that there could be significant impacts on providers, counties, the State, and youth served resulting

from the establishment of minimum treatment standards which include the type and frequency of services to be provided. Therefore we recommend that the Department work closely with all concerned parties to revise the current RTC rules to establish a defined treatment framework.

Recommendation No. 9:

The Department of Human Services should establish mental health treatment standards which include the type and frequency of services required to be provided.

Department of Human Services Response:

Agree. Estimated Completion Date: No later than October 1, 2003. The Department is already examining the RTC treatment system. Two methods are being used to consider the most effective treatment determination method:

a. A state-wide workgroup of stakeholders (RTC administrators, county officials, state officials and others) is meeting to address the Level of Care system and alternatives.

b. A grant has been approved ($100,000) to provide a comprehensive examination of the RTC system in Colorado, comparing it to those of other state and federal agencies, to determine whether Colorado could adapt proven methods to our needs.

Based on the recommendations of the stakeholder workgroup and the findings of the research, the goal of more specific and controlled treatment plan development and implementation will be achieved by necessary changes to HCPF Staff Manual, Volume 8.

Ensure Services Are Provided and Documented

RTC rules require providers to develop a comprehensive written service plan for every client. Overall, we found (1) treatment plans are often not tailored to individual needs, and (2) mental health treatment services provided are not adequately documented.

Generic treatment plans and boilerplate goals are prevalent. Contrary to expectations, in the client files we examined, we found that, for the most part, treatment plans are often not tailored to individual needs. For example, most treatment plans called for weekly individual therapy, monthly or bimonthly family therapy, and daily group and milieu therapy. A youth with a conduct disorder could be assessed with needing the same amount and type of mental health treatment as a sexual perpetrator.

Not only did some of the files we reviewed fail to individualize treatment, but many also listed several of the same goals for youth with very different needs. One provider's files contained some of the same goal statements for almost every youth despite the fact that they had different assessed needs. These goal statements included to develop a healthy expression of needs and feelings, to develop age-appropriate social skills, and to develop a positive sense of self and identity. The same "boilerplate" goals were listed for youth with problems ranging from animal abuse to post traumatic stress disorder. In 29 of the 48 files (60 percent) we could not determine if the goals addressed the identified needs of the youth. In fact, only 19 of the 48 files (40 percent) had goals that seemed to relate to the youth's needs. In addition, although the youth's assessment identified mental health treatment needs or issues, in some cases the treatment plan did not address these needs. For example, all six youth at one provider had a history of sexual abuse and/or sexual perpetration. The provider documented that all six youth needed an assessment to determine if offense/victim-specific treatment was necessary. We found that only one youth received this assessment. This youth is the only one that we can verify received treatment that addressed the sexual abuse and/or perpetration history.

Services are not well documented. We requested that each provider give us all existing treatment information for each youth. As noted earlier, we reviewed daily progress notes, monthly progress summaries, group notes, and individual therapy notes. Based on the information in the files, we were unable to determine if providers furnished all of the mental health services in the frequency detailed in the treatment plan. Every file we reviewed contained gaps in service documentation. In some cases the files lacked any documentation to support the mental health services reported to the youth's caseworker through the monthly report. Thirty-eight of the forty-eight files (79 percent) lacked documentation demonstrating that all mental health services were provided to the youth as outlined in the treatment plan. Another eight files did not detail the service frequencies that were to be provided.

The results of our case file review were not surprising to those involved in overseeing services. Representatives of several entities informed us that they were well aware that RTC providers do not always meet the treatment plan requirements. For example, a representative of the Administrative Review Division reported that its reviews often find a lack of documentation to prove that treatment services were provided. In addition,

Administrative Review staff reported that they often find "boilerplate" treatment plans with one youth's name crossed out and another name inserted.

County case workers were also aware of RTC-provider failures to furnish mental health services. In interviews we conducted with a sample of county case workers and staff, concerns were raised about providers not following the treatment plan. One reason cited for not taking action against the provider was the need for RTC beds. We attended a review of a provider that included the 24-Hour Monitoring Team. Similar to our findings, the Team identified several issues related to service provision including a lack of documentation of treatment services and a failure to meet frequencies listed in the treatment plan.

