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An Audit Report on Contract Management at the Commission on Alcohol and Drug Abuse

December 2000

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A culture that did not rely on good management information to make decisions has hindered the Agency's effective monitoring and managing of state and federal funds. In addition, former management did not always follow business processes meant to award contracts to the best-qualified service providers and ensure providers spend funds appropriately. Eighty-three percent of the Agency's $180 million revised fiscal year 2000 budget went to substance abuse service providers.

Key Facts and Findings

- Mismanagement by former executives led to a budget shortfall reported in October 1999 that caused the Agency to reduce its fiscal year 2000 contracts by $23 million (13 percent).
- Agency-reported data indicates that although the Agency was able to spend 29 percent more than its original fiscal year 1999 appropriation, it did not meet several key performance targets primarily related to the number of clients served and the average cost of providing services during that year.
- The Agency's oversight of providers did not always identify those that spent Agency funds inappropriately. Visits to eight providers identified $791,000 in questionable costs. For example, the Agency reimbursed one provider for $82,000 worth of remodeling although the Agency approved a maximum of $25,000 in minor remodeling.
- In addition to problems with provider oversight, the Agency had problems that made it difficult to (1) select the best providers available, (2) protect its interests with strong contract provisions, and (3) pay providers reasonable amounts for services.

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This audit was conducted in accordance with Texas Government Code, Section 481.008.

Executive Summary

The Commission on Alcohol and Drug Abuse (Agency) faces the task of correcting a decade of serious management problems. The problems hampered the Agency's ability to ensure that contract funding was expended as intended. The Agency has begun to correct contract management problems by establishing a culture of accountability and revising its contract procedures for fiscal year 2001 contracts with providers. The Agency has also undergone significant changes in upper management, including the hiring of a new executive director in February 2000 and a new chief fiscal officer in November 1999.

Because of a culture that did not rely on good management information to make decisions, the Agency mismanaged state and federal funds, which led to a budget shortfall reported in October 1999. In addition, former management did not always follow business processes meant to award contracts to the best-qualified substance abuse service providers and ensure that providers spent funds appropriately.

Continue Improving Business Processes to Correct Long-Standing Problems

During fiscal years 1999 and 2000, the Agency did not sufficiently manage the money used to pay substance abuse service providers and did not prevent financial problems such as the budget shortfall it experienced in fiscal year 2000. In October 1999, Agency employees reported there was not enough money to fund existing fiscal year 2000 provider contracts. To maintain the 1999 level of service, the Agency reduced its fiscal year 2000 contracts by $23 million and received an additional $12 million in funding.

Statewide accounting and performance management systems indicate that even though the Agency was able to spend 29 percent more than its original fiscal year 1999 appropriations, it did not meet several key performance targets. The targets not met were generally for the number of clients served and the average cost of providing services.

The problems the Agency faces are long-standing and complex. Previous management made plans to improve operations after the conservatorship ended, and some changes were made to business processes. However, the planned changes were not fully implemented and conditions deteriorated over time.

Given this history, it is critical that all of new management's planned corrective actions be implemented. Once actions are implemented, the Agency should notify the Board of Commissioners (Board), the Health and Human Services Commission (HHSC), its internal audit department, and the State Auditor's Office that these actions have resulted in:

- Sound financial and management procedures, and oversight and controls over all phases of contracting.
- Information systems that meet the Agency's needs.

The Agency has a business plan, which it provides to oversight entities, that guides its management improvements. The Agency could report implementation of its corrective actions in this business plan. The oversight entities can then decide how to verify that business processes are working efficiently and effectively.

Strengthen the Four Phases of Contract Management to Improve Oversight of Service Providers

The Agency's contract management had problems that made it difficult for the Agency to ensure providers spent funds appropriately. Eighty-three percent of the Agency's $180 million revised fiscal year 2000 budget was used to contract for

substance abuse services. Safeguarding these funds depends upon the four phases of contract management (see Figure 1 on page 5 and Appendix 3):

- The procurement process should ensure the Agency selects the best-qualified applicants to provide services.
- Contracts between the Agency and the providers should have provisions to protect state and federal funds.
- The payment method should ensure the State pays a fair price for the services it receives.
- Oversight of providers should identify inappropriate spending.

Historically, the Agency has not taken sufficient action in the first three phases to prevent inappropriate spending. For example, visits to eight treatment providers identified $791,000 in questionable costs. Each of the eight providers, located throughout the state, had fiscal year 2000 contracts over $500,000. The Agency's former management had an opportunity to review the providers' proposed budgets early in the contracting process, but did not reject or reduce unreasonable costs.

Review Data for Accuracy and Use it to Determine Program Effectiveness

Agency decision makers do not have a reliable management information system, which makes it difficult to make decisions about substance abuse programs. Without accurate and meaningful information, the Agency and its oversight agencies cannot make good decisions about providing services to clients.

The Agency's information system is not always accurate or complete. In addition, the Agency does not have systems in place to ensure that performance measures are correctly calculated or reported at the provider level or at the Agency level.

The Agency has not used available information to analyze outcomes for its various programs, nor has it worked with other agencies to reduce reliance on self-reported outcome measures. Available information could help determine program effectiveness and identify best practices for other programs to duplicate.

Summary of Management's Response

The Agency's response indicates that it has implemented or partially implemented the recommendations in this report. For some corrective actions, more time is needed to complete implementation and to verify the change. Specific responses, which outline corrective actions taken by the Agency, are included at the end of each section of the report.

Summary of Objectives, Scope, and Methodology

The objectives of the audit were to evaluate the Agency's management of contracts for substance abuse services and to identify the cause of the budget shortfall in fiscal year 2000. To evaluate management of substance abuse contracts, we focused on determining whether substance abuse contracts:

- Were awarded to the best qualified applicants.
- Protected state and federal funds.
- Ensured that the State paid a fair price for services received.
- Were properly monitored to ensure contractor performance.

The scope of the audit included the Agency's fiscal year 1999 and 2000 contracts for prevention, intervention, and treatment

services and related policies and processes and included on-site visits to eight treatment service providers. Information from prior and subsequent fiscal years was considered as necessary.

The methodology for this audit consisted of collecting financial and performance information, performing audit tests and procedures, and analyzing and evaluating the results against established criteria.

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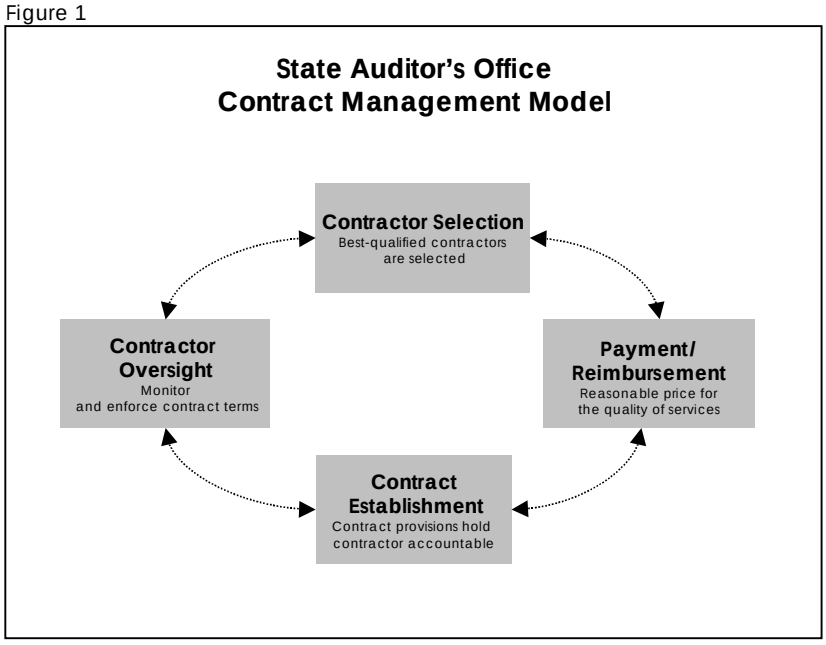
Overall Conclusion

The Commission on Alcohol and Drug Abuse (Agency) faces the task of correcting a decade of serious management problems. The problems hampered the Agency's ability to ensure contract funding was expended as intended. The Agency has begun to correct contract management problems by building a culture of accountability and revising its contract procedures for fiscal year 2001 contracts. The Agency has also undergone significant changes in upper management, including the hiring of a new executive director in February 2000 and a new chief fiscal officer in November 1999.

Figure 1



During fiscal years 1999 and 2000, the Agency mismanaged state and federal funds because of a culture that did not rely on good management information to make decisions. The mismanagement led to a budget shortfall reported in October 1999 that caused the Agency to reduce its fiscal year 2000 contracts by $23 million (13 percent). In addition, the Agency did not always follow its business processes meant to award contracts to the best-qualified substance abuse service providers and ensure providers spent funds appropriately. Visits to eight providers identified $791,000 in questioned costs (see Appendix 2). The Agency reports that services provided through contracts accounted for 83 percent of its $180 million revised fiscal year 2000 budget.

The Agency's problems, which new management is trying to correct, include:

- An environment that allowed the Agency and its providers to ignore business processes without consequences
- Inadequate information to make financial and other management decisions
- Insufficient actions at the beginning of the contracting cycle (see Figure 1 and Appendix 3) to keep providers from spending Agency funds inappropriately

Section 1:

Continue Improving Business Processes to Correct Long-Standing Problems

The problems current management faces are long-standing and complex.[1] Previous management's lack of focus on internal controls, which serve to give reasonable assurance of the accomplishment of an agency's mission, led to significant problems that were not detected promptly (see text box).

Internal Controls
An integral component of an organization's management that provides reasonable assurance that the following objectives are being achieved:

- Effective and efficient operations
- Reliable financial reporting
- Compliance with applicable laws and regulations

Source: U.S. General Accounting Office

Previous management made plans to improve operations after the conservatorship ended, and some changes were made to business processes. However, the planned changes were not fully implemented and conditions deteriorated over time. Given this history, it is critical that current management implement all planned corrective actions, such as creating a culture of accountability and improving Agency information systems.

Section 1-A:

Continue to Create an Environment That Supports Controls

The weak control environment under the previous management created conditions in which business processes could be ignored. Also, oversight entities did not have reliable financial and performance reports to detect problems. In fiscal year 1999, the Agency had poor financial controls and failed to achieve several key objectives. Current Agency management has begun to correct problems by establishing a culture of accountability and revising its contract procedures for fiscal year 2001 contracts.

The Agency's environment allowed management and employees to ignore or circumvent established rules and processes without consequences. In 1995 when the Legislature placed the Agency under conservatorship, the conservators created policies and procedures and a system of internal controls to regulate the Agency's operations. After the conservatorship ended, the Agency focused its priorities on spending funds and rebuilding its provider base instead of being accountable for how the money was used. The Agency regularly disregarded or rescinded controls when management felt the controls conflicted with priorities.

Due to the previous management environment, Agency employees were reluctant to report to higher authorities questionable actions made by providers, peers, and management. In interviews, employees recounted many stories about provider abuses like those the Agency reported in *State of TCADA*.[2] One story was of a provider with two employees and two clients who spent about $80,000 in equipment (mostly

[1]Current management includes the Agency's executive director and the three branch deputies. The Executive Director started in February 2000, the Deputy of the Finance and Administration Branch (chief fiscal officer) started in November 1999, the Deputy of the Program Branch started in February 1999, and the Deputy for the Licensing and Enforcement Branch (previously Quality Assurance Branch) started in March 1999.

