STATE OF NORTH CAROLINA

AUDIT RESULTS FROM

CAFR AND SINGLE AUDIT PROCEDURES

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FOR THE YEAR ENDED JUNE 30, 2001

OFFICE OF THE STATE AUDITOR

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

We have completed certain audit procedures at the North Carolina Department of Health and Human Services related to the State's *Comprehensive Annual Financial Report (CAFR)* and the State's *Single Audit Report* for the year ended June 30, 2001. Our audit was made by authority of Article 5A of *North Carolina General Statute § 147*.

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

We noted several internal control weaknesses and instances of noncompliance with State and federal regulations at the Division of Central Administration. Controls were not in place to ensure that expenditures made with State funds were reimbursed by the appropriate federal programs. Management decisions on subrecipient audit reports were not issued within the required time frame. Control weaknesses allowed Basic Support claims to be paid at incorrect rates. Other noted deficiencies pertained to invoices being paid twice, failure to update fixed asset records and noncompliance with cash management regulations. Findings 1 through 10 describe these and other conditions.

The Division of Child Development paid an employee a full, regular salary during a four-month period while absent from work without earned leave. Finding 11 describes this condition.

The Division of Social Services did not take appropriate enforcement action on child support cases in the Child Support Enforcement program and did not have adequate monitoring efforts in place in the Social Services Block Grant program. Documentation was not always available to show that criminal records checks were conducted on prospective foster parents. Findings 12 through 16 describe these and other conditions.

The patients' medical records for several claims processed by the Division of Medical Assistance did not adequately document services rendered. The Division did not receive required cost reports on 221 nursing facilities and had completed only 70 desk audits of the 120 nursing facility cost reports it had received. Some employees of the Division had improper access to the Medicaid Management Information and the Eligibility Information systems. Findings 17 through 21 discuss these and other conditions.

The Division of Mental Health, Developmental Disabilities and Substance Abuse Services did not provide adequate documentation to support several compliance requirements in the Substance Abuse Prevention and Treatment Block Grant program resulting in questioned costs of $33.8 million. Audit findings 22 through 25 describe these and other conditions.

There were control weaknesses related to the determination and documentation of client eligibility in the Rehabilitation Services-Vocational Rehabilitation Grants to States program. Finding 26 describes this condition.

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

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

Fund for the *Comprehensive Annual Financial Report*:

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

Federal Programs for the *Single Audit Report*:

Food Stamps

Special Supplemental Nutrition Program for Women, Infants, and Children

Child and Adult Care Food Program

State Administrative Matching Grants for Food Stamp Program

Rehabilitation Services – Vocational Rehabilitation Grants to States

Temporary Assistance for Needy Families

Child Support Enforcement

Low-Income Home Energy Assistance

Child Care and Development Block Grant

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

Foster Care – Title IV-E

Social Services Block Grant

State Survey and Certification of Health Care Providers and Suppliers

Medical Assistance Program

Block Grants for Prevention and Treatment of Substance Abuse

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

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

Respectfully submitted,

Ralph Campbell, Jr.
State Auditor

AUDIT FINDINGS AND RECOMMENDATIONS

Matters Related to Financial Reporting or Federal Compliance Objectives

DIVISION OF CENTRAL ADMINISTRATION

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

1. FEDERAL REVENUE NOT COLLECTED

   The Department failed to claim approximately $546,000 of federal reimbursement that it was owed. The Department used State funds to pay $1,093,000 in postage costs but failed to charge the Medicaid program for the federal share of these costs. General Statute 147-86.11 states that money due to a State agency shall be promptly billed.

   Recommendation: The Department should charge the Medicaid program and claim reimbursement for the federal share of all permitted expenditures and should implement procedures to ensure that expenses paid from State funds are immediately billed to the appropriate users and promptly collected.

   Agency's Response: The DHHS Controller's Office concurs with the audit finding. Discussions regarding funding with the participating DHHS division will continue to bring this issue to resolution. Our goal is to have resolution by the end of this calendar year.

   Internal control procedures are currently being revised and/or developed to ensure that postage utilization reports be received in a timely manner and that billings to other divisions are prepared and monitored for receipt of funds. If funding is not available from other divisions, documentation will be maintained explaining the circumstances.

2. MANAGEMENT DECISION ON SUBRECIPIENT AUDIT REPORTS NOT ISSUED

   The Department did not issue a management decision within the required time frame for audit findings that relate to federal awards made to subrecipients. Of the fifty-eight audit reports requiring a management decision for the year ending June 30, 2000, we noted that forty management decisions were issued from one to nine months after the required six-month time frame. Additionally, we noted that the Department failed to issue a management decision, stating its position on the audit findings or any corrective action to be taken, for four subrecipient audit reports. As of January 2002, the management decisions for these four audit reports were from five to seven months past the due date.

OMB Circular A-133 requires the pass-through entity to make a management decision within six months of receipt of the audit report and to ensure that subrecipients take appropriate corrective action.

Recommendation: The Department should ensure that management decisions are issued within the federal time frame.

Agency's Response: The DHHS Controller's Office Management concurs with the finding and with the State Auditor's recommendation. The condition noted in this finding, which is a repeat of a similar condition noted in the FYE 6/30/00, resulted from a combination of staff shortages and increased workload in the Audit Resolution Unit ("the Unit"). Currently, the Unit's two full-time employees and a temporary employee are handling audit resolution/report tracking for 152 local government agencies, nearly 700 nongovernmental entities, and approximately 1,100 organizations that receive funding through the Division of Public Health's Child and Adult Care Food Program. However, the Unit has struggled with a workload that has more than doubled over the past 4 years. The majority of the increase is directly related to the transfer of Public Health to the Controller's Office with no additional staff provided.

For the FYE 6/30/00, all determination letters for local government subrecipients have been issued for which all DHHS division responses have been received. For the seven (7) FYE 6/30/00 audits that remain open, we await the following: (1) division-specific responses for two counties and three area programs that are needed for completion of determination letters and (2) responses to DHHS determination letters from two counties. Additionally, the Unit's other full-time staff has been cross-trained, thereby strengthening the Unit's capacity to issue management letters within the required timeframe. The Unit will continue to strive to maintain compliance with OMB Circular A-133 with respect to any outstanding or delinquent management decisions and audit resolutions.

The Unit (and hence the Controller's Office) has completed all aspects of the remaining unissued determination letters for FYE 6/30/00 except to insert division responses to program-specific audit findings. Therefore, the Controller's Office has taken every action within its control toward resolution of the remaining open audits.

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

3. INVOICES ERRONEOUSLY PAID TWICE

The Department did not have written procedures in place instructing its staff on the way invoice numbers should be entered into the accounts payable system. In addition, the Department made payments from copies of invoices. As a result, three duplicate payments were made, once from the original invoices and a second time from copies of the invoices. Because the copies of the original invoices were not entered into the accounts payable system in exactly the same format as the original invoices, the accounts

payable system's built-in control of not letting the same invoice be processed twice was ineffective. The Department did not detect that the payments were made twice and the related expenditures totaling $10,790 had not been reimbursed to the Department.

The Department's Cash Management Plan states that payments are to be made from an original invoice, not a copy.

Recommendation: The Department should ensure that all personnel responsible for paying invoices understand that payments are not to be made from invoice copies. Additionally, procedures should be established to ensure that invoice numbers are entered in standard formats. Finally, the Department should recoup the $10,790 that was paid in error.

Agency's Response: The DHHS Controller's Office concurs with the audit finding. Payments from copies are executed when originals are lost or not received. Technicians are instructed to research for duplicates before paying. We agree this occurs when there is no uniformity for entering invoices having no invoice or reference number to enter in the invoice reference field in the AP screen. The Office of the Controller is studying this issue and will develop a uniform methodology for identifying these types of invoices in the system and strive to eliminate duplicate payments to vendors. A committee of General Accounting Supervisors will be formed and a solution will be developed to resolve this problem. We anticipate a resolution and policy to be in place no later than March 30, 2002.

The duplicate payments cited in the finding have been resolved at this time.