The Department of Human Services and county departments of social services are responsible for ensuring that RTCs provide services for which they are reimbursed. The Department needs to take immediate action to (a) correct documentation issues, and (b) ensure that services are provided. RTC rules require providers to maintain an organized, written, and current record on each youth including all treatment entries. The Department needs to ensure that the RTC providers comply with this requirement. The Department should also ensure that monitoring teams prioritize the review of mental health treatment services provided. Further, case workers and client managers should be required to periodically compare the treatment plan with the supporting documentation in the youth's treatment file. Those client managers and case workers we interviewed reported relying on verbal updates and monthly progress reports to verify treatment services. The underlying data are typically not examined.

Once documentation standards are established and adherence to the standards becomes a Department priority, Department staff can focus on ensuring that providers meet the documentation requirements. Action needs to be taken against those providers who consistently fail to meet treatment and documentation standards. The failure to consistently provide mental health treatment services constitutes Medicaid fraud, and the information should be turned over to the Office of the Attorney General's Medicaid Fraud Unit and/or the Program Integrity Unit at the Department of Health Care Policy and Financing. These are the only agencies that can seek to recover Medicaid funds.

DYC and the counties, through their contract process, could impose sanctions such as a freeze on placements or removal of youth from the facility for the consistent failure to abide by contract provisions. For example, DYC's contracts contain a provision allowing sanctions for failure to satisfy the scope of work, which includes treatment services. However, it is unclear how often DYC enforces this provision. Some representatives noted that RTC providers have them "over a barrel" because DYC and the counties need to place youth in RTC beds. That may be true to some extent. But the relationship

between RTC providers and the State is interdependent because RTC providers derive almost all of their income from state entities.

In summary, immediate action is needed to ensure that treatment plans for youth placed in RTCs outline the specific, appropriate treatment needed; that youth receive the treatment outlined in their treatment plan; and that documentation exists to support Medicaid payments.

Recommendation No. 10:

The Department of Human Services should:

a. Ensure that residential treatment centers are meeting established requirements for treatment plans and service documentation.

b. Ensure that residential treatment centers provide all treatment services by requiring periodic treatment file reviews by case workers and client managers and during monitoring visits.

c. Establish and use financial and nonfinancial penalties/sanctions against providers who consistently fail to provide and/or document treatment services.

Department of Human Services Response:

Agree. Estimated Completion Date: No later than July 1, 2003. Staff of the 24-hour monitoring team will continue to review treatment plans and service documentation for meeting established requirements during on-site visits to the facility. The Department will work with county departments to have caseworkers monitor that purchased treatment services are being provided and DYC client managers will review treatment files during monthly contact visits.

The model out-of-home placement contract used by county departments (SS Form 23a) will be modified to include sanctions, similar to those in the Youth Corrections contracts, for failure to correct consistent violations in a timely manner.

Establish Outcome Measures

Youth in out-of-home placement can access mental health services in two ways. Those youth in a foster home or residential child care facility who require mental health treatment can receive outpatient mental health services through a Mental Health Assessment and Service Agency (MHASA). The other option is placement in a residential treatment center. The State pays about $32,000 less per year for a foster care placement with outpatient mental health services through a MHASA than it does for placement in an RTC, and about $24,700 less per year for placement in an RCCF with outpatient mental health care. As noted earlier, the main cost difference between RTCs and other types of placements is the in-house provision of mental health services. Despite the substantial cost differences between types of placements, there is little if any outcome data regarding whether mental health services offered through residential treatment centers actually benefit clients.

The development of outcome measures could benefit both the State and the RTC providers. The benefits to the State include an assessment of whether expensive residential treatment services actually improve the ability of youth to function in society. The measures, if comparable across providers, could show which RTC providers do better with certain types of youth—making placement decisions easier. Outcome measures can also detail whether more expensive RTC programs have more success than less expensive alternatives. On the RTC provider side, outcome measures could help the program identify needed improvements. Outcome measures could also support rate increase requests for RTC programs that have long-term success with mentally ill youth.

