Follow-Up Audit on the Management of Billings and Collections for the Department of Health's Outpatient Adult Mental Health Services

A Report to the
Governor
and the
Legislature of
the State of
Hawaii

Report No. 97-13
October 1997

THE AUDITOR
STATE OF HAWAII

The Office of the Auditor

The missions of the Office of the Auditor are assigned by the Hawaii State Constitution (Article VII, Section 10). The primary mission is to conduct post audits of the transactions, accounts, programs, and performance of public agencies. A supplemental mission is to conduct such other investigations and prepare such additional reports as may be directed by the Legislature.

Under its assigned missions, the office conducts the following types of examinations:

1. *Financial audits* attest to the fairness of the financial statements of agencies. They examine the adequacy of the financial records and accounting and internal controls, and they determine the legality and propriety of expenditures.

2. *Management audits,* which are also referred to as *performance audits,* examine the effectiveness of programs or the efficiency of agencies or both. These audits are also called *program audits,* when they focus on whether programs are attaining the objectives and results expected of them, and *operations audits,* when they examine how well agencies are organized and managed and how efficiently they acquire and utilize resources.

3. *Sunset evaluations* evaluate new professional and occupational licensing programs to determine whether the programs should be terminated, continued, or modified. These evaluations are conducted in accordance with criteria established by statute.

4. *Sunrise analyses* are similar to sunset evaluations, but they apply to proposed rather than existing regulatory programs. Before a new professional and occupational licensing program can be enacted, the statutes require that the measure be analyzed by the Office of the Auditor as to its probable effects.

5. *Health insurance analyses* examine bills that propose to mandate certain health insurance benefits. Such bills cannot be enacted unless they are referred to the Office of the Auditor for an assessment of the social and financial impact of the proposed measure.

6. *Analyses of proposed special funds* and existing *trust and revolving funds* determine if proposals to establish these funds and existing funds meet legislative criteria.

7. *Procurement compliance audits* and other *procurement-related monitoring* assist the Legislature in overseeing government procurement practices.

8. *Fiscal accountability reports* analyze expenditures by the state Department of Education in various areas.

9. *Special studies* respond to requests from both houses of the Legislature. The studies usually address specific problems for which the Legislature is seeking solutions.

Hawaii's laws provide the Auditor with broad powers to examine all books, records, files, papers, and documents and all financial affairs of every agency. The Auditor also has the authority to summon persons to produce records and to question persons under oath. However, the Office of the Auditor exercises no control function, and its authority is limited to reviewing, evaluating, and reporting on its findings and recommendations to the Legislature and the Governor.

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OVERVIEW

THE AUDITOR
STATE OF HAWAII

Follow-Up Audit on the Management of Billings and Collections for the Department of Health's Outpatient Adult Mental Health Services

Summary

The Office of the Auditor conducted a follow-up audit on the management of billings and collections for the Department of Health's adult mental health services for the period from December 1995 through May 1997. The audit examined the extent to which the department has addressed findings and recommendations contained in our *Audit of the Management of Billings and Collections for the Department of Health's Outpatient Adult Mental Health Services*, Report No. 95-25.

In our follow-up we found that the Adult Mental Health Division continues to fall short in its management of the billings and collections activities of the centers. Specifically, the division continues to shirk its responsibility to standardize billings and collections activities at the centers. As a result, these centers cannot be assured that they are billing for all eligible charges. We also found that the division lacks a system to review and monitor its standard fee schedule. Consequently, centers are billing insurers at different rates for the same service.

In addition, the division has not established a consistent collections practice. None of the centers has a system to regularly follow up on insurance payments and rejections or to reconcile a client's account. Without a system of collections, centers are merely submitting claims and assuming that they will receive payment. Furthermore, while the Adult Mental Health Division recognizes the need for (1) an automated billing program to increase revenues and (2) a division-level billing coordinator, it has made little progress in both areas. Although the seven community mental health centers are demonstrating efforts to improve billings and collections, their efforts are hampered by the division's lack of support.

We found that the division is not effectively utilizing the Mental Health and Substance Abuse Special Fund established by the Legislature. Revenues collected by centers are to be deposited directly into the fund to be used for each program's payment of operating expenses. However, the division continues to use general funds rather than the special fund as the primary source to cover the centers' operating expenses. In addition, the division is accumulating special funds in an administrative subaccount, rather than distributing those funds to the individual centers. While the division contends that the withheld funds are intended for the

purchase of a division-wide management information system, we believe that the practice is a disincentive for the centers to bill aggressively and circumvents the purpose of the fund.

We also found that the division is not adequately planning for its proposed management information system. The division is not following state guidelines for developing information systems. The division is proceeding with little control over the project, and as a result is developing a system without knowing whether the system will be cost effective. The division's lack of adequate documentation, budget plans, and system to track expenditures made it impossible to accurately calculate projected total costs and actual expenditures of the system to date.

Recommendations and Response

Our report makes a number of recommendations that point to the division's responsibilities to direct, coordinate, and monitor the community mental health centers. We recommended that the division implement a division-wide billing system and designate a qualified billing coordinator to concentrate on implementing the division's responsibilities. We recommended that the Legislature require the Department of Health to accurately report its special fund balances and projected expenditures. In addition, the Legislature should require the department to use its special fund as a primary source for payment of operating expenses. Finally, we recommended that the department ensure adequate planning of the Adult Mental Health Division's management information system.

In its response, the department stated that overall, our report seems objective and fairly presented. While it found the summary and findings generally agreeable, the department offered additional comments on some of the findings. A point of clarification provided by the department was incorporated into the report.

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A Report to the Governor and the Legislature of the State of Hawaii

Submitted by

THE AUDITOR
STATE OF HAWAII

Report No. 97-13
October 1997

Foreword

This is a report of our follow-up audit on the Department of Health's management of the billings and collections of its outpatient adult mental health services for the period December 1995 to May 1997. The follow-up audit focused on the findings and recommendations contained in our 1995 Report No. 95-25, *Audit of the Management of Billings and Collections for the Department of Health's Outpatient Adult Mental Health Services*. Our follow-up audit was conducted pursuant to Section 23-4, Hawaii Revised Statutes, which requires the Auditor to conduct postaudits of the transactions, accounts, programs, and performance of all departments, offices, and agencies of the State and its political subdivisions.

We wish to express our appreciation for the cooperation and assistance extended by the officials and staff of the Department of Health and others who provided information.

Marion M. Higa
State Auditor

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Chapter 1
Introduction

The Office of the Auditor conducts follow-up audits to provide the Legislature and the governor with information about actions taken by state agencies in response to our prior audit reports. This audit follows up on our report, *Audit of the Management of Billings and Collections for the Department of Health's Outpatient Adult Mental Health Services*, Report No. 95-25. Both audits were initiated pursuant to Section 23-4, Hawaii Revised Statutes (HRS), which requires the Auditor to conduct postaudits of the transactions, accounts, programs, and performance of all departments, offices, and agencies of the State and its political subdivisions.

Background on the Adult Mental Health Division

Act 218, Session Laws of Hawaii 1984, amended Section 334-3, HRS, to require the Department of Health, within the limits of available funds, to provide for the establishment of a community-based mental health system. The department administers its mental health programs through its Behavioral Health Administration. Under this administration, the Adult Mental Health Division directs, coordinates, and monitors the operations of the State's adult mental health services. These services include outpatient therapy, case management, biopsychosocial rehabilitation, and emergency/crisis intervention. Outpatient services were provided to approximately 3,493 clients during FY1995-96 through the division's community mental health centers.