4. EXPENDITURES ERRONEOUSLY CHARGED TO FEDERAL PROGRAMS

The Department erroneously charged federal programs as follows:

- The Child Support Enforcement (CSE) Program was overcharged by $170,510. The accounting clerk erroneously coded one transaction so that it would be directly charged to the CSE Program even though the supporting documentation indicated that the charge benefited the entire Division of Social Services. The Department's review procedures did not detect the coding error. We question $112,536, which is the federal share of the amount overcharged.

- The Department's review procedures were inadequate and failed to detect a coding error on a reclassification entry. Postage expense of $32,020 was erroneously charged to the Low Income Home Energy Assistance Program (LIHEAP) rather than the appropriate public assistance grants. We question costs of $32,020 to the LIHEAP grant.

OMB Circular A-87 states that costs are allocable to a grant if the goods or services involved are charged in accordance with relative benefits received.

Recommendation: Accounting clerks should be reminded of the importance of charging transactions to the proper funding source. Review procedures should be reinforced to prevent errors. After discussing this issue with the auditee, an adjusting entry was made in August 2001 to correct the coding error in the CSE Program. The Department should make an adjustment to the LIHEAP grant to reclassify the postage incorrectly billed to that program.

Agency's Response: The DHHS Controller's Management concurs with the finding and recommendation. This error was corrected per BC Document #24312AP025 entered on 08/17/01 with an effective date of 07/31/01. The correction was provided within the "Child Support Enforcement Program Financial Report, Part 1: Quarterly Report of Expenditures and Estimates" for the quarter ended September 30, 2001, as a "Prior Quarter Adjustment". The situation was highly unusual concerning changes to the amount of the invoice and the fact that the individual who pre-coded the invoice for payment used the incorrect center based on an original BD-606 that was later revised using different expenditure coding. The invoice paid in error reflects the pay codes from the original BD-606 #110099 but the coding individual failed to detect the revision to this original on BD-606 #110180. Normally an expenditure of this significance would not be made without a purchase order in place but this transfer expenditure related to a major reorganization of the statewide mail distribution organization. Due to the rarity of this type of transaction and the complexities involved and multiple revisions of both budget authorizations and invoices this does not constitute restructuring of procedures but it does call for more awareness and diligence on the part of general accounting reviews and division budget personnel's analysis prior to closeout of annual budget reports.

Our procedures are to review the account codes and center combinations in order to verify that they are acceptable and also compare the coding to how budgeted positions within the cost center are coded to determine if the coding appears to be consistent. This error was an oversight and a rare occurrence. However, this event has prompted the general accounting unit supervisors to be more attentive to in-depth verification of unusual transactions where purchase orders are not used to control the expenditure coding data for extraordinary events such as occurred in this finding. In instances where there are extraordinary circumstances linked to material disbursements, and in the absence of a purchase order; the general accounting supervisors have been instructed to take the additional step of gaining written verification or at a minimum, verbal verification of the account/center coding combination from the respective divisional budget office. Verbal approvals will be noted on the pay documentation.

An adjustment to the LIHEAP program will be entered as a reclassification entry and recorded in general fund 1993 as a prior year adjustment. This will also be completed by the end of this calendar year.

5. BASIC SUPPORT CLAIMS WERE NOT PROPERLY PAID

There were weaknesses in the Department's controls over the payment of basic support claims. An examination of 204 participant files revealed the following errors:

- From November 1999 through September 2000, the Department paid inpatient hospital invoices at the incorrect Medicaid Diagnostic Related Grouping weight rates. This occurred because Medicaid rate changes were not received and properly incorporated into the Department's payment procedures in a timely manner. Our tests disclosed twenty inpatient hospital invoices paid incorrectly resulting in an overpayment to vendors of $4,950. We were unable to determine the total number and dollar costs associated with the incorrect rates but believe it to be significant.

- There were five additional exceptions involving overpayments of rates totaling $813.

- Two invoices were paid without the required documentation. Payments were made for interpreter services without an itemized list of total hours billed. We could not verify that the correct rates were paid. The Department paid $6,357 without adequate documentation.

- The Department did not obtain proper approval for payments that exceeded the authorized amount by $11,988.

- The Department paid a vendor $1,148 for an invoice without the required vendor signature.

The Department expended $25,256 on the claims in error. We are questioning the federal share of $19,876.

The Division's policies and procedures manual states that hospital invoices for inpatient and outpatient services are to be paid at the Medicaid rate and require that information on invoices include a vendor signature. Also, services must be adequately documented and the unit manager/facility director must approve all overpayments exceeding $100.

Recommendation: The Department should strengthen internal controls to ensure that all Medicaid rate changes are received in a timely manner and properly incorporated into its payment procedures. The Department should perform analysis to determine the total impact of the errors and require providers to reimburse the Department for all overpayments.

The Department should also strengthen controls to ensure that adequate documentation and approvals are obtained before payment in accordance with both Federal and internally mandated procedures.

Agency's Response: The Department concurs with the auditor's finding and recommendation. The Agency has contacted the Division of Medical Assistance (DMA) concerning changes in Medicaid rates and plans to contact DMA each year in November and December to see if subsequent changes have been made in Medicaid rates. The agency requested all appropriate refunds on 03/14/02 and has entered corrected claims for additional payment for the check write scheduled for 03/25/02. The claims payment computer system was modified on 03/05/02 so that a specific override is required before payments in excess of the authorized amount can be entered. DVR management has been contacted concerning clarification of override authority policies and will be asked for a list of managers with override authority. Appropriate documentation and signatures that were missing when the claims were paid have since been obtained. Claims errors will be addressed with staff verbally and in writing by 03/27/02 to ensure that correct payment policies are understood and are being followed.

6. UNAPPROVED ALLOCATED CHARGES TO THE MEDICAID PROGRAM

The Medicaid program was charged for allocated computer usage costs. However, the Division of Social Services' approved cost allocation plan did not include the Medicaid program as a benefiting program in the cost center used to allocate these costs. We are questioning $49,943 in unapproved allocations and charges to the Medicaid program.

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

Recommendation: The Division of Social Services should include the Medicaid program into the cost allocation plan and an amended cost allocation plan should be submitted to the federal Division of Cost Allocation for review and approval.

Agency's Response: The DHHS Controller's Office concurs with this finding. The allocation methodology for RCC 2172, Economic Independence Automation, was changed in January 2000 in response to a reorganization of the Economic Independence Section. Responsibility for EIS operations was added to the RCC and Medicaid was added as a funding source. A large number of cost centers were impacted by this reorganization and, unfortunately, the narrative for RCC 2172 was inadvertently not updated to reflect the change. The inclusion of Medicaid as a benefiting program in this RCC was correct. The Cost Allocation Branch has amended the narrative retroactive to January 1, 2000 to include Medicaid as a benefiting program. This amendment will be submitted to the Division of Cost Allocation for approval by March 8, 2002.

7. INADEQUATE CONTROLS OVER AMENDMENTS TO COST ALLOCATION PLAN

Cost allocation plan amendments initiated by the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services and sent to the Department's Controller's office are usually processed by emails or telephone calls. This practice is too informal, does not provide adequate justification for the amendments, and does not provide evidence that the amendments are properly dated, reviewed and approved.

An effective internal control structure addresses the design and use of documents, describes transactions in sufficient detail to permit proper recording, and documents that transactions are properly dated and approved.

Recommendation: The Department should develop procedures that require the Division to document, explain and justify any amendments to the cost allocation plan. Further, the documentation should be reviewed and approved prior to sending the amendments to the Department's Controller's office.

Agency's Response: The DHHS Controller's Office Management concurs with this finding. It is important to note, however, that the DMH/DD/SAS first implemented a Public Assistance Cost Allocation Plan (CAP) in SFY 1999-2000. Lack of familiarity with CAP requirements on the part of Division staff, the significant reorganization cited by Division officials, and turnover in the Controller's Office Cost Allocation Branch staff with responsibility for the DMH/DD/SAS CAP exacerbated the problems identified in this finding.

