STATE OF NORTH CAROLINA

AUDIT RESULTS FROM

CAFR AND SINGLE AUDIT PROCEDURES

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

FOR THE YEAR ENDED JUNE 30, 2003

OFFICE OF THE STATE AUDITOR

RALPH CAMPBELL, JR.

STATE AUDITOR

TABLE OF CONTENTS

EXECUTIVE SUMMARY

Audit Results from CAFR and Single Audit Procedures

North Carolina Department of Health and Human Services

June 30, 2003

North Carolina annually spends nearly 25 percent of its budget on expenses related to health care, much of it in the Department of Health and Human Services. That department also receives more federal funds than any other State agency.

This report, which also is incorporated in the annual Single Audit Report, includes audits performed by the Office of the State Auditor in eight of the Department's divisions. The Single Audit is performed by State auditors on behalf of the federal government to ensure that federal funds sent to North Carolina are spent in compliance with regulations.

This report questions $414 million in federal funds spent by the Department of Health and Human Services in the fiscal year that ended June 30, 2003. State funds associated with those questioned expenditures amount to $246 million. This information has been forwarded to federal officials who will decide how much, if any, of those questioned federal funds must be repaid by the Department.

The largest single area of questioned costs came in the Division of Medical Assistance, which administers the Medicaid program. This program provides health care for 1.4 million citizens of North Carolina, most of them children.

While the Office of the State Auditor annually audits Medicaid claims as part of the Single Audit, auditors this year also looked at the Disproportionate Share Hospital (DSH) and Supplemental payments program. That program, which represents 5 percent of all Medicaid spending, reimburses hospitals that treat unusually large numbers of poor patients for the hospitals' unreimbursed/uninsured costs.

Auditors found that the Division ceded control of this reimbursement program to the largest Medicaid hospital provider in the State and its legal adviser. Carolinas Medical Center and its attorney exercised substantial operational control over the DSH program from 1997 until this audit without Division internal controls to ensure that the DSH payments complied with State and federal regulations.

The Division also made DSH payments to an association of 41 public hospitals in North Carolina without a contract, and in apparent violation of federal regulations that require payments be made directly to providers. The association then distributed the DSH funds to its members after deducting legal, banking, and other fees.

The Division also used outdated data to calculate DSH and other payments to hospitals, made payments to hospitals that Division employees had ruled ineligible for the funding, and failed

to collect information on hospital ownership and controlling interests, third-party arrangements and criminal convictions. Also, the Division failed to verify with appropriate licensing organizations and boards that provider licenses were valid.

Many of the errors that led to the overpayment of hospitals could have been corrected had the Division complied with regulations that require cost-settlements within 12 months after receiving a completed cost report. But the Division has not performed final cost-settlements for DSH payments to hospitals since 1996.

Cost settlements compare the estimated costs used to make payments to hospitals with the actual costs those hospitals incurred. Where payments exceed actual costs, as can happen when payment formulas use outdated or incorrect data, the hospitals are required to refund overpayments.

The control environment for financial operations within the Division both before and during the year under audit was seriously deficient. Most troubling was the Division's willingness to violate rules and regulations, even when Division management was aware that its actions were prohibited. While the Department has taken steps to correct the deficiencies, more is needed.

The Division should continue its efforts to regain control of the DSH program and must conduct all business with hospital providers at arm's length to ensure the reimbursement process is fair to all Medicaid providers.

In other divisions, the Office of the State Auditor found many areas of concern to include:

- The Division of Social Services failed to correct problems discovered in the prior year's audit concerning the Child Support Enforcement Program. Those problems included failing to establish paternity within the required time and failing to take timely enforcement action.

- The Social Services Block Grant Program was not adequately monitored, another finding from the previous year.

- Basic support claims were not properly paid in the Rehabilitation Services-Vocational Rehabilitation Grants to States program.

- Foster care facility payment rates were inaccurate.

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

April 12, 2004

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 *Single Audit Report* for the year ended June 30, 2003. Our audit was performed by authority of Article 5A of Chapter 147 of the *North Carolina General Statutes.*

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

The accounts and operations of the North Carolina 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. Our 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 applicable. Our audit scope at the North Carolina Department of Health and Human Services included the following:

Audit Scope for the *Comprehensive Annual Financial Report*

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

Audit Scope 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

Immunization Grants

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

Our audit procedures at the North Carolina Department of Health and Human Services were 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 Statues require the State Auditor to provide the Governor, the Attorney General, and other appropriate officials with written notice of apparent instances of violations of penal statutes or apparent instances of malfeasance, misfeasance, or nonfeasance by an officer or employee. In accordance with that mandate, and our standard operating practice, we are providing copies of this report to the Governor, the Attorney General and other appropriate officials.

Ralph Campbell, Jr.
State Auditor

AUDIT FINDINGS AND RECOMMENDATIONS

Matters Related to Financial Reporting or Federal Compliance Objectives

The following findings and recommendations were identified during the current audit and describe conditions that represent significant deficiencies in internal control or noncompliance with laws, regulations, contracts, or grants.

DIVISION OF MEDICAL ASSISTANCE

1. FINAL COST-SETTLEMENTS NOT PERFORMED

The Division of Medical Assistance has not performed final cost-settlements for Disproportionate Share Hospital (DSH) payments to State-owned and non-State owned hospitals since 1996. The State made payments to hospitals on a prospective basis from 1997-2002 as required by the North Carolina Medicaid State Plan, but did not have controls in place to ensure that timely cost settlements were performed. It is estimated that approximately $2.5 billion of payments to hospitals have not been cost-settled. The failure to complete the cost settlements means the State does not know whether the payments made by the State exceeded the total costs of providing inpatient and outpatient services to Medicaid and uninsured patients. The Disproportionate Share Hospital program is a program designed to provide additional payments to hospitals that serve a large number of Medicaid recipients and uninsured patients.

The State Plan requires that estimated DSH payments not exceed the State aggregate upper payment limit (cost of care). In order to meet this requirement, the State Plan provides that estimated DSH payments will be adjusted or cost settled within 12 months of receipt of the completed cost report. In addition, the State Plan states that hospitals that receive payments in excess of their limits shall promptly refund such overpayments.

Recommendation: Division management should establish and maintain an internal control system designed to reasonably ensure compliance with federal laws, regulations, and the Medicaid State Plan. Division management should expedite the DSH cost settlements with all hospital providers and should comply with the requirement that cost settlements be performed within twelve months of receipt of completed cost reports.

Agency Response: There are complicated and technical legal issues involved in this finding that must not be minimalized. They include questions such as which cost-to-charge ratios may be used to convert hospital uninsured charges to costs, whether federal law in effect during the periods in question required that non-DSH Medicaid payments be applied to offset unreimbursed costs of serving the uninsured, and what is required by ambiguous Medicaid State Plan language -- issues whose resolution will substantially affect the bottom line of each individual hospital cost settlement.

While there are federal law and State plan interpretation issues that remain to be resolved, Division management is confident that there has been no failure to comply with any clear requirement of federal law in the implementation of North Carolina's DSH payment program. And finally and most importantly, the Division has developed and will soon propose amendments to its DSH program to make the payments entirely prospective, thus eliminating the need for cost settlement in the future.

Division management will continue to work assiduously to resolve these issues, but cannot control or predict the time that will be required for their resolution, since management must await input and work cooperatively with CMS. Because of the substantial dollar amounts at issue, observance of an arbitrary deadline for resolving these issues would not serve the public interest and could adversely affect health care delivery in the State.

2. THE DIVISION CEDED CONTROL OF THE DSH AND SUPPLEMENTAL PAYMENT PROGRAM WHICH CREATED A CONFLICT OF INTEREST

The Division of Medical Assistance management created a conflict of interest when it surrendered administrative and financial control of the Medicaid DSH and Supplemental payment program (a program to compensate hospitals for the higher operating costs incurred in treating a large share of low-income and uninsured patients), also known as the Medicaid Reimbursement Initiative (MRI) program, to the largest Medicaid hospital provider and its legal representative. Since 1997, management allowed Carolinas Medical Center and an attorney representing Carolinas Medical Center and a group of hospital providers to exercise substantial operational control over the MRI program but failed to establish and maintain internal control designed to reasonably ensure the program complied with federal and State laws, regulations, and the Medicaid State Plan.

- The Division allowed Carolinas Medical Center to design, calculate, analyze, and gather the cost data to prepare the payment plan used as the basis for the MRI payments that Carolinas Medical Center, as well as all other hospitals, would receive. The Division failed to verify the accuracy of the data used or the calculations made by Carolinas Medical Center in determining MRI payment amounts and merely accepted the figures as presented by Carolinas Medical Center. As a result, any final DSH payment approval made by the Division of Medical Assistance was merely a formality.

- The Division failed to establish processes and procedures to validate the self-reported hospital cost data used to calculate the MRI payments. The Division does not require hospitals to provide it documentation in support of the hospitals' Uncompensated Costs of Care (UCC) amounts. Hospitals are not required to certify the accuracy of these charges.

- For the period 1997-2002, Carolinas Medical Center and the legal representative received legal and other administrative fees of $1.6 million based on a percentage of the total DSH and Supplemental payments paid to all hospitals. The Division allowed Carolinas Medical Center to deduct these unsupported and self-determined legal and administrative fees. Division management knew or should have known the legal and administrative fees were being paid and did not question these fees even though they were evident on the face of the payment document submitted to and approved for payment by the Medicaid Director. OMB Circular A-87 requires that for costs to be allowable they must be necessary and reasonable for proper and efficient administration of the grant program. The federal portion of the legal and administrative fees paid is $1 million and is questioned.

- The Division allowed Carolinas Medical Center and its legal representative to draft State Plan amendment proposals and changes in the North Carolina Administrative code as it related to Medicaid and to help the Division secure approval from the federal Center for Medicare and Medicaid Services of State Plan amendments authorizing supplemental DSH and DRG payments.

- Finally, the Division allowed Carolinas Medical Center and its legal representative to perform all of these functions even though the Division had no legal, contractual, or employer-employee relationship with them. In addition, we found little to no evidence that Division personnel monitored Carolinas Medical Center's activities.

The Division made net disbursements of $1.3 billion through the MRI program for the years 1997-2002, making payments to an average of 121 hospitals during this period. Carolinas Medical Center received a total of $231 million or 18% of the total. Carolinas Medical Center and five other hospitals represented by the attorney received $655 million or 48% of the total MRI payments for the years 1997-2002.

The Center for Medicare and Medicaid Services' State Medicaid Manual, section 2452, requires the Division of Medical Assistance to operate the Medicaid program in a manner that will prevent the use of public office to further private interests and to prevent private interests from influencing public officials in discharging their duties. Federal regulation 45 CFR 73.735-101 requires the Medicaid program to be operated effectively, objectively, and without improper influence or the appearance of improper influence.

Recommendation: Departmental records indicate the process of regaining control over the Medicaid DSH and Supplemental payment program began in January 2003 when a DSH oversight team was created and when in June 2003 the payment calculation process began in house and the June payment to hospitals was suspended. The Department should continue its efforts to regain direct and total control over MRI payments to hospitals. The Division should gather all the necessary data used to make the

calculations for the payments to the hospitals, should verify the accuracy of that data, and should prepare the MRI payment plan.

The Division should comply with the State Medicaid Manual and federal regulations that require that the Medicaid program be operated without improper influence or the appearance of improper influence. It should investigate and question any amounts that appear unusual and should require documentation for all expenditures. The Division should include a written conflict of interest policy in the Medicaid State Plan.

Agency Response: The Division's current management has already taken steps to make sure that the needed controls, including review and reconciliation of hospital cost data and oversight of payment calculations, are being implemented.

There is no basis for the report's suggestion that Medicaid providers may not assist the Division in developing State plan language and negotiating with CMS. As such, the Division cannot fairly be criticized for cooperating with, and seeking input from, public safety-net hospitals. These are the very institutions which serve a disproportionate number of low income and uninsured citizens, and that have also provided State match for enhanced Medicaid payments to assure that these reimbursement initiatives achieve their goals.

3. DIVISION OF MEDICAL ASSISTANCE DID NOT MAKE DIRECT PAYMENTS TO PROVIDERS

The Division of Medical Assistance made approximately $1.2 billion in Disproportionate Share Hospital (DSH) payments for the years 1997 through 2003 to an ineligible organization. The organization is identified as a "business agent" in an arrangement established by 41 public hospitals in the State as a mechanism to transfer DSH payments. The Division was not a party to this agreement and, more significantly, did not have a contract with this organization and therefore could not ensure that the Medicaid payments it made would be used, or otherwise satisfy its obligations, in accordance with federal and State rules and regulations.

Rather than making DSH payments directly to or under the control of Medicaid providers, the Division made the $1.2 billion in DSH payments to the ineligible organization in violation of federal anti-assignment regulations. Federal regulation 42 CFR 447.10(a) prohibits State payments for Medicaid services to anyone other than a provider or recipient, except in specified circumstances. OMB Circular A-87 requires that for costs to be allowable they must be necessary and reasonable for proper and efficient administration of the grant program.

Failure to make Medicaid payments directly to or under the control of Medicaid providers may result in an ineligible person or organization converting the payment to its own use and control without the payment first passing through the control of the provider eligible to receive the payment.

As an exception, federal regulation 42 CFR 447.10(f) allows payments to be made to a provider's business agent if payment is made "in the name of the provider." In the matter under discussion, the Division of Medical Assistance did not meet the tests of the exception.

- The 41 public hospitals, in an agreement among themselves, designated representatives of three hospitals (Carolinas Medical Center, New Hanover Regional Medical Center, Cape Fear Valley Health System) to function as the "Hospital Liaison Committee." The Committee established an escrow account at a bank with 41 sub-accounts, one for each hospital. The Division of Medical Assistance makes DSH payments to the escrow account for all 41 hospitals. Then, at instructions of the Committee, the payments are transferred into the sub accounts and subsequently back to the Division (approximately 90% of the original payments from the Division are transferred back to the Division) as an intergovernmental transfer. After banking, legal, and other fees are deducted, the Committee then distributes, by bank wire transfer, all remaining balances in each hospital's sub-account to each hospital's bank account as designated in writing by each hospital.

  The escrow agreement precludes provider control over the DSH payments. The Hospital Liaison Committee controls the escrow account and the sub-accounts, receives the DSH payments from the Division, authorizes transfers to and payment of fees from the sub-accounts, authorizes and determines the amounts of the transfers back to the Division, and finally authorizes the transfers to each individual hospital, at which point the hospitals have finally been allowed direct control over their funds. Since the providers do not control the payments, the escrow account or the sub-accounts, the DSH payments are not made in the name of the provider.

- The escrow agreement requires the Committee to collect from the sub-accounts legal and certain other fees and pay them to Carolinas Medical Center before the payment first passes through the control of the providers. As a result, the members of the Committee act on behalf of others who have a financial interest in how much is billed and collected. Since the Committee does not act solely on behalf of the individual providers, the payments made to Carolinas Medical Center are not made in the name of the provider.

Recommendation: In order to comply with regulations, the Division of Medical Assistance should:

- Cease acquiescing to the arrangement established by the hospitals.

- Regain direct control over the mechanism of transferring DSH payments to hospitals.

- Make all Medicaid DSH payments directly to Medicaid providers.

Agency Response: Division management strongly disagrees with the report's findings because federal law permits an arrangement under which a State Medicaid agency makes Medicaid payments by wiring or otherwise paying funds to a bank that the provider has designated to receive funds, even if thereafter the bank transfers the funds between accounts at the provider's direction or at the direction of another entity that the provider has designated to act for it. *See, e.g., Matter of Missionary Baptist Foundation of America*, Inc., 796 F.2d 752, 758-59 (5th Cir. 1986) (no violation of the anti-assignment provision where Medicaid revenues "were initially deposited in the [provider's] account in order to facilitate [its] bookkeeping procedures and then those monies immediately were removed by the bank and credited to the line of credit"). The escrow arrangement clearly did not involve any assignment of Medicaid claims or any factoring arrangement, the abuses that the relevant federal law specifically targets. *See Mack v. Sec'y of Dep't of HHS*, 1997 U.S. Claims LEXIS 57 (Ct. Fed. Cl. 1997) ("Congress only wished to obviate the 'factoring' of accounts received from Medicaid. Thus, federal regulations only prohibit financial middlemen who receive payment via the discounting of claims from receiving Medicaid funds"). Accordingly, the Division believes that the report's criticisms of the DSH payment arrangement utilized in past years are invalid.