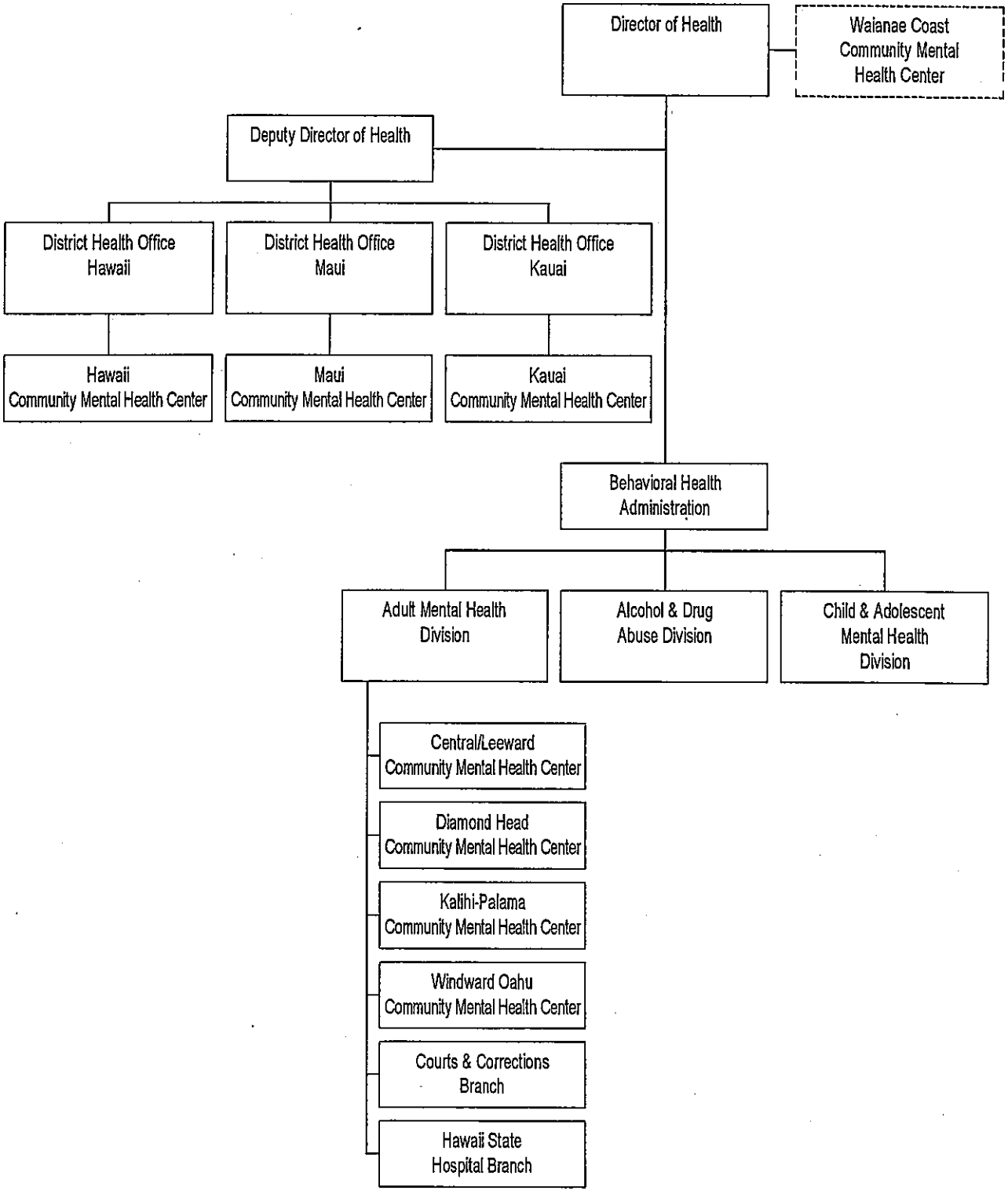
Seven centers report to the division

Seven state-run community mental health centers serve as focal points for the development, coordination, and delivery of adult mental health services in their geographic areas. Officially, three neighbor island centers are administered by their respective district health offices of the Department of Health, rather than by the Adult Mental Health Division. However, by practice and in accordance with the division's responsibilities, all seven centers report to the division.

During our 1995 audit, the division administered eight centers: five on Oahu and one center in each of the three neighbor island counties. Since then, the Central and Leeward Oahu Community Mental Health Centers have physically merged into one center. Exhibit 1.1 reflects the division's current organization.

In October 1996, the Adult Mental Health Division submitted to the director of health a reorganization concept to merge what was then five Oahu community mental health centers, into one Oahu-wide branch.

Exhibit 1.1
Organizational Chart of Community Mental Health Centers



= purchase of service contract

Source: Organizational Charts of the Department of Health.

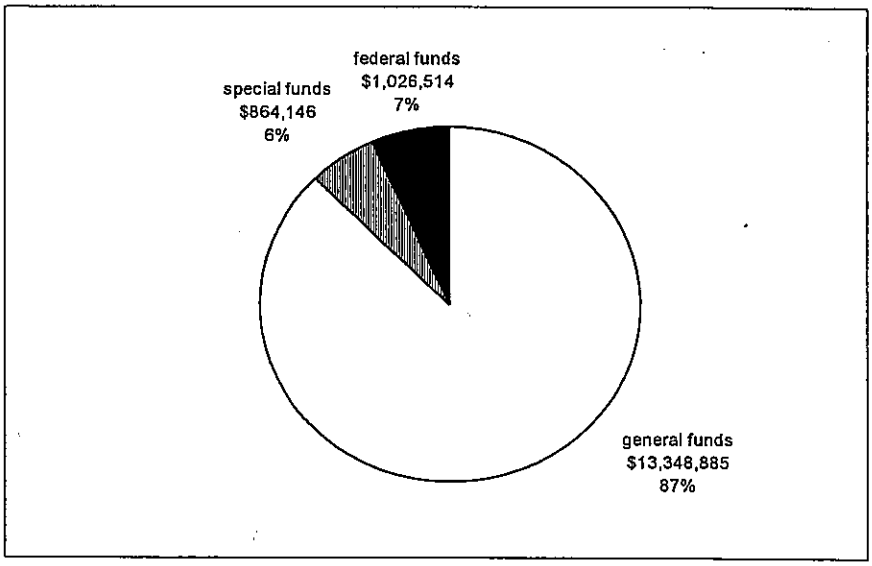
The proposed reorganization will consolidate Oahu's administrative functions such as budget, personnel, and billing into one unit to improve the effectiveness and efficiency of operations. However, treatment services will continue to be offered through the centers.

In addition, the consolidation was developed to address FY1996-97 budget restrictions that included the reduction of 25.5 positions across the Oahu centers. The division targets July 1997 for completion of the reorganization.

The division primarily receives general funds

Although the division is supported by general, federal, and special funds, approximately 87 percent of the division's budget consists of general funds. (See Exhibit 1.2.) Seven percent of the budget consists of federal block grant funds for services to the mentally ill. The Mental Health and Substance Abuse Special Fund comprises six percent of the budget. Special fund appropriations by the Legislature for FY1995-96 were $564,146 and $864,148 for FY1996-97. The special fund contains separate subaccounts for each of the centers and an administrative subaccount.

Exhibit 1.2
Adult Mental Health Division
FY1996-97 Appropriations for Outpatient Mental Health Services



Source: Act 287, Session Laws of Hawaii, 1996.

Revenues are deposited into a special fund

Section 334-6, HRS, requires the Department of Health to establish reasonable charges for mental health treatment services and makes persons receiving treatment and their spouses liable for treatment expenses. However, the law makes collecting such fees from clients discretionary with the director. No collections are to be made if a client cannot afford to pay.

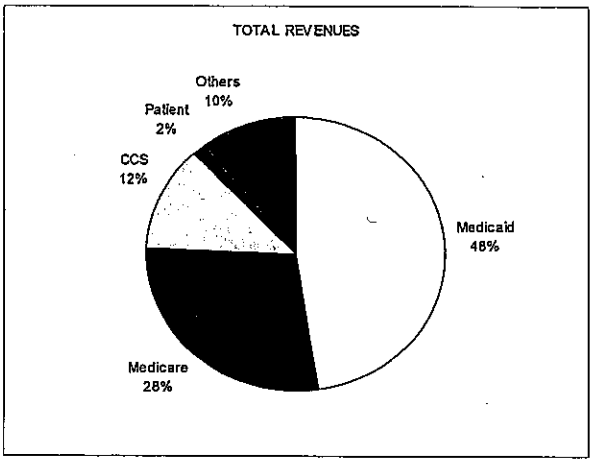
Client and insurer payments received by the centers are deposited into the Mental Health and Substance Abuse Special Fund. In FY1995-96, the centers generated nearly $1.0 million in total revenues. The division's largest revenue source is Medicaid at 48 percent of total revenues, followed by Medicare at 28 percent. Exhibit 1.3 provides further detail on the centers' total revenues.

Exhibit 1.3
Adult Mental Health Division
FY1995-96 Total Revenues

Total Revenues by Community Mental Health Center and Source
FY1995-96

Center	Source of Revenue					
	Medicaid	Medicare	CCS*	Patient	Others	TOTALS
Central	$73,217	$38,073	$8,944	$928	$12,692	$133,854
Diamond Head	70,596	67,477	28,833	12,506	9,688	189,100
Kalihi-Palama	71,464	54,389	27,668	50	17,054	170,625
Windward Oahu	38,480	28,634	7,554	--	3,058	77,726
Hawaii County	94,473	38,163	13,518	998	2,930	150,082
Maui County	40,134	22,099	7,938	69	7,712	77,952
Kauai County	81,423	29,662	27,608	834	50,021	189,548
TOTAL REVENUES	$469,787	$278,497	$122,063	$15,385	$103,155	$988,887

Total Revenues by Source
FY1995-96



*Community Care Services Behavioral Health Services QUEST Plan
Source: Adult Mental Health Division

Prior report findings and recommendations

The State Auditor initiated the 1995 audit to assess the Department of Health's management of billings and collections for outpatient adult mental health services. We found that while revenues from billings and collections had been steadily increasing, a variety of obstacles prevented the maximization of these revenues. These obstacles included staff vacancies at the centers, insufficient automation, lack of formal training, and insufficient guidance from the Adult Mental Health Division.