The Controller's Office Cost Allocation Branch will develop a procedure outlining the requirements for amendments to the CAP. The procedure will be implemented by May 1, 2002. Included in this procedure will be information detailing the conditions or circumstances that require a CAP amendment, the forms of documentation required to support requests for amendments, timing of amendment requests, and procedures for submission of CAP amendment requests to the Controller's Office. Since timely communication is critical to maintaining the integrity of a CAP, the procedure developed will permit notification to the Cost Allocation Branch by electronic mail. However, it will require e-mails to be accompanied by supporting documentation and that e-mails be initiated by or routed through the Division Budget Office with copies to the Budget Officer and responsible program official. The Controller's Office will share this procedure when it is finalized with all DHHS Divisions operating under Cost Allocation Plans. The Controller's Office will recommend that the DMH/DD/SAS then develop internal procedures to ensure timely compliance with the requirements outlined in the Controller's Office procedure.

8. EXCESS FEDERAL FUNDS HELD

Because of a failure to follow the Department's internal control procedures, the Temporary Assistance for Needy Families (TANF) grant maintained excess funds on hand. The grant had an average excess balance of $13 million on hand for a three-month period and $7 million on hand for an additional four-month period. Factors contributing to the excessive balances are described below.

- The drawdown on July 27, 2000 exceeded the program's needs by $5.3 million. A coding error on a previous receipt caused the accounting records to overstate the TANF funds needed. This error was reflected on the Department's grant reconciliation schedule but was not resolved until several months later.

- The drawdown on August 31, 2000 exceeded the program's needs by $8.7 million. The request was based on accounting records that had not closed out for the month. The Department returned the funds three months later.

The Treasury-State agreement dictates that the request for direct TANF expenditures be made not more than two business days prior to the day the State makes a disbursement. Allocated costs should be drawn down as an estimate at the end of the month and adjusted to actual in the subsequent month after cost allocation has been run and accounting records closed for the month.

Recommendation: The Department should comply with the Treasury-State agreement and its own internal control procedures when requesting TANF funds. Extra care should be taken when coding the federal receipts to ensure that the proper grant is credited. Errors that are disclosed on the grant reconciliation worksheet should be investigated and cleared monthly. If requests are made prior to the closing of the accounting records, adjustments should be made immediately when they are finalized.

Agency's Response: Controller's Office management concurs with the finding and recommendation. Management has reiterated to the Federal Funds/Financial Reporting staff the importance of following procedures and processing monthly revenue clearing draws immediately upon month end certification. The Federal Funds/Financial Reporting staff was also reminded that the grant reconciliation should be completed and adjustments made to the NCAS immediately after the monthly revenue clearing draws are processed.

9. SUBRECIPIENT AUDIT REPORTS NOT ADEQUATELY REVIEWED

The Department did not adequately review its non-governmental subrecipient audit reports in the Child and Adult Care Food Program for compliance with OMB Circular A-133. Six of the nineteen audit reports tested contained one or more errors:

- Two reports did not have the required Summary of Auditor Results section.

- One report included the Summary of Auditor Results section; however, it did not contain all required elements.

- One report did not have the Auditor's Report on Internal Control Related to the Financial Statements nor did it have the Auditor's Report on Internal Control Related to Compliance with Laws and Regulations.

- Three reports did not have a Corrective Action Plan for findings contained in the reports.

In addition, one report did not have a timely management decision issued by the Department.

OMB Circular A-133 requires that pass-through entities ensure that subrecipients expending $300,000 or more in federal awards during a fiscal year have a single audit performed in accordance with the Circular. The Circular establishes certain reporting requirements. OMB Circular A-133 requires the pass-through entity to make a management decision within six months of receipt of the audit report and to ensure that subrecipients take appropriate corrective action.

Recommendation: The Department should enhance review procedures to ensure that subrecipient audit reports comply with the requirements of OMB Circular A-133. The Department should ensure that management decisions are issued within the federal time frame.

Agency's Response: The DHHS Controller's Office Management concurs with the finding and with the State Auditor's recommendation. In regard to the exclusion of identified elements within the tested audit reports that are required by OMB Circular A-133, the Department has since received the majority of the missing documentation. The Department has contacted all of the identified entities in regard to the omitted information within their audit report and has successfully received all of the required documentation except for the Summary of Auditor Results from one entity, which the Department will continue to pursue. In two instances, the information noted in the Audit Finding as missing from the audit report was due to our office inadvertently not pulling the complete audit file. One Internal Control Report was not pulled as well as one DHHS Audit Response letter. The Auditor's finding also included the condition relating to the delay in issuing management decisions, which can occur when timely responses/information are not received from the subrecipients. The Department will continue to actively pursue responses/information as needed to close these audits in a timelier manner.

Staff reviewing the A-133 Child and Adult Care Food Program audits rely greatly on information contained in the Auditor's Findings, Questioned Costs and Recommendations. The Department concurs that its review process should include checking the audit reports for required disclosures and proper format and will revise current Internal Procedures to include an A-133 Checklist. This Checklist will be used to ensure that the correct format/language and required Summaries and Reports are included in the audit report. Audit reports determined to be substandard will be forwarded to the CPA Licensing Review Board for appropriate action. The Audit Resolution Unit's two full-time employees and a temporary employee continue to handle resolution/tracking for approximately 152 local government agencies, nearly 700 nongovermental entities, and approximately 1,100 organizations that receive funding through the Division of Public Health's Child and Adult Care Food Program. The Unit continues to manage a workload that has more than doubled since the Controller's office was consolidated in January 1997. The Program/Benefit Payment Section is confident that a greater emphasis in this area, as well as increased awareness by staff, will help prevent a reoccurrence of this condition.

10. FIXED ASSET RECORDS NOT UPDATED TIMELY

The Department did not follow established Office of State Controller procedures for updating equipment records. As of December 2001, the Department had not updated the fixed asset system to reflect $1.4 million of equipment purchased with Child Support Enforcement funds during the fiscal year ending June 30, 2001. Federal regulations require the State to maintain accurate equipment records.

Recommendation: The Department should establish procedures that ensure the fixed asset system is updated in a timely manner.

Agency's Response: The General Accounting and Financial Management Section of the Controller's Office agrees with the finding and is taking action to include better coordination and provide training for division staff in order to more properly define roles of responsibility for the FAS coordinator positions. A major part of the issue was a result of not receiving accurate and well defined locations and/or copies of purchase orders and FAS forms in order to enter the data in a timely manner. We are continuing to receive updated information and copies of purchase orders and are recording this data into FAS as quickly as possible. During the month of February $235,654.50 was recorded as new "additions" to FAS and in March another $1,366,872.59 has been added. Due to the volume and multiple locations of equipment and the recent move of the child support office from Anderson Drive to Terminal Drive, our goal is to have as much data entered prior to preparation of the physical inventory worksheets for the current fiscal year. During the inventory process for the new year it will be easier to define locations and abbreviations than to try and complete an updated inventory for this fiscal year. The inventory must be completed and all information updated prior to CAFR reports, which are due by the end of August.

DIVISION OF CHILD DEVELOPMENT

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

11. EMPLOYEE PAID FOR UNEARNED LEAVE

An employee was paid a full, regular salary during a four-month period while absent from work without earned leave. As a result, the employee erroneously received $14,455 in salary and benefits and was credited with 100 hours of vacation and sick leave.

The employee, on medical leave, had been instructed to notify the personnel office if unable to return to work. The employee failed to notify the personnel office and did not submit a request to go on leave without pay after exhausting available leave balances.

A tracking system was not in place to ensure that time sheets were received from all employees and to ensure that the personnel office was aware of each employee's status.

Adequate internal control dictates that only employees who are working or have adequate leave should be paid in full. OMB Circular A-87 states that costs are only allocable to a grant if the services involved are charged in accordance with relative benefits received.

Since the employee's return to work, an amount is being withheld from the employee's pay to recover the overpayment. We question $12,544 charged to the Child Care and Development Block Grant, which represents the portion of the overpayment that had not been recovered during the fiscal year.

Recommendation: The Department should investigate the circumstances surrounding this condition, identify any systemic weaknesses and institute corrective action. At a minimum, a tracking system should be implemented to ensure that time sheets are received from all employees and immediate action is taken on instances of overdrawn leave. In addition, the Division should recover all amounts overpaid the employee, adjust the employee's leave balances and reimburse the program all amounts refunded.

