Key Points of Report

An Audit Report on the Implementation of House Bill 2377 and the Conversion of State-Operated Community Services to Local Control

January 1998

Overall Conclusion

The Texas Department of Mental Health and Mental Retardation (Department) has taken many steps to implement the changes outlined in House Bill 2377 (74th Legislature). This legislation includes provisions for a pilot project to study a new authority structure for local service delivery. The new structure separates community mental health and mental retardation centers (community centers) into two distinct roles: the role of local authority and the role of service provider. Separate from House Bill 2377, the Department has successfully converted two state-operated community service entities to local control. This conversion is part of a program to convert all state-operated community services to local control.

At the time of our fieldwork, however, we noted areas that needed further development to successfully implement the pilot project and to ease the transition of state-operated community services to local control.

Key Facts and Findings

- While planning at the pilot-site level is well-structured and implemented, planning at the Departmental level does not include an overall action plan that identifies what resources and tasks are needed to accomplish the objectives of House Bill 2377. Such planning is important because there are as many as 32 centers (in addition to the pilot sites) that will convert to the authority/provider structure. In addition, the Department did not provide adequate guidance to state-operated community services transferring to local control. At the time of our fieldwork there were 13 state-operated community service entities.

- The Department's monitoring system should be enhanced to help ensure that (1) the program quality of the pilots will not decline without timely detection by the Department and (2) state funds are spent as intended. Including pilot sites in the Department's regular monitoring process and comparing the use of community center expenditures to budgets are two needed enhancements.

- The Department does not have an automated cost accounting system as mandated by the Legislature in 1991. Such a system would enable management to review and analyze the cost of providing community services.

Contact:

Pat Keith, CQA, Audit Manager (512) 479-4700

Office of the State Auditor

Lawrence F. Alwin, CPA

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Executive Summary

The Texas Department of Mental Health and Mental Retardation (Department) has taken many steps to implement the changes outlined in House Bill 2377 (74th Legislative Session). This legislation includes provisions for a pilot project to study a new type of authority structure for local service delivery. The new structure separates community mental health and mental retardation centers into two distinct roles: the role of authority and the role of service provider. Separate from House Bill 2377, the Department has successfully converted two state-operated community service entities to local control. This conversion is part of a program to convert all state-operated community services to local control.

At the time of our fieldwork, however, we noted areas that needed further development to successfully implement the pilot project and to ease the transition of state-operated community services to local control.

Please refer to SAO Report Nos. 98-301, 98-302, and 98-308 for a discussion of our findings, recommendations, and managements' responses related to the three authority/provider pilot sites.

Improve Department-Level Planning Activities for the Implementation of House Bill 2377

The Department's involvement in planning at the pilot-site level is well-structured and implemented. However, planning at the Departmental level does not include an overall action plan that identifies what resources and tasks are needed to accomplish the objectives of House Bill 2377.

Although the Department organized several work groups and published discussion documents, these activities were primarily geared toward providing guidance to the pilot centers. Action plans directed more toward the Department could provide guidance and help its staff by assigning responsibility, establishing deadlines, and setting priorities.

Provide Guidance for the Transfer of State-Operated Community Services to Local Control

The Department has not provided adequate guidance for the transfer of state-operated community services to community mental health and mental retardation centers (community centers).[1] Without adequate communication and proper guidance, state-operated community services that have not yet completed the transfer may not benefit from the experiences of their predecessors, which could cost the State in terms of time and money. Given that there are approximately 11 additional transfers planned, the Department risks not being able to meet its goal of a complete transfer of all state-operated community services to local control by September 1, 2005.

Also, decisions based on the reported costs of transfer may be inaccurate because the Department does not have written guidelines or justifications for determining which costs should be reported as transfer costs.

Enhance the Department's Monitoring Systems for Pilot Sites and Community Centers

Pilot Sites

- Although all three pilot sites were identified as low performers during the fiscal year 1996 performance profiling process, they were excluded from the

[1] Note: This statement does not refer to the pilot sites.

Department's regular integrated oversight review. Without being subject to the regular monitoring requirements, the program quality of the pilot sites may decline without timely detection by the Department. While the pilot sites are subject to regular reviews to monitor their progress toward implementing House Bill 2377, the scope of these reviews does not include the quality of services to consumers, data accuracy, or compliance with the performance contract.

