Summary of Significant Audit Findings for Local Mental Health Authorities for Fiscal Year 2023

As Required by
Texas Health and Safety Code
Section 534.068(f)

Texas Health and Human Services
December 2024

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Executive Summary

The Summary of Significant Audit Findings for Local Mental Health Authorities for Fiscal Year 2023 is submitted in compliance with Texas Health and Safety Code, Section 534.068(f).

Local Mental Health Authorities (LMHAs) expending $750,000 or more in federal and state awards must have a single audit conducted in accordance with 2 CFR 200 Uniform Administrative Requirements, Cost Principles and Audit Requirements, Subpart F (Audits) and the Texas Comptroller's Texas Grant Management Standards (TxGMS).

Single Audits are submitted to the Health and Human Services Commission (HHSC) Compliance and Quality Control Division Single Audit Unit (SAU). The SAU notifies the HHSC contracting areas of findings noted in each Single Audit Report. HHSC must review the fiscal audit activities and submit this report to the Governor, and Legislative Audit Committee pursuant to Texas Health and Safety Code, Section 534.068(f).

This report summarizes the independent auditor's findings of 39 LMHAs and their responses for fiscal year 2023.

Introduction

Texas Health and Safety Code, Section 534.068(f) requires HHSC to submit a report annually to the Governor and Legislative Audit Committee. The report must include a summary of the significant findings identified during a review of fiscal audit activities.

Audits are conducted and submitted to HHSC in compliance with Health and Safety Code Section 534.068(a), which states: "As a condition to receiving funds under this subtitle, a local mental health authority other than a state facility designated as an authority must annually submit to the department a financial and compliance audit prepared by a certified public accountant or public accountant licensed by the Texas State Board of Public Accountancy. To ensure the highest degree of independence and quality, the local mental health authority shall use an invitation-for-proposal process as prescribed by the executive commissioner to select the auditor."

Background

The Summary of Significant Audit Findings for Local Mental Health Authorities for Fiscal Year 2023 report summarizes auditors' findings from their review of independent financial and compliance audits, in accordance with 2 CFR 200 Uniform Administrative Requirements, Cost Principles and Audit Requirements Subpart F (Audits) and the Texas Comptroller's Texas Grant Management Standards (TxGMS).

Also noted are fiscal year 2023 findings, questioned costs, and corrective plans. In addition, follow up on prior year findings and any relevant comments, as outlined in the auditor's management letter, are included. All findings, comments and corrective actions are reproduced verbatim from the independent audit reports and are not modified by HHSC. HHSC reviewed the audits and determined all of the identified findings were significant for purposes of complying with Section 534.068(f).

Summary of Significant Findings

3.1 Abilene Regional MHMR dba Betty Hardwick Center

City: Abilene

Counties Served: Callahan, Jones, Shackelford, Stephens, and Taylor

Type of Report on Financial Statement: Unmodified

Type of Report on Compliance: Unmodified

Schedule of Findings and Questioned Costs:

Section II – Financial Statement Findings

Finding 2023-001: Performance of accurate account reconciliations (specifically cash accounts) on timely basis across all funds within the organization to ensure the accuracy of monthly and year-end financial statements. Material weakness in internal control over financial reporting.

Criteria: A properly designed system of internal control over financial reporting includes timely reconciliations of balance sheet accounts on a monthly or quarterly basis, depending on the account. Comprehensive reconciliations should include sub-ledger or alternative system documentation that supports and justifies the balance within the account, demonstrates a roll forward from the prior period which ties to revenue (where applicable), and ensures any reconciling items are timely addressed and cleared.

Condition: The Center did not consistently complete balance sheet reconciliations which were comprehensive, accurate, and that adequately justified the balances within the account throughout the year (at month end close) or at year end close.

Cause: The Center has experienced a substantial shortage of qualified workers while the industry demand for more workers continues to grow. This has caused the Center to lose focus of core activities required to produce timely and accurate financial statements.

Effect: Monthly financials that management and the board use to make decisions could be misstated without proper account reconciliations. The production of audit

schedules at year end were substantially delayed as a result of reconciliations having to be completed, reviewed, and entries made to adjust reconciling items occurring earlier in the year.

Recommendation: We recommend that management ensure all significant balance sheet accounts are reconciled on a timely basis, as is appropriate for the account, in a manner that supports the account balance, with any reconciling items being addressed in a timely manner.

Views of Responsible Officials: Management acknowledges the finding and is making every effort to ensure that accounts will be accurately and timely reconciled by the first quarter of fiscal year 2024.

Follow-up on Prior Year Findings: None

Independent Auditor's Management Letter: Yes, with no significant deficiencies

Corrective Action Plan:

Finding 2023-001

Finding Summary: Performance of accurate account reconciliations (specifically cash accounts) on timely basis across all funds within the organization to ensure the accuracy of monthly and year-end financial statements. Material weakness in internal control over financial reporting.

Responsible Individuals: Chris Mabry, Chief Financial Officer

Corrective Action Plan: Cash account reconciliations will be performed monthly for all significant bank accounts. Outstanding items that are either over $100,000, or 3 months old will be immediately investigated. The Reconciliation will tie back to the appropriate general ledger account, ensuring the accounts are accurate and complete.

Anticipated Completion Date: Effective immediately and will be ongoing.

Corrective Action Plan has been implemented.

