



Johnson County Auditor
Johnson County, Kansas
PERFORMANCE AUDIT

June 12, 2008

Mental Health Center
Financial and Management Controls

Management controls can be improved and efficiencies can be achieved



Johnson County Audit Services

June 12, 2008

To: The Johnson County Board of County Commissioners
Mental Health Center Board of Directors
Executive Director, Mental Health Center

In accordance with the approved audit plan, we performed an audit of the Johnson County Mental Health Center (the Center). Our results show the Center had good management control over inventory and assets, contracts, purchasing card purchases and expense reimbursement. We identified opportunities for improvement in the following areas:

- Upgrading the Electronic Medical Records Software
- Prescription drug controls
- Management of client funds and communications with clients
- Management of employee performance appraisals
- Compliance with Center procedures for obtaining employee background checks
- Increased use of Purchase Cards to reduce or eliminate numerous petty cash accounts
- Management of client accounts receivable

The audit was conducted according to applicable standards contained in *Government Auditing Standards*, issued by the Comptroller General of the United States, except that Peer Review has not been performed, and included such tests of the procedures and records as considered appropriate.

The Center recently contracted for and received a study of their major programs and received recommendations for improvement in management, documentation, and compliance with mental health program guidance. We reviewed the study and the management response. The response indicated general agreement with the consultant's recommendations and established a 5-year time span for implementation. Based on this review, we limited the scope of our audit to other areas of management to the extent possible.

I appreciate the cooperation received from the Center's staff during this audit.

William D. Miller, CIA, CGFM
County Auditor

The following auditors contributed to this report:

Michelle Holland, CFE
Patrick McQueen
John Middleton, CPA

**MENTAL HEALTH CENTER
FINANCIAL AND MANAGEMENT CONTROLS**

TABLE OF CONTENTS

| | <u>Page</u> |
|--|--------------------|
| NOTEWORTHY ACCOMPLISHMENTS | 1 |
| Medication controls and quality control | 1 |
| Internal controls for inventory, P-Cards, and iExpense were adequate | 1 |
| Center staff appropriately manages contracts | 2 |
| RESULTS AND RECOMMENDATIONS | 3 |
| 1. Center Management Needs to Consider Upgrading the Electronic Medical Records Software . | 3 |
| Recommendation | 3 |
| Management Comments | 3 |
| Discussion | 4 |
| 2. Center Managers Can Improve Prescription Drug Controls..... | 7 |
| Recommendations..... | 7 |
| Management Comments | 7 |
| Discussion | 8 |
| 3. Center Staff Need to Provide Refunds to Clients Equitably and Timely | 11 |
| Recommendations..... | 11 |
| Management Comments | 11 |
| Discussion..... | 13 |
| 4. Center Managers Can Improve Their Employee Performance Appraisal Process | 17 |
| Recommendations..... | 17 |
| Management Comments | 17 |

| | |
|---|----|
| Discussion..... | 17 |
| 5. Center Has Not Performed All Necessary Background Checks..... | 21 |
| Recommendations..... | 21 |
| Management Comments | 21 |
| Discussion..... | 21 |
| 6. Center Can Reduce Purchase Orders, Check Requests and Petty Cash | 25 |
| Recommendation | 25 |
| Management Comments | 25 |
| Discussion..... | 26 |
| 7. Center Staff Did Not Report Accounts Receivables Due from Clients or Write-Off Amounts as Required..... | 29 |
| Recommendation | 29 |
| Management Comments | 29 |
| Discussion..... | 23 |
| Other Matters | 33 |
| Reports to the Board of County Commissioners | 33 |

APPENDIXES

| | |
|--|----|
| I. OBJECTIVES, SCOPE AND METHODOLOGY..... | 35 |
| II. ADDITIONAL MANAGEMENT COMMENTS | 39 |

NOTEWORTHY ACCOMPLISHMENTS

Medication Controls and Quality Control

Executive level administration improved management of medications and client cases with the addition of an accomplished clinical nursing supervisor and a manager of quality improvement. Upon arrival, the nursing supervisor instituted strict controls over client medication storage and distribution and developed recurring training classes for all personnel who handle medications. Although we had issues with the medication samples and disposal of controlled substances from other sources, we found good controls over all other medications.

The supervisor's reviews and outcomes are merged in with the quality control system for case management established by the quality improvement manager. The quality improvement manager established a reporting system to give top management oversight of key quality issues in the department. Regular reviews of case files are made to determine conformance with policy and constructive feedback is given to ensure staff follows policy.

Internal controls for inventory, P-Cards, and iExpense were adequate

Inventory management

County policy requires all departments and agencies to record and maintain a physical inventory of assets in its possession that have a cost of \$1,000 or more and useful lives of less than 6 years. Capital assets, assets with a cost exceeding \$10,000 and useful lives exceeding 5 years, are recorded in the County's Fixed Asset system. Assets with a value of less than \$1,000 should be inventoried as needed for the prudent care of county funds and property.

We tested a statistical sample of 177 small equipment items and capital assets. All of the items tested were located or accounted for accurately. Physical inventories occur on small and capital equipment. Timely updates to inventory listings take place with the purchase, transfer or disposal of equipment. Center staff maintained an accurate capital and small equipment inventory listing in compliance with County and departmental policies and procedures.

P- Card and iExpense transactions

County departments and agencies are obligated to follow County expenditure policies and procedures. We tested a statistical sample of 75 P-Card transactions totaling \$13,120.92 and 131 iExpense items totaling \$35,319. Sample tests sought to ensure compliance with County and Department policies and procedures including:

- Transactions were made by authorized personnel
- Inclusion of proper documentation including receipts
- Compliance with individual authorized spending limits
- Supervisory approval

Nothing came to our attention that would indicate problems in the P-Card and iExpense transactions.

Center staff appropriately manages contracts

The majority of contracts with outside vendors include appropriate contract elements:

- Identification of the parties including contact information
- Responsibilities of the parties
- Performance standards minimally referring to compliance with laws, rules and regulations
- Term or duration
- Default and remedy considerations
- Liability issues including indemnity and insurance requirements
- Standard operative provisions such as notifications, governing law, independent contractor status, non-discrimination, etc.
- Execution by authorized individuals
- Reviewed by Legal Counsel (Legal Counsel signature on contract)

We reviewed 50 percent of the most recent contracts over \$25,000 for the appropriate contract elements listed above. Only 1 out of the 12 contracts we reviewed was missing basic elements. The MCPP contract did not have default and remedy considerations or require the contractor to have liability or indemnity insurance.

RESULTS AND RECOMMENDATIONS

1. Center Management Needs to Consider Upgrading the Electronic Medical Records Software

The Center staff has written and maintains a medical records database system (Electronic Medical Records or EMR). The software, Look Up Client Information (LUCI), has shortcomings which may be overcome by the use of software that is written and maintained by commercial software specialists. A consultant review of Center operations completed in 2007 recommended upgrading the Center's EMR system to a commercial programmed and maintained system.

The use of the LUCI system is strongly supported at the Center because of familiarity with the current system. Commercially available software could provide much improved functionality, increase the efficiency and effectiveness of functional staff, possibly allow redirection of resources to mission critical functions and reduce overhead costs, and bring the operations of this vital function up to the standards applicable in 2008.

Recommendation

We recommend the Executive Director, Mental Health Center:

- 1.1 Use County ITS expertise in conjunction with the Mental Health staff to develop a needs analysis leading to a Request for Proposal for an Electronic Medical Records system which will meet the Center's current requirements and provide the flexibility to meet future needs.

Management Comments

We agree with the importance of regularly assessing the availability of other database products in the marketplace that most effectively meet JCMHC requirements, and plan to continue this practice. Staff are well informed about, and stay abreast of, available products designed for the highly specialized community mental health center (CMHC) market. JCMHC previously solicited formal proposals for a packaged database system in 1991, and again in 2000. The lack of an adequate product resulting from these RFPs led to the development of the current LUCI system. We do not rule out the possibility at some point of preparing an RFP for a commercially owned and maintained product to replace the current LUCI system. The primary question is timing.

