LOS ANGELES COUNTY
AUDITOR-CONTROLLER

John Naimo
AUDITOR-CONTROLLER

Arlene Barrera
CHIEF DEPUTY

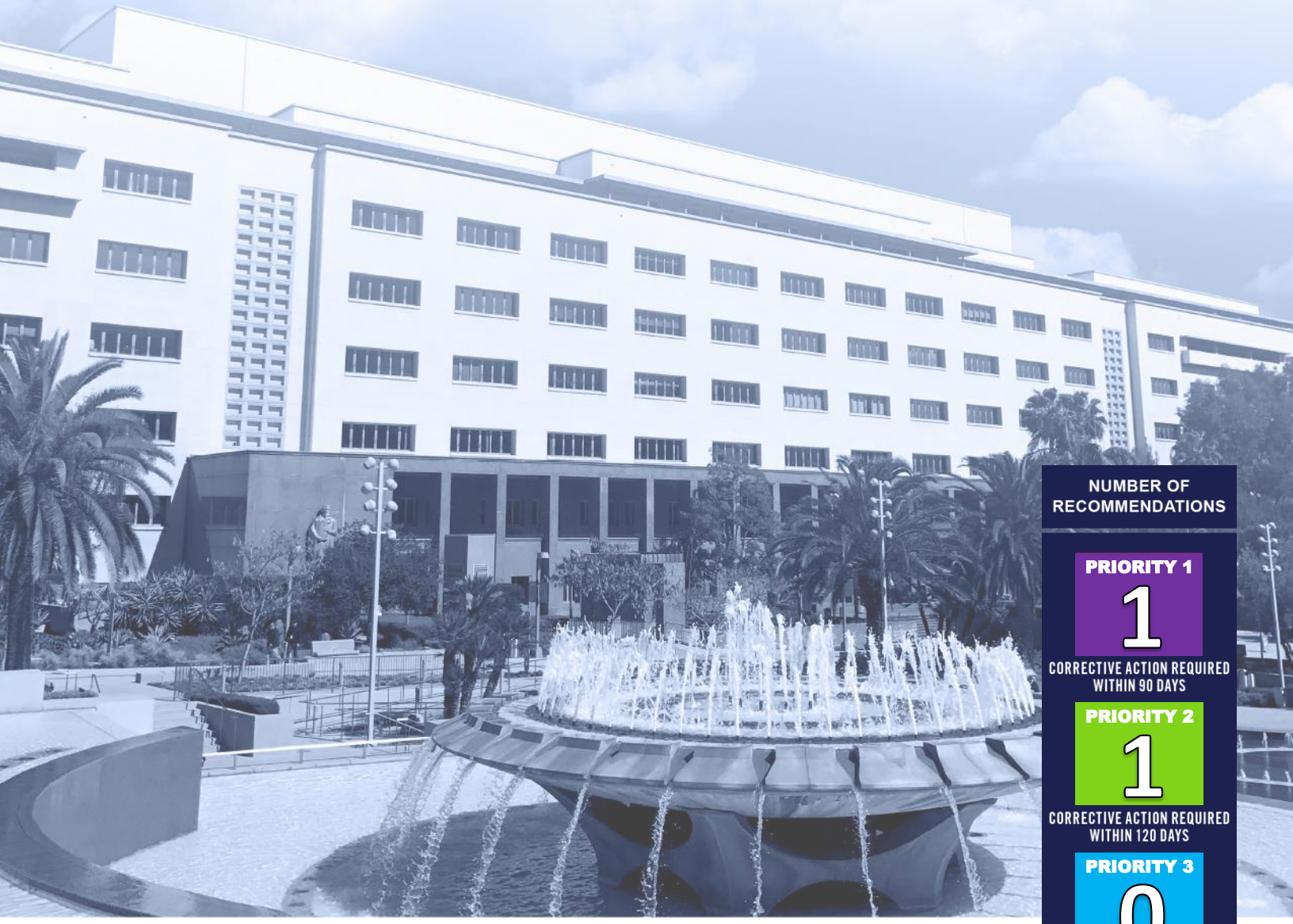
Peter Hughes
ASSISTANT AUDITOR-CONTROLLER