Nevertheless, beginning with DSH payments made on March 18, 2004, for the quarters ending December 31, 2003 and March 31, 2004, the Division has ceased making DSH payments pursuant to the escrow arrangement. This change in practice already has obviated the report's recommendations that the Division cease acquiescing in the arrangement established by the hospitals, "regain direct control over the mechanism of DSH payments to hospitals," and make all Medicaid DSH payments directly to Medicaid providers. Accordingly, the final report should acknowledge that the Division has already taken steps to address and resolve the report's concerns.

4. UNREIMBURSED UNINSURED PATIENT COST OR "SUPER" DSH PAYMENTS WERE MADE TO INELIGIBLE HOSPITALS

Management of the Division of Medical Assistance made "super" DSH payments to hospitals that failed to meet the super DSH eligibility criteria of the Medicaid State Plan amendments for fiscal years 1997-2003. The failure by management to ensure compliance with the super DSH criteria contained in the amendments resulted in an estimated overpayment of $240 million (State funds of $89 million and federal share of $151 million) to ineligible hospitals for fiscal years 1997 through 2003. The federal portion of $151 million is questioned.

The State Plan limits super DSH payments to qualified public hospitals. A qualified public hospital, according to the language of the State Plan, is a hospital that, among other things, qualifies for disproportionate share status. The criteria to qualify as a disproportionate share hospital are outlined in paragraph (a) and subparagraphs (a)(1) through (5) of the Medicaid State Plan Attachment 4.19-A, a summary of which is reproduced below. Paragraph (a) and subparagraph (a)(1) are also federal criteria.

a. Hospitals that serve a disproportionate share of low-income patients and have a Medicaid inpatient utilization rate of not less than one percent (1%) are eligible to receive rate adjustments.

   1) The hospital has to have at least two obstetricians with staff privileges at the hospital that have agreed to provide obstetric services to individuals eligible for Medicaid; and

   2) The Medicaid inpatient utilization rate must be at least one standard deviation above the mean Medicaid inpatient utilization rate for all hospitals that receive Medicaid payments; or

   3) The low income utilization rates exceeds 25%; or

   4) The indigent care proportion exceeds 20%; or

   5) The hospital ranks among the top group that accounts for 50% of the total Medicaid patient days provided by hospitals in the State.

To be eligible for super DSH payments, a hospital must meet, at a minimum, the criteria contained in paragraph (a) and subparagraph (a)(1) plus the criteria in any one of the subparagraphs (a)(2) through (a)(5). The results of our tests provide numerous instances where management authorized super DSH payments to hospitals that did not meet the State Plan criteria.

a. In fiscal year 1997, fourteen hospitals failed to meet the minimum eligibility criteria. These ineligible hospitals received total super DSH payments of $31.4 million. In addition, two of these hospitals did not satisfy the federal guidelines; one hospital did not certify the obstetrical statement required by paragraph (a)(1), and the other hospital received $1.3 million without submitting its Disproportionate Share Worksheet that would have determined its qualification for both basic and super DSH payments.

b. In fiscal year 1998, thirteen hospitals did not meet the requirements for super DSH payments as stipulated by the State Plan. These ineligible hospitals received total super DSH payments of $21.2 million. Significant other non-compliance with the State Plan centered on three hospitals. The Division paid one of the hospitals $613,369 even though the hospital's CEO did not sign the worksheet while another received $761,668 for submitting a blank worksheet. Also, a hospital revised its worksheet in August 2003 for fiscal year 1998 that made it eligible for super DSH payments by 1/100th of a percent. Despite its CEO's failure to sign any of the eligibility forms, the Division paid the hospital $338,474.

c. In fiscal year 1999, the number of hospitals that failed to meet the eligibility criteria for super DSH payments increased to fifteen. The ineligible payments totaled $37.1 million. In addition, there were other issues with several hospitals.

The Division paid a hospital $662,654 even though the CEO did not sign the worksheet. Another hospital met the indigent care proportion criteria after revising its worksheet in August 2003 for fiscal year 1999 that changed the care percentage from 16% to 20.5%. However, the CEO of the hospital signed none of the forms submitted, yet the Division paid the hospital $589,819.

d. In fiscal year 2000, fourteen hospitals failed to meet the eligibility criteria contained in the State Plan. The ineligible payments totaled $39.6 million. There were several other issues related to these fourteen hospitals. The Division paid one hospital $428,326 even though the CEO did not sign the worksheet. The Division paid another hospital $688,704 even though it failed to meet the indigent care proportion criteria, even after revising its worksheet in August 2003 for the 2000 fiscal year. The CEO also signed none of the forms submitted by his hospital. Also, a hospital did not complete the worksheet and another did not submit a worksheet. The hospitals received super DSH payments of $1.1 million and $1.5 million, respectively.

e. In fiscal year 2001, fourteen hospitals did not comply with super DSH eligibility criteria in the State Plan. The Division made super DSH payments totaling $42.7 million to these ineligible hospitals. These payments were made even though the Division's own personnel documented that eight of the hospitals were "not qualified." In other issues, the CEOs of two hospitals did not sign the worksheets, yet the Division paid these hospitals a combined total of $3.5 million. Another hospital failed to meet the indigent care proportion criterion even after revising its worksheet in August 2003 for the 2001 fiscal year. The CEO of this hospital also failed to sign any of the forms submitted. The Division made a super DSH payment of $579,821 to the hospital.

f. In fiscal year 2002, our testing of super DSH payments showed that fourteen hospitals did not meet the eligibility criteria stipulated in the State Plan. The ineligible payments totaled $50.7 million. Additionally, the CEO of one these hospitals did not sign the worksheet, yet the Division paid the hospital $752,871. Two hospitals failed to complete their worksheets, but the Division paid one of them $1.2 million and the other $1.4 million. One hospital submitted a revised worksheet in August 2003 that was punctuated with questionable, potentially erroneous, information that was not resolved. For instance, its low-income utilization rate was 13-15% higher and its indigent care proportion rate was 10-11% higher than those respective rates were for all previous years. Although Division personnel flagged the questionable information as "need backup," there was no evidence indicating that the concerns of Division staff were satisfied. The hospital was paid $584,898.

g. In September 2003 (FY 2003), Division management continued to make super DSH payments to hospitals that did not meet the criteria documented in the State Plan. The Division made $17.2 million of super DSH payments to twelve

ineligible hospitals. Also, one hospital was paid $4.6 million despite failing to complete the worksheet.

There were other general issues and deficiencies that affected the conditions detailed above:

- Division management failed to implement a system to adequately validate the self-reported hospital cost data used to determine super DSH eligibility. The Division had custody of the hospital cost reports that supported the worksheets, but there was no evidence that Division personnel reconciled the amounts stated on the worksheets to the cost reports.

- Also, Division management could not provide any explanation how it calculated the standard deviation requirement in the State Plan for fiscal years 1997-2001. A review of the standard deviation calculation for fiscal year 2002 showed that it did not include the appropriate data from all hospitals nor was all the cost report data used in the calculation from year 2002.

- Most significantly, Division personnel commented on many of the worksheets submitted by the hospitals that the hospitals did not meet the super DSH criteria in the State Plan. Despite their comments, Division management made super DSH payments to ineligible hospitals.

Recommendation: Management should ensure compliance with the Medicaid State Plan by developing and implementing a sound internal control system. The control system should be designed to ensure that it safeguards State resources, complies with federal laws and regulations, and requires adequate documentation to support Medicaid disbursements.

Agency Response: The Division has complied with federal law and has been consistent in its administration of the DSH and Supplemental Payment program.

The Department provided the Office of the State Auditor with a memorandum from our legal counsel, Covington & Burling, which clearly establishes that the audit finding is invalid. Since the Auditor knowingly disregards our legal counsel, we reiterate points of that memorandum by offering the following legal analysis:

> *The State Plan plainly does not say that to be eligible for super DSH payments, a hospital "must meet, at a minimum, the criteria contained in paragraph (a) and subparagraph (a)(1) plus the criteria in any one of the subparagraphs (a)(2) through (5)," and it is a mistake to interpret the plan language in that way. In many places the State Plan language is, unfortunately, ambiguous and somewhat convoluted, and the true intent of several of its provisions can be understood only when read in the context of, and harmonized, with, the Plan as a whole. What is clear is that the report has misquoted the super DSH*

eligibility paragraph, paragraph (k), and that their interpretation of the paragraph is misguided and cannot be sustained.

By its literal terms, paragraph (k) authorizes super DSH payments for hospitals that qualify for DSH status "under Subparagraphs (a)(1) through (5) of this Plan." However, federal law (42 U.S.C. 1396r-4(d)) states generally that no hospital may be treated as a DSH hospital unless the hospital has "at least 2 obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to individuals who are entitled to medical assistance for such services under such State plan" and has a Medicaid inpatient utilization rate of at least 1 percent. When read literally, paragraph (k) purports to authorize super DSH payments for hospitals without regard to whether they meet the 1% Medicaid utilization test, which is not described in Subparagraphs (a)(1) through (5). Several other paragraphs of the Plan (paragraphs (j), (m), and (n)) also authorize categories of DSH for hospitals that qualify "under Subparagraphs (a)(1) through (5) of this Plan." Since a literal reading of paragraph (k) and these other DSH eligibility paragraphs of the Plan would mean that the federally- approved Plan does not comply with federal law, the literal reading cannot be correct.

Paragraph (k) and these other paragraphs make sense, and comply with federal law, when it is recognized that their references to hospitals that qualify under "under Subparagraphs (a)(1) through (5) of this Plan" are intended to be references to hospitals that qualify "under Paragraph (a) and subparagraph (a)(1) of this Plan." That is because Paragraph (a) contains the minimum 1 percent Medicaid utilization requirement and subparagraph (a)(1) described the two-obstetrician requirement of section 1396r-4(d). If the reference to "Subparagraphs (a)(1) through (5)" in super DSH paragraph (k) is read as a reference to "paragraph (a) and subparagraph (a)(1)," the result is that paragraph (k) does not limit eligibility for super DSH to public hospitals that meet one or more of the requirements of subparagraphs (a)(2) through (5). Instead, super DSH payments are for all non-State public hospitals that satisfy the 1 percent Medicaid utilization and two-obstetrician requirements of section 1396r-4(d) (as repeated in paragraph (a) and subparagraph (a)(1)).

That is precisely how the Division interpreted the Plan in practice. Under pertinent case law, because the Division's consistent administrative practice in interpreting its obviously-mistaken literal Plan language is a reasonable interpretation of the Plan language as a whole and because it harmonizes the approved Plan with the requirements of federal law, the Division's interpretation is entitled to deference. The report's interpretation (which, the Division acknowledges, is premised in part on erroneous interpretations by some former Division personnel) is mistaken, and the findings regarding super DSH overpayments should be deleted from the audit report.

Division management confirms that it has taken steps to assure that internal controls are strengthened and that a system is in place to validate hospitals' self-reported data. The Division does note that despite the documentation lapses described in the report, there is no valid basis for a finding that the Division made DSH payments to ineligible hospitals.

5. THE DIVISION MADE EXCESSIVE MEDICAID INPATIENT SUPPLEMENTAL PAYMENTS

The Division knowingly did not use the most recent inpatient payment data to calculate the Medicaid inpatient cost deficits for the years 2000-2002. The Division's failure to use the most recent, and available, Medicaid inpatient payment data resulted in an inflated statement of the Medicaid inpatient cost deficit, estimated at $345 million, and an overpayment estimated at $190 million (State funds of $71 million and the federal share of $119 million), for the years 2000 through 2002.

The Division makes Medicaid inpatient supplemental payments based on the estimated amount of hospital Medicaid inpatient cost deficits. Medicaid cost deficits are calculated by subtracting the Medicaid inpatient payments received by the hospital from the estimated hospital Medicaid inpatient costs. Medicaid inpatient payment data is obtained from the Division's claims processing contractor and Medicaid inpatient cost data is obtained from hospital Medicare and Medicaid cost reports.

For the periods from 2000 through the third quarter of 2002, Division management used the same 1999 Medicaid inpatient cost and payment data as a basis for calculating Medicaid inpatient cost deficits.

The 1999 Medicaid inpatient cost and payment data were used to estimate and calculate the Medicaid inpatient cost deficits for 2000, as required by the State Plan. However, because of certain changes in 2000, the Center for Medicare and Medicaid Services extended the due dates for filing the 2000 and 2001 cost reports. As a result, hospital cost reports for 2000 and 2001 were not available to the Division for making Medicaid inpatient cost estimates for 2001 and 2002.

Management has offered this occurrence as a reason for not using the most recent cost data to calculate the supplemental payments. However, the necessary inpatient cost data to make up-to-date current calculations for 2001 and 2002 were readily available from the hospitals' "schedule B" forms.

Additionally, current EDS paid claims data was available for use in making Medicaid inpatient payment estimates for 2001 and 2002. Contrary to the State Plan, management continued to use 1999 Medicaid inpatient payment data as a basis for calculating Medicaid inpatient cost deficits for 2001 through the third quarter of 2002. Management did not document the reason for choosing 1999 data as a base year to estimate the Medicaid inpatient payments for 2001 through the third quarter of 2002.

Management could not explain why current data was not used, but more significantly, could not explain why management knowingly used other data that was flawed, used inconsistent and unreasonable assumptions, permitted errors to occur, and allowed them to persist for two years.

- The 1999 EDS Medicaid inpatient payment data was flawed. The reason for the error was that EDS included Medicaid inpatient payments for the months of June, July, and August in the report for the fourth quarter of 1999 instead of the months of July, August, and September. This error caused Medicaid inpatient payment data to be understated by approximately $148 million in 1999.

- Simultaneous with using the flawed 1999 EDS Medicaid inpatient payment data, the adverse effect of which rippled through and increased in each succeeding year, management inflated the 1999 inpatient costs used in the calculation of the payments for the periods from 1999 through the third quarter of 2002. Management used "annual inflation factors" that were neither supported by documentation nor tied to any identified price index to adjust the unchanged 1999 inpatient costs upwards. The inflation rates ranged from 3.4% in 2000 to 7.9% in 2002. Also, instead of using the same inflation rate for all hospitals, management used different rates for the hospitals for each respective year without any documented explanation.

- Conversely, management did not inflate 1999 Medicaid inpatient payment data. As a result, the calculation of Medicaid inpatient cost deficits for 2000, 2001, and the first three quarters of 2002 were made based on the assumption that Medicaid inpatient costs had increased but that Medicaid inpatient payments to the hospitals had remained the same since 1999. This assumption was incorrect because Medicaid inpatient payments to the hospitals had increased every year as evidenced by reports from EDS and the Division's annual reports for 1999 through 2002. The Division's annual reports indicate that from 1999 to 2002, total Medicaid inpatient payments to the hospitals increased 26%, from $684 million to $863 million.

- A memo dated 7/9/02 from the Chief Financial Officer of Carolinas Medical Center, the State's largest qualified public hospital, to Division management indicates that management was aware that the use of the 1999 Medicaid inpatient payment data could result in overpayment of Medicaid supplemental payments. The memo reads in part, "Although we all knew using 99 cost deficits for the quarterly's (sic) posed some risk, the magnitude of the issue is much greater than any of us expected."

The failure to use correct and the latest available Medicaid inpatient payment data, or at least to inflate the 1999 payment data with a reasonable inflation factor, resulted in overestimates of the hospital Medicaid inpatient cost deficits and excessive Medicaid

inpatient supplemental payments to the hospitals. The federal share of the estimated overpayments of $119 million is questioned.