[2] *The State of TCADA*; Jay Kimbrough, J.D., Executive Director; August 1, 2000.

computers) on the last day of its contract. An Agency auditor found three computers on each desk and others unopened in boxes.

Poor management information and a weak internal audit department under previous management hindered oversight activities by the Board of Commissioners (Board) and the Health and Human Services Commission (HHSC).[3] The Board and HHSC could have detected problems if they had received financial and performance reports on a regular basis as discussed in Section 1-C. Also, the internal audit department could have detected problems and reported them to the Board if it had tested control systems. However, the internal audit department has been cited for serious weaknesses four times since 1993 (see Table 1). In May 2000, the State Auditor's Office reported that internal audit was ineffective in assessing the adequacy of the Agency's internal controls. Executive management, the Board, and the internal audit department play a critical role in the effectiveness of internal controls. Management puts controls in place, the Board checks to ensure that objectives are being achieved, and the internal audit department reports on the adequacy of the controls.

Table 1

Prior Findings Regarding the Agency's Internal Audit Department	
Source	**Finding**
The 1999 Statewide Single Audit Report (May 2000, SAO Report No. 00-555)	The internal audit function was ineffective in assessing the adequacy of the Agency's internal controls. Although documentation of work performed had improved, it continued to be inadequate because internal audit did not comply with auditing standards for three out of four projects.
A Report on the 1998 Financial and Compliance Audit Results (June 1999, SAO Report No. 99-555)	The internal audit department did not complete any of the five planned audits for fiscal year 1998, nor was there documentation of other audit work performed during the year.
An Audit Report on the 1997 Financial and Compliance Audit Results (June 1998, SAO Report No. 98-041)	Internal audit deficiencies include: • Insufficient communication between the Board, executive management, and the internal auditor • Lack of compliance with the internal audit charter regarding the annual evaluation of the internal auditor, biannual Audit Committee meetings, and Audit Committee membership reappointment • Lack of Board approval for audit plan revisions
Review of Management Controls (September 1993, SAO Report No. 94-001)	The Agency's internal audit function is not a reliable management control because its contracted internal audit function: • Has not been independent of management • Has not developed mechanisms to review multiple levels of the agency for changes that could affect the audit plan • Has not made required annual reports to the Governor and others as required

[3] House Bill 2641, effective September 1999, gave the HHSC greater authority over health and human service agencies, such as authority over management of daily operations and effective use of federal funds.

The prior management environment allowed financial controls to become lax, which led to the Agency facing fiscal year 2000 with $27 million less than estimated and with contracts that had to be reduced by $23 million (13 percent). According to the Agency, it initially contracted for $173 million in services, then limited contracts with over 200 service providers to $150 million because of the shortfall. (See text box for an explanation of what led to the budget shortfall.)

What led to the fiscal year 2000 budget shortfall?

In 1997, the Agency adopted a risky budgeting strategy that caused serious consequences two years later. This strategy required the Agency to set its budget and write contracts in excess of revenues. The underlying assumption in this budget strategy was that, overall, provider spending would not exceed available revenues. The goal was to liquidate a cash surplus by increasing service levels and expanding the provider base. To do so, the Agency encouraged providers to raise their expenditures and increase services.

The Agency had surplus cash because the federal government increased Texas' block grant at the same time the provider community was weakened by scrutiny from the Joint General Investigating Task Force. In 1995, the task force and the Legislative Audit Committee had recommended that the Agency be placed under conservatorship. In April 1995, the Agency became the first agency in the history of the State to be placed under the control of a State Conservatorship Board. Unexpended federal dollars further increased in 1999 when the federal award to Texas grew by $33.3 million above the 1998 award amount of $89.2 million.

Under pressure to spend the funding or return it to the federal government, the Agency awarded providers more funds than it thought would be spent. This strategy allowed the Agency to use funds left over from the previous year's contracts (carry forward) to strengthen and expand services the following year.

However, the Agency did not have internal financial systems to closely or accurately monitor and project provider spending as required under this budget strategy. The Agency failed to track the carry forward balance on an annual basis, which resulted in overestimating the amount of money available for fiscal year 2000 contracts.

In October 1999, the Agency's former financial officers became concerned that there might not be enough cash for October if the Agency did not receive expected federal funds from a block grant until November. When it prepared the fiscal year 2000 budget in August 1999, former management estimated that the Agency would have $35 million in funds left over from previous block grants (called "carry forward"). However, the Agency did not thoroughly analyze the carry-forward balance until after it discovered the budget shortfall. The analysis showed that former management had been overestimating the carry-forward amount since fiscal year 1997. The Agency estimated that the carry-forward amount for fiscal year 2000 was about $35 million when it was closer to $8 million.

Because of the shortfall, the Agency had to rely on funding from other state agencies, which allowed it to serve as many citizens as it had served in fiscal year 1999. For fiscal years 2000 and 2001, the Legislative Budget Board authorized the Agency to use up to $12 million per year of Temporary Assistance for Needy Families funds that other state agencies did not use.

Reports from statewide accounting and performance management systems indicate that, although funding was increased in fiscal year 1999, the Agency did not achieve key objectives to serve as many clients as targeted. According to data from the Uniform Statewide Accounting System, the Agency had available and spent more than the Legislature originally appropriated for the 1998 and 1999 biennium. (See Appendix 4 for original appropriation and actual spending figures.) At the same time, the Agency reported to the Automated Budget and Evaluation System of Texas (ABEST) that it did not meet some performance targets for the number of clients served and the average cost of services. For example, for fiscal year 1999, the Agency reported:

- The number of youth served in prevention programs was 30 percent lower than its goal.
- The average cost for adult prevention services was 90 percent higher than its goal; youth prevention services was 248 percent higher than its goal.

(See Appendix 4 for selected performance measures for the 1998-1999 biennium.)

New Agency management has begun correcting problems, as outlined in its Business Plan, by taking the following actions:

- The Agency is establishing an environment of accountability. The Agency, the Board, and the internal audit department have undergone various changes:
  - The Agency implemented an integrity program in February 2000. All staff members were required to sign a document that informed them of their responsibility to report their concerns and all violations of law and ethics to their supervisor, any member of executive management, or the State Auditor's Office.
  - Fiscal year 2001 contracts include a provision requiring the chief executive officer to report to the Agency or the State Auditor's Office any knowledge of suspected fraud, program abuse, possible illegal expenditures, or unlawful activity.
  - In March 2000 the Board created a Budget and Planning Committee to monitor the Agency's financial activities more closely. Beginning in February 2000, the Agency also began to provide monthly financial reports to the Board.
  - In April and July 2000, the Agency's internal audit director and only staff member resigned, which resulted in complete turnover in that department. The Board hired a new internal audit director in June 2000, and by October 2000, the department staff had grown to three auditors. The internal audit department is reviewing its charter and partnering with a private accounting firm to identify the areas that most need the attention of the internal audit department.
- The Agency is strengthening contracting processes by revising its rules and contracts with service providers for fiscal year 2001 contracts (see Sections 2 through 5).

Recommendation:

The Agency should:

- Continue to implement the corrective actions in the Agency's Business Plan and additional recommendations in this report. As the Agency implements actions to correct problems, it should notify the Board, HHSC, the internal audit department, and the State Auditor's Office through progress updates. The Agency could include these progress updates in its business plan to notify

these oversight entities on the status of corrective actions. Upon notification of completed corrective action, these oversight entities should determine how to verify that business processes are working efficiently and effectively.

- Create a process for ensuring that allegations of ethical or legal lapses are investigated and acted upon.

Management's Response:

We agree that prior management's lack of focus on key management controls contributed to an environment that led to the Agency's financial problems. Current management, under the leadership of a new executive director, has taken significant steps since February 1, 2000 to build a culture of accountability at this agency.

Creation of the TCADA Business Plan and implementation of the Agency Integrity Program (AIP) represent key steps taken by current management to correct prior problems and build a control environment focused on accountability. Recommendations made in this report will be incorporated in the Business Plan for implementation and distributed to Agency management and all relevant oversight agencies periodically. In addition, the AIP adopted on February 9, 2000 describes the process for ensuring that allegations of ethical or legal lapses are investigated and acted upon.

As noted in the State of TCADA *report (www.tcada.state.tx.us/info_research /stateoftcada.pdf), issued August 1, 2000, the current management team at the Commission on Alcohol and Drug Abuse is committed and determined to build a culture of accountability at this agency.*

Section 1-B:

Ensure Information in Agency Computer Systems Is Accurate

The Agency's information system is not always accurate or complete. Results of tests of the Agency's Integrated Management System indicate information is unreliable. Financial data from service providers and the Agency are consistently more complete than information about clients. However, both types of information contain errors. Without accurate and meaningful information, the Agency and its oversight agencies might find it difficult to make good management decisions.

Problems with the Agency's information include:

- Some important client-related data fields have missing and potentially invalid data values that the Agency cannot explain. (For example, the field for gender might contain a "2" instead of an "M" or "F.") Providers enter some of this information, but it must pass through Agency-administered data validation routines before the Agency's computer system will accept it.
- The computer system has substantial data input edit flaws that the Agency is still correcting. Data input edits do not allow invalid data to be entered into

the system. These edit flaws should have been detected before using the software in daily agency business. Data integrity testing revealed that invalid values were entered into the system during fiscal year 1999.

- The Agency's automated system overstates the number of amendments to contracts because it identifies any change to the budget as an amendment. For fiscal year 1999, the system erroneously identified 128 budget changes as amendments. These budget changes were the result of consolidating contracts before the beginning of the fiscal year.

Without effectively and accurately verifying data entered in critical computer systems, the Agency may not have complete and accurate information about its clients or its finances, making it difficult to provide effective treatment and prevention services.

The Agency reported at the time of fieldwork that it was testing data entry input edits for portions of the Integrated Management System.

Recommendation:

The Agency should:

- Complete testing of data entry input edits currently being conducted for portions of the Integrated Management System. The Agency could do this by using computer programs to analyze the data values, frequencies, and ranges of the existing data files to ensure that they are valid. The root cause for any discrepancies should be identified and system repairs should be made if necessary.
- Verify the integrity of key data files currently in the computer system.

Management's Response:

Edit checks will be re-evaluated by agency personnel by January 31, 2001. Any discrepancies detected will be immediately corrected. The data integrity issues identified by the state auditors will be included in this re-evaluation process. The Agency also plans to develop and run data integrity monitoring reports, at least semi-annually, to test billing and client data to check for any mismatches within the two sets of data. Any discrepancies detected will be immediately corrected.

Section 1-C:

Establish a Standard Reporting Process to Give Decision Makers Needed Information

The fiscal year 2000 budget shortfall demonstrates that Agency decision makers need accurate reports on finance, programs, and operations to monitor the Agency's performance. (See text box for comments on the Agency's lack of data.) In February

Lack of Data

"...many of the problems that [the Agency] has experienced have been due to the lack of timely data, the lack of accurate data, or the complete absence of data at all. This issue was a factor in every aspect of agency performance. However, when accurate and timely data was available, it does not appear to have been used in decision making."