Robert Campbell
DIVISION CHIEF

OFFICE OF COUNTY INVESTIGATIONS

March 27, 2019

Department of Mental Health
IMPROVEMENT OPPORTUNITIES NOTED DURING LIMITED REVIEW #2017-13348



NUMBER OF RECOMMENDATIONS

PRIORITY 1
1
CORRECTIVE ACTION REQUIRED WITHIN 90 DAYS

PRIORITY 2
1
CORRECTIVE ACTION REQUIRED WITHIN 120 DAYS

PRIORITY 3
0
CORRECTIVE ACTION REQUIRED WITHIN 180 DAYS

BOARD OF SUPERVISORS

Hilda L. Solis
FIRST DISTRICT

Mark Ridley-Thomas
SECOND DISTRICT

Sheila Kuehl
THIRD DISTRICT

Janice Hahn
FOURTH DISTRICT

Kathryn Barger
FIFTH DISTRICT

#2017-13348

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COUNTY OF LOS ANGELES
DEPARTMENT OF AUDITOR-CONTROLLER

KENNETH HAHN HALL OF ADMINISTRATION
500 WEST TEMPLE STREET, ROOM 525
LOS ANGELES, CALIFORNIA 90012-3873
PHONE: (213) 974-8301 FAX: (213) 626-5427

JOHN NAIMO
AUDITOR-CONTROLLER

ADDRESS ALL CORRESPONDENCE TO:
OFFICE OF COUNTY INVESTIGATIONS
500 W. TEMPLE ST., ROOM 515
LOS ANGELES, CA 90012-3756

March 27, 2018

TO: Jonathan E. Sherin, M.D., Ph. D., Director
Department of Mental Health

FROM: Robert G. Campbell, Chief
Office of County Investigations

SUBJECT: **IMPROVEMENT OPPORTUNITIES NOTED DURING LIMITED REVIEW #2017-13348**

During a limited review at the Department of Mental Health (DMH), we noted areas where DMH can strengthen its internal controls over contractor invoice processing and improve the quality of its internal audits and compliance reviews. Please see Attachment I, Table of Findings and Recommendations for Corrective Action, for details of our observations and recommendations. The Auditor-Controller's follow-up process and internal control disclosures are included in Attachment II.

Review of Report

We discussed our report with DMH management. The Department's response (Attachment III) indicates general agreement with our findings and recommendations.

We thank DMH management and staff for their cooperation and assistance during our review. If you have any questions please call me at (213) 893-0058, or your staff may contact Greg Hellmold at (213) 893-0243.

RGC:GH:vm
IOR-2017-13348

Attachments

c: John Naimo, Auditor-Controller
Audit Committee
Auditor-Controller Audit Division

