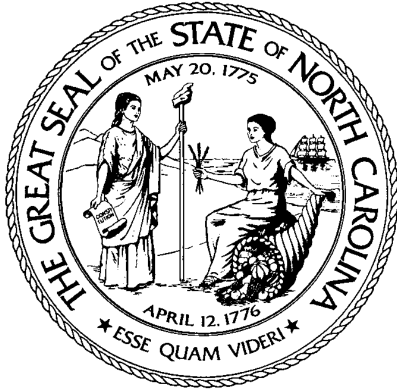


STATE OF NORTH CAROLINA

AUDIT RESULTS FROM

CAFR AND SINGLE AUDIT PROCEDURES

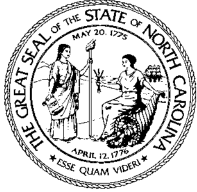
NORTH CAROLINA TEACHERS' AND STATE EMPLOYEES' COMPREHENSIVE MAJOR MEDICAL PLAN

FOR THE YEAR ENDED JUNE 30, 2002

OFFICE OF THE STATE AUDITOR

RALPH CAMPBELL, JR.

STATE AUDITOR



STATE OF NORTH CAROLINA
Office of the State Auditor

Ralph Campbell, Jr.
State Auditor

2 S. Salisbury Street
20601 Mail Service Center
Raleigh, NC 27699-0601
Telephone: (919) 807-7500
Fax: (919) 807-7647
Internet http://www.osa.state.nc.us

May 21, 2003

The Honorable Michael F. Easley, Governor
Members of the North Carolina General Assembly
Dr. Jack Walker, Executive Administrator
North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan

We have completed certain audit procedures at the North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan 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 North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan related to the State's general-purpose financial statements and the State's federal financial assistance programs that required disclosure in the aforementioned reports. We also identified during the current audit significant deficiencies in the management control processes for matters not directly related to financial reporting and federal compliance objectives. These findings are included in the findings and recommendations section contained herein. Our recommendations for improvement and management's response follow each finding.

> The Plan does not have an active program in place to periodically evaluate whether established healthcare plan options could be beneficial to the Plan and/or its members and has not actively promoted and achieved the increased use of its mail order prescription service.
>
> The Plan does not adequately monitor nor has it administratively organized itself to monitor its contractors effectively. The Plan failed to seek a reduction in the fees paid the Claims Processing Contractor when the Plan contracted the drug claims processing function to a pharmacy benefit manager. Accounting procedures, internal control, clearly written policies and procedures, long-range planning, and the system of physically maintaining accounting records are inadequate to govern the level of financial activity conducted by the Plan.

The accounts and operations of the North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan 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 program of the State were subjected to audit procedures at the North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan:

Fund for the *Comprehensive Annual Financial Report*:

Other Employee Benefit Trust Fund: State Health Plan

Federal Program for the *Single Audit Report*:

State Children's Insurance Program

The individual fund and federal program subjected to audit at the North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan are substantially less in scope than would be necessary to report on the general-purpose financial statements that relate solely to the Plan or the administration of federal programs by the Plan. 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

The following findings and recommendations were identified during the audit and, except as noted below, describe conditions that represent significant deficiencies in internal control or noncompliance with laws, regulations, contracts, or grants. Findings numbered 1, 4, 8, and 9 represent significant deficiencies in the management control processes for matters not directly related to financial reporting or federal compliance objectives.

1. THE PLAN HAS NOT INCLUDED SOME OPTIONS IN ITS HEALTHCARE PLAN RESEARCH

The Plan does not have an active program in place to evaluate whether established healthcare plan options, as well as less traditional ones, could be beneficial to the Plan and/or its members. Due to continuous changes and rising costs in the healthcare industry, the State of North Carolina may not be providing its teachers and employees with the most cost-effective plan if all available and reasonable options are not researched and assessed. While the Plan has performed some research, the research generally was in response to and at the request of others and not based on a continuous program of periodic evaluations.

North Carolina's teachers and state employees are currently provided only one healthcare plan option, the self-funded indemnity plan. The Plan provided us with documentation that indicated that it had performed research on several other options, as follows:

- Self-funded health maintenance organization (HMO) option
- Low-option preferred provider organization (PPO) for family coverage
- Employee and spouse option
- Age banding, or rates based on the age of the subscriber

Our research of healthcare options provided to employees of other states, the federal government, and the private industry indicates other types of healthcare plans exist and are made available to their employees (see table). Our research also revealed the following:

- At least thirty-one states offer a choice of two or more options.
- Eleven benefit plans are offered to federal employees nationwide.
- Private industry employers are implementing wellness programs to help control cost.