The Medicaid State Plan Amendments require that Medicaid inpatient supplemental payments be derived from costs incurred and payments received for Medicaid services as reported on the most recent cost reports and supplemented by additional financial information available to the Director.

Recommendation: Management should comply with the State Plan by using the most recent cost and payment data available. Additionally, management should institute an internal control system that ensures compliance with the State Plan. Management should also review and verify all hospital provider data used to calculate Medicaid supplemental payments and perform cost settlements in accordance with the State Plan. Identified overpayments should be requested and collected in a timely manner.

Agency Response: Division staff informed the auditors that there was a delay in availability of hospital cost reports for 2000 and 2001. The State Plan requires use of the most recent available hospital cost report data supplemented by additional financial information that is available "if and to the extent that the Director concludes that the additional financial information is reliable and relevant." Thus, while some more recent non-cost report data were available, the Division was not required to use them if they were not deemed reliable and did not represent best estimates of trends. In addition, while there were errors in the use of payment data, the results were both over and under-estimates of hospital Medicaid deficits. Moreover, in the aggregate, supplemental payments were well below the upper payment limit established by 42 CFR 447.272 and incorporated by reference in the Plan.

The Division has taken steps to implement these recommendations. We have also developed and will propose amendments to the Supplemental Program to make the payments entirely prospective, eliminating the need for cost settlement.

6. REQUIRED DISCLOSURES NOT OBTAINED AT ENROLLMENT OF PROVIDERS AND LACK OF CONTROLS IN THE PROVIDER ELIGIBILITY ENROLLMENT PROCESS

The Division of Medical Assistance failed to collect all required information from provider-applicants when they were enrolled into the Medicaid program and collected federal matching funds for these providers contrary to what is permitted in the regulations. The Division lacks the type of internal control policies and procedures needed to identify and exclude ineligible providers from participating in the Medicaid program.

Required Information Not Collected at Enrollment of Providers

We reviewed 62 different types of provider enrollment packages to determine whether the Division requested the required disclosures at enrollment of providers into the

Medicaid program. Each enrollment packet was tailored to the type of provider and various forms were included in each packet. The results of this test work revealed that not all disclosures required by 42 CFR 455.104 through .106 are being requested. The enrollment packages for 39 out of the 62 types of providers did not require the provider-applicant to disclose the name and address of each person who has ownership or controlling interest, or who is an agent or managing employee, of the provider or to disclose related party arrangements. These 39 types of providers were paid an estimated $3.86 billion this fiscal year, including matching federal funds, despite 42 CFR 455.104 which requires that a provider not be approved if the provider fails to disclose ownership and which states that federal match is not available for payments to providers that fail to disclose the required information.

System of Enrollment of Providers Has Design Flaws

A review of the Division's system for enrolling providers, which includes all providers other than practitioners, revealed several deficiencies. The Division:

- as previously discussed, failed to collect ownership and controlling interest information from provider-applicants. Additionally, it does not require providers to disclose related party arrangements and does not require that providers disclose whether they had ever been convicted of a criminal offense as required by 42 CFR 455, and does not require an application for enrollment into the program from all providers.

- does not require providers to periodically re-enroll in order to detect changes in eligibility status;

- requests a copy of the provider's license, but does not verify with the appropriate licensing organizations/boards that the license is valid; and

- does not conduct background checks on providers before admission to the program to ensure ineligible providers are not admitted.

Blue Cross and Blue Shield of North Carolina is responsible for the enrollment of practitioners as Medicaid providers for North Carolina. The Division has not conducted any monitoring of Blue Cross to ensure compliance with its contract and to ensure that the enrollment process Blue Cross uses complies with rules and regulations.

These inadequate controls increased the risk of improper payments to ineligible providers or payments not adequately documented or evidencing compliance with the regulations. For instance, in testing a sample of 30 provider files for required disclosures, our testing revealed 13 instances of provider eligibility errors that related to the lack of documentation:

- Eleven provider files lacked evidence of the disclosures required by 42 CFR 455 related to ownership and controlling interest and convictions for a criminal offense.

- One provider file did not have evidence of the required license for the applicable provider type.

- One provider application was processed without the provider's signature.

The lack of adequate internal control policies and procedures increases the risk that Medicaid funds will be inappropriately paid to unqualified or unscrupulous providers.

Recommendation: Management should consider a standard application to be completed by all providers to ensure that all of the disclosures required by 42 CFR 455 are provided. Additionally, management should consider other disclosure information that would provide a more complete history of the provider. For high-risk providers this may include more extensive application reviews and on-site visits.

Management should design and implement adequate internal controls to provide reasonable assurance ineligible medical providers are excluded from participation in the Medicaid program. This should include a review of the application and forms included in the provider enrollment packages. Management should re-enroll providers on a regularly scheduled basis, should perform criminal background checks for higher risk provider types, and should verify the validity of provider licenses.

Management should also monitor Blue Cross to ensure its compliance with required laws and regulations related to practitioner enrollment.

Agency Response: It is acknowledged that this situation has apparently existed for numerous years, and prior to this administration. This is, however, the first such finding to be issued by the State Auditor's office for the past 10 years.

In early SFY 2003-04, the Division of Medical Assistance (DMA) acted on initiatives by Division staff regarding greater controls in provider enrollment. DMA is in the final stages of refining the Participation Agreements and adopting, with modifications, the NC Department of Insurance Uniform Application. An implementation plan will be put into place after the documents are approved by the Attorney General's Office (AG), DMA Management Team and CMS. DMA will begin with new enrollments and then work towards re-enrollments for existing providers. This transition must also be coordinated with the new Fiscal Agent Contract that will be awarded for July 2005.

Many of the facilities DMA enrolls are licensed by other State Agencies. Ownership information is obtained during the licensure or approval process. DMA recognizes the need for consistency across all provider types. Additionally, DMA receives the Medicare Exclusion Database from the OIG and runs it against all providers enrolled in the program monthly to ensure that they are excluded from NC Medicaid as well.

DMA agrees that a standard application will ensure that all required conditions for participation in the Medicaid program are met. DMA will consider including additional disclosure information in the new application. It should be noted, however, that a majority of our providers also participate in the Medicare program and that Medicare certification is a requirement for 46% of those providers in the "disclosing entity" category. The Medicare application does require the providers to complete all of the information noted in the report's findings, so DMA does indirectly require disclosure for those.

DMA is uncertain as to the report's definition of "high-risk". There are providers, like Durable Medical Equipment (DME) and Personal Care Services (PCS) providers, which are operated by non-licensed individuals and so, in some ways, these providers might be high risk. We are considering requiring performance bonds for some of these providers, although analysis of providers with outstanding indebtedness to the program does not indicate that these providers are high-risk from a financial perspective. Once the new Application/Participation agreements are complete, DMA will determine (after consultation with the AG's office and other DMA areas) if performance bonds and other safeguards are appropriate.

DMA agrees that systematic re-enrollment of providers and verification of valid licenses is important. Once the new provider enrollment form is completed, a plan for re-enrolling all providers will be developed. This plan will be coordinated with the re-enrollment requirements of the new MMIS (currently scheduled to become operational in July 2005). While current laws require background checks on certain direct care workers, the laws do not prohibit administrators and owners with felony convictions from enrolling in the Medicaid program.

DMA agrees that monitoring of the BCBSNC contract is important. DMA is in the final stages of preparing a Request for Proposal (RFP) – which will be issued prior to June 30, 2004 for provider enrollment to upgrade the functions currently performed by BCBS to include provider credentialing for all professionally licensed provider types.

7. MEDICARE COSTS INAPPROPRIATELY INCLUDED IN MEDICAID COST DETERMINATION

The Division of Medical Assistance has failed to adjust Medicaid reimbursement payments to nursing facilities to exclude Medicare cost. Nursing facilities are incorrectly including Medicare costs when determining their average daily cost for Medicaid reimbursement. Based on an internal study by the Division on cost reports filed for the years 1998 and 1999, approximately $31 million of unallowable costs were included in the computation of Medicaid reimbursement payments to nursing facilities. No estimate is available for unallowable costs included in the Medicaid reimbursement calculation for the years after 1999.

Since costs are used to determine average daily cost rates, which are specific to each facility, the exact distribution and amount of over or under payments are not readily determinable.

OMB Circular A-87 states that for costs to be allowable under Federal awards, costs must not be included as a cost or used to meet cost sharing or matching requirements of any other Federal award in either the current or a prior period, except as specifically provided by Federal law or regulation.

Recommendation: Management should design and implement internal control policies and procedures to ensure that Medicare costs are not reimbursed, in whole or in part, by Medicaid payments.

Agency Response: DMA disagrees with the report's assertion that it has inappropriately included Medicare costs in its determination of average daily rates paid to long-term care Medicaid providers. Medicare costs are recognized and excluded from payments made to such providers when cost settlements are effected annually. This annual cost allocation and settlement process recognizes costs attributable to Medicare patients and excludes them by utilizing patient census and ancillary patient charges information according to payor type, including the Medicare payor type.

42 CFR Section 447.253 states that rates paid by the Medicaid agency for long term care services must be determined in accordance with methods and standards specified in an approved State plan.

8. FAILURE TO ADJUST INTERIM PAYMENT RATES USED TO CALCULATE PAYMENTS TO HOSPITALS

The Division of Medical Assistance failed to adjust interim payment rates for hospital outpatient costs as cost data was updated. Although more current data was available, the Division chose to make interim payments to hospitals for the years 2000-2003 using "costs-to-charge" ratios based on fiscal year 1994 Medicare cost report data. The effect is that hospitals have increased charges to Medicaid at a faster rate than their costs have increased, as documented by their cost reports, resulting in overpayments estimated by the Division to be $57 million for fiscal year 2000 alone. Because the actual costs-to-charge ratios have been decreasing since 1997, a conservative estimate of the total overpayments made to hospitals by the Division for the years 2000 through 2003 is $228 million. The federal portion of overpayments is approximately $143 million, while the State's portion is $85 million. The federal portion is questioned.

Although the costs are required to be cost settled (a process where the hospitals' actual costs are determined based on cost data submitted by them and reimbursements are made), the Division has failed to make timely cost settlements, being as late as three years after the end of the hospitals' fiscal year. For example, 1997 cost reports were settled in 2000 and 1998 cost reports were settled in 2001.

The State Plan, Attachment 4.19-B indicates that reasonable costs shall be obtained in accordance with the provisions of the Medicare Provider Reimbursement Manual. In Part I, Chapter 24 of this manual, it states that it is policy of the program that each provider's current interim rate of payment approximate as closely as possible the reimbursable cost the provider is currently incurring in furnishing covered services to program beneficiaries; that the program be properly responsive to actual changes in a provider's reimbursable cost; and that the provider's current interim rate be timely adjusted to bring it into line with estimated reimbursable costs for the period. Additionally, the State's Cash Management policy requires that monies due State agencies be promptly billed and collected.

The failure to properly adjust interim payment rates made State funds unavailable for other services to the citizens of North Carolina, precluded the State from collecting potential investment income on these funds, and could result in a liability to the federal government.

Recommendation: The Division should design and implement policies and procedures to timely adjust interim payment rates for hospital outpatient services so that payments approximate as closely as possible the reimbursable costs the provider is currently incurring in furnishing covered services to program beneficiaries. Additionally, the Division should ensure that cost settlement procedures are performed in a timely manner in accordance with requirements in the State Plan.

Agency Response: The Department has already taken action to adjust interim payment rates in a timely fashion. During the management transition in the last quarter of SFY 2002-03, the cost to charge ratios (CCR) were updated based on the latest filed cost report. Interim settlements for SFYs 1997 – 1999 are being completed and funds are being collected from the hospitals in accordance with the DHHS Cash Management Plan. In addition, settlements for SFYs 2000 through 2002 are being scheduled. It is anticipated that those settlements will be completed during SFY 2004 – 05. The CCRs will be updated once all SFY 2002 cost reports are received. Policies and procedures are being developed to ensure that staff are fully aware of their responsibilities associated with this matter.

9. INPATIENT HOSPITAL AND LONG-TERM CARE FACILITY AUDITS WERE NOT COMPLETED

The Division of Medical Assistance failed to perform any of the required inpatient hospital costs audits for fiscal year 2002. Total expenditures for inpatient hospital care were $1.12 billion for fiscal year 2002. Additionally, the Division completed only 33% of the required long-term care facility cost report audits. For fiscal year ending June 30, 2002, there were 417 long-term care facility cost reports that required audits to be completed by June 30, 2003. The Division was able to complete only 139 of these audits. Total expenditures for long-term care were $1.25 billion for fiscal year 2002.

The audits are performed to ensure that the cost reports support the rates facilities use for cost reimbursement. Failure to perform inpatient hospital and long-term care facility audits may result in the establishment of rates that under or over reimburse Medicaid providers. Management failed to plan for and ensure the performance of the required inpatient hospital cost audits. Inadequate staffing and personnel changes in the Division's audit section precluded the completion of the long-term care facility audits.

In accordance with 42 CFR 447.253(g), Medicaid agencies must provide for periodic audits of the financial and statistical records of participating providers. The North Carolina State Plan requires all cost reports to be audited within 180 days of the date the cost report was filed or within 180 days of December 31 of the fiscal year to which the report applies, whichever is later.

Recommendation: The Division should ensure that its audit section is adequately staffed and has the necessary resources to complete the audits. Additionally, it should enhance controls to ensure that required inpatient hospital and long-term care facility cost report audits are completed on a timely basis.

Agency Response: The Department concurs with the finding and agrees with the report's recommendation that reviews of inpatient hospital costs and associated cost reports should be conducted. Currently, DMA is expanding the scope of the Clifton Gunderson, LLP contract to include the annual audit of the four teaching hospitals, the ten hospitals with the highest Medicaid revenue and 25% of the balance of the hospitals receiving Medicaid reimbursement.

The contract amendment addresses the expanded scope of work that will be processed prior to June 30, 2005. Work related to the expanded scope will be initiated in early SFY 04-05.

DMA agrees that adequate staffing and resources are necessary to complete long-term care facility audits. As of December 31, 2003, 99.4% of all FYE 9/30/02 desk audits were completed. Currently, two audits remain outstanding: one cannot be completed pending investigation of the provider by the Attorney General's Office; and in regard to the second, payments to the provider have been reduced by 20% pending receipt of a valid working trial balance by the Audit Section. To complete desk audits of the FYE 2003 cost reports, DMA will consider performing limited scope audits, auditing selected cost reports from chain providers, increasing productivity with regular training sessions, revising the State Plan to allow for a longer period to complete the audit and supplementing staff with temporary auditors.

10. DUTIES NOT ADEQUATELY SEGREGATED

The Division's Assistant Director of Financial Operations was responsible for multiple financial and program functions of the Medicaid program. This resulted in one individual having the incompatible duties of approving provider reimbursement rates,

settling provider rate disputes, directing the Division's audit section, and reviewing and authorizing cost settlements.

Improper segregation of duties may allow interim provider reimbursement rates to be set at levels that do not reflect actual provider cost data. Improper rate setting may go undetected when one individual has authority over establishment, review and audit of rates, disputes, and cost settlements which impact financial reporting.

The Office of the State Controller's internal control standards require adequate segregation of duties to reduce the risk of error, waste, or wrongful acts and the risk that these events will go undetected. This is achieved by ensuring that no one individual controls all key aspects of a transaction or event.

Recommendation: The responsibilities of the Assistant Director of Financial Operations were divided during the last quarter of the fiscal year. Management should continue to evaluate the organizational responsibility for reimbursement processing, rate setting, financial operations, and auditing in an effort to provide adequate segregation of duties.

Agency Response: It is acknowledged that this situation has apparently existed for numerous years, and prior to this administration. The State Auditor's Office had in-depth contact over many years with the Assistant Director for Financial Operations and his management organization. This is, however, the first such finding to be issued by the State Auditor's office for the past 10 years.

