STATE OF NORTH CAROLINA

AUDIT RESULTS FROM

CAFR AND SINGLE AUDIT PROCEDURES

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FOR THE YEAR ENDED JUNE 30, 2002

OFFICE OF THE STATE AUDITOR

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Ralph Campbell, Jr.
State Auditor

June 26, 2003

The Honorable Michael F. Easley, Governor
Members of the North Carolina General Assembly
Ms. Carmen Hooker Odom, Secretary
North Carolina Department of Health and Human Services

We have completed certain audit procedures at the North Carolina Department of Health and Human Services related to the State's *Comprehensive Annual Financial Report (CAFR)* and the State's *Single Audit Report* for the year ended June 30, 2002. Our audit was made by authority of Article 5A of Chapter 147 of the General Statutes.

The results of these procedures, as described below, yielded audit findings and recommendations for the Department related to the State's financial statements and the State's federal financial assistance programs that required disclosure in the aforementioned reports. The findings are included in the findings and recommendations section contained herein. Our recommendations for improvement and management's response follow each finding.

We noted several internal control weaknesses and instances of noncompliance with State and federal regulations at the Division of Central Administration. Control weaknesses allowed Basic Support claims to be overpaid and errors in the Foster Care rate setting process caused one facility to be overpaid. Controls were not sufficient to ensure that Food Stamps expenditures were reported correctly in the financial statements. Other noted deficiencies pertain to inadequate subrecipient monitoring in the Low-Income Home Energy Assistance Program, failure to follow proper procedures when making payments, employees having improper access to computer systems, failure to properly update fixed asset records. Findings 1 through 11 describe these and other conditions.

The Division of Social Services did not take appropriate enforcement action on child support cases in the Child Support Enforcement program and did not document monitoring efforts in place in the Social Services Block Grant program. Documentation was not always available to show that criminal records checks were conducted on re-licensed foster parents. Also, incorrect facility rates were entered into the Foster Care system, resulting in overpayments. Contract vendors responsible for compliance requirements were not monitored. Some current and

former Division and county social service employees had improper access to several of the State's computer systems. Monitoring of Nutrition Education subrecipients was inadequate. Findings 12 through 21 describe these and other conditions.

The Division of Medical Assistance did not receive required cost reports on 215 nursing facilities and had completed only 102 desk audits of the 142 nursing facility cost reports it had received. The patient's medical records did not always adequately document services rendered. The Division did not have an adequate system in place to ensure that annual medical audits for Health Maintenance Organizations were performed and one employee had improper access to the Medicaid Management Information System. Findings 22 through 25 discuss these conditions.

There were errors in the Department's cost allocation plan for the Division of Services for the Blind in the Rehabilitation Services - Vocational Rehabilitation Grants to States program. Finding 26 describes this condition.

The accounting records of the Division of Mental Health, Developmental Disabilities and Substance Abuse Services did not adequately document compliance with certain earmarking compliance requirements in the Substance Abuse Prevention and Treatment Block Grant program. The Division did not have a tracking system in place to ensure that all time sheets were received. Audit findings 27 through 30 describe these and other conditions.

There were control weaknesses related to the determination and documentation of client eligibility in the Rehabilitation Services – Vocational Rehabilitation Grants to States program. Finding 31 describes this condition.

The accounts and operations of the Department of Health and Human Services are an integral part of the State's reporting entity represented in the *CAFR* and the *Single Audit Report*. In the *CAFR*, the State Auditor expresses an opinion on the State's financial statements. In the *Single Audit Report,* the State Auditor also presents the results of tests on the State's internal control and on the State's compliance with laws, regulations, contracts, and grants applicable to the State's financial statements and to its federal financial assistance programs. The audit procedures were conducted in accordance with auditing standards generally accepted in the United States of America, *Government Auditing Standards* issued by the Comptroller General of the United States, and Office of Management and Budget Circular A-133.

As part of the work necessary for issuance of the *CAFR* and the *Single Audit Report*, the following fund and federal programs of the State were subjected to audit procedures at the Department of Health and Human Services:

Fund for the *Comprehensive Annual Financial Report*:

General Fund, excluding the Division of Mental Health, Developmental Disabilities and Substance Abuse Services

Federal Programs for the *Single Audit Report*:

Food Stamps

Special Supplemental Nutrition Program for Women, Infants, and Children

Child and Adult Care Food Program

State Administrative Matching Grants for Food Stamp Program

Rehabilitation Services – Vocational Rehabilitation Grants to States

Temporary Assistance for Needy Families

Child Support Enforcement

Low-Income Home Energy Assistance

Child Care and Development Block Grant

Child Care Mandatory and Matching Funds of the Child Care and Development Fund

Foster Care – Title IV-E

Social Services Block Grant

State Children's Insurance Program

State Survey and Certification of Health Care Providers and Suppliers

Medical Assistance Program

Block Grants for Prevention and Treatment of Substance Abuse

Social Security – Disability Insurance

The fund and federal programs subjected to audit at the Department of Health and Human Services are substantially less in scope than would be necessary to report on the financial statements that relate solely to the Department or the administration of federal programs by the Department. Therefore, we do not express such conclusions.

North Carolina General Statutes require the State Auditor to make audit reports available to the public. Copies of audit reports issued by the Office of the State Auditor may be obtained through one of the options listed in the back of this report.

Respectfully submitted,

Ralph Campbell, Jr.
State Auditor

AUDIT FINDINGS AND RECOMMENDATIONS

Matters Related to Financial Reporting or Federal Compliance Objectives

DIVISION OF CENTRAL ADMINISTRATION

Current Year Finding and Recommendation Also Reported in Prior Audit - The following finding and recommendation was identified during the current and prior audits and represents a significant deficiency in internal control or noncompliance with laws, regulations, contracts, or grants.

1. BASIC SUPPORT CLAIMS WERE NOT PROPERLY PAID

   There were weaknesses in the Department's controls over expenditures in the Rehabilitation Services - Vocational Rehabilitation Grants to States program. A large number of the Department's Basic Support payments contained errors. Thirty-eight transactions of the 210 tested by us were in error and resulted in overpayments to providers of $107,781. An examination of the 210 client files revealed the following:

   - Twenty-one inpatient claims were overpaid $75,822. Agency personnel indicated that these overpayments were due to a programming error in the software used to process medical invoices and because certain Medicaid rate tables were not updated in the system.

   - Three inpatient claims were paid as outpatient claims resulting in an overpayment of $10,730.

   - One inpatient claim was paid twice on the same check resulting in an overpayment of $7,327.

   - The Department paid three vendors $12,231 for invoices without the required vendor signatures.

   - The amount paid for one invoice was more than the total on the documentation resulting in an overpayment of $103.

   - Two client files did not contain documentation showing whether there were comparable services and benefits available while these clients were in school. The Department continued to pay school tuition for four semesters for one of the clients and three semesters for the other client without Pell grant denial/award letters and without obtaining unit manager approval. These payments totaled $1,717.

   - Seven claims were paid using incorrect rates resulting in an underpayment of $149.

Of the $107,781 expended by the Department in error, we are questioning the federal share of $84,824.

The policies and procedures manual of the Division of Vocational Rehabilitation Services (Division) is the source criteria for the Department's Basic Support payments. Those policies and procedures require that hospital invoices for inpatient and outpatient services are to be paid at the Medicaid rate and require that information on invoices include a vendor signature. In addition, costs must be adequately documented in accordance with OMB Circular A-87. Further, 34 CFR 361.53 and the Division's policies and procedures require that prior to providing vocational rehabilitation services to an eligible individual, a counselor should determine whether comparable services and benefits are available to the client. Also, if a client has not provided the Division with a copy of the Pell grant award/denial letter before the end of the client's first semester of school, the Division should discontinue support until such time the individual gives this information. Any exceptions to this policy require Unit Manager approval.

Recommendation: The Department should strengthen internal controls to ensure that all claims and invoices are properly processed and paid and all applicable rate changes are received in a timely manner and properly incorporated into its payment procedures. Also, the Department should perform analysis to determine the total impact of the errors and require providers to reimburse the Department for all overpayments. The Department should also strengthen internal controls to ensure that vendor signatures and adequate documentation are obtained for all invoices before payment in accordance with both federal and internally mandated procedures.

Agency's Response: The Department agrees with this finding. Adjustments have been processed for all claims that were underpaid and recoupments have been received for all but three claims identified as having been overpaid. We will continue to pursue recoupment on the remaining three overpayments. We have also taken measures to strengthen internal controls. Controller's Office and DVR staff met on August 20, 2002 to discuss the importance of updating reimbursement rates in the system on a timely basis and have proceeded with making this more of a priority. Programming errors in the pricing software that caused incorrect payments were corrected by the Department's Division of Information Resource Management on December 20, 2002. The Claims Unit supervisor notified Claims Unit staff on February 10, 2003 of the processing errors detected during the audit. Each of the errors was addressed and explained so staff will be sure to avoid such errors in the future. Beginning in February 2003, the Claims Unit supervisor began conducting audits of outgoing payments to determine if claims processing errors have been made. Errors will be corrected at that time and the processor will be counseled or retrained to assure that similar errors do not continue. Also, the Claims Unit supervisor has begun checking the Medicaid Bulletin each month to determine whether rate changes have been announced that will affect DVR reimbursement. Rate changes will be implemented as appropriate.

Other Current Year Findings and Recommendations **-** The following findings and recommendations were identified during the current audit and represent significant deficiencies in internal control or noncompliance with laws, regulations, contracts, or grants.