The Plan has not documented that it performed any study of the health plan programs utilized by these other organizations, in particular the other states, or assessed the pros and cons of those more frequently occurring options utilized and their efficacy to the program in North Carolina. In particular, the Plan has not investigated these options:

- Point of service which combines the features of HMOs and PPOs
- Defined contribution where members choose from among several options, to include the purchase of insurance directly from an insurance company
- A benefit option directly related to the lifestyle of the subscriber and family members, i.e. smokers, weight control, etc.

Healthcare Options		
Type of Plan	Advantages	Disadvantages
<u>Indemnity</u> *Traditional or Fee for Service Plan: Patients are able to see any doctor without referral and are responsible for paying a deductible. After the deductible has been met, the provider pays a percentage of "usual and customary" charges for covered services.*	• Free to choose healthcare provider. • Do not need referrals or authorizations to see specialists.	• Premiums and out-of-pocket expenses are higher. • Must meet a deductible. • Must pay co-insurance.
<u>HMO</u> *Health Maintenance Organization: Primary care physician is first medical provider and may make referrals to specialists. Patients are only covered within the network, except for emergencies, and are responsible for co-payments.*	• Low out-of-pocket expense. • No deductible (usually). • Focus on wellness and preventive care. • Typically no lifetime maximum payout.	• Fixed monthly fee regardless of how much medical care needed. • Must receive referral from primary care physician before seeing a specialist. • Must use network providers. HMOs will not pay for treatment outside the network (except for emergencies).

Type of Plan	Advantages	Disadvantages
PPO *Preferred Provider Organization: Similar to HMOs. Patients are covered outside of the provider network but at a higher cost. The patient is responsible for a deductible.*	• Free to choose healthcare provider. • Do not need referrals to see specialists. • Limited out-of-pocket expense. • Pay for services as rendered.	• Less coverage for treatment received from non-network provider. • Larger co-payments. • Must meet a deductible (usually). • Must pay co-insurance until out-of-pocket maximum is met (usually).
POS *Point of Service: Combines the features of HMOs and PPOs. Patients may stay within the network and pay a flat rate, or they may go outside of the network and pay a deductible and coinsurance fee.*	• Free to choose healthcare provider in or outside of network. • No deductible within network. • Low co-payments within network.	• Must receive referral from primary care physician before seeing a specialist within the network. • Must meet a deductible outside of network. • Higher co-payments outside of network.
Defined-Contribution *Consumer driven health plan in which the employer gives employees the funds to purchase their own insurance/healthcare. There are many variations to the defined-contribution model.*	• Gives employees more control over plan design. • Rewards efficient healthcare purchasing /consumption. • Ability for users to roll over any unspent balances.	• Plan is new and untested. Cost impact is uncertain. • Large deductible after spending account is exhausted. • Shifts costs from employer to employee. • May punish employees with higher medical bills. • May encourage employees who have not been over-consuming healthcare to start.

Recommendation: The Plan should have an active program in place to periodically investigate benefit options, industry trends, and the current state and structure of health plans, especially those most similar to North Carolina's program. The Plan's research and analysis should be reviewed and updated to support suggested changes for improvement in the healthcare benefits for North Carolina's employees.

Agency Response: The Plan will present the finding and recommendations to the Board of Trustees and the legislative Committee on Employee Hospital and Medical Benefits

for their evaluation. In the past, the Plan's consulting actuary has indicated that adding options could create an "adverse selection" opportunity. The legislative fiscal research department also believes that adding options would result in adverse selection in one or more of the options.

In response to the comment about private sector wellness programs, the Plan has been piloting programs with the Orange County schools, Department of Public Instruction, and Cumberland County. (See Attachment I) [The Plan should be contacted for a copy of the referenced attachment.]

Each of these pilot programs includes a health risk assessment, and targeted interventions to assist the participant to change modifiable risk factors for disease. A key requirement of a health promotion and wellness program is behavior change. Few employers have demonstrated that their programs have been effective in changing behavior. The Plan will continue to search for a series of programs which will result in a significant improvement in participant health, which will positively impact future medical and pharmacy claims expenditure. Several initiatives, including research projects with area universities and partner programs with other state agencies are currently in progress. The Plan will continue to assess, plan, implement and evaluate programs that have proven results and return on investment (ROI), and incorporate these programs as part of the Plan's future endeavors to help control cost.