Colorado Client Assessment Record Can Be Used to Measure Outcomes

The Colorado Client Assessment Record (CCAR) is a mental health assessment tool already used by the State. Department staff indicated that the CCAR can provide a good indication of a youth's overall ability to function in society. The client assessment record yields numerical scores that DYC and counties use to determine a youth's Level of Care. The CCAR can also be used to measure progress. RTC rules require that CCARs be administered at the point of entry and exit from an RTC. In addition, according to RTC rules, the CCAR must be administered before a youth can move to a different Level of Care.

Some analysis of client assessment record scores already takes place, although not necessarily to determine outcomes for youth receiving residential treatment services. For example, the Department's Division of Mental Health Services (MHS) administers the

Colorado Client Assessment Record to adults in their system and produces an annual report with demographic information on individuals receiving mental health services through MHASAs and Mental Health Centers in Colorado. The Department could consider expanding the Division of Mental Health Services' responsibilities by requiring that it also collect data on RTC clients and track outcome information for these youth.

Alternatively, the Department could maintain all client assessment record information within the Colorado Trails system and designate the RTC Administrator as the person to track outcomes. As designed, the Trails database is a case management system that will contain information regarding all services received by the youth including client assessment record data. As noted earlier, implementation of the Trails system has been seriously delayed. Presently, some data are input into Trails, but report production is limited. On the basis of information received from the Department, it appears that it will be Fiscal Year 2003 before the Trails system will be able to produce reliable outcome information.

Support for Outcome Measures Exists

There is support in the RTC and mental health communities for developing outcome measures. Two RTC providers have already developed outcome measures for internal use. One uses its outcome data to conduct follow-up studies on discharged youth to determine whether the treatment provided was successful. The other initiated outcome studies for all youth at its two facilities in October 2001, and it plans to use the outcome measures to track the progress of all youth as well as to identify gaps in its program. Their method uses two questionnaires to identify behaviors needing to be addressed and resulting progress. The information can be used throughout the treatment process and also upon discharge to evaluate treatment outcomes.

The Colorado Association of Family and Children's Agencies, Inc. (CAFCA), an association of providers serving youth, established a subcommittee of its members to study the feasibility of developing industrywide outcome measures. The subcommittee is in the initial stages of its work but is beginning to review existing software packages to determine if they can be used by all providers. The Association hopes to create comparable measures but at the very least wants RTC providers to develop outcome measures for their specific programs. The RTC Work Group has also discussed how outcome measures could be developed and implemented. Finally, the Division of Child Welfare recently received grant funding to conduct a study and to develop a methodology by which outcomes can be measured. Individual outcome measures are a step in the right direction, but outcome measures that allow for comparison across all RTC providers produce the most useful information.

Recommendation No. 11:

The Department of Human Services should:

a. Work with residential treatment center providers and other interested parties to develop specific outcome measures that can be used to measure the progress of youth receiving residential treatment services and the success of individual programs.

b. Develop a system for monitoring the progress of youth by tracking the outcome measures.

Department of Human Services Response:

Agree. Estimated Completion Date: No later than July 1, 2003. The Department already uses the well-researched Colorado Client Assessment Record (CCAR) to assess and document mental health and youth corrections clients as well as all Child Welfare children placed in RTCs. Completion of CCARs at RTCs on admission, change of Level of Care, and discharge is already required by Rule. An Agency Letter will be published, requesting copies of all CCARs be maintained in the county department of social/human services casefile. Additionally, DYC will strengthen contract language to require CCARs upon admission, change of level of care and at discharge. Plans are already in place for CCARs to be included in Trails; this Trails enhancement is scheduled concurrent with Youth Corrections implementation of Trails.

Strengthen Controls Over Eligibility

RTC rules require an independent review of the youth's application for residential treatment services. The application includes the youth's mental health diagnosis, initial treatment plan, and justification for residential treatment services. An independent eligibility review is intended to verify an eligible psychiatric disorder and the need for residential services. Currently the Colorado Foundation for Medical Care (Foundation) serves as the State's peer review organization. For its services, the Foundation receives $28 for every initial and continued service request application it receives. In Fiscal Year 2001 the Foundation received about $129,000 for the review of about 4,600 applications for service.