Although many products designed specifically for CMHCs are currently on the market, there remains a lack of consensus in our field about which products are best suited for this highly specialized application. Numerous examples exist of CMHCs purchasing an EMR package, only to replace it within a short period of time because of inadequacies. An informal survey of CMHCs earlier this year by our national trade association found that of 24 CMHCs responding, 14 different EMR products were currently being utilized, with several CMHCs reporting 2 or 3 changes of software vendors due to underperforming products.

The current LUCI based EMR is nearing completion of its development, with two remaining components nearly finished, and the medical/medication package expected to be installed by the end of 2008. The JCMHC medical record is now nearly 80% paperless. Since its inception 13 major enhancements have been made to the overall LUCI system. Additional enhancements continue to be developed. Conversations with colleagues around the state lead us to believe the JCMHC data system functions as well or better than any currently in use in Kansas.

(See Appendix II for additional management comments)

Audit Comment:

Center staff has made two attempts to find alternate systems in 17 years. They have declined to act on the primary recommendation of the contractor they engaged in 2007 that the Center replace the LUCI system with a more modern and functional EMR/billing system. Our audit found sufficient evidence to concur with the recommendation of the contractor. We believe that prudent management practice requires that the recommendations developed by objective, third-party analysis be given substantial weight in the planning and timing of this critical software enhancement.

The County's ITS department is capable of providing resources to begin this process. Our recommendation is to begin the process of evaluation and preparation before the change is mandated by others or becomes so critical that it is an emergency situation. We believe that our analysis is valid and our recommendation is reasonable and prudent.

Discussion

LUCI System

The LUCI system used as an "electronic medical records" and billing system was created by the Center in 1991. LUCI began as a database for employees to look up client information. Since its inception, the Center staff programmers have added limited functionality to the system by programming additional functions.

LUCI is not functional for all the Center's responsibilities

We interviewed staff who gave good and bad comments about the LUCI functionality for their job responsibilities. New functions were recently added to the LUCI system to make intake and appointment setting easier for staff. However, LUCI has limited functionality for clinical and medical staff. It is not an actual EMR system based on the capabilities and needs of the medical professionals.

More can be done to provide medical recordkeeping

The only electronic medical records in LUCI are clinical notes. There are other documents such as the treatment plan that are scanned into the LUCI system, but these are actually prepared in Word documents. LUCI does not have the functionality needed by the nurses and psychiatrists at the Center. Medical documentation and clinical notes for staff are still maintained in hard copy

document files. Once a client begins visiting one location of the Center, they are not capable of making any appointments at any other locations because they have to visit the location where their medical file is kept. With a true functional EMR system, clients would be able to make appointments at any of the locations that their psychiatrists are seeing patients at that day.

LUCI is also limited in its functions for pharmaceuticals. There are no capabilities for entering prescriptions and dosages in separate fields that can easily be tracked by the medical staff. With LUCI's limited capabilities, medical staff are required to spend time reviewing several months of past clinical notes in order to find prescription and dosage information. The medical staffs also have to use additional web based software to determine prescribed drug interactions. Actual medical records are still maintained in hard copy files. With a modern EMR system, the medical staff would have all the necessary functionality.

Consultant recommended the Center update EMR system

In 2007, the Center paid for MCPP Healthcare Consulting (MCPP) to provide an independent review and evaluation of organizational efficiency, structure, utilization of staff, methodologies, processes, managerial responsibilities, and best practices of the Center. MCPP completed the independent review and evaluation and provided Center management with recommendations for improving services and staff efficiency in a 5-year plan.

Consultant recommends major improvements

The first recommendation for agency wide system improvements was to begin an assessment of the current EMR functionality and complete a program versus buy cost analysis. MCPP reported:

There are products now on the market that likely will meet Center needs, with the potential to support a more rapid leap to the next level of EMR functionality... the Center should go back to the EMR marketplace to re-assess these products and complete a make versus buy cost-benefit analysis. A first step, prior to the market assessment, would be to complete an updated usability analysis of the current system, as a foundation for assessing all of the options available. The Center should consider piloting EMR components that target physician and nurse practitioner functionality including prescribing, psychiatric evaluation and progress notes, and prescription refills. Another high priority for the future EMR includes developing the secure capacity to take the EMR into the field, so CSS and FF community based staff can complete treatment plans and progress notes without returning to the office, ideally in a concurrent process within the client interview.

Center management responded that they would contract with MCPP for further consulting services to assist in the reassessment. Among the services MCPP proposed was a survey of current EMR users, followed by a usability analysis of the current EMR system. An accompanying priority will be to identify a medication management package (the last remaining unfinished major component) that can be integrated into the EMR.

Management stated they would begin assessing EMR software in Spring 2008. The proposed assessment was to consider only a medication management package that would work easily with the existing LUCI system. Management said they believed the current functionality of LUCI for billing and other Center services was fine and they did not want to consider having to retrain staff on a new system. Furthermore, management felt they would not have the capabilities to customize a commercial EMR program to more closely match the Center's needs.

In our discussions with management, we were advised the management team kept abreast of developments in the commercially available software field through vendor presentations at national conventions and queries with organizations that have purchased and used commercially available software. They stated those experiences were not positive and that others had bought and abandoned such software. However, none of these methods of review address the needs assessment that would be required at the Center to determine what type of system would be needed and how to solicit vendors to provide such a system. Additionally, without some study of the experiences of the other counties, there is no assurance that these sources are comparable to the Johnson County situation.

The billing system, currently handled with LUCI, is not adequate. MCPP also recommended that the Center update the current billing system software in order to maximize revenues, create a better workflow for staff, and auto-post client co-pays based on the billing rules regarding co-pays and sliding scale discounts. Center management responded that they would address the billing recommendation at a later date but were unwilling to establish a time frame for this.

MCPP stated the goals for a modern EMR system should include the identification and implementation of a set of software modules and ongoing training and support that:

- Provides comprehensive and easy to use billing and electronic medical records functionality to JCMHC staff
- Results in a high level of customer/user satisfaction
- Supports rapid and flexible deployment of functionality across all users
- Assures long term viability as technology and functional requirements change over time

Taking the first step sooner rather than later

Based on our review and the recommendations of the MCPP study group, the Center should begin the process of acquiring a full-featured EMR system as soon as possible. The County Information Technology Service (ITS) has business analysts who are trained in assisting other departments in developing an objective needs analysis and converting that analysis into a viable request for proposal. We estimate the process from the start of the needs analysis to a final decision on a way to move forward could take as much as 1 to 2 years. Using the resources available through ITS would allow the Center to begin this process immediately with the smallest investment of the Center's current resources.

2. Center Managers Can Improve Prescription Drug Controls

The Center's management of samples donated by pharmaceutical companies creates an environment conducive to fraud and compromised patient safety. There are no records of incoming samples to establish a beginning inventory and no inventories are maintained once the samples are in the possession of Center staff. The Center does not account for the donated samples in their financial records and has no record of the value of these samples. Additionally, staff takes possession of unused drugs, including controlled substances, from clients and disposes of them but does not document the disposal. The Center has good internal controls for storage and disbursement of prescription drugs purchased by the Center, but they were unaware of the need to include the donated samples in this control system. Consequently, managers cannot be assured that pharmaceuticals have not been lost or stolen.

Recommendations

We recommend the Executive Director:

- 2.1 Maintain a constant inventory of all prescription drug samples.
- 2.2 Establish procedures to test the inventory of prescription drug samples periodically.
- 2.3 Determine appropriate values for the prescription drug samples received by the pharmaceutical companies and record the value of the inventory in the accounting records.
- 2.4 Document the disposal of controlled substances from outside sources.