- Pilot sites' use of the pilot budget is not carefully reviewed during the Department's on-site monitoring visits. Without proper monitoring of the use of pilot funds, there is increased risk that funds may not be used for the resources or services intended. We noted that one pilot site over-budgeted its pilot expenditures without changing the initial budget estimates. In some cases, the pilot budget included staff salaries and benefits for positions not filled, an inappropriate percentage of staff time dedicated and charged to the pilot budget, and planned purchases of information system software that appeared to be a regular system upgrade.

Community Centers

- Although the Department's monitoring of community centers has recently become more centralized by implementing the integrated oversight approach, its data system remains fragmented. The Department receives and generates data related to the operations and activities of individual community centers, but it does not have a centralized mechanism to analyze this information between centers.

  Also, performance indicators used for integrated oversight surveys by the Department are not comprehensive. Without a centralized mechanism to analyze information between centers, or the use of comprehensive indicators, identifying common types of improper activities, targeting a center for more intensive monitoring, or providing training or technical assistance to centers is difficult.

- The Department also does not perform active monitoring of the use of state funds by community centers. Currently, the Department's financial review of community centers focuses on an analysis of the overall financial condition of a center using ratio analysis and limited site reviews of high-risk expenditure items. However, the Department does not analyze the use of general revenue relevant to the performance contract. As a result, there is an increased risk of community centers making improper purchases with state funds.

- The Department's performance contracts do not contain provisions defining which financial activities are reasonable and prudent. As a result, the Department is unable to hold center management accountable for possibly inappropriate financial activities. In addition, although the fiscal year 1997 performance contract required community centers to maintain fund accounting, the Department has not developed specific guidelines regarding its expectations or the requirements of the fund accounting system. Without these guidelines, inconsistencies may occur from center to center.

Develop and Manage Needed Management Information Systems

The Department has experienced delays in implementing a cost accounting system that was to have been fully operational by September 1991. Without a cost accounting system, the Department is unable to determine the cost to provide services to consumers. It was the intent of the 71st Legislature that the Department establish a uniform cost allocation

system that reflects the cost of providing services in state facilities and all other facilities funded through the Department, including community programs. The system is to include establishment of a standardized definition of services and cost of services. This system was not in place at the completion of our fieldwork.

The current automation environment is outdated and is not flexible enough to meet management information needs. Consequently the automated systems cannot deliver information in a timely manner and may not meet future needs. However, a new automation project called the Enterprise Data Delivery System should improve the efficiency and effectiveness of operations at the Department.

Summary of Management's Responses

The implementation of HB 2377 requirements in three separate areas of the state is a tremendously complex undertaking, involving a large number of stakeholders. Implementation planning was, therefore, an exercise in negotiated change, making traditional planning models inappropriate. Therefore, the Department disagrees that the HB 2377 pilots suffered from inadequate plans. The Department agrees that transition planning for the state-operated community services to community mental health and mental retardation centers is important and believes we have undertaken this adequately. Further the Department agrees that it is important to know the costs and benefits of these transfers and has developed and submitted such analyses as required. The Department has concerns about the finding that the three HB 2377 pilot sites have not undergone adequate monitoring during the pilot period; monitoring efforts have intensified during the pilot period, with results showing in marked improvement in contract compliance in each of these centers. The Department notes that the field work for this audit was conducted very early in the development stages of the HB 2377 initiative and does not reflect the considerable progress made in the last six months. The Department agrees that financial and compliance audits should be comprehensive and should be done by appropriately trained personnel. The Department agrees that a data base to capture comprehensive aspects of community MHMR center performance is desirable and such a data base has been implemented. The Department agrees that continued improvement in contracting processes and requirements is needed and has a process in place to accomplish this. The Department agrees that a cost accounting methodology is needed; such a methodology has been developed and is being piloted. The Department agrees that development of the enterprise data delivery system is desirable and notes that such a system is under development.

Summary of Audit Objectives and Scope

The objectives of this audit were to evaluate plans for the House Bill 2377 (74th Legislature) pilot project, to review selected management controls at the community centers participating in the pilot, and to evaluate the plans to convert state-operated services to local control.

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Section 1:

Improve Planning for Initiatives Such as House Bill 2377 and the Transfer of State-Operated Community Services to Local Control

The Texas Department of Mental Health and Mental Retardation (Department) has taken many steps to implement the changes outlined in House Bill 2377 (74th Legislature). This legislation includes provisions for a pilot project to study a new type of authority structure for local service delivery. The new structure separates community mental health and mental retardation centers (community centers) into two distinct roles: the role of authority and the role of service provider. The Department has employed experienced managed care staff and has involved the pilot sites in providing input through work groups and the development of pilot policies and procedures. Also, the Department has strengthened the performance contract with the community centers by adding sanctions and requiring the use of best practices. Separate from House Bill 2377, the Department has successfully converted two state-operated community service entities to local control. This conversion is part of a program to convert all state-operated community services to local control.