2. THE PLAN DOES NOT HAVE EFFECTIVE CONTRACT MONITORING PROCEDURES IN PLACE

The Plan does not adequately monitor nor has it administratively organized itself to monitor its contractors effectively. With contractors providing extensive services to the Plan, processing or impacting in excess of $1.2 billion in transactions annually at a cost of $30 million, and with the failure to adequately monitor its contractors, the Plan cannot be assured that key contract performance criteria are being met.

The Plan has no formal or written policies and procedures in place regarding contract monitoring and little documentation to demonstrate that the Plan monitored many of the performance criteria of its contractors. The Plan presented some information and records that could form the core of an effective monitoring program. However, the Plan did not present clear evidence that it reviewed, analyzed, and assessed the adequacy of such information; reached conclusions as to compliance with each contract requirement; and took appropriate follow-up and corrective action, if needed, to ensure contractor compliance with each contract term. Prior to the completion of the audit fieldwork, we noted that the Plan began formatting policies and procedures and instituted some monitoring activities related to one of its major contracts.

Many of the administrative duties of the Plan have been contracted to private organizations. The primary function of the Plan, processing health claims of state employees, teachers and retirees, has been contracted out to two private organizations. Blue Cross and Blue Shield of North Carolina, referred to as the Claims Processing

Contractor (CPC), processes regular claims ($932 million for 2002). Advance PCS, referred to as the Pharmacy Benefit Manager (PBM) manages the Plan's prescription drug program and processes drug claims ($250 million for 2002). The Plan also contracts with several private organizations for services related to disease case management and for administrative services such as actuarial studies and claims auditing. We noted the following deficiencies in the Plan's monitoring of specific contractors:

- The Plan did not adequately monitor that component of the hospital bill audit function that the CPC outsourced to independent contractors. (The CPC contracted with two independent firms to audit inpatient and outpatient hospital medical claims.) Specifically, the Plan failed to monitor overpayment recoveries and did not have records on file pertaining to audit recoveries. We found no reports in house supporting the hospital overpayment recoveries for the last seven years and had to obtain the records for the most recent four years from the CPC. Those records indicate that the CPC collected $3.5 million, paid its independent contractors $1.02 million, and remitted $2.48 million to the Plan. The records, however, do not disclose how many audits were done, who was audited, and do not identify the recoveries by source when they were deposited to the credit of the Plan. As a result, the Plan cannot be assured that it received all amounts that it is due resulting from the CPC's outsourced hospital bill audit function. Also, the failure to receive the overpayment recovery reports would have greatly handicapped the Plan's ability to evaluate the effectiveness of this component of the CPC's provider audit process.

  In addition, there is little evidence that Plan management was consulted by the CPC or allowed to approve the providers selected for audit by the CPC's independent contractors. As a result, the Plan may not have been afforded the opportunity to exercise appropriate oversight over the audit process or to steer the hospital audits toward providers that the Plan may have felt posed the greatest risk.

- There is little evidence that the Plan has assessed the overall results of the CPC's hospital bill audit effort, judged the effort the CPC is expending on this function, or considered alternatives that would increase recoveries. As previously stated, the CPC reported recoveries of $3.5 million resulting from its outsourced hospital audit function. The CPC has also reported recoveries of $9.35 million resulting from its separate in-house audits of inpatient hospital bills, for total recoveries of $12.85 million. These recoveries apply to claims from a four-year period, on claims of over $4.15 billion, or just .3% of total claims. Government and other health care professionals estimate the national average of the total improper health care outlay as high as 5%, or greater.

- The PBM did not bill for its services in accordance with contract terms. Plan staff failed to take timely action on the inappropriate billings even though the basis of some of the amounts billed was apparent on the PBM's billings. This situation

resulted in a $23 million overpayment by the Plan. Subsequent negotiations with the PBM have resulted in a payback plan scheduled to run until November 2005.

- A special required audit from the PBM was not received by the Plan until well after its usefulness for monitoring purposes had largely expired and after the Office of the State Auditor had made inquiries regarding its status. The PBM was required to obtain a special audit of its internal control as related to the Plan's operations.

Management has assigned monitoring duties and the responsibility for developing the monitoring procedures to its staff. Because the majority of the monitoring duties have been assigned to employees who have numerous other job responsibilities, many of the performance criteria may not be adequately monitored. Consequently, the Plan cannot ensure that its contractors will be in complete compliance with its contracts. Management has recently engaged the services of an outside health benefits consultant to monitor certain areas of one of the Plan's contracts. We believe management's use of outside professionals to assist the Plan has met with a degree of success.