Management Comments

While we agree in principle with the recommendation to inventory and value drug samples received, it would be difficult and costly to do so. The MHC Nursing Supervisor responsible for assuring the security of on-site pharmaceuticals has estimated it would require up to one additional staff member at each of the three facilities to accomplish this task. In an effort to determine how such an inventory process might be developed, we inquired of Mental Health Centers in both Kansas and Missouri to determine if other CMHCs had implemented this practice. We could find no CMHC in either state that maintains an inventory of sample drugs. The question was then posed in a list serve forum maintained by our national trade association. We discovered one organization in Illinois that maintains such an inventory, supported by a grant from the local United Way, and maintained for the purpose of demonstrating to funding sources the full cost of providing mental health services.

Plans are currently underway to develop an on-site contract pharmacy within the next year. At the time this occurs we will ask the on-site pharmacy to assess the feasibility of maintaining an inventory of drug samples. It should also be noted that the MHC does not receive samples of controlled or addictive substances. Thus, any motivation for abusing or profiting from unauthorized access to samples is minimal.

We agree with the recommendation on disposal of controlled substances brought to the MHC by case managers or clients. A procedure will be developed to record and document the disposal of these medications.

Audit Comment:

This response is inadequate because it relies on unproven assumptions and ignores the substantial risks and applicable accounting requirements.

While benchmarking against other agency practices is often a useful management tool, the findings in this instance indicate an industry-wide problem and should not be used to reinforce a poor management practice. Similarly, the estimate of a staff member, with no corroborating testing or evaluation, does not provide a legitimate basis for a decision.

Center staff does not respond to the key issues involved:

- The County, the Center, and the patients are at risk because of inadequate records of prescription drugs dispensed at the Center.
- The drugs are subject to misuse even if not controlled substances. Misuse scenarios include self medication by doctors, unauthorized use by friends and family including teenagers, and mixed drugs with alcohol which prompted one state to identify one of the drugs as abusive.
- Current GAAP rules require the value of the donated drugs be posted to the County's accounting records and, possibly, disclosed in the annual financial report.
- The plan to discuss a control system with a potential contract pharmacist is not responsive to the immediate need for controls and extends the risk of abuse for an uncertain time period.

We do not believe that it would require three full time positions to maintain adequate records for the donated drugs. We do believe that maintaining adequate records for psychoactive drugs dispensed by a County agency is imperative. Failing to protect the Center's patients because "no one else is doing it" or "it is time consuming" should not be an option.

Discussion

Pharmaceutical companies donate drug samples to Center to promote their products

Center staff issues the donated drug samples to clients who cannot afford to pay for prescriptions and clients whose drug regimens are still uncertain. There are 62 different types of prescription drug samples provided to the Center by 9 pharmaceutical drug companies. Pharmaceutical representatives make weekly visits to the Center to review and restock drugs, and introduce new drugs.

Center staff does not record the receipt of these drugs, maintain an inventory, or reconcile drug stock balances with drug issuance. Consequently, there is no reconcilable record of the drugs received, dispensed, or on hand and no assurance that drugs have not been lost or stolen. This is a breakdown in internal and management controls. Management stated that implementing controls over samples must be weighed in terms of cost-versus-risk. Senior management advised that their queries showed other government entities did not control their samples.

Controls over drug samples were needed

Additionally, there are no financial records of these drugs. The lack of documentation related to these donations makes it impossible for the organization to include their value into the agency's financial records. As a result, their financial impact cannot be currently quantified. For example, the organization would be ill prepared to analyze the impact of changes in the law or practice of accepting donated samples. Valuing these samples and recording that value in the accounting records is required by generally accepted accounting principles (GAAP). The receipt of the samples meets the definition of a non-exchange transaction under GAAP. County policy requires the use of GAAP accounting.

Center management's reasons for not implementing an inventory of the samples do not negate the need for controls over these drugs. The samples can be lost or misappropriated without accountability. The current practice also presents a risk to the clients if drug samples are recalled. Recalls are managed by lot numbers. Since Center staff does not maintain detailed records of the samples they dispense, they could not comply with a recall without a substantial investment of time and effort in reviewing each and every client record to determine the drugs dispensed to the client.

The Center did not appropriately document the disposal of certain controlled substances

The Center maintains appropriate internal controls and documentation on the disposal of controlled substances within the agency's medication inventory. These medications are disposed of in accordance with federal Drug Enforcement Administration recommendations. A registered nurse and one witness administer the disposal process. Documentation of this action occurs in the form of a signed Controlled Substance Record form.

However, there are times when clients or a case manager bring expired or no longer required prescribed controlled substances into the agency. In these situations, a registered nurse and one witness will dispose of the medication in a similar manner but they do not document the process in any way. Applying internal controls already in place with inventoried controlled substances mitigates the risk of theft or misuse in these circumstances.

[This Page Intentionally Blank]

3. Center Staff Need to Provide Refunds to Clients Equitably and Timely

Center staff did not take a proactive approach to refunding overcharges to clients.

- Clients were unaware of entitlement to refunds because staff did not tell them.
- Clients with refund balances less than \$10 were not given the refunds.
- Current clients did not receive refunds because staff held them to offset against future visits.
- Refunds due, but not paid, were written off after 5 years, which did not comply with state mandated unclaimed property rules.
- Some refund balances over \$10 were not delivered timely (46 refunds totaling \$4,020).

Center staff did not refund small amounts because they believed processing costs were excessive. Center staff were also unaware of state statutes concerning reporting and transferring unclaimed property to the state. As a result, 479 clients are owed \$20,410 and \$5,450 is due to the state.

Recommendations

We recommend the Executive Director:

- 3.1 Develop and implement written policy and procedures for processing and accounting for pre-payments, co-payments, and fees for services that might result in overpayments and handling refunds to clients.
- 3.2 Provide clients with materials informing them of the Center's policy and procedures for fee overpayment pursuant to K.A.R. 30-60-15.
- 3.3 Ensure the Center refunds overpayments to clients as soon as all claims are paid in full and the overpayments are recognized as refundable.
- 3.4 Send notification to clients when a refund is due to them.
- 3.5 Provide refunds to all clients due overpayments including clients whose balances may have been written off.
- 3.6 Report unclaimed overpayments over a year old that cannot be refunded to clients to the Kansas Secretary of State pursuant to K.S.A. 58-3950.

Management Comments

- 3.1 *A refund policy will be developed that documents the policy and procedures pertaining to client refunds. Additional consultation will be sought to ascertain what is legally required. The policy will balance the legal requirements with good customer service, and the staff resources available to perform the tasks.*

- 3.2 *The Fee Policy Information form will be updated to reflect the Center's policy.*
- 3.3 *JCMHC will be looking to allocate more resources to auditing and processing of refunds. However, the current status of refunds, as reflected on the February 12, 2008, report, does not indicate any major problems in our current processing. The information in the auditors' report indicating lax processing of refunds cited "the Center was holding 46 refunds over \$10...for closed cases". The time span that the credits were on our books averaged only 38.75 days from closure or the date of the payment. The statement "Three of the clients' cases had been closed for over two years," does not reflect late refunds. These clients had balances due and were paying on accounts after their case was closed.*

Contrary to the auditors' report, at no time did the Center owe clients \$25,858. Client payments are automatically applied to the oldest unpaid charge through an electronic batch process. Due to timing differences between when the money is collected and the charge is entered on the account, payments will stay in this batch. For most clients this is just a few days after the service has been provided.

