Office of the State Auditor

Audit Report

Department of Human Services
Division of Mental Health Services

July 1, 1993 to April 30, 1995
# Audit Report

## Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transmittal Letter</td>
<td>1</td>
</tr>
<tr>
<td>Scope</td>
<td>2</td>
</tr>
<tr>
<td>Objectives</td>
<td>2</td>
</tr>
<tr>
<td>Methodology</td>
<td>2</td>
</tr>
<tr>
<td>Conclusions</td>
<td>3</td>
</tr>
<tr>
<td>Findings and Recommendations</td>
<td></td>
</tr>
<tr>
<td>Audit Disposition Unit</td>
<td>4</td>
</tr>
<tr>
<td>Essex County Overpayment</td>
<td>5</td>
</tr>
<tr>
<td>Revenue Incentive</td>
<td>6</td>
</tr>
<tr>
<td>Community Care Payments</td>
<td>7</td>
</tr>
<tr>
<td>Bureau of Licensing and Inspections</td>
<td>9</td>
</tr>
<tr>
<td>Departmental Response</td>
<td>10</td>
</tr>
</tbody>
</table>
The Honorable Christine Todd Whitman  
Governor of New Jersey  

The Honorable Donald T. DiFrancesco  
President of the Senate  

The Honorable Jack Collins  
Speaker of the General Assembly  

Mr. Albert Porroni  
Executive Director  
Office of Legislative Services  

We have completed an audit of the Department of Human Services, Division of Mental Health Services for the period July 1, 1993 to April 30, 1995.

We found that the financial transactions included in our testing were related to the agency's programs, were reasonable, and were recorded properly in the state accounting system. However, we did note areas where improvement is needed. The division is not performing financial and programmatic reviews of third party nonprofit mental health providers in a timely manner. The division's recently initiated revenue incentive policy has resulted in $9.2 million in reduced recoveries from third party providers. Details of the findings and recommendations are included in our report.

This audit was conducted pursuant to the State Auditor's responsibilities as set forth in Article VII, Section 1.6 of the State Constitution and Title 52 of the New Jersey Statutes.

Richard L. Fair  
State Auditor  
June 10, 1996
Department of Human Services
Division of Mental Health Services

Scope

We have completed an audit of the Division of Mental Health Services for the period July 1, 1993 to April 30, 1995. Our audit included financial activities accounted for in the state's General Fund and Capital Project Funds.

Total expenditures of the agency during the 22 month audit period were $536.8 million. The prime responsibility of the Division of Mental Health Services is to fund private nonprofit third party providers that provide community care services to those in need of mental health care. Revenues of the agency totaled $93.3 million during our audit period and the major component of revenue was payments by county governments for a portion of the cost of county indigents in state hospitals.

Objectives

The objectives of our audit were to determine whether financial transactions were related to the agency's programs, were reasonable and were recorded properly in the state accounting system. We also tested for resolution of significant conditions noted in our prior report.

This audit was conducted pursuant to the State Auditor's responsibilities as set forth in Article VII, Section 1.6 of the State Constitution and Title 52 of the New Jersey Statutes.

Methodology

Our audit was conducted in accordance with Government Auditing Standards, issued by the Comptroller General of the United States.

In preparation for our testing, we studied prior audit work papers, legislation, administrative code, circular letters promulgated by the State Comptroller, and policies of the agency. Provisions that we consider significant were documented and compliance with those requirements was verified by interview and observation and through our samples of financial transactions. We also read the budget message, reviewed financial trends, and interviewed agency personnel to obtain an understanding of the programs and the internal control structure.
A nonstatistical sampling approach was used. Our samples of financial transactions were designed to provide conclusions about the validity of transactions as well as internal control and compliance attributes. Revenue populations were stratified and large dollar transactions were examined. Expenditure transactions were selected through a dollar unit sampling method. Other transactions were randomly or judgmentally selected.

We also interviewed staff in charge of the program review function to determine the effectiveness of their monitoring of third party providers. We reviewed the division’s revenue incentive policy and its effect on potential recoveries from providers.