In addition, we found that the centers' individual subaccount expenditure ceilings within the Mental Health and Substance Abuse Special Fund needed re-evaluation so that the centers would not be discouraged from pursuing revenues. Finally, we found that the Adult Mental Health Division, to which the state centers report, had not aggressively pursued the maximization of their billings and collections. The division provided no overall plan or guidelines, little formal training, and weak oversight.

Our report made recommendations to address these concerns and the Department of Health agreed with our overall findings and recommendations. On October 22, 1996, the Auditor wrote to the Department of Health requesting information on actions taken on our recommendations. In its November 13, 1996 response, the department indicated that the Adult Mental Health Division had sustained heavy personnel losses totaling nearly 60 positions since our prior report. In addition, due to expanded requirements for enhanced services set forth by the Department of Justice, the department stated that the division was currently operating under extremely difficult circumstances.

The department reported that despite these difficulties, the following improvements had been made:

- The division is reorganizing the five Oahu centers into one large center, with a centralized billing unit;
- All centers have a position dedicated to billing and collections and have their own systems in place for capturing and documenting billable services;
- The division has re-evaluated and adjusted the centers' special fund subaccount ceilings within the legislative appropriation;
- The division has planned and implemented a division-wide overall billing system for the centers via the reorganization into a centralized billing unit on Oahu. Standard policies and procedures are being developed both at the administrative and local levels;

- Division personnel conduct training on billing issues with both center chiefs and technical personnel within each center;
- The division is establishing a Public Health Administrative Officer IV position dedicated to reimbursement issues across the division; and
- The division has issued a request-for-proposal for a new management information system with full billing, managerial, and clinical software applications.

Objectives of the Follow-Up Audit

1. Review the extent to which findings and recommendations contained in our prior audit are being addressed.
2. Make recommendations as appropriate.

Scope and Methodology

This follow-up audit focused on the Adult Mental Health Division's oversight of the seven state-operated community mental health centers and the extent to which the division guides, supports, and monitors the billings and collections activities of the centers. We reviewed relevant state statutes, administrative rules, and legislative documents. We conducted interviews and examined files at the division's administrative office and Data Systems Unit. Our review of files included organizational charts and functional statements, policies and procedures, and planning documents relevant to the planned reorganization of the Oahu centers and of the proposed management information system.

We studied budget, expenditure, and revenue information with particular emphasis on FY1995-96. We also examined the division's special fund and subaccount activities.

We visited the seven community mental health centers to determine the extent of the division's oversight of their billings and collections. We interviewed center staff involved with billings and collections and reviewed a selected sample of case files at each center.

Our work also included interviews with personnel of government and state insurance carriers, other state and private outpatient mental health service providers, and private billing vendors.

Because the Waianae Coast Community Mental Health Center is a contracted service provider of the Department of Health, the department does not set policies and procedures nor manage the day-to-day operations of this center. Therefore, we excluded this center from the audit proper, although we interviewed its staff for informational purposes.

Our work was performed from January 1997 through May 1997 in accordance with generally accepted government auditing standards.

Chapter 2

The Adult Mental Health Division Is Not Maximizing Its Revenues

This chapter presents the findings and recommendations of our follow-up audit of the management of billings and collections for the Department of Health's adult mental health outpatient services. Despite the improvements cited by the department, the division continues to fall short of satisfactory management of the billings and collections activities of the centers. Although the individual centers are doing their best to generate revenues, the division's failure to properly manage the centers' activities has resulted in a loss of potential revenues, and an underutilization of the division's special fund. In addition, the division's proposed management information system is poorly planned.

Summary of Findings

1. The division has failed to manage the billings and collections of the community mental health centers. As a result, the centers continue to operate without a division-wide, overall billing system.

2. The division is not fully utilizing the Mental Health and Substance Abuse Special Fund. Centers continue to depend on general funds to pay for expenses that should be paid for with special funds.

3. The division is not adequately planning for its proposed management information system. State planning guides are not followed and important documentation is poorly maintained.

The Adult Mental Health Division Has Failed to Manage the Billings and Collections of the Community Mental Health Centers

Under the general direction of the director of health and the division chief, the Adult Mental Health Division is responsible for directing, coordinating, and monitoring the operations of the State's adult mental health programs, services, activities, and facilities. The division is responsible for developing policies and procedures for third-party reimbursements for services, such as Medicare, Medicaid, and private insurers. In addition, the division is responsible for establishing and maintaining a system of charges for services that is based upon a proper review of cost-data and billings, collections, write-offs, and accounts receivable.

In our 1995 report, we found that the division did little to carry out these responsibilities. We recommended that the division adopt an aggressive, pro-active role in the assumption of its responsibilities. Our follow-up

audit found, however, that the division has accomplished little in this regard. The centers continue to operate without a uniform system for billings and collections, systemwide policies and procedures, a system to review and monitor the standard fee schedule, proper automation, and a division-level billing coordinator.

No division-wide, overall billing system

Functional statements of the Department of Health indicate that the Adult Mental Health Division is responsible for establishing and maintaining a *system* of charges for services that includes billings, collections, write-offs, and controls of accounts receivable. A *system* is defined as a regularly interacting or interdependent group of items that form a unified whole.[1] We found that the centers' billing operations do not form a unified whole.

Although the division has established charges, is billing for services, and collects revenues, we found that it does not have an overall system for billings and collections throughout the seven state-operated centers. As a result, the centers continue to fend for themselves in an area that is complex, and for which they do not have ready expertise.

Inadequate policies and procedures

The division continues to shirk its responsibility to develop adequate policies and procedures that guide and standardize center activities. In July 1995, the division organized a billing task force whose primary objective was to make recommendations to the division on the development of a uniform billing system. Although the task force met for approximately one year, the policies and procedures that resulted from its efforts are neither enforced nor complete.

The policies and procedures developed by the task force were authorized by the division chief and supposedly put into effect in July 1996. We found, however, that the division has not enforced these policies and procedures. The division maintains that it has postponed enforcement until it establishes a new management information system.

We question the division's assertion. Of the ten policies and procedures developed by the billing task force and authorized by the division chief, only two depend upon proper automation. For example, given the present resource limitations at the centers, flagging outstanding account balances over 60 days old may require an automated accounts receivable program. On the other hand, requiring centers to collect client payments is a policy that can be implemented immediately. One neighbor island center has been collecting client payments since our previous report and continues to do so without additional automation.

In addition, we found that these policies and procedures are incomplete because they address collections but not billing. The authorized policies and procedures set forth by the task force establish only a uniform collection policy, which includes collecting client co-payments, handling past due accounts, establishing client payment plans, and writing off bad debts.

We found that the division has failed to establish standard procedures that provide detailed instructions for billing—performing a sequence of actions for submitting claims to insurers. Due to the lack of complete and enforced policies and procedures for billings and collections, individual centers are operating with their own, individual billing procedures. Furthermore, because the centers' procedures are not based on a division-wide standard, they are heavily dependent on the actions of individuals—on individual motivation and work ethics to maintain continuity of the billing processes at the individual centers. Such heavy dependence on individuals has resulted in inconsistencies in billing practices. In addition, the division is in direct violation of a departmental administrative rule that establishes a payment fee schedule and billing procedures.

Our visit to the centers confirmed the need for a uniform billing system. Lacking systemwide procedures, the centers have developed their own billing systems. Several centers do not maintain proper documentation for billing, such as progress notes and charge tags. These centers cannot be assured that they are billing for all eligible charges.

For example, one center does not keep copies of claim forms that are sent to insurers for payment. In addition, this center does not regularly update a client's billing information. As a result, there is no way for center management to know whether a particular charge was billed and whether a claim was actually filed with an insurer.

System to review and monitor fee schedule needed

Title II, Chapter 179 of the Department of Health Administrative Rules, establishes a payment fee schedule and requires the establishment of billing procedures. The rules state that every client who receives services at a community mental health center shall be liable for payment according to the rates in the schedule. The division's most recent, official fee schedule was adopted after a public hearing in October 1991.

We found that because the division does not monitor the center's billing activities to ensure that they are all billing at the same rate, there are inconsistencies among centers. For example, we found that for pharmacological management, only three of the seven centers are actually charging the $20 rate set by the fee schedule. One center

charges $44, another center charges $42, and yet another, $15. Finally, one center does not even list this charge on its fee schedule. One center stated that it charges as much as $42 because it knows that insurers will reimburse up to that amount. Centers are taking it upon themselves to adjust fees in order to maximize reimbursements because the division has not assumed its responsibility to regularly review and update its fee schedule.