According to Foundation representatives, its review is limited to a desk audit that focuses on the completeness of the application and the notation of an eligible diagnosis. The review does not include any evaluation of the underlying supporting documentation. In addition, Foundation representatives informed us that no youth's psychiatric disorder diagnosis or application for RTC services has ever been rejected. The current peer review provides little assurance that youth actually need residential treatment center services. In fact, the RTC Administrator estimates that up to 60 percent of the youth currently receiving residential treatment center services have primary diagnoses that are not appropriate for residential treatment. The Department of Human Services should ensure that youth are appropriately placed by improving oversight of eligibility. This would include verifying that the youth has an eligible psychiatric disorder that will benefit from residential treatment.

Recommendation No. 12:

The Department of Human Services should develop a cost-effective peer review process that ensures the need for residential treatment center services.

Department of Human Services Response:

Agree. Estimated Completion Date: No later than April 1, 2002. Since federal Medicaid rules do not require an external peer review process, the Department will not establish a new procedure. However, the CCAR completion process and addition of medical necessity statements to administrative processing will provide an assessment of the need for residential treatment center services. An RTC Workgroup subcommittee is meeting to devise the details of the new system and submit necessary Volume 8 rule changes prior to expiration of the current contract in March 2002.

Ensure That Deficiencies Are Corrected

In our 1999 audit of the Division of Youth Corrections' (DYC) out-of-home placement program, we noted numerous instances of repeated safety, security, and service deficiencies at the Division's private commitment programs. As a result, DYC prioritized the immediate correction of violations identified in on-site reviews. DYC now works with providers on violations that must be corrected immediately and has a designated representative to ensure corrections take place. The Department of Human Services also

established the 24-Hour Monitoring Team to immediately investigate providers whose conditions could put youth in immediate danger. The 24-Hour Team has the authority to shut down providers that represent a danger to youth. While the Department has taken important first steps to ensure correction of deficiencies, we continue to find significant issues that have not been addressed.

As noted earlier, we accompanied a Departmentwide joint monitoring team on an on-site review of an RTC. The RTC serves 79 youth and receives on an annual basis $55,115 per youth from the counties and $66,795 per youth from DYC. During this review, the Division of Youth Corrections representatives identified 76 violations, 40 (53 percent) of which were repeat violations. Some violations were significant service issues such as missing required staff background checks, the use of unlicensed teachers, and the fact that female clients do not receive equal access to programs and services. Others addressed issues such as cleanliness and safety of the physical plant. The Department's 24-Hour Monitoring Team found some issues related to the documentation of treatment services. The joint team identified an issue involving the locking of egress doors and the lack of related safety approval documentation that had been cited for over three years. The problem was fixed only when the Division of Child Care's Licensing Specialist threatened to require the provider to unlock the doors and use staff to maintain security.

The Department does a good job of identifying deficiencies. It is evident, however, that deficiencies are not quickly remedied. The Department follows a policy of working with providers to correct violations so that the provider can remain open. We understand the need to work with providers in a time when there is a shortage of RTC beds. However, at the same time the Department needs to make sure violations are corrected. Violations impact the overall quality of the program. The Department needs to penalize those providers who consistently fail to correct identified problems. DYC contracts give it the ability to impose sanctions and/or penalties for failure to abide by the scope of work. One contract requirement is complying with all DYC rules and regulations. Penalties and sanctions can be both financial, such as reducing the daily payment, and nonfinancial, such as freezing placements. In at least one case, DYC did briefly freeze placements at one RTC provider after repeated violations. Imposition of such actions puts providers on notice that the Department is willing to take steps to get all violations corrected in a timely manner.

Recommendation No. 13:

The Department of Human Services should include appropriate enforcement actions including financial and nonfinancial sanctions in its contracts with providers and use those sanctions when providers fail to correct violations in a timely manner.

Department of Human Services Response:

Agree. Estimated Completion Date: No later than July 1, 2002. The model out-of-home placement contract used by county departments (SS Form 23a) will be modified to include sanctions, similar to those in the Youth Corrections contracts, for failure to correct consistent violations in a timely manner.

