



MICHIGAN

OFFICE OF THE AUDITOR GENERAL

AUDIT REPORT



THOMAS H. MCTAVISH, C.P.A.
AUDITOR GENERAL

The auditor general shall conduct post audits of financial transactions and accounts of the state and of all branches, departments, offices, boards, commissions, agencies, authorities and institutions of the state established by this constitution or by law, and performance post audits thereof.

– Article IV, Section 53 of the Michigan Constitution

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Michigan
Office of the Auditor General
REPORT SUMMARY

Financial Audit
Including the Provisions of the Single Audit Act

Report Number:
 391-0100-10

Department of Community Health

October 1, 2007 through September 30, 2009

Released:
 June 2010

A Single Audit is designed to meet the needs of all financial report users, including an entity's federal grantor agencies. The audit determines if the financial schedules and/or financial statements are fairly presented; considers internal control over financial reporting and internal control over federal program compliance; determines compliance with requirements material to the financial schedules and/or financial statements; and assesses compliance with direct and material requirements of the major federal programs.

Financial Schedules:

Auditor's Report Issued

We issued an unqualified opinion on the Department of Community Health's (DCH's) financial schedules.

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Internal Control Over Financial Reporting

We identified significant deficiencies in internal control over financial reporting (Findings 1 through 5). We consider Finding 1 to be a material weakness.

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**Noncompliance and Other Matters
 Material to the Financial Schedules**

We did not identify any instances of noncompliance or other matters applicable to the financial schedules that are required to be reported under *Government Auditing Standards*.

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Federal Awards:

Auditor's Reports Issued on Compliance

We audited 11 programs as major programs and reported known questioned costs of \$489.0 million and known and likely questioned costs totaling \$4.4 billion. Known and likely questioned costs were based on documentation

provided to us by DCH during our audit fieldwork. However, it is possible that DCH could obtain additional documentation that would reduce the amount of known and likely questioned costs. Therefore, the financial risk to the State is indeterminable. DCH expended a total of \$15.2 billion in federal awards during the two-year period ended September 30, 2009. We issued 7 unqualified opinions, 2 qualified opinions, and 2 adverse opinions. The opinions issued by major program are identified on the back of this summary.

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Internal Control Over Major Programs

We identified significant deficiencies in internal control over federal program compliance (Findings 6 through 13 and 15 through 35). We consider Findings 9, 12, 13, 15, 16, 26, 28, 33, and 35 to be material weaknesses.

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Required Reporting of Noncompliance

We identified instances of noncompliance that are required to be reported in accordance with U.S. Office of Management and Budget (OMB) Circular A-133 (Findings 6 through 27, 29, and 31 through 35).

Systems of Accounting and Internal Control:
 We determined that DCH was in substantial compliance with Sections 18.1483 - 18.1487 of

the *Michigan Compiled Laws*. However, we did identify a significant deficiency (Finding 1).

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We audited the following programs as major programs:

<u>CFDA Number</u>	<u>Program or Cluster Title</u>	<u>Compliance Opinion</u>
10.557	Special Supplemental Nutrition Program for Women, Infants, and Children	Unqualified
93.044	<u>Aging Cluster:</u> <ul style="list-style-type: none"> Special Programs for the Aging - Title III, Part B - Grants for Supportive Services and Senior Centers 	Unqualified
93.045	<ul style="list-style-type: none"> Special Programs for the Aging - Title III, Part C - Nutrition Services 	
93.053	<ul style="list-style-type: none"> Nutrition Services Incentive Program 	
93.705	<ul style="list-style-type: none"> ARRA - Aging Home-Delivered Nutrition Services for States 	
93.707	<ul style="list-style-type: none"> ARRA - Aging Congregate Nutrition Services for States 	
93.069	Public Health Emergency Preparedness	Unqualified
93.268	<u>Immunization Cluster:</u> <ul style="list-style-type: none"> Immunization Grants 	Qualified
93.712	<ul style="list-style-type: none"> ARRA - Immunization 	
93.283	Centers for Disease Control and Prevention - Investigations and Technical Assistance	Unqualified
93.558	<u>Temporary Assistance for Needy Families (TANF) Cluster:</u> <ul style="list-style-type: none"> Temporary Assistance for Needy Families 	Unqualified
93.767	Children's Health Insurance Program	Qualified
93.777	<u>Medicaid Cluster:</u> <ul style="list-style-type: none"> State Survey and Certification of Health Care Providers and Suppliers 	Adverse
93.778	<ul style="list-style-type: none"> Medical Assistance Program 	
93.778	<ul style="list-style-type: none"> ARRA - Medical Assistance Program 	
93.917	HIV Care Formula Grants	Unqualified
93.959	Block Grants for Prevention and Treatment of Substance Abuse	Adverse
93.994	Maternal and Child Health Services Block Grant to the States	Unqualified