In addition, we found that some centers have their own version of the division's fee schedule, different from the official schedule. The division's "official fee schedule" includes charges that have not yet gone to public hearing and that do not appear on the fee schedules of five out of seven centers. Furthermore, we found that at least one procedure code is no longer used by insurers for reimbursement.

If the division is to maximize reimbursements, it should regularly review, analyze, and update its official fee schedule. Furthermore, the division should monitor the centers' use of the authorized fee schedule to ensure compliance with administrative rules and to maintain consistency with billings and collections of fees throughout the division.

No system of collections

In addition, we found that the division has not established a consistent collections practice. Only one of the seven centers attempts to collect client payments and has a formal policy to that effect. None has a system to regularly follow up on insurance payments and rejections or to reconcile a client's account. The degree to which such follow-up is done varies from center to center. Some centers attempt to update client ledger information with insurance payments. One center's billing clerk, however, does not receive insurance payment reports with which to do payment follow up.

Without a system of collections, centers are merely submitting claims and assuming that they will receive payment. None of the centers can determine whether they are in fact receiving all of the payments that are owed to them by insurers.

A fundamental responsibility of the division, as explicitly stated in its functional statement, is to monitor the operations of the state's mental health facilities. This includes establishing controls for accounts receivable. We found that the division does not monitor or evaluate the billings and collections activities of the centers, nor does it require regular reports on these activities from the centers. Consequently, the Adult Mental Health Division cannot know whether it is maximizing its revenues. It does not receive the information necessary to make that kind of assessment. Furthermore, as we pointed out in our previous

report, the absence of monitoring and evaluation of the centers' billings and collections nullifies the division's stated commitment to maximizing billing revenues.

Automation continues to be insufficient

Our previous report explained the need for proper automation to eliminate time-consuming, laborious, manual billing processes. We highlighted several hardware and software problems at the community mental health centers that hampered the centers' ability to maximize billings and collections.

For example, we reported that many centers were still using outdated 286 or 386SX Wang personal computers, which were slow in processing and were no longer manufactured. We also reported that the division lacked appropriate software. In 1995, the division was using a database software that was not originally intended for billing purposes. The division's data systems unit developed the database into a makeshift billing software used by the centers for collecting and maintaining billing and collections statistics. Finally, we pointed out that the lack of integration between the division's software for billing and its overall management information system—the Mental Health Field Assessment and Statistical Information System (MFASIS)—resulted in insufficient information to management and duplicative data entry tasks.

During our follow-up audit, we found that hardware at the centers has been upgraded slightly. Hardware used for billing at all of the centers has been upgraded to at least 386 IBM compatible computers. One center uses a Pentium 90 computer for billing and several other centers have upgraded to at least 486DX33 models.

However, the division has not acquired new billing software nor has it integrated existing software with the division's management information system. Furthermore, one center was still performing fully manual billing functions and had not yet implemented the division's makeshift billing software. The center received this software only recently, in January 1997.

As before, the makeshift software is used primarily to print the standard Federal Health Care Financing Administration 1500 claim forms. Some centers use the program to keep client billing histories in an attempt to maintain an electronic client ledger and accounts receivables system. However, payment and adjustment information must be manually entered. In addition, the current software cannot produce sufficient data to assist billing clerks in reconciling balances.

Private outpatient mental health service providers stress the importance of automation in billing. One vendor maintains that automated and integrated billing systems are necessary to produce accurate reports for management to assess billings and collections and to improve the timeliness of reimbursements. The Adult Mental Health Division itself recognizes that an automated billing program will increase revenues. Yet the division continues to operate with insufficient automation.

Still no billings and collections coordinator

In our previous report, we recommended that the division appoint a qualified employee to serve as the billing coordinator. Responsibilities of this individual would include advocating for the centers and the division with outside parties, serving as a resource person for the centers, and evaluating the division's progress toward maximizing revenues.

The division recognized its need for a billing coordinator and is establishing a position for a Public Health Administrative Officer dedicated to reimbursement issues across the division. We found during our follow-up audit, however, that the division has made no progress beyond drafting the position description. Given the lack of a uniform billing system and the need for adequate oversight of the division's billings and collections, we strongly urge the division to make it a priority to establish and fill this position.

Centers demonstrate efforts despite division's weak management

Our visit to each of the seven community mental health centers has revealed that despite the division's lack of oversight, the centers are taking positive steps toward maximizing revenues. The most comprehensive initiative has been the centers' efforts to capture all charges for services rendered. Although the division has not established a policy or procedure that requires billing for all eligible charges, many of the centers have developed their own policies on this issue. Individually, centers also have initiated efforts that deserve recognition.

For example, at the Windward Community Mental Health Center, the clinical supervisor has proactively increased revenues for QUEST case management services. One of the billing clerk's projects at Windward is to assist clients in transferring from their current non-participating QUEST plans to the Behavioral Health Administration's Community Care Services Plan. With the proper support and leadership of the division, this effort could be duplicated at all centers.

For approximately one year, the Diamond Head Community Mental Health Center made use of Medicare's free software and submitted claims electronically to Medicare. The center stopped these electronic claims submissions when the billing clerk left her position. Although the center's billing clerk took this initiative, the center was unable to

continue the process for several reasons that point, once again, to the division's lack of support for the centers. The task of billing electronically required additional data entry that contributed to an already inefficient billing situation. In addition, without a uniform billing system that includes proper training across the division, the Diamond Head center was unable to train new billing personnel in electronic claims processing. As a result, the continuity of electronic claims processing was dependent upon the previous billing clerk.

Kauai Community Mental Health Center's entire staff participated in an all day training session to streamline center operations by clarifying roles and responsibilities, resolving inconsistencies, and incorporating standard billing practices into its daily functions. This center has continued to develop procedures for capturing client information at an early stage by requiring the billing clerk's direct involvement in the client orientation and registration process. Once again, standardized billing and collections policies and procedures would support this center's efforts and would extend this kind of training and awareness of billings and collections to all of the adult mental health centers.

Individual center staff meeting minutes reveal that some center managers have attempted to raise staff awareness about the importance of billing. Minutes have revealed ongoing discussions about proper billing procedures and the need for authorizations and appropriate documentation for billing purposes.

The billing clerks have made the greatest effort toward improving billings and collections among the centers. In our previous report, we found that the billing clerks used their monthly meetings as training opportunities to assist one another in resolving billing issues, problems, and questions. Although the billing clerks were not able to meet regularly during the current period under review due to limited time and resources, we found that these meetings continue to be platforms for training and sharing information. More support from the division could ensure that these meetings continue regularly. Furthermore, with the proper support from a division-level billing coordinator, the billing clerks could be guided in their efforts.

Our assessment of the centers' billing efforts are supported by the findings of Deloitte and Touche, which was contracted by the Department of Accounting and General Services to provide consulting services to maximize federal reimbursements for the State. Deloitte and Touche found that the centers were doing a good job of billing for services rendered. It also identified additional revenue possibilities that involve review of reimbursements and costs for services. Such reviews are the duty of the division's administration and the responsibility of the division chief.

Although the centers are demonstrating efforts to improve billings and collections, their efforts are strained due to the division's failure to establish and maintain a division-wide, standardized billing system. Despite its recognition that it has the potential to increase revenues, the Adult Mental Health Division continues to neglect its responsibilities to manage its billings and collections activities. The division is looking to its proposed management information system—discussed later in this report—as the solution to many of its problems with billings and collections. It fails to recognize, however, that computer systems are management tools and not an end or solution to management problems by themselves.

The Division Is Not Effectively Utilizing the Mental Health and Substance Abuse Special Fund

The Adult Mental Health Division is not effectively using the Mental Health and Substance Abuse Special Fund. Consequently, individual centers potentially have less incentive to aggressively bill for services, and the Legislature lacks clear information about the status of the special fund.

In 1991 the Legislature established the Mental Health and Substance Abuse Special Fund, which is now codified in Section 334-15, Hawaii Revised Statutes (HRS). The law stipulates that all revenues and other moneys collected for treatment services provided by the mental health and substance abuse programs operated by the State shall be deposited into the fund. The law also authorizes the department to establish separate accounts for each center into which are deposited all revenues and other moneys collected from each program. Moneys deposited in each subaccount are to be used for payment of the operating expenses of the respective program. Use of the special fund in this manner provides an incentive for the centers to bill for services because revenues collected are returned directly to them, rather than to the general fund. In accordance with Section 334-15, Hawaii Revised Statutes (HRS), the division has maintained one administrative subaccount and separate subaccounts for each of its seven centers.