To ascertain the status of findings included in our prior report, we identified corrective action, if any, taken by the agency and walked through the system to determine if this action was effective.

**Conclusions**

We found that the financial transactions included in our testing were related to the agency’s programs, were reasonable, and were properly recorded in the state accounting system. In making this determination, we noted certain significant internal control weaknesses and matters of compliance with laws and regulations meriting management's attention.

We also found that the agency has resolved the significant issues noted in our prior report.

Details of our findings and recommendations follow.
Audit Disposition Unit

Finding

Under the Department of Human Service’s Information Memorandum P93-1, each provider agency is required to submit an independent auditor’s report each year. The report must be received by the Audit Disposition Unit (the unit) no later than 150 days after the close of the agency’s fiscal year.

We found that 30 out of 78 fiscal year 1994 audit reports had not been received by their due date. Of those 30 late reports, 13 were more than seven months late. Some audit reports that were finally reviewed during 1995 resulted in questioned costs dating back to contract year 1988.

Once an audit report is received, it usually sits in a backlog. The unit’s audit log indicated that only nine of the 1994 audit reports were in some stage of review as of May 9, 1995. The division has a responsibility to complete a timely review of audit reports in order to ensure that provider agencies’ expenditures are allowable under the terms of their contract.

As a result of the unit not taking the necessary steps to make sure that all audit reports are received by their due date and reviewed in a timely manner, provider agencies are reluctant to make payments for questioned costs from years long since past. Some agencies believe that some of their unallowable costs could have been avoided if the unit had reviewed audit reports in a more timely manner.

Recommendation

We recommend that the Audit Disposition Unit take the steps necessary to ensure that audit reports are received and reviewed in a timely manner. Then unallowable costs can be detected at the earliest possible moment and appropriate follow up can be instituted.
Essex County Overpayment

Finding

In accordance with P.L. 1991, c. 63 the state will assume 90 percent of the reasonable and equitable cost of mental health services for indigent clients with county settlement in county psychiatric hospitals. During calendar year 1994 the County of Essex budgeted $31.5 million in anticipated revenues to be received from the state's Department of Human Services, Division of Mental Health Services for indigent clients residing in the Essex County Hospital Center. Actual payments to the County of Essex amounted to $23.8 million. The division withheld $7.7 million in payments due to prior year rate adjustments and overpayments. The County of Essex requested from the division the remaining $7.7 million they had anticipated in order to balance their budget. In December 1994 the division's fiscal office was instructed to pay this amount.

In addition, the County of Essex was to pay by January 31, 1995 $4.7 million due to the State of New Jersey, Department of Human Services as part of a $11.8 million settlement resulting from the reversal of the court's December 6, 1990 decision in the Essex I lawsuit. Essex County never paid this amount.

The net effect of the above transactions is an advance of $12.4 million in state aid to Essex County from state appropriation accounts not appropriated for that purpose.

Recommendation

We recommend that the division adjust future payments to Essex County to reflect the $7.7 million overpayment in calendar year 1994 and discontinue the practice of advancing funds to meet the county's budgeted anticipated revenue. We further recommend that the Department of Human Services request the $4.7 million due to the state, in accordance with the reversal of the December 6, 1990 court decision in the Essex I lawsuit.
Revenue Incentive

Finding

One of the division’s main purposes is to fund private nonprofit community care agencies that provide mental health services to the public. Until fiscal year 1992 the policy of the division was to fund the agencies using a deficit-funding model. This meant that the division would compute the difference between the agency’s estimated expenditures less revenues. The division then agrees to fund the difference or deficit.

In calendar year 1991 the division adopted the revenue incentive policy which was intended to encourage provider agencies to seek additional revenue sources. The policy allows them to keep any additional revenue they collect. The division does not reduce funding if an agency generates revenue beyond their budgeted amount. In the third year under the revenue incentive policy the state was allowed to recover one-half of any recurring additional revenue. During our review of fiscal year 1993 and 1994 contracts we noted no allocation of any excess revenue back to the state. Prior to the adoption of the revenue incentive, the nonprofit agencies were required to refund to the Division of Mental Health Services all revenues collected in excess of those originally budgeted.