At the time of our fieldwork, however, we noted areas that needed further development to successfully implement the pilot project and to ease the transition of state-operated community services to local control.

Please refer to SAO Report Nos. 98-301, 98-302, and 98-308 for a discussion of our findings, recommendations, and managements' responses related to the three authority/provider pilot sites.

Section 1-A:

Improve Department-Level Planning Activities for the Implementation of House Bill 2377

The Department's involvement in planning at the pilot-site level is well-structured and implemented. However, planning at the Departmental level does not include an overall action plan that identifies what resources and tasks are needed to accomplish the objectives of House Bill 2377.

Although the Department organized several work groups and published discussion documents, these activities were primarily geared toward providing guidance to the pilot centers. Action plans directed more toward the Department could provide guidance and help Department staff by assigning responsibility, establishing deadlines, and setting priorities. In our opinion, the lack of an overall Department-level action plan contributes to the following:

- The effectiveness of the pilot project may not be achieved as initially intended because the results from the current pilot sites will not provide findings related to community centers located in rural areas. Initial regional sites

representative of the rural condition of the State dropped out and there were no contingency plans to replace them. The geographic conditions of the State should be considered in designing the proper service delivery system. Piloting in rural areas is important because contracting opportunities may not be readily available and more coordination may be required.

- Some essential tasks, including developing standard service definitions and a uniform chart of accounts, were not performed prior to full implementation of the pilot project. Without standard service definitions, information on how clients use the centers could not be collected. Also, the Department cannot determine the cost to provide services to consumers without a uniform chart of accounts to ensure consistency in reporting from center to center. The Department, as the state authority, is in the best position to provide these guidelines.

- The Department identified the overall goals and objectives of the pilot project such as access, consumer choice, quality of care, cost containment, and the relevant performance indicators. However, the performance indicators were not clearly defined and were not measurable with the existing community center data systems. As a result, no performance measure data had been reported from the pilot sites to the Department. Without this data, the Department is unable to ensure that the individual goals of the pilot are being achieved at each pilot project site.

- Although the pilot contract term started in September 1996, it was not signed until March 1997. Delays in negotiating the contract and funding the project caused delays in retaining needed staff for some pilot sites.

- The criteria the Department uses to determine whether a pilot site receives incentive funding are not effective and may not provide the incentive management intended. The incentive funds of the pilot project are directly tied to the pilot site's fulfillment of implementation time lines. However, because the Department routinely approves a pilot site's request for an extension, these criteria are not always meaningful. Additionally, there are no major accomplishments or predominant tasks specifically identified with the incentive funding. Instead, there are a substantial number of implementation action items which must be 95 percent completed.

Recommendation:

The Department should improve its planning activities for the pilot by:

- Developing an overall Department-level action plan to guide and monitor the use of the Department's resources in pilot-related activities

- Including typical rural sites in the House Bill 2377 pilot project so that the results of the pilot project can be used for different types of community centers throughout the State
- Establishing the necessary infrastructure including standard service definitions and a uniform chart of accounts
- Clearly defining its performance indicators and ensuring they will be accurately measured
- Preparing and negotiating the pilot contract on a timely basis to ensure that it is signed prior to the effective date of the contract
- Modifying design of the incentive funding by directly associating the five major elements of the pilot project with a specific dollar amount

Management's Response:

The implementation of HB 2377 requirements in three separate areas of the state is a tremendously complex undertaking, involving local boards, local officials, consumers, family members, as well as multiple divisions within the Department administration. Because implementation planning became, by necessity, an exercise in negotiated change, traditional planning models referenced by the staff of the State Auditor's Office simply were not appropriate. The Department therefore disagrees with the finding that the HB 2377 pilots suffered from inadequate plans. Evidence that the Department has successfully managed the change process related to HB 2377 may be found in the fact that each of the pilot sites was acknowledged by the State Auditor's Office to have "well structured and implemented [planning for HB 2377]."

Additionally, the Department notes that a significant amount of the first year's activity was devoted to a participatory process to develop tools for key systems such as local planning, utilization management, cost accounting and network development to be tested in the pilot sites for the purpose of ultimate statewide applicability. This activity was in addition to the individual site planning referenced by the State Auditor's Office.