- 3.4 *Sending client's notification when refunds are due would be duplicative. When we know a refund meets the criteria for repayment, a check would be requested with an accompanying letter of explanation. A process will be developed to notify clients of small credits such as \$.01 to \$1.00 or \$2.00 and to return the credit in the most cost efficient manner.*
- 3.5 *The Center was unaware of the provisions of the Unclaimed Property Act and have since notified the Kansas State Treasurer's Office and entered into their voluntary compliance program. A check for \$ 6,341.25 has subsequently been sent to the state Treasurer's office, bringing the Center into compliance. This amount represents overpayments spanning 18 years and 764 clients This averages \$352.30 per year, and \$8.30 per client.*

Client credit balances were not "written off", but were being tracked in a separate client history file, which also included amounts for refund checks returned as undeliverable. If the client is readmitted for services any credits in the history file are moved back to the live area to be applied to their new services. There was no time limit applied to this process. These amounts will now be sent to the state.

It is the practice of Johnson County Mental Health Center to refund client overpayments when the credit is confirmed (e.g. does not belong to another client or to a family member) and the credit is not likely to be used to pay for current services (e.g. the client's case is closed or the client now has a third party payor such as Medicaid that does not require a co-payment). JCMHC adheres to state standards that require admission and discharge for each episode of care. As long as a chart is open there is an expectation that the client is still under care and will be receiving on-going services.

Audit Comment:

The Center should comply with all legal and GAAP accounting requirements. Unless client overpayments can be applied to a current service charge or open claim, the overpayment belongs to the client and should be refunded as soon as practical.

The Center has used two dates to determine the time span the “credits were on the books”. They have used the “closure date” or the “date of payment” whichever is later. Using two dates creates a difference between the Center’s calculation and the audited calculation which uses one, consistent date.

The actual number of days that client funds were held by the Center averaged 231 days not 38.75. Based on the Center’s own records, client funds were held by center up to 2,054 days (5 years). There were 222 instances where client funds were held by the center in suspense for over 365 days.

An analysis of client open claims and payments held in suspense as of February 12, 2008, showed the Center held over \$20,400 paid by 479 active clients who did not owe anything to the Center. On that date, the Center also held \$5,450 in clients’ history files (archives) due to clients.

Discussion

Kansas State Regulations

Center staff are required to follow certain Kansas Department of Social and Rehabilitation Services regulations as a Kansas Mental Health provider. KAR 30-60-15 (d) states in part:

- (d) Each Center shall make available at the Center, and at other appropriate locations, materials that provide information about the following:
 - (1) A description of the Center and the services that the Center or its contractors provides
 - (2) A description of any affiliated Center or affiliate with which the Center has an affiliation agreement and the services that each provides
 - (3) The rights of consumers
 - (4) The Center's policy on fees and adjustments to those fees
 - (5) The ways to contact the Center for services

- (e) The materials specified in subsection (d) shall be designed to be comprehensible to persons with only a limited education

Center staff provide information about the Center’s policy for fees and adjustments at each client’s intake meeting. During this meeting, the intake coordinators do not provide the clients any information regarding policy or procedures for overpayment of fees.

Kansas Disposition of Unclaimed Property Act

According to K.S.A. 58-3950, holders of unclaimed property must annually report the property to the Kansas State Treasurer's Office. K.S.A. 58-3935 states that property is presumed abandoned when held by a court, state or other government, governmental subdivision, agency or instrumentality, a year after the property becomes distributable. The annual report is due November 1 of each year and covers the 12 months preceding July 1 of that year. Part of the report process is to remit the amounts determined to be abandoned to the State Treasurer.

Payment Processing

Center staff collect co-payments or fees for service from clients as necessary. These payments are held in suspense until all other third party payers, such as Medicaid, Medicare, or insurance companies have paid the allowable amount on the claim. The funds held in suspense are applied to any remaining balances due on the claim. Clients are entitled to refunds of any balances after third party payers make their payments.

As of February 12, 2008, the Center held in suspense payments made by 479 clients totaling \$20,409.24 that did not have any open unpaid claims due. An additional \$5,449.26 in credit balances were held in an undetermined number of clients' history files. Based on the last payment dates provided to us by the Center, the overpayments were held in suspense an average of 231 days. As of February 12, 2008, over 479 clients were due refunds totaling \$25,858.50.

Refunds due to clients need to be managed properly

The Center's procedures for paying refunds were based on the following criteria:

- Refunds under \$10.00 were held in suspense for 5 years and then written off as undeliverable.
- Refunds over \$10.00 were held in suspense to apply to future client visits.
- Refunds over \$10.00 for clients with closed cases were remitted to clients when the case was closed.

The cash was retained in the Center's bank accounts.

Center staff did not inform clients of any of these practices. As a result, clients were generally unaware of any refunds due until they received a check or a reduction in billing. If a client knew about a refund and requested it, Center staff would encourage the client to leave the balance for application to future services (clients with open cases). If the client preferred, the refund would be given. Failure to inform clients does not conform to Kansas administrative regulation requirements in KAR 30-60-15.

Center clients did not receive entitled refunds

Not all refunds for clients with closed cases were remitted when the case was closed. As of February 12, 2008, the Center was holding 46 refunds over \$10 totaling \$4,020 for closed cases. Three of the clients' cases had been closed for over 2 years.

Center staff did not refund amounts under \$10 because they believed processing costs exceeded the amount of the refund. Even if the processing costs exceed the balances, the funds belong to the client and should not be subjected to this practice. After 5 years, the amounts were written off. The Center kept the money.

Center management and staff were unaware of Kansas statutes (KSA 58-3950) addressing unclaimed property. Consequently, they did not properly identify refunds as unclaimed property or transfer the property to the state as required. As of March 2008, \$5,450 was kept by the Center that should have been remitted to the Kansas Treasurer.

Accounting practices for pre-payments and co-pays do not comply with standards

According to Generally Accepted Accounting Principles (GAAP), revenue recognition does not occur until the service has been provided and all of the conditions have been met to determine the amount and timing of the transaction. The Center posts pre-payments and co-pays to a revenue account for private patient care when the payments are received. At the time the Center accepts the pre-payment or co-payment, the conditions necessary for revenue recognition under GAAP have not been met.

In the case of prepayments, services have not yet been provided to the client. In addition, payments may be received from insurers which will offset all or part of the payment received from the client. Therefore, at the time of the original receipt from the client, the pre-payments should be posted to a liability account in the County's accounting system (Oracle) until the service is provided, and the amount due from the client can be determined. Any client's payments that were not required after subsequent determinations should be refunded immediately to the client.

[This Page Intentionally Blank]

4. Center Managers Can Improve Their Employee Performance Appraisal Process

Center supervisors did not complete 405 of 679 (60%) employee annual performance appraisals when they were due. Center management did not emphasize the importance of timely employee performance appraisals. In three instances, annual appraisals were not completed until over a year past the original due date. Late appraisals can negatively affect employee morale, diminish the value of salary increases, and may consume additional resources needed to retroactively apply merit pay increases.

Recommendations

We recommend the Executive Director:

- 4.1 Ensure performance evaluations are completed when due for each employee.
- 4.2 Hold department supervisors accountable for the evaluation process.

Management Comments

We agree that timeliness of performance appraisals needs to be improved, and will establish a procedure to assure that supervisors complete appraisals on a timely basis. Special attention will be given to the 17% of appraisals over 30 days late.

Discussion

Human Resources Policy

County departments and agencies are responsible for completing and submitting timely employee performance appraisals to the Department of Human Resources. Employee merit increases are based on department recommendations, supported by the annual performance appraisal. Late appraisals may result in the need for retroactive pay to account for missed merit increases.

Human Resource Policy 301-10 states:

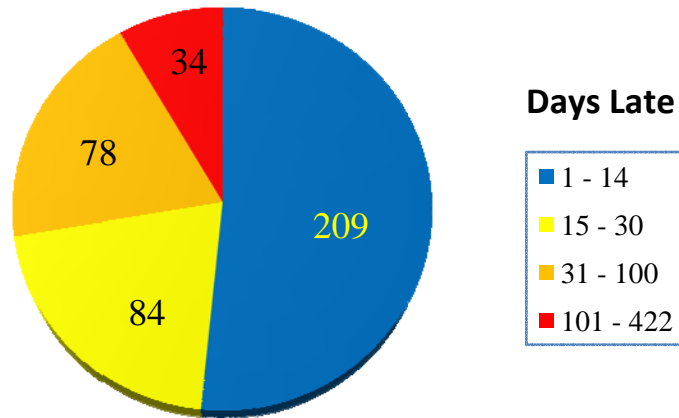
Departments/agencies are responsible for submitting merit pay rate increases to the Department of Human Resources no later than the last day of the pay period prior to the employee's performance review date. ***Merit pay rate increases should not be submitted retroactively*** (emphasis added). Supervisors will be held accountable in their performance appraisals for conducting and processing late merit pay rate increases.