Source: *Texas Commission on Alcohol and Drug Abuse Process Review Report*; Health and Human Services Commission; January 21, 2000

2000, the Agency began producing detailed monthly financial statements for the Board and executive management. However, the Agency's information system does not produce these reports automatically. Staff members must prepare customized or ad-hoc reports, which increases the risk that the reports will be incomplete or inaccurate.

Although the Agency spent $3.9 million between 1997 and 1999 on its Integrated Management System, the system did not include a report design feature. Moreover, the Agency did not begin to plan how to create reports until after the system was in operation for two years. Report design is a feature in automated systems that helps ensure that the most current data is used to make decisions. Report design is usually included in costly systems designed specifically for a given agency.

To generate reports, Agency employees must extract data from the Integrated Management System and use other computer programs to analyze it. This extra step creates problems because:

- The Agency does not have adequate quality control standards or procedures to ensure that reports created from the Integrated Management System are consistently complete and accurate. Because each staff member could extract data and analyze it in a different way, there are insufficient assurances that decision-making reports will be consistent or accurate.
- The Agency's reliance on customized and "ad hoc" reporting creates a significant risk that critical reports will not be available if key employees leave. In fact, the Agency had a difficult time preparing certain May 2000 reports because personnel who prepared these reports left the Agency.

Recommendation:

The Agency should:

- Establish formal quality control procedures for report generation. These procedures should address automated reports generated by departments as well as those generated by centralized information technology staff members.
- Document the computer programs currently used for customized, periodic, and ad-hoc reporting, so that knowledge of how to create the reports will be retained.
- Ensure that more than one person is familiar with computer programs and the report generation process, thereby creating a backup for the process.
- Formally assess the feasibility of integrating report generation into the existing computer system.

Management's Response:

The Agency created a report portal to its data warehouse, the Query Reporting System (QRS), to satisfy its reporting needs. One component of this system is an intranet site, QRS Central, that features an extensive menu of available reports that can be run by agency staff. Reports are added to QRS Central only after a quality review by the data warehouse manager is performed. QRS Central is meant to be a continually evolving resource. Reports will be added as required and developed by staff. QRS Central was implemented and available to all Agency employees effective October 2000.

The data warehouse manager has also begun a series of assisted tutorials that will transfer report generation knowledge to certain users across the agency to enable them to run ad-hoc reports. The need for additional tutorials will be assessed quarterly with consideration of staffing levels and departmental need for ad-hoc reports. Deputy Directors and/or Division Managers will assist in identifying personnel assigned to prepare ad-hoc reports.

Section 2: CONTRACTOR SELECTION

Continue Improvements to Provider Selection Process

Prior to fiscal year 2001, the Agency's process for selecting contractors resulted in the award of some funds to applicants that performed poorly, were financially unstable, or that owed money to the Agency. (See text box on contractor selection.) Previous Agency management did not always consider contractors' past performance and financial data when renewing and awarding new service contracts.

Contractor Selection

The procurement process should be sufficient to ensure that the best contractors are fairly and objectively selected.

(See Appendix 3 for more information.)

As the Agency moves to consistently contract with providers who best satisfy application criteria, it might have difficulty finding qualified applicants in a given region. The Agency's commitment to follow its selection process beginning with fiscal year 2001 contracts resulted in the Agency initially being unable to award almost $1.3 million earmarked for services in the Panhandle region. All funding was not initially awarded because a number of applicants failed to get acceptable scores. The Agency plans to award the remaining funds to community organizations that can provide the needed services to Panhandle clients.

To improve the efficient use of available substance abuse services, the Agency can also:

- Improve the system for matching available beds and individuals on waiting lists.
- Identify funding available to transport poor and priority individuals, such as pregnant substance abusers, to locations where services are available.

Section 2-A:

Revise Capacity Management Program for Efficient Use of Substance Abuse Services

The Agency is at risk of not complying with federal block grant requirements to develop capacity management and waiting list systems. The Substance Abuse Prevention and Treatment Block Grant, which awarded the Agency $124 million in fiscal year 2000, requires that the Agency comply with requirements to develop capacity management and waiting list systems for intravenous drug users and pregnant women.

In its 1996 review of the Agency, the Sunset Advisory Commission recognized that an inadequate range of treatment might increase the State's costs because providers cannot move clients into less expensive levels of treatment when warranted. Substance abuse and dependency treatment is a continuum of various levels of intensity and care. (See Appendix 5.)

According to the Agency, it provides a continuum of services on a statewide, not necessarily regional, basis. However, to access services throughout the state, it is necessary to match individuals on waiting lists to available beds. The Agency must also do what it can to remove barriers to services, such as providing transportation for poor and priority populations.

In fiscal year 2000, the Agency awarded $186,212 to a contractor to match individuals on waiting lists with available beds, but the Agency is not receiving the service it expected. The Agency requires treatment providers to report available capacity and waiting list information to its capacity management contractor every day. However, visits to eight providers indicated that providers:

- Are unaware of this reporting requirement.
- Report the wrong information.
- Under-report available beds or do not maintain waiting lists.

In addition, the contractor generally does not try to match individuals on waiting lists to available beds because of inaccuracies in and poor access to the information. As a result, the contractor has set up its own parallel system. When someone calls asking for a referral, a telephone operator calls providers in the prospective client's service area instead of using the automated system to find an available bed.

The Agency does not currently provide transportation for priority and poor clients who must travel to receive services. A common barrier that prevents women from seeking substance abuse treatment is the lack of transportation. If there is no treatment available in the prospective client's area, that person must travel to where the treatment is offered.

Recommendation:

The Agency should:

- Continue to work closely with communities to identify possible gaps in service and develop a strategy for filling them.
- Review the current method of matching available beds to individuals on waiting lists to maximize available resources.
- Give providers additional training on how to maintain and report waiting lists and available beds.
- Consider making funds available to transport poor and priority individuals to locations where services are available.

Management's Response:

Currently through the procurement process as outlined in the Statewide Service Delivery Plan, the Agency identifies services to be purchased to create a Regional Continuum of Care, based on needs assessment data and other relevant information. Through the available funds, services are purchased to address the substance abuse needs in the identified communities in the regions. The Agency uses Regional Advisory Consortia (RACs) and public hearings conducted biennially throughout the state to gather additional information on local needs, gaps in services, and recommendations on how to improve the distribution of services.

Effective December 1, 2000, the Agency changed the Capacity Management System, initiating an on-line system by which every program reports daily as to its bed and outpatient slot capacity. Each program in the state can access these data to maximize available space and to decrease the size of the waiting lists. This system provides a management tool to enable the Agency to monitor utilization of each program on a daily basis.

Providers were notified about changes to the Capacity Management System with instructions for its use. Additional training will be provided to treatment providers as the system is enhanced. Agency staff will be trained in each step of the process.

The Agency allows providers to charge costs related to transporting individuals seeking services. Transportation expense can include, but is not limited to, public transportation costs, taxicabs, and provider-owned vehicles.

Section 2-B:

Continue Efforts to Select Best Contractors

In the past, the Agency did not always comply with its previous selection process, as described below. The Agency reports that it is committed to following its revised selection process for fiscal year 2001 contracts.

The Agency did not always award contracts in compliance with its previous contractor selection process. Failure to follow the established selection process increases the risk that the best contractor will not receive the contract award. Problems in the selection process used during fiscal years 1999 and 2000 included:

- Relevant information about applicants was not considered by the Agency. Peer review comments were not available to Agency teams reviewing fiscal year 2000 proposals because the peer review and the Agency's review were performed at the same time. Consequently, program weaknesses identified by experts on the peer review teams were not considered when assigning application scores.
- Six treatment programs totaling $1,370,360 were funded in fiscal year 2000 through a financial assistance payment mechanism although the Agency's request for proposal stated that all treatment programs would be reimbursed based on a unit cost basis (not financial assistance). No documentation was available on why this decision was made.
- On two occasions involving fiscal year 1999 contracts, the Agency's former executive director made decisions outside of the normal contracting process. These actions included adding $615,291 to selected providers' contracts with only one month left in the fiscal year. Also, management awarded $2,868,169 in new contracts. According to Agency staff, these awards were made to providers that did not submit applications, submitted late applications, or scored too low to receive a competitive contract award.

Former management did not always use criteria to select providers for non-competitive awards and identify awards for easy tracking to ensure funds were spent as intended. In 1998, the Agency created a plan for awarding $10 million to providers as one-time awards to decrease its large unexpended balance. Providers were to spend the funds during fiscal years 1998 and 1999. However, we noted the following problems with how funds were awarded and tracked:

- Former management failed to develop criteria for all the categories of programs and services it planned to fund with the $10 million. Some categories had criteria, but management did not follow the criteria when awarding funds.
- Agency funds were not awarded as outlined in the Agency's plan. For example, the Agency awarded some providers additional funding to increase space in ongoing programs, instead of using the funds on nonrecurring programs and services as originally intended.

- The Agency did not track how providers spent the $10 million or verify if funds were spent as intended. The Agency was unable to track the funds because it did not issue new contracts for the one-time awards. Instead, it amended existing contracts and rolled the one-time funds into those contracts. This process made it impossible to differentiate between existing funds and the one-time award funds. Communication among the Agency's departments was poor. The budget department was not kept informed of the contract award information, so it could not track the awards and expenditures.

Given the problems noted above, the Agency was unable to show specifically how this $10 million in funding was spent.

Recommendation:

The Agency should:

- Continue efforts to make available and consider all pertinent applicant information to ensure the selection of the most qualified applicants. This includes improving processes for compiling provider information such as historical performance data, financial data, and peer review comments so information is readily available during the procurement process.
- Develop and consistently use criteria for non-competitive awards and identify those awards so they can be easily tracked to ensure they were spent as intended.

Management's Response:

We agree that former management did not always follow the contractor selection process. Current management is committed to establishing controls and processes to achieve accountability and ensure the effective use of state and federal funds. The process used to select new contractors and renew existing contracts experienced significant revisions in fiscal year 2000. The new process includes consideration of several factors, including historical performance, financial data, and peer review comments for each applicant. This new process was used for the procurement of prevention, intervention, and treatment services for fiscal year 2001. More importantly, this new procurement process was strictly followed.

The Agency has proposed revisions to Chapter 143 – funding rules that outline the parameters for funding when it is not feasible to use a competitive process. Once the revised rules are adopted by the Board, procedures will be established that include developing criteria, tracking and monitoring non-competitive contracts.

Section 3: CONTRACT ESTABLISHMENT

Enforce and Enhance Contract Rules

Contract Establishment

Contract provisions and agency regulations should be sufficient to hold contractors accountable for delivery of quality services and prevent the inappropriate or inefficient use of public funds.

(See Appendix 3 for more information.)

The Agency did not always follow contract provisions restricting how public funds should be spent. Also, the Agency's contracts for fiscal year 2000 did not include all the provisions necessary to hold providers accountable. Contract provisions are needed to clearly identify what is being purchased, how the Agency will evaluate if the contractor's performance was satisfactory, and what rules and regulations the contractor must follow. (See text box on contract establishment.)