Streamline Oversight of RTCs

The Department devotes significant resources to monitoring residential treatment centers. Since RTCs serve both committed and noncommitted youth, various agencies within the Department set standards that RTCs must meet. These individual agencies monitor RTCs to ensure compliance with their requirements. Requirements vary from the physical condition of the facility to the safety and security of the youth to educational and treatment services to documentation requirements. On its face, this extensive monitoring system provides some assurance that RTC providers meet standards, furnish required services, and provide a safe environment. However, extensive monitoring is costly and is not necessarily resulting in the quick correction of deficiencies. We believe that monitoring could be streamlined and more attention placed on enforcement activities.

There are six separate divisions within the Department that monitor RTCs on at least an annual basis. While each entity monitors compliance with specific standards, several of the standards categories overlap. For example, a number of divisions have safety, security, and physical plant standards. Service standards also overlap. Many times these entities collect the same information and review similar documentation. Below we describe the different monitoring entities and their duties related to RTCs:

- **The Division of Youth Corrections Quality Assurance Team** formally audits all state-operated facilities and secure private residential contractors on an annual basis. This includes those RTCs designated as staff secure. The Quality Assurance Team evaluates every aspect of a program including personnel, food

service, physical plant, security and control, education, sanitation, and hygiene. Inspections conducted by the Division of Child Care and the 24-Hour Monitoring Team also cover some of these areas. The Quality Assurance Team ensures that contract facilities are in compliance with the Division of Youth Corrections policies, standards, and contract provisions. The Quality Assurance Team visits are unannounced. The Team has three permanent members and uses other DYC staff to help with audits.

- **The 24-Hour Monitoring Team** is administratively attached to the Division of Child Care. The 24-Hour Team conducts monitoring visits to ensure requirements regarding health and safety are met—these requirements are also covered in some cases by DYC's Quality Assurance Team, the Division of Child Care, and the RTC Monitor. The frequency of the 24-Hour Team's visits is determined using risk-based criteria but occur at least every six months. The 24-Hour Team also responds to emergency situations regarding possible abuse or neglect of youth. All of these visits are unannounced. The Team has eight full-time staff.

- **The Division of Administrative Review** conducts a twice yearly review of youth who have been in out-of-home placement for over a six-month period. This review takes place at the county level and involves the examination of the youth's file that is maintained by the county case worker. Similar to monitoring done at the provider, the review seeks to ensure the safety of the youth, compliance with the case plan, continuing necessity and appropriateness of placement, and eligibility for Title IV-E foster care. In addition, the review includes an examination of the eligibility for RTC placement. These visits to counties are announced. The Division has a total of 29 individuals who conduct these reviews. A review of a youth's file involves one person from the Administrative Review Division.

- **The RTC Monitor** reviews each RTC annually for recertification purposes and to ensure compliance with RTC rules. The RTC recertification process includes reviewing youth records, grievances filed by the youth, critical incident reports, staff training, and physical plant issues. Generally, 33 percent of an RTC's total population's files are reviewed prior to recertification. These visits occur annually and may duplicate the work done by other monitoring units within the Department. For example, DYC's Quality Assurance audits at secure RTCs examine the same issues. In addition, the 24-Hour Monitoring Team also visits all RTCs at least every six months. Currently the RTC monitor is a .5 FTE position.

- **The Division of Child Care** reviews each RTC for compliance with state residential child care facility licensing standards. The Division uses risk-based

criteria based upon substantiated complaints, licensing violations, and child abuse allegations to determine the frequency of licensing visits. These visits occur either once per year or once every two years. The 24-Hour Monitoring Team also uses these standards for its visits, and DYC has similar facility standards.

- **The Alcohol and Drug Abuse Division (ADAD)** makes announced annual visits to facilities that are certified to provide ADAD programs.