Center appraisals are submitted late

There were significant deficiencies in the timeliness of completed appraisals. We reviewed the entire population of Center employee performance appraisals submitted to Human Resources in

2006 and 2007. Of the 679 appraisals submitted, 405 or 60 percent, were late. Some of the appraisals were significantly late, including 34 appraisals that were over 100 days late and 3 appraisals submitted over a year late .

Table 4.1: 2006 - 2007 Breakdown of Late Annual Appraisals



Source: Audit analysis of a 2006-2007 Employee Appraisals submitted to Human Resources

Late appraisals are preventable

We selected a sample of retroactive pay transactions and asked the department to provide corresponding justifications. These included, but were not limited to the following:

- Supervisor preoccupation
- Paperwork processing delays
- Involvement in the MCPP study
- Supervisor workload challenges
- Employee did not provide the information needed to complete the appraisal
- Employee scheduling difficulties
- Waiting for MNH Board Approval

Late performance appraisals and retroactive pay could have been prevented if Agency management practiced due diligence. Department supervisors should anticipate potential processing delays and account for them accordingly in the performance appraisal process. In addition, the County Oracle Human Resource Management System generates and sends a performance appraisal reminder notice to supervisors 60 days in advance of the review due date and at regular intervals after that time.

Late evaluations could cause morale problems

Performance evaluations are given annually. This is the time for employees and supervisors to officially convey actual performance concerns and accomplishments. From an employee

standpoint, the evaluation date is critical and anticipated annually. A delay or an oversight by supervisors sends the wrong message to the employee about management's interest in them.

[This Page Intentionally Blank]

5. Center Staff Has Not Performed All Necessary Background Checks

Center staff did not comply with County and Center requirements for 418 of 3,559 employee background checks. The Center did not perform 118 background checks and was late in performing an additional 300 background checks. Each Center employee is subject to multiple checks and the 418 improperly performed checks applied to 132 employees. The Center has not developed written policy for the required background checks, and procedures that instruct administrative staffs are vague and inadequately documented. Center administration staff stated the employee background checks were costly and batching background check requests slowed the process down. The required background checks protect the clients from employees with potential criminal or abuse records. Clients are at risk when all appropriate background checks are not performed in applicable timeframes.

Recommendations

We recommend the Executive Director:

- 5.1 Develop and implement written policy and procedures for performing the appropriate employee background checks to protect clients.
- 5.2 Ensure that all required background checks are performed on a timely basis.

Management Comments

We agree that timeliness of background checks needs to be improved. Center Management has begun discussions of ways to make this process more efficient. The procedures have been redistributed to staff and the requirements for consumers have been clarified.

Discussion

Center employees must undergo a series of background checks to maintain employment

Center staff selected appropriate background checks from various state and local agencies to ensure the safety of clients and other employees. With employees easily moving across Kansas and Missouri state lines within the Kansas City metropolitan area, it is necessary to obtain background checks from both states. Three annual background checks are required of all Center employees:

- Kansas Bureau of Investigation (KBI) provides the Kansas criminal history record search.
- Missouri Highway Patrol (MHP) provides the Missouri criminal history record search.
- Department of Health and Human Services Office of the Inspector General (DHHS OIG) maintains a listing of individuals and businesses excluded from providing services for Medicare and Medicaid.

The following background checks are required of all clinical/program, residential, and maintenance staff:

- Kansas Adult Central Registry – list of individuals charged with adult or elderly abuse in Kansas.
- Kansas Child Abuse and Neglect Central Registry – list of individuals charged with child abuse or neglect in Kansas.
- Missouri Department of Mental Health Disqualified Registry – list of individuals disqualified from providing services to the mentally ill or developmentally disabled in Missouri.
- Missouri Department of Social Services – list of individuals charged with child abuse or neglect in Missouri.
- Missouri Department of Aging – list of individuals charged with elderly abuse in Missouri.

Staff are required to check driving records at appropriate state motor vehicle divisions for drivers of county vehicles.

Background checks for some employees were either late or not done

Records show 132 employees had background checks that were late or never done. Of these, one employee had not had any required background checks and four other employees had all nine required background checks either late or never done.

The Center has not developed written policy for the required background checks. Center background procedures are maintained on a Microsoft Excel spreadsheet. The spreadsheet does not indicate how often background checks are to be performed or clearly identify who is required to have the various checks.

Clarity needed on background check requirements

Center staff stated background checks are supposed to be updated annually. This ensures employees have not had criminal charges and/or adult or child abuse accusations filed against them in the past year. The DMV checks are important to ensure that employees' driver's licenses have not expired or been suspended.

The table below shows the number of background checks that should have been performed and which background checks are more regularly missed or not done.

Table 5.1: Late/Missing Background Checks

| Type of Background Check | No. of Background Checks Required | No. of Employees Did Not Have the Background Check | No. of Employees Have Not Had the Background Check in >365 days | Percent Late or Missing |
|---------------------------------|-----------------------------------|--|---|-------------------------|
| KBI | 459 | 1 | 62 | 14 % |
| MHP | 459 | 19 | 44 | 14 % |
| DHSS – OIG | 459 | 16 | 63 | 17% |
| KS Child Central Registry | 395 | 15 | 18 | 8 % |
| KS Adult Central Registry | 395 | 15 | 18 | 8 % |
| MO Child Abuse | 395 | 18 | 21 | 10 % |
| MO Dept of Aging | 395 | 15 | 12 | 7 % |
| MO DMH Disqualification | 395 | 18 | 17 | 9 % |
| Kansas DMV | 221 | 0 | 35 | 16 % |
| Missouri DMV (Out of State DMV) | 50 | 1 | 10 | 22 % |
| Total Background Checks | 3,559 | 118 | 300 | 12% |

Source: Audit Services analysis of Mental Health Center employee background checks for all current employees.

Center staff indicated that the MHP background checks were late due to processing requirements. MHP requires that agencies provide payment at the time the background checks are requested. In order to reduce the number of check vouchers that are processed by the county, Center staff groups employees into a large request batch and makes one payment for the processing fee.

Center staff stated the cost of running all the background checks was rising and the department was having difficulties keeping up with the costs of performing the required background checks. Center administration stated they were considering contracting with a company to perform the appropriate background checks.

Based on the cost of the background checks provided in the Center procedures, the Center pays between \$21.50 and \$28.00 per employee each year to perform all the required background checks. The Center would pay \$9,618 per year to perform all of the required background checks on all employees.

Center staff also stated some administrative staff were not clear on the background check requirements for consumer employees. The procedures did not specify which checks should be performed on consumer employees. Most consumer employees work within Center programs that would require the three background checks that are performed on all employees and the five additional background checks that are required for all program, residential and maintenance staffs.

The Center should develop written policy and procedures clearly defining which background checks are required for which employees and define how often the background checks should be performed.

6. Center Can Reduce Purchase Orders, Check Requests, and Petty Cash Amounts

Using statistical sampling techniques, we estimate 2,228 of 5,251 checks issued by the Center under \$10,000 were unnecessary. The Center should have used the County purchasing cards (P-Card) or automated expense reimbursement system (iExpense) to make these purchases instead of using purchase orders (PO) or check requests. The Center processed the PO and check requests to pay store charge accounts, reimburse employees' expenses, and reimburse petty cash accounts that were unnecessary. Officials stated the employees making purchases and requesting reimbursements were not long term employees, so they did not want to issue P-cards to them and manage the issue and return of the cards upon employee arrival and departure. This resulted in at least \$90,489 in unnecessary processing costs.