Section 3-A:

Enforce Rules on Spending Limits and Prior Approval

Visits to eight substance abuse treatment providers identified two instances in which the Agency paid at least $70,917 for unapproved expenditures or expenditures that exceeded the approved amount. (Each of the eight providers, located throughout the state, had fiscal year 2000 contracts over $500,000.) In one case a provider did not request prior approval for expenditures as required, and also exceeded the designated spending limits. For example:

Examples of Questioned Costs

Remodeling	$57,000
Fixed Assets	$13,917
Total	**$70,917**

- In fiscal year 1999, the Agency approved $25,000 to remodel a provider's leased building. However, the final remodeling cost was $82,000 or $57,000 over the approved amount. The provider notified the Agency of the increase after the remodeling was complete.
- A provider purchased equipment totaling $13,971 without receiving prior written approval as required. According to the provider, an Agency contract specialist verbally approved these purchases during a phone conversation. The provider did not have any written documentation to show that purchases were approved.

The Agency has adopted new contract rules that (1) clarify under what circumstances the Agency will pay and (2) limit how much the Agency will pay. These new rules:

- Limit costs for minor remodeling to an aggregate of $5,000 per year.
- Clarify that if a program is funded only in part by the Agency, the Agency may be charged only the percentage of minor remodeling costs that reflects the percentage of funds the Agency contributes to the program.

Recommendation:

The Agency should:

- Compare approved requests for remodeling and equipment against actual costs charged to the Agency to ensure that providers do not exceed approved limits.
- Refuse to pay providers when their expenditures exceed limits or do not have prior Agency approval.

Management's Response:

The Agency reviewed and updated Agency contract rules effective September 1, 2000, to lower the limit for minor remodeling costs that may be charged to Agency awards. Agency policy now directs that approval to expend funds for minor remodeling will be granted only if the work is necessary to support an Agency funded substance abuse program.

To ensure that providers comply with Agency requirements for using Agency contract funding for minor remodeling, all requests to expend grant funds for minor remodeling are now reviewed and approved for programmatic necessity before providers are allowed to expend funds. A review of proposed provider requests to perform minor remodeling with Agency funds is conducted during the budget review process that occurs during the annual evaluation of new contract applications and contract extensions.

As part of the ongoing provider oversight process, the fiscal contract management section now performs a routine review of reported actual expenditures to ensure that providers are complying with the fiscal requirements of their Agency contracts. Appropriate steps, including suspension of payments to providers, will be used when non-compliance is detected.

Section 3-B:

Enforce Rules Limiting Contract Amendments

During fiscal year 1999, some providers did not follow their approved budgets because the Agency generally approved budget amendments to accommodate actual spending practices. The Agency did not consistently comply with its requirement to amend contracts. For fiscal year 2000, Agency rules required that all requests for contract amendments be received at least 60 days before the end of the contract period, barring extenuating circumstances.

In fiscal year 1999, before the 60-day rule was in place, providers amended their contracts so they could spend remaining contract funds instead of allowing the Agency to use these funds for services the following year. Agency data showed that 69 of 238 (29 percent) amendments to fiscal year 1999 contracts occurred after July 1,

1999 (the date after which Agency rules said amendment requests would not be accepted). Through these amendments, about $842,000 was transferred. Of the 69 amendments, 36 occurred after the end of the contract period.

Also, budget amendments did not always appear reasonable because they gave providers large sums of money to spend over a short period of time. Examples that demonstrate problems with fiscal year 1999 budget amendments include:

- Two providers' annual budgets were increased by $148,597 and $104,055 for new or expanded programs during the third quarter of the fiscal year.
- One provider was awarded an additional $96,000 less than two weeks before the end of the fiscal year because it reported increased capacity.
- One provider transferred $94,000 from one contract to another two days before the contract ended.

The Agency's fiscal year 2001 contracts include stricter limits on amendments. In its rules, the Agency replaced the contract amendment reference with a contract provision that, unless waived, restricts the provider from requesting an amendment during the first or last 90 days of the contract term.

Recommendation:

The Agency should notify oversight entities when the new contract provision limiting amendments are implemented so that oversight can verify that the new provisions are enforced and working as intended.

Management's Response:

Effective September 1, 2000, the Agency included in its fiscal year 2001 contracts, language that limits requests for contracting amendments within the first 90 days and the last 90 days of the contract term, unless waived by the Executive Director. In addition, effective September 1, 2000, the Agency requires providers to submit an inventory of Agency owned property at closeout (within 60 days after the close of Provider's fiscal year) and request disposition instructions if necessary. A statement will be added to the Business Plan so oversight agencies will be aware that the new contract language has been implemented.

Section 3-C:

Continue to Strengthen Contracts to Increase Provider Accountability

The Agency's contracts for fiscal year 2000 did not include all provisions necessary to hold providers accountable, such as requirements for inventories of assets purchased with Agency funds and disclosure of related parties. Also, some contracts did not include performance targets necessary to ensure contractors provided purchased

services. The Agency has revised fiscal year 2001 contracts, which now require providers to conduct an annual physical inventory of all equipment and controlled items purchased with Agency funds.

Fiscal year 2000 contract provisions did not require providers to report assets purchased with Agency funds. Some providers had no current inventory of equipment and had not placed inventory tags on equipment. Inventory tags would help providers track equipment and would be beneficial during physical inventory. Without an inventory report, it is difficult for the Agency to take possession of state-owned equipment when its contractual relationship with a provider ends. The Agency could also use an inventory report to determine if requests for equipment are reasonable (see Section 4-A) and ensure that purchased items match those approved by the Agency.

Related party: a person or organization related to the provider through common ownership (including an immediate family relationship) or any association that permits either entity to significantly influence or direct the actions or policies of the other.

Related-party transaction (or "less-than-arms-length"): a transaction in which there is an exchange of services, equipment, facilities, or supplies between the provider and the related party.

Agency contracts do not require providers to disclose related-party transactions. (See text box.) Related-party transactions are commonplace among providers. The risk that related parties might use undue influence is greater when the parties have a great deal of authority over financial matters, such as members of management or board members. For example, a consultant who received $66,000 for consultant services in fiscal year 2000 was president of the provider's board in 1998. The following relationships existed between another provider's employees:

- The chief executive officer and chief operating officer were married.
- The director of screening and a clinical director were married.
- The director of human resources and a clinical director were married.
- The social services coordinator and a clinical director were married.
- The chief operating officer and an evaluator/researcher were brothers.

While not always inappropriate, related parties provide an opportunity for the misuse of state funds through related-party transactions. For example, in 1999, a grand jury indicted a husband and wife for forgery and theft. The couple, who served as director and assistant director of a rehabilitation program, stole more than $20,000 in checks from the State of Texas and a substance abuse facility.[4]

At a minimum, contract provisions should do the following:

- Define "related party."
- Require contractors to maintain documentation sufficient to allow the Agency to ensure the appropriateness of these arrangements.
- Make specific reference to applicable state regulations and federal circulars that govern related-party transactions.

[4] *Special Investigations Unit Report Regarding the Cottage*, SAO Report No. 00-001, September 1999.

Some prior year contracts for services other than substance abuse services did not have performance targets. Without specific performance goals, it is difficult for the Agency to hold the provider accountable for under-performing or to make future award decisions. (See Section 2-B.) Examples of services purchased through contracts that did not include performance targets are as follows:

- Operation of the Capacity Management Program. The contractor was awarded $186,212 for fiscal year 2000 to operate the program. For problems with the program, see Section 2-A.
- Development of the Agency's Integrated Management System. During fiscal years 1998 and 1999, the contractor was paid $3.9 million, which was $1.2 million more than the amount approved in the original and amended contracts.

Recommendation:

The Agency should:

- Conduct oversight to ensure that providers are complying with recent contract changes
- Address related-party transactions in all contracts
- Include performance targets for all contracted services

Management's Response:

In the summer 2000, the Agency established Contract Oversight Teams to provide comprehensive oversight of providers' compliance with contract provisions and rules. Project Officers regularly review information on their assigned providers. A key element of the oversight process is QRS Central, an electronic data repository in which detailed reports of provider activity are compiled and stored. When on-site visits occur, Project Officers can verify compliance with contract changes. To help providers reach and maintain compliance with contract and rule changes, the Agency continues to provide training and technical assistance.

As of September 1, 2000, Agency fiscal staff have begun to perform regular reviews of actual expenditures to ensure that providers are complying with the fiscal requirement of their Agency contracts. These reviews include verifying that providers have provided all required documentation for requested contract changes, that approved expenditure limits for certain categories of expense have not been exceeded, and that overall expenditure levels are reasonable as compared to approved budgets.

Future funding solicitations will require a related-party disclosure from all applicants. For fiscal year 2002, the contract general provisions will be reviewed for specific related-party language.

All Agency contracts, both service and non-service, now have established performance goals, targets, and/or expected deliverables.

Section 4: PAYMENT/REIMBURSEMENT METHODOLOGY

Ensure That Contractors Use State and Federal Funds for Intended Purposes

Payment/Reimbursement Methodology

Methods used to establish contractor reimbursement should be sufficient to ensure that the State pays a fair and reasonable price for services.

(See Appendix 3 for more information.)

The Agency did not scrutinize providers' proposed budgets to detect unreasonable items or ensure that providers are charging the Agency only for its fair share of expenses. Moreover, the Agency continues to pay providers unit rates per services without completing an analysis of how much the services should cost. (See text box on payment/reimbursement methodology.)

To ensure funds are spent as intended, controls are needed that complement the payment/reimbursement method. For example, proposed budgets should be reviewed under the cost reimbursement method, and rates should be validated under the unit rate payment method. A State law in effect since September 1999 requires agencies to reevaluate payment methods and rates for purchased client services at least biennially. Performing both budget reviews and rate validations for the same programs is not necessary.

For fiscal year 2000 contracts, the Agency used a unit-cost payment method that was actually a hybrid of the fee-for-service method and the cost reimbursement method. Under this hybrid method, the Agency reimbursed providers only what it cost to provide a service, as long as the cost did not exceed a maximum rate. Beginning with fiscal year 2001, the Agency will use a unit-rate payment method.

Based on the payment method used, the Agency needs to:

- Ensure that proposed expenses are reasonable and are necessary to accomplish the program's objectives.
- Verify that costs charged to the Agency and to providers' other funding sources are allocated appropriately and accurately so that the Agency does not pay more than its fair share of operating costs.
- Set rates that reasonably correlate program costs and the quality of services being delivered to the rates the Agency pays.

Section 4-A:

Review Providers' Budgets and Expenditures for Reasonableness

Examples of Questioned Costs

Contractors	$ 80,000
Headquarter Fees	$ 15,788
Vehicles	$ 131,842
Total	**$ 227,630**

The Agency approved unreasonable budget requests and other unallowable items. Visits to eight providers identified $227,630 in questioned costs that providers charged to the Agency. A factor for determining if a cost is allowable is whether the cost is reasonable for the contracted services. The federal government says a cost is reasonable if, in its nature or amount, it does not exceed the costs a prudent person would incur.

By not critically reviewing provider requests and rejecting or reducing unreasonable budget items, the Agency has made it more difficult to identify and question unreasonable costs after the fact. If an Agency auditor later questions a cost that was included in the provider's approved budget, the provider can become confused and distrustful of the Agency.