The Department recognized in April 2003 that the multiple functions of the Assistant Director of Financial Operations did not have appropriate segregation of accounting duties. In April 2003, the duties of the Assistant Director were split between two newly established Assistant Director positions: (1) the Assistant Director for Budget Management and (2) the Assistant Director for Financial Management.

The Assistant Director (AD) for Budget Management has responsibility for the oversight of the budget, contracting, monitoring of the fiscal agent contract, review of audit appeals for nursing facilities, and agency financial policy and procedures. The Assistant Director (AD) for Financial Management has oversight responsibility for rate-setting, service provider auditing, MMIS, and hospital reimbursements. It should be noted that the DMA Audit Section under the AD for Financial Management does not review any internal administrative activities. Rather, the DMA Audit Section monitors/reviews outside agencies funded with Medicaid dollars. Therefore, DHHS does not believe that the organizational placement of auditing and rate-setting functions under the same AD presents a conflict of interest. The DHHS Office of the Internal Auditor (OIA), which reports directly to the DHHS Secretary's Office, has audit responsibilities over DMA administration. The DHHS OIA will review the appeals process and determine if there is an opportunity to relocate that function.

The Department will continue to assess its operations and organizational structure to ensure that the appropriate segregation of duties exists.

11. INTERNAL CONTROL WEAKNESSES OVER SUSPECTED FRAUD AND ABUSE INVESTIGATIONS AND INEFFECTIVE RECIPIENT VERIFICATION OF RECEIPT OF MEDICAID SERVICES

The Division's Program Integrity Section does not have an effective system of internal control over investigations involving suspected fraud and abuse cases. The following deficiencies were noted:

a. The Home Care Review Section and the Payment Error Rate Measurement Section do not have written policies and procedures for their investigators. The Home Care Review Section has a notebook showing examples of actual case investigations based on standard forms, which is available to its investigators, but it fails to provide guidance sufficient to serve as a policy and procedures manual. The Provider Administration Review Section and the Pharmacy Review Section have informal guidelines for investigating suspected fraud and abuse cases, but they lack the details that would document the methodology and evidence used to investigate a case.

b. The Home Care Review Section, Provider Administration Review Section, Pharmacy Review Section and the Payment Error Rate Measurement Section did not have evidence of review by a section chief on all closed cases.

c. Each section chief maintains his or her own informal process for documenting cases that were determined not to warrant preliminary investigations. Although this information is available, it is not summarized or used for tracking or evaluation purposes.

d. Management does not accumulate or report a summary of the fraud, abuse and error cases uncovered and worked by the Program Integrity Section to the Division, other Department of Health and Human Services (DHHS) agencies with a need to know, or to senior Department officials.

Although written notice is provided each month to a sample of recipients as required by 42 CFR 433.116, the process in place is ineffective and does not meet the objective of verifying with recipients whether services billed by providers were received. The average Medicaid recipient may not be able to easily understand the information and format of the current Recipient Explanation of Medicaid Benefits (REOMB) form. Recipients are only asked to return the REOMB if there is an error. According to management, only about 10 to 12 REOMBs out of the 400 sent each month are returned. Additionally, there is no evidence of any returned REOMBs because they are discarded if deemed not questionable. No list is kept of returned REOMBs that are discarded.

The State Plan and 42 CFR 455.13 through 455.21 and 455.23 require that the Division maintain methods, criteria and procedures for prevention and control of program fraud and abuse. Section 10 NCAC 26G.0103 further states that the Division shall develop, implement and maintain methods and procedures for preventing, detecting, investigating, reviewing, hearing, referring, reporting, and disposing of cases involving fraud, abuse,

error, over utilization or the use of medically unnecessary or medically inappropriate services. It also indicates that the Division should have methods and criteria for identifying suspected fraud cases.

The inadequacy of written policies, procedures, and case documentation standards may result in incomplete and inadequate case investigations, incomplete and/or undocumented claim and program reviews, and improper conclusions. In addition, the lack of evidence of supervisory reviews, the failure to document and communicate findings to upper management, and the ineffective verification procedures used to verify that Medicaid beneficiaries actually received the services billed by providers may hinder the agency's ability to prevent fraud and abuse in the Medicaid Program.

Recommendation: Management should continue the process of developing formal written policies and procedures. We offer the following comments regarding this as well as other recommendations:

a. To improve the effectiveness and efficiency of operations and compliance with applicable laws and regulations, management should strengthen and maintain internal controls. Policies and procedures should be developed and updated as necessary. Section chief reviews should be documented.

b. Management should establish policies to require communication of findings to other Division sections, Division managers, and other DHHS agencies. A standard summary report should be used and the report should be issued to Division managers and other DHHS agencies on a periodic basis to assist in the identification of problematic policies and procedures.

c. Management should also establish a report that summarizes the types of cases that are not investigated and the reasons why. This information can be used to analyze the reasons and the effectiveness of the initial identification of potential cases.

d. Management should work with Division sections and managers and other DHHS agencies to improve provider education in order to prevent errors, fraud, and abuse.

e. The current REOMB form should be reassessed. Specifically, the medical terminology used to describe the reason for payment on the form may need to be translated into a statement that the average person would understand. The Division should consider using a confirmation format where a response is required even if there is no error on the REOMB, which may yield greater response and information that is more useful.

Agency Response: NC is routinely singled out by CMS as a "model" program integrity State. Our fraud spotlight software is now in use by numerous States (e.g., Louisiana, Wyoming, Florida, and Mississippi), while several other States are currently evaluating its use in their Program Integrity operations. Additionally, the PI section has consistently

out-paced all of our neighboring States in Region IV – garnering the highest collection for 10 out of the past 11 years. Last year's recoveries totaled $11M and year-to-date recoveries are $22M.

The Division of Medical Assistance shall continue to enhance the formal policies and procedures in Program Integrity. The Division will incorporate the recommendations of the report. With respect to the specific recommendations:

- While review procedures have been in place, they have been more formally documented for the new MMIS+ contract. All Section Chiefs will initial the case tracking sheets to indicate their sign-off on every case

- A summary report will be created and issued periodically to assist in the identification of problematic policies and procedures. The DMA Director will determine the reporting time period and frequency.

- A report that summarizes the types of cases that are not investigated and associated rationale will be developed. If feasible, it will be incorporated into the summary described in above.

- Program Integrity will work with Division sections and managers and other agencies to improve provider education in order to prevent errors, fraud and abuse.

- The replacement and correction of the REOMB process was included in the MMIS+ re-bid. The Division will work with the vendor to develop an easier to read REOMB and ask that all mail-outs be returned.

Note of Clarification: Program Integrity (PI) does not conduct "Fraud and Abuse Investigations" per se. That is the responsibility of the Attorney General's Medicaid Investigations Unit (MIU). Four of seven PI units conduct utilization reviews and investigate to identify possible overpayments. If a billing provider's claims are suspected of fraud or abuse, they are sent to the MIU. PI staff is responsible only for investigating and recovering administrative (non-fraudulent) overpayments. PI nurses do provide nurse consultant support to the MIU.

12. CLAIMS PAYMENT SYSTEM HAS WEAKNESSES

Our tests disclosed several weaknesses with the claims processing system.

Medical Assistance Payments Not Reconciled

The Division failed to reconcile medical assistance payments, which represents the largest expenditure for the Department, to the Medicaid Accounting and Medicaid Management Information System subsystems. The Division's claims processing

contractor maintains the Medicaid Management Information System. Additionally, the Program Expenditure Report and Federal Participation Report were not reconciled to the accounting records and subsystems. The failure to reconcile could lead to inaccurate reporting of the funds expended.

Claim Payments Made in Error

Certain Medicaid claims were processed incorrectly due to incorrect programming, as follows:

- The discharge date is incorrectly included in the calculation of the number of covered days for inpatient claims that qualified for day outlier payments.

- Claims with the procedure code 80048, which are paid at the per-unit rate of $11.08 when billed alone, were paid as procedure code 80053, which are priced at the higher bundled rate of $11.67 per unit.

- The provider specialty type 072 with procedure codes D0220 and D0230 was incorrectly recognized by the system due to a programming error. This error caused the system to default to a generic coding rate, which paid less than the provider should have received.

These programming errors were confirmed by our testing of individual claims. The sample of 272 Medicaid claims contained seven of such claims. Another seven claims were in error due to other reasons:

- One error was due to a claim that was billed twice.

- One claim was billed using improper medical coding.

- For three claims, there were no medical records or other evidence to indicate that billable services were provided. One claim did not have documentation to support the number of units billed; there were no records submitted by the provider to substantiate services for a second claim; and for the third claim, there was no evidence to support the billing and payment of a Holter Monitor EKG.

- Two claims were in error due to violation of Medicaid policy. Medical records indicated that a non-billable service was billed and paid on one claim. For the second claim, review of medical records showed that billed services were provided concurrently. Medicaid policy does not permit the billing of these services that were provided concurrently on one claim.

The 272 Medicaid claims tested totaled $449,170, of which $9,350 was made in error. Since likely questioned costs are in excess of $10,000, the federal share of $5,874 is questioned. Based on a projection of the statistical estimation sample, the overpayment of Medicaid claims is estimated to be $117 million from $6.4 billion in claims paid.

OMB Circular A-87 requires allowable costs to be adequately documented and program costs to be necessary and reasonable for proper and efficient administration of the grant program. Federal regulation 42 CFR 431.107 and State Regulation 10 NCAC 26G.0107 require that medical records disclose the extent of services provided to Medicaid recipients. Additionally, the Hospital Provider Manual provides the guidance and formula for computing the day outlier and states that the day of discharge is not to be counted as a day of patient care.

Recommendation: The Division should evaluate and strengthen internal controls and procedures to ensure the accuracy of the claims payment process. Claim payments by its claims processing contractor should be reconciled to the accounting records and any differences should be investigated. Management should ensure that payment edits and/or audits are working appropriately; that providers are educated on the proper coding and documentation for medical services being provided; and that over or under paid claims are identified and appropriate collection or payment procedures are performed.

Agency Response: DHHS agrees that claims payments by its claims processing contractor should be reconciled to the accounting records and any differences should be investigated and more fully documented. The Federal Participation Report (FPR) and BD-701 are reconciled through the use of a vendor clearing account, and there is high level reconciliation of the Medicaid Accounting System (MAS) to the BD-701. The Division of Medical Assistance will work with the DHHS Controller's Office to review the reconciliation process and identify options for documenting the BD-701 reconciliation.

The Department concurs with the finding concerning the calculation for outlier payments includes the day of discharge. DMA will review the State Plan with EDS and prepare the necessary documentation to ensure that the payment calculation is in compliance with Medicaid reimbursement policy.

The Department also agrees that the Division of Medical Assistance should ensure that edits and/or audits are working, service providers are educated on the proper coding and documentation and that over and under-paid claims are identified and paid appropriately. Upon discovery of overpayments, referrals are made to appropriate DMA and EDS staff for corrective action. DMA has taken steps to address these concerns:

- PI wrote a Bulletin article on Payment Accuracy Measurement (PAM) sampling and the need for providers to provide documentation for the claims selected in the PAM Sample (and by default the report's sample). This provider education was transmitted in the March 2004 Medicaid Provider Bulletin and the March 2004 Pharmacy Bulletin. DMA will continue to explore ways to reinforce proper coding and documentation.

- During 2003, the DMA contract fiscal agent, EDS, performed forty provider education workshops across the State. Billing requirements are emphasized

during workshops to instruct providers that through the signature on the claim, the provider is certifying that the services were provided as billed. Through Medicaid Bulletin articles, providers are reminded that documentation is a vital part of the billing process. Documentation, they are told, must support the service and level of service billed. They are told that records must be kept a minimum of five years and made readily available to DMA or it's fiscal agent for review. They are also reminded that their documentation may be subject to Program Integrity review. It should be noted that the provider assumes accountability for documentation of a service. It is the provider's responsibility to document the level of service provided.

- In the past, only edits created through the Computer Service Request (CSR) process, were subject to testing prior to implementation of the edits. Sign-offs from DMA were required. However, audits were not subject to the same prior review. System audits, now table driven, are subject to this same prior review. Any new audit must have test claims run and DMA must review the results of the test claims before the audit can be implemented. This process ensures that the audit is performing as directed through the memo and policy that initiated the audit.

- A current project to facilitate a web-based approach to distributing provider material will result in every policy being documented and reformatted. These narrative policies are expected to be completed by May 2004. Publication on the web will occur after this date. This work will ensure that all policies published to date will be available for purposes of updating the policy as well as any audit/edit changes that might be needed.

13. THE DIVISION LACKS WRITTEN POLICIES AND PROCEDURES OVER IMPLEMENTATION, REVIEW AND RECONCILIATION OF RATE CHANGES

The Division's Rate Setting Section and the Medical Policy Section do not have written internal policies and procedures for setting rates or for implementing, reviewing, and reconciling rate changes.

Effective Date of Rate Changes Not Clearly Defined

There are no written policies and procedures to define or determine the effective date for rate changes for procedures and services billed on claims or to determine when a rate change should be applied retroactively. As a result, it appears many claims were paid at rates that should not have been in effect, based on underlying information available to the Division, at the time the service was performed. During our testing of 272 Medicaid claims, we found that rates used to pay 17 claims were changed after the claims were paid. The new rates had an effective date that was before the service dates of the claims reviewed, but were not entered into Medicaid Management Information System until after the service dates. Several of these claims, e.g. inpatient and long-term care claims,

will be adjusted and paid the new rate in the form of a cost settlement, which effectively applies the rate retroactively. The other claim types would not be paid the retroactive rate.

To better clarify the problem, we present the following occurrence uncovered during the audit as an example. A dental claim for services on 01/03/2003 was paid at the rate of 4.3465 per unit. However, the rate that should have been in effect in the Medicaid Management Information System on 01/03/2003 was 4.5204. Because this rate was not actually entered into the Medicaid Management Information System until 01/31/2003 and because the claim was filed and paid before this date, the provider was reimbursed at the old 4.3465 rate. Had the provider filed the claim on or after 01/31/2003, the claim would have been paid at the new, and higher, rate.

Controls Over Rate Change Processing Are Weak

Both sections send rate change information to EDS, the claims processing contractor. The sections have no written internal policies and procedures for implementing, reviewing, and reconciling rates changes. The following deficiencies, related to the processing of rate changes, were noted:

- There is no reconciliation of the number of rate changes authorized by the Division to the actual number of rate changes processed by EDS to ensure that all authorized rate changes were processed, and that only authorized rate changes were processed.

- The Division's Rate Setting Section's review of the rate changes submitted via written memo to EDS for processing is four months in arrears.

- The Division's Rate Setting Section does not review rate changes that are sent to EDS by tape or disk nor does it have effective procedures in place to ensure the accuracy of data input. Accurate data entry is assumed.

- The Division's Medical Policy Section does not review rate changes that are sent by it to EDS. Again, accurate data entry is assumed.

Correct Rate Not Always Used

Another weakness, related to the proper use of rates, had to do with how and what type of rate information is displayed and made available on certain key computer screens used by Division staff. The rate information is not always accurate or complete increasing the risk that inappropriate decisions may be made. We noted several instances where the rate displayed on the screen output and purported as the rate applied to the claim was not in fact the actual rate applied to the claim. Also, there were no indications displayed on these screens that the rates had been changed. Division staff utilizing these screens included the Division's Rate Setting Section and Program Integrity and the Provider Relations Department at EDS.

The risk that payments are made at rates which are not consistently applied or that do not comply with the State Medicaid Plan and/or federal regulations increases because of the failure to have written internal policies and procedures and the failure to perform adequate review and reconciliation of rate changes.

Recommendation: Management should establish and maintain written policies and procedures that govern the implementation of rate changes, including effective date of rate changes, allowances for retroactive application of changes to claim payments, and procedures for reviewing and reconciling rate changes.