Recommendations

We recommend the Executive Director:

- 6.1 Evaluate employees' use of check requests and petty cash to ensure that the employees that need P-cards are assigned them.
- 6.2 Ensure employees use iExpense for reimbursement of business related expenses instead of using check requests.
- 6.3 Evaluate the use of all petty cash accounts and consider eliminating the five client activity fund petty cash accounts totaling \$2,100.

Management Comments

The Mental Health Center is committed to carrying out all segments of its operations in an effective and efficient manner. The change to the use of iExpense and P-cards has been one that we have worked hard on, while still respecting the pace at which all of our staff can come on board. We currently have over 74 staff utilizing P-cards and in 2007 over 4,555 purchases were made. I-expense is used by all staff who routinely have expenses eligible for reimbursement and resulted in 3798 i-Expense transactions submitted in 2007.

We have reviewed the transactions in the auditors' sample of check requests cited as payments that should have been made through the use of a P-card or submitted through i-Expense. Most of these transactions had already been transitioned to the recommended process. Of those remaining, some could only be made through a check request, such as reimbursements to consumer employees, payments to organizations that do not accept the P-card, etc, and a few we will act on to make the change.

With respect to the petty cash activity funds, we disagree that these should be closed. We do not consider \$2,100 of cash at 5 different offices to be a significant risk. The accounts in question are activity funds used by our community based programs for client therapeutic activities. Each program has staff who have been issued P-cards and use them whenever possible for client

activities. For those instances when P-cards cannot be used, or the staff with the P-card is not available, petty cash is necessary. We will continue to review the adequacy/need of the accounts and make changes according to those reviews.

Discussion

County Purchasing Policy and Goals

County purchasing policy (110.110) is to obtain needed goods and services at the lowest ultimate cost consistent with prevailing economic conditions, appropriate standards of quality and continuity of service, while establishing and maintaining a reputation for openness, fairness and integrity.

The related county procedure (110.110) states, in order to achieve value, a purchase must be effective, efficient, and economic. The procedure states efficiency of a purchase includes:

The time and effort expended, from definition of need through final delivery, and the costs associated with acquiring the needed goods and/or services are reasonable in order to achieve value.

P-Cards and iExpense transactions provide efficiency in purchases and provide internal controls. Johnson County Office of Financial Management (OFM) has a goal for departments to use purchase cards for 80 percent of transactions under \$10,000. OFM also recommends using the automated iExpense system for reimbursement of employee expenses.

OFM updated its purchasing procedures in 2007 and eliminated the county's use of store charge accounts. Previously, county agencies could open store charge accounts and provide suppliers with a listing of employee names authorized to make purchases on the account. The store would bill the agency monthly for the purchases made on the charge account. The agency would process a purchase order or check request through OFM to pay the bill. Store charge accounts lack the internal controls that are built in to P-Cards.

The Center's purchasing practices are inefficient

We reviewed a statistical sample of the Center's paid invoices that included 167 checks, 165 of which were under \$10,000. We found 24 percent (41 of 165) checks were for purchases that should have been made with a P-Card. An additional 18 percent (29 of 165) checks should have been processed through iExpense.

Our statistical sample was based on a 90 percent confidence level with a 5 percent interval. This means that based on our sample, we can project the results of our sample review to the population with 90 percent confidence that we would find the same results in the population within a range of 5 percent above or below the sample results.

The Center requested 5,251 checks under \$10,000 from January 1, 2006, through September 30, 2007. Based on a statistical sample, we estimate 1,305 of the 5,251 could have been made using

P-Cards saving the County approximately \$90,489. (OFM estimates a savings of \$69.34¹ for each payment made with a P-Card rather than a check.) We estimate that an additional 923 of the 5,251 checks requested by the Center, should have been made through iExpense. OFM has not calculated the savings in processing reimbursements through iExpense instead of check requests to employees, but does acknowledge there is a cost savings.

Center used check requests to pay for the store charge accounts instead of providing employees with P-cards and eliminating the added expense of check requests. Center management said it was easier to update the lists of authorized employees at the stores than to provide employees with P-Cards because the Center turnover rate was high. Since OFM changed its procedures and eliminated the use of store charge accounts, Center has increased its use of P-cards, told employees not to use the store charge accounts, and closed at least three of the accounts.

P-Cards would be a more effective purchase method

The Center also used check requests to process employees' job related expense reimbursements. Officials said many of the employees do not have access to Oracle, the county's financial software, or iExpense while they are in the community. iExpense has built in internal controls and can be processed more quickly than a check request. All county employees should have access to iExpense when necessary.

Petty cash accounts can be reduced

The Center has 19 petty cash accounts totaling \$8,000 cash in 6 locations. Four of the locations have at least three different petty cash accounts. The petty cash accounts are reconciled and reimbursed monthly. From January 2006 through September 2007, the petty cash accounts were reimbursed \$94,928.

Not all of the petty cash accounts are needed

We reviewed all but one of the petty cash accounts. Three of the petty cash accounts are actually client subsidy accounts that provide emergency financial assistance to Center clients. Over 80 percent of the cash reimbursed through the petty cash funds was through these three accounts for housing, utility and other emergency assistance.

Below is a table of the types of petty cash accounts and the total amount of cash available:

¹ OFM reports it costs the county \$91.13 to process a purchase order while the cost of processing a P-Card transaction is only \$21.79. Based on OFM reports, the county saves \$69.34 for each transaction processed with a P-Card instead of a PO. OFM based these cost savings on a survey from the National Institute of Governmental Purchasing (NIGP).

Table 6.1 Petty Cash Accounts Available

| Type of Cash Account | Total Number of Accounts | Total Cash Amount | Number of Locations with Account Type |
|-----------------------------------|--------------------------|-------------------|---------------------------------------|
| Administrative Petty Cash Account | 7 | \$ 950 | 6 |
| Client Activity Fund | 5 | \$ 2,100 | 5 |
| Change Accounts | 4 | \$ 275 | 4 |
| Client Subsidy Account | 3 | \$ 4,675 | 3 |
| Total | 19 | \$ 8,000 | |

Source: Audit Services analysis of petty cash accounts.

Five of the petty cash accounts were client activity funds totaling \$2,100 used for employee purchases of food, entertainment and supplies for client activities. We found \$14,171 (15%) of the cash reimbursed were to these accounts. Most of the purchases we reviewed could have been made with a P-Card.

If P-cards or iExpense can not be used for a client activity, there are an additional 7 administrative petty cash accounts from \$50 - \$300 at the various Mental Health Center locations that can be used if cash is needed.

There were additional reimbursements totaling \$496 to employees that could have been processed through iExpense. The charges included mileage reimbursement, parking tolls, lodging and fuel. The Center has an unwritten practice of allowing employees mileage reimbursement and other job related expenses reimbursement from the petty cash accounts up to \$10. If the reimbursement is over \$10, the employee creates a check request or uses iExpense.

Center officials said employees that use the petty cash funds are usually in positions with high turnover rates and for that reason management did not want to authorize P-Cards. Many of these same employees are in the community often enough that they do not have access to iExpense. MHC has a FTE turnover rate of 15.1 percent, which is just slightly higher than the overall county rate of 14.3 percent. All Johnson County employees should have access to iExpense.

Center officials said they wanted to limit the liability to the county by providing employees cash for the business related purchases. Neither cash nor store charge accounts have the same internal controls that P-Cards and iExpense contain. The Center can limit liability and save processing costs to the county by managing transactions and monthly purchasing limitations on the P-Card and providing access to iExpense. Furthermore, the risks associated with having \$2,100 of cash on hand can be eliminated.