Visits to providers identified questioned costs charged to the Agency. Some of the provider expenses charged to the Agency were explicitly unallowed—such as late fees, luncheons, and gifts to volunteers—but these were generally for small amounts. Other expenses were questioned because they were unreasonable. The examples below highlight some of the questioned costs charged through fiscal year 2000 contracts:

- One provider paid two contractors a total of $74,000 to review its programs. However, the reviews did not appear to give the provider useful information to improve its programs. Another provider paid a contractor $6,000 ($1,000 per month) to review its programs during a six-month period in which it had a full-time employee devoted to reviewing its programs.
- During fiscal year 2000, a provider inappropriately paid $15,788 in program funds to its national office. Two percent of funding for women and children programs was paid to the service provider's national office although it did not provide specific services to support the programs.

The Agency could have prevented some of these unreasonable expenses when reviewing budget requests. Providers submit a line-item budget to the Agency for approval that includes items such as salaries, contractual services, and equipment. By requesting detail to support some of the most significant costs, the Agency could reject or reduce those costs it believes do not contribute to the success of the program. The Agency could also use this information to assess the reasonableness of its rates.

In some cases, the Agency did not realize that provider requests were excessive or unreasonable because it reviewed the requests in too narrow a context or did not review supporting documentation. For example, a provider acquired a fleet of 21 vans, some with Agency funds, over a 10-year period. In fiscal year 1999, the Agency paid for four of the vans—at a cost of over $101,850. The following year, the Agency paid for another van at a cost of $29,990. The provider requested the vans for individual programs, although most of the vans were kept at a central location and could have been shared. Had the Agency reviewed the requests as a whole and reviewed information on previous purchases, it might have rejected the requests. With the $131,842 spent on five vans, the Agency could have provided approximately 1,000 days of detoxification treatment to adolescents or over 2,060 days of residential treatment to adults.

Excessive equipment expenses can result in additional expenses in other categories, such as salaries. The provider in the example above had annual salary expenses of $111,800 because of its fleet. Total annual costs for a mechanic and eight drivers were $20,800 and $91,000, respectively. We were unable to determine how much of these salary costs were charged to the Agency, but we conservatively estimate that it

was about half. We based this estimate on our understanding of the provider's cost allocation method and on the percentage of funding the provider received from the Agency. We assumed costs to the Agency were proportional to funding to the provider.

Recommendation:

To ensure it does not approve unreasonable expenses, the Agency should evaluate budget requests for contracts paid by the cost-reimbursement method and request details for line items. At a minimum, the Agency should review contracted services, indirect costs, and equipment to ensure these items and the amounts requested are necessary to the program.

Management's Response:

For contracts effective fiscal year 2001, budgets are reviewed at the beginning of the contract period. As part of the ongoing provider monitoring process, the fiscal contract management section now performs a routine review of reported actual expenditures against budgeted amounts to ensure that providers are complying with the fiscal requirements of their Agency contracts. Changes to existing contract budgets requested by providers are now reviewed individually for programmatic necessity and to ensure that they conform to state and agency contract expenditure guidelines.

Section 4-B:

Review Providers' Cost Allocation Plans and Verify That Providers Use Them Properly

Examples of Questioned Costs	
Repair and Maintenance	$ 5,353
Salaries	$ 74,843
Total	**$ 80,196**

Prior Agency management did not guide providers on how to use cost allocation plans or require providers to submit cost allocation plans for review. Visits to eight providers identified $80,196 in costs that providers incorrectly charged to the Agency because of problems with their cost allocation plans. Providers use cost allocation plans to determine how their expenditures will be divided among their various funding sources, including the Agency. However, the Agency did not review plans to ensure that the Agency paid only its fair share of provider costs. Fiscal year 2001 contracts require providers to submit their cost allocation plans to the Agency as part of the contract renewal and award process. Once the Agency agrees that cost allocation plans are fair, the Agency should verify that providers follow their plans.

Some providers did not apply their cost allocation plans correctly, resulting in excessive charges to the Agency. Others lacked a valid method for allocating expenditures or did not update information critical to allocating expenditures accurately. For example, for fiscal year 2000 contracts we found that:

- A provider sometimes charged all of its repair and maintenance costs to the Agency instead of following its policy of splitting the expenses evenly between two funding sources. This resulted in the Agency paying $5,353 more than it should have for maintenance costs.
- A provider applied its cost allocation plan to salaries and direct program costs without supporting information. Administrative staff did not maintain supporting documentation such as timesheets or activity logs as required by federal requirements. For December 1999, salaries totaling $99,792 could not be supported. The provider charged 75 percent of salaries ($74,843) to the Agency. Also, direct program costs, such as drug screenings, could not be tracked to individual clients and charged to the appropriate funding source.
- A provider whose allocation plan was based on a monthly client census failed to update percentages charged to the Agency and other funding sources for several months. Because of contract reductions, the percentage of clients funded by the Agency decreased significantly during this time. Because the provider did not update census data, the provider over-charged an estimated 20 percent of costs to the Agency.
- A provider used informal estimates to allocate the contract award amount between the program and the contract administrator resulting in unsupported costs being allocated to the Agency.

Recommendation:

The Agency should continue its review of all providers' cost allocation plans and verify that providers are following the plans and charging the Agency accurately.

Management's Response:

The Agency is responsible for reviewing provider cost allocation plans for reasonableness and notifying the provider that their plan has been reviewed and deemed reasonable based upon information submitted. A process was developed in summer 2000, and implemented September 1, 2000 that involves tracking providers that have not submitted the required cost allocation plans and suspending payment until all plans are received and reviewed. During on-site compliance reviews, staff determine whether providers are following their cost allocation plan and issue findings with recommendations when there are inappropriate deviations from the plan. Costs charged to the Agency that are not reasonable, necessary and allocated according to the plan will be disallowed.

Section 4-C:

Continue Efforts to Simplify Payments and Validate Rates

The Agency has moved to simplify how it pays providers but has done so without first validating the rates it uses. (See text box for various payment methods.) For fiscal year 2000 contracts, the Agency used a unit-cost payment method that was actually a hybrid of fee-for-service and cost reimbursement. Under this method, the Agency reimbursed providers only what it cost to provide a service, as long as the cost did not exceed a maximum rate.

Payment Methods

Unit Cost (lower of unit rate or actual cost): The rate of reimbursement is based on a line-item budget of estimated program costs and an approved bid rate for services. The provider can only be reimbursed for actual costs up the maximum allowable rates. If allowable expenditures are less than the unit rate for service units, the provider receives the actual cost amount.

Unit Rate (effective with fiscal year 2001 contracts): Treatment providers report the service units delivered during the previous billing period and are reimbursed at a set rate per unit of service. The unit rate cannot exceed the maximum allowable rates.

This method was administratively burdensome for the Agency and providers alike because it requires regular reporting and monitoring of expenditures. The unit-cost method required the Agency to compare providers' allowable expenditures to the unit rate after the fact. Providers that charged at the maximum rate but whose expenditures supported a lower rate had to refund the excess payments to the Agency.

Beginning with fiscal year 2001, the Agency will use a unit-rate payment method, although it has not validated the maximum rates it allows for specified services (see Appendix 5). The Agency made this change without waiting for completion of a rate validation study. In 1996, the Sunset Advisory Commission recommended that the Agency study a unit-rate reimbursement system through August 1998 and, if favorable, implement the system for fiscal year 1999 contracts. The Agency hired a consultant who concluded that the case rate payment methodology was favorable to unit rates. The federal government then agreed to conduct a rate validation study for the Agency, but the Agency had not received the results as of September 2000 when the new contracts went into effect.

Although a competitive process for selecting providers can serve to validate rates, the Agency's current process sets maximum rates for specific services. This limits applicants' ability to bid at a true market price. Until it validates the maximum rates, the Agency cannot know if it is paying a reasonable rate for the services provided.

Recommendation:

The Agency should:

- Obtain and use the results of the federal validation study to set rates.
- Comply with requirements to reevaluate payment methods and rates at least biennially.

Management's Response:

The Agency requested a rate study through the Substance Abuse and Mental Health Services Administration's (SAMHSA) Technical Assistance Program. The consultants performing the rate study are accountable to the grantor agency (SAMHSA) and report results to both the Commission on Alcohol and Drug Abuse and the federal government. A new timeline provided by the consultants indicates the rate study's revised completion date is August 31, 2001. This completion date complies with the statutory requirement that an evaluation be performed at least biennially, as this legislation became effective September 1, 1999.

Section 5: CONTRACTOR OVERSIGHT

Increase Monitoring Efforts Throughout Contracting Process to Improve Oversight of Service Providers

Prior Agency management's oversight of provider expenditures was not sufficient to ensure that providers spent state and federal dollars reasonably and appropriately and achieved the desired results. (See text box on contractor oversight.) The Agency's oversight includes:

Contractor Oversight

Contractor oversight should be sufficient to ensure that contractors consistently provide quality services (by measuring performance against well-documented expectations) and spend public funds effectively and efficiently.

(See Appendix 3 for more information.)

- Monitoring program results and spending
- Conducting on-site compliance audits
- Ensuring corrective actions have been taken

Reviews of expenditures and client files identified areas in which providers need additional oversight and guidance. The Agency needs to:

- Verify that providers establish clients' financial eligibility and charge the Agency only if other funding sources are not available.
- Ensure the new accounts receivable system results in collection of money owed by providers.
- Compare provider budgets to reported expenditures and use the information to identify providers that need additional review.
- Take steps to improve documentation in contractor files and guide providers.

Because of its insufficient action in other areas of the contracting process, the Agency has to over rely on its on-site monitoring of providers to detect inappropriate spending and noncompliance. (See quote from *State of TCADA* in the text box on the next page.) In fiscal years 1998 and 1999, the State Auditor's Office reported that the Agency had a serious problem monitoring providers.[5] While oversight is considered

[5] *A Report on the 1998 Financial and Compliance Audit Results*, June 1999, SAO Report No. 99-555 and *The 1999 Statewide Single Audit Report*, May 2000, SAO Report No. 00-555.

Previous State of Contract Oversight

"I have no doubt that anyone who scrutinizes this agency's dealings in the past several years will be able to find numerous examples where lax controls allowed or failed to detect questionable transactions by providers. When asked for examples of the agency's poor controls, one employee said, 'Just throw a dart at the file room.'

"The agency's contract oversight was in shambles."

State of TCADA, Jay Kimbrough; J.D., Executive Director; August 1, 2000

a separate phase of the contracting model (see Appendix 3), monitoring of providers also occurs in other phases of the contracting process. For example, monitoring can include review of provider budgets and cost allocation plans for reasonableness (see Sections 4-A and 4-B). Moreover, continuing to grant additional funds to providers that have prior performance problems can only increase the number of provider visits needed to ensure funds are spent appropriately.

Section 5-A:

Verify Accuracy of Provider Billings

Providers do not consistently follow the Agency's rules on charging for client services. Also, the Agency's audits of providers do not always identify inaccuracies, such as double billing. Agency funded clients cannot be easily matched against clients funded by other agencies because other agencies use different client identifiers, such as social security numbers. A state law in effect since September 1999 requires agencies to design and implement procedures to detect and report double billings by providers (more than one agency is billed for the same service).