Agency's Response: The Division concurs with the auditor's finding. The Division's corrective action will be as follows. The Director, Division of Child Development will notify all employees formally, via official memorandum, as to the importance of accurately reporting their leave status and time worked in a timely manner. It will establish the following guidelines: 1) DCD employees are required to submit their timesheet to their supervisor within five (5) calendar days of the end of the reporting month; 2) Field based supervisors will ensure timesheets for all employees for which they are responsible are submitted to their respective section timekeepers in Raleigh within ten (10) calendar days from the end of the reporting month; 3) timekeepers for each section will ensure they have a timesheet for every employee, on a monthly basis, based on up-to-date employee rosters; 4) that supervisors will notify Personnel anytime an employee is absent or going to be absent for an extended period and/or Leave Without Pay status, within 48 hours or as soon as is feasible, to preclude an overpayment situation; and 5) that failure to comply with these guidelines which results in an overpayment situation may result in disciplinary action being taken against the responsible person(s). Finally, action has been taken to recoup the remaining 100 hours that were credited in error, and will be completed by June 30, 2002. We believe these controls will preclude similar such incidents from occurring in the future.

DIVISION OF SOCIAL SERVICES

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

12. APPROPRIATE ACTION NOT TAKEN IN CHILD SUPPORT CASES

The prior audit of the Child Support Enforcement program disclosed cases in which the Division of Social Services had not taken appropriate or timely enforcement action to ensure that absent parents complied with court orders related to the payment of child support. The prior audit noted that appropriate action was not taken to ensure that paternity or support orders were established within required time frames. Also, the audit noted that there were interstate cases in which the appropriate action was not taken and cases in which medical insurance coverage was not enforced.

Our current audit indicated no improvement in controls except for enforcing medical support obligations. The Division failed to take the appropriate action or failed to take the required action in the established time frames for a number of cases. All cases tested originated from State operated offices. The case errors are described as follows:

a. Paternity was not established within the required time frame for twenty-three of the thirty cases tested in paternity status, a 77% error rate. Actions contributing to the noncompliance included failure to take action on successful "locate matches," failure to verify potential mailing addresses or employment, failure to contact the absent parent when a verified address was available, or failure to take action on the case within the required time frame.

b. A support obligation was not established or no attempt was made to establish a support obligation within the required time frame for nineteen of thirty cases tested in establishment status, a 63% error rate. Actions contributing to the noncompliance included failure to take action on successful "locate matches," failure to verify potential mailing addresses or employment, or failure to "serve process" within ninety days.

c. Appropriate or timely enforcement action was lacking for thirteen of thirty cases tested in delinquent status, a 43% error rate. There was no enforcement action taken for seven of these cases. In two cases the "service of process" actions were not adequately documented. Enforcement action was not taken for the other four cases within the required time frames. The actions taken were from one month to four months late.

d. Appropriate enforcement action was lacking for five of the thirty cases tested to determine if medical support obligations had been secured or enforced, a 17%

error rate. In three cases the absent parent was working and insurance was available but the child had not been included on the absent parent's insurance policy. In the other two cases, the case files were not documented sufficiently to determine if insurance was available.

e. Appropriate action was not taken within the required time frame for seventeen of the thirty interstate cases tested, a 57% error rate:

    1) Four cases were not referred to other states within the required twenty calendar days of locating the absent parent in the other state. Documents for these four cases were sent to the other states from eight to ninety-one days late.

    2) The interstate transmittal documents were never sent to the other states in five cases.

    3) There was no contact with the responding states to check on two cases even though there had been no activity on the cases during the year.

    4) No action was taken on four cases after receiving a request from the initiating state. There was no indication that action should have been delayed due to additional information needed from the initiating state.

    5) In two cases, the responding interstate cases were not processed within the required time frame.

    6) In one of the cases noted above, the central registry section acknowledged receipt of the case six days after the required time frame.

Our sample error rates, with the exception of medical support, exceed the 25% error rate allowed by the federal government when determining whether the State substantially complied with these requirements. According to Division personnel, large case loads and unfilled vacant positions contributed to the numerous errors noted.

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

Recommendation: Management should ensure that the necessary actions on child support cases are taken within the required federal time frames.

Agency's Response: DSS concurs with the audit finding. Child Support Enforcement (CSE) has developed a corrective action plan that includes multiple components. This year, CSE implemented the Monthly Performance Report to measure each County's performance in the areas of Establishment of Paternity and Support, Medical Enforcement, Review and Adjustment and Interstate. Additionally, CSE has made reports available that identify the specific cases that are out of compliance in these areas. The reports are available to each local office supervisor and to the Area Supervisors via the mainframe reporting system, X/PTR. The Monthly Performance Reports are in production and local corrective action plans are also in place. The local plans will be updated based on local office performance. The data warehouse training for Area Supervisors has begun and training for the local offices will begin in April, 2002.

13. PROGRAM WAS NOT MONITORED

As similarly reported in the prior audit report, the Division of Social Services did not perform monitoring procedures to provide reasonable assurance that the counties used Social Services Block Grant (SSBG) funds for only eligible individuals and allowable service activities. The Division's monitoring plan did not include monitoring procedures for the SSBG program. The Division paid $31.9 million to the counties for SSBG benefit payments and services.

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

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

Agency's Response: The Department does perform monitoring activities on the SSBG grant; however, these monitoring activities have not been formalized in the Division's monitoring plan and have not been as extensive as they might be due to budgetary and personnel constraints. The Division will incorporate formal SSBG monitoring activities into their overall monitoring plan that will comply with OMB Circular A-133. DSS will move forward with the implementation of the plan next fiscal year 2002-03.

14. FEDERAL REPORTS CONTAINED ERRONEOUS OR UNDOCUMENTED DATA

The review procedures employed by the Division of Social Services did not ensure accuracy in Temporary Assistance for Needy Families (TANF) reports. Also documentation was not available to support the number of families reported on one report. We noted the following errors:

- Employment hours were incorrectly reported in three of the seventy-five cases in the January section of the "SSP-MOE Data Report" for the quarter ending March 31, 2001. Keying errors caused the mistakes.

- Documentation was not available to support the number of families reported in fifteen of the eighteen programs included in the "ACF 204 Annual Report."

Good internal controls dictate that amounts reported on federal reports be accurate and agree to the supporting documentation.

Recommendation: The Division should implement review procedures to ensure that data reported on federal reports are accurate and agree to the supporting documentation. Review procedures could include periodic comparison of reports to supporting records. Also, documentation should be maintained to support all amounts disclosed on the reports.

Agency's Response: DSS concurs with the audit finding. Corrective Action for the SSP-MOE Data Report was completed on January 18, 2002, with re-transmission of the data for the affected quarter. All documentation and formulae for the 2001 ACF-204 report are maintained by the Planning and Information Section. This report, with accompanying documentation, was completed in December 2001.

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

15. CRIMINAL RECORD CHECKS NOT DOCUMENTED

The Division of Social Services did not provide documentation that criminal record checks were conducted on prospective foster parents in three of the thirty foster family home records tested. The procedures in place during the audit period did not ensure that criminal record checks were performed on each individual in a licensed foster family home.

Federal and State regulations require the State to provide documentation that criminal record checks were conducted on prospective foster parents. The federal share of the payments made to the homes noted above total $1,178. Because likely questioned costs exceed $10,000, we are questioning the payment of $1,178.

Recommendation: After the end of the fiscal year the Division changed its policy and began requiring criminal background checks prior to the foster home license being issued. The Division should follow its revised procedures ensuring that it has on file evidence of criminal record checks on prospective foster parents prior to licensing foster home facilities.

Agency's Response: DSS concurs with the audit finding. As noted above, the Division did change policy and is following new procedures. The corrective action on this issue was completed effective October 1, 2001.

16. PERIOD OF AVAILABILITY NOT DOCUMENTED

The Department reported on the federal SF-269A Financial Status Report for September 30, 2000 that the Low Income Home Energy Assistance Program (LIHEAP) 2000 grant was totally obligated, yet it was unable to provide evidence in support of this period of availability requirement.

The federal program's period of availability regulations require that at least 90% of the LIHEAP block grant funds be obligated in the fiscal year appropriated.