Recommendation: Management should complete the process of developing monitoring procedures for all of the Plan's contracts. The written monitoring procedures should specify the content and degree of monitoring documentation required, should require that monitoring be performed on a current basis and continuously for the duration of the contract, and should require that all performance criteria of the various contracts be addressed and sufficient information as to contractor compliance be obtained. This monitoring information should be used not only to judge the degree of contractor compliance, but it should also be used by the Plan to help assess whether the inclusion of specific contract requirements is cost beneficial.

Hospital bill audit overpayment recoveries should be supported by adequate documentation, including its source and deposit to the Plan's account. In order to improve collection results, the Plan should assume direct responsibility for the hospital bill audit function. The Plan should either perform the audits itself or contract them.

The Plan should further investigate the use of outside professional help to assist it in the monitoring of its contracts.

Agency Response: The Plan continues to improve its contract monitoring functions, with emphasis on assessment of specific performance criteria for each vendor. Appropriate Plan staff and outside professional consultants have been assigned monitoring

responsibilities for each contract. Three additional staff are being hired with responsibilities for (1) policies and procedures, (2) planning, and (3) health education and disease management programs, all of whom will have additional contract management duties.

With regard to the specific deficiencies noted in the finding:

1.) Hospital Bill Audits: The Plan will require appropriate reporting from the CPC regarding the two outsourced auditing functions. The Plan is also seeking a change in the payment method for the two independent contractors to a "percent of recovery" incentive basis. The CPC reports that the previous Executive Administrator would not agree to a shared savings reimbursement formula such as that used by BCBSNC for its own claims under the same contracts. The Plan believes that: (1) there is evidence that the Plan was consulted during the contracting process; and (2) the reimbursement structure is a possible explanation for the recovery results being lower than the Auditors' expectations, due to a lack of incentive and the cessation of bill auditing processes when the quarterly spending limits were reached.

    As discussed with the Auditors on numerous occasions, the Plan has concentrated its bill auditing efforts on the APDRG-based hospital inpatient claims, directing a program which has recovered two and two-thirds times the refunds from the outsourced bill audit functions. Additionally, the Plan has now contracted with a Credit Balance Recovery Vendor (AIM) on a shared savings basis. This contractor has begun inspecting hospital patient accounts on site, and collecting overpayments on behalf of the Plan.

2.) PBM Overbilling: The Plan's previous independent claims auditing firm was slow to report the overbilling and to raise the appropriate level of alarm. When the Executive Administrator was presented the facts of the improper billings, he negotiated a reparations plan with the PBM. This repayment has taken the form of a contract amendment which was approved by the Board of Trustees and the Legislative oversight committee. The PBM is now being monitored by Plan staff, the Plan's actuarial consulting firm, and the Plan's new independent claims auditing firm.

3.) Copy of PBM's Audit: The Plan did everything in its power to obtain the PBM's SAS-70 audit, including giving notice of contract termination for noncompliance. The PBM stated the audit was delayed due to integration of systems functions related to its corporate merger and other factors beyond its control.

The Plan agrees with the Auditors' recommendations regarding the development of monitoring procedures for all of the Plan's contracts and the expanded use of outside professional consultants to evaluate the contractual performance standards. However, the Plan disagrees with the recommendation to assume direct operation of the hospital bill

audit functions. This bill auditing is a required service of the CPC and would require numerous additional Plan accounting staff hours. The additional review of the collection and posting of refunds, however, is a necessary auditing task, which the Plan believes should be performed by either the Plan's independent claims auditors as a special project or by the State Auditors on site at the BCBSNC accounting offices.

3. Fees Were Not Adjusted For Reduced Services

The Plan did not seek nor receive a reduction in the fee structure paid the CPC when the Plan removed the drug claims processing function from the CPC and contracted it to a pharmacy benefit manager. The Plan's rationale for not requesting a reduction in the monthly processing fees paid the CPC for this reduction of services was based on the factors described below:

- The Plan cited certain system design changes the CPC had to implement to enable the CPC to receive claims tapes from the PBM as one reason not to seek a reduction in the fee structure. This one-time implementation effort, however, was already compensated for by the Plan by the payment to the CPC of an implementation fee of approximately $1 million.

- A second reason cited by the Plan for not seeking a reduction was acceptance of the CPC's argument that the CPC "did not have high staffing levels on pharmacy before the change." The Plan noted that over 95% of the pharmacy claims were being submitted electronically and that the CPC did not have a reduction in staff because of the change. We disagree with what seems to be the core of the Plan's argument: there are no costs associated with electronic processing of claims. Additionally, we assume there were some costs associated with the claims that were not processed electronically and that, at a minimum, there should have been some recovery of fees made for this.

