STATE OF NORTH CAROLINA

RESULTS OF

STATEWIDE FINANCIAL AUDIT PROCEDURES AT THE

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

FOR THE YEAR ENDED JUNE 30, 2004

OFFICE OF THE STATE AUDITOR

LESLIE W. MERRITT, JR., CPA, CFP

STATE AUDITOR

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State Auditor

April 29, 2005

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 of North Carolina reporting entity as presented in the *Comprehensive Annual Financial Report (CAFR)* and *Single Audit Report* for the year ended June 30, 2004. Our audit was performed by authority of Article 5A of Chapter 147 of the *North Carolina General Statutes.*

In the *CAFR*, the State Auditor expresses an opinion on the State's financial statements. In the *Single Audit Report*, the State Auditor presents the results of tests of internal control and 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 the Single Audit Act as applicable. Our audit scope at the North Carolina Department of Health and Human Services included the following:

State of North Carolina's Financial Statements

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

State of North Carolina's Administration of Federal Financial Assistance Programs

Aging Cluster:

- Nutrition Services Incentive Program
- Special Programs for the Aging – Title III, Part B – Grants for Supportive Services and Senior Centers
- Special Programs for the Aging – Title III, Part C – Nutrition Services

Block Grants for Prevention and Treatment of Substance Abuse

Child Support Enforcement

Food Stamp Cluster:

- Food Stamps
- State Administrative Matching Grants for Food Stamp Program

Foster Care – Title IV-E

Immunization Grants

Low-Income Home Energy Assistance

Medicaid Cluster

- Medical Assistance Program
- State Survey and Certification of Health Care Providers and Suppliers

Rehabilitation Services – Vocational Rehabilitation Grants to States

Social Services Block Grant

Special Supplemental Nutrition Program for Women, Infants, and Children

State Children's Insurance Program

Temporary Assistance for Needy Families

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 its administration of federal programs. Therefore, we do not express such conclusions.

The results of our audit procedures 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. These findings are included in the findings and recommendations section contained herein. Our recommendations for improvement and management's response follow each finding.

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

Leslie W. Merritt, Jr.

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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 discuss conditions that represent significant deficiencies in internal control and/or noncompliance with laws, regulations, contracts, or grants. Findings 1-8, 11, 13, 14, 19, 23, 24, 28, 29, and 32-34 were also reported in the prior year.

As required by OMB Circular A-133 Compliance Supplement, we have also summarized from the county audit reports for certain major programs administered by your Department the findings, recommendations, and agency responses that related to eligibility and have included them below as audit findings 9, 10, 20 and 21.

DIVISION OF MEDICAL ASSISTANCE

1. FINAL COST-SETTLEMENTS NOT PERFORMED

As noted in the prior year, the Division of Medical Assistance had not performed final cost-settlements for Disproportionate Share Hospital (DSH) payments to State-owned and non-State owned hospitals since the 1997 State fiscal year. The DSH 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 DSH payments to be adjusted or cost settled within 12 months of receipt of the completed cost report to ensure that payments do not exceed the State aggregate upper limits for such payments (cost of care). The failure to complete the cost settlements means the State does not know whether DSH payments made by the State exceeded the total costs of providing inpatient and outpatient services to Medicaid and uninsured patients.

In an effort to address this issue, the Division submitted a plan to the Center for Medicaid and Medicare Services of the U.S. Department of Health and Human Services to settle this and other DSH issues. The Division also contracted with two vendors to perform desk reviews and audits of hospital cost reports and determine cost settlement amounts. While some desk reviews and audits have been performed, no cost settlements have actually been made with providers.

The Division also submitted a State plan amendment requesting that both DSH and supplemental payments be paid on a "prospective basis." A second State plan amendment was submitted to clarify language concerning DSH payments and cost settlements.

Although the Division continues its discussions and negotiations to resolve the DSH issues, the two State plan amendments and the proposed settlement have not been approved by the Center for Medicaid and Medicare Services. Therefore, the Division is

required to cost-settle DSH payments in accordance with the current State Plan until otherwise approved by the Center for Medicaid and Medicare Services.

Recommendation: Division management should continue to 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 12 months of receipt of completed cost reports.

Agency's Response: The Division of Medical Assistance (DMA) appreciates the acknowledgement from the Office of the State Auditor that significant progress has been made towards addressing and resolving this finding. DMA has submitted a State Plan Amendment which clarifies the long-standing practice and intent of the current State Plan language, and makes the DSH program payments prospective – thereby eliminating the need for cost settlements in the future. DMA has also contracted with two nationally recognized firms to provide analysis and technical advice on its DSH program and to perform desk and field audits on state-owned/operated hospitals, teaching hospitals, 40 inpatient hospitals, and 125 hospital outpatient cost settlements on an annual basis.

DMA maintains that while there are still complex technical and legal issues which must be resolved regarding federal law and State Plan interpretation on cost settlements of DSH payments, there has been no failure to comply with requirements of federal law in the implementation of North Carolina's DSH payment program. Division and Department management are still in discussions with the Centers for Medicare and Medicaid Services to reach a final resolution of these issues.

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

It was noted in the prior audit that the Division of Medical Assistance made Disproportionate Share Hospital (DSH) payments to an ineligible organization for 41 public hospitals. The problem continued into the current audit period with the September 2003 DSH payment of $94.4 million that was paid to an ineligible organization rather than directly to hospital providers. The Division 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. 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.

Title 42 CFR section 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.

Effective with the March 2004 DSH and supplemental payments, which were for the December 2003 and March 2004 quarters, the Division ceased making payments to the ineligible organization. The payments are now being made directly to the hospital providers. The Division also implemented a policy in June 2004, that requires all DSH payments to be made directly to the individual hospital's normal operating account or another hospital-controlled bank account specified by the hospital.

However, it should be noted that the 41 public hospitals continue to have an escrow agreement, as described in the prior audit report, under which each hospital agrees to transfer its entire DSH payment to an escrow account that is controlled by the Hospital Liaison Committee. Also, a majority of the DSH payment amounts are still being transferred to the Division of Medical Assistance to be used to make certain additional supplemental payments to hospitals.

Recommendation: The Division should continue to make all DSH, supplemental, and other Medicaid payments directly to the providers or in the name of the provider as required by federal regulation.

Agency's Response: The Division of Medical Assistance (DMA) appreciates the acknowledgement from the Office of the State Auditor that the Division has ceased making DSH payments pursuant to the escrow agreement – thereby resolving this finding. All payments are made to the hospital's normal operating bank account or other hospital owned bank account as designated by the hospital. The finding, however, mentions that "41 public hospitals continue to have an escrow agreement..." The Division is not a party to this agreement and asserts that there is no known irregularity or finding which precludes the public hospitals from establishing an escrow agreement to facilitate a transfer of funds back to the State.

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

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. The failure by management to ensure compliance with the super DSH criteria contained in the amendments resulted in an estimated overpayment of $26.6 million (State funds of $9.1 million and federal share of $17.5 million) to 13 ineligible hospitals for fiscal year 2004. The federal portion of $17.5 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 for State fiscal year 2004 showed that DMA management authorized $26.6 million in super DSH payments to 13 hospitals that did not meet the State plan criteria.

Additionally, management did not have controls in place to ensure that the Division obtained the necessary information from all hospitals that received State Medicaid payments to accurately calculate the standard deviation or the fiftieth percentile requirements stipulated in the State Plan.

The Division submitted a State plan amendment to the Center for Medicaid and Medicare Services on March 30, 2004, proposing changes to clarify DSH eligibility criteria. The Center for Medicaid and Medicare Services has not yet approved the changes but requested additional information from the Division. Nonetheless, Division management has affirmed that the Division is currently complying with the proposed/revised State plan amendment when determining eligibility for DSH and supplemental payments.

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's Response: The Division of Medical Assistance (DMA) appreciates the acknowledgement from the Office of the State Auditor that significant improvements have been made to its DSH and Supplemental Payment Program. In fact, the Division

has submitted State Plan Amendments to CMS which propose changes to and clarifies DSH eligibility criteria. We have also ensured compliance with the proposed Medicaid State Plan and have developed and implemented a sound internal control system. Some of those improvements have included: performing trend analysis of all self-reported eligibility data and confirming all noted anomalies; and notifying and securing eligibility data from all hospital providers receiving Medicaid payments.

The Division's nationally recognized legal counsel, Covington-Burling, has stated that:

[NC's] 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 (State Auditors) interpretation of the finding 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 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 (1) 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 in section 1396r-4(d) (as repeated in paragraph (1) and subparagraph (a)(1)).

This is precisely how the Division has 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.

4. CLAIMS PAYMENT SYSTEM HAS WEAKNESSES

Our tests disclosed several weaknesses with the claims processing system.

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.

We uncovered errors in 24 claims from a sample of 273 Medicaid claims tested.

a. Ten of the errors were due to improper medical coding by providers, which resulted in a net overpayment of $31.

b. For one claim there were no medical records or other evidence to indicate that billable services were provided, resulting in overpayment of $197.

c. Ten claims were in error due to improper documentation in the medical records, resulting in an overpayment of $2,311.

    1) Medical necessity was not sufficiently documented for three claims and services that were billed and paid were not consistent with the diagnosis.

    2) For five claims, there was insufficient documentation in the medical records to indicate whether the services were consistent with the procedure billed or the diagnosis.

    3) The provider billed for more units of service than was documented in the medical records for one claim.

    4) Medical records for a claim that was paid did not have the required "plan for services" documentation.

d. Two claims were in error because the provider improperly coded services and incorrectly calculated the amount to be paid.

   1) A claim was improperly coded as a discharge instead of a transfer patient. Also, the provider coded the service to DRG 801 instead of the more appropriate DRG 385. This caused the claim to be overpaid by $42,565.

   2) A claim was improperly coded by the provider to DRG 804 instead of the more appropriate DRG 802. This caused the claim to be underpaid by $8,422. This claim was also incorrectly calculated based on a system programming error that adds one day to the day outlier calculation. (See below discussion on outlier calculations.)

e. For one claim, dental services were not consistent with the medical documentation.

The errors in the sampled claims totaled a net of $36,682. The federal share of this is $24,135 and is questioned.

Additionally, it was noted in our prior year audit that a system programming error added an extra day to the day outlier calculation. Due to the re-occurrence of this programming error in the current year, we tested all claims identified as having a day outlier calculation. Of the 200 claims that met this criterion, 168 claims were found to be in error for a total overpayment of $210,082. The federal share of this amount is $138,087 and is questioned.

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. Title 42 CFR section 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 amount.

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 underpaid claims are identified and appropriate collection or payment procedures are performed.

Agency's Response: The Division of Medical Assistance (DMA) concurs with the portion of the finding that notes that it failed to reconcile medical assistance payments to the Medicaid Accounting System. To address this portion of the finding, DMA has collaborated with the DHHS Controller's Office personnel (who enter the Medicaid payment information into the North Carolina Accounting System) to derive a means of

reconciling the data entered into NCAS as well as those entries created by the Medicaid subsystem. This reconciliation is being performed on a monthly basis. The collaboration to develop this process commenced in the early part of State fiscal year 2005.