Examples of Questioned Costs

Double Billings	$ 25,000
Did not Meet Financial Requirements	$ 2,650
Over Billing	$ 3,961
Total	**$ 31,611**

Eight provider visits found $31,611 in questioned client billings. For example:

- A provider whose contract with the Agency included providing housing and treatment billed both a housing authority and the Agency for services provided to a single group of clients. In December 1999, the provider billed the housing authority at least $25,000 to house homeless clients who were also funded by the Agency. The provider's acceptance of the housing authority funds would have been permissible if the money had been used to decrease the amount charged to the Agency; however, that did not occur.
- A provider billed for services to clients after the clients had completed treatment. The provider allowed clients to remain as residents of the facility until new living arrangements were ready. According to the provider, clients generally stayed one week after graduation but had stayed as long as one month. The Agency paid $1,106 per week for a maximum of four weeks ($4,740) for clients who had completed treatment, while others needing treatment remained on waiting lists.
- A provider billed a client's methadone treatment to the Agency for almost four years, although documentation in the client file showed he was eligible for Medicaid. The provider appears to have made no attempt to bill Medicaid. The annual cost to the Agency for methadone treatment was about $2,650 ($10,600 for four years).
- A provider that also had a contract to provide services to adult probationers was not diligent in attempting to use Department of Criminal Justice funds

first. Also, its counselors did not closely screen adolescent clients to establish Medicaid eligibility.

- One provider overbilled $3,961. The provider's overall method of tracking which services to bill was inadequate and documentation was insufficient. As a result, the Agency was overbilled in some instances and underbilled in others.

The above examples show that providers do not consistently follow relevant Agency rules in the Texas Administrative Code:

- Providers should bill the Agency for chemical dependency treatment only if there are no other funding sources. Also, the provider should not bill the Agency for a unit of service that has been billed to Medicaid or another funding source (Chapter 40, Section 144.105).
- Providers should complete and document a financial assessment of each client at admission (Chapter 40, Section 14.521).
- Providers should maintain complete documentation for all services paid with Agency funds (Chapter 40, Section 144.553[g]).
- When a client's length of stay in a level of treatment exceeds the guidelines, the provider should clearly document in the client's record the needs and conditions justifying the variance (Chapter 40, Section 144.526).

Recommendation:

The Agency should:

- Consider partnering with other state and federal agencies that fund substance abuse services, in a manner consistent with confidentiality requirements, to detect double billing by providers.
- Continue to train providers on how to determine financial eligibility and how to properly document services rendered.
- Analyze billing and performance data to identify providers that might be over or under billing for services; conduct additional review as necessary.

Management's Response:

In the context of partnering with other agencies, the Agency will continue to explore ways to detect double billing. One of the benefits of the Enterprise System, in which all HHSC agencies will participate, will be the ability to share information as appropriate across agencies to address common problems with double billing. In addition, the Commission on Alcohol and Drug Abuse is seeking legislative changes that will allow the Agency to review all financial records of a funded provider,

regardless of funding source. Currently, the Agency has authority to review only those accounting records associated with agency-funded programs.

The Agency continues to provide financial eligibility and documentation training to providers. On September 11, 2000, the Agency provided financial eligibility training, which included expert training on Children's Health Insurance Plan (CHIP) and Medicaid. Financial Eligibility training was offered again to providers on December 4, 2000. The annual training and technical assistance calendar ensures all providers have access to critical information. The Provider Bulletin *is another avenue through which the Agency conveys eligibility and documentation information to providers.*

As previously mentioned, under the new provider monitoring process, the Agency now prepares an analysis of provider expenditures as compared to actual budgets. This analysis will include, at a minimum, a quarterly comparison of actual expenditures to budgeted expenditures.

Section 5-B:

Ensure the New Accounts Receivable System Has Complete and Accurate Information

The Agency did not have an accounts receivable system to track money that providers owed. The task of tracking accounts receivable information was fragmented throughout many different departments. Under previous management, one provider's debt grew to $750,000. The outstanding amount came to the attention of current management and the Board in February 2000 when the provider requested a special agreement to repay the debt.

Providers might owe the Agency for various reasons, which include:

- During the contract closeout, the Agency may find it paid a provider more than the provider's reported expenditures.
- During audits, Agency compliance auditors may identify unallowable expenditures.

The Agency would request a refund or repayment in both cases.

In March 2000, the Agency created its first central report of amounts owed and paid. However, the report does not provide the same assurances an accounts receivable system would. To create the report, Agency staff members must gather information manually from various departments. The report is difficult to maintain because the information changes constantly. Also, the accuracy, timeliness, and completeness of the accounts receivable information depend on employees forwarding information on time.

According to preliminary and unaudited reports from the Agency, the total owed by all providers as of March 2000 was $2.9 million, which was reduced to $1.3 million by August 2000. However, this amount will likely grow as the Agency finalizes

compliance audits that include questioned costs still under review. For example, a monitoring visit to one provider in June 1999 resulted in questioned costs of about $11,300. The costs were referred to the Agency's compliance auditors for review. As of October 2000, the Agency's audit report was still in draft. As a result, the questioned costs identified in 1999 had not been resolved (dismissed or determined unallowable) over a year later.

The Agency has begun pursuing provider debt. In the past, the Agency allowed some providers to accumulate debt over the years without jeopardizing their continued funding. According to the Agency's August 2000 accounts receivable report, 54 percent ($716,163) of provider debt dates from fiscal year 1998 or before. Of the $1.3 million still outstanding as of August 2000, 28 percent ($369,833) of provider debt is from fiscal year 1997 or before. In addition, as of August 1999, the Agency had referred 11 delinquent providers for a total of $700,857 to the Attorney General's Office for collection. (The report on amounts referred for fiscal year 2000 was not available at the conclusion of audit fieldwork.)

When the Agency requested repayment, it sometimes did not collect in cash, although it appeared that the providers were financially able to pay in cash. The Agency allowed providers to repay with services instead of cash. Some reasons providers gave for not being able to repay the Agency in cash were that they needed the money to do the following:

- Pay for building a new facility.
- Ensure that they had at least three months of working capital.
- Pay for major renovations and upgrades of buildings.

By not pursuing cash payments in these situations, the Agency allowed providers to spend funds on other projects instead of repaying the Agency. The debt from providers that appeared to be able to pay cash but were allowed to pay with services totaled $307,404. According to the Agency's Board minutes, the practice of accepting services instead of payment was discontinued effective February 2000. The Agency indicated it would honor preexisting agreements with providers as long as they were in good standing as of April 30, 2000.

Recommendation:

The Agency should notify oversight entities when its new accounts receivable system is fully implemented so they may verify that information collected is complete, timely, and accurate.

Management's Response:

The Agency has completed implementation of a policy and procedure for timely identifying, recording, and collecting valid service contract accounts receivable owed to the agency. The policy includes deadlines for collection and application of penalties associated with non-payment of amounts owed.

The focal point of the procedure is the accounts receivable component of the Services Management module in the Integrated Management System (the Source). This component of the Source was designed to track and monitor accounts receivable activity and produce timely reports for management decision-making.

A statement will be added to the Business Plan to notify oversight agencies that the accounts receivable system is fully implemented.

Section 5-C:

Monitor Financial Information to Detect Unusual or Inappropriate Activity

The Agency can improve its monitoring of provider financial information. During fiscal years 1999 and 2000, the Agency did not always monitor providers' spending to determine which providers need assistance or increased on-site financial monitoring. Also, the Agency did not keep track of budget transfers to ensure that providers did not circumvent the Agency's approval process.

Example of Questioned Cost	
Over-Reported Provider Expenditures	$381,000

The Agency did not always monitor the expenditure activity of providers to detect unusual spending levels. Providers report their expenditures to the Agency in quarterly financial status reports. The Agency reviews these to determine if the expenditures support the rates that providers charge for treating clients. However, the Agency could also use these reports to identify unusual spending levels. For example, the following spending activities should have prompted the Agency to investigate:

- A provider overreported its second quarter expenditures by approximately $381,000. In calculating its second quarter expenditures, the provider erroneously included expenses from the first quarter.
- A provider incorrectly allocated payroll costs across its programs. This resulted in a total outlay of over $41,000 in the first three months of a program with an $80,000 budget. However, the Agency did not contact the provider to ask why over 50 percent of the program's budget had been spent in a three-month period.

The Agency did not track budget transfers cumulatively, which allowed providers to exceed the 10 percent cap on transfers within line items and between contract programs without Agency approval. For fiscal years 1999 and 2000, the Agency required approval when year-to-date transfers between direct cost categories exceeded 10 percent of the total approved budget. The Agency approves

program budgets at the beginning of the year. By transferring funds between line items, the provider can circumvent its approved budget.

Beginning with fiscal year 2001 contracts, the Agency plans to enforce the 10 percent cap. However, the automated system does not track cumulative changes. As a result, employees will have to track transfers manually to ensure providers do not exceed the limit, which is time-consuming and increases the chance of errors.

Recommendation:

The Agency should:

- Monitor provider budgets to identify potential problems, such as over- or under-spending by providers. Research those potential problems and provide assistance or take corrective action.
- Create an automated process for tracking budget transfers to enforce the cumulative 10 percent cap.

Management's Response:

Tracking of budget transfers will be automated as a part of a project to track contract amendments in greater detail in the IMS. This project will be completed by August 31, 2001.

Under the new fiscal monitoring process, the Agency will prepare an analysis of provider expenditures as compared to actual budgets. The analysis will include, at a minimum, a quarterly analysis that compares actual expenditures to budgeted expenditures.

Section 5-D:

Continue to Improve Documentation in Contract Files and Guidance to Providers

For fiscal years 1999 and 2000, the Agency's contract files did not always contain necessary information. Also, the Agency can enhance information already available to providers on its web site by reinstating the provider compliance guide. Beginning with fiscal year 2001, the Agency reports that it will begin filing documents in an organized and secure manner. It also plans to institute a checkout procedure for documents.

The Agency's contract files were in such poor condition that the Agency could not ensure that all pertinent documents were in the files or that important documents were not lost. Problems with contract files include the following:

- All pertinent provider information, such as audit reports and sanction letters, was not found in contract files. Various departments had to provide information missing from the contract files.
- The Agency did not have a process for checking out files or for ensuring that departing employees returned files to the file room.
- Documents were not secured to the folders or arranged in any particular order. As a result, documents could be lost; it was difficult to find specific documents.

The Agency does not have a comprehensive, easy-to-use guide to help providers comply with Agency rules and regulations. In 1995, conservators found that the Agency had not clearly articulated its expectations of the providers and that providers had to search through multiple sources for guidance. In response, a multidisciplinary team wrote a compliance guide for providers that went into effect January 1, 1996.

The *Provider Compliance Guide* (Guide) was designed to provide information, policies, and procedures so providers could meet their obligations. The Guide, which was meant to train personnel in day-to-day procedures, covered the minimum requirements to achieve compliance with licensure, program, organization, fiscal, reporting, and auditing requirements. However, as of August 31, 1998, the Agency withdrew the Guide. With so many recent changes to rules, this is a good time to reinstate a provider guide.

Recommendation:

The Agency should:

- Implement planned procedures for contract files.
- Enhance information currently available to providers by creating a comprehensive source of guidance on how to operate programs in compliance with the Agency's rules and regulations.