3.2 Anderson-Cherokee Community Enrichment Services

City: Jacksonville

Counties Served: Anderson and Cherokee

Type of Report on Financial Statement: Unmodified

Type of Report on Compliance: Unmodified

Schedule of Findings and Questioned Costs: None

Follow-up on Prior Year Findings: None

Independent Auditor's Management Letter: No findings/comments

Corrective Action Plan: No finding(s) requiring corrective action

3.3 Andrews Center

City: Tyler

Counties Served: Henderson, Rains, Smith, Van Zandt, and Wood

Type of Report on Financial Statement: Unmodified

Type of Report on Compliance: Unmodified/Qualified

Schedule of Findings and Questioned Costs:

Section III – Federal and State Awards Findings and Questioned Costs

2023-001: United States Department of Health and Human Services
Federal Assistance Listing Number 93.498; Reporting Period 4
COVID-19 Provider Relief Fund and American Rescue Plan Rural Distributions (PRF)

Reporting Material Weakness in Internal Control over Compliance and Material Noncompliance; Reporting Period 4

Criteria: 2 CFR 200.303(a) establishes that the auditee must establish and maintain effective internal control over the federal award that provides assurance that the entity is managing the federal award in compliance with federal statutes, regulations, and conditions of the federal award.

Condition: The Center was not able to provide records to support amounts reported for 2021 Total Revenue / Net Patient Charges, a part of the Lost Revenue

Calculation on the PRF required reporting. Additionally, the Reporting Period 4 PRF Report did not contain evidence of proper review and approval prior to submission.

Cause: The Center had a change in CFO in March 2022. The incoming CFO was unable to locate records used by the prior CFO to support the full lost revenue calculation. Further, Center policy did not require evidence of review to be included on the PRF reports prior to submission.

Effect: Lost revenue calculation amounts are partially unsupported, and may be materially misstated. Additionally, the Center is unable to demonstrate that the PRF reports were properly reviewed and free of other errors. However, the risk is mitigated as the Center claimed no lost revenue in Period 4.

Questioned Costs: None

Context/Sampling: Key line items related to the reporting were tested for the Period 4 report. Errors (unsupported amounts) were only noted in the Lost Revenue calculation (amounts reported for 2021 Total revenue). Lost Revenue calculation amounts for 2019, 2020, and 2022 were properly supported.

Repeat Finding from Prior Year(s): No

Recommendation: Because the PRF program is winding down, no future PRF reports are required to be filed. Accordingly, we recommend that management require the following be maintained for all federal and state program required reports: evidence to support all reported amounts, and evidence that report review occurred prior to submission.

Views of Responsible Officials: Management agrees with the finding. Refer to Corrective Action Plan.

Follow-up on Prior Year Findings:

Finding 2022-001

Finding Summary: The Center did not consistently reconcile certain balance sheet accounts throughout the year on a timely basis.

Responsible Individuals: Becki Mangum, Chief Financial Officer

Corrective Action Plan: Management will ensure all significant balance sheet accounts are reconciled on a timely basis and reviewed by the CFO or the Controller.

Anticipated Completion Date: Completed.

Independent Auditor's Management Letter: Yes, with no significant deficiencies

Corrective Action Plan:

Finding 2023-001

Finding Summary: The Center was unable to provide records to support amounts reported for 2021 Total Revenue / Net Patient Charges, a part of the lost revenue calculation on PRF required reporting. The Reporting Period 4 PRF Report did not contain evidence of proper review and approval prior to submission.

Responsible Individuals: Becki Mangum, Chief Financial Officer

Corrective Action Plan: Management will ensure the following evidence is maintained for all required reports: review of all reports prior to submission, and documents to support all reported amounts.

Anticipated Completion Date: Ongoing

For 2023, the finding did not pertain to HHS funds so follow up was not conducted.

3.4 Austin-Travis County MHMR dba Austin Travis County Integral Care

City: Austin

Counties Served: Travis

Type of Report on Financial Statement: Unmodified

Type of Report on Compliance: Unmodified

Schedule of Findings and Questioned Costs: None

Follow-up on Prior Year Findings: None

Independent Auditor's Management Letter: No findings/comments

Corrective Action Plan: No finding(s) requiring corrective action

3.5 Bluebonnet Trails Community MHMR Center dba Bluebonnet Trails Community Services

City: Round Rock

Counties Served: Bastrop, Burnet, Caldwell, Fayette, Gonzales, Guadalupe, Lee, and Williamson

Type of Report on Financial Statement: Unmodified

Type of Report on Compliance: Unmodified

Schedule of Findings and Questioned Costs: None

Follow-up on Prior Year Findings: None

Independent Auditor's Management Letter: No findings/comments

Corrective Action Plan: No finding(s) requiring corrective action

3.6 Border Region Behavioral Health Center

City: Laredo

Counties Served: Jim Hogg, Starr, Webb, and Zapata

Type of Report on Financial Statement: Unmodified

Type of Report on Compliance: Unmodified

Schedule of Findings and Questioned Costs: None

Follow-up on Prior Year Findings: None

Independent Auditor's Management Letter: No findings/comments

Corrective Action Plan: No finding(s) requiring corrective action

3.7 Burke Center

City: Lufkin

Counties Served: Angelina, Houston, Jasper, Nacogdoches, Newton, Polk, Sabine, San Augustine, San Jacinto, Shelby, Trinity, and Tyler

Type of Report on Financial Statement: Unmodified

Type of Report on Compliance: Unmodified

Schedule of Findings and Questioned Costs: None

Follow-up on Prior Year Findings: None

Independent Auditor's Management Letter: No findings/comments

Corrective Action Plan: No finding(s) requiring corrective action

3.8 Camino Real Community MHMR Center dba Camino Real Community Services

City: Lytle

Counties Served: Atascosa, Dimmit, Frio, La Salle, Karnes, Maverick, McMullen, Wilson, and Zavala