7. Center Staff Did Not Report Accounts Receivables Due from Clients or Write-Off Amounts as Required

The Center had an accounts receivable balance for unpaid client fees of \$1.2 million as of December 31, 2007. Only \$52,598 was reported to OFM at the year end because Center administration did not anticipate receiving all of the \$1.2 million. The failure to record the accounts receivable accurately is the result of failing to comply with GAAP requirements for revenue recognition.

Center officials stated the bulk of the open charges due from clients are written off once they have remained unpaid for 5 years. However, the Center received \$575,181 from clients' fees in 2007, which included \$202,293 in accounts receivable from prior years. During the audit, Center staff estimated 27 percent of the original accounts receivable will be uncollectible. We estimate that \$874,000 of the unreported accounts receivable is collectible. The actual accounts receivable, amounts written off, and an estimate of uncollectible accounts receivable should have been reported to OFM at year end.

Recommendations

We recommend the Executive Director:

- 7.1 Comply with GAAP requirements for revenue recognition and posting of accounts receivable.
- 7.2 Report accurate Accounts Receivable amounts to OFM at year end.
- 7.3 Develop procedures for determining amounts to include in an allowance for uncollectible accounts.

Management Comments

The auditors report noted the Center had \$1,270,295 in unpaid charges at 2007 year end, yet reported only \$52,598 to OFM as accounts receivable. The auditors "...estimate \$874,000 of the unreported accounts receivable is collectible" and should have been reported as such to OFM at year end. We strongly disagree with the estimated amount of open items that will be collected, and the method used to calculate this amount. Using the figures as reported in the Performance Audit would grossly overstate our revenues and fund balance, thus seriously misstating the Center's financial position.

We performed an in-depth analysis of 7 years of payments and charges which showed an average total collection of 73.5% of yearly client charges over time. Approximately 50% is collected in the year the service is provided. The remaining 23.5% is collected in the next 3 years. The remaining amounts stay as open items until the Mental Health Center's criteria for write-offs is met. For most accounts this is 5 years after no payments or clinical contact has been

made. Our most optimistic estimate of the amount of the original \$1,270,295 that would be collectible in 2008, based on this 7-year analysis, is \$157,450.

The auditors noted “Staff did not follow the generally accepted accounting principles (GAAP) when reporting accounts receivable.” We have reviewed at length our procedures for reporting accounts receivable at year end for the Comprehensive Annual Financial Report with the county’s external auditor, and Office of Financial Management (OFM) staff. Both found our current procedure to be in compliance with GAAP. Recording transactions in accordance with GAAP on a daily basis is not the current county policy. County policy 100.3 requires GAAP for “preparation of the County’s annual audited financial statements.”

Audit Comment:

Center staff misunderstands the audit comment and recommendations. Accounts Receivable balances need to be reported at year end. We understand that they do not need to be recorded during the course of daily operations. Our recommendations for revenue recognition and year end reporting to OFM are designed to correct the current practice of underreporting receivables at year end. Discussions with OFM subsequent to this reply indicated that OFM staff was not aware of the total amounts unreported or the methodology used in calculating the net accounts receivable.

Center staff agrees that as of December 31, 2007, there were outstanding accounts receivable, on a GAAP basis, of \$1,270,295. They did not report this amount to OFM at year end nor did they report a net amount consisting of this amount and a calculated allowance for uncollectible accounts, nor did they report the \$157,450 they now conclude was receivable. Instead they reported \$52,598. We believe that reporting \$52,598 when the reported balance should be \$927,315 indicates an area for improvement and does not give OFM or the external auditors the information needed to value the receivables and make decisions about appropriate reporting.

Discussion

County Policy and Financial Guidelines

County Financial Policy 100.3 states that all agencies, departments, elected officials, boards, commissions, representatives, and authorized agents:

...will follow accounting principles generally accepted in the United States of America applicable to government units (GAAP), as promulgated by the Governmental Accounting Standards Board (GASB), in the preparation of the County’s annual audited financial statements.

OFM has developed Accounts Receivable Guidelines and Year End Closing guidelines to ensure county agencies and departments are following generally accepted accounting principles for reporting financial information for year end reporting. County financial data is reported in the Comprehensive Annual Financial Report, the Schedule of Schedule of Federal Expenditures of

Federal Awards (Single Audit), and the Social and Rehabilitation Services (SRS) Audit. Year end financial data must be reported appropriately to provide accurate financial information for the external auditors to review and audit the County's financial records, These guidelines require departments or agencies that bill for services to report all accounts receivable in aggregate over \$2,000 and all amounts written off.

The Center staff stated since these were guidelines and not policy they did not think they were required to follow the guidelines as written.

The OFM guidelines are created to ensure the county departments and agencies follow GAAP in reporting and county financial policy.

Center did not report accurate Accounts Receivables or Write-Offs

Staff did not follow the generally accepted accounting principles when reporting accounts receivable. At the year end 2007, staff reported \$52,598 in accounts receivables due from clients' fees. The amount reported to OFM included amounts billed and receivable on some closed cases but did not include any amounts from open cases, which, at the end of 2007, was \$1,217,697. Center did not report any of the accounts receivable amounts that were written off in 2006 or 2007. In those years, Center wrote off \$122,975 and \$98,377 respectively. At the end of 2007, the Center actual accounts receivable was \$1.27 million.

GAAP requires that revenue be recognized as soon as the amount of revenue can be determined. This occurs when a bill for services is generated. This results in posting the appropriate revenue and an offsetting accounts receivable. Center staff has routinely waited until the payment has been received from the billed amounts before posting the revenue. This process works except at the end of the year when all GAAP basis revenue needs to be recognized for accrual basis reporting. Failure to accurately make these accrual basis entries results in an understatement of current revenue, current accounts receivable, and fund balance for reporting purposes.

The table below details how the accounts receivable should have been recorded by the Center and reported to OFM at year end:

Table 7.1 Accounts Receivable Balance

| Year | Accounts Receivable Balance | Estimated Uncollectible* | Net Accounts Receivable | Reported to OFM | Unreported Accounts Receivable |
|-------------|------------------------------------|---------------------------------|--------------------------------|------------------------|---------------------------------------|
| 2006 | \$ 878,280 | \$ 237,136 | \$ 641,144 | \$ 46,144 | \$ 595,000 |
| 2007 | \$ 1,270,295 | \$ 342,980 | \$ 927,315 | \$ 52,598 | \$ 874,717 |

*Amounts estimated based on average collectible amount of 73% per year
 Source: Audit Services analysis of unpaid claims, write offs, and accounts receivable.

The Center bills clients for fees for service within 30 days of the service. After the bill is unpaid for 90 days, the clients' fees go to collections. The Center writes off clients' unpaid balances after 5 years. In 2007, the Center billed clients \$941,046 and received \$372,888 of the 2007

billed fees. The Center received an additional \$202,293 in 2007 from clients' fees that were billed in 2006 or prior years, when only \$46,144 was reported in accounts receivable at year end 2006.

Administrative staff stated they did not want to report the total accounts receivable because they did not want the users of the financial reports to assume the total amount was collectible. During the audit, Center staff estimated 27 percent of the original accounts receivable will be uncollectible.

The Center needs to report all accounts receivable and develop procedures for determining uncollectible amounts in order to comply with GAAP and the county policy.

OTHER MATTERS

Reports to the Board of County Commissioners

In the 2008 State of the County report, Center staff reported a 3-month average wait time for initial psychiatric evaluations. Subsequent audit analysis revealed emergent patients (those requiring immediate care) were excluded from the cited average.

In 2007, Center staff performed 1,602 new psychiatric evaluations. Of these, 1,147 or 71.6 percent were routine appointments and 455 or 28.4 percent were emergent. Adjusting the analysis for emergent evaluations reduces the average initial wait time for psychiatric evaluation from 90 to 65 days.