It is important to note that the 24 claims referenced were provider billing errors that are ascertained by an audit of provider files. The NC DMA Program Integrity section is well-known as one of the leading states for their extensive work in determining provider compliance and recouping improper Medicaid billings. DMA staff have thoroughly researched each of the 24 claims cited in the finding. Four (4) of the sampled claims involved missing or incorrect documentation from the provider that was subsequently submitted or corrected. There was no overpayment in these four cases. Of the remaining twenty (20) claims, all have been resolved through recoupment/repayments and continuing education efforts to the provider community.

DMA concurs with the portion of the finding related to a system programming error for day outlier calculations. To address this portion of the finding, DMA issued a numbered memo (FO 04.351) on June 12, 2004, instructing EDS to remove the day of discharge in the calculation of Day Outliers. EDS began work under customer service request (CSR) NC012126 and the CSR was completed in October 2004. The overpayments are being recouped during the current State fiscal year.

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

For a significant portion of the audit period, the Division's Rate Setting and Medical Policy sections did not have written internal policies and procedures for setting rates or for implementing, reviewing, and reconciling rate changes. There were no written policies and procedures to define or determine the effective date for rate changes for procedures and services billed on claims. Also, there were no procedures defining how rate changes should be applied retroactively to previously processed claims.

There is no reconciliation of the number of rate changes authorized (submitted) by the Division with 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 does not receive a change report from EDS that could be useful in performing the reconciliation. Additionally, not all rate changes are verified for accuracy by the Division to ensure that individual rate changes are made correctly in accordance with instructions from the Division.

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. The rate applied to the claim was removed from

the system and 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. Subsequent to our audit period, the Division submitted a program change request to EDS to prevent rates from being removed or overlaid in the system.

The Rate Setting Section implemented a policies and procedures manual in May 2004. As a result, the section began verifying all rate changes submitted to EDS, the Division's claims processing contractor, within two weeks of submission and retroactively verified all changes submitted during the 2004 State fiscal year.

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 continue to develop and maintain policies and procedures that govern the implementation of rate changes, including procedures for reviewing and reconciling rate changes. The Division should obtain an appropriate change report from the claims processing contractor that will enable it to reconcile rate changes authorized with rate changes made. Additionally, the Division should ensure that the program change request to the claims processing contractor to prevent rates from being removed or overlaid in the system is implemented properly.

Agency's Response: The Division of Medical Assistance (DMA) appreciates the acknowledgement from the Office of the State Auditor that significant corrective action has been taken regarding the rate setting reconciliation process and associated procedures. As noted in the finding, DMA implemented standard rate setting policies and procedures during May 2004 which govern the rate setting process and the monitoring and control actions to be followed by its rate setting analysts on all rate changes. These procedures also include instructions to EDS on the effective date for a rate change, whether retroactive rate changes require recoupment and repayment by EDS, and that EDS is to furnish verification to DMA that EDS has correctly implemented all rate changes within two weeks of submission to them by DMA. Further, the procedures instruct EDS not to accept or implement rate change memoranda from DMA unless it contains the signatures of the Rate Setting Section Chief and Assistant Director for Finance Management. DMA has also retroactively verified all rate changes submitted by it to EDS during SFY2004.

DMA acknowledges and concurs with the recommendation for a reconciliation of rate changes it authorized to the rate changes implemented by EDS. DMA researched with EDS to determine whether existing reports can be generated to serve this purpose. Several reports already are available from EDS on the report-to-web which document all the rate changes made to the system. The reports identified are HMVR120R (accommodation rates), HMPR2001 (fee schedule/PD rates) and HMPR3101 (PR rates).

DMA Rate Setting will review these reports periodically for the 2005 State fiscal year to assure that only requested rate changes are made. DMA also intends to work with the new fiscal intermediary, ACS, to design a report that would allow for this rate change reconciliation after transition to the new intermediary.

However, the audit does not take into consideration that DMA's fiscal agent, EDS, has controls in place to verify rate changes. While DMA should and does monitor the contract, it is not practical or feasible to verify each and every transaction that EDS personnel enters into the MMIS system. Rather, DMA should test transactions to assure accuracy. If the monitoring reveals control and accuracy issues, a corrective action plan will be implemented.

DMA has also taken steps to implement EDS programming changes that would prevent the overlay of accommodation rates in the system and allow for EDS accommodation rate computer screens to display rate changes, associated effective dates and the DMA numbered memorandum authorizing the rate change. Development and testing of this programming change is completed and implementation by EDS is expected to occur by month-end April 2005.

Expansion of displayed rate changes in the current system beyond accommodation rates would require extensive additional programming time and costs by EDS and may jeopardize the system transition timetable to the new fiscal intermediary. DMA is currently in the design phase with the new fiscal intermediary, ACS. It is intended that the design of the new system will expand to all rates and display the current active rate, historical inactive rates and the associated dates of change used for claims pricing.

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

In our prior year audit, we noted a number of weaknesses with internal controls over investigations involving suspected fraud, abuse, and payment error cases. Generally, management has taken action to correct the weaknesses; however, the problems continued to exist during a significant portion of the current audit period. The specific weaknesses and corrective actions taken by management during the year are as follows:

a. The Home Care Review Section and the Payment Error Rate Measurement Section did not have written policies and procedures to provide sufficient guidance and documentation for their investigators. The section chiefs developed desk procedures in January 2004, which were incorporated into formal policies and procedures manuals for investigators in May 2004.

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. As of late

calendar year 2003, section chiefs review all cases, and evidence of this review is on the case tracking form.

c. Each section chief maintains his or her own informal process for documenting cases determined not to warrant preliminary investigations. However, this documentation is not summarized or used for tracking or evaluation purposes. Currently each section chief maintains a log and prepares a monthly summary report of the types of contacts that do not result in opening a case file for investigation.

d. Management did 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 agencies with a need to know, or to senior Department officials. In June 2004, a communication policy was implemented that requires Investigative Unit supervisors to prepare quarterly written reports for the assistant director of Program Integrity and which provides guidance on communicating findings to the appropriate management personnel. However, the process did not begin until after close of State fiscal year 2004.

e. Although written notice is provided each month to a sample of recipients as required by 42 CFR section 433.116, recipients were asked to return the Recipient Explanation of Medicaid Benefits (REOMB) form only if there was an error. Returned REOMBs were discarded if deemed not questionable. Subsequent to year-end, the REOMB was updated to request that all forms be returned whether or not there was an error.

The State Plan and 42 CFR sections 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 and the failure to document and communicate findings to upper management may hinder the agency's ability to prevent fraud and abuse in the Medicaid Program.

Recommendation: Management has taken action to address many of the issues, but we recommend that management continue the process of developing and updating formal written policies and procedures. Management should continue to expand and enhance

internal controls to ensure the effectiveness and efficiency of operations and compliance with applicable laws and regulations.

Agency's Response: The Division of Medical Assistance (DMA) appreciates the acknowledgement from the Office of the State Auditor that significant action has been taken to correct weaknesses with regard to internal controls involving review of fraud and abuse cases. The Division's Program Integrity (PI) organization constantly seeks to improve internal controls to ensure more efficient operations and compliance with laws and regulations, and continues to be recognized by CMS as a model program.

DMA agrees with the finding that the Home Care Review Section and Payment Error Rate Measurement Section did not have written policies and procedures in place during most of the audit period such that its investigators received sufficient guidance in the conduct of their investigations. It should be noted that all units in PI have completed and implemented formal policy and procedure manuals during May 2004. PI staff now use these procedure manuals to guide them in investigative work of fraud and abuse cases, case closure and the appeals process. These procedure manuals are updated as necessary when work procedures change.

DMA agrees with the finding that the Home Care Review Section, Provider Administration Review Section, Pharmacy Review Section and the Payment Error Rate Measurement Section could not demonstrate that closed cases had been reviewed by a Section Chief prior to case closure during the first half of the period audited. During late calendar year 2003 (and subsequently), potential closed cases are reviewed by Section Chiefs prior to closure. Evidence of that review includes the Section Chief signature and date on the case tracking form which is part of the permanent case file.

DMA agrees with the finding that during the audit period, Section Chiefs maintained their own informal processes for tracking telephone complaint cases. Procedures have been implemented such that, presently, each Section Chief maintains a monthly log of telephone complaints received. Complaints not opened as cases are documented and sent to the PI Assistant Director each month for subsequent review.

DMA agrees with the finding that management did not accumulate and report a summary of the fraud, abuse, and error cases uncovered to the Division or other senior Division officials. A new communications policy was implemented in Program Integrity during June 2004. Presently, identified issues/problems that need follow up by another section of DMA or another DHHS agency are documented and tracked by each unit within PI. A memorandum documenting the issue and a suggested corrective action is submitted by each Section Chief and approved by the Assistant Director. Each quarter these communications are summarized and reported to the Assistant Director for distribution to the Division's Senior management team. Quarterly reports have been completed for July 2004, October 2004 and January 2005.

DMA also acknowledges that the previous Recipient Explanation of Medicaid Benefits (REOMB) was not easily understood by the typical recipient. A modified and improved REOMB letter has been developed, and the revised form was first mailed to recipients in July 2004. The letter was modified asking the recipient to return the letter to PI regardless of whether the recipient noted an error. Of the 400 mailings per month, Provider Administrative Review Section (PARS) has received the following responses:

Run Month	Number of Returns	Errors Identified/Cases Opened
7/2004	92	0
8/2004	139	0
9/2004	107	0
10/2004	139	0
11/2004	118	0
12/2004	146	0
1/2005	128	0
2/2005	49	0
3/2005	None recorded yet	0

PARS staff has met, and will continue to meet, with ACS in the development of the REOMB process and other tools for the new MMIS system, NC Leads. It is intended to further improve the REOMB letter and the ACS version of the letter will have a look and language that is easier for the average recipient to understand. In addition, the REOMB case management process has been strengthened through development and implementation of a PARS procedure Manual which documents the procedures to be followed by staff at both DMA and at the fiscal intermediary.

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

The Division failed to perform for fiscal year 2003 any inpatient hospital cost audits of facilities that provided inpatient hospital services. Total inpatient hospital care expenditures for non-State owned facilities and for State owned/operated facilities were $907 million and $447 million, respectively. In addition, the Division did not complete the required long-term care facility audits on 13 of the seventeen 2002 hospital based nursing facility cost reports. Total payments made to these 13 facilities in State fiscal year 2002 were $13.5 million.

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 periodic cost audits of non-State owned inpatient hospital facilities. Inadequate staffing in the Division's audit section precluded the completion of the hospital based nursing facility and State owned facility cost audits.

In accordance with 42 CFR section 447.253(g), Medicaid agencies must provide for periodic audits of the financial and statistical records of participating providers that provided inpatient hospital services. The North Carolina State Plan required all cost reports of long-term care facilities 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 applied, whichever is later. As of October 1, 2003, the State Plan requirement for audit of nursing facility cost reports was amended to expand the 180-day requirement for an audit to one year.

The Division has contracted with two vendors to perform various types of audits on hospital inpatient services.

Recommendation: The Division should enhance controls to ensure that inpatient hospital audits are performed on a periodic basis and that required long-term care facility cost report audits are completed on a timely basis. The Division should ensure that its audit section is adequately staffed and has the resources to complete the required audits or should expand its vendor contracts to fulfill its audit requirements.