Type of Report on Financial Statement: Unmodified

Type of Report on Compliance: Unmodified

Schedule of Findings and Questioned Costs: None

Follow-up on Prior Year Findings: None

Independent Auditor's Management Letter: No findings/comments

Corrective Action Plan: No finding(s) requiring corrective action

3.9 The Center for Health Care Services, Bexar County MHMR Center

City: San Antonio

Counties Served: Bexar

Type of Report on Financial Statement: Unmodified

Type of Report on Compliance: Unmodified

Schedule of Findings and Questioned Costs: None

Follow-up on Prior Year Findings: None

Independent Auditor's Management Letter: No findings/comments

Corrective Action Plan: No finding(s) requiring corrective action

3.10 Central Texas MHMR dba Center for Life Resources

City: Brownwood

Counties Served: Brown, Coleman, Comanche, Eastland, McCulloch, Mills, and San Saba

Type of Report on Financial Statement: Unmodified

Type of Report on Compliance: Unmodified

Schedule of Findings and Questioned Costs: None

Follow-up on Prior Year Findings: None

Independent Auditor's Management Letter: No findings/comments

Corrective Action Plan: No finding(s) requiring corrective action

3.11 Central Counties Center for MHMR Services

City: Temple

Counties Served: Bell, Coryell, Hamilton, Lampasas, and Milam

Type of Report on Financial Statement: Unmodified

Type of Report on Compliance: Unmodified

Schedule of Findings and Questioned Costs:

Section II – Financial Statement Findings

Item 2023-001: Material Weakness Related to Controls Over Financial Reporting – Year-end adjustments

Criteria: Central Counties Center for MHMR Services (Center) is responsible for maintaining proper internal controls over financial reporting.

Condition: Significant adjusting entries were posted to the Center's financial statements in February and March 2024 for the year ending August 31, 2023. Adjustments included but were not limited to increasing deferred revenues and reducing accounts receivable to their estimated net realizable value, which resulted in decreasing grant and contract revenues; expensing prepaid IGT for DPP-BHS; and increasing capital outlay for a building purchase. Significant adjusting entries were also required to reverse out prior year accrued expenses and to reconcile cash and investment accounts.

Context: During the course of the audit, the following adjustments were required: 1) deferred contract revenue increased by approximately $700,000; 3) [*sic*] grant contract revenues decreased by approximately $400,000, HCS revenues decreased by approximately $300,000, and patient fees and insurance revenues decreased by approximately $500,000; 4) accrued expenses decreased by approximately $650,000 for the reversal of prior year accruals then increased to accrue $200,000 for current year expenditures; 5) cash and investments increased by approximately $350,000; 6) the General Fund's due to Internal Service Fund increased by approximately $600,000; 7) DPP-BHS revenues decreased by approximately $1,000,000 after expensing of prepaid intergovernmental transfers; and 8) capital outlay increased by almost $2,000,000.

Questioned Costs: None

Cause: The Center does not have an effective method of reconciling balance sheet accounts on a periodic basis. In addition, the Center does not have an effective method of reconciling grant contract revenues and deferred revenues on a periodic basis.

Effect: The Center's financial statements required significant adjustments in these financial statement areas.

Recommendation: The Center should develop procedures to reconcile balance sheet accounts monthly. Receivables due from other governments (primarily from state contracts) should be reconciled to the individual grant records on a monthly basis. The Center should also develop procedures to recognize contract revenues received in advance as expended. Deferred revenues from grant contracts should

be reconciled to the general ledger on a monthly basis. These procedures will assist with more accurate and timely financial reporting.

Views of Responsible Officials: See corrective action plan.

Follow-up on Prior Year Findings:

Status of prior year finding 2022-001: Material Weakness Related to Controls over Financial Reporting – Year-end adjustments

Ongoing.

See current year finding 2023-001: Material Weakness Related to Controls over Financial Reporting – Year-end adjustments

Partial correction action taken: Staff have reconciled bank accounts, established processes for monitoring contracts and grantee revenues and will continue to check and correct adjustments to identify and resolve adjusting entry transactions in addition to implementation of the A/P module.

Reason for recurrence: Recurrence is due to continued implementation and improvement of work processes and training.

No other findings for fiscal year 2022.

No findings for fiscal year 2021.

Independent Auditor's Management Letter: Yes, with no significant deficiencies

Corrective Action Plan:

Item 2023-001: Material Weakness Related to Controls Over Financial Reporting – Year-end adjustments

Corrective Action Plan:

1. The "Center" will continue improving procedures that outlines the requirements for reconciliation of balance sheet accounts. Balance sheet accounts will be subject to risk assessments performed to ensure that the financial statements are fairly stated, reviewed and reconciled by the CFO and Business Office fiscal team.

2. Reconciliations will contain specific details, supporting documentation, analysis and planned corrective action. Designated staff in the Business Office team will be receiving and reviewing ALL balance sheet reconciliations to ensure that reconciliation procedures are being applied consistently, and that errors are being corrected in a timely manner.

3. The Internal Audit committee will review risks which underlie the findings are mitigated and repeat audit findings are minimized.

Responsible Parties with contact information: DeWayne HaGans, Chief Financial Officer, DeWayne.HaGans@CCS1967.org

Estimated Completion Date: June 30, 2024

Corrective action plan has been implemented.