Agency Response: During the last quarter of SFY 2002-03, the new Division of Medical Assistance (DMA) management identified that there was no systematic verification of rate changes. Testing of appropriate payments and payment comparisons is being incorporated into daily operations for the rate setting staff. Staff have been notified through an e-mail on December 31, 2003, as well as through their work plan, that all rate adjustments should be verified within 2 weeks of being sent to the fiscal agent. In January 2003, Secretary Hooker Odom established (via DHHS Directive) a Rate-Setting review Board, which was comprised of the Secretary, Deputy Secretary, Assistant Secretary, DHHS General Counsel, DMA Director and DHHS Controller. Also DMA has gone back to June 2003 and validated that all rates submitted on numbered Financial Operations memorandums to the fiscal agent have been appropriately and accurately placed in the MMIS. Further, the fiscal agent, under the auspices of the contract to be awarded shortly, will be required to provide validation to DMA documenting that all rates have been implemented correctly.

The Division of Medical Assistance is committed to developing/compiling written policies and procedures. Temporary staff have been hired to better document and codify Medicaid medical policy. As rates are set, supporting documentation is maintained and there is an active effort to pursue proper adjustments in a timely, concise, and well-documented manner. In fact, defined, regimented procedures are a priority for the Rate Section. The Division of Medical Assistance anticipates that development of comprehensive written policies and procedures for rate changes will be completed by no later than June 30, 2005.

Several actions have been taken to improve rate-setting. A numbered memorandum (FO04.225) was submitted to EDS on February 12, 2004, which provides for the automatic generation of a rate adjustment report if a rate is put in the system with a prior effective date. Also, there is a rate adjustment request (FO04.159) in place for the adjustment of the dental rates that were highlighted in this audit, and this adjustment is complete. Lastly, there is a system change request (FO03.367) that was submitted to modify the accommodation rate screen so rates do not overlay each other when they apply to the same payment period. This will allow auditors as well as others to see all the rate changes that have occurred.

14. CONTROL ENVIRONMENT OVER CERTAIN FISCAL OPERATIONS WAS SERIOUSLY DEFICIENT

The control environment governing fiscal operations surrounding the DSH and Supplemental Payment program at the Division of Medical Assistance for periods before and during the year under audit was seriously deficient. This report has presented many deficiencies, violations of rules and regulations, and weaknesses in internal control. Not only is the quantity of failings noteworthy, but it must also be emphasized that the findings are serious, many constituting material failings with the potential to subject the State to severe financial consequences, such as payback of $414 million of costs questioned in this report.

Certain actions and aspects of the Division's judgment greatly concerned us. We found very troubling the Division's willingness to violate rules and regulations, even when Division management was aware that its actions were prohibited, such as the use of Medicaid inpatient payment data that was flawed, resulting in questioned costs of $119 million. The failure to place appropriate emphasis on implementing sound internal control policies and procedures as required by federal regulations, in particular the failure to segregate the duties of senior management employees or to scrutinize their relationship with certain hospital providers, contributed significantly to the compliance violations cited in this report. Troubling also was the disregard for legitimate questions raised by staff, such as the failure to follow up on conclusions of the Division's own personnel that certain hospitals were ineligible for DSH payments, contributing to questioned costs of $151 million.

The Department of Health and Human Services has taken steps to correct the control deficiencies. Departmental records indicate the process of regaining control over the Medicaid DSH and Supplemental Payment program began in January 2003 when a DSH oversight team was created and when in June 2003 the payment calculation process began in house and the June payment to hospitals was suspended. Departmental records also indicate that in January 2003 a rate setting review board was created to review and approve provider reimbursement rates. The Secretary of Department of Health and Human Services reassigned an employee from her staff to the Division and hired an outside consultant to document the DSH payment processes. However, significant management changes were not made until the last quarter of the audit period.

Recommendation: While these moves have been beneficial, we believe more is needed.

The Department of Health and Human Services is responsible for all levels of management and for the proper administration of the Medicaid program. The Department should hold Division management accountable and must require its employees to follow all guidelines, rules and regulations, and policies. Needed policies and procedures and fiscal and programmatic controls must be formulated and implemented. Line staff at the Division must be reassured that legitimate and proper concerns will be dealt with appropriately and must be encouraged to execute their duties diligently and forthrightly.

The Division should have a process in place where risks relevant to achievement of its objectives related to effectiveness and efficiency of operations, compliance with laws and regulations, and financial reporting are identified, assessed, and managed. The Department should monitor the achievement of these objectives. The Department should consider expanding its internal auditing efforts in reviews and audits of the Division's operations.

The Division must conduct all business with hospital providers at arms length to ensure the process remains fair and equitable to all participating Medicaid providers.

The Division should continue its efforts to regain control of the DSH program, in part, by bringing in house all functions related to the DSH and Supplemental Payment program.

The Department of Health and Human Services should, on an on-going basis, review and evaluate the Division to include organizational structure, personnel, management control, programmatic controls, and fiscal controls.

Agency Response: It is acknowledged that this situation has apparently existed for numerous years, and prior to this administration. The DSH and Supplemental Payment program is one the largest programs in Medicaid - $2.5B by the Auditor's own statement. It should be noted that this is the first such finding to be issued by the State Auditor's office since the inception of the DSH program.

The audit report fails to adequately capture the extensive corrective action that Department management initiated and accomplished during SFY 02-03 and thereafter. That missing information clearly documents that management not only took immediate and decisive action to investigate these problems, but we also undertook documented and measurable activities to improve internal controls, segregate duties, as well as return to DMA the control and operation of the DSH and Supplemental Payment programs. Included in those actions was the expansion of our internal audit staff by two auditors who are dedicated to the audit/review of DMA operations and related compliance activities.

As evidenced by the actions outlined in the chart below, both the Department and Division are committed to, and have already engaged in, a review of DMA's organizational structure, personnel, management control, programmatic controls, and fiscal controls. We welcome the participation of the Office of the State Auditor in this process and hope that future concerns are both identified and communicated in a timely manner with DHHS and DMA management.

Month/Year	Action
AUGUST 2002	• DHHS Management sends D. Mosley of DHHS Office of Policy and Planning to Division of Medical Assistance (DMA) to review activities related to CAP-MR/DD Program. • Mosley discovers and informs DHHS Management of DMA's failure to conduct timely cost settlements for Disproportionate Share Hospital (DSH) Program. • Mosley prepares initial estimates of potential costs of settlement. • DHHS Management meets with DMA Management Team to discuss situation and continues investigation into DSH issues.
SEPTEMBER 2002	• DHHS Management evaluation of DSH Program issues continues with regular reports from Mosley and DMA Management.
OCTOBER 2002	• DHHS Management assigns D. Mosley to DMA full-time effort in assisting DMA Director in reviewing DSH Program and other DMA activities. • DHHS and DMA Management determine importance of an independent review of DSH Program policies and procedures and begins search for appropriate independent consultants.
NOVEMBER 2002	• DMA Management has initial meeting with firm of Tucker-Alan, Inc., to discuss scope of DSH review.
DECEMBER 2002	• Contract with Tucker-Alan executed 12/05/02, and independent review of DSH Program begins. • DHHS solicits legal counsel from Covington & Burling regarding DSH and Medicaid State Plan.
JANUARY 2003	• Secretary Hooker Odom receives letter from Governor Easley dated 01/13/03, instructing the Secretary to take all necessary actions to deal with DSH and any other issues. • Secretary Hooker Odom organizes DHHS Rate-setting Review Board consisting of Secretary, Deputy Secretary, Assistant Secretaries, DHHS General Counsel, DMA Director, and DHHS Controller. Purpose of board to provide oversight over all reimbursement rates set by DMA and other DHHS divisions and build upon expanded knowledge base of

the rate-setting processes and procedures within DHHS.

- Secretary Hooker Odom establishes DHHS DSH Program Oversight Team consisting of key individuals throughout the Department, including the DHHS Controller and the Director of Budget and Analysis, to provide oversight over the operation of the DSH Program independent of DMA staff and build an expanded knowledge bases of the DSH Program within DHHS
- First meeting scheduled for DHHS Rate Setting Review Board was held on 01/28/03.
- DHHS Management determines that greater audit oversight of DMA operations and regulatory compliance is both important and necessary, and instructs staff to develop job descriptions, which were completed 01/30/03, for two additional auditors within the DHHS Office of Internal Auditor (OIA) to be devoted to DMA and Medicaid.
- Secretary Hooker Odom responded to Governor Easley by letter dated 01/31/03, setting forth activities within DHHS to begin addressing DSH issues and DMA management.
- Secretary Hooker Odom and Deputy Secretary Cansler have a phone conversation with J. Wilkerson at CMS concerning the potential of immediate deferral of any future DSH payments by CMS until management issues are addressed. Corrective actions by NCDHHS and DMA were discussed and immediate deferral ultimately avoided.

FEBRUARY 2003

- DHHS Management met with Tucker-Alan, Inc. consultants on 02/06/03, to hear preliminary findings from their review.
- Secretary Hooker Odom establishes DHHS DSH Technical Oversight Team to become familiar with DSH rules, regulations and policies in order to provide additional insight/advice to the DSH Oversight Team regarding payment calculations, variables and assumptions used in those calculations.
- DMA announces the creation of a new DMA management team for DSH Program consisting of K. Faye (previously in DHHS Division of Budget and Analysis), D. Mosley and M. Sanford to develop internal expertise in DSH Program operations, computations and compliance.
- Deputy Director of DMA, D. Lyon, announces her separation from DMA to accept a position in the Office of State Budget and Management (OSBM).
- Assistant Director for Financial Operations, A. Gambill, announces his retirement to be effective March 31, 2003.

- DHHS Rate-setting Review Board holds regular monthly meeting on 02/24/03.
- First meeting scheduled for DHHS DSH Program Oversight Team was held on 02/26/03.
- DHHS OIA positions to be dedicated to DMA and Medicaid were posted on 02/26/03.
- DHHS DSH Oversight Team holds initial meeting on 02/26/03, and receives DSH Program Report from Tucker-Alan, Inc., dated 02/26/03.
- Secretary Hooker Odom directs Deputy Secretary Cansler to work closely with DMA Financial Team to verify development of necessary financial controls.

MARCH 2003

- DHHS Management assigns G. Brogden, past Assistant Director of DHHS Division of Budget and Analysis and member of the Office of Policy and Planning, to DMA to begin transition process prior to retirement of Assistant Director for Financial Operations.
- Final quarterly DSH payment computed by hospital group made on 03/28/03, after review by new DMA DSH management team and DHHS consultants.
- DHHS Rate-setting Review Board meets on 03/24/03
- Assistant Director for Financial Operations, A. Gambill, retires on 03/31/03.

APRIL 2003

- G. Brogden appointed acting Assistant Director for Financial Operations on 04/01/03.
- First of numerous conference calls held with Washington, DC law firm of Covington & Burling to discuss DSH and Supplemental Payment issues.
- DMA staff met with CMS in Atlanta to discuss DSH issues. DMA's presentations in Atlanta addressed CMS' concerns about the DSH payment model – and thus avoided a potential deferral of federal funds.
- DHHS DSH Program Oversight Team holds meeting on 04/09/03.
- Two DHHS OIA positions dedicated to DMA and Medicaid filled on 04/10/03 and 04/21/03.
- Restructuring of DMA Financial Operations proposed on 04/09/03, to divide responsibilities between Assistant Director for Budget Management and Assistant Director for Financial Management.
- Deputy Secretary holds meeting to discuss plans for restructuring the responsibilities of DMA Financial

Operations on 04/16/03, resulting in improved segregation of duties in DMA financial areas.

- G. Brogden named acting Assistant Director for Budget Management and D. Mosley named acting Assistant Director for Financial Management.
- Deputy Secretary Cansler begins weekly meetings with new DMA financial management team.
- DHHS Rate-setting Review Board meets on 04/24/03
- N. Yeager, Director of DMA, discusses her plans for retirement on 04/24/03, to be effective 05/31/03.

MAY 2003

- G. Fuquay, DHHS Controller, moves to DMA for transition process to prepare for DMA Director retirement.
- DHHS DSH Program Oversight Team holds meeting on 05/06/03.
- G. Fuquay named acting Director for DMA, effective 05/31/03.
- DHHS Management begins weekly meetings with G. Fuquay to monitor DMA issues and provide assistance in proceeding with needed DMA management structure planning and changes.
- DHHS Rate-setting Review Board meets on 05/23/03.
- N. Yeager, Director of DMA, retires on 05/31/03.

JUNE 2003

- Normal quarterly DSH payments to hospitals postponed as DHHS and DMA Management continue to build internal expertise for operation of DSH Program and to perform required computations and allocations, and to solidify internal control of DSH Program.
- G. Fuquay, acting Director of DMA, names new DMA Audit Chief on 06/03/03.
- DHHS Rate-setting Review Boards meets on 06/23/03.
- G. Fuquay, acting Director of DMA, names new DMA Rate-setting Chief on 06/30/03.
- Gary Fuquay, acting Director of DMA, begins weekly meetings (now, monthly) with DHHS Office of Internal Auditor and DHHS Office of Policy and Planning to garner the Department's perspective of organizational improvements, process and procedures changes needed.

AUGUST 2003

- DHHS and DMA Management meet with CMS officials to discuss DSH settlement for SFY 97. DHHS presented legal position papers in support of the State's intent and practice, thereby reducing a potential payback to CMS.

- Management receives memorandum dated 08/03/03 from legal counsel regarding DSH

SEPTEMBER 2003

- DHHS makes DSH and Supplemental Payments for April 2003 – September 2003. DHHS takes back the entire DSH and Supplemental calculation and verification process. More timely cost information utilized.

NOVEMBER 2003

- On 11/05/03, DHHS and DMA Management traveled to Baltimore, MD, to meet with CMA officials regarding the 1997 DSH settlement issues. CMS requested that the years of 1997-2002 be addressed collectively. DHHS committed to development of NC's approach to settlement for transmission to CMS by 01/15/04 for1997-2002.

DECEMBER 2003

- Upon notification of concerns raised by the NC Office of State Auditor and subsequent discussions with Atlanta CMS official, DHHS Management notified the NC Hospital Association (NCHA) that future DSH payments would be made directly to the 41 Qualified Public Hospitals (QPH) and not through the escrow agent.

JANUARY 2004

- Secretary Hooker Odom announces appointment of G. Fuquay as the permanent director for DMA on 01/06/04.
- On 01/15/04, DHHS sends NC's DSH settlement approach to CMS for FY's 1997-2002. A subsequent revision was sent to CMS on 01/29/04. As of this date, we are awaiting CMS' return response.
- M. Benton, past Assistant Director for Budget and Planning, DHHS Division of Facility Services, appointed as Deputy Director over Budget and Finance, to improve oversight and enhance internal controls, policies and procedures.

MARCH 2004

- SPA to be submitted prior to 03/31/04 to eliminate ambiguity, codify intent and practice, and move to prospective payment.

DIVISION OF SOCIAL SERVICES

15. APPROPRIATE ACTION NOT TAKEN IN CHILD SUPPORT CASES

The Division of Social Services failed to take appropriate action or failed to take the required action in the established periods for a number of child support 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 30 of the 40 cases tested in "paternity status," a 75% error rate. Actions contributing to the noncompliance included failure to "serve process" within the required period, failure to take action with non-custodian parent's address or employer information, failure to take action on successful "locate matches," or failure to take any 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 26 of 37 cases tested in "establishment status," a 70% error rate. Actions contributing to the noncompliance included failure to "serve process" within 90 days, failure to take the appropriate action on the case, or failure to take any action on the case.

c) Appropriate or timely enforcement action was lacking for 18 of 30 cases tested in "delinquent status," a 60% error rate. There was no enforcement action taken for 8 of these cases. In 10 cases, the "service of process" actions were not taken within the required period. The "service of process" actions were two months to eleven months late.

d) Appropriate enforcement action was lacking for 16 of the 42 cases tested to determine if medical support obligations had been secured or enforced, a 38% error rate. In one case, the order indicated that the custodial parent would obtain insurance but the case file indicated that neither the custodial parent nor the non-custodian parent had any insurance. In eight cases, the child had not been added to the non-custodial parent's insurance policy. In another eight cases, the child had been added to the non-custodian parent's insurance policy but it was not documented that Medicaid and the custodial parent had been notified.

e) Appropriate action was not taken within the required period for 17 of the 35 interstate cases tested, a 49% error rate. Seven "initiating" cases were not referred to other states within the required 20 calendar days of locating the absent parent in the other state. The interstate transmittal documents were never sent to the appropriate states in eight initiating cases. In one "referring" interstate case, no action was taken after the interstate case was opened. In another "referring" interstate case, the case was 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 30 days of identifying noncompliance. Regulations require that within 90 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 20 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 system of internal control to ensure compliance with federal child support processing requirements.