A copy of the full report can be obtained by calling 517.334.8050 or by visiting our Web site at: <http://audgen.michigan.gov>



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THOMAS H. MCTAVISH, C.P.A.
AUDITOR GENERAL

June 30, 2010

Ms. Janet Olszewski, Director
Department of Community Health
Capitol View Building
Lansing, Michigan

Dear Ms. Olszewski:

This is our report on the financial audit, including the provisions of the Single Audit Act, of the Department of Community Health (DCH) for the period October 1, 2007 through September 30, 2009.

This report contains our report summary, our independent auditor's report on the financial schedules, and the DCH financial schedules and schedule of expenditures of federal awards. This report also contains our independent auditor's report on internal control over financial reporting and on compliance and other matters, our independent auditor's report on compliance with requirements applicable to each major program and on internal control over compliance in accordance with U.S. Office of Management and Budget Circular A-133, and our schedule of findings and questioned costs. In addition, this report contains DCH's summary schedule of prior audit findings, its corrective action plan, and a glossary of acronyms and terms.

Our findings and recommendations are contained in Section II and Section III of the schedule of findings and questioned costs. The agency preliminary responses are contained in the corrective action plan. The *Michigan Compiled Laws* and administrative procedures require that the audited agency develop a formal response within 60 days after release of the audit report.

We appreciate the courtesy and cooperation extended to us during this audit.

AUDITOR GENERAL

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INDEPENDENT AUDITOR'S REPORT AND
FINANCIAL SCHEDULES



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THOMAS H. MCTAVISH, C.P.A.
AUDITOR GENERAL

Independent Auditor's Report on the Financial Schedules

Ms. Janet Olszewski, Director
Department of Community Health
Capitol View Building
Lansing, Michigan

Dear Ms. Olszewski:

We have audited the accompanying financial schedules of the Department of Community Health for the fiscal years ended September 30, 2009 and September 30, 2008, as identified in the table of contents. These financial schedules are the responsibility of the Department's management. Our responsibility is to express an opinion on these financial schedules based on our audit.

We conducted our audit in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial schedules are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial schedules. An audit also includes assessing the accounting principles used and the significant estimates made by management, as well as evaluating the overall financial schedule presentation. We believe that our audit provides a reasonable basis for our opinion.

As described in Note 1, the financial schedules present only the revenues and other financing sources and the sources and disposition of authorizations for the Department of Community Health's General Fund accounts, presented using the current financial resources measurement focus and the modified accrual basis of accounting. Accordingly, these financial schedules do not purport to, and do not, constitute a complete financial presentation of either the Department or the State's General Fund in conformity with accounting principles generally accepted in the United States of America.

In our opinion, the financial schedules referred to in the first paragraph present fairly, in all material respects, the revenues and other financing sources and the sources and disposition of authorizations of the Department of Community Health for the fiscal years ended September 30, 2009 and September 30, 2008 on the basis of accounting described in Note 1.

In accordance with *Government Auditing Standards*, we have also issued our report dated June 28, 2010 on our consideration of the Department's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing and not to provide an opinion on the internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* and should be considered in assessing the results of our audit.