3.12 Central Plains Center

City: Plainview

Counties Served: Bailey, Briscoe, Castro, Floyd, Hale, Lamb, Motley, Parmer, and Swisher

Type of Report on Financial Statement: Unmodified

Type of Report on Compliance: Unmodified

Schedule of Findings and Questioned Costs: None

Follow-up on Prior Year Findings: None

Independent Auditor's Management Letter: No findings/comments

Corrective Action Plan: No finding(s) requiring corrective action

3.13 Coastal Plains Community MHMR Center

City: Portland

Counties Served: Aransas, Bee, Brooks, Duval, Jim Wells, Kenedy, Kleberg, Live Oak, and San Patricio

Type of Report on Financial Statement: Unmodified

Type of Report on Compliance: Unmodified

Schedule of Findings and Questioned Costs: None

Follow-up on Prior Year Findings: None

Independent Auditor's Management Letter: No findings/comments

Corrective Action Plan: No finding(s) requiring corrective action

3.14 Collin County MHMR Center dba LifePath Systems

City: McKinney

Counties Served: Collin

Type of Report on Financial Statement: Unmodified

Type of Report on Compliance: Unmodified

Schedule of Findings and Questioned Costs:

<u>Section II – Financial Statement Findings</u>

<u>Item 2023-001 – Fraudulent actions by LifePath employee</u>

Criteria: LifePath is responsible for maintaining controls to limit the misappropriation of assets.

Condition: An employee in the information technology department had access to the server area where Iphones [*sic*], Ipads [*sic*], and hard drives were stored that were not presently in use. This access allowed the employee to remove some of these items.

Context: Management made us aware that mobile phones, an Ipad [*sic*], and hard drives has [*sic*] been stolen from the Center. This was discovered when a mobile phone that was not currently in service by the Center had been activated. Further investigation of the video of the server storage area disclosed an employee removing multiple Iphones [*sic*], hard drives and an Ipad [*sic*] from the server room. It was determined that the devices were taken without permission or using proper procedures to remove the items from the LifePath premises. The employee was requested to return all of the items that had been removed, but the employee

has yet to return any of the items. LifePath notified the police as well as the insurance carrier about the theft. The police report indicates that approximately 40 Iphones [*sic*], 13 hard drives, and an Ipad [*sic*] were removed. The employee has been terminated.

Questioned Costs: None

Cause: An employee had access to the server storage area after hours which allowed the removal of the assets above.

Effect: An estimated 40 Iphones [*sic*], 13 hardrives [*sic*], and an Ipad [*sic*] were stolen from the LifePath.

Recommendation: LifePath procedures to identify the use of inactive equipment led to the discovery of the theft. Lifepath [*sic*] should consider limiting access to Iphone [*sic*], Ipads [*sic*], and hard drives that are not in use.

View of Responsible Officials: The employee responsible for the theft had worked alongside multiple staff for many years at LifePath, as well as multiple centers and vendors throughout the state. He had built trust and had been promoted through the company into a management role when the theft began. As a leadership team, we were disappointed that this employee would risk his reputation and future with the industry, but quick action was taken to ensure he was not allowed to continue once the theft was discovered.

We are committed to protecting the public funds entrusted to LifePath Systems and have already begun to implement better safeguards to prevent this from recurring.

Follow-up on Prior Year Findings: None

Independent Auditor's Management Letter: No findings/comments

Corrective Action Plan:

Item 2023-001 – Fraudulent actions by LifePath employee

Corrective Action Plan:

1. Server rooms will receive enhanced video surveillance and locks after hours.

2. Staff with access will attend public funds investment act training with a certificate provided for acknowledgement of understanding the use of public funds and sign an attestation to be kept on file with HR.

3. All phones and assets not in use will be moved to the Purchasing suite and kept behind 2 locks with limited access and constant video monitoring.

4. A log will be maintained daily showing access to each server room in addition to video and badge access data.

Responsible Parties:

1. Colby McClatchy 972-562-0190 – cmcclatchy@lifepathsystems.org

2. Jennifer Morgan 972-562-0190 – jmorgan@lifepathsystems.org

3. Willy Villavicencio 972-562-0190 – wvillavicencio@lifepathsystems.org

Completion Date: Most changes above have already been activated. Training and attestation of public funds (assets, restrictions, etc.) for all staff with access to these assets will be signed and kept in HR files by April 1, 2024. Security has been enhanced in the server rooms and rooms that house assets and limited to work hours only.

Corrective action plan has been implemented.

3.15 Denton County MHMR Center

City: Denton

Counties Served: Denton

Type of Report on Financial Statement: Unmodified

Type of Report on Compliance: Unmodified

Schedule of Findings and Questioned Costs: None

Follow-up on Prior Year Findings:

2022 finding was fully corrected.

No findings were noted in fiscal year 2021.

