

SOUTHWEST BUSINESS OFFICE

Audit Report No. SWBO0108

June 20, 2008



**MENTAL HEALTH MENTAL RETARDATION
AUTHORITY OF HARRIS COUNTY**

Internal Audit Report

AUDITOR'S REPORT

Southwest Business Office

Harris County, Texas

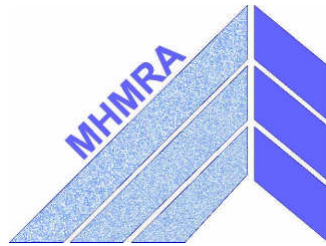
Internal Audit Report

June 20, 2008

Henry E. Webb, CFE

Internal Auditor





**MENTAL HEALTH MENTAL RETARDATION
AUTHORITY OF HARRIS COUNTY**

June 20, 2008

Steven B. Schnee, Ph.D.
Executive Director
MHMRA of Harris County
7011 SW Freeway
Houston, TX 77074

Re: Southwest Business Office
(Report No. SWBO0108)

BACKGROUND

Southwest Clinic is one of four clinics under the direction of the Assistant Deputy Director for Mental Health Services. There were approximately 2,015 open cases during the audit period. Generally, clients served at the clinic (who are diagnosed with schizophrenia, bipolar, major depression, or emotional disturbance), are adults 17 years of age or older, children and adolescents between the ages of 3 and 17, and new clients (intakes) referred from crisis centers, inpatient facilities, and/or other sources.

The Business Office of the Southwest Clinic is currently comprised of eight employees; it supports the clinic in managing operations and financial information. The Business Office's primary function includes (re)scheduling appointments, authorizing Continuity of Care (COC), collecting payments, assessing financial eligibility, verifying client information, and checking clients in and out of the clinic.

In performing these activities, various modules of the Anasazi system are utilized. The Scheduler module is used to process appointments and generate the Consumer Encounter Form (CEF) and Appointment Form. These forms are used to check clients in and out of the clinic. Demographic and Outpatient Treatment Reviews (OTR) are conducted in the Assessment and Treatment Plan (ATP) module. These electronic forms contain client profiles and medical information. The Client Data module contains authorized COC plans, insurance coverage, financial review, and collection and billing information. In addition, insurance coverage is verified via WebCARE and telephone to ensure all third-party insurance is active for service billing.

STATE REGULATIONS

TEXAS RECOMMENDED ASSESSMENT GUIDELINE FOR ADULTS, CHILDREN AND ADOLESCENTS

The Texas Recommended Assessment Guideline (TRAG) is a systematic assessment process for measuring mental health service needs based on clients' recent principal diagnosis and nine dimensions for adults (AMH), and recent principal diagnosis and ten domains for children and adolescents (CAS).

As a requirement, the results of the clinical assessment must be updated in the Client Assignment and Registration (CARE) system every 90 days. To ensure the deadline is met, the Business Office communicates verified TRAG dates to providers regarding whether to reassess clients by noting on CEFs.

In order to bill rendered services accurately, the clinical assessments must correspond to the service package(s) authorized in the system.

TEXAS ADMINISTRATIVE CODE CHAPTER 412.C – “CHARGES FOR COMMUNITY SERVICES”

The Texas Administrative Code (TAC) Chapter 412.C was established to comply with Texas Health and Safety Code 534.067 and with the purpose that fee collection is equitable, collections are provided, and contributions to local revenue are maximized.

The following is a general highlight of the requirements:

- Financial assessment for clients (or parents) must be conducted within the first 30 days of services and annually thereafter, except by other situations as defined in the rule. There are three criteria used to calculate Monthly Ability-to-Pay (MAP) which determines the financial obligation for clients: income, extraordinary expense, and number of family members.
- Deferred payments are allowed for clients with qualified financial hardships.
- Denying services to clients is prohibited due to a client’s inability to pay as defined in the rule, or because any of the following occur: incomplete financial assessment, undetermined financial responsibility, past-due account balance, involuntarily reduced or terminated services due to non-payment, or resolution of an issue relating to payment for services pending.
- Clients have the opportunity to appeal for involuntary changes in services or referral of an approved provider because third-party insurance would not reimburse the Agency.
- The Agency is responsible for identifying all available funding sources before accessing TDMHMR funds, assisting clients to identify approved providers, and providing assistance in applying for Federal/State benefits.
- Children are required to enroll in Medicaid or Children’s Health Insurance Program (CHIP) if their parents are eligible for these funds.
- Adults are required to apply for Supplemental Security Income (SSI) if they are eligible for Medicaid.
- Full subsidy eligible clients are required to choose and enroll in a Medicare Part D prescription drug plan. For non-full subsidy eligible clients, the Agency must educate and assist clients in assessing the cost and benefits of Medicare Part D enrollment.
- A client (or parent) will incur standard charges for services for non-compliance with assignment of benefits authorization, CHIP enrollment for CAS, or Medicare Part D enrollment for full subsidy eligible client. However, the client’s account is allowed a retroactive adjustment if he or she complies within 30 days of the initial non-compliance.
- A plan is to be developed and implemented if there is a documented clinical determination (with client’s team input) to address reducing compliance, discontinuing service charges, and reducing or terminating services for non-payment. The clinical determination process involves the consideration of client’s illness, functioning level, continuation of the needed services, risk of serious deterioration of his or her health, and/or court-ordered outpatient service.
- The Agency’s staff performing these tasks related to the Charges for Community Services must demonstrate initial and annual competency (MHMRA of Harris County requires 85% passing score to satisfy the competency).