Agency Response: The Department concurs with this finding. Improving performance is a primary goal of the The Child Support Enforcement (CSE) program. The audit findings will be addressed with CSE's plans for improving performance compliance scores in each of the program areas. CSE management will bring this audit finding to the attention of each Area Consultant and each local office's management.

Crowded courtroom dockets are a major deterrent to meeting timeframes for paternity establishment, establishment of court orders and enforcement of court orders. Often, child support agents must wait many weeks to file a legal action due to courtroom dockets being filled for weeks into the future. CSE will initiate discussions and share audit findings with Chief District Court Judges in an effort to increase court days available for child support hearings. CSE is hopeful that these discussions will increase court time in some jurisdictions; however, the actual outcome is dependent on the decisions made within the court system.

The federal Office of Child Support Enforcement (OCSE) requires CSE to submit a Self-Assessment report by March 31 of each year. OCSE requires CSE to measure the same performance compliance requirements that this audit addresses; however, OCSE focuses on "results" rather than on timeframes alone. Many cases that OCSE considers to be "action cases" because appropriate action was taken during the review period do not pass the State's audit. This year CSE completed the process of developing data warehouse programs to automate the OCSE Self-Assessment reports. This automation allows CSE to expand the Self-Assessment process to review every case for performance compliance

and to generate reports quarterly in addition to annually. CSE utilizes these reports to determine performance scores for each county and for each CSE agent. It allows CSE to identify cases that need corrective action and to identify individuals and counties that require additional training. CSE will continue to utilize these reports to identify where corrective action is needed. CSE believes that this corrective action will cause improvement in performance compliance scores.

16. INADEQUATE MONITORING OF SOCIAL SERVICES BLOCK GRANT PROGRAM

The Division of Social Services' monitoring procedures were not sufficient to provide reasonable assurance that counties used Social Services Block Grant awards in compliance with grant requirements. The lack of subrecipient monitoring increases the risk that unauthorized activities and/or costs at the subrecipient level may occur and go undetected. In prior years, the Division did not perform formal on-site monitoring of Social Services Block Grant activities. However, the Division has since revised its plan to include such monitoring for a sample of subrecipients each year. The revised plan was partially implemented in fiscal 2003, focusing only on adult and family services for a small number of subrecipients.

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

Recommendation: The Division should continue its efforts to develop and implement a monitoring process over subrecipient activities in the Social Services Block Grant program.

Agency Response: The Department concurs with the finding. As originally planned, in state fiscal year 2004, the Division of Social Services intends to implement its updated monitoring plan, which includes monitoring of SSBG activities and services in the child welfare program area. As of early 2004, the Division has two monitors responsible for SSBG activities and services as well as other child welfare services. Under this plan, by June 30, 2004, the Division will monitor SSBG services and activities for minors under age 18 in 30 counties.

The Division of Aging and Adult Services will continue its monitoring activities and monitor adult services and general services for adults over age 18 in 30 counties by June 30, 2004.

17. INCORRECT FACILITY RATES IN THE FOSTER CARE COMPUTER SYSTEM

As noted in the prior year, incorrect rates were entered into the Foster Care Licensing System. We identified ten child caring agencies where facility rates entered into the system did not agree with the approved facility rates for fiscal year 2002-2003. The

incorrect facility rates in the system resulted in the overpayment of federal Foster Care funds of $11,299 to two foster care facilities. The amount has been questioned.

Recommendation: Control procedures should be strengthened to ensure that facility rates are correctly entered into the Foster Care Licensing System. The foster care payment reports should be reviewed monthly to ensure that the proper facility rates are applied to the facility's payment calculation.

The Division should adjust or recoup funds from the facilities that were overpaid the $11,299. In addition, the Division should determine if any overpayments were made to any other foster care facility and if overpayments are identified, they should be recouped and the federal share should be reimbursed to the Foster Care program.

Agency Response: The Department concurs with this finding. It is our opinion that the primary source of incorrect rates is the human error inevitable when using the current methodology. The Division of Social Services (DSS) has initiated a request to the Division of Information Resource Management to develop an automated method of rate setting. Currently, each facility for which a rate has been established requires accessing that facilities record in the Foster Care Licensing System. Approximately 4,000 to 5,000 facilities are approved each year. The development of an automated system has required detailed research into the computer code as well as a review of past payment reports by DSS and Controller staff to ensure the integrity of the system is preserved.

Additionally, as a quality assurance methodology, DSS implemented the same procedures utilized by the state auditor for reimbursements paid for placements beginning January 1, 2004. This consists of a review of the PQA120 report and comparing the rates to the Dear County Director of Social Services letter.

Adjustments to correct the $11,299 in overpayments have been made. Correct rates have been developed by Rate Setting and compared to the rates in the system. These rates have been forwarded to DSS. DSS will determine the necessary adjustments for each facility and complete the process by June 2004.

18. MONITORING NOT PERFORMED ON VENDORS RESPONSIBLE FOR COMPLIANCE REQUIREMENTS

As noted in the prior year, the Division of Social Services did not have a documented monitoring plan in place to ensure that fiscal and programmatic monitoring was performed on compliance requirements passed to vendors and subrecipients. As a result, three contracts, for approximately $700,000 in Foster Care funds, were not monitored. The lack of monitoring increases the risk that unauthorized activities and/or costs by contractors may occur and go undetected. The Division was in process of developing a monitoring plan and procedures at fiscal year ended June 2003.

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

Recommendation: The Division should continue its efforts to develop and implement a monitoring plan for vendors and subrecipients 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 Response: The Division concurs with this finding. These and other contracts were reviewed in an informal manner during the audit period. A formal monitoring plan has now been established to ensure the integrity of programs and the subrecipients utilizing funding sources. This plan has been fully developed and explained to appropriate staff in this Division. Two full time positions (Program Compliance Representatives) have been identified in the Family Support and Child Welfare Section to conduct the monitoring of child welfare programs in counties and the staff in the program areas will conduct reviews of their programs. Standardized monitoring tools and instructions have or will be developed to monitor the individual program areas and related funding sources based on the existing Audit Compliance Supplements and/or contract requirements. The monitoring tools and the compliance supplements are based on applicable laws and regulations that govern each of the funding sources being monitored.

The Family Support and Child Welfare Section will monitor contractors for compliance with both fiscal and programmatic criteria using varied methods, including desk audits, review of sub-recipient reports, site visits, case record reviews, among others.

The specific tools for the programs identified in this audit are now being developed and technical assistance will be sought from the auditor. These tools will be used for monitoring in fiscal year 2004-2005. If a substantial non-compliance issue is found, a corrective action plan will be developed within 30 days to alleviate the areas of non-compliance.

19. IMPROPER ACCESS TO FOSTER CARE COMPUTER SYSTEMS

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

- Two former employees were listed on the security table report of the Child Payment and Placement System with inquiry and add/update access.

- One former employee was listed on the security table report of the Foster Care Licensing System with access to all critical menus and add/update/delete/inquiry access.

- One former county user was listed on the security table report of the Foster Care Licensing System with inquiry access.

- One current county user and two child support enforcement users were listed on the security table report of the Foster Care Licensing System with improper inquiry access.

Recommendation: The Division should evaluate and strengthen its computer system access controls to ensure that former and unauthorized Division employees and county users are removed in a timely manner. Periodic security access reviews should be conducted to ensure that access is restricted to authorized users.

Agency Response: The Department concurs with this finding. All invalid access was fixed in the System by February 15, 2004. The Division of Social Services reorganized effective May 1, 2003. With this reorganization, additional resources were dedicated to the Family Support and Child Welfare services section, data management team. This team will develop, implement and maintain a systematic methodology for tracking and updating employee access to the information systems.

20. FISCAL MONITORING NOT PERFORMED ON NUTRITION EDUCATION SUBRECIPIENTS

As noted in our prior audit, the Division of Social Services did not perform sufficient monitoring procedures to provide reasonable assurance that its Nutrition Education subrecipients used Food Stamp funds for allowable 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 Food Stamp funds provided these subrecipients were $5.4 million.

Although the Division developed a monitoring plan and a schedule for conducting monitoring visits, no fiscal monitoring had been performed on its Nutrition Education subrecipients as of June 2003. OMB Circular A-133 requires that a pass-through entity monitor subrecipient activities to provide reasonable assurance that subrecipients administer federal awards in compliance with federal requirements.

Recommendation: The Division should continue its efforts to develop and implement a monitoring process over its Nutrition Education subrecipients.

Agency Response: The Department agrees with the finding. Programmatic monitoring was completed for FFY 2003 on all projects operating in counties where a Management Evaluation Review was completed. Fiscal monitoring for FFY 2003 was completed in December 2003 for projects operated through North Carolina State University (NCSU);

the review was delayed due to Hurricane Isabel's impact on staff availability. Using the results from FFY 2003 monitoring activities (fiscal and programmatic), additional refinement of the process and procedures for monitoring are being developed. Fiscal and programmatic monitoring is scheduled to be completed for all approved projects for FFY 2004 by September 30, 2004.

21. MONITORING PROCEDURES IN THE TEMPORARY ASSISTANCE FOR NEEDY FAMILIES PROGRAM CONTAINED WEAKNESSES

Monitoring procedures in the Temporary Assistance for Needy Families Program are not sufficiently designed to ensure that cases identified as "non-cooperative" with child support requirements are properly sanctioned. A penalty could be imposed on the State by the federal government for failure to enforce penalties on recipients who fail to cooperate with child support requirements. In a sample of 24 cases identified as non-cooperative, five cases were not sanctioned properly. Controls were not in place to ascertain if the caseworker had reviewed the case.

Title 45 of the Code of Federal Regulations Part 92.40 requires grantees to monitor grant and subgrant activities to ensure compliance with Federal requirements and to ensure performance goals are being achieved. A reduction or elimination of assistance is required by 42 USC 608(a)(2) for recipient non-cooperation in establishing paternity or obtaining child support. Title 45 CFR 264.31 allows a reduction in the state's State Family Assistance Grant for failure to enforce penalties against recipients.

Recommendation: The Division should implement procedures to ensure sanctions are imposed and resolved timely.

Agency Response: The Department concurs with the finding. Beginning in August 2003, the Work First Representatives, who were responsible for Work First monitoring for the first half of the 2003-2004 fiscal year, pulled cases from the DHREJ NON-COOP WITHOUT A IVD SANCTION report to supplement their monitoring process and identify specific cases where the Work First recipient has not cooperated with Child Support Enforcement. Work First Monitoring tools were also modified to reflect whether or not cases pulled for monitoring from other sources had also been required to apply a IVD Non-Coop sanction, and whether the requested sanction was applied appropriately. With the modification of the Work First Monitoring tools, the modification of the Work First Monitoring Plan, and the hiring of two Work First Program Compliance Monitors who have assumed the responsibility of monitoring the Work First Program, the Division of Social Services, Family Support and Child Welfare Section, believes that the TANF monitoring procedures are now sufficiently reinforced and implemented to ensure that cases identified as non-cooperative with Child Support requirements are properly monitored for IVD sanctions and that sanctions are imposed or resolved timely.

22. WEAKNESSES IN CONTROL OVER PHYSICAL INVENTORY OF FIXED ASSETS

Weaknesses were noted in the Division's internal control over physical inventory of fixed assets, which could lead to loss, damage, or theft of equipment. Inaccurate information in the fixed asset system could also result in the misstatement of financial statements.

- The Division's own tracking system revealed that 32 locations failed to turn in annual inventory reports before the June 30, 2003 deadline. Seven of the 32 inventory reports could not be located as of February 2004. Locations that fail to submit inventory information when required prevent the Department from updating fixed asset records with current information.

- A sample of 25 inventory packets from county and child support enforcement locations was tested and disclosed three errors. These errors include packets sent to the wrong location and packets returned without the documentation supporting that an inventory had been performed.

- The packet from the Raleigh child support enforcement office was tested to determine if inventory items were adequately safeguarded and tagged. From a sample of 45 items, 12 items that were certified as being inventoried could not be located. Two additional items did not have fixed asset decals displayed.

Title 45 CFR 74.34 requires the recipient to take a physical inventory of equipment and reconcile the results with equipment records at least once every two years. Any differences between quantities determined by the physical inspection and those shown in the accounting records should be investigated to determine the causes of the difference. The recipient is required to maintain a control system to insure adequate safeguards exist to prevent loss, damage, or theft of equipment.

The North Carolina Office of the State Controller's physical inventory policy requires an annual physical inventory to be taken to verify that assets recorded in the Fixed Asset System are physically located in an agency. North Carolina Department of Health and Human Services Office of the Controller's inventory procedures require each item at each site to be physically examined annually in order to determine that the asset has been properly tagged and accurately described.

Recommendation: The Division should ensure that all inventory worksheets are distributed to the appropriate locations and should follow up on missing inventory packets. A fixed asset should be properly tagged and accurately described and its location properly documented.

Agency Response: The Department agrees with the finding as documented. The Division of Social Services has implemented a tracking system to track the annual inventory sheets. The Division is also in the process of gathering contact information to assist with the follow up needed to prevent this finding in the future. The existing procedures will be modified to include a follow up contact to each location to provide a

reminder prior to the deadline. Procedures will also be modified to include contact after the deadline to locate any missing inventory packets.

During the time the audit was being completed, the Child Support Office was in the process of transitioning to new equipment as a result of seat management and inventory was in the process of being moved. One of the missing items has been located and Child Support is continuing to attempt to locate the other 12 items. The two items that did not have asset tags (acquisition dates of 1983 & 1999) are scheduled to be surplused and will be removed from the inventory list by the end of the state fiscal year.

23. FOSTER CARE CHILD MAINTENANCE ADJUSTMENTS FROM COUNTIES NOT PROCESSED

As of February 2004, the Division of Social Services had not processed a substantial number of foster care assistance adjustments received from counties. Failure to make timely adjustments increases the risk that the Foster Care program may be charged with unallowable amounts. The adjustments are for amounts paid to child care facilities for the care of foster children.

The employee position responsible for processing the requests has been vacant since April 2003.

Recommendation: The Division should process requests for adjustments received from counties in a timely manner.

Agency Response: The Department concurs with this finding that adjustments were not processed because the position responsible for handling the adjustments was vacant. The Division of Social Services (DSS) is working on the backlog of adjustments but does not anticipate being current until the vacant position is filled. The position responsible for this activity has been reclassified based on a new job description in order to attract qualified applicants following three unsuccessful postings. Necessary signatures were obtained for unfreeze and post authorizations. DSS expects that recruitment of qualified individuals will occur. If a qualified person applies, it is anticipated that a suitable individual can be begin employment by June 1, 2004.

DIVISION OF CENTRAL ADMINISTRATION

24. BASIC SUPPORT CLAIMS NOT PROPERLY PAID

There were weaknesses in the Department's controls over the payment of basic support claims in the Rehabilitation Services - Vocational Rehabilitation Grants to States program, resulting in errors that produced overpayments of $14,893. We are questioning the federal share of $11,720. An examination of 210 client files revealed the following:

- Three inpatient claims were paid as outpatient claims resulting in an overpayment of $13,326.
- Because of a system miscalculation, a claim was paid using incorrect rates resulting in an overpayment of $382.
- The Department paid a vendor $1,163 without the required vendor signatures.
- Two other claims were paid amounts not in agreement with documentation or at an incorrect rate.