Agency's Response: The North Carolina State Plan does not speak to audits of non-state owned inpatient hospitals, and the governing regulation for audits of non-state owned inpatient hospitals - 42 CFR 447.253(g) - states only that periodic financial and statistical audits must be performed on participating providers. There is no requirement that audits be conducted within a particular period or with any particular frequency.

With regard to periodic audits, DMA executed a contract with an audit firm, Clifton Gunderson, LLP, in January 2004 to perform audits. The scope of this contract includes annual audits on numerous provider types, including audits on all state owned/operated hospitals, teaching hospitals, and 40 non-state owned/operated inpatient hospitals. Review of the 40 non-state owned/operated audits began with the provider's fiscal year end 2003 cost report. These reviews consist of an annual field audit of inpatient and outpatient costs for the ten hospitals identified as having the highest Medicaid revenue and annual desk audits of inpatient costs for the remaining 30 hospitals. For the first year of the contract, Clifton Gunderson is scheduled to complete 40 audits by June 30, 2005.

DMA concurs with the finding regarding 13 FYE 2002 hospital based nursing facility cost reports. Desk audits for these cost reports had not been completed as of SFY ended 6/30/2004. To address the completion of timely audits of nursing facility cost reports, the Division has taken a multi-fold approach. First, six of the thirteen outstanding audits were completed by March 23, 2005, and an additional six will be completed by May 31, 2005. On the remaining audit, the provider has failed to furnish required documentation and DMA has penalized the provider. Second, the State Plan was

amended and approved by CMS in 2004 to extend the audit timeframe of nursing facility cost reports from 180 days to one year. This change has an effective date of October 1, 2003. Third, DMA continues to take steps to ensure the Audit Section has adequate resources and staffing in place to complete desk reviews of cost reports within mandated timeframes.

8. 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 71 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 sections 455.104 through 455.106 are being requested. The enrollment packages for 42 out of the 71 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 42 types of providers were paid an estimated $3.29 billion this fiscal year, including matching federal funds, despite 42 CFR section 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.

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

- The Division does not require providers to periodically re-enroll in order to detect changes in eligibility status.

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

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

Also, the Division has not conducted any monitoring of the contractor responsible for the enrollment of practitioners to ensure compliance with its contract and to ensure that the enrollment process the contractor uses complies with rules and regulations.

These inadequate controls increase 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 11 instances of failure by providers to supply disclosures related to ownership and controlling interest and convictions for a criminal offense.

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

These deficiencies were also identified in the prior year audit. During the current fiscal year, the Division began a project to make enhancements to the provider enrollment process. This included revision to the application to obtain the necessary disclosures and to have a standard application for all providers. The Division has begun to develop procedures for sharing information internally and with agencies that have licensure or enrollment responsibilities to prevent unacceptable providers from enrolling in Medicaid. A procedure to re-enroll providers is being developed. However, as of June 30, 2004, these proposed procedures and enhancements have not been implemented.

Recommendation: 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 continue to work to implement a standard application to be completed by all providers to ensure that all of the disclosures required by 42 CFR part 455 are provided. Management should re-enroll providers on a regularly scheduled basis, should consider performing criminal background checks, and should verify the validity of provider licenses.

Management should also monitor the contractor responsible for the enrollment of practitioners to ensure the contractor's compliance with required laws and regulations related to practitioner enrollment.

Agency's Response: The Division of Medical Assistance (DMA) appreciates the acknowledgement from the Office of the State Auditor that it has taken significant

corrective actions to improve the provider enrollment procedures. Enrollment procedures are being modified to address the deficiencies noted. For example, physician enrollments are no longer processed by Blue Cross Blue Shield as DMA has brought this enrollment activity in-house. In addition, a revised application and agreement were developed and made available to these type providers on the DMA website during December 2004. These new forms require full disclosure by the provider applicant, including disclosure of ownership information. As of January 2005, these new forms are being utilized for all new enrollments and re-enrollments.

Additionally, DMA has contracted with a vendor to verify licensure, perform criminal background checks and review for possible OIG sanctions before providers are enrolled. For group practices, criminal background checks and reviews for possible OIG sanctions are conducted on all individuals with 5% or greater ownership interest in the enrolling provider organization. All organizations and individuals on the OIG Exclusion List have been reviewed and compared to the provider listing for the last couple of years on a monthly basis.

DMA continues to develop a fully comprehensive solution for all provider types in conjunction with the development and conversion to the new MMIS system, NCLeads.

9. DOCUMENTATION LACKING IN COUNTY MEDICAID CASE FILES

In North Carolina, each county determines eligibility for Medicaid benefits. The CPAs performing the county audits tested 2,883 case files for Medicaid recipients and found deficiencies in two cases. These files did not contain the re-determination dates. Program regulations require the proper completion of a re-determination form including proper signatures and dates that show the certification period or when the recipient is eligible for benefits.

If the dates are not included on the re-determination form, then it is difficult to ensure when the person was eligible to receive services.

Recommendation: The local government auditor recommended that the county increase the number of case files that are reviewed by the caseworkers' supervisor.

Agency's Response: The county responded that review procedures would be improved to reduce the instance of incomplete documentation. The Division of Medical Assistance appreciates the acknowledgement from the Office of the State Auditor that the CPA's performing the county audits found deficiencies in only two cases. We are very pleased with the 99.93% accuracy rate and believe that this extraordinarily high rate is a tribute to the staff in the 100 county departments of social services and State Division of Social Services that handled over 1.5 million cases in SFY 2004.

10. DOCUMENTATION LACKING IN COUNTY STATE CHILDREN'S INSURANCE PROGRAM CASE FILES

In North Carolina, the county Department of Social Services offices process applications related to the State Children's Insurance Program. The CPAs performing the county audits tested 642 case files and found deficiencies in one case. This case did not have a budget worksheet in the file.

If documentation is not obtained, clients that do not qualify may be allowed into the program.

Recommendation: The local government auditor recommended that the county ensure that policies and procedures related to adequate documentation exist and be adhered to.

Agency's Response: The one client budget worksheet was prepared and included in the file by the county. The county has reviewed and improved policies and procedures related to maintaining adequate documentation in client files. The Division of Medical Assistance appreciates the acknowledgement from the Office of the State Auditor that the CPA's performing the county audits found deficiencies in only one case that has subsequently been corrected. We are very pleased with the 99.84% accuracy rate and believe that this extraordinarily high accuracy rate is a tribute to the staff in the 100 county departments of social services and State Division of Social Services.

DIVISION OF SOCIAL SERVICES

11. 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 improvements 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 continue to contribute to the numerous errors noted. (All cases tested originated from State-operated offices.)

a.) Paternity was not established within the required period for 23 of the 37 cases tested in "paternity status," a 62% error rate. Actions contributing to the noncompliance included failure to take action on successful "locate matches," failure to verify mailing addresses or employment, failure to contact the absent

parent when a verified address was available, and 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 25 of the 35 cases tested in the "establishment status," a 71% error rate. Actions contributing to the noncompliance included failure to take any action on the case and failure to take the appropriate action on the case within the required period.

c.) Appropriate or timely enforcement action was lacking for 20 out of the 34 cases tested in "delinquent status," a 59% error rate. Actions contributing to the noncompliance included failure to take the required action and failure to take the appropriate action within the required period.

d.) Appropriate enforcement action was lacking for 15 of the 44 cases tested to determine if medical support obligations had been secured or enforced, a 34% error rate. In four cases, 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 seven cases, the child had not been added to the non-custodial parent's insurance policy. In another four 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 24 of the 45 interstate cases tested, a 53% error rate. Actions contributing to the noncompliance of interstate cases included interstate transmittal documents not being sent to the appropriate states, referrals not sent within the required 20-calendar day referral timeframe, and no action taken after the interstate case was opened.

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 services necessary as a responding state.

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

Agency's Response: Based upon the federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), the federal Office of Child Support Enforcement (OCSE) now requires each state's Child Support Enforcement program to monitor program compliance in accordance with OCSE Action Transmittal 98-12. AT 98-12 states: *"In moving towards a more results oriented review, if the State achieved a successful outcome (during the 12 month review period), the State will consider the case to be an Action case and will not evaluate required time frames for the review period for that Review Criterion."* Based on this federal mandate, North Carolina's Child Support Enforcement Program (CSE) utilizes data warehouse technology and reviews every case quarterly in eight performance categories. The data warehouse quarterly Self-Assessment reports are available to all area and local office management. The reports identify the percent of cases that pass or fail based on OCSE's 1998 criteria and identify each case that fails.

CSE is required to review cases for both the establishment of paternity and the establishment of support in the category of "Establishment of Paternity and Support Orders." CSE's scores in the Self-Assessment category of Establishment of Paternity and Support Orders have improved each year since 2001.

CSE is required also to review cases for the category of Enforcement. CSE's scores in the Self-Assessment category of Enforcement have improved each year since 2002. The NC CSE Program utilizes enforcement remedies in addition to the show cause hearing or income withholding notice addressed in the audit. CSE submits the noncustodial parents for federal and state tax intercept and the financial institution data match (FIDM). Often, these enforcement actions are the only action left to take after income withholding; however, these actions are not considered for the state level audit. Monies collected from tax intercept for FY 04 was *$34,555,474*. CSE centralized the FIDM process in February 2004. Since that time, we have collected more than *$3 million* from the bank accounts of our child support payors. CSE also intercepted funds from the NC Treasurer's unclaimed property through a centralized project. More than *$173,000* was collected and disbursed to families. CSE will continue to use local office corrective action plans and the quarterly Self-Assessment reports as tools for sustained improvement.

Cases are also reviewed for the category of Medical Support Enforcement. CSE's scores in the Self-Assessment category of Medical Support Enforcement have improved each year since 2002. For Federal Fiscal Year October 1, 2003-September 30, 2004, the score is 80% overall and also 80% for the state operated counties. This *exceeded* the compliance standard of 75%. While the pass rate for FFY2003-2004 is outside of the review period for this audit finding, it validates our efforts to improve in this area. CSE will strive to continue to improve in this area as part of our overall strategic plan for performance improvement.

CSE's scores in the Self-Assessment category of Interstate have improved since 2003; however, Interstate cases remain one of most challenging program areas. This is because

Interstate cases involve not one, but two or more states. North Carolina workers are dependent upon another state to take whatever action is needed on the case. No matter how aggressively the local worker pursues the child support case, an action or response from the other state is necessary to establish or enforce a child support order. Recognizing the need to have the most accurate information about Interstate cases, CSE is participating in the Federal Interstate Case Reconciliation Project. This is a voluntary project where participating states agree to perform mutual data updates to ensure that accurate and reliable information is communicated. Having reliable data stored in each state's data base will expedite the transmission of information and improve the establishment and enforcement of child support orders. CSE will continue to use local office corrective action plans and the quarterly Self-Assessment reports as tools for continued improvement. Additionally, modifications to the ACTS case management system will be implemented by October 2005, to automatically generate certain Interstate documents when they are required. These efforts are expected to further improve the Self-Assessment scores in the category of Interstate.