2. SUBRECIPIENT MONITORING PROCEDURES WERE INADEQUATE

There was no documentation on hand to demonstrate that annual monitoring visits and on-site home inspections were conducted by the Office of Economic Opportunity, Weatherization Services Section, on community action agencies in the Low-Income Home Energy Assistance Program. The Department paid $3.9 million to community action agencies in the Low-Income Home Energy Assistance Program. Without adequate monitoring, noncompliance or poor internal controls at the subrecipient level could go undetected.

The Office of Economic Opportunity, Weatherization Services Section, provided documentation that its program monitors reviewed monthly performance reports submitted by the community action agencies, but could not provide documentation in support of its assertion that annual monitoring visits and on-site home inspections were performed.

OMB Circular A-133 requires that a pass-through entity monitor subrecipient activities to provide reasonable assurance that the subrecipient administers federal awards in compliance with federal requirements. Also, the State Plan requires that monitoring be performed at least annually and that program monitors review client files and conduct on-site home inspections of a minimum of 10% of completed units at each community action agency.

Recommendation: Monitoring visits and inspections should be performed as required by federal regulations. All monitoring activities should be documented in a format that clearly defines the procedures performed, the results obtained, and the corrective action planned if instances of noncompliance are identified.

Agency's Response: The Department concurs with this finding. The weatherization program was transferred from the N.C. Department of Commerce to the N.C. Department of Health and Human Services, Office of Economic Opportunity in October 2000 and a 100% turnover in staff occurred during the audit period. The time required to hire and train new program and management staff limited the Office's ability to meet on-site visit goals. Documentation is available for some on-site visits made by program monitors to subgrantees to review records and inspect dwellings weatherized during the audit period. In recognition of the staffing situation during SFY 2001-2002, in-office or desktop monitoring was expanded to assure subgrantee contract compliance. By July 2002, new management and program monitoring staff had been hired. They have been trained and are conducting on-site monitoring visits in accordance with the revised monitoring plan for the current year. Current year's on-site monitoring visits to local agencies, which included the review of files and the inspection of completed units for July 1, 2001

through June 30, 2002, have confirmed the accomplishments that were reported by subgrantees during the period of the audit and that contracts for this period were operated in compliance with federal and state requirements.

3. INADEQUATE CONTROLS OVER FOSTER CARE RATE SETTING

There were some internal control weaknesses in the Department's method of calculating and reviewing 2001-2002 facility rates for child caring institutions in the Foster Care Program. Administrative costs are an allowable component in the rate calculation, but the Department did not always consider it correctly, resulting in the overpayment of one facility. The Department's review procedures of the rate calculations failed to detect the errors. We are questioning an estimated overpayment to the facility of $145,848. Also, the Department did not take follow-up action on two facilities when they failed to submit adequate documentation to support the social services expenses used in the facility rate calculation.

Recommendation: The Department should improve controls over the facility rate setting process. The rate computations should be sufficiently reviewed before they are finalized to ensure that facility costs are appropriately used in rate calculations and adequate documentation exists to support the facility costs. The Department should seek reimbursement for the overpayments and reimburse the Foster Care Program.

Agency's Response: The Controller's Office concurs with this finding. The Foster Care Rate Setting function was in a transition phase during the 2001-2002 rate setting process. The function was being transferred from DSS to the Controller's Office. Simultaneously, a new version of the cost report was introduced. Supplemental information previously not required due to the format of the Application For Assistance cost report that was replaced by the Residential Treatment/Foster Care Cost Report was no longer available. Transition staff was unaware of this condition. We have requested and received supplemental documentation to support the approved rates for one of the facilities in question. The issue raised regarding the overpayment to one of the facility rates is valid. We calculate that the error resulting from misstated administrative costs created an overpayment to one agency of $204.07 per child, per month which equates to the $145,848 finding. The Division will seek reimbursement for the overpayment and reimburse the Foster Care Program.

The following enhancements have been and/or are currently being made to the Residential Treatment and Foster Care cost reporting process. This will ensure that these types of errors do not occur in the future.

- A documented review process is now in place for all *Residential Treatment and Foster Care Cost Reports* and *Individual Facility Rate Forms.* This review process will be applied thoroughly to all reports on a consistent basis.

- Automated reporting is now in place, which requires the supplemental detail that was missing from the 2001-2002 facility rate process. Clarification and/or supplemental schedules will be obtained as part of the review process.

- The Individual Facility Rate form pulls from the Schedule C that contains cost data. This allows for systematic checks and balances and eliminates much of the manual process involved on the Rate form.

- The Individual Facility Rate form will be further modified to elaborate more specifically on the expenditures to be used in Step 2 (the determination of the total program cost figure) and Step 4 (the determination of the administration expenses to be used). The total costs to be used in Step 2 should be total agency costs less administrative costs. The administrative costs used in Step 4 should be the allocated portion of costs only if the administrative costs are not directly assigned to the programs in the audit. If administrative cost is assigned in the audit, the assigned amount is to be used.

4. ERRORS IN ELECTRONIC BENEFITS TRANSFER RECONCILIATIONS

Errors were detected in the Department's electronic benefits transfer (EBT) reconciliation worksheets for the Food Stamp program. (This worksheet reconciles the Food Stamp program's EBT authorized drawdowns with recipient food benefit payments.) This condition resulted in an understatement of $17.3 million in Food Stamp expenditures on the Department's June 30, 2002 financial statements.

The EBT reconciliation is the basis for recording paid Food Stamp benefits on the financial statements. Formulas in four of the twelve monthly reconciliation spreadsheets omitted some of the federal authorized drawdowns and daily point-of-sale transactions amounts. Additionally, established review procedures by Department staff failed to detect errors in the reconciliations.

Recommendation: The Department should implement procedures to ensure the EBT reconciliation is properly performed and clerically accurate. All reconciling data and spreadsheet calculations should be reviewed to detect errors and prevent misstatements.

Agency's Response: The Department concurs with the finding. In order to prevent this from occurring again, the Controller's Office has strengthened internal procedures retroactively to July 2002. All spreadsheet formulas used in the reconciliation process have been reviewed and corrected. Additional control totals within the reconciliation worksheet have been included to ensure all data elements are recorded. More extensive and frequent supervisory review has been initiated. These changes will be incorporated into an addition to the procedures manual by April 30, 2003.

5. UNTIMELY RECEIPT AND REVIEW OF SUBRECIPIENT AUDIT REPORTS

The Department was not aware that five of its subrecipients in the Child and Adult Care Food Program had not submitted their audit reports by the deadline. The Department cannot assure itself that its subrecipients have complied with federal audit requirements when its audit report tracking system is not followed. After contact with the five subrecipients, all the required audit reports were submitted.

Recommendation: The Department should follow procedures to periodically review the subrecipient audit report tracking logs and perform procedures that ensure timely receipt and review of subrecipient audit reports.

Agency's Response: The Department concurs with this finding and recommendation. Unlike other programs, DHHS cannot, by law, suspend payments on CACFP agreements when financial reports are not received. A DHHS procedure has been established that allows Audit Resolution Coordinators for Non-Governmental entities to send only one reminder letter for overdue CACFP sworn statements or audits supplemented by follow-up telephone calls. The new procedure will be implemented effective April 1, 2003. In addition to the revised internal procedures, the importance of following established procedures and additional process steps was conveyed to staff responsible for tracking the receipt of audits for CACFP providers in a memorandum dated March 14, 2003.

6. FIXED ASSET RECORDS WERE NOT PROPERLY UPDATED

The Department did not have a tracking system to ensure that all inventory worksheets distributed during the physical inventory were returned to the Controller's office for processing. In addition, there was no system in place to ensure that changes noted from the physical inventory were made to the fixed asset records. Without an effective tracking system, the Department cannot ensure that a physical inventory was taken at all locations and that all fixed assets have been accounted for.

Our test of a sample of twenty-seven inventory worksheets, containing assets purchased with Child Support Enforcement (CSE) funds, revealed the following:

- Serial numbers were not added or changed in the equipment records as requested on three worksheets.

- Two assets were added to one inventory worksheet but were not subsequently added to the equipment records.

- Items totaling $266,669 were still listed in the equipment records for one location even after requests had been made to remove the equipment from the listing.

- Equipment totaling $16,324 was deleted from the equipment records in error.

In addition, the Department did not follow established Office of the State Controller procedures for updating equipment records. As of December 2002, the Department had not updated the fixed asset system to reflect $5,574 of equipment purchased with CSE funds during the fiscal year ending June 30, 2002.

Federal regulation 45 CFR 74.34 requires the Department to maintain adequate safeguards to prevent loss or theft of equipment. Equipment records are to be maintained accurately including description, serial number or other identification number, location, cost and disposition data.

Recommendation: The Department should implement a tracking system to ensure that all inventory worksheets are returned and that all required changes are made to the equipment records. The Department should also implement follow-up procedures to ensure that newly purchased equipment is accurately added to the fixed asset system in a timely manner. In addition, the Department should ensure that the errors identified above are corrected in the equipment records.

Agency's Response: The Department agrees with the findings as stated and will correct the detailed items as listed with an anticipated completion date of March 31, 2003.

As a plan of correction, the Controller's Office will coordinate meetings with the division Fixed Asset System (FAS) coordinator and other division staff to establish a detailed scheme for location codes. Schemes will identify where items are actually located. Those schemes will be shared with all staff who will be involved in the physical inventory for the current state fiscal year.