DEPARTMENT OF MENTAL HEALTH
IMPROVEMENT OPPORTUNITIES NOTED DURING LIMITED REVIEW #2017-13348

TABLE OF FINDINGS AND RECOMMENDATIONS FOR CORRECTIVE ACTION

	ISSUE	RISK	RECOMMENDATION	P[1]	SUMMARY OF RESPONSE
1	**Contractor Invoice Processing:** The Department of Mental Health (DMH) can strengthen its review of service provider billings, to ensure service recipients are eligible and billings comply with contract requirements. DMH processed and paid invoices in excess of $700,000 to a contractor for services to clients who were ineligible per the terms of the service provider's contract. DHM identified the eligibility issues and directed the provider on several occasions to cease submitting ineligible claims, but nevertheless continued to process and pay those claims for at least sixteen months.	Approving service provider invoices that have not been adequately reviewed could result in County overpayments, including for services and clients that are not specified in the contract. These improper payments could result in County losses, and resources being diverted from eligible clients.	**DMH implement procedures and controls to ensure that service provider billings are routinely reviewed, on at least a sample basis, for client eligibility and compliance with contract terms and provisions, and develop a process to timely withhold and/or terminate payment for ineligible, improper, or questioned claims.**	1	**Agree** Target Implementation Date: June 21, 2019 DMH created a Contract Management and Monitoring Division (CMMD) that plans to initiate a redesign of the contractor invoice process workflow; finalize invoice claim template alignment efforts; and ensure that subject matter experts are reviewing invoices to confirm the appropriateness of expenditures.
2	**Quality Assurance (QA) Process for Internal Audit and Compliance Activities:** DMH needs to implement a more comprehensive quality assurance process over internal audit and compliance activities to ensure that findings are accurate and well documented in accordance with industry standards of due professional care.	Inaccurate and/or inadequately documented audit findings undermine the credibility and utility of the Department's internal audit function, and could impair management's ability to make informed decisions about significant matters involving contracts, service delivery, and finances. This could impair the delivery of services, impact strategic goals and objectives,	**DMH Compliance, Privacy, and Audit Services Bureau develop and implement a comprehensive QA program to ensure that findings and recommendations resulting from its internal audits and compliance reviews are accurate and adequately documented, and train internal audit and compliance staff on the QA program.**	2	**Agree** Target Implementation Date: July 19, 2019 DMH arranged for the Auditor-Controller to provide four full days of training, during the months of April and May 2019, to their line-level employees and leadership staff from

[1] **Priority Ranking:** Recommendations are ranked from Priority 1 to Priority 3 based on the potential seriousness and likelihood of negative impact on departmental operations if corrective action is not taken. See Attachment IV for definitions of priority rankings.

TABLE OF FINDINGS AND RECOMMENDATIONS FOR CORRECTIVE ACTION					
	ISSUE	**RISK**	**RECOMMENDATION**	**P[1]**	**SUMMARY OF RESPONSE**
	We reviewed work performed by DMH audit and compliance staff for a specific engagement, which management subsequently relied upon in making various consequential business decisions. Our review identified that the testwork and analysis performed by DMH staff contained material errors and misstatements, which likely would have been detected if the testwork had been subject to a more robust quality assurance process.	and create potential liability for the Department.	**DMH should reference industry standards and processes, such as those promulgated by the Institute of Internal Auditors (IIA), in developing its QA program. The Department should also ensure that staff responsible for performing audits and compliance reviews have the necessary education, training, knowledge, skills, and abilities to carry out their assigned duties.**		the Office of Administrative Operations who have a nexus to administrative and fiscal monitoring programs. Additionally, DMH is also planning on sending a core team of Compliance and CMMD staff to the Institute of Internal Auditors 4-day Tools & Techniques I: New Internal Auditor Course offered during the 3rd quarter of 2019.

[1] **Priority Ranking:** Recommendations are ranked from Priority 1 to Priority 3 based on the potential seriousness and likelihood of negative impact on departmental operations if corrective action is not taken. See Attachment IV for definitions of priority rankings.

FOLLOW-UP AND INTERNAL CONTROL DISCLOSURES

FOLLOW-UP PROCESS

The Auditor-Controller (A-C) has a follow-up process designed to provide assurance to the Board of Supervisors (Board) that departments are taking appropriate and timely corrective action to address audit recommendations. Within six months of the date of an audit report, departments must submit a Corrective Action Implementation Report (CAiR) detailing the corrective action taken to address all recommendations in the report. Departments must also submit documentation with the CAiR that demonstrates the corrective action taken. We will review departments' reported corrective action and supporting documentation, and report the results to the Board. For any recommendations not fully implemented, departments must report the status of corrective action within six months after our first follow-up report is issued.

MANAGEMENT'S RESPONSIBILITY FOR INTERNAL CONTROLS

As indicated in County Fiscal Manual Section 1.0, management of each County department is primarily responsible for designing, implementing, and maintaining a system of internal controls that provides reasonable assurance that important departmental and County objectives are being achieved. Internal controls should sustain and improve departmental performance, adapt to changing priorities and operating environments, reduce risks to acceptable levels, and support sound decision-making.