To address the needs of the program, CSE has embarked on a mission called "Journey to Excellence." This is a five year plan developed by our committee of DSS Directors, CSE Agents and Central Office staff. The plan includes utilization of the Malcolm Baldrige Business Performance Improvement Plan. Efforts from this Committee and utilization of the Baldrige plan are underway. Using the recommendations from this committee will assist CSE in reaching the Federal goal of 75% cases in compliance. A few of these recommendations follow. Legislation to eliminate the requirement to have a certified copy of the birth certificate for the child has been prepared for the current legislative session. Waiving this requirement will decrease the length of time required to establish paternity and assist with meeting the mandatory time frame. CSE is training local agents in DNA testing to reduce the time by eliminating missed appointments and making it convenient for both parents to receive the testing at the local office rather than at a lab. The goal is to have one worker per county trained (21 counties have already been trained.) The establishment training modules have been revised and a statewide training effort for establishment workers is underway. Training on a continuous basis is needed because of the high turnover rate. The annual turnover rate is as much as 40% in some State operated offices, with an average turnover rate of 15% in all of the State operated offices. This compares to a turnover rate of 9% in all local offices.

Statewide since FY01 to FY04 our percent of cases under order has gone from 65.8% to 78.8%, and for State operated local programs from 61.8% to 74.1%. As a result of this growth in cases under order, our collections statewide have gone from $459.5 million in FY 01 to $561.3 million in FY 04 for a growth of 22.1%. During the same period of time, the State operated local CSE programs collections grew from $111.9 million in FY 01 to $134.3 million in FY 04 for a growth of 20.0%. This growth occurred even as the local offices dealt with a turnover rate as much as 40% in some State operated offices, with an average turnover rate of 15% in all of the State operated offices. This compares to a turnover rate of 9% in all local offices.

Child Support acknowledges these audit findings and will inform all area supervisors and local office supervisors of the findings. The audit findings will also be incorporated into CSE's program monitoring plan. CSE's corrective action plan requires each area supervisor to review North Carolina Single Audit findings and the federally mandated Self-Assessment and OCSE 157 reports for each local office within their area. Based upon the results, area supervisors work with local supervisors to develop a corrective action plan for each local office. Area supervisors are required to monitor each local office's performance monthly and to ensure that the corrective action plan is being implemented.

12. SUBRECIPIENT MONITORING DOCUMENTS IN THE TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF) PROGRAM WERE NOT MAINTAINED

The Division of Social Services did not adequately document that Work First cases were monitored. From our sample of 14 counties, we noted that for two counties the Division's Work First monitor could not locate the case selection worksheets or any of the Work First monitoring guides required to be completed for the cases. For a third county tested we also noted that the monitoring guide for one case could not be located. In the absence of adequate monitoring procedures, noncompliance with federal regulations could go undetected.

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

Recommendation: All monitoring activities should be documented and retained in a format that clearly defines the procedures performed, the results obtained, and the corrective action planned.

Agency's Response: Before we address the actual audit finding, it should first be noted that:

- OMB Circular A-133 does require monitoring but it does not require annual monitoring. In fact, both monitoring and audit activities are to be prioritized based on risk assessment. Counties are typically low risk which is further substantiated by other findings in this Single Audit report indicating state-wide accuracy in a number of programs of over 99% (99.5% for the TANF Program).

- Secondly, monitoring documentation is not limited to "monitoring guides," but can be documented "*through reporting, site visits, regular contact, or other means to provide reasonable assurance that the subrecipient administers Federal awards in compliance with laws, regulations, and the provisions of contracts or grant agreements and that performance goals are achieved*." (OMB Circular A-133)

On-site monitoring activities did occur in these counties in September and October 2003. However, during this period monitoring activities were being conducted by the Work First field staff during routine county visits. Montgomery County was monitored on September 17, 2003, Henderson on September 23, 2003, and Polk County on October 2, 2003. Field staff used the established monitoring tool for record review. Monitoring forms, related verification information, and follow-up corrective action correspondence were to be maintained by the Work First Representatives for a period of time to be determined. During the transition between field staff completing the monitoring activity and compliance monitors assuming those duties in January 2004, some documentation was misfiled.

Subsequent to these reviews, the Division has hired two full-time compliance monitors who began monitoring activity for TANF subrecipients in January 2004. These two monitors secured all available completed tools from field staff and established a new filing system in the Central Office. The revised monitoring plan and tools are now being completed by the compliance monitors. Completed tools, notices of monitoring visit, and all supporting documentation is now being filed as soon as completed in the monitoring filing system in the Central Office.

There is ample documentation to verify that monitoring activities did occur in the counties in question. However, the Division is not able to produce the completed monitoring tool for the selected case in Montgomery County or the sample logs for either Polk or Henderson Counties. The actions taken by the Division effective January 2004 will ensure these findings are not repeated in future audit events.

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

As noted in our prior audit, 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, six 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 applicable 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's Response: The Division acknowledges these identified weaknesses in monitoring the IV-D Non-Cooperation cases. Prior to January 2004 compliance monitoring in TANF cases (including IV-D cooperation) was conducted by the Work First field staff during the course of their regular visits to assigned counties. 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 had 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 IV-D Non-Coop sanction, and whether the requested sanction was applied appropriately.

In January 2004, the Division hired two full-time compliance monitors to conduct monitoring activities on TANF (Work First) cases in all 100 counties. Subsequent to their hiring, the Division has revised the Work First monitoring plan and updated the monitoring tools. The plan and tool now require the monitors to examine the DHREJ NON-COOP WITHOUT A IV-D SANCTION report to identify any cases for the county being monitored. The monitors select a sample to be monitored from that list. These actions taken by the Division will ensure these findings are not repeated in future audit events.

14. 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. 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 2004. 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 $4.1 million.

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's Response: Before we address the actual audit finding, it should first be noted that:

- OMB Circular A-133 does require monitoring but it does not require annual monitoring. In fact, both monitoring and audit activities are to be prioritized based on risk assessment.

- Secondly, monitoring documentation is not limited to monitoring visits, but can be documented in a variety of ways such as *"through reporting, site visits, regular contact, or other means to provide reasonable assurance that the subrecipient administers Federal awards in compliance with laws, regulations, and the provisions of contracts or grant agreements and that performance goals are achieved*." OMB Circular A-133

The audit finding is correct in a narrow sense, that is, on-site monitoring visits were not complete by June 30, 2004. However, on-site monitoring visits were completed for federal fiscal year 2004 projects during the months of July and August 2004 (within the Federal grant year) to meet federal monitoring time-frames. As previously indicated, OMB's definition of monitoring is a much broader concept than actual site visits. For example, fiscal monitoring activities take place each time a subrecipient invoice is reviewed for payment. It is not possible to schedule all monitoring visits in the first few months of the year. However, visits were made to a site for each project to evaluate programmatic requirements and a fiscal review was also completed for each project. Subsequent annual monitoring visits will be scheduled within federally required time frames to complete both programmatic and fiscal monitoring for each project. A monitoring visit, even late in the fiscal year, is beneficial to the following year's grant to the subrecipient. During the first nine months, other monitoring activities were taking place.

15. ERRORS IN THE ACF-TITLE IV-E-1, FOSTER CARE AND ADOPTION ASSISTANCE FINANCIAL REPORT

Amounts reported in and deemed to be critical information in the ACF-Title IV-E-1, Foster Care and Adoption Assistance Financial Report were misstated. Line 1 of this report was overstated by $13,387 and the amount reported on line 8 was understated by $109,954. Misstatements could result in costs incorrectly charged to the federal program. The errors were due to an incorrect formula/missing field on the agency prepared worksheet used to accumulate the amounts for the federal report.

Good internal controls dictate that amounts reported on federal reports be accurate and agree with the accounting records.

Recommendation: The Division of Social Services should implement review procedures to ensure that amounts reported on the federal reports are accurate and agree to the supporting accounting records. Review procedures could include recalculations and periodic comparison to supporting documentation. Also, formulas in supporting worksheets should be periodically reviewed to ensure accuracy.

Agency's Response: The Division acknowledges this finding regarding the amounts reported in the ACF Title IV-E-1 report. During the period under review, the Child Welfare Waiver Demonstration Project (IV-E Waiver) was in transition through agreement with the United States Department of Health and Human Services Administration for Children and Families. The errors identified were miscalculations resulting from a formula error in the spreadsheet. At the time, the Division had one person completing all aspects of reporting expenditures associated with this demonstration project.

As of July 2004, the Division has begun implementation of phase II of the demonstration project, which includes contracting with an outside evaluator to track outcomes and costs under the demonstration project. This effort will allow the Division to cross-check calculations and expenditures. The Division will also be coordinating with the DHHS Controller's Office to develop a streamlined reporting process for the demonstration project that utilizes more system generated reports and relies less on human calculations.

In addition, the Division has created a new position that will assume tracking and reporting responsibilities under the demonstration project. This staffing addition will allow for a minimum of two-level checks and balances in costs reporting between the new position and their supervisor. It is anticipated this position will be filled by June 30, 2005.

The Division believes these changes will ensure this finding is not repeated in future audit events.

16. FEDERAL AWARD INFORMATION PROVIDED TO SUBRECIPIENTS NOT SUFFICIENT

The Division of Social Services did not include all of the required grant information in its Weatherization Assistance subrecipient contracts issued under the Low Income Home Energy Assistance Program. As a result, the nonprofit organizations receiving Weatherization Assistance funds did not have sufficient information to properly report federal expenditures in the Schedule of Expenditures of Federal Awards.

The Division did not adequately identify the federal awarding agency or Catalog of Federal Domestic Assistance (CFDA) number in the subrecipient contracts. Also, the Division did not identify the amount of expenditures reimbursed to subrecipients from each funding source. The Weatherization Assistance component of the program receives funding from the U.S. Department of Energy, the U.S. Department of Health and Human Services and the State's Petroleum Violation Escrow Funds. Since detailed funding information was not provided, many of the subrecipients reported the grants as funded solely by the U.S. Department of Energy or the U.S. Department of Health and Human Services.

OMB Circular A-133 requires pass-through entities (the Division) to inform each subrecipient of the CFDA title and number, award name and number, and the name of the

federal funding agency. The Department of Health and Human Services is currently instituting a system that would allow nonprofit organizations to obtain reports of expenditures by federal award via the Internet.

Recommendation: The Division should provide subrecipients all information needed to properly report federal program expenditures.

Agency's Response: The Department acknowledges the finding and has initiated the following action. Effective August 23, 2004, all subsequent Office of Economic Opportunity contracts for the Weatherization Assistance Program and the Heating and Air Repair and Replacement Program will show CFDA numbers of both the U.S. Department of Energy Weatherization Assistance Program, CFDA 81.042, and the U.S. Department of Health and Human Services' Low Income Home Energy Assistance Program, CFDA 93.568. The matrix for CFDA 81.042 for SFY 2004-05 will correctly reflect that special tests and provisions apply. Both matrices for CFDA 93.568 show that special tests and provisions apply.

A new DHHS system to provide audit confirmation of DHHS financial assistance payments made to nongovernmental entities has been loaded on the Internet as of November 19, 2004. The site provides three (3) years of data for financial assistance payments that accommodates different fiscal years and facilitates accrual reporting as needed. The reports can be read with the Adobe Acrobat Reader (version 4.0 or higher) software. The Search is by name or Federal ID number (EIN). The N.C. Center for Nonprofits included a paragraph announcing the new website in their latest newsletter. The N.C. Association of Certified Public Accountants has indicated an interest in announcing the new website in one of their future member mailings. These actions will provide subrecipients all information needed to properly report federal program expenditures.