Three copies of the inventory worksheets will be produced for the current year inventory. The Controller's Office will maintain one complete copy (as a control copy) and will share two copies with the division FAS coordinator. On the control copy as pages are received, the Controller's Office will record the date received and the dates that the corrections are entered in FAS. Follow up for missing pages and questionable information will be coordinated with the division FAS coordinator.

When the Controller's Office is notified of new purchases, e-mail correspondence will be sent to division staff in order to obtain any information necessary to enter the new purchases in FAS. Initial e-mails will be followed up with a second request within 8 to 10 days and pursued thereafter until the information is obtained.

7. CERTIFICATIONS FOR TIME WORKED NOT ON FILE

The Department did not have time worked certifications on file for employees who worked solely on a single federal program. Consequently, payroll costs and certain allocated costs may not be appropriately charged to the Child Support Enforcement program.

The time sheets used by the Department in the Child Support Enforcement program did not identify the work performed by the employee. Instead, they only accounted for the total hours worked and the leave taken.

OMB Circular A-87 requires employees that are expected to work solely on a single federal award to certify at least semi-annually that they worked solely on that program.

Recommendation: The Department should implement procedures to ensure that the certifications are obtained. After our initial discussion, the Department issued a memo in August 2002, describing the need for the payroll certification and the procedures to be followed. In order to eliminate the need for additional paperwork, we recommend that the Department consider incorporating a certification statement on the existing time report to fulfill this requirement.

Agency's Response: We agree with this finding. When this finding was initially brought to management's attention by the auditors, the Controller sent a letter dated August 6, 2002 to all Division Directors and Budget Officers reminding them of the time certification requirement and transmitting forms to be used to track compliance. Another letter was sent in February 2003 reminding Division Budget Officers that certifications for the period ended December 31, 2002 should have been submitted by that time. The Office of the Controller will send a reminder letter after each six-month certification period to Division Budget Officers requesting their written confirmation that all required certifications for the period have been completed.

8. ALLOCATIONS NOT IN ACCORDANCE WITH COST ALLOCATION PLAN

Expenditures for one of the twelve responsibility cost centers (RCC) we tested at the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (Division) were not allocated in accordance with the Division's cost allocation plan. Personnel changes affecting this RCC were not reflected in the allocation basis until seven months after the changes had occurred. This caused the Substance Abuse Prevention and Treatment (SAPT) Block Grant to be overcharged by approximately $4,500.

In addition, two RCCs that charged costs directly to the SAPT should have been, but were not, included in the cost allocation plan. Review procedures were inadequate to detect the omissions.

Cost allocations and methods of charging costs should be in accordance with the cost allocation plan approved by the Federal cognizant agency.

Recommendation: The Department should make an adjustment to correct the overcharge to the SAPT. The Department should ensure that changes affecting the cost allocation plan are communicated timely and that changes in the allocation basis are made timely. The Department should also prepare an amendment to the cost allocation plan to include

the two RCCs that were omitted. Additionally, procedures should be implemented to ensure that the cost allocation plan is complete.

Agency's Response: The Department is in fundamental agreement with these findings and recommendations. New procedures were put in place early in the current State fiscal year (Controller's Office procedure CF001) to improve the communication of changes needed to the Cost Allocation Plan (CAP). The new procedures should prevent a recurrence of the type of error noted in the first example. We will remind all Divisions of the importance of exercising diligence in adhering to those procedures. A prior year adjustment was entered in NCAS during February 2003, to correct the improper cost allocation for the time period between November 2001 and May 2002.

The CAP Amendment process is designed so that only RCCs that require changes are included in an amendment. One of the two RCCs noted in the finding had not changed since the Division converted to a CAP in SFY 2000 and the fact that it was inadvertently omitted from the initial document was not caught. It will be included in the CAP Amendment currently being prepared for submission to the Division of Cost Allocation with a request for approval retroactive to July 1, 2000. The other RCC identified by the auditors is included in the Access database simply for the purpose of using the cost allocation interface to record the earned revenue and associated receivable. It is an institution RCC and is not included in the DMH/DD/SAS Cost Allocation Plan. The Cost Accounting Branch in the Controller's Office will implement a new procedure by April 1, 2003 to compare the CAP narrative to both the BD-701 RCC and the Access cost allocation database on a quarterly basis to identify any discrepancies between those three reference sources. As part of that reconciliation, any RCCs included in the database that are not supposed to be included in the CAP will be noted.

9. CASH DISBURSEMENT CONTROL PROCEDURES NOT ALWAYS PERFORMED

The Department did not always follow prescribed procedures when processing cash disbursements. The risk of inappropriate disbursements increases when procedures are not followed. In our sample of thirty-nine disbursements, we noted the following deficiencies:

- Two disbursements did not have evidence of approval for payment.
- Five invoices were not properly cancelled.
- Two disbursements were not supported by original documentation. One of the payments was made based on a faxed copy of the invoice and there was no evidence that the original documentation had been cancelled.
- One utility invoice was paid sixteen days after the due date.
- Two invoices were paid fifty-four days and ninety-two days, respectively, after their invoice dates.

Recommendation: The Department should follow prescribed procedures when processing cash disbursements.

Agency's Response: The Department concurs with the finding and continues to use due diligence in processing cash disbursements. On October 31, 2002, the findings and written reinforcement of our cash disbursement process were discussed with staff in a formal meeting. The Department's Cash Management Plan describes the process in place to manage original and duplicate invoices or requests for reimbursement. "…the original and all copies of the invoice or reimbursement request are stamped "PAID" with the date it is processed." The written reinforcement of that policy calls for all original and duplicate invoices to be stamped "ENTERED" or "KEYED". Further, original documentation if it exists is included in the batch when a payment has been made from a copy. This will be presented again to staff as a reminder to adhere to process. Supervisors will audit to ensure compliance of properly canceling invoices.

There were two instances mentioned in the finding, i.e. invoices not paid timely which were out of our control. Invoices that require signature approval are sent back to the Divisions and sometimes are not sent back expeditiously.

10. IMPROPER ACCESS TO COMPUTER SYSTEMS

Instances were noted where former Department employees had improper access to several of the State's computer systems. Improper access to computer systems can result in alteration, unauthorized use, or loss of information. The following exceptions were noted:

- Three former employees were still listed on the various security reports of the North Carolina Accounting System.

- Two former employees and one transferred employee were still listed on the user listing report of the Central Payroll System.

Procedures for terminating access to several of the computer systems utilized by the Department were not followed. Supervisors of the affected employees did not inform the security administrator of the change in status of the former employees.

Recommendation: The Department should evaluate and strengthen its security procedures to ensure that individuals no longer authorized to use the Department's computer systems are promptly removed. Supervisors should inform the system security administrator, in writing, of any changes in the user's status of employment. Periodic security access reviews should be conducted to ensure that access is restricted to authorized users.

Agency's Response: The Department concurs with this finding and recommendation. The Department's Security Administrator with the Division of Budget and Analysis has

reiterated to Division/Office security officers the importance of identifying and communicating changes needed in NCAS access. Division/Office security officers have been instructed to run and review the NCAS report OSCOPF SECURITY USERS TABLE LIST monthly and immediately communicate any changes identified to the Department's Security Administrator. Since the majority of DHHS NCAS users are located in the Controller's Office, that Office will take an additional step. The Controller's Office security officer has developed a schedule of names and operator ids by section that will be provided on a monthly basis to each Section Chief. The Section Chief will verify that the permanent, temporary, or part time employee should still have NCAS access.

11. ACCOUNTING RECORDS DO NOT SUFFICIENTLY SUPPORT FEDERAL REPORTING AND PERIOD OF AVAILABILITY REQUIREMENTS

Food Stamp funds were not always drawn from the correct federal grant award and expenditures were not always reported in the proper funding period. Consequently, the Division of Social Services may under or over expend federal grant awards and report erroneous expenditure information to the federal government. This condition exists because the Division's accounting system does not track Food Stamp expenditures by federal fiscal year.

Employment and training cost adjustments and the Electronic Benefit Payment (EBT) monthly service charges for July, August, and September 2001 were not reported to the proper funding period. Specifically, the Division erroneously reported federal fiscal year 2001 EBT service charges of $1,636,347 and employment and training costs adjustments of $800,886 to the Financial Status Report (FSR) 269 report for September 30, 2002. In addition, federal funds awarded for federal fiscal year 2002 were used to pay for these federal fiscal year 2001 expenditures. We question $2,437,233, which is the total cost paid outside the period of availability.

Federal regulation 7 CFR 3016.23(a), states that where a funding period is specified, a non-Federal entity may charge to the award only costs resulting from obligations incurred during the funding period, unless carryover of unobligated balances is permitted.

Recommendation: To ensure that financial reporting and period of availability compliance requirements are met, the Division should establish a method to track and account for Food Stamp program expenditures by federal fiscal year. In addition, the federal FSR-269 reports for federal fiscal years 2001 and 2002 should be revised to report the amounts previously noted to the proper reporting period.

Agency's Response: The Department has historically reported expenditures under the Food Stamp entitlement program on a cash basis. The Department sought clarification from USDA on the matter following their on-site visit but, to date, we have not received a response to our inquiry. We will continue to seek guidance from USDA to determine if expenditures under the Food Stamp program must be reported on an accrual basis or, if it

is as we believe, discretionary. Based upon the guidance received from USDA, we will modify our accounting procedures as necessary to ensure compliance with all applicable federal regulations and requirements. We would also like to point out that reporting will be simpler, less costly in terms of tracking expenditures and less likely to have errors for the Department to report on a cash basis.