Recommendation: The Department should establish procedures to track, account for, and document obligations of the LIHEAP block grant by federal grant award and federal fiscal year to ensure that the period of availability of federal funds compliance requirement is met.

Agency's Response: The Department concurs with the audit finding. The DSS will work with the Controller's Office and Budget Planning and Analysis to develop and implement a policy that will ensure all aspects to track the LIHEAP block grant by fiscal year thus, ensuring that the period of availability of funds requirements are met.

DIVISION OF MEDICAL ASSISTANCE

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

17. SOME EMPLOYEES HAD IMPROPER ACCESS TO THE MEDICAID MANAGEMENT INFORMATION SYSTEM AND THE ELIGIBILITY INFORMATION SYSTEM

We noted weaknesses in computer systems access controls:

- Two employees of the Division of Medical Assistance had more access to the Medicaid Management Information System (MMIS) than was necessary for their jobs. The employees, who should have been restricted to inquiry functions, were granted update capabilities. Also, a user who could not be identified had inquiry and/or update access to MMIS.

- Instead of assigning a unique user ID for each employee, the Division assigned one user group ID for an entire group of employees.

- Five former employees continued to have access to the Eligibility Information System (EIS).

Unwarranted access and unauthorized use can compromise the integrity and confidentiality of financial data. Individual accountability cannot be established for system activities when a unique user ID is not assigned for each employee.

Recommendation: The ability to access MMIS and EIS should be limited on a need-to-use basis and should be promptly removed from individuals who leave the Division. The appropriate security officer should be notified when an employee separates. Also, the Division should periodically review security access to evaluate access rights for existing employees and ensure that access for separated employees is revoked. We noted that before the completion of our fieldwork the Division had removed unauthorized users from EIS and had prepared a detailed draft security policy manual.

Agency's Response: The Division of Medical Assistance's management concurs with the overall audit finding and also concurs that some of the corrective actions were out of the scope of DMA's Security Control Officer's job. A semi-annual security audit is being proposed within DMA. This will require current supervisors to verify that their employees have a continuing need for the identified rights and privileges for both EIS and MMIS. The DMA Security Control Officer is currently developing such a report to assist the supervisors in their review of their employees' access rights and privileges with the design to be coordinated with EIS and MMIS staff. We believe that these recommended actions will provide DMA Security Administration the information necessary to ensure that all users of both the EIS and the MMIS are valid users and have appropriate access and functionality in both systems. Specific responses follow:

- Two employees had more access to MMIS than was necessary for their work. These employees should have been restricted to inquiry functions but were granted update capabilities.

  One employee had changed positions within DMA. Her most recent DMA supervisor indicated that she had used the update option in her previous position. The DMA Security Control Officer at that time was not notified of the employee moving to a different position. This person is no longer employed at DMA and her access has been terminated.

  A long time EDS employee previously had update access to the CR Screen. Her supervisor stated that this employee's role previously required her to have approval to use this screen for updates. Her access was changed to inquiry only for her work with Medicare Buy-In. Her account activity is sponsored by DMA's Recipient & Provider Services.

- One unidentified user had inquiry and/or update access to MMIS through Clerk ID VIHA EDS stated that the ID should have been deleted during an EDS "clean up" and was inadvertently missed. This user account has been deleted.

At the beginning of the startup of the MMIS project a group identification MHMA was contemplated and established for the Mental Health Section of EDS. EDS indicated to the auditor that each person previously planned for inclusion in this group identification was assigned individual access rather than using a group identification. This group identification has been deleted.

ACTION: In 2001, DMA implemented an internal online "Employee's Moving Positions" form as an added process to the DMA Security Policy and Procedures Manual. DMA Assistant Directors reviewed this form and notified Supervisors of the requirement to complete the online form for submittal to the DMA Security Control Officer. As the Security Control Officer is a member of the DMA.Account.Setup1 distribution list, the submittal of the online "Employee's Moving Positions" form notifies the Security Control Officer of the appropriate action.

The employee's new supervisor is required to identify the access that his new employee needs for the new position. For an employee changing positions, the new supervisor completes a New Employee form to restate the access the user needs. All other previous access held by that employee in his former position is removed.

Monthly, the Human Resources staff also sends a list of personnel changing positions or leaving DMA. This requirement is also stated in the DMA Security Policy and Procedures Manual. The DMA Security Control Officer crosschecks the supervisors' requests with the report from Human Resources to assure that unnecessary access is deleted.

All DMA supervisors/sponsors are now aware of the DMA Policy & Procedure Manual requirement that any changes in employment are to be sent to the DMA Security Officer via the online forms.

A report called Security Master File Listing (hmpr0951) is a listing of all DMA access to EDS. There is also the EDS Corporate Information Security NACOS Network Logon ID Report. The DMA Contract Monitoring staff and the DMA Security Officer are working on possible revisions to these reports so the Contract Monitoring staff can review the reports by last access date and notify the DMA Security Control Officer of users that are no longer accessing MMIS within an appropriate time limit. If there are users who have left and the DMA Security Control Officer was not notified, then the DMA Security Control Officer will request deletion of the IDs as appropriate.

- Five former employees continued to have access to EIS after they separated. A record of their IDs continued to show on the audit report. However, the IDs had actually been deleted. One safety feature built into accessing EIS is that a separate

RACF ID must be active and is required to access EIS. The RACF is automatically disabled if a user does not use it for access within 45 days from the previous access. The DMA Security Control Officer is the only one who can reactivate the ID should it be necessary to do so.

Procedures are in place for the Security Control Officer to assure the user is an active employee or authorized business associate before the reset would take place. The EIS for these people were deleted previous to the follow-up from the auditor. The DMA Security Policy and Procedures Manual now in place requires supervisors and sponsors of business associates to notify the DMA Security Control Officer when staff leave or change positions.

ACTION: DMA requested the development of a RACF-ID based Security Report for DMA users of the N.C. Office of Information Technology Services (ITS) mainframe environment – especially as it relates for access to the Eligibility Information System. Security Profiles Report of EIS lists user names and IDs and identifies the type of access to the specific screens given to that user. This report is not easily audited. Sometimes when a U is displayed for a specific screen, this does not mean that the user actually has Update access. It may mean that the specific screen is a pass-through point to inquiry on subsequent screens.

The DMA EIS section is currently working with the DMA Security Control Officer and DHHS to clarify what EIS screens are legitimate update screens, what individuals have access to these screens, and verification of the business reason for the specific access. This process is in the final stages and will soon be added to the DMA Security Policy and Procedures Manual. The DMA Security Control Officer will develop an MS-ACCESS report from this information that will provide verification of changes, modifications and necessary purging of RACF-ID rights and privileges as well as tighter control of update rights given for access to the Eligibility Information System.

18. REQUIRED SYSTEM REVIEW REPORT WAS NOT ISSUED

The Division of Information Resource Management (DIRM) did not issue a completed and approved "Biennial Security Review Report" for 2000 as required by regulations. DIRM completed a draft report of the 2000 biennial security review; however, the report was not approved at the appropriate levels and was not issued.

Forty-five CFR Section 95.621 requires State agencies to review, on a biennial basis, the ADP security system of installations involved in the administration of Health and Human Services and to maintain reports of the reviews.

Recommendation: The Division of Information Resource Management should obtain the appropriate approvals and issue the 2000 security review report. Also, DIRM should ensure that reports on future reviews are approved and released in a timely manner.

Agency's Response: The Division's Management concurs with the finding and recommendation. The 2000 Biennial Security Review was completed by the DHHS DIRM Security Administrator on April 9, 2001. The plan is being reviewed by DHHS Management and will be published by mid April 2002.

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

19. SERVICES BILLED WERE NOT SUPPORTED BY MEDICAL RECORDS

From tests of 300 Medicaid claims we uncovered five claims that were in error:

- Four claims were for services that were not adequately supported by the patients' medical records. The providers did not submit the complete medical records needed to form a conclusion on the medical necessity of the services received. The claims totaled $84,672; the federal share of $52,896 is questioned.

- One of the claims had more units billed than was documented. The Division expended $25 on the claims in error. Because likely questioned costs are in excess of $10,000, the federal share of $16 is questioned.

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

Recommendation: The Division should require providers to submit complete documentation to enable a more complete examination of the claims. For the claims billed incorrectly, the Division should recoup the overpayment.