Section 1-11 of the Division of Vocational Rehabilitation internal policies manual requires that invoices for inpatient and outpatient hospital services be paid at the Medicaid rate and requires that invoice information include vendor signature. In addition, costs must be adequately documented in accordance with OMB Circular A-87.

Recommendation: The Department should strengthen internal control to ensure that all invoices are properly processed and paid. Also, the Department should ensure that all applicable rates are properly incorporated into its payment procedures. The Department should perform an 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 control to ensure that vendor signatures and adequate documentation are obtained for all invoices before payment is made in accordance with both federal and internally required procedures.

Agency Response: The Department concurs with the finding and the Auditor's recommendation. The Department will strengthen internal control to ensure all invoices are properly processed and paid, applicable rates are properly incorporated into payment procedures, and adequate documentation is obtained before payment is made. In all of the cases where an overpayment was made the provider has been contacted and a refund has been requested.

25. FOSTER CARE FACILITY RATES INACCURATE

As in the prior year, there were some internal control weaknesses in the Department's method of reviewing and calculating the 2002-2003 facility rates for the child caring agencies in the Foster Care program. Errors in the facility rates were not detected until after they had been applied to the foster care payment calculations for the entire year.

In a sample of ten child caring agencies tested by us and receiving over $700,000 in federal Foster Care funds, the Department determined and applied incorrect facility rates for nine of them. The facility rates for these child caring agencies were overstated in amounts ranging from $11 to $712 per month for each child. The Department identified an additional thirty facility rates that were overstated and twenty-three facility rates that were understated.

The Department has yet to apply the correct rates to determine the over and underpayments made to the child caring agencies. Although the total overpayments are unknown, we believe they are likely to exceed $10,000 in federal Foster Care funds.

Recommendation: The Department should improve internal control over the facility rate setting process. The facility rate computations should be sufficiently reviewed before approved and applied to the foster care payment calculations. Additionally, the Department should determine and correct the effect of the errors made to the child care agencies. The federal share of the overpayments should be reimbursed to the Foster Care program.

Agency Response: The Department concurs with the finding. The Rate Setting Branch of the Controller's Office began a total review of the SFY 2002-03 rates after an audit from the prior year uncovered a procedural problem. However, the SFY 2002-03 rates were already in effect when the review began. Correct rates have been developed by Rate Setting and compared to the rates in the system. These rates have been forwarded to the Division of Social Services (DSS). DSS will determine the necessary adjustments due to overcharges for each facility and complete the process by June 2004. Both DSS and the Controller's Office have established better communication links as a result of this process.

26. FIXED ASSET RECORDS INCOMPLETE/INACCURATE

Weaknesses were noted in the Department's controls over fixed asset records. The Department failed to update in a timely manner the fixed asset records for equipment purchased during the fiscal year. In addition, the asset listing did not contain all pertinent fixed asset information, such as the permanent fixed asset number, description, and serial number of the item. Our test of a sample of twenty-five inventory worksheet packets revealed the following:

- Two locations notified the Department that equipment items were to be added to the fixed asset records, however, equipment records were not updated to include all of the items.

- Inaccuracies were found in the equipment records for four locations. Errors in the fixed asset records include assets with the incorrect serial number and multiple assets with the same serial number.

- Two inventory packets distributed to the County and Child Support Enforcement offices for annual inventory were incomplete. Prior year worksheets were used to complete the inventory.

Inaccurate information or the omission of information in the fixed asset system increases the risk that missing and/or stolen items will not be detected. Inaccurate asset records could result in incomplete inventory packets used to perform the annual physical inventory. The lack of updated fixed asset records could also result in misstatement of fixed asset account balances in the financial statements.

Title 45 CFR 74.34 requires the recipient to maintain adequate safeguards to prevent loss, damage, or theft of equipment. The recipient is to complete a physical inventory of equipment and reconcile any differences noted with equipment records at least once every two years. The regulation also requires that the records include a description of the equipment, manufacturer's serial number or other identification number, acquisition date, location of equipment, unit acquisition cost, and disposition data.

Recommendation: The Department should implement a tracking system to ensure all changes noted on the inventory worksheets are made to the equipment records. Inconsistencies or errors uncovered when updating fixed asset records should be investigated and corrected.

Agency Response: The Department agrees with the finding that equipment reported by two counties was not added to the fixed asset records. The fixed asset coordinator is responsible for adding or updating asset records with historical data such as asset description, cost of asset, serial number and any other information needed for input purpose. This issue will be resolved by the end of April 2004. The Department agrees with the finding that inaccuracies were found in the system records for four locations because of incorrect information that was sent from the field offices. One county's information has been secured and the system updated with correct information. This issue will be fully resolved by the end of April 2004.

The Department agrees with the finding that a temporary asset was not assigned a permanent asset number in a timely manner. The permanent asset number is assigned by the fixed asset coordinator, whom we have contacted and from whom we are awaiting the missing information. This issue will be resolved by the end of April 2004.

27. COST ALLOCATED TO PROGRAMS INCORRECTLY

Costs have been incorrectly allocated to State and Federal programs. The effect of incorrect cost allocation percentages and the improper allocation of costs resulted in the Substance Abuse Prevention and Treatment Block Grant (SAPT) program being overcharged by $57,621. This amount is questioned. Our test of the Mental Health cost allocation plan disclosed the following:

- Cost allocation percentages are calculated based on statistical data and the criteria detailed in the cost allocation plan. The allocation rates and amounts allocated should vary each month. However, for two months during the fiscal year, costs were allocated to programs using the same calculated percentages as applied during the prior month.

- Expenditures for two of the twelve responsibility cost centers tested were not allocated in accordance with the cost allocation plan.

Title 45 CFR 95.517 requires that when a State claims federal financial participation for allocated costs associated with a program that it be in accordance with its approved cost allocation plan. Adequate internal control requires that adequate systems be in place to prevent, identify, and correct accounting errors in a timely manner.

Recommendation: The Department should make adjustments to correct overcharges to the SAPT program. The Department should ensure that changes in the cost allocation basis and changes to the Cost Allocation Plan are timely. Procedures should be developed requiring review of the cost allocation report for any improper percentage calculations before the cost allocation process is initiated.

Agency Response: The Department concurs with the finding and recommendation. The Cost Allocation Branch of the DHHS Controller's Office has completed the analysis of the cost centers for the Division of Mental Health, Developmental Disabilities and Substance Abuse Services from December 2002 forward. Journal entries correcting the SAPT overcharge will be prepared and entered into the North Carolina Accounting System prior to certifying March 2004. The Cost Allocation Branch is also reviewing the procedure CF027 "Quarterly Reconciliation of Cost Allocation Pan Narratives, RCC Report and Access Database Records" and will modify this procedure to ensure that the computed rates for the Access Cost Allocation Database is the same as the method reflected in the Cost Allocation Plan narratives. This procedure will be revised by March 30, 2004.

28. COST ALLOCATION PLANS NOT SUBMITTED FOR APPROVAL IN A TIMELY MANNER

Amendments to the cost allocation plans for two of the Department's divisions were not submitted for approval in a timely manner.

- Amendments to the Mental Health cost allocation plan for the first quarter of fiscal year 2003 (July 2002 through September 2002) were submitted for approval late, in February 2004. Amendments for the remaining October 2002 to June 2003 period have not been submitted for approval as of February 2004.

- As of February 2004, the Department has not submitted for approval the Division of Social Services' cost allocation plan amendments applicable for the period January 2003 through June 2003. Since the unapproved allocation methods and the federal participation rates have been applied by the cost allocation accounting system, approximately $17.9 million in costs have been allocated for this period.

Without timely approved amendments, costs may be incorrectly charged and the risk of errors increases if adjustments are necessary. Title 45 CFR 95.509 requires the State to promptly amend the cost allocation plan and submit the amended plan for approval if there are organizational changes, changes in federal law, a material defect in the cost allocation plan or other changes which make the allocation basis invalid.

Recommendation: The Department should submit cost allocation plan amendments for federal review and approval as soon as changes are determined and implemented.

Agency Response: The Department concurs with the finding and recommendations. The January 2003 through March 2003 Cost Allocation Plan (CAP) amendments for the Division of Social Services (DSS) were submitted for Federal approval on December 19, 2003 and receipt was acknowledged by the Department of Health and Human Services Division of Cost Allocation on January 28, 2004.

The April 2003 through June 2003 CAP amendments for DSS were completed on March 15, 2004. CAP amendments for the period October 2002 through June 2003 were completed on March 17, 2004 for the Division of Mental Health, Developmental Disabilities and Substance Abuse Services.

The Cost Allocation Branch of the DHHS Controller's Office expects to be up to date on all the required CAP amendments for the Division of Social Services by April 30, 2004 and for the Division of Mental Health, Developmental Disabilities and Substance Abuse Services by June 30, 2004.

29. TENTATIVE SETTLEMENT REPORTS NOT FINALIZED IN A TIMELY MANNER

The Tentative Settlement Reports for three Mental Health Centers reported significant unearned amounts and were not finalized as of February 2004 for fiscal year 2002. Because of period of availability regulations, the Department is exposing itself to the risks that the unearned amounts will eventually be deemed unallowable if the settlement reports are not finalized during 2004.

The Department has no written established timeframes for the final settlement of the reports. The Tentative Settlement Reports are a vital link to the settlement of the funds between the State and the Area Mental Health programs. Three major federal programs were affected by this condition:

- Temporary Assistance for Needy Families
- Social Services Block Grant
- Substance Abuse Prevention and Treatment Block Grant

Adequate internal control dictates that the Tentative Settlement Reports between the State and the Area Mental Health Programs be completed on a timely basis.

Recommendation: The Department should develop timeframes for the finalization of Tentative Settlement Reports. Reports should be finalized in a timely manner to ensure that funds will be expended in accordance with rules and regulations.

Agency Response: The Department concurs with the finding and agrees with the recommendation. The completion of the Tentative Settlement Reports (TSR) involves receiving and processing information from other DHHS agencies and entities outside of the Department. The Department will work with these agencies and entities to develop procedures that will allow TSRs to be completed on a timely basis. Federal Grant adjustments, if necessary, will be appropriately applied upon final settlement of the identified Area Programs' TSRs.

30. INADEQUATE DOCUMENTATION OF FEDERAL DRAWDOWN ESTIMATES

The Department did not have adequate documentation of estimated cost calculations to support eleven drawdowns of federal funds. The Department does not use the method prescribed in the Treasury-State Agreement, nor does it have an approved and formally documented method, for computing federal drawdown estimates. According to the approved Treasury-State Agreement between the U.S. Department of Treasury and the State of North Carolina, estimates should be based on actual expenditures for the prior three months.

The Department uses historical payments from prior years, adds an inflationary factor, and makes adjustments based on communication with the Division's budget office to compute the drawdown estimate. Adjustments supplied by the Division's budget office were not supported.

The lack of documentation and the Department's method of estimating drawdowns cause it to be out of compliance with the Treasury-State Agreement. Also, this deficiency may lead to the Department's drawing of federal funds in excess of its needs and federal funds held for more than three business days.

Recommendation: The Department should implement procedures to maintain supporting documentation for all draws of federal funds. The Department should use the approved process for estimating the federal funds needed or develop a process for this estimation and gain approval from the U.S. Department of Treasury. The method should be one that computes estimates close to the actual anticipated expenditures in an effort to prevent excessive balances being held and to ensure compliance with the Treasury-State Agreement.

Agency Response: The Department concurs with this finding. The Department reviewed prior agreements between the U.S. Department of Treasury and the State of North Carolina implementing the provisions of the federal Cash Management Improvement Act of 1990 and determined that prior to 2003, there were no instructions in the agreement which indicated how estimates for the drawing of federal funds were to be done. We will review our current draw procedure based upon the new criteria and will develop a written procedure for future draws. This new procedure will be developed and utilized by the end of May 2004. Our current procedure has been based on using historical data for the same timeframe from prior years and adding an inflationary figure and then discussing the projected draw with the DMA budget office. We document the amount of the draw on a Checkwrite History Schedule and include notes for any variance from this figure (for example, if program funds are over/under drawn and the amount of the EDS draw is adjusted.) The amount of federal funds on-hand is constantly monitored by the Controller's Office. The CMIA Worksheet, updated daily, reflects the amount of expenditures and revenues for Program and Administrative funds. If we are excessively over/under drawn, an adjustment is made as a result of that review.

31. INTERNAL CONTROL WEAKNESSES OVER ACCOUNTS RECEIVABLE

We noted numerous internal control weaknesses and shortcomings in the accounts receivable system:

a. There is no independent review of the information entered into the accounts receivable system by accounting technicians. This makes the immediate identification of errors and mistakes nearly impossible.

b. The accounts receivable system does not provide reports that would benefit the Department and does not provide the information often needed for effective management and record keeping. For instance, the system does not allow for the review of items and tracking of monies once a receivable has been paid in full. Also, the system flags disputed amounts and reports them as current rather than maintaining their proper aging date.

c. The Department has failed to develop policies and procedures for the recognition of disputed accounts receivable in the year-end accrual process. This has a significant impact on the amounts that are being reported as allowance for doubtful accounts, which could lead to over or understating accounts receivable.

d. The Department failed to follow the cash management plan for writing off outstanding accounts receivable that have been deemed uncollectible. For example, the Department continued to book $7.5 million of third party recovery accounts receivables that were in excess of a year.

e. The Department failed to seek collection of $566,000 in accounts receivable amounts that had been transferred from its claims processing contractor, as required by the Department's cash management plan.

f. The Department failed to submit amounts over $500 and 90 days outstanding to the Attorney General's Office for collection as required by GS 147-86.11.

g. The Division of Medical Assistance has not ensured that its claims processing contractor follows the same policies and procedures that are followed by the Department for the recognition of accounts receivable, allowance for doubtful accounts, and bad debt write-offs.

These weaknesses in internal controls over accounts receivables could cause into question the accounts receivable amounts reported on the financial statements.

Recommendation: The Department should implement controls to ensure that accounts receivables information is reported accurately, completely, and reliably. Written policies and procedures should be developed for the recognition of disputed claims to accurately age accounts receivables for financial statement reporting. The Department should make active efforts to collect accounts, seek legal remedies, report past due amounts as required to the Attorney General's office and write off uncollectible accounts as appropriate.

The Division should ensure that its claims processing contractor is aware of and following the same accounts receivable policies as the agency regarding accurate reporting of accounts receivable, allowance for doubtful accounts, and bad debt write-offs.

Agency Response: A response for each internal control weakness or shortcoming in the accounts receivable system follows.

a. The Department agrees with the finding that there is no independent review of the information entered; however, we feel that there are other controls in place that are sufficient to assure the accuracy of the data keyed into the system. Data entered into the system by the Accounts Receivable (A/R) Technicians is subject to batch control (each Tech develops and enters a batch total prior to setting up the individual accounts) and a quarterly review of accounts is performed by the Branch Head to determine all accounts in excess of 60 days old. As an additional control measure, the A/R Supervisor will immediately initiate the process of selecting a random group of transactions for tracing from source documentation to

the keyed data in the A/R System. This method will be necessary since the NCAS A/R System does not produce a batch register for preview prior to posting.

b. The Department agrees with the finding that the accounts receivable system is outdated and requires replacement with a system that would provide basic reports, transaction registers, and invoices/collection letters. This system is the State Accounting System's Accounts Receivable Module and is provided by the Office of the State Controller (OSC). With OSC's concurrence DHHS is currently assessing the feasibility of converting all DHHS Accounts Receivable to a commercial accounts system. However, it should be noted that while some commercial systems would better meet DHHS's basic reporting needs, none of the commercial packages reviewed to date, at any price, can meet all DHHS requirements without custom reports and programming; therefore, should this option be selected it will be necessary for sufficient Information Technology support to be budgeted to assure adequate compliance.