Management's Response:

The Agency changed the structure and organization of fiscal year 2001 contract files. Each contract file has separate components for filing specific documents and all documents are secured in the file folders. Plans to include audit reports and sanction information with the contract files are in the process of being implemented. Files are checked in and out using a scanner system. To ensure that departing employees have no delinquent files, a process will be established that adds the Central File Room to the contact list regarding outstanding information prior to an employee's exit interview.

The Agency now provides extensive guidance to providers including: (1) a continually updated website which furnishes new information and clarification; (2) the Provider

Bulletin *which gives details on issues relating to rules and regulations; (3) guidance letters from the Agency when new regulations go into effect; (4) a training calendar developed in response to provider needs; (5) special purpose conferences; (6) program directors' meetings; and (7) technical assistance tailored to individual provider needs. In addition, Agency management will assess the feasibility of developing a provider guidance manual.*

Section 6:

Review Data for Accuracy and Use It to Determine Program Effectiveness

Agency decision makers do not have access to meaningful data about the effectiveness of substance abuse service programs because of problems with the collection of accurate data and concerns about client confidentiality. In addition, the Agency does not have systems in place to ensure that performance measures are correctly calculated or reported at the provider level or at the Agency level.

Section 6-A:

Review How Performance Measures Are Set, Reported, and Used

Low-Performing Providers

"There is a 6-month performance review of targets whereby providers explain any variance to achieving their targets. For those providers significantly above or below their performance targets, a 'corrective action plan' (CAP) is required. However, these CAPs have little impact and no enforcement to improve the performance of low-performing providers. Most CAPs generally involve the provider requesting a reduction in their contractually stated performance targets."

Source: *Texas Commission on Alcohol and Drug Abuse Process Review Report*; Health and Human Services; January 21, 2000

Performance measure data currently collected is unreliable because of inconsistencies in how measures are defined and calculated and because they rely too heavily on information that clients give to providers. The results of treatment programs are essential in determining whether providers are improving client health; reducing client illness, death, and disability; and reducing costs to society. The Agency needs a system for tracking clients so that it can identify the programs with the best outcomes and detect fraud.

The Agency does not have adequate controls in place to ensure that performance measures are correctly calculated and reported at the provider level or at the Agency level. Incomplete and inaccurate performance measure information might provide management with a misleading picture of provider performance, which could lead to bad decisions during the contracting process and the monitoring of providers. Problems with the reliability of performance measure information might also affect the decisions of state leaders regarding the Agency. The following conditions are indicators of insufficient monitoring and inadequate controls:

- Ineffective consequences exist for poor performance. Performance measures were not used to assess providers performance during prior contracting award cycles. In addition, prior management generally allowed low-performing providers to reduce their targets. Both of these factors resulted in providers

having very little incentive to meet or exceed targets. (See text box for information on low-performing providers.)

- Inadequate target setting methodology exists. To develop performance targets for fiscal year 2000, the Agency used the median of the performance that providers reported for each program the previous year. This method of target setting makes it difficult for some providers to succeed and very easy for others. In fact, for some providers, the target does not provide much initiative to improve or expand services because the new target is actually lower than their reported performance the year before. In fiscal year 1998, the reported performance of 137 providers exceeded targets by 200 percent. In fiscal year 1999, 19 providers exceeded targets by 200 percent. Furthermore, the Agency's target setting methodology did not take into consideration the unique characteristics of each program and the population served.
- Rules for calculating performance measures are unclear. Performance measure calculations differ significantly from provider to provider. The most significant difference was in determining if a client successfully completed a program. These differences arise because the Agency did not provide adequate guidance to providers on calculating performance measures.
- Performance measures reported to the Legislative Budget Board (LBB) contained an error. The Agency misreported some of its performance measures to LBB. The Agency found out about this error during a meeting with LBB. At LBB's request, the Agency recalculated the associated performance measures and re-entered them into the Automated Budget and Evaluation System of Texas (ABEST).[6]

The Agency does not have the necessary controls in place to ensure that all key performance measures are received from providers and entered into the Agency's systems in a timely manner. For fiscal year 1999, there were 31 prevention and intervention programs that Agency staff found did not have goals in the system. Additionally, 70 fiscal year 2000 prevention and intervention programs did not have any goals in the system. Without this data, the Agency may not be able to make a correct evaluation of provider performance.

The Agency has experienced significant delays in merging monthly data from providers into the master files against which billings are run. Much of the Agency's data is formatted using a specialized computer program. The Agency has had difficulty replacing employees who were experienced in using the computer program and who have resigned or been terminated.

[6] ABEST is a system the LBB maintains. It contains data on agency strategic plans, appropriations requests and recommendations, and performance monitoring.

Recommendation:

The Agency should:

- Hold providers accountable for meeting performance targets by:
  - Enforcing sanctions, including terminations, for low performance
  - Using performance history when considering future contracts
- Set individualized performance targets for provider programs based on program characteristics, norms for similar programs, populations served, and past program performance.
- Clarify how performance measures should be calculated, provide training to Agency employees and providers, and test the accuracy of performance measure information submitted by providers. Refer to the *Guide to Performance Measure Management* for guidance on input, process, and control systems. Also, study the feasibility of standardizing current treatment effectiveness performance measure definitions with those being developed by the Substance Abuse and Mental Health Services Administration.
- Review performance measure data prior to submitting it to the LBB to ensure that information placed in statewide systems is accurate.
- Ensure performance measure data is promptly entered in Agency systems.
- Review staffing needs for the performance management function and ensure that resources are adequate to perform necessary tasks.

Management's Response:

A process has been implemented for the fiscal year 2001 contracts where demonstrated performance of providers was evaluated by Agency review panels. The results of the performance evaluations were considered in funding decisions and incorporated into contracting recommendations when applicable.

Through its new contract management process, the Agency will hold providers accountable for overall performance. Performance targets are one of several factors considered. Other factors include results of program performance reviews, audits, documented noncompliance with applicable rules and regulations, and performance in reporting requirements. The Agency will enforce sanctions against overall low-performing providers, including terminations. The Agency also places providers on high-risk status for contract non-performance. High-risk status is an intervention process designed to move the provider into compliance and away from termination.

During the contract selection and renewal process, performance targets/goals are reviewed for appropriateness. The Agency now negotiates appropriate levels with the applicants. The approved targets/goals are then included as part of the provider's contract. Provider performance reviews will be conducted regularly to determine whether providers are meeting their performance targets, and this performance will

be used to adjust targets for future years. As part of an ongoing contract management process, regular reports of activity will be prepared and stored in QRS Central, an electronic data repository for provider information. Information in QRS Central is accessed on-line by Agency staff for use in reviewing contractor performance.

Agency contract requirements now define program measures and the requirements for completion of treatment, abstinence, and employment. Providers are expected to report measures based on guidelines in their contracts and in Agency rules. Measures are compiled for outside reports by the Agency. In addition, Agency staff are actively involved in working with the Substance Abuse and Mental Health Services Administration and the National Association of State Alcohol and Drug Abuse Directors as program performance measures are set for the States through the Substance Abuse Prevention and Treatment Block Grant. These measures will standardize treatment effectiveness definitions nationwide.

The Agency has established a new process for reviewing all performance measure information submitted to LBB:

1. *All original performance data provided to the Agency is reviewed at the deputy level before it is accepted.*
2. *The data are entered into templates from which a draft performance report is created.*
3. *The final draft report is reviewed and approved for entry into ABEST.*
4. *The approved draft report is entered into ABEST and submitted via ABEST to the LBB by the prescribed deadline.*

The assessment of staffing needs across the agency is performed on an on-going basis.

Section 6-B:

Analyze Program Outcomes to Determine Effectiveness

The Agency has not used available information to analyze outcomes for its various programs, nor has it worked with other agencies to reduce its reliance on self-reported outcome measures. The Legislature required the Agency to implement a system to track clients throughout multiple episodes of substance abuse treatment in programs throughout the state. The Agency complied but has not used this system to determine program effectiveness.

The Agency does not currently analyze how clients move in and out of different service levels and programs, in part because of concerns with client confidentiality. However, federal laws permit the use of client data for research purposes as long as clients are not identifiable to external parties. Although the Agency has client data that it could use for internal research on effectiveness, the information is not being used. This data could help the Agency develop best practices for other programs to try to duplicate.

The outcome measures that the Agency currently uses rely too heavily on providers reporting information received from clients, especially concerning client abstinence

following completion of a treatment program. In addition, Agency employees said providers are allowed to obtain follow-up information about abstinence from persons other than the client. Not only is this an unreliable source of information, but it may violate confidentiality rules.

To reduce reliance on self-reported data, the Agency could create interagency agreements with other agencies that have information that could be used in combination with Agency data to determine the effectiveness of prevention and treatment services. This would include agencies such as:

- Public school agencies (to determine if youths remain in school)
- Employment agencies (to determine if persons completing treatment are re-employed)
- Health and human service agencies (to determine the use of other services)
- Criminal justice agencies (to determine rate of incarceration)

Recommendation:

The Agency should:

- Analyze internal client data to identify best practices.
- Work with other agencies to determine the effectiveness of substance abuse programs by measuring client outcome, such as drug use, health service utilization, employment status, and criminal activity.

Management's Response:

The Agency is aggressive in its work in analyzing client data to determine treatment outcomes. The Agency currently has a grant from the Substance Abuse and Mental Health Services Administration for Treatment and Outcomes and Performance Pilot Studies (TOPPS). Under the TOPPS study, the Commission on Alcohol and Drug Abuse will address issues that lead to best practices.

While the Agency's outcome measures do rely on reports from providers, self-reported data is the norm in substance abuse evaluation studies, according to numerous sources including the Substance Abuse and Mental Health Services Administration, which administers the Agency's federal block grant. However, the Agency recognizes the risk that exists with reliance on self-reported data. The new contract oversight process includes steps to assess the accuracy of information submitted by providers.

The Agency will continue to explore ways to share this information with other agencies. Initially, the Agency's participation in HHSC's Enterprise System will provide new opportunities for data exchange and analysis.

Appendix 1:

Objectives, Scope, and Methodology

Objectives

The objectives of the audit were to evaluate the Agency's management of contracts for substance abuse services and to identify the cause of the fiscal year 2000 budget shortfall. To evaluate management of substance abuse contracts, we focused on determining whether substance abuse contracts:

- Were awarded to the best qualified applicants.
- Protected state and federal funds.
- Ensured that the State paid a fair price for services received.
- Were properly monitored to ensure contractor performance.

Scope

The scope of the audit included the Agency's fiscal year 1999 and 2000 contracts for prevention, intervention, and treatment services and their related policies and processes. It also included on-site visits to eight treatment service providers and information from prior and subsequent fiscal years as deemed appropriate to accomplish the audit objectives.

Methodology

The methodology for this audit consisted of reviewing related reports, collecting information, performing audit tests and procedures, and analyzing and evaluating the results against established criteria. Fieldwork was conducted from December 1999 through August 2000.

Related Reports:

- *The 1999 Statewide Single Audit Report*, SAO Report No. 00-555, May 2000.
- *The State of TCADA: Assessment of the Strategic Mission, Structure and Culture of the Texas Commission on Alcohol and Drug Abuse*; Jay Kimbrough, J.D., Executive Director; August 1, 2000.
- *Texas Commission on Alcohol and Drug Abuse Process Review Report*; Health and Human Services Commission; January 21, 2000.
- *Operational Review of Selected TCADA Organizational Divisions*, Tonn & Associates, January 2000.