Agency's Response: Four claims did not have adequate documentation supplied by the provider by the State Auditor's deadline. DMA Program Integrity (PI) could not determine without those records whether the case had, or did not have, incorrect payments. The total amount paid for the four claims was $84,938.78. The status as of 3/5/02 is listed below. One has been found to be correct.

05 J 129: The medical records were received 2/27/02. The review has begun.

08 J 233: The provider assures the records are being mailed to DMA within the next few days.

09 J 262: The records have been received and submitted to physician for review.

10 S 285: The medical records have been received and reviewed. Staff found no incorrect payments. (Claim value: $41,409.36). No overpayment on this claim.

One claim found to have incorrect billing.

04 J 113: This claim was in error due to erroneous units. After reviewing the medical records, a PI case was opened, #2001-1135 (7/25/01). The provider had billed for more units of service than provided by the documentation provided for the following dates:

- 09/18/2000 – Provider billed for twelve units of service, but Aide flow sheet indicated she worked for two hours (eight units). Recoupment requested for four units of service, $12.72.

- 09/27/2000 – Provider billed for eighteen units of service, when the Aide flow sheet indicated that she provided fourteen units of service (three and one-half hours). Recoupment requested for four units of service billed and not delivered to the client, $12.72.

Total recoupment requested was $25.44. The provider requested a paper appeal (received in PI on 09/17/01) for reconsideration of the recoupment requested for 09/18/2000, and provided additional documentation to support that twelve units of service were provided to the client. PI recommended the Hearing Office withdraw the recoupment request for this DOS, and reduce the total recoupment amount from $25.44 to $12.72. This request was forwarded to the Hearing Office on 10/23/01.

20. NURSING FACILITY DESK AUDITS WERE NOT COMPLETED

The Division of Medical Assistance (DMA) completed only 20% of the required nursing facility cost report desk audits. For fiscal year ending June 30, 2000, there were 341 nursing facility cost reports that required desk audits to be completed by June 30, 2001. DMA was able to complete only 70 desk audits and had 50 other desk audits in process. DMA did not receive audit reports on the remaining 221 facilities. Because of these conditions DMA was not able to verify the accuracy of the nursing facility cost reports.

The North Carolina State Plan, Section .0104(e), requires that nursing facility cost report desk audits be completed within 180 days after receiving the cost reports, which are due by December 31st.

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

Agency's Response: The Division of Medical Assistance (DMA) concurs with the State Auditor's recommendation that steps be taken to ensure that desk audits of cost reports be completed on a timely basis.

DMA is required to desk audit the annual nursing facility cost reports by June 30th of each year. Over the years, the Audit Section has been performing a more comprehensive desk audit. Also, the number of nursing facilities to audit has increased. DMA desk

audits encompass 100% of the nursing facilities. To audit these cost reports, 8 full-time auditors and one part-time auditor (8.5 positions) are available. (In prior years, we had 9 full-time auditors available for 350 nursing facility desk audits.) During the audit of the 2000 nursing facility cost reports, there were two vacant auditor positions. The State-hiring freeze of 2001 prevented filling these vacant positions. In addition, we had three other auditors with less than one year's experience. Our two experienced auditors were responsible for reviewing the 200 yearly field audited cost reports. This contributed to the failure of completing the audits by June 30th.

Suggestions to complete desk audits of cost reports on a timely basis:

- Extend 180-day desk audit time table to 270 days to prevent limited scope audits and to comply with the North Carolina State Plan, or

- Increase staff by approximately 2-3 auditors in order to complete audits by June 30th

- Take steps to retain experienced auditors. (Some experienced auditors have gained valuable experience in our section and have left for positions in CPA firms, Attorney General's Medicaid Investigations Unit and other State government departments.), or

- Limit the scope of the desk audits, therefore decreasing the time to complete the audits.

Note that non-compliance with the June 30th deadline will likely continue for the 2001 cost report audits. These cost reports are required to be desk audited by June 30, 2002. We lost two additional auditors recently. One left for a budget analyst position within DMA. The other was recalled to military active duty due to the War in Afghanistan. We have hired three new auditors in the past three months. We still have one vacant auditor position that has been frozen. We hired one temporary auditor to alleviate the workload. We currently have only one auditor with more than 18 months experience.

21. INTERNAL CONTROL WEAKNESSES WERE IDENTIFIED IN THE DIVISION'S CONTRACTING PROCESS

Our tests of 15 contracts disclosed the following:

- The Division did not obtain a required certification regarding debarment and suspension for one contract. Failure to have secured the certification increased the risk that the Agency may have contracted with or provided funds to a debarred company or individual.

- The Division did not obtain approval from the State's Purchasing and Contracting Division (P&C) for an addendum to a sole source contract.

- Five contracts were not submitted to the Division's designated contract officer for required approval.

- Two contracts did not have the minimum internal agency approvals required by the Department's Purchasing Manual.

The federal government may prohibit individuals or organizations convicted of fraud or found in violation of government contracts or federal laws from contracting for or receiving awards from federal funds. Forty-five CFR 76.510(b) requires contractors receiving individual awards of $100,000 or more to certify that the organization and its principals are not suspended or debarred.

The State Purchasing & Contracts purchasing manual states that P&C must approve contracts over a department's delegation amount and that sole source contracts must be justified. Also, contracts should be submitted to the Division's designated contract officer for approval.

The Department's Purchase and Contracts Manual requires agency approval from the initiator (chief, Assistant Director, Business Officer), the contract office, a budget officer, and a director or designee.

Recommendation: The Division should obtain the required debarment certification from its contractors as part of the standard procurement process. Also, the Division should ensure all contracts are initiated through the contract office and required approvals are obtained. We noted that the debarment certification was obtained during our audit.

Agency's Response: The Division agrees with the auditor's recommendations and have implemented the corrective actions stated below:

Future requests to contract, including personal service agreements, will be submitted to the DMA Contract Office for review and consideration. All initiators of contract requests will provide, as a minimum, a completed Contract Approval Form and justification for contracting. Upon the approval of the DMA Contract office, this information will be

routed to the appropriate individuals within DMA, DHHS and State Purchase and Contract for approval.

The debarment certification for EDS, as noted in the Discussion Summary, was obtained before the end of the audit. Future certifications will be obtained as required and stated in the DHHS Purchasing Manual.

DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES

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

22. ACCOUNTING RECORDS ARE INADEQUATE TO SUPPORT FEDERAL GRANT COMPLIANCE REQUIREMENTS

    The accounting records are not designed to track Substance Abuse Prevention and Treatment (SAPT) Block Grants separately by federal fiscal year. In fact, all SAPT grant awards are commingled and tracked under just one, generic federal reimbursement code. Consequently, no audit trail is available to match recorded (actual) expenditures to a specific grant.

    Additionally, accounting records are not designed to classify SAPT expenditures in sufficient detail to support grant-earmarking requirements. Our audit tests revealed the following problems:

    - *Of the amount earmarked for alcohol and drug prevention/treatment, not less than 20% of the grant shall be expended for SAPT primary prevention programs (45 CFR section 96.135(b)(1)).*

      Documentation to support compliance with this earmarking requirement was done on the State's fiscal year and the documentation included a combination of estimated and recorded (actual) expenditures. We were unable to correlate the earmarking documentation provided on the State's fiscal year to a specific grant.

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

      Documentation to support compliance with this earmarking requirement was done on the State's fiscal year and the documentation included a combination of estimated and recorded (actual) expenditures. We were unable to correlate the earmarking documentation provided on the State's fiscal year to a specific grant.

- *No more than 5% of the grant may be expended to pay costs to administer the grant (45 CFR section 96.135(b)(2)).*

  Documentation to support compliance with the costs to administer the grant was tracked in the accounting records. However, the tracking of administrative costs is virtually a moot point since we are unable to associate the recorded administrative costs to a specific federal grant award. However, even under the Division's method of tracking administrative costs on the State's fiscal year, the administrative costs reported exceeded the 5% earmarking limit.