Consistent in-depth monitoring of RTC facilities is critical. However, the current monitoring effort is fragmented and unduly burdensome. The Department recognizes this fragmentation and has taken initial steps to coordinate monitoring efforts. Over the past two years, the Department has encouraged coordination and has conducted joint monitoring visits. When we accompanied the joint monitoring team on one visit, a total of 12 Department employees, representing four entities, participated in the visit. Representatives appeared familiar with each other's standards and in some cases reviewed the same issues. To minimize fragmentation and make better use of resources, the Department could combine all of the various monitoring standards and create a set of core standards that could be used for all 24-hour care providers. This would present an opportunity to cross-train all of the monitoring units and reduce duplication within the Department. While we applaud the coordination, we have concerns that sending 12 staff is unnecessary. The development of core standards and implementation of cross training could have allowed this facility to be thoroughly inspected with a much smaller team.

In addition to coordinating monitoring efforts, the Department should consider further consolidation of monitoring for all 24-hour providers. It is our understanding that some consolidation has already taken place. A Department representative informed us that the 24-Hour Monitoring Team would take over duties related to monitoring licensing requirements and renewals for 24-hour providers. The Division of Child Care will continue to handle initial licensing issues. This allows the staff at the Division of Child Care to focus more resources on under 24-hour care providers. Additionally in recent months, the Department allowed the 24-Hour Monitoring Team to handle the RTC monitoring and certification process. By reducing staff needs for on-site audits, the Department could allocate more time to enforcement efforts.

Recommendation No. 14:

The Department of Human Services should streamline monitoring efforts by:

a. Identifying core monitoring standards and cross-training staff on those standards.

b. Streamlining monitoring functions to eliminate duplication.

Department of Human Services Response:

Agree. Estimated Completion Date: No later than July 1, 2003. The Department has already begun streamlining the number and type of visits to providers. Department representatives will work to identify core monitoring standards and cross-train staff as appropriate. The Department will streamline monitoring functions to eliminate duplication where possible.

Improve Case Management

County case workers and DYC client managers oversee services provided to individual youth. Case management standards require these workers to maintain at least monthly contact with youth regardless of changes in placement. Responsibilities include ensuring the safety and security of the youth as well as overseeing the youth's treatment progress.

We interviewed a sample of case workers and client mangers to determine how they manage cases and work with youth in RTCs. Our interviews and review of case files prompted concerns in the following case management areas:

- **Meeting alone with the youth.** In our 1999 audit of the Division of Youth Corrections we raised concerns about the fact that only one-third of the client managers regularly met alone with their clients. We noted that this was a safety issue in that client managers were more likely to identify youth safety issues if they met with the youth in a private, confidential environment. At that time, the Division reported that it required client managers to meet alone with the youth on a regular basis. In our current audit we found that 3 of the 10 client managers we interviewed still do not meet alone with their clients on a regular basis. Interviews with county case workers showed that at least 4 of the 18 interviewed do not regularly meet alone with their clients. Although not a requirement for county case

workers, the same safety issue exists for youth placed at RTCs by the counties. Therefore, we believe the Department should establish a requirement that both county case workers and DYC client managers must meet alone with youth on a regular basis.

- **File review/Service delivery.** In addition, we note that of the 28 county case workers and DYC client managers interviewed, only 3 review the youth's treatment file to ensure that appropriate services are being provided. While they may review monthly progress reports, these reports contain only limited information that may not be supported by the underlying treatment documentation. According to DYC procedures, client managers are required to review the youth's case notes during the monthly visit. Volume VII of the Department of Human Services' rules requires county case workers to monitor the services purchased for the youth on a monthly basis.

While a youth is under the supervision of the State, the county case worker or the DYC client manager work as the youth's guardian and advocate. These individuals are critical in ensuring the successful treatment of troubled youth. The Department needs to ensure that case workers are well trained on requirements and that oversight requirements are being met.

Recommendation No. 15:

The Department of Human Services should:

a. Establish requirements for case workers and client managers to regularly meet alone with youth.

b. Train case workers and client managers in the evaluation of treatment plans and methods to evaluate plan compliance.

c. Develop procedures to require supervisors to evaluate compliance with standards by case workers and client managers.

Department of Human Services Response:

Agree. Estimated Completion Date: No later than July 1, 2003.

a. The Department will establish a requirement for case workers and client managers to meet alone with youth during their scheduled periodic visits.

b. Case workers and client managers will be provided guidance in treatment plan evaluation and plan compliance.

c. The Department will establish a requirement for supervisory review of case worker/client manager compliance with standards.