DIVISION OF SOCIAL SERVICES

Current Year Findings and Recommendations Also Reported in Prior Audit - The following findings and recommendations were identified during the current and prior audits and represent significant deficiencies in internal control or noncompliance with laws, regulations, contracts, or grants.

12. APPROPRIATE ACTION NOT TAKEN IN CHILD SUPPORT CASES

The Division failed to take appropriate action or failed to take the required action in the established periods for a number of cases. These failures exceeded the 25% error rate used by the federal government to determine substantial compliance with child support requirements.

Our prior audit of the Child Support Enforcement program disclosed weaknesses in the Division's system of managing and bringing enforcement actions related to child support cases; our current audit indicated no improvement in this system. We noted cases in which appropriate or timely enforcement action was not always taken. According to Division personnel, unfilled vacant positions and large caseloads contributed to the numerous errors noted. (All cases tested originated from State operated offices.)

a) Paternity was not established within the required period for twenty-one of the thirty cases tested in "paternity status," a 70% error rate. Actions contributing to the noncompliance included failure to "serve process" within the required period, to take action on successful "locate matches," to verify potential mailing addresses or employment, to contact the absent parent when a verified address was available, to take appropriate action on the case when paternity was no longer an issue, or to take action on the case within the required period.

b) A support obligation was not established or no attempt was made to establish a support obligation within the required period for twenty of thirty cases tested in "establishment status," a 67% error rate. Actions contributing to the noncompliance included failure to "serve process" within ninety days, to take the appropriate action on the case, or to take any action on the case.

c) Appropriate or timely enforcement action was lacking for ten of thirty cases tested in "delinquent status," a 33% error rate. There was no enforcement action taken for four of these cases. In six cases, the "service of process" actions were not

taken within the required period. The "service of process" actions were one month to seven months late.

d) Appropriate enforcement action was lacking for eight of the thirty cases tested to determine if medical support obligations had been secured or enforced, a 27% error rate. In two cases, the files were not documented sufficiently to determine why medical support was not included in the court order. In four cases, the child had not been added to the non-custodial parent's insurance policy. In the other two cases, there was no evidence that the Medicaid agency and the custodial parent were notified when the child was added to the non-custodial parent's insurance policy.

e) Appropriate action was not taken within the required period for fifteen of the thirty interstate cases tested, a 50% error rate. Four "initiating" cases were not referred to other states within the required twenty calendar days of locating the absent parent in the other state. Documents for these four cases were sent to the other states from 6 to 121 days late. The interstate transmittal documents were never sent to the appropriate states in three initiating cases. In one "referring" interstate case, no action was taken after the interstate case was opened. In seven cases, the responding interstate cases were not processed within the required period.

Federal regulations require child support agencies to maintain an effective system of monitoring compliance with support obligations. The appropriate enforcement action must be taken within thirty days of identifying noncompliance. Regulations require that within ninety days of locating an absent parent the Division must establish an order for support, establish paternity, or document unsuccessful attempts to achieve the same. Federal regulations require the child support agency to petition the court for medical support and enforce the health insurance coverage required by the support order. Federal regulations also require actions to be taken on interstate cases in specified time frames including referring cases to other states within twenty calendar days of locating an absent parent in the other states and providing any services necessary as a responding state.

Recommendation: Management should evaluate and enhance its internal control to ensure compliance with federal child support processing requirements.

Agency's Response: The Department concurs with this finding. The federal Office of Child Support Enforcement (OCSE) requires states to meet these compliance requirements in at least 75% of the cases to which they apply. The errors noted by the auditors exceed that allowable standard. State Child Support Enforcement (CSE) management will bring this audit finding to the attention of each local office's management. The audit findings will be incorporated immediately into CSE's new plans for improving compliance scores in each of the program areas.

The regions for CSE area supervisors and consultants are being realigned to provide improved support to local office staff. A Performance Monitoring and Improvement Team has been created in the Central CSE office to consistently identify and address

training and performance needs of local IV-D offices. Performance needs will be identified in two ways. First, the OCSE's self-assessment monitoring and report process, which measures program performance in eight areas, is being fully automated via the DHHS data warehouse. Six of the eight assessment categories have been automated to date; the remaining two will be completed by June 30, 2003. This new automated process will enable CSE to identify for local offices every case that failed to meet OCSE's performance standards so that these cases can be acted upon. It will also enable the identification of training needs specific to each performance area and to each IV-D agent. Secondly, a quality assurance assessment tool has been developed and implemented to proactively review cases and identify areas where assistance or training is needed. This tool will be used on an on-going basis to review cases in local IV-D offices.

13. SSBG PROGRAM WAS NOT MONITORED

The Division of Social Services did not perform monitoring procedures to provide reasonable assurance that counties used Social Services Block Grant (SSBG) funds for only eligible individuals and allowable service activities. The lack of subrecipient monitoring increases the risk that unauthorized activities and/or costs at the subrecipient level may occur and go undetected.

The Division's monitoring plan did not include monitoring procedures for the SSBG program. OMB Circular A-133 requires that a pass-through entity monitor subrecipient activities to provide reasonable assurance that the subrecipient administers federal awards in compliance with federal requirements.

Recommendation: The Division should continue its efforts to develop and implement a monitoring process that addresses the federal requirements applicable to the subrecipients of SSBG funds.

Agency's Response: The Department does perform monitoring activities on the SSBG grant, however these monitoring activities have not been formalized in the Division of Social Services (DSS) monitoring plan and have not been as extensive as they might otherwise have been due to budgetary and personnel constraints. The Department believes that risk assessment plays a vital role in determining the type and number of monitoring activities that should take place. The DSS considers SSBG to be a low-risk activity and has, therefore, performed less monitoring in this area. Additionally, monitoring is a broad function and certain monitoring activities such as internal control assessments and the review of activities funded by multiple funding sources results in coverage of SSBG funds. SSBG funds are also monitored through the budgeting and expenditure reporting processes in the DSS and by other Divisions that utilize SSBG funding. The DSS plans to strengthen SSBG monitoring and the Division's revised monitoring plan includes specific instructions for monitoring SSBG. Pilot monitoring activities under the revised plan will be completed this fiscal year prior to June 30, 2003.

The revised monitoring plan, including SSBG, will be fully implemented for SFY 2003-04.

14. TANF REPORTS CONTAINED ERRONEOUS OR UNDOCUMENTED DATA

Errors were noted in the federal reports filed by the Division of Social Services for the Temporary Assistance for Needy Families (TANF) program. Such errors may reduce the usefulness of the data to federal funding sources. The following errors were noted:

- Information was incorrectly reported on the ACF-199 TANF Data Report for the quarter ending March 30, 2002. The information related to the type of family for one case, the employment hours for one case, and the date of birth for six cases were incorrect due to computer program command errors. Also, documentation was not available to support the TANF work participation code included on the ACF-199 report.

- The documentation did not support the number of families reported on the ACF-209 SSP MOE Data Report for the quarter ending March 30, 2002. The report is submitted electronically, and the Division did not review or verify the accuracy of the case data totals reported on the report summary.

- The June 30, 2001 expenditure amounts were used to estimate the number of families served with MOE funds as reported on the ACF-204 Annual Report for federal fiscal year ending September 30, 2001. The September 30, 2001 expenditure amounts were available to more accurately determine the estimates. In addition, the Division used county daysheets to determine the number of families served with MOE Funds for the Work Subsidies program. The information should have been taken from the Employment Program Information System which provides more detail information.

The control procedures employed by the Division did not ensure accuracy in these federal reports. Adequate internal control would provide reasonable assurance that amounts reported on federal reports are accurate and agree with supporting documentation.

Recommendation: The Division should enhance control procedures to ensure that data reported on federal reports are accurate and agree with supporting documentation. Procedures could include recalculations, scans for unusual variances, and periodic comparison of reports to supporting documentation. Proper documentation should be used to prepare the federal reports, and documentation should be maintained to support all amounts disclosed on the federal reports. Computer program commands to extract and compute data should be reviewed and tested to ensure that data reported is correct and accurate, and agree with supporting documentation.

Agency's Response: The Department concurs with this finding. The Division of Social Services has reviewed each of these findings and taken appropriate corrective action as outlined below.

- ACF-199 TANF Data Report – All errors were corrected in the coding for the reports and corrected data was retransmitted to ACF on December 13, 2002 and February 25, 2003. The documentation of the code used to produce the results for TANF work participation code is available as of December 12, 2002. The documentation details each data element used and the formulae for computing the code for each adult recipient.

- ACF-209 SSP-MOE Data Report, for quarter ending March 31, 2002 - Division procedures required that a staff member validate data from the spreadsheets from the counties through the data entry process and the file transmission validation for the SSP-MOE report. This process was not followed to insure that there were no data errors. This report is no longer being produced; the SSP-MOE Housing Program no longer exists; all cases were closed as of June 30, 2002.