By excluding the emergent patient numbers from the calculation, the average wait time for initial psychiatric evaluations is distorted. To present an accurate statistic, references to these figures should clearly disclose emergent appointments are excluded from the calculation. Other alternatives would be to include emergent appointments in the average calculation or split the measurement to give the consumer of the information a more complete picture of the reported conditions.

Further, the 3-month average wait period was calculated through periodic informal surveys of staff rather through a data collection and evaluation tool. The actual average for routine appointments may be more or less. Formal quantitative data on patient wait times would make this management measure more accurate and meaningful.

[This Page Intentionally Blank]

OBJECTIVES, SCOPE AND METHODOLOGY

Objectives

To determine if Center programs are managed effectively and efficiently and in accordance with applicable policies, procedures and statutes by performing the following specific objectives:

- Review the consultant's Mental Health Center Independent Review and Evaluation of JOCO Mental Health Center and determine if management plans to implement the recommendations set forth in the action plan.
- Review Accounts Payable and P-Card expenditures to determine if savings can be achieved by eliminating waste and determine if internal controls are in place to reduce risk in purchasing.
- Review purchasing practices to ensure compliance with applicable County policies and procedures including the utilization of purchasing within County established contracts.
- Review employee meal and travel expenses to determine if the Center is in compliance with applicable County policy and procedure and if effective management controls are in place over such expenses.
- Review contract management to determine if contracts are managed effectively and efficiently.
- Review medication control and management to determine if the Center is in compliance with state and federal laws and ensure pharmacy orders are managed effectively and efficiently.
- Review the Center's procedures for background checks to determine if due diligence is used in selecting and maintaining appropriate personnel.
- Review Accounts Receivable, Medicaid and third party billing procedures to determine effectiveness and efficiency in billing and coding.
- Perform an asset inventory review to determine compliance with applicable County policies and procedures.
- Analyze and test the Performance Measurement System to determine if goals and measures specifically describe the outcome desired and develop specific performance measures to measure the outcomes and goal achievements.
- Review Grant management to determine if all avenues of funding are explored for the Mental Health Programs and expended accordingly.

Between January 1, 2005, and September 30, 2007, Center staff received \$18.9 million in grant funds. They applied for \$100,000 in additional grants that they were not awarded. We reviewed grant expenditures. Nothing came to our attention which required further audit.

- Review of outpatient client treatment plans to determine if Center policy and procedures and Kansas guidelines were followed in the maintenance of the treatment plans.

We reviewed a small sample of outpatient client treatment plans. We stopped our review of the client treatment plans when we found the same issues that were found in the Kansas SRS licensing review done in November 2007. The Center was in transition to make improvements to the management of treatment plans based on the findings from the licensing review.

Background

Johnson County, Kansas is located in the metropolitan Kansas City area, includes 16 suburban cities and has a population of 501,584. The Johnson County Mental Health Center (Center) operates under the auspices of Johnson County government, with a governing board appointed by the County Commission. The Mental Health Center's Budget for 2007 exceeded \$30.9 million.

The Center is mandated to provide medically necessary mental health services to state designated target populations – adults who have Serious and Persistent Mental Illness (SPMI) or children/youth who have Serious Emotional Disturbance (SED). In addition, the Center provides medically necessary mental health services to indigent residents of Johnson County as well as providing mental health services within the County justice system. In 2006, the Center operated six service sites with 385 staff, and served 9,020 unduplicated people in general outpatient clinics (Mission, Olathe and Blue Valley) and specialized programs.

Scope and Methodology

We limited the scope of our review after reviewing the recently issued consultant's report on management operations and the Executive Director's response. The consultants made substantial recommendations regarding management and compliance with mental health guidance and standards. The Center responded with general agreement and a plan of action to ensue for 5 years. We focused our audit on management and control of assets, inventories, medications and other operations. We examined transactions for the 2 - year period 2006 - 2007.

Audit procedures used included interviews, policy and procedure reviews, and reviews of literature in the field, and selected tests of transactions.

Computer Data

We used data from various computer systems in performing this audit including, but not limited to: The County's Oracle financial and human resources system (Oracle), the Center's LUCI database system, and other systems used to gather information and report on operations.

The Oracle system data has been validated by others as part of the annual audit process. We tested the information from the LUCI database system and did not find anything to indicate that the data in that system was unreliable. We did not rely on any other systems other than to make selections for testing purposes.

Our review of the LUCI system and its functionality did not include a review of the information system security or the related documentation of the security.

Statistical Sampling

We used both statistical and judgment sampling to select items for review. We used statistical sampling to select testing samples in a number of audit steps. We designed our samples to provide 90 percent assurance with a 5 percent margin of error. Both sample sizes and items to be reviewed were generated by commercial statistical software. Judgment sampling was used primarily for attribute testing – procedural compliance.

[This Page Intentionally Blank]

ADDITIONAL MANAGEMENT COMMENTS

1. Center Management Needs to Consider Upgrading the Electronic Medical Records Software

The Audit Report contains several statements regarding LUCI we find to be inaccurate or incomplete in their description of the current system:

“Since its inception, Center staff programmers have added limited functionality to the system”

We disagree with the statement of limited functionality. As noted above, 13 major enhancements, plus numerous smaller improvements have been made to the LUCI system since its inception. Some examples of the major enhancements include:

- *Electronic Appointment scheduling for all clinical staff.*
- *Electronic documentation of all after hours contacts (approximately 4500 annually).*
- *Electronic documentation of all new service inquiries/requests (approximately 2000 per month) regardless of whether or not the individual becomes a client.*
- *Electronic billing for all client services; third party insurance; and Medicaid Waiver services (over 15,000 bills/claims generated per month).*
- *Electronic submission to state of all state required data (admissions, discharges, client demographics, client outcomes, etc.).*
- *Development of an electronic medical records (EMR) system, resulting in a medical record that is currently 80% paperless (approximately 16,000 clinical notes now entered electronically each month).*
- *Electronic access to digitized archived medical records (over 22,000 archived medical records dating to 2002).*

These, and other, enhancements have led to a system that would be scarcely recognizable from its original version. Contrary to the audit statement, an enormous amount of functionality has been added, and continues to be added, to the system.

“LUCI has limited functionality for clinical and medical staff. It is not an actual EMR system for clinical and medical staff.”

It is important to note that the vast majority of JCMHC clinical services are provided by non medical staff. LUCI is an actual EMR system for the over 240 MHC non medical clinical/program staff. While LUCI provides EMR functionality for most clinical staff, we still need to add functionality for the 22 medical staff. A medical/prescribing package to integrate with LUCI will be sought, probably from an outside vendor,

“The billing system, currently handled with LUCI is not adequate.”

Although needed enhancements are constantly identified and worked on, the current electronic billing system functions better than most in our industry. Over 15,000 electronic client bills and third party claims are generated monthly, utilizing standards developed for private third party insurance, Kansas Medicaid, and Medicare. We were recently approached by another Kansas

CMHC inquiring about the possibility of temporarily using our billing system, as one they identified as an effectively operating system. This CMHC had purchased a vendor owned data system from one of the national CMHC data vendors. The Center currently has a nine month backlog in billing due to failures in their purchased system. This outside request to utilize our billing system is a testament to the ability of the LUCI system to meet the needs of CMHCs in Kansas.

Audit Comment:

Center staff has made two attempts to find alternate systems in 17 years. They have declined to act on the primary recommendation of the contractor they engaged in 2007 that the Center replace the LUCI system with a more modern and functional EMR/billing system. Our audit found sufficient evidence to concur with the recommendation of the contractor. We believe that prudent management practice requires that the recommendations developed by objective, third-party analysis be given substantial weight in the planning and timing of this critical software enhancement.

The County's ITS department is capable of providing resources to begin this process. Our recommendation is to begin the process of evaluation and preparation before the change is mandated by others or becomes so critical that it is an emergency situation. We believe that our analysis is valid and our recommendation is reasonable and prudent.