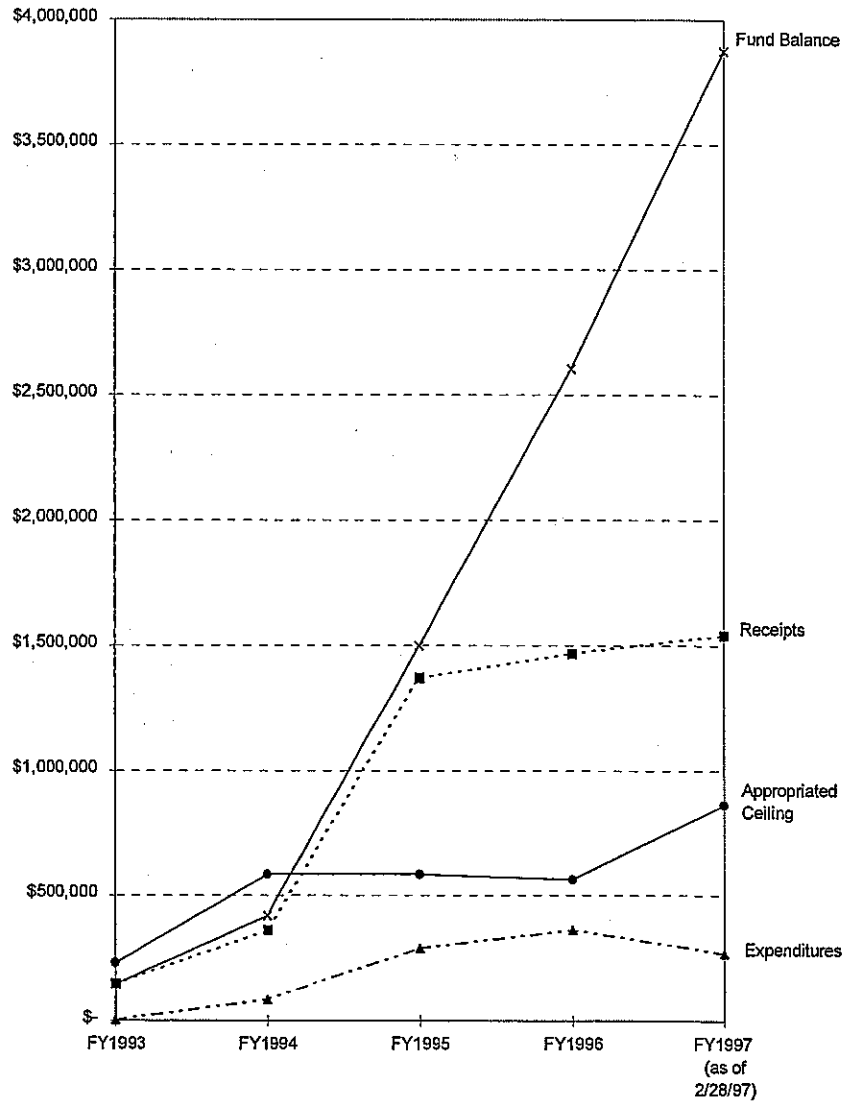
Special fund balance continues to grow while special fund expenditures remain low

Revenues collected by centers are to be deposited directly into the special fund to be used for each program's payment of operating expenses. However, the division has used general funds to cover the centers' operating expenses, while the special fund balance has continued to grow. The division treats the special fund as supplemental to the general fund rather than the opposite. Relying on the general fund as the primary source of revenue for operating expenses increases the state's financial obligation to the programs.

At the end of the first year of the fund's establishment in FY1992-93, the total fund balance was $145,550. By the end of FY1995-96, the balance increased to over $2.6 million. Over this time period, less than 17 percent of the total deposits were used to cover expenses.

Exhibit 2.1 illustrates the Mental Health and Substance Abuse Special Fund activities since it was established in FY1992-93.

Exhibit 2.1
Mental Health and Substance Abuse Special Fund



Source: Financial Accounting Management Information System Reports

Funds in an administrative subaccount belong to the centers

The division's distribution of moneys between subaccounts within the special fund contravenes the intent of the fund. The special fund comprises eight subaccounts; one subaccount for each of the community mental health centers and an administrative subaccount. The administrative subaccount contains a one-time retroactive reimbursement for QUEST client services, ongoing reimbursements for administrative services from the Preadmission Screening and Annual Resident Review agreement, and Medicaid matching fund collections. During FY1994-95 and FY1995-96, about $1.1 million was deposited into the administrative subaccount.

At least $751,530 in the administrative subaccount was collected by the centers as a result of their billings for QUEST clients under the Department of Human Services and Community Care Services plans. In accordance with Section 334-15, HRS, these funds should have been deposited into the appropriate centers' subaccounts to be used for operating expenses. The division, however, has no intention of redistributing these funds to the individual centers' subaccounts. Division administrators intend to use the balance in the administrative subaccount to purchase a division-wide management information system.

The division's decision to retain these special funds for the management information system is a disincentive for the centers to bill aggressively because it removes the linkage between billings and payment of center operating expenses. In addition, purchasing a division-wide computer system with funds that belong to the individual centers circumvents the purpose of the fund and prevents the Legislature from reviewing a major programmatic adjustment.

The Division Is Not Adequately Planning for Its Proposed Management Information System

In our previous report, we found that without proper automation, billing and collecting is a time-consuming, labor-intensive, and potentially discouraging process. We recommended that the division purchase a billing software package that integrates billing functions with the division's management information system to enhance the centers' ability to maximize revenues. In response, the Department of Health reported that the Adult Mental Health Division was planning the implementation of its Behavioral Health Management Information System (BHMIS)—a full billing, managerial, and clinical information computer system.

Although more than three years have passed since initial planning for a system began, the division has yet to finalize a contract with a software vendor. Some of the project's problems and delays remain unexplained. We found poor management control over the project and inadequate efforts to follow state standards for planning and developing the system. The division's failure to follow state guidelines may result in a waste of valuable state resources on a system that may not meet its needs.

Systems Development Methodology not followed

Systems Development Methodology is an application development tool to guide departments in creating and implementing information systems and in producing documentation at the end of their projects. The Department of Budget and Finance's Information and Communications Services Division requires executive departments to use this tool. Properly using it ensures that:

- the system meets user needs;
- the work of those involved is of the highest quality;
- the system is built correctly; and
- appropriate management control of the project is in place to complete the system on time and within budget.

Systems Development Methodology divides the development of an information system into four major functions and nine phases. Within each phase, step-by-step tasks are clearly described and guidance on proper documentation is provided. This tool also delineates guidelines on estimating costs and scheduling for the project's completion.

The nine phases of Systems Development Methodology are outlined in Exhibit 2.2. Because each phase forms the base for subsequent phases, initial phases are very important to the overall development effort.

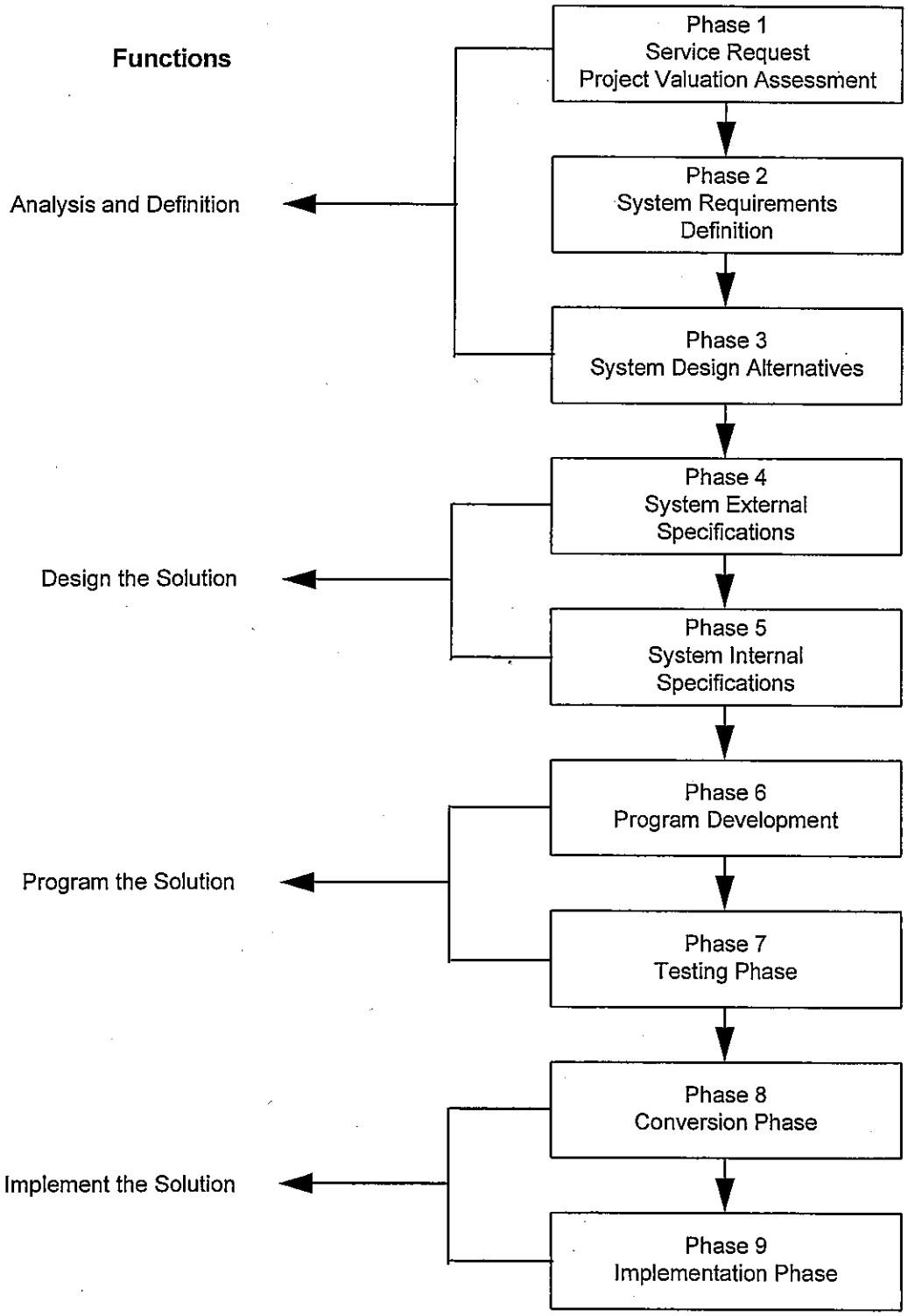
We found that the division has not followed these planning procedures. The division's approach to developing its system does not ensure the success of any new system. Specifically, the division has not completed two major planning functions: "Analysis of the Problem" and "Design the Solution." As a result, the division has virtually skipped phases two through five in the development of its information system. In addition, the division does not maintain proper documentation, has not developed accurate cost estimates, and has no system to track expenditures.