- ACF-204 Annual Report, for federal fiscal year ended September 30, 2001- The Department concurs that at the time preparation of this report commenced, the latest available expenditure report through July 31, 2001 was used to estimate the number of families served with MOE. The percentage of total expenditures attributed to MOE for the services relevant to this finding did not change enough over the subsequent two months of the FFY to significantly impact the client counts reported. This issue was addressed, however, in the preparation of the FFY 2002 ACF-204 when the appropriate expenditures through September 30, 2002 were utilized. The issue of the number of families served with MOE funds for the Work Subsidies program being under reported was addressed in the preparation of the ACF-204 report for FFY 2002. For the Work Subsidies program, a count of individuals served in the Work Subsidies program was obtained from the Employment Program Information System (EPIS) and an estimate of those served with MOE funds was obtained by applying the percentage of total expenditures attributed to MOE to the unduplicated recipient count(s) from EPIS.

15. FOSTER CARE PROGRAM CRIMINAL RECORD CHECKS NOT ALWAYS DOCUMENTED

The Division of Social Services did not provide documentation that criminal record checks were conducted on re-licensed foster parents in two of the thirty-three foster family home records tested. This condition increases the risk that ineligible foster parent arrangements may exist.

Federal and State regulations require the State to provide documentation that criminal record checks were conducted on all foster parents applying for licensure and re-licensure of a family foster home. Because likely questioned costs exceed $10,000, we are

questioning $8,304, which represents the federal share of the payments made from the Foster Care program.

Recommendation: The Division should follow established procedures ensuring that it has on file evidence of criminal record checks on every foster parent prior to licensing and re-licensing foster home facilities.

Agency's Response: The Department concurs with the findings. During the audit period the Division of Social Services had experienced several months wherein the position responsible for this activity was vacant. At the time a new employee was brought on board it appears the new employee inadvertently failed to follow existing policy and verify the criminal records check had been done. The Division is now fully staffed in this critical area and is processing all requests accurately and within two weeks. Additionally, a manual check of all family homes is being completed to ensure that no other criminal records checks were missed.

Each of the affected foster parents has now been fingerprinted. One set was received on March 5, 2003 and sent to the SBI on March 6, 2003. Once received from the county department of social services, the other set of fingerprints will be immediately sent to the SBI.

Other Current Year Findings and Recommendations - The following findings and recommendations were identified during the current audit and represent significant deficiencies in internal control or noncompliance with laws, regulations, contracts, or grants.

16. INCORRECT FACILITY RATES IN THE FOSTER CARE COMPUTER SYSTEM

Incorrect rates were entered into the Foster Care Licensing System for three facilities, resulting in overpayments of $21,310 for the care of children. This amount has been questioned. Controls to ensure that foster care facilities were paid the proper rates were not effective.

Recommendation: Control procedures should be strengthened to ensure that correct rates are entered into the systems that control foster care payments. The foster care payment reports should be reviewed monthly to ensure that proper rates are applied to the cost of care calculation. The Division of Social Services should adjust, or recoup, from the facilities that were overpaid the $21,310 identified as overpayments. In addition, the Division should determine if any overpayments may have been made to any other foster care facility and if overpayments are identified, they should be recovered.

Agency's Response: The Department concurs with the finding. To correct the overpayments, adjustments were prepared on February 13, 2003 and have been submitted to the Controller's Office for processing. In February 2003, staff were reminded of the importance of following existing procedures which require that preliminary payment reports for institutions be reviewed monthly prior to the payment cut-off date

(20th of each month) to ensure that proper rates are applied to the cost of care calculation for each home under the facility. By June 30, 2003, the Division will review the facility payment reports for each month during SFY 2002 for other incorrect rates and adjust as needed.

17. MONITORING NOT PERFORMED ON VENDORS RESPONSIBLE FOR COMPLIANCE REQUIREMENTS

The Division of Social Services did not have a documented monitoring plan in place to ensure that fiscal and programmatic monitoring was performed for compliance requirements passed to vendors. As a result, eight vendor contracts, at a cost of $2.1 million in Foster Care funds for the year ending June 30, 2002, were not monitored and there is little, if any, assurance regarding the vendors' compliance with regulations.

We identified eight contracts with six vendors that the Division had determined to be purchase of services/vendor contracts. The compliance requirements the Division required of these vendors were: 1) determine eligibility for student awards, 2) provide matching funds, 3) supplement contract activities and not supplant them, and 4) ensure that expenditures are only for allowable activities and allowable costs. There was no documented evidence that the Division had monitored these vendor contracts for compliance with these requirements.

OMB Circular A-133 states that the auditee is responsible for ensuring compliance for vendor transactions that are structured such that the vendor is responsible for program compliance or the vendor's records must be reviewed to determine program compliance.

Recommendation: The Division should monitor any vendor contractors who are required to comply with laws and regulations governing federal awards. Monitoring activities should be documented in a format that clearly defines the procedures performed, the results obtained, and the corrective action planned when instances of noncompliance are identified.

Agency's Response: After careful review of the contracts and the criteria for contract determination, the Department/Division of Social Services concurs that Contract 126-02 with the University of North Carolina at Chapel Hill is a financial assistance contract and is, therefore, subject to OMB Circular A-133 monitoring. Although the Division had considered this contract to be purchase of service and had not developed a formal monitoring plan, the services rendered under the contract were closely monitored. The contract administrator met frequently (usually monthly) with the principle investigator to review progress, discuss the project, and evaluate any issues that arose. The contract administrator also served on the advisory committee for the project funded through the contract and reviewed expenditure reports each month. These actions and others will be documented in a formal monitoring plan for the next contract year.

The Department/Division of Social Services disagrees that the other contracts cited by the auditor meet the criteria for financial assistance contracts. The Division believes they are appropriately classed as purchase of service because the vendors have no responsibility to: determine client eligibility, authorize services on a client specific basis, determine the appropriateness of services, provide programmatic functions such as evaluation, planning, monitoring, develop program standards, procedures and rules, program compliance. Also, the vendors have no obligation to the funding authority other than the delivery of services, they operate in a competitive environment and they provide similar goods and services to many different purchasers, operating within normal business operations. The only compliance issue that was passed to the vendor on these contracts is to provide matching funds. One contract, 020-02, was with a non-profit agency and the matching requirement was 25% or 50% dependent on the funding source. The Division monitored compliance with the match requirement through review of expenditure reports. The remaining contracts were all with institutions of the University of North Carolina system. The Division monitored that services were provided as required through review of expenditure and activity reports and by critiquing contract deliverables such as newsletters produced and training events conducted.

Auditor's Response: We agree that the seven contracts referred to in the last paragraph of the Division's response may not meet the Division's definition of financial assistance. This is, however, not the issue in this finding. Regardless of whether the contracts were purchase of service contracts or financial assistance grants, there were several requirements that the Division imposed on these vendors. We were not provided evidence that the Division monitored that its vendors had complied with all of the requirements as listed in the second paragraph of the audit finding.

18. IMPROPER ACCESS TO COMPUTER SYSTEMS

Instances were noted where current and former Division of Social Services and county social service employees had improper access to several of the State's computer systems. Improper access to computer systems can result in alteration, unauthorized use, or loss of information. The following exceptions were noted:

- Three former employees were listed on the various security reports of the North Carolina Accounting System.

- One former employee was listed on the security table report of the Child Placement and Payment System. Also, one employee was listed with two user IDs, each with a different level of access.

- One former employee and one transferred employee were listed on the security table report of the Foster Care Facility Licensing System.

- Nine county employees have entry/update/add/delete authority in the Foster Care Facility Licensing System.

Control procedures for terminating access to several computer systems utilized by the Division were not followed. The Division supervisors did not inform the security administrator that the former employees no longer needed access to the various systems. Division management was unable to explain why county employees needed access to the Foster Care Facility Licensing System.

Recommendation: The Division should evaluate and strengthen its security procedures to ensure that unauthorized users are removed in a timely manner. Division supervisors, or other appropriate officials, should inform the system security administrator in writing of any changes in the user's employment status. The Division should evaluate the appropriateness and reasons that certain county employees were given access to the system. Periodic security access reviews should be conducted to ensure that access is restricted to authorized users.

Agency's Response: The Department concurs with this finding. The following corrective action has been taken.

A review of the individuals found to have access to the Foster Care Facility Licensing System (FCFLS) has been conducted. On March 11, 2003, all individuals separated from the Children's Services Section have been removed. Additionally, some individuals were removed as they have been assigned to other duties where access was not needed to perform assigned functions. All county user ID's were modified on March 13, 2003 to have read only rights in the FCFLS.

The Children's Services Section issued written guidelines to all staff on March 14, 2003 on the maintenance of access to all systems in support of the programs administered by the Section. This policy which covers both the FCFLS and Child Placement and Payment System (CPPS) is being implemented immediately. County users are only permitted read only access to FCFLS under these guidelines. To ensure that only employees whose job duties require access to the CPPS, as employees of the Children's Services Section separate, their ID's will be sent in writing to DIRM for termination, unless an employee is transferring to another Division or section, in which case only their access to applications supporting Children's Services programs will be terminated.

Regarding the individual with two security IDs, both were necessary for the employee in question at the time as the Child Placement and Payment System (CPPS) could not provide adequate access rights to all necessary functionality under one ID to perform the job duties of the position. Subsequently the access issues were resolved and the duplicate ID was removed in January 2003.

19. FISCAL MONITORING NOT PERFORMED ON NUTRITION EDUCATION SUBRECIPIENTS

The Division of Social Services did not perform sufficient monitoring procedures to provide reasonable assurance that subrecipients used Food Stamp funds for allowable

activities. The Food Stamp program's share of expenditures paid to these subrecipients was $5,301,654.