OBJECTIVE

The objectives of the audit were to determine whether:

- (1) The Business Office's systems of internal controls were reasonably adequate;
- (2) The Business Office personnel appropriately complied with applicable laws, regulations, policies and procedures;
- (3) Financial and operating data is reasonably complete, accurate, and recorded properly in the system;
- (4) Operational resources are effectively, efficiently utilized and allocated to maximize output.

SCOPE

The scope of the audit did not constitute an evaluation of the overall internal control structure of the unit. The examination was designed to evaluate and test compliance with established policies, procedures, laws, and regulations. The audit scope was for the period November 1, 2007 through April 1, 2008.

Department management is responsible for establishing and maintaining a system of internal controls to adequately comply with approved policy and procedures. The objectives of an internal control system are to provide management with reasonable, but not absolute, assurance that assets are safeguarded against loss, and that transactions are executed in accordance with management's authorization and are recorded properly.

Because of inherent limitations in any system of internal control, errors or irregularities may occur and not be detected in a timely manner. Also, projection of any evaluation of the system to future periods is subject to the risk that procedures may become inadequate because of changes in conditions, or the degree of compliance with procedures may deteriorate.

The purpose of the audit report is to furnish management independent, objective analyses, recommendations, and information concerning the activities reviewed. The audit report is a tool to help management discern and implement specific improvements. The audit report is not an appraisal or rating of management.

Although due professional care in the performance was exercised, this should not be construed to mean that unreported noncompliance or irregularities do not exist. The deterrence of fraud is the responsibility of management. Audit procedures alone, even when carried out with professional care, do not guarantee that fraud will be detected. Specific areas for improvement are addressed later in this report.

Other minor findings, not included in this report, have been communicated to management and/or corrected during the audit process. Internal Audit would like to thank management and staff for their cooperation throughout the audit.

METHODOLOGY

In order to meet the objectives, Internal Audit flowcharted and evaluated controls over the Business Office activities, reviewed the system relating to accounts, and reviewed laws, regulations, policies and procedures for compliance. Information and records were obtained from the Business and Clinical Office, Eligibility Center, and Revenue Management personnel. Audit tests and procedures are conducted as considered necessary.

The sample size and selection were statistically generated using a desired confidence level of 95%, an expected error rate of 5% to 6%, and a desired precision of +/-5%. Statistical sampling was used in order to infer the conclusions of test work performed on a sample of the population from which it was drawn and

to obtain estimates of sampling error involved. When appropriate, judgmental sampling was used to improve the overall efficiency of the audit.

STATEMENT OF AUDITING STANDARDS

The audit was conducted in accordance with generally accepted government auditing standards (GAGAS). Those standards require that Internal Audit plan and perform the audit to afford a reasonable basis for the judgments and conclusions regarding the organization, program, activity, or function under audit. An audit also includes assessments of applicable internal controls and compliance with requirements of laws and regulations when necessary to satisfy the audit objectives. An audit also includes assessing the estimates, judgments, and decisions made by Agency management. It is believed that this audit provides a reasonable basis for the findings, conclusions, and recommendations.

RESULTS

As a result of the audit procedures and surveys conducted, it was determined that departmental compliance with established criteria to govern Business Office activities generally meet Agency policy and procedures.

-S-

-S-

Henry E. Webb

Michele Johnson

Cc: Rose Childs, MSW, CSWM, Deputy Director, Mental Health Division
Kenneth Collins, LMSW, Deputy Director, Mental Retardation Division
Barbara Dawson, MSE, Deputy Director, Comprehensive Psychiatric Emergency Program Division
Daryl Knox, MD, Medical Director, Comprehensive Psychiatric Emergency Program Division
Sarah Flick, MD, Medical Director, Mental Retardation Services
Sylvia Muzquiz, MD, Medical Director, Mental Health Services
Jeanne Mayo, MS, JD, General Counsel
Alex Lim MBA, CPA, Chief Financial Officer
Tom Pederson, CPA, External Audit Firm

Audit Committee:

Tom Hamilton, Ph.D. (Chairman)
Jane B. Cherry
Paige M. Cokinos
Charles O. Buckner, CPA
Vicki S. Raynold, CPA
Bob Borochoff

ATTACHMENT A
SUMMARY OF RECOMMENDATIONS
June 20, 2008

Unit: Southwest Clinic		
Area: Business Office		
Inherent Risk: Low Moderate High	Control Environment: Well Controlled Acceptable Poorly Controlled	Overall Risk: Low Moderate High
Type of Procedures: Audit		
Scope: <ul style="list-style-type: none"> * Using Internal Control Evaluation (ICEs) forms, documented internal controls * Conducted a preliminary survey reviewing applicable policies and procedures, etc. * Interviewed various staff, obtained understanding of management controls * Examined detailed receipts, vouchers, and supporting documentation 		
Priority Rating:	Audit Recommendations:	
Follow-up: One Year		

Priority Rating

1. Implement immediately (30 - 90 days) - Serious internal control deficiencies or recommendations to reduce cost, maximize revenues, or improve internal controls that can be easily implemented.
2. Work towards implementing (6 - 18 months) - Less serious internal control deficiencies or recommendations that can not be implemented immediately because of constraints imposed on the unit (i.e., budgetary, technological constraints).
3. Implement in the future (2 - 3 years) - Recommendations that should be implemented but that can not be implemented until significant and/or uncontrolled events occur (i.e. legislative changes, buy and install major systems, requires third party cooperation).