Incomplete systems analysis and definition

We found no evidence that the division thoroughly analyzed and defined a new management information system. An analysis of the problem that gives rise to the project should take place in the first function of systems development. A Project Valuation Assessment is necessary to define the existing problem and justify the need for a new system.

Although the division completed a Project Valuation Assessment, it did not properly complete the remaining phases in analyzing and defining the problem. The division failed to conduct a System Requirements

Exhibit 2.2
System Development Methodology
System Life-Cycle Functions and Phases



Source: Systems Development Methodology Project Administration Manual
Information & Communication Services Division of the Department of Budget and Finance

Definition, which involves a thorough analysis of user problems and needs. This step would have resulted in a fully documented assessment of the present system, specific user requirements, anticipated benefits of a new system, project recommendations, and supporting data.

The division developed a proposal to implement a replacement system without undertaking this analysis. The division did so despite a recommendation from its Administrative Information Needs Analysis (AINA) committee to conduct a technical analysis of the division's needs *prior* to developing the proposal.

Without a System Requirements Definition, management is unable to make informed decisions about whether to continue investing in the development of a project. The division's failure to complete the essential steps of this phase may lead to the development and purchase of a short-lived "quick fix" system which will not meet its needs.

System design is incomplete

The second major function is the design of the system. System design commences only after system requirements are understood and agreed upon. These requirements are translated into the general design of the system; for example, specifications of the reports to be generated and of the information that the system will provide. The design is further detailed and specifications on how these requirements will be implemented are documented on a final blueprint for building the system.

Bypassing systems design may lead to additional costs and/or long-term problems for the division. If the vendor's software package does not satisfy user needs and requirements, the division will need to either contract with the vendor for additional programming or modify the system in-house at the risk of invalidating warranty and maintenance agreements.

Two-phase approach has too many unknowns

Skipping two essential planning functions suggests that the division's approach to implementing the Behavioral Health Management Information System is to "plan while implementing." This approach leaves the division with little control over the project and forces it to implement a system based on many unknowns. The division cannot foretell when the system will be implemented, how much it will cost, or whether the system will be implemented in the most effective way possible.

According to the division, the Behavioral Health Management Information System is designed to be implemented in two phases. Phase

one is based upon the selection of vendor to "furnish, supply, deliver, install, maintain, and provide training for a Behavioral Health Management Information System for the Department of Health."[2] After completion of the first phase, the division will conduct a comprehensive review and analysis of what it has learned from the experience. The division will then enter the second phase—the full implementation, rollout phase.

However, the division has inserted an "escape clause" into the contract proposal allowing it to proceed with a new vendor with no further obligation to the vendor of the first phase. Because the result of the first phase is unknown and division management has not planned for second phase alternatives, it may find itself back at square one with the entire process.

The division does not have any planned alternatives should the entire project fail. If division management invokes the escape clause in the contract proposal, it will lose the time and money invested in the first vendor. The division will be forced to repeat the time-consuming process of request for proposals development, vendor selection, contract negotiations, and project implementation.

Second phase implementation plan may lead to future problems

The division has currently planned for the second phase of the project to be initiated before the end of the first phase. According to the draft implementation plan, the division will begin the development of a contract extension for the second phase more than two months before the end of the first phase. The same draft plan calls for a review of the first phase to begin two weeks after contract development begins for the second phase. The division contends that the first and second phase schedules must overlap so the centers do not experience a break in service. However, a thorough evaluation of the first phase is essential to the long-term success of the project.

The division's two-phase approach may also suggest that the system is being implemented using a hybrid development method called prototyping. A prototype is a component of a system that is refined over several stages of testing and redevelopment until a final system is realized. However, the prototype approach to systems development also requires Systems Requirements Definition and Systems Design—two crucial steps that the division has skipped.

Potential for inefficient use of state resources

The implementation of the division's information system is currently proceeding with yet another unknown factor—an unproven software package that may lead to costly implementation and the need for modification.

The division has selected a software package that is still in "BETA" site development. A software package in BETA site development is one which has not been successfully implemented in a real world environment. Although the division will not be the first mental health program to implement the software, results of the BETA site development are still unknown. Additional time and effort needed to install an unproven software may result in a higher cost to the state.

No documentation of the entire project

Various documents to record accomplishments are necessary vehicles of communication and are tools enabling management to maintain control of the project. Systems Development Methodology details five distinct components of proper administration and documentation for a project under development. These include work plans, phase workbooks, project administration documents, status reports, and committee minutes.

The division could not produce any comprehensive, formal planning documents for the project. There is no evidence that division management has effectively monitored the project through any clear, concise documents summarizing the progress of the project. The division's project files contain only bits and pieces of meeting minutes, undated memos, purchase orders, invoices, and correspondence. These documents did not provide sufficient detail about phase schedules, plans, project statuses, time frames, expenditures, and problems encountered. As a result, much remains unexplained about project delays and problems.

A factor that greatly contributed to the delay in the project's implementation was the withdrawal of the first vendor selected. However, due to the lack of proper documentation, circumstances surrounding the withdrawal remain questionable. While the division maintains that the first vendor withdrew for personnel reasons, an August 1996 letter from the first vendor to the division states otherwise. The letter points to the Department of Health's significant delay in signing the agreement as the reason for withdrawing. We found no further documentation to confirm either of the claims.

The division also lacks phase work plans that provide credible estimates of needs and costs. Consequently, it has underestimated projected computer needs for the initial phase of the project by 75 percent. In addition, the division has underestimated the cost of the system by 63 percent. Systems Development Methodology states that any difference greater than 30 percent between the actual cost and "committed" cost is a *quite severe* estimating problem, which requires management action. In 1995, the division estimated that 20 personal computers were required for phase one at a cost of $44,000. However, the division has purchased 35 computers and computer-related equipment for phase one at a cost of

$71,424. There are indications that the division has also underestimated the computer needs for the second phase by 100 percent at an increased cost of more than 86 percent.

Budget plans are inadequate

Systems Development Methodology's guidelines for estimating costs could have helped the division develop an accurate budget for the project. According to the guidelines, costs are estimated in detail on a task-by-task basis at the start of each phase. After each phase is completed, estimates for the remaining phases are updated.

According to Systems Development Methodology, realistic project costs and schedules are realized only after five steps have been completed:

- The scope of the project is clearly understood and properly defined;
- The user requirements, needs, and problems have been defined;
- An effective solution has been conceived for the most cost-effective way to deal with the defined needs and requirements;
- Sufficiently detailed specifications are available to define the extent of system complexity; and
- The architecture of the system has been fully formulated.

We found that the division proceeded to develop a cost estimate without completing any of these steps. The division estimates that the total system will cost $418,520 to implement. Exhibit 2.3 details the division's cost estimates for both phases.