The Division's monitoring plan did not include fiscal monitoring procedures for the subrecipients awarded the Nutrition Education contracts. OMB Circular A-133 requires that a pass-through entity monitor the subrecipient activities to provide reasonable assurance that the subrecipient administers federal awards in compliance with federal requirements.

Recommendation: The Division should develop and implement a fiscal monitoring process that addresses the federal requirements applicable to subrecipients of the Nutrition Education contracts funded by the Food Stamp program.

Agency's Response: The Department/Division of Social Services concurs with the finding as stated. Corrective action has been taken and is explained below.

The original Food Stamp Nutrition were carefully reviewed and based on the interpretations at the time were classified as Purchase of Service contracts because of the scope of the contracts and the deliverables expected. However, the contracts have now been reevaluated and reclassified as financial assistance contracts. New contracts for FFY 2002-03 are covered under the new fiscal monitoring guidelines. The FFY 2002-03 contracts are revised to include adherence to A-133.

A Management Evaluation plan was submitted to and approved by USDA/FNS for FFY 2003, that including monitoring activities for the Nutrition Education programs for each county in which the Food Stamp Program is being reviewed. The Economic Independence Section of the Division has two full-time staff persons dedicated to program compliance monitoring. Per the Division's monitoring plan and the Management Evaluation plan, the Division has monitored the planned 33 counties this year.

While the monitoring plan did not specifically address Nutrition Education contracts, monitoring did occur. Beginning July 2001, federal USDA/FNS conducted a review of the contracts with NCSU for nutrition education for the period FFY 2000. The review included, among other things, a validation of program and administrative expenditures. The review was finalized in July 2002 and there were no unallowable activities or expenditures identified. Staff responsible for the contracts review activity and expenditure reports from county contracts. Both NCSU and county providers are subject to single audit requirements.

The Division of Social Services conducted training for all Division contract administrators regarding overall procurement/contracting issues, including determination of contracts as financial assistance or purchase of services using material developed by the DHHS Controller's Office. Training sessions were conducted January 23 and 30, 2003, February 6, 2003 and March 6, 2003.

20. TANF MONITORING PROCEDURES CONTAINED WEAKNESSES

Monitoring procedures are not sufficiently designed to ensure that all Temporary Assistance for Needy Families (TANF) cases that have been identified as non-cooperative with child support requirements are monitored. When TANF monitors check for the proper imposition of child support non-cooperation sanctions, they rely on information contained in county files and/or computer systems. Because information in the computer systems can be and is often deleted, the potential exists that cases of interest would not be available to the monitors at the time of their reviews. As a result, the monitors may not detect the existence of cases that should be sanctioned for non-cooperation with child support requirements.

OMB Circular A-133 requires that a pass-through entity monitor subrecipient activities to provide reasonable assurance that the subrecipient administers federal awards in compliance with federal requirements.

Recommendation: Subrecipient monitoring procedures related to the application of sanctions due to non-cooperation with child support should be revised to ensure that the monitors have access to, as well as utilize, accurate and complete information regarding which TANF recipients have been identified by the child support enforcement agency as being non-cooperative.

Agency's Response: The Department/Division of Social Services concurs with the finding. A system generated monthly report titled DHREJ NON-COOP WITHOUT A IVD SANCTION is available to identify cases where the Work First recipient has not cooperated with Child Support Enforcement and has not been sanctioned. Thirty-six (36) versions of the report will be maintained for historical purposes. This maintains a history of these cases during a given time period that cannot be altered or purged from the worker's desktop. Monitoring procedures require the use of this report. On February 19, 2003 in the quarterly meeting of Work First monitors, the importance of using this report when performing the required subrecipient monitoring reviews was stressed. The report will be referenced by name in the written monitoring guide when it is republished by June 30, 2003.

21. CONTROLS OVER PHYSICAL INSPECTION OF FIXED ASSETS WERE INADEQUATE

The Division of Social Services did not have controls in place to ensure that equipment purchased with Child Support Enforcement (CSE) funds were physically accounted for during the annual inventory as described below. Inadequate controls increase the risk that missing and/or stolen items would not be detected during the inventory process.

- Two of the twenty-seven locations in our sample did not complete the annual inventory of fixed assets. The inventory worksheets had been sent to the incorrect location for verification and did not reach the proper custodian.

- Four of the forty-one assets in our sample, which had been certified as inventoried, could not be located at their designated location during our physical inspection. We were also unable to locate an additional eighteen items that were listed at the same location.

- Six of the forty-one sample items listed as being at the central office were actually located at another site.

- Three assets observed during our physical inspection did not have a visible asset tag.

In addition, controls were not in place to ensure that all equipment purchased with CSE funds, was recorded in the equipment records. Five items totaling $5,574 were not entered in the equipment records because the Division did not supply the needed information.

Federal regulations require the State to maintain accurate equipment records. State policies require that an annual physical inventory be held and that tags be placed in a manner as to allow the fixed asset number to be easily seen.

Recommendation: The Division should ensure that inventory worksheets are distributed to the correct location for verification. A tracking system should be maintained to ensure that all inventory sheets are completed and returned. Physical inventory procedures should be closely followed and changes in asset location should be noted. All assets should have a visible identifying decal. In addition, the Division should provide the department's Controller's Office with the required information so that the fixed assets can be added to the equipment records in a timely manner.

Agency's Response: We agree with this finding and have taken the following corrective action. The Division of Social Services has notified the counties that did not receive inventory worksheets. The Division will work with the Controller's Office to take steps including development of a diagram for location of assets and implementation of a tracking sheet to ensure that the inventory worksheets are distributed to the correct location for verification.

The physical location of the Child Support Enforcement office moved in September 2001 and several items were surplused. This created some confusion in tracking the equipment. Three of the four items that we were unable to locate should have been removed from the inventory list. The fourth item, 20 key telephone sets, was transferred with the telephone system to Vital Records. A request was processed on March 3, 2003 to remove this from our inventory.

A request has been submitted to update the inventory list to reflect the correct physical location for the six items that were located outside of Raleigh and physical inventory procedures will be closely followed. These items were updated on the inventory list on March 3, 2003. Replacement tags were requested for the 3 items that were missing an

asset tag. In February 2003 the replacement tags were received and placed on the equipment. The five items totaling $5,574 have been entered into the inventory system. The items totaling $557 were entered on 02/07/03 and the balance of the items totaling $5,037 were entered on 02/14/03.

The importance of accurately tracking equipment has been stressed with staff and managers in various meetings.

DIVISION OF MEDICAL ASSISTANCE

Current Year Findings and Recommendations Also Reported in Prior Audit - The following findings and recommendations were identified during the current and prior audits and represent significant deficiencies in internal control or noncompliance with laws, regulations, contracts, or grants.

22. NURSING FACILITY DESK AUDITS WERE NOT COMPLETED

The Division of Medical Assistance (DMA) completed only 29% of the required nursing facility cost report desk audits. Because of this condition, DMA was not able to verify the accuracy of the nursing facility cost reports. The desk audits are performed to ensure that the cost reports support the rates the nursing facilities used and to identify overpayments, if any.

For fiscal year ending June 30, 2001, there were 357 nursing facility cost reports that required desk audits to be completed by June 30, 2002. DMA was able to complete 102 desk audits and had 40 other desk audits in process. DMA did not receive audit reports on the remaining 215 facilities.

The North Carolina State Plan, section .0104(e), requires desk audits of nursing facility cost reports to be completed within 180 days after their receipt. The cost reports are due by December 31 of each year.

Recommendation: DMA should enhance controls to ensure that the required desk audits of the nursing facility cost reports are completed on a timely basis.

Agency's Response: The Department agrees with this finding. The Division of Medical Assistance (DMA) Audit Section will take the following steps to ensure that desk audits of cost reports are completed on a timely basis: 1) perform limited scope audits of Nursing Facility cost reports which take less time than full audits; 2) perform sampling to audit selective cost reports from chain providers and apply the findings from the sample to the entire chain; and 3) endeavor to increase productivity through regular staff training sessions. Most of the audit staff is new to DMA and management believes that increased training will shorten the learning curve and thus increase productivity.

23. SERVICES BILLED WERE NOT SUPPORTED BY MEDICAL RECORDS

From tests of 270 Medicaid claims, we noted eleven claims that were in error:

- The medical records for seven claims did not contain adequate documentation of the medical necessity of services performed. The claims totaled $2,672; the federal share of $1,642 is questioned.

- Medical services reported on three claims should have been at the intermediate level of care instead of the skilled level of care that was provided. The difference between what was billed and what would have been allowed under the correct level of care totaled $1,358. The federal share of $835 is questioned.

- One claim was billed using the wrong service code. The difference between what was billed and what would have been allowed under the correct service code totaled $5,537. The federal share of $3,403 is questioned.

Although, the claims in error only totaled $9,567, the likely questioned costs are in excess of $10,000. Therefore, the federal share of $5,880 is being questioned.

OMB Circular A-87 states that allowable costs must be adequately documented and program costs must be necessary and reasonable for proper and efficient administration of the grant program. Federal regulation 42 CFR 431.107 and State regulation 26G.0107 require that medical records disclose the extent of services provided to Medicaid recipients.

Recommendation: The Division should evaluate and, if necessary, strengthen procedures to ensure that providers adequately document medical services provided.