In accordance with 45 CFR Subpart C, section 96.30, fiscal controls and accounting procedures must be sufficient to (a) permit preparation of reports required by statute authorizing the grant and (b) permit the tracing of funds to a level of expenditure adequate to establish that such funds have not been used in violation of the restrictions and prohibitions of the statute authorizing the block grant. Under OMB A-133, control procedures should be in place to provide reasonable assurance that compliance requirements are being met, and the information and communication system should ensure reports are provided timely and, when necessary, appropriate corrective action is taken.

Since controls and accounting procedures are not sufficient to provide reasonable assurance that federal compliance requirements are met, we question $33.8 million in SAPT block grant expenditures expended during the State's fiscal year ended June 30, 2001.

Recommendation: The Division should design its accounting records to identify and track expenditures by each block grant awarded. Further, expenditures should be classified and segregated in sufficient detail to support federal earmarking requirements.

Agency's Response: As discussed with the State Auditor staff during the exit conference, it was agreed that the Division was not out of compliance in meeting the obligation of the SAPT primary prevention amount earmarked for alcohol and drug prevention/treatment. It was also agreed that the Division was not out of compliance in meeting the requirement for early intervention services for HIV disease. The issue was how the Division currently tracks the SAPT block grant funds on the State's fiscal year. Beginning with the FFY02 award, the Division will work with the DHHS Controller's Office to set up unique RCC's to track how the SAPT block grant awards are expended in order to correlate the earmarking requirements more clearly. In addition, separate accounts have been established to track prevention set-aside and HIV requirements as follows:

Acct: 536911 UCR Child SA Prevention

Acct: 536912 UCR Adult SA Prevention

Acct: 536913 UCR HIV

The unique RCC's will be established to clearly track the SAPT expenditures and cost will be reclassed back to the beginning of Federal Fiscal Year 2002 prior to June 30, 2002.

Auditor's Response: We take issue with the agency's assertion that we "agreed that the Division was not out of compliance in meeting…" earmarking requirements. The statements we made at the exit conference were consistent with the contents of the audit finding and bear repeating herein. Determination of the agency's compliance related to the Period of Availability of Federal Funds requirements was not possible because the agency commingled federal financial participation from different grant years. Because accounting records and expenditures to support earmarking could not be associated (matched) to a specific grant, compliance with earmarking requirements also could not be audited.

23. REGULATIONS ONLY ALLOW TWO-DAY CASH ADVANCES TO SUBRECIPIENTS

The Division contracts with 39 area mental health centers for delivery of SAPT related services. During July the centers draw approximately $1/12^{th}$ of the state funds budgeted. During August and for each subsequent month approximately $1/11^{th}$ of both state/federal funds budgeted are disbursed. The Division considers these payments as "reimbursement based"; however, the payments are not supported from expenditure reports submitted by the centers. In our opinion, if the "reimbursements" are not based on expenditure reports for clients served, then the $1/11^{th}$ monthly payment process is nothing more than a monthly advance system. Therefore, we question $26.7 million in payments made to the area mental health centers for the State's fiscal year ended June 30, 2001.

The Division also has contracts with numerous non-profit entities. The Division permits these entities to obtain advances from thirty to sixty-days before the actual expenditures are incurred.

OMB A-133 cash management requirements state that the Division must assure that subrecipients conform to substantially the same timing requirements that apply to the State, which is a two-day advance under the Treasurer-State Agreement (TSA).

Recommendation: The Division should develop new policies and procedures for making payments to these entities. These procedures should ensure that contract payments are based upon expenditure reports submitted for clients served. Further, the Division should adhere to the TSA two-day advance rules.

Agency's Response: The Division concurs with the Auditor's finding. The DHHS Cash Management Plan was revised to ensure compliance with federal regulations that federal funds were not advanced to the area mental health centers. Within the Pioneer system of reporting and payments, it was assumed that delaying federal funds payments until August was the best method to ensure funds had been spent at the area mental health center in July and the August payment would be considered a "reimbursement". In the Pioneer reporting/payment methodology, there is no opportunity to compare payments

and expenditures. The Division will work with the DHHS Controller's Office to address the Pioneer reporting/payment methodology in the Substance Abuse Block Grant plan to gain concurrence from the federal agency that the Pioneer system complies with the regulations as stated in 45 CFR 92.20. The Division and the DHHS Controller's Office are also in the statewide implementation phase of the Integrated Payment and Reporting System (IPRS). In the IPRS, area mental health centers will submit claims to the MMIS+ and be paid for each claim submitted. Final implementation is expected by June 30, 2003. At that time, the Pioneer system will no longer be utilized and area mental health centers will be paid as claims are filed. Accordingly, the Division feels that the question of advance payments will no longer exist.

Also, the Division will monitor contract payments to ensure that federal funds will not be advanced before actual expenditures have been incurred as required under the Treasurer-State Agreement (TSA) two-day advance.

24. MONITORING PROCEDURES FOR SUBRECIPIENTS NEED IMPROVEMENTS

Last year an audit finding was written that sufficient monitoring documentation was not presented to support monitoring requirements. In the Division's response to the finding, the Division identified on-site monitoring and desk reviews of the *Semi-Annual SAPT Compliance Reports* as the two main monitoring procedures that they would implement during fiscal year 2001.

The results of our current year tests related to monitoring are:

- On-site monitoring visits at the area mental health centers were performed and documented by the Program Accountability Unit of the Department of Health and Human Services Controller's Office. However, the on-site monitoring visits did not include procedures related to eligibility determination. Thus, on-site visits do not provide reasonable assurances that services were provided to only eligible clients. Further, the results of the on-site visits were not forwarded to the Division's program staff. Consequently, the Division did not perform appropriate follow-up and corrective actions.

- The Division obtained semi-annual compliance reports from the centers. In the corrective action plan to the prior year finding, the Division stated that specialty program staff in the Substance Abuse Services Section would be responsible for reviewing the report, assessing compliance, communicating findings with the area programs, taking necessary corrective action (including assessing a financial penalty if necessary) and documenting all monitoring activities. However, we found no evidence that these activities were performed.

- The Division's primary monitoring procedure for non-profit entities is a desk review of the *Contractor Progress Reports*. We found that the desk reviews were not consistently performed. There were instances where the Division did not

receive *Contractor Progress Reports* and there was no evidence that follow-up was done to obtain the reports. There were other instances where reports were received, but there was no evidence that appropriate reviews had occurred.

OMB A-133 states that the pass-through entity is responsible for monitoring the subrecipients' activities to provide reasonable assurance that the subrecipient administers Federal awards in compliance with federal requirements.

Recommendation: The Division should develop and implement an effective monitoring process. The process should ensure that all monitoring compliance requirements are met, including corrective action plans when necessary.

Agency's Response: The Division concurs with two of the three items noted in the finding. In cooperation with the Program Accountability Branch, the Substance Abuse Services Section will immediately proceed with the delineation, adoption, and implementation of an amended SAPT block grant monitoring protocol to include the auditor's review of the Level of Eligibility (LOE) Reporting Form which determines eligibility in the clinical record of all Substance Abuse Services clients to ensure that services are being delivered to individuals with a Primary Disability of Substance Abuse.

The Division does not agree with the finding related to the semi-annual compliance reports. The Division's response to last years audit finding (ref.# DHHS-DMH-SAPTBG CFDA #93.959 #4460 00-SA-70) stated that, "Beginning in SFY00-01, the following specialty program staff in the Substance Abuse Services Section will be responsible for additional SAPTBG monitoring of area program compliance with designated SAPTBG requirements included in the Performance Agreement." Upon review of this statement, the Division contacted [personal identifying information omitted], State Auditor, at 9:40 am on November 29, 2001 to report the incorrect SFY documented in the final audit. The auditor agreed that the SFY printed was incorrect. The correct audit response should have read, "Beginning in SFY01-02,…." The original audit finding was documented in March, 2001 with a correction action plan to begin July, 2001.

The Contractor Progress Reports are received monthly, quarterly and/or annually depending on the type of services provided for a particular project. The Substance Abuse Section, in conjunction with the Administration and Contracts Unit, will establish guidelines for monitoring the receipt of these reports in a timely manner depending on each contractor's timeframe submission of the Progress Report. Each Progress Report will be reviewed by the Substance Abuse Contract Administrator within 30 days of receipt of the report for approval.