Independent Auditor’s Management Letter: Yes, with no significant deficiencies

Corrective Action Plan: No finding(s) requiring corrective action

3.16 El Paso MHMR dba Emergence Health Network

City: El Paso

Counties Served: El Paso

Type of Report on Financial Statement: Unmodified

Type of Report on Compliance: Unmodified

Schedule of Findings and Questioned Costs: None

Follow-up on Prior Year Findings: None

Independent Auditor's Management Letter: No findings/comments

Corrective Action Plan: No finding(s) requiring corrective action

3.17 Gulf Bend MHMR Center

City: Victoria

Counties Served: Calhoun, DeWitt, Goliad, Jackson, Lavaca, Refugio, and Victoria

Type of Report on Financial Statement: Unmodified

Type of Report on Compliance: Unmodified

Schedule of Findings and Questioned Costs: None

Follow-up on Prior Year Findings: None

Independent Auditor's Management Letter: No findings/comments

Corrective Action Plan: No finding(s) requiring corrective action

3.18 The Gulf Coast Center

City: Galveston

Counties Served: Brazoria and Galveston

Type of Report on Financial Statement: Unmodified

Type of Report on Compliance: Unmodified

Schedule of Findings and Questioned Costs: None

Follow-up on Prior Year Findings: None

Independent Auditor's Management Letter: No findings/comments

Corrective Action Plan: No finding(s) requiring corrective action

3.19 The Harris Center for Mental Health and IDD

City: Houston

Counties Served: Harris

Type of Report on Financial Statement: Unmodified

Type of Report on Compliance: Unmodified

Schedule of Findings and Questioned Costs: None

Follow-up on Prior Year Findings: None

Independent Auditor's Management Letter: No findings/comments

Corrective Action Plan: No finding(s) requiring corrective action

3.20 Heart of Texas Region MHMR Center

City: Waco

Counties Served: Bosque, Falls, Freestone, Hill, Limestone, and McLennan

Type of Report on Financial Statement: Unmodified

Type of Report on Compliance: Unmodified

Schedule of Findings and Questioned Costs: None

Follow-up on Prior Year Findings:

Finding 2022-001

Financial Reporting

Material weakness in internal control over financial reporting

Finding Summary: The Center does not have an internal control system designed to provide for the preparation of the financial statements and related financial statement disclosures being audited. We proposed several audit adjustments to the Center's recorded account balances, which if not detected by our auditing procedures, could have resulted in a material misstatement of the Center's financial statements.

Responsible Individuals: Chief Financial Officer

Corrective Action Plan: The Center will review and evaluate financial reporting policies and procedures to improve the controls over financial reporting to ensure accurate and timely financial reports can be completed.

The Center will review and evaluate staff duties to provide proper segregation of duties. This will ensure that errors or irregularities are prevented or detected on a timely basis in the normal course of business and promptly corrected.

The Center will perform reconciliations on a more frequent basis to identify and correct errors in a timely manner.

The Center will review and evaluate staff training to ensure transaction processing is performed in accordance with policies and procedures.

The Center will review and evaluate transaction review and approval processes to identify and reduce errors in a timely manner.

Completion Date: Resolved as of August 31, 2023.

Finding 2022-002

Federal Agency Name: United States Department of Health and Human Services, Health Resources & Services Administration

Program Name: Medicaid Administrative Claiming (MAC)

CFDA #: 93.778

Finding Summary: We noted that the Center filed the quarterly reports as required; however, upon reviewing the support for the expenditures for the second quarter, it was noted that reported numbers were inaccurate which resulted in incorrect reporting and the receipt of unearned grant funds.

Responsible Individuals: Chief Financial Officer

Corrective Action Plan: With specific regard to Medicaid Administrative Claiming (MAC) reporting…

The Center will review and evaluate staff duties to provide proper segregation of duties. This will ensure that errors or irregularities are prevented or detected on a timely basis in the normal course of business and promptly corrected.

The Center will review and evaluate staff training to ensure MAC reporting is performed in accordance with policies and procedures.

The Center will review and evaluate MAC reporting review and approval processes to identify and correct errors prior to submitting the MAC reports.

Completion Date: Resolved as of August 31, 2023.

Independent Auditor's Management Letter: No findings/comments

Corrective Action Plan: No finding(s) requiring corrective action

3.21 Helen Farabee Centers

City: Wichita Falls

Counties Served: Archer, Baylor, Childress, Clay, Cottle, Dickens, Foard, Hardeman, Haskell, Jack, King, Knox, Montague, Stonewall, Throckmorton, Wichita, Wilbarger, Wise, and Young

Type of Report on Financial Statement: Unmodified

Type of Report on Compliance: Unmodified

Schedule of Findings and Questioned Costs: None

Follow-up on Prior Year Findings: None

Independent Auditor's Management Letter: Yes, with no significant deficiencies

Corrective Action Plan: No finding(s) requiring corrective action

3.22 Hill Country Community MHMR dba Hill Country MHDD Centers

City: Kerrville

Counties Served: Bandera, Blanco, Comal, Edwards, Gillespie, Hays, Kendall, Kerr, Kimble, Kinney, Llano, Mason, Medina, Menard, Real, Schleicher, Sutton, Uvalde, and Val Verde

Type of Report on Financial Statement: Unmodified

Type of Report on Compliance: Unmodified

Schedule of Findings and Questioned Costs: None

Follow-up on Prior Year Findings: None

Independent Auditor's Management Letter: No findings/comments

Corrective Action Plan: No finding(s) requiring corrective action

3.23 Lakes Regional MHMR Center dba Lakes Regional Community Center

City: Terrell

Counties Served: Camp, Delta, Franklin, Hopkins, Lamar, Morris, and Titus

Type of Report on Financial Statement: Unmodified

Type of Report on Compliance: Unmodified

Schedule of Findings and Questioned Costs: None

Follow-up on Prior Year Findings: None

Independent Auditor's Management Letter: No findings/comments

Corrective Action Plan: No finding(s) requiring corrective action

3.24 MHMR Authority of Brazos Valley

City: Bryan

Counties Served: Brazos, Burleson, Grimes, Leon, Madison, Robertson, and Washington

Type of Report on Financial Statement: Unmodified

Type of Report on Compliance: Unmodified

Schedule of Findings and Questioned Costs:

Findings – Financial Statement Audit

Significant Deficiencies

2023-001

Condition: Certain general ledger accounts were not analyzed and reconciled on a timely basis.

Criteria: Internal controls should be in place to ensure that all material general ledger accounts are critically analyzed and reconciled on a monthly or quarterly basis.

Cause: The Center experienced turnover in some key accounting and IT positions. Additionally, there were new programs and an implementation of new software and current personnel are still in the process of being trained and becoming familiar with the programs.