Agency's Response: We agree with this finding. The Division of Medical Assistance has reviewed all of the cases included in the auditors' sample. One case remains under review, with the appropriate dispensation pending the outcome of a more detailed review. Three cases involved a Level of Care change for which it is DMA's policy to ensure that corrective action is taken to place the individual at the correct level of care without seeking recoupment. Of the remaining cases, recoupment has been received for three and recoupment efforts are continuing on the others. The DMA recognizes that this is a recurring situation and will be working through random audits of claims, provider education and use of the Fraud and Abuse Detection System (FADS) to identify, correct and prevent these problems in the future.

24. ONE EMPLOYEE HAD IMPROPER ACCESS TO THE MEDICAID MANAGEMENT INFORMATION SYSTEM

Our review of the application and general controls at Electronic Data Systems Corporation (EDS) revealed that one EDS employee had more access to the Division's Medicaid Management Information System (MMIS) than was necessary for the

employee's job. Inappropriate access to MMIS increases the likelihood of errors and unauthorized transactions.

Although the Division has a security system in place to review and monitor access rights granted to individual users, this unnecessary access was never detected. We advised EDS of this weakness during the course of our fieldwork and EDS immediately responded and took appropriate corrective action. The Division has contracted with EDS to process Medicaid claims through the Division's MMIS.

Recommendation: The Division should strengthen its security system to ensure access is limited to individuals on a need-to-use basis.

Agency Response: We agree with this finding. The following management oversight and controls have been put in place between the DMA and Electronic Data Systems Corporation (EDS):

- EDS has agreed to monitor the HMPR0951 and HMPR0952 security reports on a quarterly basis for their own employees and their directly sponsored contractors. (DMA performs this type of audit for their own staff and DMA sponsored contractors).

- At least quarterly, the access of EDS users granted MMIS update capabilities will be verified with the respective user's manager or contract sponsor. EDS will notify the DMA Security Control Officer in writing that this process has been completed, noting any findings or irregularities, status thereof and the date of the completion of this internal audit.

This process, coupled with the current security controls in place at EDS should further minimize inappropriate access to MMIS by EDS employees and/or their contractors.

Other Current Year Finding and Recommendation - The following finding and recommendation was identified during the current audit and represents a significant deficiency in internal control or noncompliance with laws, regulations, contracts, or grants.

25. MEDICAL AUDITS OF HEALTH MAINTENANCE ORGANIZATIONS WERE NOT PERFORMED ANNUALLY

The Division did not have an adequate system in place to ensure that annual "medical audits" for health maintenance organizations (HMOs) were performed. Division personnel stated that budget cuts in the Managed Care Section limited their ability to perform, or contract out, the annual site reviews. Because annual site reviews were not performed, there is an increased risk that HMOs may not be providing an acceptable level of health care to enrolled recipients.

There were two HMO contracts in effect during the fiscal year:

- Since the inception of one of the HMO contracts, two audits would have been required for this HMO as of June 30, 2002. Although an audit commenced July 2002, as of December 9, 2002, the first audit report on this HMO is yet to be finalized.

- The other HMO was last audited in October 2000 with a report issued in May 2001. This HMO is lacking at least one additional audit.

Federal regulation 42 CFR Section 434.53 requires the Division to audit, at least once a year, each HMO to ensure the contractor furnishes quality and accessible health care to enrolled recipients. The audits are to encompass multiple areas of review including administrative structure, financial status, provider networking, quality improvement, customer services, utilization review processes, and information systems.

Recommendation: To comply with federal requirements, the Division should ensure that HMOs are audited as required by the regulations. The Division should take steps to have its one remaining HMO audited.

Agency's Response: We agree with this finding. The Division of Medical Assistance (DMA) was unable to accomplish the required audits (operational reviews) on an annual basis due to staffing shortages and budgetary constraints imposed by legislative mandates. In July of 2002, DMA contracted with Myers and Stauffer to conduct a thorough audit of South Care (the Plan), currently the only HMO contracting with DMA. DMA Managed Care staff participated in the onsite audit in conjunction with a team from Myers and Stauffer. The audit encompassed multiple areas of review including administrative structure, financial status, provider networking, quality improvement, customer services, utilization review processes, and information systems. The onsite review, with face-to-face and telephonic interviews and document review, was accomplished over a three-day period. In addition, DMA staff plans an additional onsite visit to the Plan prior to or during the third quarter of the calendar year 2003 to assess the status of the cited deficiencies. DMA plans to contract out an annual audit or perform an audit with DMA staff annually from this point forward.

United HealthCare terminated its contract with the agency effective December 1, 2002. Because operational reviews are used to work with the HMOs prospectively on how they can continue to meet their contractual obligations and serve the Medicaid clients linked with them, DMA has no plans of conducting a retrospective operational review with United HealthCare. South Care is the only contracted HMO at the present time.

DIVISION OF SERVICES FOR THE BLIND

Current Year Finding and Recommendation - The following finding and recommendation was identified during the current audit and represents a significant deficiency in internal control or noncompliance with laws, regulations, contracts, or grants.

26. ERRORS IN THE DEPARTMENT'S COST ALLOCATION

Our review of costs allocated by the Department to the Division's Rehabilitation Services – Vocational Rehabilitation Grants to States Program revealed the following:

- Errors were identified in the Department's calculation of percentages used to allocate costs to the federal program. For example, certain cost centers were to be allocated based on the way other cost centers were allocated. This did not always happen, resulting in incorrect allocations.

- Because the Cost Allocation Plan (CAP) did not adequately describe the procedures used to allocate costs to the federal program, it was difficult to make informed judgments on the accuracy and fairness of the procedures used for allocating costs.

The effect of these errors was not readily determinable. Costs were under-allocated and potentially over-allocated to the federal program.

Federal Regulation 45 CFR 95.507 requires that the CAP describe the procedures used to identify, measure, and allocate costs to each program. Also, the CAP should contain sufficient information in such detail as to make an informed judgment on the correctness and fairness of the State's procedures for identifying, measuring, and allocating costs to each program. In addition, OMB Circular A-87 requires that the method of allocating costs should produce an equitable distribution of costs.

Recommendation: The Department and the Division should continue to jointly review the CAP as it impacts the Division and should update it as considered necessary to ensure that all procedures for identifying, measuring, and allocating costs are adequately defined and that all costs are properly allocated and charged to the federal programs.

Agency's Response: The Department agrees with this finding. We have analyzed the differences identified by the auditors for the month they reviewed and, although the net amount of federal funds underclaimed is small, we agree that procedures and processes can be improved to ensure that more material errors are prevented. The Office of the Controller and the Division of Services for the Blind have taken multiple steps to strengthen the cost allocation process. The Division has established additional RCCs to eliminate the need to split staff paid in one RCC between two or more supervisors in the cost allocation step-up process. The Division has developed a procedure for initiating updates to the Cost Allocation Plan (CAP) in accordance with the Office of the

Controller's procedure # CF 001. With the Division's assistance, the Office of the Controller has updated the formal, written CAP to incorporate these new RCCs and to clarify the description of services and allocation basis of other RCCs. Although the CAP is not submitted to the U. S. DHHS, per their instructions, the Division and the Office of the Controller intend to ensure that it is updated in a timely manner. Adherence to the new procedures will accomplish this goal.

DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES

Current Year Finding and Recommendation Also Reported in Prior Audit **-** The following finding and recommendation was identified during the current and prior audits and represents a significant deficiency in internal control or noncompliance with laws, regulations, contracts, or grants.

27. EXCESSIVE FUNDS ADVANCED TO SUBRECIPIENTS

The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services advanced excessive funds to three of the seven subrecipients tested, causing the Division to be out of compliance with federal cash management requirements. The excessive advances during the audit period totaled $644,794.

These advances, paid with Substance Abuse Prevention and Treatment Block Grant funds, were to fund estimated expenditures for sixty days. Federal regulations require the Division to assure that subrecipients conform substantially to the same timing requirements that apply to the State, which is restricted by the Treasurer-State Agreement to two days.

Recommendation: The Division should ensure that future advances do not exceed the timing requirements.

Agency's Response: The Department concurs with the Auditor's finding. Effective July 1, 2002, the Division has developed and implemented policies and procedures to ensure that Federal funds are not advanced to contract vendors. Any approved contract advances are paid from State funds and not Federal funds. The Division continuously monitors contract payments to ensure that Federal funds are not paid before actual Federally reimbursable expenditures have been incurred as required under the Treasurer-State Agreement (TSA) two-day advance.

These Division policies and procedures have been accepted by the U.S. DHHS, Substance Abuse and Mental Health Services Administration per October 30, 2002 correspondence from the Financial Advisory Services Officer of the Grants Management Branch, OPS, SAMHSA to the Division of Mental Health/Developmental Disabilities and Substance Abuse Services.

Other Current Year Findings and Recommendations - The following findings and recommendations were identified during the current audit and represent significant deficiencies in internal control or noncompliance with laws, regulations, contracts, or grants.

28. ACCOUNTING RECORDS DID NOT ADEQUATELY SUPPORT EARMARKING REQUIREMENTS

The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services was unable to document compliance with certain earmarking requirements for the 2001 federal fiscal year (FFY). (Earmarking requirements specify the minimum and/or maximum amount or percentage of a program's funding that must/may be used for specified activities, including funds provided to subrecipients.) Since accounting records were not sufficient to provide reasonable assurance that federal compliance requirements were met, we question $8.6 million, which is the amount required by the earmarking requirements to be expended with the 2001 FFY Substance Abuse Prevention and Treatment (SAPT) block grant.