The schedule of expenditures of federal awards, required by U.S. Office of Management and Budget Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*, is presented for purposes of additional analysis and is not a required part of the Department's financial schedules referred to in the first paragraph. Such information has been subjected to the auditing procedures applied in the audit of the financial schedules and, in our opinion, is fairly stated, in all material respects, in relation to the financial schedules taken as a whole.

AUDITOR GENERAL

June 28, 2010

DEPARTMENT OF COMMUNITY HEALTH
Schedule of General Fund Revenues and Other Financing Sources
Fiscal Years Ended September 30

	<u>2009</u>	<u>2008</u>
REVENUES		
Taxes (Note 4)	\$ 1,272,226,077	\$ 1,449,492,025
From federal agencies (Note 5)	8,339,853,366	6,647,229,067
From local agencies	42,030,770	40,558,663
From services	31,297,306	31,718,203
From licenses and permits	27,615,701	28,635,549
Special Medicaid reimbursements	135,666,840	115,797,453
Miscellaneous	102,129,471	77,549,773
Total revenues	<u>\$ 9,950,819,531</u>	<u>\$ 8,390,980,733</u>
OTHER FINANCING SOURCES		
Transfers from Compulsive Gaming Prevention Fund	<u>1,949,872</u>	<u>2,990,000</u>
Total revenues and other financing sources	<u><u>\$ 9,952,769,403</u></u>	<u><u>\$ 8,393,970,733</u></u>

The accompanying notes are an integral part of the financial schedules.

DEPARTMENT OF COMMUNITY HEALTH
Schedule of Sources and Disposition of General Fund Authorizations
Fiscal Years Ended September 30

	<u>2009</u>	<u>2008</u>
SOURCES OF AUTHORIZATIONS (Note 2)		
General purpose appropriations	\$ 2,473,752,600	\$ 3,217,758,000
Balances carried forward	119,215,272	64,943,118
Restricted financing sources (Note 5)	10,323,364,533	8,754,734,806
Less: Intrafund expenditure reimbursements and expenditure credits	<u>(372,408,571)</u>	<u>(370,683,859)</u>
 Total	 <u><u>\$ 12,543,923,834</u></u>	 <u><u>\$ 11,666,752,065</u></u>
 DISPOSITION OF AUTHORIZATIONS (Note 2)		
Gross expenditures and transfers out	\$ 12,747,915,532	\$ 11,884,935,930
Less: Intrafund expenditure reimbursements and expenditure credits	<u>(372,408,571)</u>	<u>(370,683,859)</u>
Net expenditures and transfers out	<u>\$ 12,375,506,961</u>	<u>\$ 11,514,252,071</u>
Balances carried forward:		
Multi-year projects	\$ 12,987,617	\$ 3,528,208
Encumbrances	2,895,557	42,812,289
Restricted revenues - not authorized or used	91,432,896	72,874,775
Total balances carried forward	<u>\$ 107,316,070</u>	<u>\$ 119,215,272</u>
Balances lapsed	<u>\$ 61,100,803</u>	<u>\$ 33,284,722</u>
 Total	 <u><u>\$ 12,543,923,834</u></u>	 <u><u>\$ 11,666,752,065</u></u>

The accompanying notes are an integral part of the financial schedules.

Notes to the Financial Schedules

Note 1 Significant Accounting Policies

a. Reporting Entity

The Department of Community Health (DCH) was created by executive order in January 1996. DCH is generally composed of the former Departments of Mental Health and Public Health; the Medical Services Administration, which was part of the Department of Human Services (DHS); and several programs transferred from the Department of Technology, Management, and Budget. Executive Order 2003-18 transferred the Bureaus of Health Systems and Health Professions to DCH from the Department of Energy, Labor & Economic Growth effective April 1, 2004. DCH's mission is to protect, preserve, and promote the health and safety of the people of Michigan with particular attention to providing for the needs of vulnerable and under-served populations.