Auditor's Response: Although there was a technical date error in the Division's response to last year's finding (*Single Audit Report* issued in March 2001), the Division did not bring this to our attention until approximately eight months after the *Single Audit Report* was issued. It is not practical to reissue a released report for a technical error made in an agency response.

Due to the timing of the prior year finding, we agree that it is unreasonable to have expected all corrective actions suggested by the Division to have been in-place and operational prior to July 2001. However, the purpose of obtaining the semi-annual compliance reports from each center is to provide the Division with a means to monitor subrecipients for compliance with federal and state requirements. When the Division fails to review the reports for compliance, communicate findings and take corrective actions; then, the Division is in violation of federal monitoring requirements.

25. INADEQUATE CONTROL OVER LEVEL OF EFFORT REPORTS

The Division does not have effective internal controls in place when preparing the level of effort (LOE) reports. Problems encountered are:

- There was no evidence that the source documents used to support the LOE reports were reviewed for allowability and reasonableness. In fact, some of the supporting documents are not generated or obtained by the Division, thus limiting the Division's ability to assess the reasonableness of the data.

- There was no evidence that the final LOE reports, which are submitted to the federal Department of Health and Human Services as part of the SAPT Block Grant Application, are reviewed by the Division for accuracy and consistency.

The Division's internal control should provide reasonable assurance that the LOE requirements are met using only allowable costs that are properly calculated and supported. Proper controls should include reviews to assess the accuracy and allowability of the transactions that support the reports and to ensure that the individual reports are complete and fairly presented.

Recommendation: We recommend that the Division strengthen its internal control over the gathering, preparing, reviewing, and approving of LOE reports.

Agency's Response: The Division concurs with the audit finding. The Division will revise current internal controls when providing information used in preparation of the level of effort (LOE) reports. Information used in preparing the LOE reports, as part of the SAPT block grant application, includes data from various source documents within the Division and other State agencies. Source documents will be required by the Division as part of the internal controls for review and approval before becoming an official part of the LOE report.

The Division will review all data and supporting documents for accuracy and consistency of information provided as part of the SAPT block grant application.

DIVISION OF VOCATIONAL REHABILITATION

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

26. CONTROL WEAKNESSES OVER DETERMINATION AND DOCUMENTATION OF CLIENT ELIGIBILITY

    There were control weaknesses related to the determination and documentation of client eligibility in the Rehabilitation Services-Vocational Rehabilitation Grants to States program. Our examination of 204 client files revealed cases in which eligibility and/or allowable benefits were determined based on inconsistent or incomplete information.

    - Information regarding physical and/or mental impairment in two client files was incomplete or contradictory resulting in the incorrect determination of eligibility. There was no documentation that a third client, determined ineligible, was informed of the agency's decision, as evidenced by a Certificate of Ineligibility document. Thirty-four CFR 361.42 and the Division's policies and procedures manual require that an applicant's eligibility for vocational rehabilitation services be based on a physical or mental impairment that constitutes or results in a substantial impediment to employment. Also, 34 CFR 361.43 requires that the ineligibility decision and the reasons for that decision be communicated to the applicant in writing. The Division expended $7,195 for ineligible clients as a result of these exceptions. Because likely questioned costs exceed $10,000, the federal share of $5,662 is being questioned.

    - Financial eligibility for seven clients was not assessed, not assessed completely, or assessed incorrectly based on inconsistent information in the client files. Thirty-four CFR 361.54 and the Division's policies and procedures require that financial eligibility be established before planning or providing any services and be continuously monitored with changes documented appropriately. The costs associated with these errors were $23,734. The federal share of $18,678 is being questioned.

    - One client did not sign the individualized plan for employment (IPE). Thirty-four CFR 361.45 requires that the IPE be signed by each individual determined to be eligible.

    - The Division expended $1,000 for a client for services that were not included in the client's IPE. Thirty-four CFR 361.45 requires that services be provided in accordance with the provisions of the IPE. Because likely questioned costs exceed $10,000, the federal share of $787 is being questioned.

    - Two files did not contain documentation showing whether there were comparable services and benefits available to the clients. Thirty-four CFR 361.53 and the Division's policies and procedures require that prior to providing vocational

rehabilitation services to an eligible individual, a counselor should determine whether comparable services and benefits are available to that individual. The Division expended $2,820 for services for which there was no documentation in the case file related to this requirement. Because likely questioned costs exceed $10,000, the federal share of $2,219 is being questioned.

Recommendation: The Division should strengthen internal controls to ensure that, prior to providing services, eligibility information in client files is complete and consistent. Clients determined ineligible should be informed in writing by completion of the Certificate of Ineligibility document. The IPE should be signed by the client and reviewed by a qualified counselor at least annually to ensure that only approved services are provided. The outcome of the investigation of available comparable services should be documented.

Agency's Response: The Division of Vocational Rehabilitation agrees with the audit finding. Training regarding policy and procedures will be implemented at the Executive Meeting, Regional Management Team Meetings and at the Unit Staff Meetings. The policy manual will be reviewed to determine if changes are needed and will be completed by July 2002. The policy manual will also be reviewed for clarity and to insert cross-references if needed. Quality Development Specialist will implement training for new counselors and review with current counselors. This will be completed by September 2002.

The Eligibility, Financial Eligibility and Comparable Services errors outlined in the finding are addressed below:

Eligibility

#187 [personal identifying information omitted] The note in the record that was a part of the doctor's preliminary discussion with the client was incorrect in the documentation that the disability of the client did not interfere with work. This documentation was forwarded to the counselor with the follow-up notes for surgery. This doctor works with VR regularly and is clear that work-related limitations/impediments to employment are the reason for a referral to the Division. The MRI and the doctor's referral that was used by the counselor to make the eligibility decision indicated that the disability would interfere with the client's ability to work. Dr. [personal identifying information omitted] has provided documentation of this error and a copy is in the client's case record. This individual is eligible for services.

#64 [personal identifying information omitted] Concur with audit findings. Although a diagnosis of substance abuse is not available in the file, there is reference to "Primary Treatment" before entering DART. The only reason an individual enters DART is if they have been diagnosed with a disability of substance abuse prior to or during their incarceration.

Financial Eligibility

#30 [personal identifying information omitted] Despite the indication on the application that [personal identifying information omitted] salary was $900.00 per month, he was not going to have any income from the date of the application and DVR-0116 until the end of his recuperation. So the salary reflected on the application is not available for the three months that are used to calculate excess income.

#107 [personal identifying information omitted] This client's marital status had changed between the time of the application and the DVR-0116. The financial statement is the official form reflecting the financial status of the client.

#209 [personal identifying information omitted] The client worked in a sandwich shop making $5.15 an hour for 30 hours a week prior to her application. She needed surgery to return to employment and would have no income during the 3 months following the date of the DVR-0116. There was no certainty that she would return to this job following treatment.

#151 [personal identifying information omitted] This client's excess income was calculated for three months and applied to the ancillary services for the surgery provided by the Division. These expenses generally exceed the amount of this individual's excess resources. These costs cannot be calculated precisely prior to the surgery. The expenses exceeded his excess income. Extenuating circumstances section indicates that [personal identifying information omitted] will be responsible for any ancillary services. This includes everything not specifically covered by VR. This statement covers the contribution of excess.

#176 [personal identifying information omitted] Concur with audit findings.

IPE

#106 [personal identifying information omitted] Amendment was mailed to the client who did not return it.

#109 [personal identifying information omitted] Concur with audit findings. The room and board was not added to the IPE. The Unit Manager will monitor this to prevent future exceptions in this area.

Comparable Benefits

#51 [personal identifying information omitted] The current counselor discussed the PELL Grant with the client several times, however, the form was not submitted by the client. The form is being placed in the file at this time.

#112 [personal identifying information omitted] Concur with Audit findings. However, the new counselor discussed the issue with [personal identifying information omitted] who then missed his next scheduled appointment.

OTHER DEPARTMENTAL DIVISIONS

The results of our tests disclosed no instances of noncompliance and no material weaknesses in internal control, which require disclosure under Government Auditing Standards for the Division of Services for the Blind and the Division of Public Health.

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

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June 28, 2002

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