Prior to FFY 2002, the Division's accounting records were not designed to track the SAPT block grant separately by federal fiscal year. Instead, the Division tracked the grant expenditures on the State fiscal year. As a result, we were unable to determine compliance with the following earmarking requirements for the 2001 FFY:

- Of the amount earmarked for alcohol and drug prevention/treatment, not less than 20% of the grant is required to be expended for SAPT primary prevention programs (45 CFR 96.124(b)(1)).

- Not less than 2% and not more than 5% of the grant is required to be expended on projects that provide early intervention services for HIV disease (45 CFR 96.128(a)(1) and (d)).

The Division, however, attempted to show compliance with the HIV early intervention services earmarking requirement by comparing the 2002 state fiscal year expenditures with the earmarking requirement for the 2002 FFY. In the process, the Division erred in its interpretation of the earmarking limitation. Rather than treating 5% as the maximum amount to be spent for this requirement, the Division mistakenly interpreted the 5% figure as the minimum amount. This resulted in $86,408 of expenditures more than the 5% allowed by the 2002 FFY grant award. Since the grant period has not ended for the 2002 FFY grant, we are not questioning this cost.

In accordance with 45 CFR 96.30, fiscal controls and accounting procedures must be sufficient to (a) permit preparation of reports required by the statute authorizing the grant and (b) permit the tracing of funds to a level of expenditure adequate to establish that such funds have not been used in violation of the restrictions and prohibitions of the statute authorizing the block grant.

Recommendation: The Division should track expenditures by federal fiscal year in order to determine that the earmarking requirements have been met. In addition, the Division should use 5% as the maximum amount allowed for HIV early intervention services when tracking the HIV expenditures for the 2002 FFY grant. The Division should also contact the federal agency when questions arise concerning earmarking requirements to ensure that it is using the correct percentages.

Agency's Response: The Department has implemented changes in its accounting practices to track Substance Abuse Prevention and Treatment (SAPT) block grant expenditures by federal fiscal year (FFY) in the accounting records. These changes were implemented in State fiscal year 2001-2002 in response to the auditors' recommendations from the audit for SFY 2001, which were issued in March 2002. The finding has been repeated this year because some FFY 2001 SAPT block grant funds were expended in SFY 2001, prior to the auditors' recommendation and before expenditures were tracked by FFY.

Although we agree with and have implemented the auditors' recommendation to track expenditures by FFY, we disagree with the questioned cost. The federal granting agency, the Substance Abuse and Mental Health Services Administration (SAMHSA), has always accepted the Department's use of State fiscal year data and supplementary information to document compliance with earmarking and set-aside requirements. SAMHSA has indicated that those methods continue to be acceptable to them.

We do agree with the finding related to HIV earmarking. Monitoring methods, developed with the assistance of SAMHSA, are now in place to track the amounts required to meet, but not exceed, the percentages allowed for the HIV earmarking requirement for the FFY2002 and subsequent grant awards.

29. INADEQUATE CONTROL OVER LEVEL OF EFFORT REPORT FOR TUBERCULOSIS SERVICES

The Division did not have adequate internal controls in place when preparing the level of effort report for tuberculosis services. (Level of effort is, in part, the requirement that a specified level of expenditures from non-Federal or Federal sources for specified activities be maintained from period to period.) Unless controls are in place to ensure accurate reporting of level of effort expenditures, the Division cannot assure that these requirements have been met. The amounts reported as being expended during the 2002 State fiscal year did not agree with the supporting documentation:

- The "total of all state funds spent on TB services" amount was reported as $3,418,712; however, the documentation supported only $2,852,316.

- The "percentage of TB expenditures spent on clients who were substance abusers in treatment" amount was reported as 19.5%. The documentation showed that it was actually 23.3%.

- The "total state funds spent on clients who were substance abusers in treatment" amount was calculated and reported to be $666,649. The revised total based on the changes noted above is $664,590.

Since the Division's adjusted expenditures exceeded the $359,692 level of effort requirement, the Division is in compliance with this requirement.

Recommendation: The Division should strengthen its internal control over the preparation of the level of effort reports by requiring and maintaining documentation to support the amounts and percentages that are reported.

Agency's Response: The Department agrees with this finding and recommendation. We have revised our reporting to the Substance Abuse and Mental Health Services Administration (SAMHSA) to correct the amount reported as having been spent on clients who were substances abusers in treatment and that revised report has been accepted. The initial information was based upon data collected prior to the end of the State fiscal year. The Division of Mental Health, Developmental Disabilities and Substance Abuse Services has revised the timeframe for gathering this data for the grant application to ensure that final year-end expenditures are used. The Division will also require that supporting documentation accompany reports of expenditures from other State agencies expending SAPTBG funds.

30. SYSTEM OF TRACKING TIME CONTAINS CONTROL WEAKNESSES

The Division did not have a written policy requiring monthly time sheet submission or a tracking system to ensure that all employees submitted monthly time sheets. Unless time sheets are reviewed monthly, there is a risk of overpaying an employee who is not working or whose leave balance has been exhausted.

One of the nineteen employees tested submitted his July 2001 through December 2001 time sheets to his supervisor in January 2002. In addition, the employee prepared and submitted time sheets for the entire 2002 calendar year in February 2003 after inquiries were made about the status of this employee's time sheets.

Good internal controls dictate that employees submit monthly time sheets of hours worked and leave taken.

Recommendation: The Division should develop a policy for time sheet submission. A tracking system should be implemented to ensure that the time sheets are received monthly from all employees. In addition, time sheets should be reviewed so that adjustments to the employees' pay can be made on a timely basis.

Agency's Response: The Department agrees with this finding and recommendation. The Division of Mental Health, Developmental Disabilities and Substance Abuse Services has developed a written policy to ensure that time sheets are received from all employees

by the fifth working day of the following month. The policy includes procedures to verify that the employee and their supervisor have signed the time sheets. This policy became effective March 1, 2003 and all time sheet submissions for SFY 02-03 will be current at March 31, 2003.

DIVISION OF VOCATIONAL REHABILITATION

Current Year Finding and Recommendation Also Reported in Prior Audit - The following finding and recommendation was identified during the current and prior audits and represents a significant deficiency in internal control or noncompliance with laws, regulations, contracts, or grants.

31. CONTROL WEAKNESSES OVER DETERMINATION AND DOCUMENTATION OF CLIENT ELIGIBILITY

    There were internal control weaknesses in the Rehabilitation Services – Vocational Rehabilitation Grants to States program at the Division of Vocational Rehabilitation Services. Because of these weaknesses, which were related to eligibility and the determination of client financial needs, the Division assumed an increased risk of paying costs related to ineligible participants. Our examination of 210 client files revealed:

    - Financial need for three clients who had excess income and/or resources was not assessed completely. Missing was documentation of the clients' contribution to their cost of rehabilitation or approved justification of extenuating circumstances. Also, inconsistent financial information was provided for one of these clients. The client's application indicated monthly income of $1,530; however, the DVR 0116 (dated the same day) indicated monthly income of $532. Federal regulation 34 CFR 361.54 and the Division's policies and procedures require that financial needs be established before planning or providing any services and should be continuously monitored with changes documented appropriately. The costs associated with these errors are $13,308. The federal share of $10,473 is being questioned.

    - Required eligibility extension forms were not obtained for two clients. Federal regulation 34 CFR 361.41 and the Division's policies and procedures manual require that the extension forms be filed if eligibility cannot be determined within 60 days. Because both clients were later determined eligible, there are no questioned costs.

    - One client did not sign the Individualized Plan for Employment (IPE) and another client did not sign an IPE amendment. Federal regulation 34 CFR 361.45 requires that the client sign the IPE and any IPE amendment.

Recommendation: The Division should strengthen internal control and ensure that financial information in clients' case files is consistent and procedures for determining financial needs are followed. Also, the Division should ensure that eligibility extension forms are obtained when required and clients sign their IPE and IPE amendments.

Agency's Response: The Department agrees with this recommendation. Following the issuance of the SFY 2001 audit report, the Division of Vocational Rehabilitation (DVR) provided additional training to counselors and updated policies and procedures manuals. The Division is pleased that the auditors noted that most of the errors they identified in the SFY 2002 audit occurred prior to the time that those corrective measures were put in place. The Division will continue to take action to improve error rates. The preliminary findings for FYE 2002 have been addressed in a statewide DVR management team meeting. Review and training will be implemented at every level of accountability to address each area in which there was an audit finding. The effort will include training and review of policy and procedures by the Division Director, Regional Directors, Unit Managers, and case record reviews by Regional Quality Development Specialists. Unit Managers will review all cases in which there is an exception to the required use of comparable benefits. Renewed emphasis on training in the cited areas of eligibility, financial eligibility and comparable benefits will be discussed at the statewide Quality Development Specialists meetings. Quality Development Specialists will incorporate additional training into their consultations and training with new counselors, with Unit offices, and with individuals who have developmental needs in casework. In addition, the Rehabilitation Counselor Exam will be revised to address audit findings.

Although we agree with the findings and recommendation, we disagree with the questioned cost. Following the auditors' review, DVR staff identified additional information that was missing or was unclear in the case file for each of the three cases for which costs were questioned that confirms the clients' eligibility for the services rendered and eliminates the concern with questioned costs.

OTHER DEPARTMENTAL DIVISIONS

The results of our tests disclosed no instances of noncompliance and no material weaknesses in internal control that require disclosure under Government Auditing Standards for the Division of Child Development and the Division of Public Health.

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June 30, 2003

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