We found that the division's cost estimate is not supported by any credible approaches to budgeting and is far from complete. The division admits that projected costs and needs were "best guess" estimates because it needed a quick dollar figure to receive funding approval. The division continues to adhere to its 1995 estimate which excludes major personnel expenses and other costs such as network/lines, outside consultation, travel expenses, and training. In addition, the division's lack of planning and documentation made it impossible to accurately calculate projected total cost of the system and the division's total expenditures to date.

Exhibit 2.3
Behavorial Health Management Information System
Projected Implementation Costs

Phase One	
Division Central Office	$ 54,600
Kalihi-Palama CMHC*	16,300
Windward CMHC*	13,900
Kauai CMHC* & Friendship House	18,700
Vendor (software and training)	80,120
Sub-Total Phase One	$ 183,620
Phase Two	
Diamond Head CMHC*	$ 23,700
Central Oahu CMHC*	21,800
East Hawaii CMHC*	23,600
West Hawaii CMHC*	17,800
Maui CMHC*	21,800
Molokai	4,200
Lanai	4,200
Hawaii State Hospital	17,800
Vendor (software and training)	100,000
Sub-Total Phase Two	$ 234,900
TOTAL	**$ 418,520**

* Community Mental Health Center

Source: Adult Mental Health Division

No system to track costs

The division does not have a system in place to track how much it has actually spent on its management information system to date. In March 1997, our office requested information on project expenditures. The division could not provide us with a complete and accurate cost breakdown. In the absence of accurate estimates and cost data, division management cannot effectively manage the project. Furthermore, division management cannot maintain control of the project through evaluations of personnel and overall project performance.

Department of Health has failed to ensure proper planning

Systems Development Methodology states that management should take more than just a peripheral interest in building a successful system. Management must make a genuine commitment to using information

systems resources in a planned manner and provide for the growth of the information systems environment. The director of health should: (1) establish specific objectives in information systems to support the department's interests; (2) set specific directions in the use of computers to forward the department's goals; (3) set priorities; (4) ensure that information systems planning be done thoroughly; and (5) follow through to ensure that objectives are realized. These responsibilities should not be relegated to information systems staff or to division management.

Finally, the Department of Health does not have an overall plan addressing its informational needs and goals. The Department of Budget and Finance requires every department to have a distributed information processing and information resource management (DIPIRM) plan to promote the effective and efficient integration of information systems. Furthermore, the Department of Budget and Finance also requires departments to submit periodic DIPIRM updates.

The division has not submitted an update to Budget and Finance's Information and Communications Services Division since 1985. The Department of Health's Information Systems Office admits that the department does not have a comprehensive DIPIRM plan. Without a departmental plan, the division has been unable to successfully implement its information system in an efficient, economical, or controlled manner.

Conclusion

Problems with billings and collections of the Adult Mental Health Division that are identified in this follow-up audit center on the division administration's weak management. The division's lack of guidance and overall direction has resulted in a continued loss of potential revenues. Although the community mental health centers are creating opportunities and initiatives to improve their billings and collections, they do so with little support from the division. The Adult Mental Health Division's management of the special fund negates the incentive for the centers to aggressively bill for services, increases the centers' dependence on state general funds, and underscores the division's lack of support for the centers. Finally, the division's poor planning for the Behavioral Health Management Information System to improve its billings and collections increases the potential for inefficient use of state resources.

If the division is to move toward maximizing revenues, the director of health must hold accountable the chief of the Adult Mental Health Division to ensure proper performance of the duties and responsibilities designated to that position. Furthermore, the division chief should

ensure that the division's administration as a whole accepts and adequately performs its duties and responsibilities to direct, coordinate, and monitor the community mental health centers.

Recommendations

1. The Director of Health should ensure that the Adult Mental Health Division assumes its responsibilities to direct, coordinate, and monitor the community mental health centers and address the concerns outlined in this report. Specifically, the director should ensure that the division performs the following:

    a. Implement a division-wide overall billing system for the state-operated community mental health centers. This system should include comprehensive policies and procedures for billings and collections that are fully implemented and formal monitoring and evaluation activities to ensure compliance with policies and procedures; and

    b. Obtain or designate a qualified billing coordinator to concentrate on implementing the division's billing and collections responsibilities.

2. To ensure that appropriations from the Mental Health and Substance Abuse Special Fund more accurately reflect the fund's current balance, the Legislature should require the Department of Health to accurately report the special fund and special fund subaccount balances and projected expenditures of each subaccount to offset operating expenses. In addition, the Legislature should require that the Department of Health use its special fund as a primary source for payment of operating expenses prior to using general funds.

3. The Department of Health should ensure that the Adult Mental Health Division has adequately planned and developed its proposed management information system before it begins implementation. Specifically, the department should require that the division postpone implementing the system and complete first the requirements of the Systems Development Methodology. These requirements should include:

    a. Completion and proper documentation of system requirements definition and design functions prior to actual implementation of the system;

    b. Completion of project administration documents such as work plans, status reports, and meeting minutes; and

    c. Thorough budget plans that include a system to track total costs throughout the entire project.

Notes

Chapter 2

1. *Webster's Ninth New Collegiate Dictionary*, 1983, p. 1199.

2. Hawaii, Department of Health, Adult Mental Health Division, *Request for Proposals to Furnish, Supply, Deliver, Install, Maintain and Provide Training for Behavioral Health Management Information System*, September 1995, p. 7.

Response of the Affected Agency

Comments on Agency Response

We transmitted a draft of this report to the Department of Health on August 27, 1997. A copy of the transmittal letter to the department is included as Attachment 1. The department's response is included as Attachment 2.

The department generally concurs with our findings and recommendations. In its response, the department states that the report seems objective and fairly presented. While the department found our summary and findings generally agreeable it offered the following comments.

In response to our finding that the Adult Mental Health Division still did not have a billings and collections coordinator, the department stated that because of classification issues, the division was still in the process of finalizing the position. Until the position is established and filled, the Adult Mental Health Public Health Administrative Officer has been assigned as the interim billing coordinator. We restate our recommendation that the department expedite its establishment of this position.

The department also commented on our finding that the Mental Health and Substance Abuse Special Fund balance continues to grow while expenditures remain low. The department stated that the fund balance at the end of FY1995-96 and FY1996-97 includes state matching portions of Medicaid payments received for case management services. This factor is acknowledged in our report.

The department also maintains that the funds contained within the administrative subaccount of the special fund are being used appropriately. The department argues that the purchase of a division-wide, centralized management information system is an operating expense that is an effective incentive for the centers to bill aggressively. While we recognize that the management information system is intended for division-wide use, the incentive to centers that revenues collected will directly offset expenses incurred by each individual center is lost. In addition, we believe that the purchase of such a system is a major programmatic endeavor that should be reviewed by the Legislature through the budgetary process. Use of the special fund for this purpose circumvents legislative oversight.

In addition, the department argues that the appropriation ceiling for the special fund is not intended to reflect the fund's current balance.

Furthermore, the department maintains that "Any fiscally responsible organization utilizing special funds for operating expenses will not expend all of their special fund balance each fiscal year if future revenue cannot be accurately projected." The department believes that the "uncertainty of future revenue" will affect our recommendation that the department be required to use its special fund as a primary source for payment of operating expenses prior to using general funds.

We note that our recommendation is for the special fund to be used as the primary source for payment of operating expenses. We do not suggest that the entire special fund balance be expended, but that the fund be utilized in the manner for which it was intended by the Legislature. With respect to "uncertainty of future revenue" we agree, but note that the department which bills and collects the moneys in the special fund has more control and certainty in this source of funding than in its competition with all other state agencies for general funds.

The department also offered comment on our findings related to the Adult Mental Health Division's management information system. With regard to our finding that the division had not yet finalized a contract with a software vendor for the purchase of a management information system, the department responded that shortly after the end of our fieldwork, a contract with a vendor was executed, software has been installed, and training on the system has begun.

In response to our finding that the Adult Mental Health Division has not followed state guidelines, such as Systems Development Methodology, for implementing an information system, the department maintains that it has applied a "current, industry-standard methodology" called Rapid Application Development (RAD). We wish to point out that the Rapid Application Development technique is not a "methodology" that encompasses the planning of a system's whole life cycle. A technique such as Rapid Application Development addresses only a portion of the system's life cycle, as in the case of the division, only the planning portion. Once planning is complete, the division will have no methodology to help guide the project to completion. Furthermore, we point out in the audit report that the division failed to complete a System Requirements Definition—an essential step in both the Rapid Application Development technique and the Systems Development Methodology.

Concerning our finding that the division has planned for the second phase of its management information system implementation to be initiated before the end of the first phase, the department argues that it had never planned to overlap phases. The department maintains that the time required to execute a contract may necessitate the drafting of an agreement for the second phase to begin during the first, however, the contract for the second phase will not be executed until the first phase is complete.