Information collected to accomplish our objectives included the following:

- Information regarding selected policies and processes for fiscal years 1999 through 2001 for selecting, paying, and monitoring substance abuse providers.
- Boilerplate for substance abuse contracts for fiscal years 2000 and 2001.
- Uniform Statewide Accounting System data for fiscal years 1998 and 1999.
- Automated Budget and Evaluation System for Texas data for fiscal years 1998 and 1999.
- *Texas Commission on Alcohol and Drug Abuse Business Plan*; Jay Kimbrough J. D., Executive Director; May 2000 and related monthly updates.
- *TCADA Internal Assessment*, April 1998, Commission on Alcohol and Drug Abuse.
- *TCADA "Best Practices" Contracting Model*; DMG Maximus; October 16, 1998.
- Commission and provider financial and performance data for fiscal years 1999 and 2000 and prior and subsequent years as deemed appropriate.
- Board meeting minutes for fiscal years 1999 and 2000 and transcripts for June and August 1999.

Procedures and tests conducted:

- Gained an understanding of the Agency's control environment and organizational structure (including various reorganizations) through interviews and review of the status of prior findings by oversight entities and internal reports.
- Gained an understanding of selected contract management processes through interviews with Board members, management, and staff in all three branches of the organization and review of related documents and reports.
- Reviewed fiscal year 2000 budget shortfall by conducting interviews with Board members, Agency management, and staff; reviewing various documents including Board minutes and transcripts; and attending meetings with legislative staff members and management of the Health and Human Services Commission.
- Reviewed the Agency's May 2000 business plan for improving operations to correct identified problems and related monthly updates.
- Reviewed the Agency's process for non-competitive awards made in fiscal years 1998 and 1999.
- Reviewed payment methods for provider contracts to determine compliance with the terms of the request for proposals.

- Reviewed the rate-setting methodology and compliance with the statutory requirements regarding implementation of a unit rate payment reimbursement system.
- Reviewed the sufficiency of provider contract boilerplate for fiscal years 2000 and 2001.
- Analyzed number and types of fiscal year 1999 contract amendments and reasons for amendments.
- Reviewed fiscal year 1999 billings submitted by providers with cost reimbursement contracts and the related policies and procedures.
- Reviewed the accounts receivable process including fiscal year 1999 services-in-lieu-of-payment arrangements.
- Reviewed fiscal year 1999 and 2000 financial data from providers and determined compliance with contract terms.
- Reviewed fiscal year 2000 Capacity Management Program.
- Reviewed the collection, analysis, and use of fiscal years 1998 and 1999 performance measures data.
- Reviewed the Agency's fiscal years 1998 through 2000 information system and reporting process and analyzed the quality of data and information produced.
- Judgmentally selected eight fiscal year 2000 providers for on-site reviews based on an informal risk assessment to identify high-risk providers.
- Conducted on-site visits at eight providers by interviewing management and staff, and reviewing fiscal year 1999 and 2000 client files and financial and performance data.
- Reviewed the results of the eight provider visits with Agency management and staff to obtain additional information and finalize the results.

Criteria used:

- Code of Federal Regulations, Title 45, Subtitle A, Part 96, Subpart L, Substance Abuse Prevention and Treatment Block Grant.
- *Cost Principles for Non-Profit Organizations*; Office of Management and Budget Circular A-122; effective June 1, 1998.
- General Appropriations Act, Article II-100, Rider 13, 2000-2001 Biennium, 76th Legislature.
- Texas Health and Safety Code, Section 461.0143.
- Texas Government Code, Section 2259, State Contracting Standards and Oversight.

- Uniform Grant Management Standards, Governor's Office of Budget and Planning, January 1998 (as Revised December 1998).
- Texas Administrative Code, Title 40, Section 144; effective February 1999, September 1, 1999, and September 1, 2000.
- State Auditor's Office Contract Management Model (see Appendix 3).
- Client Data System (CDS) Reference & Instruction Manual, Commission on Alcohol and Drug Abuse, 1999 Edition.
- *Administration and Operations Manual*, Commission on Alcohol and Drug Abuse, September 2000 Update.
- *Drug Abuse Treatment: Efforts Underway to Determine Effectiveness of State Programs*, February 2000, GAO/HEHS-00-50.
- *Staff Performance Report to the 76th Legislature*, Legislative Budget Board, January 1999.
- *Texas Commission on Alcohol and Drug Abuse, Staff Report*, Sunset Advisory Commission, 1996.
- Developmental Youth Treatment Services and Specialized Female Treatment Services Request for Proposals; Commission on Alcohol and Drug Abuse; December 22, 1998; Part 4 Funding Availability and Selection Process.

Statement of Compliance With Applicable Auditing Standards

The audit was conducted in accordance with generally accepted government auditing standards.

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

- Sandra Vice, MPAff (Project Manager)
- Dorothy Turner, CPA (Assistant Project Manager)
- Dean Duan, CISA
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- Leslie Ashton, CPA (Quality Control Reviewer)
- Joanna B. Peavy, CPA (Audit Manager)
- Deborah L. Kerr, Ph.D (Audit Director)

Appendix 2:

Summary of Questioned Costs

Table 1

Summary of Questioned Costs at Eight Provider Visits		
Type of Questioned Cost	**Questioned Cost**	**Report Section**
Remodeling	$ 57,000	3-A
Fixed Assets	13,917	3-A
Contractors	80,000	4-A
Headquarter Fees	15,788	4-A
Vehicles	131,842	4-A
Repairs and Maintenance	5,353	4-B
Salaries	74,843	4-B
Double Billings	25,000	5-A
Did not Meet Financial Requirements	2,650	5-A
Over Billing	3,961	5-A
Over-Reported Provider Expenditures	381,000	5-C
Total Questioned Costs	**$ 791,354**	

Appendix 3:

State Auditor's Office Contract Management Model

Key Area	Objective	Components
Contractor Selection	The procurement process should be sufficient to ensure that the best contractors are fairly and objectively selected.	Whenever feasible, and unless otherwise prohibited by law or other restrictions, contractors should be selected through competitive procurement proceedings. Past performance should be considered in subsequent selection/contract renewal decisions. Formal, documented procedures should be used to assess prospective contractors' strengths and weaknesses.
Payment/ Reimbursement Methodology	Methods used to establish contractor reimbursement should be sufficient to ensure that the State pays a fair and reasonable price for service.	Prior to the contract award, the cost of services, as well as the services themselves, should be analyzed in order to determine the most effective payment methodology. Approval of proposed contractor budgets should focus on ensuring that proposed expenses are reasonable and necessary to accomplish program objectives. Both program results and contractor efficiency should be considered as part of the budget approval process. For unit-rate contracts, the rate setting process should ensure that there is a reasonable correlation between the quality of the services provided, the costs of providing the services, and the rate paid.
Contract Establishment	Contract provisions and agency regulations should be sufficient to hold contractors accountable for delivery of quality services and prevent the inappropriate or inefficient use of public funds.	Clear statements of services and goods expected from the contractor should be included in contracts. Clearly defined performance standards and measurable outcomes should be included in contracts. Clear statements describing how contractor performance will be evaluated should be included in contracts. Contracts should include sanctions sufficient to hold contractors accountable for failing to meet intended objectives. Contracts should include appropriate restrictions regarding contractors' use of public funds. Contracts should include specific audit clauses that allow the funding agency and other oversight entities access to contractor books and records.
Contractor Oversight	Contractor oversight should be sufficient to ensure that contractors consistently provide quality services (by measuring performance against well-documented expectations) and that public funds are spent effectively and efficiently.	Monitoring functions should focus on the outcomes of services provided and the cost-effectiveness/prudence of contractor expenditures in addition to compliance with regulations. Results of monitoring reviews, audits, and investigations should be routinely followed up on to ensure corrective actions have been taken and to identify common problem areas. A formalized risk assessment process should be used to select contractors for review and identify the level of review necessary for each contractor. Standardized criteria should be established to evaluate contractor performance.

Source: State Auditor's Office

Appendix 4:

Agency Financial and Performance Information 1998-1999 Biennium

Table 2

Original Appropriation and Actual Spending for the 1998-1999 Biennium			
Fiscal Year 1998			
Goal	**Original Appropriation**	**Actual Spending**	**Variance**
Services Distribution	$ 125,764,297	$ 134,535,990	7%
Quality Assurance	6,070,911	7,382,948	22%
Indirect Administration	4,302,412	5,238,662	22%
Total	**$ 136,137,620**	**$ 147,157,600**	**8%**
Fiscal Year 1999			
Services Distribution	$ 121,885,244	$ 157,850,233	30%
Quality Assurance	6,070,911	7,317,052	21%
Indirect Administration	4,217,412	5,503,846	31%
Total	**$ 132,173,567**	**$ 170,671,131**	**29%**
Combined for Biennium			
Total	**$ 268,311,187**	**$ 317,828,731**	**19%**

Source: Uniform Statewide Accounting System

Table 3

Selected Performance Measures for the 1998-1999 Biennium						
Performance Measure	**1998**			**1999**		
	Goal	Reported	Variance	Goal	Reported	Variance
Number of Adults Served in Prevention Programs	390,470	225,755	(42%)	390,470	260,882	(33%)
Number of Youth Served in Prevention Programs	618,255	350,433	(43%)	618,255	431,780	(30%)
Number of Adults Served in Treatment Programs	31,061	26,604	(14%)	29,531	33,773	14%
Number of Juvenile Justice Clients Served in Treatment Programs	647	524	(19%)	647	761	18%
Average Cost per Adult for Prevention Services	$ 32.78	$ 55.21	(68%)	$ 32.78	$ 62.25	(90%)
Average Cost per Youth for Prevention Services	$ 30.74	$ 101.23	(229%)	$ 30.74	$ 106.91	(248%)
Average Cost per Adult Completing Treatment Programs	$ 1,804.00	$ 2,733.00	(52%)	$ 1,804.00	$ 2,362.00	(31%)
Note: The variance is negative (and appears in parentheses) if the Agency fell short of the goal and positive if it met or exceeded the goal.						

Source: Automated Budget and Evaluation System for Texas

Appendix 5:

The Agency's Maximum Allowable Rates Effective September 1, 1999

Substance Abuse Levels of Care and Rates	
Level I Detoxification (Residential Only)	
Adult	$123 Per Day
Adolescent	$132 Per Day
Level II	
Adult Residential	$64 Per Day
Adult Residential Females with Children	$158 Per Day
Adolescent Residential	$132 Per Day
Adult Outpatient Services	$47 Per Individual Per Hour $16 Per Group Hour
Adolescent Day Treatment	$84 Per Day
Level III	
Adult Residential	$32 Per Day
Adolescent Residential	$90 Per Day
Adult Residential Specialized Female	$46 Per Day
Outpatient Services	$47 Per Individual Per Hour $16 Per Group Hour
Level IV	
Outpatient Adult and Adolescent	$47 Per Individual Per Hour $16 Per Group Hour
Pharmacotherapy	$8 Methadone Per Day $56 LAAM (levo-alpha-acetyl-methadol) Per Week

Source: Commission on Alcohol and Drug Abuse Comprehensive Services Request for Proposals (CS2001 RFP)