Regarding the issue of the lack of a rural site, it must be noted that the Department's original selections included a regional site that was largely rural, but the participants withdrew in light of concerns over issues of governance and shared business functions. In the fall of 1997, two regional and largely rural sites were selected for the second "round" of pilots which will be underway by the end of January 1998. These sites will face issues that are quite different from the existing pilot sites, particularly relating to governance and shared business functions. By staging their implementation later, they will receive the scrutiny and support they will need to be successful.

Section 1-B:

Provide Guidance for the Transfer of State-Operated Community Services to Local Control

The Department has not provided adequate guidance for the transfer of state-operated community services to local operation and control. Without communication and proper guidance, state-operated community services that have not yet completed the transfer may not benefit from the experiences of their predecessors, which could cost the State in terms of time and money. Given that there are approximately 11 additional transfers planned, the Department may not be able to meet its goal of a complete transfer of all state-operated community services to local control by September 1, 2005.

Key executives of transferring state-operated community services reported that they did not receive sufficient information from the Department to adequately plan for the transfer. Dates and goals were reportedly arbitrary and based solely on the transfer target date rather than the actual time needed to complete tasks. The Department did not provide guidance on the amount of time required for various tasks such as implementing new information systems, changing contracts, transferring leases and payable agreements, and negotiating employee benefit transfers. It also did not prioritize the tasks of center staff between operating the state-operated community services and performing the tasks required to bring the entity under local control.

The lack of guidance on the part of the Department may be partly attributable to the fact that only two state-operated community service entities had been transferred at the time of our fieldwork. Also, detailed plans to transfer state-operated services to community-operated centers were missing important elements including specific goals and tasks, time frames, assignment of responsibility, monitoring provisions, training requirements, and contingency planning.

As the state authority, the Department is in the best position to analyze information on completed transfers and communicate this information to transferring state-operated community services.

Recommendation:

The Department should ensure that it communicates potential problems and other important information to its state-operated community services that will transfer to community centers in the future. It should also ensure that the detailed transition plans include important planning elements such as those discussed above.

Management's Response:

The Department agrees with this recommendation but notes that we have consistently used the lessons from previous conversions to guide subsequent ones. The Department also responds to the needs, desires and resources specific to the local service area to inform the process.

The Department notes that the implementation time lines have been shortened based on the experiences of transition to date. The transition targets for FY97 were achieved, and the revised implementation plan contemplates statewide completion of this initiative by FY2002, well ahead of the originally projected completion date of FY 2005.

Section 1-C:

Define Costs of Converting State-Operated Community Services to Local Control

The Department does not have written guidelines or justifications for determining which costs should be reported as transfer costs. Consequently, decisions based on the reported costs of transfer may be inaccurate. Also, compliance with state law cannot be determined without a clear definition of the costs of conversion.

Generally, the Department has not been concerned about tracking these costs. Budgets for costs associated with transfer are included in the plans for the transfer of state- to community-operated centers. However, costs that would not have been incurred without transfer are not always reported. For example, overtime related to transfer and improvements to facilities have not been included.

State statute dictates that the actual cost of transferring services to a community center should not exceed the actual cost currently incurred by the State. Also, the generation of consistent, timely, and useful cost information requires a clearly defined and understandable policy on transfer costs.

Recommendation:

Develop a clear definition for the costs of transfer. The definition should incorporate the best available information about the intent of the Legislature. The Department should also justify the exclusion of any costs that would not have been incurred if the transfer had not taken place.

Management's Response:

The Department agrees that it is important to know the costs and benefits associated with the transfer of state-operated community services to local sponsorship. These costs and benefits must, however, be viewed both in the short term and in the long term. The audit does not recognize that there are some short-term costs associated with some conversions that are more than offset in the long run by cost savings to the state.

The recommendation refers to an uncited state statute and may be predicated on an appropriations rider from the 74th Legislature, which required the Department to demonstrate the cost-benefit of each transfer made during that biennium. Those state-operated community services which transitioned during the period underwent such an analysis, and each was submitted to the Legislature as required. That rider no longer appears in the Department's appropriation.

Section 2:

Improve the Department's Monitoring Systems for Pilot Sites and Community Centers

By exempting pilot sites from its integrated oversight review, there is increased risk that the program quality of the pilot sites may decline without timely detection by the Department. The Department does not closely review how pilot sites spend pilot funds or compare community centers' annual budget to quarterly expenditure reports. As a result, there is increased risk that funds may not be used for the services intended. Both a centralized database and the use of comprehensive indicators will help the Department refine its current risk assessment process to consider other important indicators of performance in deciding where to target its monitoring resources. Finally, the Department's performance contracts are missing some provisions which should enable it to hold center management accountable for inappropriate activities.