- The third reason cited by the Plan not to seek a reduction in the rate was acceptance of the CPC's argument that the CPC lost about $150,000 in revenue from the formulary rebate program when the Plan began using the PBM. We believe that concern for the CPC's loss of revenue was inappropriate. The contract between the CPC and the Plan neither provided for nor obligated the Plan to reimburse the CPC for loss of this revenue.

Historically, whenever the Plan required changes to the health plan, the CPC sought and received additional compensation not only for implementation of the changes, but also for the ongoing costs associated with the changes. We believe the addition of responsibilities is a justification for increasing fees; conversely, fairness dictates the reduction of fees when responsibilities are eliminated or reduced. The Plan failed to seek such a reduction.

Recommendation: The Plan should work for and require a reduction of fees paid contractors whenever contracted services are reduced or eliminated.

Agency Response: The Plan does not agree with the auditor's conclusions.

The CPC had been receiving 2% of pharmacy rebates (See Attachment II). [The Plan should be contacted for a copy of the referenced attachment.] With the installation of the pharmacy benefit manager (PBM), AdvancePCS, all of the rebates now go to the Plan. The CPC now receives no rebate income. The CPC had been receiving approximately $150,000 per year in rebate funds.

Despite the transfer of the pharmacy claims processing function (which is nearly all automated), the CPC still provides customer service for members calling the CPC with pharmacy questions. Although the more complicated calls are referred to the PBM, CPC customer service time is also utilized. The CPC is handling approximately 4,000 pharmacy calls per month which is equivalent to 2 FTEs. Also, the medical director for the CPC assists in the administration of the Pharmacy and Therapeutics Committee meetings and medical policies associated with that activity. That time is equivalent to 0.09 FTEs. The CPC had been paid in amendment two for claims history corrections for returned scripts (0.03 FTEs). In addition, the CPC assists the PBM in handling "real time" membership changes (one FTE which was part of amendment Number 2-Delayed Hiring) and the CPC now employs one claims person to manually correct claims history resulting from the increased volume of returned scripts. The leased phone line cost of $41,349 (includes indirect cost) was eliminated when AdvancePCS became the PBM as was provider education ($27,311) and production system reports ($40,243). The cost to coordinate the PBM activity and assist in administration of the P&T Committee is approximately $175,000 ($190,326-$364,985) more than the CPC receives from amendment number two. (See Attachment III) [The Plan should be contacted for a copy of the referenced attachment.] Therefore, it is the Plan's opinion that the transfer of the pharmacy claims processing without a change in reimbursement was a fair exchange.

4. THE PROMOTION OF MAIL ORDERED PRESCRIPTIONS HAS BEEN LIMITED

The Plan has not realized certain available savings because it has not actively promoted and achieved the increased use of its mail order prescription service. As of October 2002, the total number of mail order prescriptions for the calendar year 2002 was only about 7,000. Currently, the efforts to inform the membership of this service have been limited to an order form included with the insurance card and information on the Plan's website.

We estimate that annual savings of $1.5 million could be realized if only 10% of the Plan's four million maintenance prescriptions were processed using its mail order prescription service. (Maintenance prescriptions are prescriptions for medications taken over extended periods, generally requiring multiple refills, and are most likely to benefit from the Plan's mail order prescription service.) The Plan saves about 7% of the cost of

the prescription plus the $1.50 dispensing fee when the mail order service is used. The following table displays the savings possible at various levels of participation.

Potential Savings Using Mail Order Prescription Service					
(a)	(b)	(c)	(d)	(e)	(f)
Number of maintenance prescriptions	Percentage of mail ordered maintenance prescriptions	Dispensing fee saved (a)x(b)x(g)	Percentage difference in mail order cost and pharmacy cost	Ingredient cost savings (a)x(b)x(d)x (h)x(i)	Total annual savings (c)+(e)
4,000,000	5%	$300,000	7%	$466,620	$ 766,620
4,000,000	7%	$420,000	7%	$653,268	$1,073,268
4,000,000	10%	$600,000	7%	$933,240	$1,533,240
(g) Dispensing fee			$ 1.50		
(h) Average cost of drugs to the Plan			$50.00		
(i) Percentage of non-generic drugs ordered Note: No ingredient cost savings on generic drugs			66%		
Source: State Health Plan Office					

Management states the reason the mail order prescription service has not been promoted more actively is that the staff's time has been consumed with other efforts to save funds such as developing contracts with hospitals and physicians.