Effect: Because of the failure to have timely reconciled general ledger accounts, several adjustments had to be made during the audit process.

Recommendation: The Center should continue to train existing employees on significant accounting matters and ensure that all material general ledger accounts are reconciled on a monthly basis.

Views of Responsible Officials and Planned Corrective Actions: Management of the Center agrees with the finding and the recommended procedures will be implemented.

Follow-up on Prior Year Findings: None

Independent Auditor's Management Letter: Yes, with no significant deficiencies

Corrective Action Plan:

Management of the Center agrees with the finding and the recommended procedures will be implemented.

Corrective action plan has been implemented.

3.25 Nueces County MHMR Community Center dba Behavioral Health Center of Nueces County

City: Galveston

Counties Served: Brazoria and Galveston

Type of Report on Financial Statement: Unmodified

Type of Report on Compliance: Unmodified

Schedule of Findings and Questioned Costs: None

Follow-up on Prior Year Findings: None

Independent Auditor's Management Letter: No findings/comments

Corrective Action Plan: No finding(s) requiring corrective action

3.26 Concho Valley Center for Human Advancement dba MHMR Services for the Concho Valley

City: San Angelo

Counties Served: Coke, Concho, Crockett, Irion, Reagan, Sterling, and Tom Green

Type of Report on Financial Statement: Unmodified

Type of Report on Compliance: Unmodified

Schedule of Findings and Questioned Costs:

Section II – Financial Statement Findings

Finding No. 2023-001: Generally Accepted Accounting Principles (GAAP) and Governmental Accounting Standards Board (GASB)

Type of Finding: Significant deficiency in Internal Control over Financial Reporting

Criteria: The Center should issue accurate and timely financial statements for all stakeholders to satisfy the audit requirements imposed by federal and state laws and regulations, and grant contracts.

Condition: The Center closed books and provided the financial statements almost seven (7) months after the August 31, 2023 year-end, after posting a significant number of journal entries affecting numerous revenue, receivables, and deferred amounts, among others.

Questioned Costs: None

Cause: The lack of adequate internal controls over accounting processes precluded the Center to ascertain about the accuracy, completeness, and timely preparation of the financial statements and related disclosures in accordance with GAAP for the year ended as of August 31, 2023.

Effect: The relevance and potential impact of the decision-making processes over programmatic operations of the Center stemming from the issuance of untimely financial statements may be flawed due to the passage of time and hinders management's timely assessment for making sound business decisions. Furthermore, this delay providing financial statements and monitoring results may allow, and further increase the risk that fraud, which if perpetrated, will not be detected on a timely basis or not detected at all.

Recommendation: The Center should develop formal policy and procedures to ensure that balance sheet accounts are reconciled monthly. Receivables due from other governments (primarily from state contracts) should be reconciled monthly to the individual grant records. The Center should also develop procedures to recognize contract revenues received in advance as expended. Deferred revenues from grant contracts should be reconciled monthly to the general ledger. These procedures will assist with more accurate and timely financial reporting. Management should allocate adequate resources to help achieve the objective of accurate and timely financial reporting.

Views of Responsible Official (Unaudited): Refer to Corrective Action Plan.

<u>Finding No. 2023-002: Directed Payment Program revenues</u>

Type of Finding: Other Matter

Criteria: The Directed Payment Program for Behavioral Health Services (DPP BHS) is a value-based payment program for Community Mental Health Centers (CMHC)

to incentivize the continuation of providing services to Medicaid-enrolled individuals aligned with the Certified Community Behavioral Health Clinic (CCBHC) model of care. As part of the application requirements, each provider needs to include, among other information, data sources for historical units of service.

Condition: The Center's FY24 DPP-BHS enrollment application omitted several National Provider Identifiers. A National Provider Identifier (NPI) is a unique 10-digit identification number for insured healthcare providers.

Questioned Costs: None

Cause: The lack of adequate internal controls over accounting processes precluded the Center from ascertaining the accuracy and completeness of the DPP-BHS application.

Effect: The amount of program funds under the DPP-BHS program will be substantially lower in FY2024 than in FY2023 due to the omission of the significant payors' NPIs on the FY2024 enrollment application.

Recommendations: The Center needs to ensure that internal controls exist to effectively comply the [*sic*] DPP-BHS enrollment process.

Views of Responsible Official (Unaudited): Refer to Corrective Action Plan.

Follow-up on Prior Year Findings: None

Independent Auditor's Management Letter: No findings/comments

Corrective Action Plan:

Finding No. 2023-001: Generally Accepted Accounting Principles (GAAP) and Governmental Accounting Standards Board (GASB)

Finding Summary: Scott, Singleton, Fincher, and Co., PC identified a significant deficiency in internal control over Financial Reporting. The relevance and potential impact of the decision-making processes over programmatic operations of the Center stemming from the issuance of untimely financial statements may be flawed due to the passage of time and hinders management's timely assessment for making sound business decisions. The length of time to complete the audit and present audited financial statements to users created a lack of ability to present accurate, complete and timely.

Responsible Individuals: Patsy Larson, CFO

Corrective Action Plan: The finance department in MHMR has hired additional staff to increase the ability within the department. The staff person was hired in January 2024. The staff will be trained to take on duties to separate fiscal reporting duties, adhere to internal controls, and help meet the needs of the department in regards to reporting requirements. Current procedures within the department have already been updated and changed to ensure more timely review of accounts receivable, revenues, and expenditures.

Anticipated Completion Date: April 2024

Finding No. 2023-002: Directed Payment Program revenues.