Section 2-A:

Include House Bill 2377 Pilot Sites as Part of the Department's Regular Quality Monitoring Schedule

Although all three pilot sites were identified as low performers during the fiscal year 1996 performance profiling process, they were excluded from Department's regular integrated oversight review. Without being subject to the regular monitoring requirements, the program quality of the pilot sites may decline without timely detection by the Department.

Departmental policy dictates that the performance profiling process identify local mental health authorities that need increased oversight by the Department. The performance profiling process includes desk reviews and monitoring visits. Being selected as a pilot site itself imposes a risk factor. While the pilot sites are subject to regular reviews by the Department to monitor their progress toward implementing House Bill 2377, the scope of these reviews does not include program quality, data accuracy, or compliance with the performance contract. The pilot sites were excluded because the Department's Mental Health Quality Management Section mistakenly assumed that the House Bill 2377 pilot sites were exempted from monitoring by participation in the pilot program.

Recommendation:

The pilot sites should be subject to the Department's regular integrated oversight review. A community center's participation in the pilot project should be considered as one of the risk criteria.

Management's Response:

The Department has concerns about the finding that the pilot sites have not undergone adequate performance monitoring during the pilot period. It is in fact the case that monitoring efforts have intensified during this period, with the results showing in the form of marked improvement in contract compliance in each of these centers. Ongoing provider activities of the pilot sites were routinely monitored, using the same profiling and integrated oversight processes used to monitor other community MHMR centers. The Department notes that the field work for this audit was conducted very early in the development stages of the HB 2377 initiative and that considerable progress has been made by each of these centers over the last six months.

Section 2-B:

Enhance Monitoring of Financial Activities of the Pilot Sites and Other Community Centers

Pilot Sites - Pilot sites' use of the pilot budget is not carefully reviewed during the Department's on-site monitoring visits. Without proper monitoring of the use of pilot project funds, there is increased risk that funds may not be used for the resources or services intended. We noted that one pilot site over-budgeted its pilot expenditures without changing the initial budget estimates. In some cases, the pilot budget included staff salaries and benefits for positions not filled, an inappropriate percentage of staff time dedicated and charged to the pilot budget, and planned purchases of information system software appeared to be a regular system upgrade.

The pilot contract specifies that the local authorities expend funds in accordance with the line-item budget and agree to secure the positions budgeted. Any expenditure that results in a greater variance than 10 percent of each individual line item of expense and any deviation from budgeted positions requires the prior approval of the Department's Director of Community Services.

Community Centers - The Department also does not actively monitor the use of state funds by community centers. As a result, there is increased risk of centers making improper purchases with state funds. Currently, the Department's financial review of community centers focuses on an analysis of the overall financial condition of a center using ratio analysis and limited site reviews of high-risk expenditure items. However, the Department does not analyze the use of general revenue funds relevant to the performance contract. Also, the Department has not developed clear policies and procedures related to the center's transfer of general revenue funds between multiple programs and services.

The Department has not assigned any staff having financial management experience to the on-site review team. The staff members who have trained in this area have been addressing financial issues only at the state level. During negotiations of the performance contract, community centers and the Department agreed to performance targets. Specific dollar amounts are allocated to meet these targets.

Recommendations:

Improve fiscal monitoring of pilot sites and other community centers by:

- Assigning properly trained financial personnel to review community centers' use of state general revenue funds including pilot funds
- Developing clear policies and procedures for the specific use of state general revenue funds
- Reviewing budget and actual expenditures to ensure funds are expended as intended
- Expanding the scope of field audits to include review of community centers' internal allocation of funds

Management's Response:

The Department agrees that properly trained financial management staff should be reviewing community center finances. The audit does not recognize that in early FY97 the Department consolidated management audit activities under the Director, Community Services. This group provides routine monitoring of all community centers including each pilot site.

Future independent financial and compliance audits will place greater emphasis on the expenditure of general revenue. The Department has recently released a compliance guide which outlines specific requirements for the review of general revenue expenditures. In addition, local authorities will submit quarterly financial statements which management audit will use for analysis, monitoring and comparison across centers.