Management must monitor internal controls on an ongoing basis to ensure that any weaknesses or non-compliance are promptly identified and corrected. The A-C's role is to assist management by performing periodic assessments of the effectiveness of the department's internal control systems. These assessments complement, but do not in any way replace, management's responsibilities over internal controls.

LIMITATIONS OF INTERNAL CONTROLS

Any system of internal controls, however well designed, has limitations. As a result, internal controls provide reasonable but not absolute assurance that an organization's goals and objectives will be achieved. Some examples of limitations include errors, circumvention of controls by collusion, management override of controls, and poor judgment. In addition, there is a risk that internal controls may become inadequate due to changes in the organization, such as reduction in staffing or lapses in compliance.

Los Angeles County
DEPARTMENT OF MENTAL HEALTH
JONATHAN E. SHERIN, M.D., Ph.D.
DIRECTOR

March 22, 2019

TO: Robert G. Campbell, Chief
Office of County Investigations

FROM: Jonathan E. Sherin, M.D., Ph.D.
Director

SUBJECT: **RESPONSE TO AUDITOR-CONTROLLER FINDINGS AND RECOMMENDED CORRECTIVE ACTIONS**

The Department has reviewed the Auditor-Controller's report and is in general agreement with the findings and recommendations. The Department will report the corrective actions planned and/or taken to address the recommendations within the respective timeframes established by the priority rankings.

If you have any questions or require additional information, please contact me at (213) 738-4601, or your staff may contact Ed Soto, Administrative Deputy III, at (213) 738-2891.

Attachment

JES:GP:ES

c: Gregory Polk
Edgar Soto
Terri Boykins

PRIORITY RANKING DEFINITIONS

Auditors use professional judgment to assign rankings to recommendations using the criteria and definitions listed below. The purpose of the rankings is to highlight the relative importance of some recommendations over others based on the likelihood of adverse impacts if corrective action is not taken and the seriousness of the adverse impact. Adverse impacts are situations that have or could potentially undermine or hinder the following:

a) The quality of services departments provide to the community,
b) The accuracy and completeness of County books, records, or reports,
c) The safeguarding of County assets,
d) The County's compliance with pertinent rules, regulations, or laws,
e) The achievement of critical programmatic objectives or program outcomes, and/or
f) The cost-effective and efficient use of resources.

Priority 1 Issues

Priority 1 issues are control weaknesses or compliance lapses that are significant enough to warrant immediate corrective action. Priority 1 recommendations may result from weaknesses in the design or absence of an essential procedure or control, or when personnel fail to adhere to the procedure or control. These may be reoccurring or one-time lapses. Issues in this category may be situations that create actual or potential hindrances to the department's ability to provide quality services to the community, and/or present significant financial, reputational, business, compliance, or safety exposures. Priority 1 recommendations require management's immediate attention and corrective action within 90 days of report issuance, or less if so directed by the Auditor-Controller or the Audit Committee.

Priority 2 Issues

Priority 2 issues are control weaknesses or compliance lapses that are of a serious nature and warrant prompt corrective action. Priority 2 recommendations may result from weaknesses in the design or absence of an essential procedure or control, or when personnel fail to adhere to the procedure or control. These may be reoccurring or one-time lapses. Issues in this category, if not corrected, typically present increasing exposure to financial losses and missed business objectives. Priority 2 recommendations require management's prompt attention and corrective action within 120 days of report issuance, or less if so directed by the Auditor-Controller or the Audit Committee.

Priority 3 Issues

Priority 3 issues are the more common and routine control weaknesses or compliance lapses that warrant timely corrective action. Priority 3 recommendations may result from weaknesses in the design or absence of a procedure or control, or when personnel fail to adhere to the procedure or control. The issues, while less serious than a higher-level category, are nevertheless important to the integrity of the department's operations and must be corrected or more serious exposures could result. Departments must implement Priority 3 recommendations within 180 days of report issuance, or less if so directed by the Auditor-Controller or the Audit Committee.