Finding Summary: The Directed Payment Program for Behavioral Health Services (DPP BHS) is a value-based payment program for Community Mental Health Centers (CMHC) to incentivize the continuation of providing services to Medicaid-enrolled individuals aligned with the Certified Community Behavioral Health Clinic (CCBHC) model of care. As part of the application requirements, each provider needs to include, among other information, data sources for historical units of service.

Responsible Individuals: Greg Rowe, CEO, Melinda McCullough, COO, & Patsy Larson, CFO

Corrective Action Plan: During the FY 2025, year 4 enrollment, Melinda McCullough, COO, prepared the DPP enrollment. Patsy Larson, CFO, reviewed the application and assisted with ensuring all Center billing NPIs were included in the application. The Center’s complete NPI list is enrolled in FY 2025.

Anticipated Completion Date: February 2024

Corrective action plans have been implemented.

3.27 Texoma Community Center

City: Sherman

Counties Served: Cooke, Fannin, and Grayson

Type of Report on Financial Statement: Unmodified

Type of Report on Compliance: Unmodified

Schedule of Findings and Questioned Costs: None

Follow-up on Prior Year Findings: None

Independent Auditor's Management Letter: No findings/comments

Corrective Action Plan: No finding(s) requiring corrective action

3.28 MHMR of Tarrant County

City: Fort Worth

Counties Served: Tarrant

Type of Report on Financial Statement: Unmodified

Type of Report on Compliance: Unmodified

Schedule of Findings and Questioned Costs: None

Follow-up on Prior Year Findings:

Finding 2022-001

Finding Summary: Performance of accurate account reconciliations on a timely basis across all funds within the organization to ensure the accuracy of monthly and year-end financial statements. Material weakness in internal control over financial reporting.

Responsible Individuals: Aaron Bovos, Chief Financial Officer

Status: Resolved. MHMR of Tarrant County fully implemented a four-pronged approach to addressing this material weakness, including: implementing a structure of clear responsibility and accountability; developing month-end close checklists and processed [*sic*]; documenting required processes and procedures as they relate to account and balance sheet reconciliations; and ensuring trainings were offered and provided to staff.

Independent Auditor's Management Letter: No findings/comments

Corrective Action Plan: No finding(s) requiring corrective action

3.29 North Texas Behavioral Health Authority

City: Dallas

Counties Served: Dallas, Ellis, Hunt, Kaufman, Navarro, and Rockwall

Type of Report on Financial Statement: Unmodified

Type of Report on Compliance: Unmodified

Schedule of Findings and Questioned Costs:

Section II – Financial Statement Findings

Item 2023-001: Unauthorized Breaches of Information Technology (IT) System

Criteria: Management of NTBHA is responsible for maintaining controls to prevent penetration of the IT system and safeguard assets.

Condition: In September 2022, an unauthorized user gained access to the Chief Financial Officer's (CFO) email and initiated email correspondence with a grantor. The unauthorized user requested that a grant contract payment be paid via physical check instead of the usual electronic deposit. The grantor called the NTBHA CFO to verbally confirm the payment change request. The NTBHA CFO stated she did not initiate the request, at which time NTBHA determined there was an email breach. No funds were rerouted to the unauthorized user.

In June 2023, an unauthorized user gained access to the Controller's email. The unauthorized user accessed the Controller's email and redirected communications between the Controller and one of NTBHA's supporting organizations. Then, the unauthorized user created a fictitious domain name that is very similar to NTBHA's and sent email correspondence to the sponsoring organization and requested that the upcoming quarterly contribution (in the amount of $1,226,069) be deposited into a different bank account that did not belong to NTBHA. The sponsoring organization rerouted the ACH direct deposit to the fraudster's bank account, and NTBHA did not receive the funds. The sponsoring organization acknowledged that they did not follow their normal procedures for changing bank account information prior to making payments. The sponsoring organization has turned the matter over to the authorities.

Context: NTBHA has not received $1,226,069 in local funds that it expected to receive for the fourth quarter of FY2023.

Questioned Costs: None.

Cause: Both the CFO's and Controller's email accounts were penetrated by unauthorized users in attempts to redirect funds during FY2023.

Effect: NTBHA has not received $1,226,069 as a result of the penetration of the Controller's email. The CFO's email was also penetrated, but no financial impact has been detected.

Recommendation: NTBHA should review controls in place over the information technology system to better ensure the system cannot be penetrated.

View of Responsible Officials: NTBHA agrees with the above finding and has implemented additional IT security measures by extending their contract with their IT service provider to implement 15 additional security measures specifically targeted to address unauthorized access to email systems as well as other possible threats (see Corrective Action Plan for detailed items).

Follow-up on Prior Year Findings: None

Independent Auditor's Management Letter: No findings/comments

Corrective Action Plan:

Item 2023-001: Unauthorized Breach of Information Technology (IT) System

Corrective Action Plan: NTBHA has implemented additional IT (Information Technology) security measures by extending the contract with their IT service provider to implement 15 additional security measures specifically targeted to address unauthorized access to email systems as well as other possible threats. These measures include penetration testing, vulnerability scanning, network monitoring, security information and event management (SIEM), security operations center (SOC), "threat hunting" intrusion detection and prevention system (IDS/IPS), managed extended detection and response (EDR/MXDR), least privilege (Zero Trust), application whitelisting (Zero Trust), ring fencing data (Zero Trust), privileged access management (PAM), advanced phishing protections, secure DNS filtering, and always-on VPN. As of May 2024, 14 of the 15 planned enhancements are in place.

Other key elements of the organization's upgraded security measures include Privileged Access Management which provides additional security monitoring of accounts with higher levels of access.