Recommendation: The Plan should include in its cost-cutting plans a strategy to promote the mail order prescription service to its members. Because they are closely associated with members of the Plan, organizations representing active and retired state employees and teachers should be included in the promotion process.

Agency Response: The Plan will present the findings and recommendation to the Board of Trustees and the legislative Committee on Employee Hospital and Medical Benefits for their evaluation and recommendations.

5. INADEQUATE CONTROLS OVER THE PROCESSING OF FINANCIAL TRANSACTIONS

The Plan's accounting procedures and internal control and the system of physically maintaining accounting records are inadequate to govern the level of financial activity conducted by the Plan. With in excess of $1.2 billion in transactions being processed

annually by the Plan, failure to establish and to adhere to a good system of internal control, to follow sound accounting practices and to properly store and maintain accounting records increases the risk of loss of critical accounting data and the risk of misappropriation of funds. The results of our tests uncovered many errors and omissions as follows:

- The Plan's financial statements contained errors caused by the failure to reverse the prior year claims liability accrual, record the current year Health Choice accounts receivable accrual entry, reconcile material accounts to the year-end financial statement balances, or to reconcile general ledger balances to the monthly summary spreadsheets provided by the Plan's CPC.

- Payments to the Plan's CPC, the largest category of administrative expense of the Plan, representing $26.3 million, or 91% of total administrative costs of the Plan, were not reviewed and approved prior to payment. This failure to verify billings resulted in incorrect payments being made on at least four occasions.

- Many expenditure vouchers tested by us were not adequately supported, were not reviewed or approved by an authorized official, were paid from copies of invoices rather than from the original invoices, or were not cancelled or defaced to prevent duplicate payment.

Adding further strain on the Plan's control environment was the Plan's failure to maintain a good back office system of physically maintaining and keeping current the accounting records and related documents. The Plan's accounting records were not maintained in an orderly manner and often were incomplete. Many accounting records were not filed or were piled on the floor in the accounting office. Oftentimes, it was difficult to find requested information, took an inordinate amount of time to locate, or was never located. In some cases, related documentation was not filed together but dispersed in numerous locations. Although not as extensive, we noted similar problems with the Plan's personnel records and contract files.

Recommendation: Management should review and revise its internal control policies and procedures governing the processing of financial transactions. The Plan should record all required financial transactions to ensure the integrity of the financial statements. Accounts should be reconciled to year-end financial statement balances and supporting worksheets. All payments should be properly supported, and reviewed and approved by authorized officials. Documentation should be cancelled or defaced to prevent duplicate payment. Management should ensure that records are well organized and filed in an orderly manner.

Agency Response: In response to the first statement that the Plan's financial statements contained errors caused by the failure to reverse the prior year claims liability accrual, record the current year Health Choice accounts receivable accrual entry, reconcile

material accounts to the year-end financial statement balances, or to reconcile general ledger balances to the monthly summary spreadsheets provided by the Plan's CPC:

> Last year was the first year that the Plan's Chief Financial Officer had completed a CAFR package. The Chief Financial Officer relied on information from OSC. Because of lack of experience, the Chief Financial Officer did not accurately make all of the required entries. However, with respect to some entries for Health Choice, the Chief Financial Officer was informed that DHHS was responsible for making those entries.
>
> With respect to the current Fiscal Year, the Chief Financial Officer has received additional training and expects to complete the statements as error-free as possible.

In response to the payments to the Plan's CPC, and the failure to verify billings which resulted in incorrect payments being made on at least four occasions:

> Because of staff turnover, the Chief Financial Officer did not fully understand the billing process and contractual terms of the CPC agreement. The errors have been corrected and future invoices will be checked thoroughly.

In response to the item that stated that many expenditure vouchers tested by us were not adequately supported, were not reviewed or approved by an authorized official, were paid from copies of invoices rather than from the original invoices, or were not cancelled or defaced to prevent duplicate payment:

> At the time of the audit, the Chief Financial Officer was still learning the filing process of the previous Chief Financial Officer. Because of the difficulty in locating supporting documentation filed by the previous Chief Financial Officer, this has lead the auditor to believe that documentation was incomplete.
>
> Since the time of the audit, the Plan has added accounting support staff. This addition should insure that all invoices are checked for accuracy and any backup documentation is reviewed prior to payment. All invoices are approved for payment prior to being paid. Also, all invoices are stamped paid after the checks are printed. There are times when an invoice is faxed to this office for payment. Generally it is for a payment that had not been paid and the original invoice was never received in this office. All such faxed copies are completely researched to make sure that it is not a duplicate request that has already been paid prior to cutting the check.
>
> The Plan has also acquired additional file cabinets, reassigned verification and certification tasks, caught up on its backlog of filing, and ordered "Void" stamps to prevent duplicate payment opportunities.