Improve Out-of-State Monitoring Standards

In recent years both the Division of Youth Corrections (DYC) and the counties placed youth with out-of-state providers. At the time of our audit, DYC had approximately 267 youth at 8 out-of-state providers, while 16 counties placed 54 youth at 19 out-of-state providers. With the recent opening of the 500-bed Ridgeview facility, DYC plans to return most of its youth to Colorado providers within the next year. It will, however, continue to use a couple of out-of-state facilities that provide unique services. According to information we received from county case managers and representatives of the Division of Child Welfare, counties elect to place youth at out-of-state providers because they have either failed in numerous in-state placements, no in-state facility is willing to serve the youth, or the out-of-state facility has the ability to better meet the needs of the youth. Both DYC and the counties have developed strict monthly face-to-face meeting requirements for youth residing with Colorado providers. However, the standards for contact with youth placed out-of-state are much less stringent and vary widely. We have concerns that youth placed out-of-state have less contact with their local support systems and therefore need the assurance of consistent contact including regular face-to-face meetings with their case worker or client manager.

DYC mandates that its client managers have at least monthly face-to-face contact with youth placed at in-state providers. No comparable standard exists for youth placed out-of-state. However, one DYC regional director noted that DYC policies do require client managers to have monthly contact with the youth to determine the youth's progress in placement. He interprets this to mean that out-of-state youth should have at least telephone contact with their client managers on a monthly basis. The Division also monitors out-of-state providers on a quarterly basis. DYC representatives indicated that each DYC youth is interviewed as part of these quarterly monitoring visits. However, meeting face-to-face with all youth during these monitoring visits is not specifically required

by the monitoring rules. In our interviews, DYC client managers also reported that some regions send client managers to out-of-state facilities on a monthly basis. During these visits client managers speak with all youth placed by that region, providing these youth with the opportunity for monthly face-to-face meetings with a DYC client manager.

Similar to DYC, rules governing out-of-home placement for children under the authority of a county require monthly face-to-face contact with youth placed in a Colorado facility. Out-of-state contact requirements include a minimum face-to-face visit once a year but not necessarily by a county representative. The face-to-face requirement could be handled by a public agency in the receiving state or a contract custodial agency in the receiving state. Additionally, the rules require monthly face-to-face or telephone contact with providers but not with the youth. We contacted three counties that had placed youth at out-of-state providers. Overall, representatives of these counties informed us that they currently exceed the once per year face-to-face contact requirement, but actual meetings with the out-of-state youth vary by county and provider. In addition, none of the practices detailed by the county representatives exist in written form and therefore may not be consistently enforced.

As part of our audit work, we contacted representatives from four states that send youth to Colorado RTC facilities to determine how often they have contact with their youth. The representatives stated that they are required to have regular contact with the youth while they are in Colorado including periodic face-to-face meetings. A representative from one state reported a requirement for monthly meetings. Representatives from two states detailed that their requirements are for quarterly visits with the youth. The representative from the fourth state informed us that youth are visited every six months. In addition, representatives from two of the states reported that they have weekly telephone contact with the youth and/or the treatment staff.

Youth placed out-of-state are cut off from their local support system. As a result, they need consistent contact with their client manager or case worker. Additionally, many youth placed out-of-state have numerous placement failures or special needs indicating the need for regular contact with their case worker or client manager. DYC, the Division of Child Welfare, and the counties have all acknowledged the importance of regular face-to-face meetings between the youth and their case workers as evidenced by the existing requirements for monthly visits with youth at Colorado providers. The same importance should be placed on contact with youth residing out-of-state.

Recommendation No. 16:

The Department of Human Services should amend current requirements for monitoring youth placed at out-of-state providers to require at least quarterly face-to-face meetings and monthly telephone contact.

Department of Human Services Response:

Agree. Estimated Completion Date: No later than December 1, 2002. The Department agrees that more frequent contact is needed for these children, either by the responsible county/youth corrections region or by the receiving state supervisory agency. We will develop standards and procedures for inclusion in Rule.

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