17. SUBRECIPIENT MONITORING DOCUMENTS NOT THOROUGHLY REVIEWED

The Division of Social Services did not thoroughly review some of the documents used to monitor subrecipient compliance in the Low Income Home Energy Assistance Program. As a result, the effectiveness of compliance monitoring was reduced.

For some grants, the Division performs during-the-award monitoring by having subrecipients complete and submit several self-monitoring forms. We examined the "Review Guides" and "Case Review" documents for 25 counties that received Low Income Energy Assistance and Crisis Intervention funds and noted that a Review Guide for one county and Case Review documents for 10 counties were not completely filled out. There was no indication of field representative follow-up concerning the omitted information as required by the Division's official monitoring plan.

Recommendation: The Division should strengthen internal controls to ensure that all self-monitoring forms are reviewed and appropriate personnel follow up on any

omissions or other issues. The Division should consider requiring the reviewer to sign and date each form indicating that the review was completed.

Agency's Response: The Division agrees with the finding. We are taking steps to ensure that self-monitoring forms are being completed and properly reviewed by the assigned field representatives before forwarding to the state social services office. The field representatives were advised in an email dated January 6, 2005 that beginning with the self-monitoring guides due in late January 2005, each field representative is required to sign and date the front page of each review guide to affirm review and acceptance of the completed guide.

18. IMPROPER ACCESS TO COMPUTER SYSTEM

Two former Division of Social Services employees continued to have access to the State's North Carolina Accounting System and were still listed on its various security reports. Control procedures for terminating access to the 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's 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's Response: The Division of Social Services concurs with the finding. All Section Chiefs in the Division will be reminded that the Security Administrator must be notified immediately in the event of a termination. The Security Administrator will review access lists for all major systems quarterly to ensure that only active and authorized staff have access. The Personnel Section will add "Notify Security Administrator to revoke employee's access to computer systems" to their Exit Interview Check List to ensure notification is provided to the Security Administrator.

A new Information Security Procedures Manual is being written as part of a larger DHHS Information Security project. The above procedures will be part of it, which will be communicated to all employees.

19. WEAKNESSES IN CONTROL OVER PHYSICAL INVENTORY OF FIXED ASSETS

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

a.) The Division's own tracking system revealed that of the 121 child support enforcement locations, 55 locations failed to turn in annual inventory reports before the May 15, 2004, deadline and of these, 11 were after June 30, 2004. Also, four locations submitted incomplete inventory packets. The Division also sent incorrect inventory listings to some locations. Locations that fail to return completed inventory packets when required prevent the Department from updating fixed asset records with current information.

b.) A sample of 25 inventory packets from county and child support enforcement locations were tested and disclosed the following errors for 13 locations:

- Thirty-two assets were added to the inventory worksheets but were not subsequently added to the equipment records. Also, one location was not corrected in the system based on the inventory worksheets. For these 33 assets, FAS-1 forms were not obtained.

- Two assets were removed from the system or locations changed, which was not consistent with the inventory worksheets, and there was no FAS-1 form for documentation.

- Six assets were noted as missing or traded on the inventory FAS-1 forms but were not corrected in the system. Three assets had incorrect serial numbers.

- Fourteen assets were removed or updated in the fixed asset records based on inventory worksheets without the proper FAS-1 form documentation.

c.) Two inventory packets distributed to county and child support enforcement offices for annual inventory were incomplete. One was missing pages and one had no indication that an inventory had been performed.

d.) The inventory packet for the Raleigh child support enforcement office was tested to determine if inventory items were adequately safeguarded and tagged. From a sample of 45 items, four items that were certified as being inventoried could not be located. Four additional items did not have a fixed asset decal displayed and three of these had incorrect serial numbers.

e.) In addition, controls were not in place to ensure that all equipment purchases with child support enforcement funds were recorded in the equipment records. Seven items totaling $10,375 were not entered in the equipment records.

Title 45 CFR section 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 ensure 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. The Department's Office of the Controller's inventory procedures require that 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 completed inventory worksheets are submitted in a timely manner, that equipment records are changed to correctly reflect the results of the physical inventory, and that all equipment purchases are entered into the fixed asset system. Physical inventory procedures should be closely followed. The Division should also emphasize the fixed asset policy to use FAS-1 forms when changes to the fixed asset records are needed and the importance of fixed assets being properly tagged.

Agency's Response: The Division agrees with the findings. The Division has made progress in improving the Fixed Assets management process. Currently the Division is developing Asset Management procedures and will be conducting training during the SFY 04-05. The training will cover acquisition of assets, assigning and affixing asset decals, asset accountability and disposition. All state staff that have been designated as Fixed Asset Coordinators will be required to participate in this training. Coordination with the DHHS Controller's Office will continue to ensure effective maintenance of the equipment records. Procedures have been developed and implemented to ensure that newly assigned decals are affixed to the asset as required. The Division will continue to utilize and improve the tracking matrix first developed for the SFY 03-04 asset inventory to ensure more thorough follow-up on missing and incomplete asset inventories.

20. DOCUMENTATION LACKING IN TANF CASE FILES

North Carolina grants Temporary Assistance to Needy Families (TANF) funds to counties as part of the Work First County Block Grant. Each county is responsible for ensuring that only eligible families are approved for Work First. The CPAs performing the county audits tested 1,533 case files for the TANF Program and found seven deficiencies. The findings are summarized below.

- In two cases, the application for re-certification was not completed properly. The State Plan requires counties to maintain documentation in the case file related to the application.

- Three case files did not contain the "Mutual Responsibility Agreement." Program regulations require this agreement, signed, in order to receive TANF benefits.

- Two clients had their applications approved and received benefits prior to registering with the First Stop Employment Assistance Program. One of these clients did not have the substance abuse screening performed as required. The Work First Manual requires all adults to register with the First Stop Employment Assistance Program before the application is approved. In addition, a substance abuse screening must be performed on all applicants.

The questioned costs in these cases total $9,061, and we believe that it is likely that questioned costs exceed $10,000 in the population.

Recommendation: The local government auditors recommended that a process be implemented to ensure that the case files are complete and contain all the required documentation. Also, procedures should be developed to verify that individuals are eligible for the program.

Agency's Response: The counties that were impacted agreed with the findings. While there is always room for improvement, we are very pleased that the counties' accuracy rate for the audit sample selected was 99.5% which is quite an accomplishment.

21. INELIGIBLE PAYMENTS CHARGED TO FOSTER CARE IV-E PROGRAM

In North Carolina, each county is responsible for determining Foster Care IV-E eligibility. The CPAs performing the county audits tested 656 case files and found deficiencies in two cases. In these cases, the individuals were not eligible for subsidy under the Foster Care IV-E program as income limits were exceeded in each instance.

The questioned costs in these two cases are $2,483, and we believe that it is likely that questioned costs exceed $10,000 in the population.

Recommendation: The local government auditor recommended additional training be provided to caseworkers who determine eligibility under the IV-E program and that a second review be performed of the eligibility determination for all individuals eligible under the IV-E program.

Agency's Response: The county agreed with the finding. While there is always room for improvement, we are very pleased that the counties' accuracy rate for the audit sample selected was 99.7% which is quite an accomplishment.

DIVISION OF CENTRAL ADMINISTRATION

22. FINANCIAL STATUS AND PROGRAM COST REPORTS NOT IN AGREEMENT WITH ACCOUNTING RECORDS

Errors were noted in two Financial Status Reports and one Program Cost Report submitted by the Department for the Rehabilitation Services - Vocational Rehabilitation

Grants to States Program. These errors may reduce the usefulness of data submitted to federal funding agencies. The following errors were noted:

- On the Financial Status Report submitted by the Department for the quarter ending September 30, 2003, for the Division of Vocational Rehabilitation 2003 grant, the current period total outlays did not agree with the accounting records. However, the previously reported amounts agreed with the prior report and the cumulative year-to-date amounts agreed with the accounting records. There was a change in the methodology to accumulate expenditures. The current period amounts were adjusted to make the report properly compute, but were not adequately explained in the report or supporting documentation.

- On the Financial Status Report submitted by the Department for the quarter ending June 30, 2004, for the Division of Vocational Rehabilitation 2004 grant, the "Undisbursed Program Income" amount was understated by $23,441. The error was a carryover from the March 2004 report. The agency did not discover the error because only a quarter-to-date program income report was obtained for June 30, 2004, rather than a cumulative year-to-date report to verify the amounts. The federal funding agency was made aware of the error and it was corrected in the December 2004 Financial Status Report.

- On the Program Cost Report submitted by the Department for the federal fiscal year ending September 30, 2003, for the Division of Services for the Blind, the amount reported for "Amount of Previous Fiscal Year Section 110 Allotment Carried Over and Expended This FY" was overstated by $56,771. The error was due to double counting a prior year carry-over when computing the allotment carry-over amount. The federal funding agency was made aware of the issue and requested that the correction be made in the comparable 2004 report.

Failure to accurately report program expenditures, income, and carry-overs will cause over or under statements of expenditures that result in incorrect calculations for matching and level of effort requirements. Such errors can result in a reduction of future federal funding or a required repayment to the federal government.

Recommendation: The Department should implement procedures to ensure that amounts reported on the quarterly Financial Status Report and annual Program Cost Report are supported by the financial records and adjustments are adequately explained. Quarterly and year-to-date program income amounts should be accumulated each quarter. Corrections should be made in subsequent reports as requested by the federal funding agency. The Department should ensure that report reviews are complete and adequate to prevent the errors that result in having to file multiple report revisions.

Agency's Response: The Department concurs with the finding. The September 2003 Financial Status Report for the Division of Vocational Rehabilitation 2003 grant report does not require a revision since the year to date Federal and MOE expenditures are

accurate. For quarters prior to September 2003, program income could not be identified in NCAS. Internal controls were put in place January 2004 to identify expenditures and program income in NCAS. Supporting documentation from NCAS should agree to the current quarterly totals reported on the SF 269 each quarter.

The program income should be identified only after the division has certified each month to ensure that all program income totals are final for the month. The Controller's Office sends the Division Budget Office an e-mail each month notifying them that the Division has certified. Effective immediately, the program income will not be pulled from NCAS reports until notification is received of DVR certification. The undisbursed program income was corrected on the December 2004 269 report.

The SF 269 report was corrected for quarter ending September 30, 2004 by reducing the expenditures in the amount of $56,771. Since the RSA Federal coordinator advised the Department not to correct the error on the 2003 report, we will contact the coordinator and correct the RSA 2 report in April 2005. NCAS entries will be monitored each quarter for duplicate entries. Appropriate staff will be contacted if duplicate entries are discovered.

23. BASIC SUPPORT CLAIMS NOT PROPERLY PAID

There were weaknesses in the Department's controls over the payment of basic support claims for both the Division of Vocational Rehabilitation and the Division of Services for the Blind related to the Rehabilitation Services - Vocational Rehabilitation Grants to States program. An examination of 214 client files revealed that for the Division of Vocational Rehabilitation:

- The Department paid five vendors $8,746 without the required vendor signatures.
- Three inpatient claims were paid as outpatient claims resulting in an overpayment of $29,705.
- The amount paid for three invoices was more than the total on the documentation resulting in an overpayment of $978.
- Supporting documentation for one claim could not be located. The total amount of the claim is $4,521.