We believe that before the division can consider drafting a contract for phase two, all necessary reviews and analyses of phase one must be completed in order for management to make informed decisions about what should be included in the second phase. As support for our position, we point to the division's Request for Proposal for the Behavioral Health Management Information System that states that commencement of phase two is dependent upon the results of a comprehensive review and analysis to be conducted after completion of the first phase. We are encouraged that the department recognizes the need to "reassess the schedule for implementation of phase two" as it has stated in its response that it intends to do.

Our report also points out that the software package chosen by the Adult Mental Health Division for its management information system is still in BETA site development. Additional time and effort needed to install an unproven software package may result in a higher cost to the State. The department does not consider the software package to be in BETA site development and argues that the developer of the package has twenty-six years of experience in installing software. Our evidence, however, supports our finding that during our audit fieldwork, the software package selected by the division had been implemented only at its first test site and that testing of the software was ongoing. As we point out in our report, a software package in BETA site development is one which has not yet been successfully implemented in a real world environment.

We are encouraged by the department's response that the Adult Mental Health Division will ensure proper documentation and monitoring of the remaining phases of implementation for its management information system.

Finally, the department has indicated that the Department of Accounting and General Services and not the Department of Health has contracted with financial auditors Deloitte and Touche to provide consultant services for maximizing federal reimbursements for the State. We have made the necessary adjustments to our report.

ATTACHMENT 1

STATE OF HAWAII
OFFICE OF THE AUDITOR
465 S. King Street, Room 500
Honolulu, Hawaii 96813-2917

MARION M. HIGA
State Auditor

(808) 587-0800
FAX: (808) 587-0830

September 10, 1997

COPY

The Honorable Lawrence Miike
Director
Department of Health
Kinau Hale
1250 Punchbowl Street
Honolulu, Hawaii 96813

Dear Dr. Miike:

Enclosed for your information are three copies, numbered 6 to 8 of our draft report, *Follow-Up Audit on the Management of Billings and Collections for the Department of Health's Outpatient Adult Mental Health Services*. We ask that you telephone us by Friday, September 12, 1997, on whether or not you intend to comment on our recommendations. If you wish your comments to be included in the report, please submit them no later than Friday, September 19, 1997.

The Governor, and presiding officers of the two houses of the Legislature have also been provided copies of this draft report.

Since this report is not in final form and changes may be made to it, access to the report should be restricted to those assisting you in preparing your response. Public release of the report will be made solely by our office and only after the report is published in its final form.

Sincerely,

Marion M. Higa
State Auditor

Enclosures

FAXED 9/22/97

BENJAMIN J. CAYETANO
GOVERNOR OF HAWAII

LAWRENCE MIIKE
DIRECTOR OF HEALTH

STATE OF HAWAII
DEPARTMENT OF HEALTH
P. O. BOX 3378
HONOLULU, HAWAII 96801-3378

September 19, 1997

Ms. Marion M. Higa
State Auditor
Office of the Auditor
465 South King Street, Room 500
Honolulu, Hawaii 96813-2917

Dear Ms. Higa:

SUBJECT: Draft Report, Follow-Up Audit on the Management of Billings and Collections for the Department of Health's Outpatient Adult Mental Health Services

Thank you for the opportunity to provide a response to the above draft report. Overall, the report seems objective and fairly presented. While we find the summary and findings generally agreeable, we are compelled to offer comments on some areas of the findings.

Specific comments on the report are as follows:

Page 14, Chapter 2, section "Still no billings and collections coordinator", second paragraph, comment follows:

> After discussions with staff in the Department's Administrative Services Office and Personnel Office, it was decided to establish a position for a Program Specialist (Mental Health) IV, and not a Public Health Administrative Officer IV, to function as the billing coordinator. The change in position class was made so that probable classification problems and reorganization implications could be averted. The position description for the Program Specialist is being finalized.

Page 15, Chapter 2, section "Centers demonstrate efforts despite division's weak management", fifth paragraph, comment follows:

> The Department of Accounting and General Services, and not the Department of Health, has contracted with Deloitte and Touche to provide consulting services to

maximize federal reimbursements for the state. The scope of the contract includes identifying additional revenue possibilities and providing assistance to state programs to generate the potential revenue.

The specific services to be provided by Deloitte and Touche for the Adult Mental Health Division is still being negotiated. The initial proposal for services to be provided is being revised because the Balanced Budget Act of 1997, which the President signed into law on August 5, 1997, eliminated the possibility of collecting the Medicaid Disproportionate Share.

Page 17, Chapter 2, section " Special fund balance continues to grow while special fund expenditures remain low", first paragraph and Exhibit 2.1, comment follows:

The special fund balance at the end of FY 1995-96 includes $331,809 payable to the Department of Human Services. The special fund balance as of February 28, 1997 includes $644,727 payable to the Department of Human Services. The amounts payable to the Department of Human Services are for the state match portion of Medicaid payments received for case management services.

Page 18, Chapter 2, section "Funds in an administrative subaccount belong to the centers", third paragraph, comment follows:

The purchase of a division-wide management information system is an operating expense for the centers and therefore, an appropriate use of center generated funds. The one-time retroactive reimbursement for QUEST clients was deposited into the administrative subaccount because the purchase of the management information system is centralized at the division level. The installation of a more responsive, user friendly management information system is an effective incentive for the centers to bill aggressively because it will not only enable more accurate and timely billing, but will document for management how billing is directly linked to operating expenses.

Page 18, Chapter 2, section "The Division is Not Adequately Planning for Its Proposed Management Information System", second paragraph, comment follows:

The contract with the software vendor was executed on April 29, 1997 and the official contract commencement date was May 1, 1997. The software has been installed and training on its use has begun.

Page 19, Chapter 2, section "Systems Development Methodology not followed", fourth paragraph, comment follows:

> The division used the Rapid Application Development (RAD) methodology to plan the implementation of the new management information system. While the Systems Development Methodology is appropriate for mainframe computer systems, RAD is the current, industry standard methodology used to implement personal computer and client-server technology based management information systems.
>
> The RAD methodology has four phases - requirements planning phase, user design phase, construction phase, and cutover phase. The four phases are run in parallel steps and development becomes a repeated process of refining successive versions of the application.
>
> Some of the advantages for using RAD versus Systems Development Methodology are:
>
> - end users are involved in all stages of development;
> - shorter development times;
> - reduced cost;
> - improved quality;
> - systems need not be complete to provide benefits; and
> - the life of the core system is extended and can evolve with user needs.

Page 22, Chapter 2, section "Second phase implementation plan may lead to future problems", first paragraph, comment follows:

> The first and second phases of the implementation of the management information system will not overlap and were never planned to overlap. The time required to execute a contract may necessitate the drafting of an agreement for the second phase to begin during the first phase. The contract for the second phase will not be executed until the first phase is thoroughly evaluated.

Page 23, Chapter 2 , section "Potential for inefficient use of state resources, first paragraph, comment follows:

> We do not consider the software package purchased to still be in the "BETA" site development stage. The software developer has over twenty six years of experience in installing software for mental health programs and the version of the software package being purchased has been in use for over two years.

Page 23, Chapter 2, section "No documentation of the entire project", fourth paragraph, comment follows:

> The purchase of 35 computers and computer-related equipment at a cost of $71,424 was for phase one of the project and for training. After training for phase two of the management information system is completed, these computers will be relocated to the centers.

As indicated previously, while we agree with the intent of most of the recommendations made by the State Auditor and are committed to continuing efforts to implement the intent of those recommendations, we must offer the following comments.

Specific comments on the recommendations are as follow:

1. Until the Program Specialist IV position is established and filled, the division's Public Health Administrative Officer VI has been assigned interim billing coordinator. The interim billing coordinator has been instructed to evaluate each centers' billing and collection activities and prepare a status report and corrective action plan for the division chief by the end of October 1997.

   The interim billing coordinator will also review, analyze, and update the division's official fee schedule. It is projected that a public hearing for an updated fee schedule can be held by January 1998.

2. The appropriation for the Mental Health and Substance Abuse Special Fund is an expenditure ceiling for the fund and is not intended to reflect the fund's current balance. Any fiscally responsible organization utilizing special funds for operating costs will not expend all of their special fund balance each fiscal year if future revenue can not be accurately projected. Changes in the QUEST program and their

effect on a significant portion of the Adult Mental Health Division's revenue can not be determined at this time.

The uncertainty of future revenue will also affect the recommendation that the Department should be required to use its special fund as a primary source for payment of operating expenses prior to using general funds. The implementation of the management information system will assist in projecting service utilization, revenue and expenditures.

3. The implementation of the management information system has already begun. However, the division will closely reassess the schedule for implementation of phase two of the management information system.

   The division will also ensure that the remaining phases of the implementation of the new management information system will be more thoroughly documented and monitored.

We again thank you for the opportunity to comment on your draft report.

Sincerely,

Lawrence Takamura

for LAWRENCE MIIKE
Director of Health