   Aging of disputed amounts as current is a hardwired part of the NCAS A/R System. The logic behind the System's process is that while DHHS may consider the amount due in the account receivable to be valid, it is not collectable until such time as the dispute has been heard by the appropriate party. Generally this process is accomplished in a reasonable time frame and there is a mechanism in place to require payment of cost settlements prior to dispute resolution and program integrity findings to be paid upon completion of the review process within the Division of Medical Assistance. After one year closed items cycle off the System to a Closed Item Archive which can be accessed by transaction and does not provide any reporting capacity.

c. We agree with the finding that the Department doesn't have written policy and procedure to establish an allowance for disputed accounts to reflect the amount that management estimates will be uncollectible. It is the policy of the Department to consider all disputed amounts to be collectible until such time as a resolution is reached. However, at the time this policy was established it was not foreseen that items in dispute would remain in appeal status for the extended periods of time that have been experienced. The Controller's Office will request that DMA management verify the status of all service providers shown as being in disputed status: a) to assist us in determining those accounts that would still be deemed collectable so hearings could be held and collection, if appropriate, pursued; and, b) to determine those accounts that are no longer considered collectable and should be considered for write off. A schedule of disputed accounts will be prepared and provided to DMA management beginning with the Quarter Ending June 30, 2004. Additionally, the Controller's Office will work with DMA to review all disputed accounts at year-end in excess of one year old for a determination of their collectibility and the reason resolution has been delayed.

d. Prior to the spring of 2003, DHHS did not have the ability to "write-off" an account and still retain an accounting for the accounts; as required by OSC and DHHS policy. A write-off Division (WO) has been established in the A/R System. With this new Division, it will be possible to transfer accounts to the WO Division while still having access to the information on the accounts and complying with the OSC and DHHS policy of maintaining a permanent record of the accounts.

   The accounts addressed in the finding are an example of very old accounts, which should not be considered very high in terms of collectibility; however, these accounts provide the data from which DHHS manually prepares the submission to the Department of Revenue for the Set Off Debt (SOD) Program. Some funds are recovered each year as a result of participation in the SOD Program.

   Since the creation of the WO Division, DHHS's plan to transfer all amounts to the WO Division aged greater than one year and on which regular payments are not being made will be implemented immediately. Accounts meeting these criteria will be transferred to WO status by June 30, 2004, and thereafter no less than annually.

e. The Department agrees with the finding, however, we are not able to identify the accounts involved in the finding. We will need to review the detail, because all items returned to DMA by claims processing contractor are not bad debt "write off's" of accounts receivable, but also include return of provider debts forwarded by the Controller's Office and the Division for collection by offset from claims payments (these are in the A/R system and are subject to all standard collection activity). In addition the claims processing contractor forwards administrative corrections required to keep the accounts in balance.

   Upon being provided the detail which identifies the $566,250, all amounts will be reviewed to determine their status, and all appropriate accounts that meet the criteria will be forwarded to the AG's Office for collection activity. Effective immediately, all future amounts in excess of $500 from claims processing contractor's accounts receivable will be forwarded to the AG's Office.

f. The Department agrees with the finding in that some accounts receivables of other State agencies were not forwarded to the Attorney General's Office (AG) in accordance with established policy; however, DHHS submitted over 40,000 accounts to the AG in the current year. Due to our volume of past due accounts, the AG has authorized DHHS to refer these accounts directly to the contracted collection agency.

   The noted accounts in question, State Mental Health Hospitals, were in dispute between DMA and Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH) and the AG was representing DMA in the

settlement of the dispute. Therefore, since the AG was representing the Division in the resolution of the dispute, they were in fact representing us in the collection of the accounts receivable. The significant majority of amounts to be settled between the State Hospitals and DMA were resolved as of September 30, 2003 with the completion of negotiations between DMH and the Attorney Generals Office (representing DMA). As of December 31, 2003 these accounts have been cleared from the Accounts Receivable balance. A review of all accounts will be completed by June 30, 2004. Accounts not previously forwarded to the AG's Office for action will be forwarded.

g. The claims processing contractor personnel have been informed that they are subject to the provisions of the DHHS Cash Management Plan and have been provided with a copy of the DHHS Cash Management Plan. We have taken every opportunity to inform claims processing contractor personnel that as a contractor to the State, they must comply with the requirements of the DHHS Cash Management Plan. The Controller's Office will request that the claims processing contractor provide their written policy for the recognition of accounts receivable by June 30, 2004.

DIVISION OF VOCATIONAL REHABILITATION

32. IMPROPER ACCESS TO COMPUTER SYSTEMS

Instances were noted where former Division of Vocational Rehabilitation employees had improper access to the State's North Carolina Accounting System. Six former employees were still listed on the various security reports of the North Carolina Accounting System.

Control procedures for terminating access to the North Carolina Accounting System were not followed. Division supervisors did not inform the security administrator that the former employees were no longer authorized access to the accounting system. Improper access to computer systems can result in alteration, unauthorized use, or loss of information.

Recommendation: The Division should terminate former employees' access to the State computer systems in a timely manner. Division supervisors, or other appropriate officials, should inform the system security administrator immediately and in writing of any changes in a user's employment status. Periodic security access reviews should be conducted to ensure that access is restricted to authorized users.

Agency Response: The Department concurs with the finding. It is the practice of the Division of Vocational Rehabilitation Services to immediately terminate access to the State computer systems access by revoking the Resource Access Control Facilitator (RACF) ID the same date as an employee leaves. The Division felt that this action protected our data resources and also conformed to Departmental Policy. However, based

on the findings and recommendations of the State Auditor we have initiated the following corrective action:

1. All requests for access to the North Carolina Accounting System (NCAS) must be approved by the Division Budget Office.

2. As employees terminate employment with the division, the respective manager will directly notify the Division Budget Officer to terminate access to NCAS effective with the termination date. This action will be in addition to the revocation of the RACF ID.

3. The Division Budget Office has obtained access to an on demand report identifying all Division employees with access to NCAS. This report will be generated monthly and compared to the active employee roster to ensure appropriate access revocation for terminated employees.

33. BASIC SUPPORT CLAIMS WERE NOT PROPERLY PAID

There were weaknesses in the Division's controls over the payment of basic support claims in the Rehabilitation Services – Vocational Rehabilitation Grants to States program. There were ten outpatient claims, in an examination of 210 client files, which were paid using an incorrect methodology, resulting in an overpayment of $236. Lab fees paid hospitals were not priced correctly. Because likely questioned costs for all claims exceed $10,000, we are questioning the federal share of $186.

Section 1-11 of the Division of Vocational Rehabilitation internal policies manual requires that invoices for inpatient and outpatient hospital services be paid at the Medicaid rate. The Medicaid State Plan and the Hospital Manual define the correct methodology for the payment of lab fees.

Recommendation: The Division should strengthen internal controls to ensure that all invoices are properly processed and paid. Rates for inpatient and outpatient hospital services should be properly incorporated into the Division's payment procedures. The Division should determine the total impact of the overpayments and require reimbursement from providers.

Agency Response: The Department concurs with the finding. The Division will request a joint meeting of the Division of Medical Assistance (DMA) Rate Setting Staff, Department Health and Human Services Controller staff and Division Budget Office staff to review all medical payment requirements and procedures and establish communications leading to greater checks and balances to ensure that the Division fully complies with DMA medical payment process. The Division will work with the DHHS Controller's staff to collect any overpayments.

34. CONTROL WEAKNESSES OVER DETERMINATION AND DOCUMENTATION OF CLIENT ELIGIBILITY

There were control weaknesses related to the determination of client eligibility and financial needs in the Rehabilitation Services – Vocational Rehabilitation Grants to States program. Our examination of 210 client files revealed cases in which eligibility was not determined in a timely manner and financial needs documentation was unsigned by the client. Because of these weaknesses, the Division assumed an increased risk of paying costs related to ineligible participants.

- Required eligibility extension forms were not obtained or were not obtained in a timely manner for four clients. Federal regulation 34 CFR 361.41 and the Division's internal policies manual require that the eligibility extension forms be filed if eligibility cannot be determined within 60 days. If a decision regarding eligibility was not made within the agreed-upon extension, then another agreement must be issued to the client. Since clients were later determined eligible, there are no questioned costs.

- One client did not sign the Financial Needs form (Form DVR-0116). Section 1-13 of the internal policies manual requires that clients sign forms to either affirm their participation in completing the form or to document that they received copies of the documents from the counselor.

Recommendation: The Division should strengthen internal controls to ensure that the eligibility extension forms are obtained when required and the client, when required, signs all information and forms.

Agency Response: The Department concurs with the finding. In three of the four samples in which the eligibility extension forms were obtained but were extended beyond the projected date, the individuals were made eligible for services. In one sample, the individual's case was closed after rescheduling appointments numerous times and not being able to get the individual in to complete the eligibility process. This is related to the calculation provided by the case management system in "tickler" for eligibility determination. This time calculation has already been corrected. In the one sample, with an unsigned DVR-1006, the individual was eligible and services were provided. The lack of signature was an error.

Corrective action planned for both timeliness of eligibility decisions and completion of the DVR-0116 will include:

- Review of policy for needed changes to strengthen understanding and practice
- Training at the state, regional and unit office level.
- Review of policy and orientation for new counselors.

A statewide training and review plan will be utilized along with a status report to be completed, as each office is trained and individual situations corrected.

DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE

35. INADEQUATE SUBRECIPIENT MONITORING OF SOCIAL SERVICES BLOCK GRANT (SSBG) PROGRAM

The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (Division) did not perform sufficient monitoring procedures to provide reasonable assurance that subrecipients used SSBG awards for authorized purposes in compliance with grant requirements. Lack of subrecipient monitoring increases the risk that unauthorized activities and/or costs at the subrecipient level may occur and go undetected.

OMB Circular A-133 requires that pass-through entities monitor subrecipient activities to provide reasonable assurance that the subrecipient adminsters federal awards in compliance with federal requirements. The Division uses SSBG funds primarily to provide developmental disabilities services and communicates compliance requirements applicable to these services to subrecipeints and their auditors by preparing program compliance supplements. However, the Division does not perform follow-up procedures, such as on-site monitoring, to determine whether funds are used in accordance with program requirements.

Recommendation: The Division should develop and implement monitoring procedures that are sufficient to provide reasonable assurance that subrecipients use SSBG awards and other developmental disabilities funds for authorized purposes in compliance with grant requirements.

Agency Response: The Division performs extensive fiscal monitoring of SSBG. The Division was involved in a major reorganization as part of Mental Health Reform effective in March 2003. One outcome is the establishment of an Accountability Section which includes staff designated specifically to monitoring. This will assist the Division in strengthening its current monitoring process to include programmatic monitoring in addition to the current financial tracking and monitoring of SSBG funds.

DIVISION OF PUBLIC HEALTH

36. IMPROPER ACCESS TO COMPUTER SYSTEMS

Instances were noted where current and former Division of Public Health employees had improper access to two 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:

- Fifteen former employees were still listed on the various security reports of the North Carolina Accounting System. Control procedures for terminating access to the North Carolina Accounting System were not followed. The Division supervisors did not inform the security administrator that the former employees no longer needed access to the accounting system.

- Six employees were listed on the security reports of the North Carolina Accounting System with more access than necessary for their job responsibilities. These employees had inappropriate access to paying entity policy screens and vendor setup and control document entry screens. Individuals with access to these screens can override default policy, add/delete vendors and enter invoices into the accounting system.

- Twenty of twenty-five employees tested had inquiry/add/change/delete authority for the Health Services Information System when only inquiry or inquiry/add/change was needed.

In addition, documentation was not always maintained that authorized the access rights for the Health Services Information System. The "Request for User ID Services" form was not on file for eighteen of twenty-five employees sampled, and one form was not signed by the employee's supervisor.

Adequate internal control over computer systems require: a) that former employee access be terminated in a timely manner, b) that user/employee access be limited to levels needed to perform his/her job, and c) that access to information systems be authorized.

Recommendation: The Division should terminate former employee access to the State computer systems in a timely manner. Division supervisors, or other appropriate officials, should inform the system security administrator immediately and in writing of any changes in a user's employment status. The Division should evaluate and strengthen internal control to ensure that access rights are limited to employees on a need-to-use basis. Periodic security access reviews should be conducted to ensure that access is restricted to authorized users. In addition, the Division should ensure that all requests for user access are approved by the employee's supervisor and maintained on file.

Agency Response: The Department concurs with the finding. The Division of Public Health acknowledges individuals have/had improper access to computer systems. In the future, when an

individual assumes a job within the Division of Public Health, experiences responsibility/job changes, or separates from the Division of Public Health, a form/checklist shall be completed by the supervisor with regards to said individual. An item on the form will address access to computer systems and indicate to which system(s) the individual has or requires access. If the individual is separating from the Division, the form will be submitted to the Human Resources Office as a part of the separation packet. If the individual is a new employee or a change of responsibility for an existing employee occurs, the form will also be submitted to the Human Resources Office. In all instances, Human Resources will forward the form to the Security Administrator in order that the individual's level of access to State computer systems may be determined and adjusted based on his/her status with the Division.

Effectively immediately, an internal audit of users having access to computer systems will occur in order to assure appropriate individuals have appropriate access. Thereafter, the Division will review on a bi-monthly basis a list of its employees with access to State computer systems and ensure that continued access is necessary for each employee.

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 Services for the Blind.

DISTRIBUTION OF AUDIT REPORT

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.

EXECUTIVE BRANCH

The Honorable Michael F. Easley	Governor of North Carolina
The Honorable Beverly M. Perdue	Lieutenant Governor of North Carolina
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
Ms. Carmen Hooker Odom	Secretary, Department of Health and Human Services

LEGISLATIVE BRANCH

Appointees to the Joint Legislative Commission on Governmental Operations

President Pro Tempore	Speaker of the House
Senator Marc Basnight, Co-Chair	Representative James B. Black, Co-Chair
Senator Charles W. Albertson	Representative Richard T. Morgan, Co-Chair
Senator Patrick J. Ballantine	Representative Martha B. Alexander
Senator Daniel G. Clodfelter	Representative Rex L. Baker
Senator Walter H. Dalton	Representative Bobby H. Barbee, Sr.
Senator Charlie S. Dannelly	Representative Harold J. Brubaker
Senator James Forrester	Representative Debbie A. Clary
Senator Linda Garrou	Representative E. Nelson Cole
Senator Wilbur P. Gulley	Representative James W. Crawford, Jr.
Senator Fletcher L. Hartsell, Jr.	Representative William T. Culpepper, III
Senator David W. Hoyle	Representative W. Pete Cunningham
Senator Ellie Kinnaird	Representative W. Robert Grady
Senator Jeanne H. Lucas	Representative Joe Hackney
Senator Stephen M. Metcalf	Representative Julia C. Howard
Senator Anthony E. Rand	Representative Joe L. Kiser
Senator Eric M. Reeves	Representative Edd Nye
Senator Robert A. Rucho	Representative William C. Owens, Jr.
Senator R. C. Soles, Jr.	Representative Wilma M. Sherrill
Senator Scott Thomas	Representative Thomas E. Wright

Other Legislative Officials

Mr. James D. Johnson	Director, Fiscal Research Division

DISTRIBUTION OF AUDIT REPORT (CONCLUDED)

Other Officials

Mr. Charles J. Curtis	Regional Inspector General for Audit, U.S. Department of Health Human Services
Mr. Frank D. Whitney	United States Attorney, Eastern District of North Carolina
Ms. Robin Pendergraft	Director, State Bureau of Investigation
Honorable C. Colon Willoughby, Jr.	District Attorney, 10th District

April 13, 2004

ORDERING INFORMATION

Copies of this report may be obtained by contacting the:

Office of the State Auditor
State of North Carolina
2 South Salisbury Street
20601 Mail Service Center
Raleigh, North Carolina 27699-0601

Internet: http://www.ncauditor.net

Telephone: 919/807-7500

Facsimile: 919/807-7647