Section 2-C:

Establish a Database to Capture Comprehensive Aspects of Community Center Performance

Although the Department's monitoring of community centers has recently become more centralized by implementing the integrated oversight approach, its data system remains fragmented. The Department receives and generates data related to the operations and activities of individual community centers, but it does not have a centralized mechanism to analyze this information between centers for use in risk ranking and monitoring. Also, performance indicators used for integrated oversight surveys by the Department are not comprehensive. Without a centralized mechanism to analyze information between centers or the use of comprehensive indicators, identifying common types of improper activities, targeting a center for more intensive monitoring, or providing training or technical assistance to centers is difficult.

Currently, information is scattered throughout several divisions and there is no mechanism to capture this information for comprehensive analysis. Also, there is a lack of information sharing among multiple divisions. Some risk factors, such as Medicaid billing rates, are not used in the determination of which centers need increased oversight. In addition, only 7 to 13 indicators are used to measure community center performance for the Department's integrated oversight survey, even though there are more than 120 performance and workload measures being reported to the Legislative Budget Board. Also, these indicators are not used by the Department's Mental Retardation Quality Management Section (Quality Management Section).

Because of the limited number of performance indicators used, a number of community centers have the same risk ranking. Also, because the selected indicators may not be representative of a community center's performance, the Department's resources may not be used in an efficient manner. In addition, there is duplication of quality management activities by the Quality Management Section.

Sound management decisions should be based on good management information. To assess the comprehensive aspects of a community center's performance, the Department should be able to capture multi facets of a center's operations. The amount of data being reported currently by the CARE system limits the Quality Management Section's performance profiling activities.

Recommendation:

Establish a database or other mechanism to capture individual community mental health and mental retardation center information to perform data-driven monitoring of community center performance. This information can also be used for contract renewal and improvement.

Include additional significant performance indicators in the current profiling model. Activities of other Department sections, including the Quality Management Section, should also be coordinated with these activities to avoid potential duplication of effort.

Management's Response:

The Department agrees and notes that such a database has been implemented and that additional indicators have been added to the profiling model. This continues to be an area of ongoing development and refinement.

Section 2-D:

Continue Efforts to Improve Performance Contract With Community Centers

The Department's performance contracts do not contain provisions to prohibit financial activities that are not reasonable and prudent. As a result, the Department is unable to hold center management accountable for these types of inappropriate activities. In

addition, although the fiscal year 1997 performance contract required community centers to maintain fund accounting, the Department has not developed specific guidelines regarding its expectations and the requirements of the fund accounting system. Without these guidelines, inconsistencies may occur from center to center.

Community center expenditures should be reasonable and necessary. In addition, as part of the fund accounting system, the expenditures should be directly tied to the funding sources to comply with the matching principle.

Recommendation:

The Department's Management Audit Section should be consulted to identify common types of inappropriate financial activities noted from prior audits. Consideration should be given to specifically prohibiting these activities in the performance contract, requiring reasonable and prudent management standards, and developing guidelines for sound business practices. Also, the Department should develop detailed guidelines for fund accounting.

Management's Response:

The Department agrees that, while the FY97 contract represented a significant improvement over previous contracts, additional improvements were incorporated into the FY 98 contract. Among the significant changes are a requirement that community centers comply with Uniform Grant and Contract Management Standards (UGCMS), requirements that uniformly define and limit indirect costs, expectations around adoption and compliance with travel policies consistent with state policies, expectations for quarterly submission of financial statements and fund accounting requirements. Further, a task force charged with addressing additional refinements will make its recommendations for incorporating additional improvements into the FY99 contract. The Department sees the improvement process as ongoing, informed by changes in state law, best practice and management experience.

Section 3:

Develop and Manage Needed Management Information Systems

Management information systems at the Department need improvement. The Department does not have a cost accounting system to enable management to review and analyze the cost of services. However, a new automation project is in process to help minimize the effects of an automation environment that is too outdated and inflexible to meet the needs of management.

Section 3-A:

Continue to Develop an Automated Cost Accounting and Reporting System

An automated cost accounting system for reporting costs of services was not in operation at the Department when our fieldwork ended. Without an automated cost accounting system, the Department is unable to determine the costs of providing services to consumers. It was the intent of the 71st Legislature that the Department establish a uniform cost allocation system that reflects the cost of providing services in state facilities and all other facilities funded through the Department, including community programs. The system is to include establishment of a standardized definition of services and cost of services.

The 71st Legislature appropriated $1.9 million in 1990 and $2.5 million in 1991. The cost accounting system was to be fully operational no later than September 1991. Both the 1996 *Texas Performance Review* and *Management Controls at the Texas Department of Mental Health and Mental Retardation* (SAO Report No. 96-001, September 1995) recommended the Department develop a comprehensive cost accounting system. However, the Department does not have an efficient mechanism or an internal system in place to obtain and assess the cost of services provided to consumers.