In response to the statement that related documentation was not filed together but dispersed in numerous locations:

In accordance with HIPAA's "minimum necessary" concept per access to protected health information, the patient identifying backup materials for each invoice will be retained by the appropriate Plan program monitoring staff and not filed in the accounting area.

6. THE PLAN LACKS CLEARLY WRITTEN, SPECIFIC POLICIES AND PROCEDURES

The Plan's policies and procedures manual is deficient and lacks many details. The lack of a complete set of written policies and procedures subjects the Plan to unwarranted risk of errors and omission occurring in the Plan's operations, accounting system, and internal controls.

The Plan maintains an index of forty-five policies and procedures. Review of the policies and procedure manual, however, revealed that only twelve have been formulated and are in effect. Of the twelve policies, eight lack the details that are necessary for daily operations. In addition, the manual does not address critical performance and operational functions, such as contractual services, file maintenance, monitoring, and daily deposits. This document does not contain the level of detail necessary to function as an effective internal policies and procedures manual. Such policies and procedures are especially important now due to the very high employee turnover recently experienced by the Plan. Before the completion of the audit fieldwork, management began the process of updating the policies and procedures manual.

Recommendation: Management should continue to develop a comprehensive internal policies and procedures manual addressing the daily operational issues of the office. The manual should contain clearly stated policies and the specific steps or procedures required to comply with each policy. A system for distributing and updating the manual should also be implemented to provide staff with current guidance for efficient operations.

Agency Response: The Plan will contract with a vendor to prepare a Policies and Procedures Manual and hire a new employee, one duty of which is to maintain this manual.

7. THE PLAN'S CONTROL ENVIRONMENT DOES NOT MAXIMIZE ACCOUNTABILITY

The Plan lacks a formal evaluation process for the performance of the Executive Administrator. The Administrator's performance in managing the health plan, one that received $1.2 billion in employer and member contributions in fiscal year 2001-2002 is not formally evaluated and does not require concurrence from any person or group.

The Executive Administrator is responsible for the daily operations of the Plan, which include contract negotiations, claims payments, cost management programs, illness prevention programs, office administration, and long-range planning. As defined by

General Statute 135, the Executive Administrator is appointed and can be removed by the Commissioner of Insurance (Commissioner) upon the advice of the Committee on Employee Hospital and Medical Benefits (Committee), a committee composed of members of the General Assembly. After the initial hiring, the Commissioner is not involved in the Plan's administration in any manner.

Along with advising the Commissioner on the hiring of the Executive Administrator, the Committee acts in a consultative capacity to the Executive Administrator on specific contracts. However, the authority for contract approval is with the Executive Administrator only. Although General Statute 135 states that the Committee shall not meet less than once each quarter to review the actions of the Executive Administrator and the Board of Trustees, records indicate the Committee only met formally twice in Year 2000, 8 times in 2001, and as of October, 2002 only twice. The sporadic meeting schedule, along with limited statutory requirements and the workload of the legislators, does not promote continuous oversight.

Besides the Commissioner of Insurance and the Committee, a third group having some responsibilities in the affairs of the Plan is the Plan's Board of Trustees. However, as with the other groups, the Board of Trustees, acts in a consultative capacity to the Executive Administrator. Due to a lack of authority, the Board's involvement with operational or administrative issues is limited to advisory only. An example of its limited involvement was reflected in interviews with individual board members. When questioned about the causes for the $23 million in overpayments that the Plan made to one vendor, the members' answers lacked detail and were similar to information contained in the news media.

Recommendation: A formal evaluation process for the performance of the Executive Administrator should be implemented. The General Assembly should review the oversight structure of the State Health Plan, including the duties and responsibilities of the Insurance Commissioner, Committee on Employee Hospital and Medical Benefits, and the Board of Trustees.

Agency Response: The Plan will present the findings and recommendation to the Board of Trustees and the legislative Committee on Employee Hospital and Medical Benefits for their evaluation and recommendations.

8. THE PLAN HAS NO FORMAL LONG-RANGE PLAN

The Plan does not have a formal written long-range plan. Without a formal documented plan, it is difficult to determine the Plan's goals and to track progress with them. General Statute 135-39.4A(g)(5) states that the Executive Administrator is responsible for long-range planning. The Executive Administrator stated that he has long-range plans and shares them with the Board of Trustees and the Committee on Employee Hospital and Medical Benefits on an informal basis.