During 1993 and 1994, revenue incentives in excess of budgeted revenues totaled $9.2 million. We tested a sample of ten agencies that received incentives totaling $6 million and found that the majority of the incentives were due to medicaid revenue in excess of the amounts budgeted in their contracts. Medicaid revenues are based on the agency’s medicaid eligible clients and should not vary substantially from year to year. Some nonprofit agencies are under budgeting their medicaid revenue.

Recommendation

We support a revenue incentive policy which allows the agencies to keep any discretionary revenue, such as contributions, donations, and/or endowments. We recommend that the division adjust their revenue incentive policy to exclude all or a portion of any medicaid revenue collected above the approved budgeted amounts, and take the steps needed to ensure that each contract budget is as accurate as possible.
Community Care Payments

Finding

During our review of the division's community care payments to third party providers we noted the following:

C In fiscal years 1994 and 1995 the division processed and held 68 community care checks amounting to $1,714,820 for the recovery of previous contract overpayments to community care providers. Holding Treasury issued checks does not meet any of the valid conditions in accordance with State Treasury Circular Letter 94-17. Subsequently, the held checks were deposited into the State Treasury via cash receipts vouchers. Processing hold checks and subsequently depositing the checks are unnecessary if current payments are decreased by the prior overpayment amounts.

C Two employees of the contract disbursement unit processed purchase orders and payments on the state accounting system. A strong internal control structure requires that purchasing functions be segregated from payment functions. Since the fiscal office has another person assigned to process non-community care purchase orders, it will be advantageous to have purchasing functions of the contract disbursement unit transferred to this employee.

C For the fiscal year 1994 annual contract payments to community care providers totaled approximately $113 million. The division contracts with 130 private nonprofit agencies to provide mental health services throughout the state. While a few are paid on a reimbursement basis, most agencies receive periodic scheduled advance payments based on a percentage of their contract. Currently, the division's policy, regardless of agency need, is to pay 25 percent of the total contract amount at the start of the contract period and a total of 75 percent of the contract within the first seven months. Our examination of contract payments showed that the agencies were receiving approximately 91 percent of the total contract amount within the first seven months. This payment schedule is neither in accordance with the department's policy of two months advance at the start of the contract period and equal installments thereafter, nor the division's own policy.

If agencies are paid in accordance with departmental policy, similar to the other departmental divisions, grant services should not be jeopardized
and little, if any, additional effort will be required by the division to process these payments. Since the division contracts with many of the same private nonprofit agencies as other departmental divisions, we see no reason why the division should be making payments on a different basis.

**Recommendation**

We recommend that the division:

- Decrease current purchase orders for any overpayments due from community care providers instead of issuing hold checks.

- Transfer the processing function of community care purchase orders to another employee in the fiscal office.

- Pay providers on a monthly basis consistent with the practices of other Department of Human Services divisions.
Bureau of Licensing and Inspections

Finding

The division contracts with third party nonprofit providers known as provider agencies (PA). According to NJAC 10:37-10.5, all PAs must be issued a certification for the programs funded by the division once it has been determined that the PA is in good standing with no major deficiencies. The certification is for a period of three years and the administrative code implies, but does not specify, that a site review should be scheduled to coincide with the renewal of the certification. In March 1989, the division suspended its normal site reviews for the next six months while they developed new procedures. However, site reviews were not resumed until June 1993, over four years later. Since that time the Bureau of Licensing and Inspection, which is responsible for coordinating the site review process, has completed approximately 60 reviews. There are about 40 more agencies under contract that have not been reviewed in the last four to ten years. At the current rate all agencies should be completed in a cycle of approximately five years.

According to NJAC 10:37-10.1, the results of the site reviews shall be a key factor in contract or funding renewal decisions made by the division. Also, the site reviews are necessary to determine that programs conform to the rules set forth by the division. Without timely performance of the site reviews the above objectives cannot be met by the division.

Recommendation

We recommend that the division conduct all site reviews within the three year cycle to coincide with the renewal of the certification.
Department of Human Services
Division of Mental Health Services

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The Honorable Christine Todd Whitman
Governor

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