For the Division of Services for the Blind:

- The Department paid one claim in error based on a manual miscalculation performed by agency personnel resulting in an overpayment of $89.
- Supporting documentation for one claim could not be located. The total amount of the claim is $3,899.

The errors produced total overpayments of $47,938. We are questioning the federal share of $37,727.

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 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's Response: The Department concurs with the finding and the Auditor's recommendation to 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.

The deficiencies noted by the auditors are due mostly to human error resulting from inexperienced staff. During the audit period several vacancies occurred requiring the use of temporary staff, which has been an ongoing issue in the unit. Since December 1998 there have been 30 different permanent and temporary staff working in the unit of eight (8) positions. Continual training, monitoring and evaluation of staff performance has been necessary and will continue.

24. FEDERAL FUNDS NOT DRAWN IN ACCORDANCE WITH AGREEMENT AND FEDERAL DRAWDOWN ESTIMATES INADEQUATELY DOCUMENTED

The Department did not have adequate internal controls in place to ensure that drawdowns were made in accordance with its cash management policy and the agreement between the U.S. Department of Treasury and the State of North Carolina that implemented the provisions of the federal Cash Management Improvement Act of 2004. The Department continuously maintained large positive and negative cash balances throughout the year in the Medicaid program. Examples include:

- On October 28, 2003, the Medicaid program ended the day with a federal funds balance of $50 million. This balance was not substantially eliminated until November 26, 2003. In another example, on December 29, 2003, the Program

began with a federal funds balance of $70 million. This balance was not substantially eliminated until January 27, 2004.

- On October 21, 2003, there was a deficit funds balance of $30 million. This balance was not eliminated with federal funds until October 27, 2003. Another example, on December 15, 2003, there was a deficit of $34 million that was not eliminated with federal funds until December 22, 2003. In these situations, state funds were required to cover federal expenditures.

Additionally, the Department did not have adequate documentation of estimated cost calculations to support five drawdowns of Medicaid funds. The Department uses historical payments from prior years, adds an inflationary factor, and makes adjustments based on communication with the Division of Medical Assistance budget office to compute the drawdown estimate. Adjustments supplied by the Division's budget office were not supported. The basis for the inflationary factor was not documented.

The lack of documentation and excessive balances causes the Department to be out of compliance with the Treasury-State Agreement and its cash management policy. The Treasury-State agreement requires that program and administrative costs be funded on a pre-issuance basis, but funds should not be drawn down more than three business days prior to the day of disbursement. Also, the requests for funds should not be more than the amount the State expects to disburse. The cash management policy indicates that funds should not be drawn more than two business days prior to disbursement.

The excessive deficit balances resulted in the use of state funds for federal expenditures and a loss of investment income to the State. However, holding excessive federal funds will result in an interest liability to the Federal government.

Recommendation: The Department should emphasize the importance of being in compliance with the Treasury-State Agreement and its cash management policy. The Department should consider revising policies to obtain better drawdown estimates and implement procedures to better monitor cash balances. Additionally, supporting documentation should be maintained for all draws of federal funds.

Agency's Response: The Department concurs with the finding. DHHS Controller's Office Procedure GA008 has been revised to include specific language as to how the estimate will be determined concerning the drawdown of federal funds for the EDS checkwrites and has been approved with an effective date of March 16, 2005. We have also contacted the Office of the State Controller (OSC) and have asked that the language be incorporated into the Treasury State Agreement (TSA). OSC staff indicated that the TSA draft will be submitted to FMS by April 30th for FY 2005-06 and will include the updated language in our procedure.

25. EXCESSIVE CASH BALANCES IN THE TEMPORARY ASSISTANCE FOR NEEDY FAMILIES PROGRAM

The Department maintained $8.9 million of excess federal funds on hand in the Temporary Assistance for Needy Families program for a period spanning 38 days. The Department failed to follow its own control procedures when drawing federal funds.

On January 29, 2004, federal funds were drawn down for February without consideration of the state funds adjustment that should have been subtracted from the total amount of the draw. This caused an excess of federal funds to be on hand. Additional funds were drawn down during February and the excess balance was not resolved until March 8, 2004.

The Treasury-State agreement requires that the request for funds be made not more than three business days prior to the day the State makes a disbursement. The agreement requires that the request for funds be for no more than the amount the State expects to disburse.

Recommendation: The Department should comply with the Treasury-State agreement and its own internal control procedures when requesting federal funds.

Agency's Response: The Department concurs with the finding that due to an incorrect CMIA report for February 2004 it appears that excess cash was on hand for 38 days. The Controller's Office was not aware of the availability of state funds to complete the MOE reclassification at the time of drawing federal funds for February. Therefore, federal funds were drawn for federal expenditures. The reclassification from federal expenditures to state expenditures was completed on February 24, 2004. However, the CMIA reports did not reflect the reclassfication of federal expenditures to state expenditures on February 24th. Since the expenditures were recorded as federal during the month of February, the CMIA reports should have reflected this. The CMIA report was revised on March 18, 2005 to report the expenditures as federal from February 1 thru February 23.

The Program/Benefit Payments Section is now verifying the availability of state funds prior to requesting federal funds for the month in which the MOE reclassification is scheduled to be completed.

26. ERROR IN THE DIVISION OF CENTRAL ADMINISTRATION'S COST ALLOCATION

The Division of Central Administration erroneously allocated $77,788 of costs to the Weatherization Assistance component of the Low Income Home Energy Assistance Program. After being informed of the error, the Division was able to correct the allocation error before the fiscal year-end records were closed; therefore, no costs are questioned.

The cost allocation rate for Weatherization Assistance was amended in August 2003, but became effective as of July 2003. However, the Division did not adjust the cost allocation charges for two Weatherization Assistance cost centers retroactive to July 2003.

Recommendation: The Division should strengthen internal controls to ensure that all cost allocation changes are made correctly and in a timely manner.

Agency's Response: The Department concurs with the finding and recommendation. The retroactive rate change for July 2003 was corrected by journal entry 203104C026 dated June 29, 2004. A tickler file has been established by the unit supervisor as a reminder to verify the rates on an annual basis with the Budget Office. Corrective action is complete for this issue.

27. INADEQUATE DOCUMENTATION AND FAILURE TO RECONCILE FIXED ASSETS

The Department failed to follow specific internal policies and to maintain adequate documentation in support of fixed assets purchased with federal funds from the Rehabilitation Services - Vocational Rehabilitation Grants to States program by the Division of Vocational Rehabilitation. Testing of fixed assets and inventory procedures revealed the following:

- Fixed asset forms were not filed with the fixed asset officer, as required, for two items tested.

- The fixed asset system was not reconciled to the North Carolina Accounting System on a monthly basis as required by the Department's Cash Management Plan.

- Inventory packets indicated numerous missing items. There was no evidence that missing items were researched or that reconciliation was performed between locations to determine if assets may have been transferred to other locations. Additionally, missing asset forms were not on file.

- Documentation indicating approval for the disposal of five assets was not maintained.

The Department's failure to follow policies and maintain proper documentation could result in fixed assets being misstated. Additionally, the failure to safeguard assets, perform reconciliations and follow-up on missing assets can increase the risk of misuse or theft of federally purchased assets.

The Office of the State Controller's fixed asset policies require that assets be safeguarded and inventory reconciled to the fixed asset system. Also, OMB Circular A-102 Common Rule requires that equipment records be maintained, a physical inventory of equipment

be taken and reconciled to the equipment records, and an appropriate control system be in place to safeguard equipment.

Recommendation: The Department should communicate the importance of following internal policies to ensure that proper documentation is maintained and assets are accurately recorded. Management should implement procedures to ensure that appropriate reconciliations are performed at both the Department and Division levels. The Department should establish the necessary communication channels between the respective Divisions to ensure all personnel understand their responsibilities for documenting and safeguarding fixed assets.

Agency's Response: The Department concurs with the finding and the recommendation. Management has communicated the importance of following internal policies to the Controller's Office fixed asset officer.

A new centralized filing system has been established for the fixed asset input forms. These forms will remain in the asset file for the life of the asset along with all other pertinent documentation. The two fixed asset forms that were listed as missing were found with the year end inventory information after the review by the auditor.

The Controller's Office is in the process of developing a monthly reconciliation based on models used by other divisions. This procedure will be documented and will be fully implemented beginning July 1, 2005.

Management has emphasized the importance of communication between the Controller's Office and Division to ensure all personnel understand their responsibilities for documenting and safeguarding fixed assets.

28. 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. The records also did not contain all pertinent information. In addition, the records were not properly updated for required changes uncovered during the annual inventory.

- Our tests of 27 equipment purchases during the fiscal year revealed that as of January 2005, the Department had not updated the fixed asset system to record seven items totaling $10,375 purchased with Child Support Enforcement funds. The remaining 20 items tested were all recorded in the fixed asset records, but each had one or more data elements that were in error. The 20 equipment items were recorded in the fixed asset records with coding, acquisition dates, costs, or serial numbers that were incorrect.

- Our test of a sample of 25 worksheet packets used during the annual inventory revealed the following:

    a. Thirty-two assets were added to the inventory worksheets but were not subsequently added to the equipment records. Also, one location was not corrected in the system based on the inventory worksheets.

    b. Two assets were removed from the system or locations changed, which was not consistent with the inventory worksheets. Also, there was no FAS-1 form for documentation.

    c. Six assets were noted as missing or traded on the inventory FAS-1 forms but were not corrected in the system. Three assets had incorrect serial numbers.

    d. Fourteen assets were removed or updated in the fixed asset records based on inventory worksheets without the proper FAS-1 form documentation.

- A scan of the fixed asset records as of December 23, 2004, revealed several clerical inaccuracies that included incorrect fund information and asset numbers, invalid cost information, duplicate asset numbers and missing serial numbers.

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 and could result in misstatement of fixed asset account balances in the financial statements.

Title 45 CFR section 74.34 requires the recipient to maintain adequate safeguards to prevent loss, damage, or theft of equipment. The recipient is required 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, the 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. The Department should also ensure that all equipment purchases are entered correctly into the system within a reasonable period. Inconsistencies or errors uncovered when updating fixed asset records should be investigated and corrected.

Agency's Response: The Department concurs with this finding. In direct response to this finding, the Controller's Office has updated the Fixed Asset System (FAS) with the seven items totaling $10,375 and the missing data for the 20 items. Regarding the 32 items that were added to the inventory worksheets but were not added to the FAS, we are researching whether these items were leased from our seat management contractor (which is likely) and were reported on the physical inventory incorrectly as State assets.

Regarding the two assets reported as removed from the system or locations changed, which was not consistent with the inventory worksheets, asset # 23824 was not moved and is being utilized as a copier machine in the Morehead County office and asset #23262 has proper documentation stating that it was removed in compliance with item #5 on the FAS-1 form. The finding stated that six assets were noted as missing or traded but not corrected in the system. These six items were replaced or surplused and the FAS information was updated. The finding stated that 14 assets were removed or updated without the proper FAS form. The proper asset forms have been received and the information was updated. All corrective actions needed were entered into FAS by the end of January.