Recommendation: The Executive Administrator should develop a formal long-range plan for the State Health Plan and present the plan and revisions to the Board of Trustees and the Committee on Employee Hospital and Medical Benefits on a regular basis.

Agency Response: The Plan will present the findings and recommendation to the Board of Trustees and the legislative Committee on Employee Hospital and Medical Benefits for their evaluation and recommendations. The Plan has posted a position, one duty of which is to coordinate long range planning. A draft of the long-range plan will be presented at the June Board meeting.

9. THE PLAN IS NOT IN COMPLIANCE WITH STATE PERSONNEL REGULATIONS

The Plan is not in compliance with State personnel regulations on employee evaluations and criteria related to the selection of new employees. As part of our review of the Plan's compliance with personnel regulations, we found three Office of State Personnel (OSP) requirements that have not been implemented:

- The Plan has not included any of the six required components into its Performance Management System policy. These components are:
  - The key elements of a performance management system;
  - Instructions about how the system will operate using the three-part performance management process;
  - A provision requiring that one of the responsibilities included in each supervisor's and manager's work plan is managing the performance of subordinate employees in accordance with the agency's performance management policy and procedures;
  - Sanctions to be levied by the agency head if all provisions are not met;
  - Relationships of performance management to other human resource systems; and
  - Responsibilities/roles of employees, the supervisor, the supervisor's manager, top management, and agency personnel.
- The requirement to perform employee performance evaluations has not been fully implemented. Two of the five personnel records reviewed were missing one or more annual employee performance evaluations. One of the employees, employed since 1988, had no performance evaluations on file. Management stated that recent staff turnover was the reason for missing evaluations.
- OSP regulations regarding the selection of applicants are not being followed. A review of files of two recently posted positions for an accountant and a program services specialist did not contain formal written criteria or a ranking of applicants.

- We could not find any documentation detailing the selection criteria used to choose the employees. Management stated that applicants were evaluated, but a more informal approach was used.

Without an adequate agency performance management policy, there is an increased risk that employees will fail to comply with the requirements of the system. Performance appraisal information is one of several considerations in making other personnel decisions such as promotions, performance-based disciplinary actions, performance salary increase, and reductions in force. If an agency does not follow the OSP policy regarding evaluations, needed information will not be available when making other personnel decisions. Due to the lack of formal written criteria and ranking of applicants, the Plan does not have documentation to support its decision if a non-selected candidate contests the selection decision.

Recommendation: Management should update its performance management policy to include the required components and should adhere to OSP requirements related to the annual evaluation of employees. Management should develop and implement formal written criteria for evaluation and selection of applicants.

Agency Response: The person hired to maintain the Policies and Procedures Manual will also have responsibility for compliance and oversight of the State Personnel regulations.

10. REQUIRED DEBARMENT CERTIFICATIONS WERE NOT OBTAINED

The Plan did not obtain a certification regarding debarment and suspension from its contractors receiving awards greater than $100,000. Of the five contracts examined, one was for an award greater than $100,000.

Individuals or organizations convicted of fraud or found in violation of government contracts or federal laws may be prohibited by the federal government from contracting for or receiving awards from federal funds. Federal regulation 45 CFR 76.510(b) requires a certification regarding debarment and suspension to be filed for covered transactions.

Recommendation: The Plan should obtain the required certifications from its contractors as part of the standard procurement process.

Agency Response: In response to the Plan not obtaining a certification regarding debarment and suspension from its NC HealthChoice contractors receiving awards greater than $100,000 for one of its contracts:

> The Plan agrees with that finding. Since that finding, the Plan has obtained the certification. In the future, all NC HealthChoice contracted vendors whose volume exceeds $100,000 will be checked by Accounting staff for this certification. Also the Plan's attorney will be instructed to add this requirement to all future NC HealthChoice contracts.

DISTRIBUTION OF AUDIT RESULTS

In accordance with General Statutes 147-64.5 and 147-64.6(c)(14), copies of this report have been distributed to the public officials listed below. Additional copies are provided to other legislators, state officials, the press, and the general public upon request.

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The Honorable Richard H. Moore	State Treasurer
The Honorable Roy A. Cooper, III	Attorney General
Mr. David T. McCoy	State Budget Officer
Mr. Robert L. Powell	State Controller
Dr. Jack Walker	Executive Administrator, North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan

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May 22, 2003

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