Some progress has been made in the development and use of an automated cost accounting system. A work group of key financial staff members from various community centers under leadership of the Department have drafted a uniform chart of accounts and a methodology that will standardize various definitions of client services. The pilot sites plan to use spreadsheet software to capture and monitor information on service costs. Reports will also be sent into the Department periodically.

The cost accounting methodology being drafted does not include a definition for all types of services and costs, which could lead to incomplete reporting. The methodology only considers Office of Management and Budget Circular A-87 guidelines, which set forth allowable and established direct and indirect costs based on Medicaid service codes and definitions reported. However, there may be more services provided at the community centers than those covered by Medicaid; these other services should be reported to the Department for its reporting and monitoring purposes.

A critical component to the success of the House Bill 2377 pilot project is to remain competitive in providing adequate client services at a reasonable cost. Capturing cost information is needed to compare and monitor cost information.

Recommendation:

Continue developing a cost accounting system that will automate the capturing, sorting, and reporting of all types of service-related data from community centers.

Management's Response:

The Department agrees with the recommendation since a standardized cost accounting system is an essential element in managing care. Such a system is under development and is being piloted as part of the HB 2377 initiative. Once the pilot is completed, this cost accounting methodology will be a contract requirement.

Regarding the statement that the methodology only considers the Federal A-87 guidelines for services prorated, the Department notes that the cost accounting methodology includes a comprehensive services grid which is intended to capture the cost of all services provided.

Section 3-B:

Continue Implementing the Enterprise Data Delivery System to Improve the Efficiency and Effectiveness of Operations

The current automation environment at the Department is outdated and not flexible to meet management information needs. As a result, the automated systems cannot deliver information in a timely manner and cannot be expanded to meet future needs. The infrastructure does not provide the necessary information to all levels of management and program areas. It is also not standardized to allow efficient network linkage and communication between community centers, state facilities, and the Department. Adequate information systems are necessary to support operations efficiently and to provide timely and comprehensive information to management.

The Enterprise Data Delivery System is a new automation project to improve the efficiency and effectiveness of operations at the Department. If properly developed and implemented in a timely manner, the system should (1) deliver agency information to all operation sites and (2) be expandable for future enhancements for site utilization. The data will be composed of client, financial (including cost accounting), staffing, contract, and clinical information from various systems including CARE and General Ledger. Community Centers will have access to data through standardized telecommunication networks. A request for offer was prepared and vendor responses were being reviewed by management. A prototype is in test operations and is being evaluated within the Information Services Division.

Recommendation:

Continue to implement systems needed improve the automation environment.

Management's Response:

The Department agrees with this recommendation and notes that the development of the Enterprise Data Delivery System (EDDS) is ongoing. The prototype system mentioned by the auditors is being exported to the EDDS and development and refinement will continue.

Appendix 1:

Objectives, Scope, and Methodology

Objectives

Our audit objectives were to:

- Determine whether the Texas Department of Mental Health and Mental Retardation (Department) has provided adequate planning and guidance for community centers participating in the House Bill 2377 (74th Legislature) pilot project.

- Evaluate management control systems at community centers participating in the House Bill 2377 pilot project and identify strengths and opportunities for improvement.

- Determine whether the Texas Department of Mental Health and Mental Retardation has a viable plan to transfer services from state-operated to independent community-operated programs.

Scope

The scope of this audit included consideration of the following:

- The Department's plans to develop and implement a pilot study according to House Bill 2377

- Management control systems at the three community centers participating in the House Bill 2377 pilot project:

  - Austin-Travis County Community Mental Health and Mental Retardation Center
  - Lubbock Community Mental Health and Mental Retardation Center
  - Tarrant County Community Mental Health and Mental Retardation Center

- The Department's plans to transfer services from state- to community-operated centers

Methodology

The audit methodology consisted of reviewing and analyzing the Department's planning documents and gaining an understanding of the control systems at pilot sites. In select areas, tests were then performed to determine if the Department's planning documents were adequate and whether the centers' control systems were operating as described. The

results were evaluated against established criteria to determine the adequacy of the systems and to identify opportunities for improvement.

Analysis of the Department's planning documents and an understanding of the control systems was gained through interviews with management and staff. Reviews of center documents were also used to gain an understanding of the control systems in place. Control system testing was conducted by comparing the described and actual processes. The testing methods primarily consisted of document analysis, process and resource observation, and employee interviews.