The Controller's Office and the division staff are continuing to work closely together and both offices have stressed the importance of providing accurate information and emphasizing extra care when keying data into the FAS.

29. INTERNAL CONTROL WEAKNESSES OVER ACCOUNTS RECEIVABLE

In our prior year audit, we noted a number of internal control weaknesses and shortcomings in the accounts receivable system. Management has taken action to correct most of the weaknesses; however, the problems continued to exist during a significant portion of the current audit period. The specific weaknesses and corrective actions taken by management during the year are as follows:

a. There is no independent review of the information entered into the accounts receivable system by accounting technicians. The agency implemented review procedures March 2004.

b. The accounts receivable system flags all disputed amounts and reports them as current rather than maintaining their proper aging date. A procedure was approved and implemented in the fourth quarter of the fiscal year to ensure that the disputed indicator was removed to allow proper aging of the accounts for more accurate reporting in the financial statements.

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

d. 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. The Department implemented procedures during the last half of the year to ensure all amounts were reported as required.

e. The Division of Medical Assistance had not ensured that its claims processing contractor followed 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. Policies correcting this deficiency were written and implemented by the claims processing contractor during the last quarter of the fiscal year and verified by the Division.

f. Duties associated with miscellaneous accounts receivables were not properly segregated and written procedures were lacking. The person who recorded receivables also recorded receipts against receivables and deposited cash collections. Additionally, documentation was not maintained to support the recorded receivables and collections.

Additionally, the Department's year-end accounts receivable accrual process is complex and not adequately documented to ensure that all entries are made correctly using the appropriate supporting documentation. During testing of year-end accruals, we noted numerous errors that were corrected by the agency prior to closing and through audit adjustments.

These weaknesses in internal controls could permit errors to occur in the accounting records and could result in misstatement of receivable account balances in the financial statements.

Recommendation: The Department should continue to implement and strengthen controls to ensure that accounts receivables information is reported accurately and completely. Written policies and procedures should be developed for the miscellaneous accounts and the year-end accrual processing. Management should provide for the proper segregation of incompatible duties. The Department should actively seek collection of delinquent accounts. Failing that, the Department should seek legal remedies and report past due amounts to the Attorney General's office.

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

a. The Department agrees with the finding that the information entered into the accounts receivable system by accounting technicians was not independently reviewed by the AR Supervisor until March 2004 when the review process was implemented by the AR-DMA Branch Head. The review process implemented March 2004 continues and will subsequently be incorporated into formal procedures to further ensure accuracy of the data keyed into the system.

b. The Department agrees with the finding that the accounts receivable system previously flagged all disputed amounts and reported them as current rather than maintaining their proper aging date. However, an amendment to the Cash Management Plan was approved June 24, 2004 to allow disputed accounts to continue aging. The disputed status code was removed from accounts on June 28, 2004 to allow aging of accounts as recommended.

c. The Department agrees with the finding that the Department failed to seek collection of accounts receivable amounts that had been transferred from its Medicaid claims processing contractor (EDS), as required by the Department's Cash Management Plan. The Department received accounts receivable information from DMA and EDS and submitted accounts to the Attorney General's Office and collections agency as recommended completing the necessary corrective action.

d. The Department agrees with the finding that the Department failed to submit accounts transferred from DMA and Medicaid claims processing contractor (EDS) with amounts over $500 and 90 days outstanding to the Attorney General's Office for collection, as required by GS 147-86.11. The Department submitted amounts in question, over $500 and 90 days outstanding, to the Attorney General's Office for collection on January 7, 2005. The date of the demand letters is January 10, 2005. However, it should be noted that the Department remained current in submitting accounts $500 or over and 90 days outstanding from DMA Program Integrity to the Attorney General's Office. The finding only applies to amounts transferred from DMA and Medicaid claims processing contractor (EDS) to the Controller's Office.

e. The Department agrees with the finding that the Division of Medical Assistance had not ensured that its Medicaid claims processing contractor (EDS) followed 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. Policies correcting this deficiency were written and implemented by the claims processing contractor during the last quarter of the fiscal year and verified by the Division.

f. The Department agrees that duties associated with miscellaneous accounts receivables were not properly segregated and written procedures were lacking. The Department also agrees that documentation was not maintained to support the recorded receivables and collections. Duties have been segregated by adding positions to the organizational structure and reassigning tasks that will be further documented as procedures and job descriptions are revised. The checks and supporting documentation were copied and subsequently maintained in a more efficient manner to allow staff to retrieve information more timely for future reviews and audits.

The Department further acknowledges that the Department's year-end accounts receivable and revenue accrual process is complex and will work diligently to adequately document procedure(s) and develop a checklist to ensure that journal entries are made correctly using appropriate supporting documentation.

30. CASH DISBURSEMENT CONTROL PROCEDURES NOT ALWAYS PERFORMED

The Department did not always follow prescribed procedures when processing cash disbursements. The risk of inappropriate disbursement increases when procedures are not followed. In our sample of 39 disbursements, we noted the following deficiencies:

- Five invoices were paid late. Payments were made four to 23 days after the due date.

- Three invoices were not properly cancelled.

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

Agency's Response: The Department concurs with the finding and has taken action to ensure that disbursements are made in a timely manner and cancelled so as to avoid inappropriate disbursements. As a result of these errors, staff have been reminded of the Controller's Office existing internal control measures. A memorandum was sent from the Controller to Division Directors and Business/Budget Officers dated January 11, 2005 explaining changes in process flow related to Accounts Payable to be effective February 1, 2005, if not implemented sooner. "Direct pay" invoices will now go directly to the divisions for approval for payment. Previously, these invoices were coming to the Controller's Office and had to be sent to the divisions and then returned for processing. Sometimes this caused significant delays. Problem or incomplete invoices will be entered in NCAS with a "delayed" status and division offices will access a daily report for these exceptions and will be responsible for resolving these "problems" within a five (5) to fifteen (15) day period. With the implementation of these new processes we believe the majority of invoices will be processed in a more timely manner.

In regards to invoices not being cancelled "date stamped as entered", this was an oversight and employees were reminded again of the importance of stamping paid invoices. There are also built-in features that already exist in NCAS and the Division of Services for the Blind subsystem to help prevent the possibility of duplicate payments.

31. ERROR IN THE STATEWIDE COST ALLOCATION PLAN CAUSED COST TO BE INCORRECTLY ALLOCATED

Due to a mathematical error in the 2003-2004 Fixed Statewide and Departmental Cost Plan, costs were incorrectly allocated to the Child Support Enforcement program. The effect of the incorrect cost allocation resulted in the federal program being overcharged by $26,000, which is being questioned.

OMB Circular A-87 requires that costs be allocated to a grant in accordance with the relative benefits received. Good internal controls require that mathematical calculations be reviewed for accuracy before charging costs to federal programs.

Recommendation: The Department should make adjustments to correct overcharges to the Child Support Enforcement program. Procedures should be developed to ensure the accuracy of the Fixed Statewide & Departmental Cost Plan before it is implemented.

Agency's Response: The Department concurs with the finding and the proposed corrective action. This error was corrected September 30, 2004 by Document ID 24315C0006. Future indirect cost calculations will be reviewed by management prior to submission to HHS Division of Cost Allocation.

DIVISION OF VOCATIONAL REHABILITATION

32. IMPROPER ACCESS TO COMPUTER SYSTEMS

Five former Division of Vocational Rehabilitation employees continued to have access to the State's North Carolina Accounting System and were still listed on its various security reports. Control procedures for terminating access to the 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's 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's Response: The Department concurs with the finding. The Department has taken appropriate steps to revoke user IDs and passwords for staff who should not have access to DVRS systems, IMS and CICS. NCAS is an application within CICS, and access to NCAS was revoked through revocation of access to CICS. The Department has now established further protocols to ensure that the NCAS access is revoked appropriately including monthly review of a report of all NCAS users.

33. BASIC SUPPORT CLAIMS WERE NOT PROPERLY PAID

There were weaknesses in the Division of Vocational Rehabilitation's controls over the payment of basic support claims in the Rehabilitation Services – Vocational Rehabilitation Grants to States program. An examination of 214 client files revealed the following:

a) Twelve outpatient claims were paid using an incorrect methodology. Lab fees were incorrectly included in the calculation for outpatient claims resulting in an overpayment of $1,163.

b) Fifteen outpatient claims were paid at incorrect rates. Rates were not obtained and entered into the system in a timely manner, causing claims to be paid at old rates. This resulted in an overpayment of $19,083.

c) One inpatient claim was paid incorrectly based on an incorrect formula for calculating cost outliers. This resulted in an underpayment of $234.

d) Five drug claims were paid incorrectly as follows:

- Two drug claims were paid at incorrect rates. Rates were not obtained and entered into the system in a timely manner. Also, the dispensing fee for both claims were overpaid based on the Medicaid-set dispensing fee for the drugs.

- Three drug claims were paid using an incorrect methodology for payment. Effective December 2001 a State Maximum Allowable Cost rate was initiated for certain drugs to use in determining the lowest price. The State Maximum Allowable Cost rate was not considered when pricing these claims.

The net overpayment from these errors was insignificant. The control weaknesses that allowed the errors to occur could, under other circumstances, cause other claims to be paid incorrectly by amounts that are more significant.

The Department expended $20,015 for claims in error. We are questioning the federal share of $15,752.

Section 1-11 of the Division of Vocational Rehabilitation internal policies manual requires that invoices for 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 and calculating cost outliers. The Medicaid Pharmacy manual defines the correct methodology for determining drug pricing.

Recommendation: The Division should strengthen internal controls to ensure that all invoices are properly processed and paid. Rate changes should be obtained in a timely manner and properly incorporated into the Division's payment procedures. Also, the Division should ensure that payment calculations are updated regularly in accordance with Medicaid payment methodology. The Division should perform analysis to determine the total impact of the errors and require reimbursement from providers for overpayments.

Agency's Response: The Department concurs with the finding. All claims identified within the audit as incorrectly paid have been recalculated and appropriate adjustments requested. Due to the statutory requirement that Medicaid established rates for medical services not be exceeded by any state agency, the Division of Vocational Rehabilitation Services must adhere to the Medicaid rate schedules published by the Division of Medical Assistance (DMA). Having the correct rates available to Claims Processing staff to use in paying the Division's invoices accurately depends upon several steps being

executed properly and in a timely manner. Rate changes must be shared by DMA and loaded by the Division of Information Resource Management (DIRM) staff onto the system used by the Division of Vocational Rehabilitation (DVR) for pricing. While there are several opportunities for communication to breakdown, it is our expectation that DVR, the Controller's Office, DMA and DIRM, can work together to define a procedure that will ensure accurate and timely payments to providers. The Division continues to pursue every opportunity available to comply with the statutory requirement and will:

- continue to hold frequent joint meetings with DHHS Controller staff, DMA staff and Division of Information Resources Management (DIRM) staff, seeking improved communications.
- access the DMA information memoranda on-line rate change alert system.
- pay claims appropriately based on current rate changes, as programmed by the DIRM.
- review and discuss with DMA and DHHS Controller the feasibility of DMA Fiscal Agent (currently EDS) paying all the Division's medical claims as an add-on to the DMA contract.