Estimated Completion Date: June 2024

Responsible Party Contact Information:

Name: Henson Rogers, Chief Information Officer

Email address: HRogers@ntbha.org

Corrective action plan has been implemented.

3.30 Pecan Valley MHMR Region dba Pecan Valley Centers

City: Granbury

Counties Served: Erath, Hood, Johnson, Palo Pinto, Parker, and Somervell

Type of Report on Financial Statement: Unmodified

Type of Report on Compliance: Unmodified

Schedule of Findings and Questioned Costs: None

Follow-up on Prior Year Findings: None

Independent Auditor's Management Letter: No findings/comments

Corrective Action Plan: No finding(s) requiring corrective action

3.31 Permian Basin Community Centers for MHMR dba Permiacare

City: Midland

Counties Served: Brewster, Culberson, Ector, Hudspeth, Jeff Davis, Midland, Pecos, and Presidio

Type of Report on Financial Statement: Unmodified

Type of Report on Compliance: Unmodified

Schedule of Findings and Questioned Costs: None

Follow-up on Prior Year Findings: None

Independent Auditor's Management Letter: Yes, with no significant deficiencies

Corrective Action Plan: No finding(s) requiring corrective action

3.32 Sabine Valley Regional MHMR Center dba Community Healthcare

City: Longview

Counties Served: Bowie, Cass, Gregg, Harrison, Marion, Panola, Red River, Rusk, and Upshur

Type of Report on Financial Statement: Unmodified

Type of Report on Compliance: Unmodified

Schedule of Findings and Questioned Costs: None

Follow-up on Prior Year Findings: None

Independent Auditor's Management Letter: No findings/comments

Corrective Action Plan: No finding(s) requiring corrective action

3.33 Spindletop MHMR Services dba Spindletop Center

City: Beaumont

Counties Served: Chambers, Hardin, Jefferson, and Orange

Type of Report on Financial Statement: Unmodified

Type of Report on Compliance: Unmodified

Schedule of Findings and Questioned Costs: None

Follow-up on Prior Year Findings: None

Independent Auditor's Management Letter: No findings/comments

Corrective Action Plan: No finding(s) requiring corrective action

3.34 Lubbock Regional MHMR Center dba StarCare Specialty Health

City: Lubbock

Counties Served: Chambers, Hardin, Jefferson, and Orange

Type of Report on Financial Statement: Unmodified

Type of Report on Compliance: Unmodified

Schedule of Findings and Questioned Costs: None

Follow-up on Prior Year Findings: None

Independent Auditor's Management Letter: No findings/comments

Corrective Action Plan: No finding(s) requiring corrective action

3.35 Texana Center

City: Rosenberg

Counties Served: Austin, Colorado, Fort Bend, Matagorda, Waller, and Wharton

Type of Report on Financial Statement: Unmodified

Type of Report on Compliance: Unmodified

Schedule of Findings and Questioned Costs: None

Follow-up on Prior Year Findings: None

Independent Auditor's Management Letter: No findings/comments

Corrective Action Plan: No finding(s) requiring corrective action

3.36 Texas Panhandle MHMR

City: Amarillo

Counties Served: Armstrong, Carson, Collingsworth, Dallam, Deaf Smith, Donley, Gray, Hall, Hansford, Hartley, Hemphill, Hutchinson, Lipscomb, Moore, Ochiltree, Oldham, Potter, Randall, Roberts, Sherman, and Wheeler

Type of Report on Financial Statement: Unmodified

Type of Report on Compliance: Unmodified

Schedule of Findings and Questioned Costs: None

Follow-up on Prior Year Findings: None

Independent Auditor's Management Letter: No findings/comments

Corrective Action Plan: No finding(s) requiring corrective action

3.37 Tri-County Behavioral Healthcare

City: Conroe

Counties Served: Liberty, Montgomery, and Walker

Type of Report on Financial Statement: Unmodified

Type of Report on Compliance: Unmodified

Schedule of Findings and Questioned Costs: None

Follow-up on Prior Year Findings: None

Independent Auditor's Management Letter: Yes, with no significant deficiencies

Corrective Action Plan: No finding(s) requiring corrective action

3.38 Tropical Texas Behavioral Health

City: Edinburg

Counties Served: Cameron, Hidalgo, and Willacy

Type of Report on Financial Statement: Unmodified

Type of Report on Compliance: Unmodified

Schedule of Findings and Questioned Costs: None

Follow-up on Prior Year Findings: None

Independent Auditor's Management Letter: Yes, with no significant deficiencies

Corrective Action Plan: No finding(s) requiring corrective action

3.39 West Texas Centers for MHMR

City: Big Spring

Counties Served: Andrews, Borden, Crane, Dawson, Fisher, Gaines, Garza, Glasscock, Howard, Kent, Loving, Martin, Mitchell, Nolan, Reeves, Runnels, Scurry, Terrell, Terry, Upton, Ward, Winkler, and Yoakum

Type of Report on Financial Statement: Unmodified

Type of Report on Compliance: Unmodified

Schedule of Findings and Questioned Costs: None

Follow-up on Prior Year Findings: None

Independent Auditor's Management Letter: Yes, with no significant deficiencies

Corrective Action Plan: No finding(s) requiring corrective action

Conclusion

This report summarizes the independent auditor's findings of 39 LMHAs and their responses.

Acronyms

Acronym	Full Name
ACH	Automated Clearing House
CFO	Chief Financial Officer
DBA	Doing Business As
GAAP	Generally Accepted Accounting Principles
HHSC	Health and Human Services Commission
IDD	Intellectual and Developmental Disabilities
LMHA	Local Mental Health Authority
SAU	Single Audit Unit
TxGMS	Texas Grant Management Standards