The following criteria were used to evaluate the control systems:

- Statutory requirements
- Center policies and procedures
- General and specific criteria developed by the State Auditor's Office Inventory of Accountability Project
- State Auditor's Office Project Manual System

Other Information

This audit was conducted in collaboration with the Department. Fieldwork was conducted from March 1997 through July 1997. The audit was conducted in accordance with applicable professional standards, including:

- Generally Accepted Government Auditing Standards
- Generally Accepted Auditing Standards

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

- William D. Hastings, CPA (Project Manager)
- David P. Conner, CISA
- Stephen D. Crone, CPA
- Jerry L. Davis, CMA
- Verma Elliott
- Hugh Ohn, CPA, CIA
- Pat Keith, CQA (Audit Manager)
- Deborah L. Kerr, Ph.D. (Audit Director)

Appendix 2:

Background Information

In 1965, the Texas Legislature enacted House Bill 3, the Texas Mental Health and Mental Retardation Act. This statute created the Texas Department of Mental Health and Mental Retardation (Department) as the state authority for mental health and mental retardation services. House Bill 3 also authorized establishing community mental health and mental retardation centers (community centers) as separate entities. Community centers were created to provide an effective alternative to treating mentally ill and mentally retarded citizens in large institutionalized facilities. Since their creation, community centers became the primary provider of services for the mentally ill and mentally retarded population in Texas. To ensure the continuity of care for this population, the Department contracted for services with community centers.

In 1985 the 69th Legislature passed Senate Bill 633, which required that the Department define the priority population for services and replace the grants-in-aid funding allocation with performance contracts for the community centers. Certain core services were mandated to be performed by the community centers through performance contracts in all state service areas. The entire focus was for community centers to implement certain core services to mentally ill and mentally clients, to support state initiatives, and to provide services to individuals described as the Department's priority population.

For the last 30 years, community centers functioned primarily as providers of service, although they were designated as local mental health authorities, mental retardation authorities, or both. It was the Department that predominantly performed the authority's responsibilities including planning, policy development, coordination, and resource development and allocation. As a result, there has been considerable variety among the local authorities in the roles they have played in planning, coordinating services, and developing a network of providers. Their roles have been largely driven by leadership from the Department rather than by local needs and interest.

In recognition of (1) an expanding provider base for publicly funded mental health and mental retardation services, (2) the conflicting nature of authority and provider roles, and (3) the need to clarify and strengthen the mission of the Department and its local authorities, the 74th Legislature enacted House Bill 2377. This bill authorized the Department to fully develop the concept of state and local authorities through a pilot project. The role of the Department as the state mental health and mental retardation authority responsible for planning, policy development, coordination, resource development and allocation, and ensuring the provision of services, was made explicit through House Bill 2377. Also, House Bill 2377 clearly articulated the concept of a local mental health and mental retardation authority to which the state authority may delegate certain authority functions and responsibilities. One of the important expectation is for each local authority to develop and implement a network of service providers.

Additionally, House Bill 2377 directs the local authority to consider public input, ultimate cost-benefit and client care issues to ensure consumer choice, and the best use of public funds in (1) assembling a network of service providers and in (2) determining

whether to become a provider of a service or to contract that service to another organization.

Under the general guidance of House Bill 2377, the Department has undertaken a multi-faceted approach to implementation of House Bill 2377. This approach includes communicating the new direction, identifying and implementing certain changes on a statewide basis, building the capacity of the system, and implementing pilot initiatives. The following four sites were initially selected for the pilot project:

- Austin-Travis County Mental Health and Mental Retardation Center
- Lubbock Regional Mental Health and Mental Retardation Center
- Tarrant County Mental Health and Mental Retardation Center
- A regional site including Riceland Regional Mental Health Authority, Gulf Bend Mental Health Mental Retardation Center, and Mental Health and Mental Retardation Authority of Brazos Valley

Currently there are only three pilot sites due to the regional sites dropping out of the pilot project. The Department initially budgeted approximately $3.8 million to be used by the pilot sites for the system changes.

The Department organized an oversight committee to monitor progress and guide the pilot effort. It also organized a core team that is responsible for developing the detail involved with implementation including the development of tools to assist the pilots in conducting participatory local planning, creating access to quality services, and assembling and managing a network of providers. In addition, the Department organized five work groups in essential areas such as local planning, network development, quality assessment, financial management, and information systems. Representatives from each pilot site became members of these work groups.

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