34. CONTROL WEAKNESSES OVER DETERMINATION AND DOCUMENTATION OF CLIENT ELIGIBILITY

There were control weaknesses related to the determination of client eligibility and individualized plan for employment in the Rehabilitation Services – Vocational Rehabilitation Grants to States program. Our examination of 214 client files revealed cases in which eligibility was not determined in a timely manner, eligibility determination forms were not completed and included in the client's case file, and the individualized plan for employment documentation was not updated according the specifications in federal requirements.

- Required Agreement to Extend Eligibility Decision forms were not obtained or were not obtained in a timely manner for eight clients. Title 34 CFR section 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. Since clients were later determined eligible, there are no questioned costs.
- Required Certificates of Eligibility forms were not completed and included in the client's file for two clients as required by section 3-7-6 of the internal policy manual. The payments to these clients totaled $270. Since proof of eligibility could not be determined and likely errors exceed $10,000, the federal share of $212 is being questioned.

- One client did not have an updated Individualized Plan for Employment form for the addition of a service to be provided as required in 34 CFR section 361.45 and section 5-1-3 of the internal policies. Because the client was eligible, the service was allowable, and the plan of treatment was approved by the counselor, no costs are being questioned.

These weaknesses increase the risk of paying costs related to ineligible participants or for unapproved services.

Recommendation: The Division should strengthen internal controls to ensure that all applicable eligibility forms are obtained when required and that individualized plans for employment are developed and implemented in accordance with the requirements specified in federal regulations.

Agency's Response: The Department concurs with the finding. In the Division of Vocational Rehabilitation Services there are ongoing efforts to strengthen the eligibility determination process. The following actions have or will be taken. Additional training and monitoring will be required at the Regional and Unit Office level by Regional Directors, Unit Managers and Quality Development Specialists. Additional oversight to monitor timeliness of eligibility decision, documentation of the eligibility decision and correct completion of Individual Plans for Employment (IPEs) will be provided by Unit Managers and Quality Development Specialists. Counselors will be required to demonstrate use of a tickler/tracking system with a goal of no cases that exceed 60 days without formal extension. Unit Managers will utilize the error report to track all cases in the Unit approaching the 60-day limit. Regional Directors will utilize a report generated monthly to monitor regional compliance with the 60 day requirement for eligibility determination. Unit Managers and Quality Development Specialists will monitor cases for completion of IPEs and eligibility documentation.

Based on the SFY 2004 audit finding, we have further strengthened our monitoring of eligibility processes to include a monthly computer generated report for senior management analysis of all client eligibility decisions. All corrective action has been or will be completed by July 1, 2005.

35. CONTROLS OVER FIXED ASSETS NEED IMPROVEMENT

The Division of Vocational Rehabilitation failed to follow specific internal policies related to fixed assets documentation and the safeguarding of assets purchased with Rehabilitation Services - Vocational Rehabilitation Grants to States program funds. Testing of fixed assets and inventory procedures revealed the following:

- The prescribed fixed asset input forms for newly acquired items were not on file with the fixed asset officer.

- Duties are not properly segregated in the Division's unit and regional offices. The functions of receiving, tagging, maintaining and inventorying assets are all performed by the same individuals.

- The Division failed to submit the applicable asset forms for items listed as missing during the annual inventory. Additionally, there was no evidence of efforts by the Division to determine whether assets were transferred to other locations before categorizing them as missing.

- No documentation was submitted or on file to indicate appropriate approval by the Division for the disposal of five items tested.

The Division's failure to follow policies and maintain proper documentation could result in fixed assets being misstated on the financial statements. Additionally, the failure to safeguard assets, perform reconciliations and follow-up on missing assets increases the risk of misuse or theft of assets.

The Office of State Controller's fixed asset policies require agencies to safeguard assets, complete the applicable forms for missing assets, and approve disposals. Additionally, the policy states that the person responsible for taking the inventory should not also have custody of the assets or responsibility for receiving, checking in, tagging, and recording the assets. OMB Circular A-102 Common Rule also requires that equipment records be maintained, a physical inventory of equipment be taken and reconciled to the equipment records, and an appropriate control system be used to safeguard equipment.

Recommendation: The Division should ensure all personnel understand their responsibilities for documenting, recording, and safeguarding fixed assets and the importance of following internal policies.

Proper segregation of duties should be established. During the inventory process, efforts should be made to locate missing items and the proper forms should be submitted for items designated as missing, surplus, transferred, or stolen. The Division can provide additional oversight by performing random spot check inventory counts throughout the year at the unit and regional offices. Appropriate follow up should be performed for any discrepancies noted.

Agency's Response: The Department concurs with the finding. Fixed asset items previously listed as missing have all been located and appropriately reassigned within the fixed asset inventory system. Systems have been reviewed and enhanced to properly document all fixed asset transactions:

- Periodic review of new Fixed Asset reports will be completed by senior management with automated follow-up reports.

- Segregation of duties will be established with each office assigning one individual to be responsible for asset management, separate and apart from unit management.

- All hands-on inventories will be conducted by individuals who are not purchasing or receiving items.

- Random sampling of inventory will be periodically conducted to ensure compliance by staff not housed at site being inventoried.

DIVISION OF PUBLIC HEALTH

36. IMPROPER ACCESS TO COMPUTER SYSTEMS

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:

- Fourteen former employees continued to be 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 of the status of the former employees.

- Fifteen of 32 employees tested had inquiry/add/change/delete authority for the Health Services Information System when only inquiry or inquiry/add/change was needed.

Adequate internal control over computer systems requires that former employee access be terminated in a timely manner and that user/employee access be limited to levels needed for the job.

Recommendation: The Division should terminate former employee access to the State's 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 restricted to employees on a need-to-use basis. Periodic security access reviews should be conducted to ensure that access is restricted to authorized users.

Agency's Response: The Department concurs with this finding. The Division of Public Health acknowledges these individuals had improper access to the North Carolina Accounting System (NCAS) and access granted to users of the Health Services Information System (HSIS) for the WIC program exceeded that necessary for their job duties in SFY 2003-04. As a result of the finding for this same issue in the 2003 Single

Audit, the Division of Public Health completed by April 30, 2004 an internal audit of users having access to NCAS and HSIS in order to assure appropriate individuals have appropriate access.

Access has been revoked for all the individuals identified as having inappropriate access to NCAS. The individuals cited in the 2004 single audit as having inappropriate level of access to HSIS have had their access modified as of January 24, 2005. The Division will continue to run on a quarterly basis a list of its employees with access to NCAS and HSIS to ensure that continued access is necessary for each employee.

DIVISION OF SERVICES FOR THE BLIND

37. 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. An examination of 214 client files revealed the following:

- Two outpatient claims were paid using an incorrect methodology. Lab fees were incorrectly included in the calculation for outpatient claims resulting in an overpayment of $125.

- One claim was paid at incorrect rates. Rates were not obtained and input into the system in a timely manner causing claims to be paid at old rates. This resulted in an underpayment of $1,161.

The Division underpaid claims by $1,036 on a net basis. Because the projected amount of questioned costs for the grant exceeds $10,000, we are questioning $815, which represents the federal share of the underpayment.

The Division's internal policies require that invoices for 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. Rate changes should be obtained in a timely manner and properly incorporated into its payment procedures. Also, the Division should ensure that payment calculations are updated regularly in accordance with Medicaid payment methodology. The Division should perform analysis to determine the total impact of the errors and require reimbursement from providers for overpayments.

Agency's Response: The Department concurs with this finding. Resolving this issue will require the involvement of several divisions but should be achievable. Having the correct rates available to Claims Processing staff to use in paying the Division of Services for the Blind (DSB) invoices accurately depends upon several steps being executed properly and in a timely manner. Rate changes must be shared by the Division of Medical Assistance

(DMA), loaded by the Division of Information Resource Management (DIRM) staff into the system used by the Division of Vocational Rehabilitation (DVR) for pricing, then loaded by DIRM into the system used by DEBT. While there are several opportunities for communication to breakdown, it is our expectation that we, along with DVR, the Controller's Office, DMA and DIRM, can work together to define a procedure that will ensure accurate and timely payments to providers by June 30, 2005.

DSB management reviews check write vouchers weekly. Invoices that are paid at what appears to be a very high or very low amount based on our experience are questioned through Claims Processing. When corrections are needed, they are made. However, we are not in a position to identify invoices paid at an inaccurate amount through this review.

38. MAINTENANCE OF EFFORT NOT MET

The Division did not have controls in place to ensure that the required maintenance of effort was provided for a grant award in the Rehabilitation Services – Vocational Rehabilitation Grants to State program. Our tests revealed that as of June 30, 2004, the Division provided $46,278 less for the 2002 grant than it was required to provide. (It should also be noted that as of September 30, 2004, the maintenance of effort deficit increased to $130,389.) A waiver from the federal agency was an option available to the Division, but the Division never requested it. We are questioning the $46,278 maintenance of effort deficit incurred by the Division as of June 30, 2004.

Barring a waiver from the grantor federal agency for exceptional or uncontrollable circumstances, 34 CFR, section 361.62, requires federal funding to be reduced by the amount that a grantee fails to maintain the level of effort provided by the grantee two years prior to the grant.

Recommendation: The Division should establish controls to ensure that the required maintenance of effort is maintained. Also, the Division should request a waiver whenever it believes it has met the requirements for receiving a waiver.

Agency's Response: The Department agrees that it appears that the Maintenance of Effort (MOE) was not met. However, historically, the Division of Services for the Blind (DSB) has met its MOE and had no reason to believe that it was not being met in 2002. No significant variance in spending was apparent during that time frame. Currently, DSB still has questions about if and why a MOE problem would have occurred during that year and more information is being sought through the Controller's Office. We believe that errors have occurred and that once corrected there will not be a MOE shortfall for 2002. The errors will be corrected by June 30, 2005.

39. EXPENDITURES WERE MADE AFTER THE PERIOD OF AVAILABILITY ENDED

For the 2002 Rehabilitation Services – Vocational Rehabilitation Grants to State grant, the Division expended federal funds after the ending of the 90-day liquidation period that ended December 31, 2003. The accounting records and Financial Status Reports (SF-269) as of March 31, 2004 and June 30, 2004 reported federal expenditures of $3,566 and $19,863, respectively, charged to the 2002 grant. The Division did not request a waiver to extend the liquidation date. Expending funds beyond the period of availability may result in action by the federal agency in the form of penalties, suspension of current funding or withholding of future awards. The total spent after the end of the period of availability of $23,429 is being questioned.

Title 34 CFR 80.23B requires that a grantee liquidate all obligations incurred under the award not later than 90 days after the end of the funding period to coincide with the submission of the annual Financial Status Report. The deadline can be extended at the request of the grantee. The expenditures should have been made from the 2003 grant award. The Division has subsequently adjusted the reported expenditures on the September 30, 2004 SF-269 report.

Recommendation: The Division should implement controls to ensure that expenditures are charged to the appropriate federal grant award year and that no expenditure of federal funds occurs beyond the established period of availability.

Agency's Response: The Department concurs with this finding. The expenditures for FFY2002 were incorrectly coded and the documentation has been provided to the Controller's Office to make the corrections. The errors will be corrected by June 30, 2005.

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 Mental Health, Developmental Disabilities and Substance Abuse and the Division of Aging and Adult Services.

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May 4, 2005

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