The accompanying financial schedules report the results of the financial transactions of DCH for the fiscal years ended September 30, 2009 and September 30, 2008. The financial transactions of DCH are accounted for principally in the State's General Fund and are reported on in the *State of Michigan Comprehensive Annual Financial Report (SOMCAFR)*.

For purposes of presenting the financial transactions of DCH in the accompanying financial schedules, the Hospital Patients' Trust Fund has been excluded from DCH's reporting entity. The Hospital Patients' Trust Fund receives no federal funding.

The notes accompanying these financial schedules relate directly to DCH. The *SOMCAFR* provides more extensive disclosures regarding the State's significant accounting policies; budgeting, budgetary control, and legal compliance; common cash; pension benefits; other postemployment benefits; leases; and contingencies and commitments.

b. Jointly Governed Organizations

DCH has representation and/or appointing authority on the boards of two jointly governed organizations: the Michigan Public Health Institute (MPHI) and the Detroit Wayne County Health Authority (DWCHA).

The State, the University of Michigan, Michigan State University, and Wayne State University appoint members of the board of MPHI, a nonprofit corporation. MPHI was established to plan, promote, and coordinate health services research with a public university or a consortium of public universities in the State. The State does not appoint a majority of the board, has no rights to the assets, and is not responsible for debts of MPHI. The State awarded contracts to MPHI totaling \$35.4 million in fiscal year 2008-09 and \$32.7 million in fiscal year 2007-08.

The City of Detroit, Charter County of Wayne, and DCH appoint members of the board of DWCHA, a public agency. DWCHA was established to plan, promote, and coordinate health services for at-risk populations in the City of Detroit and Wayne County. The State does not appoint a majority of the board, has no right to the assets, and is not responsible for debts of DWCHA. Therefore, the State's accountability for DWCHA does not extend beyond making the appointments. The State awarded contracts to DWCHA totaling \$5.0 million in fiscal year 2008-09 and \$3.8 million in fiscal year 2007-08.

c. Measurement Focus, Basis of Accounting, and Presentation

The financial schedules contained in this report are presented using the current financial resources measurement focus and the modified accrual basis of accounting, as provided by accounting principles generally accepted in the United States of America. Under the modified accrual basis of accounting, revenues are recognized as they become susceptible to accrual, generally when they are both measurable and available. Revenues are considered to be available when they are collected within the current period or soon enough thereafter to pay liabilities of the current period. Expenditures generally are recorded when a liability is incurred; however, certain expenditures related to long-term obligations are recorded only when payment is due and payable.

The accompanying financial schedules present only the revenues and other financing sources and the sources and disposition of authorizations for DCH's General Fund accounts. Accordingly, these financial schedules do not purport to, and do not, constitute a complete financial presentation of either DCH or the State's General Fund in conformity with accounting principles generally accepted in the United States of America.

Note 2 Schedule of Sources and Disposition of General Fund Authorizations

The various elements of the schedule of sources and disposition of General Fund authorizations are defined as follows:

- a. General purpose appropriations: Original appropriations and any supplemental appropriations that are financed by General Fund/general purpose appropriations.
- b. Balances carried forward: Authorizations for multi-year projects, encumbrances, restricted revenues - authorized, and restricted revenues - not authorized or used that were not spent as of the end of the prior fiscal year. These authorizations are available for expenditure in the current fiscal year for the purpose of the carry-forward without additional legislative authorization, except for the restricted revenues - not authorized or used.
- c. Restricted financing sources: Collections of restricted revenues, restricted transfers, and restricted intrafund expenditure reimbursements used to finance department programs as detailed in the appropriations acts. These financing sources are authorized for expenditure up to the amount appropriated. Depending upon program statute, any amounts received in excess of the appropriation are, at year-end, either converted to general purpose financing sources and made available for general appropriation in the next fiscal year or carried forward to the next fiscal year as either restricted revenues - authorized or restricted revenues - not authorized or used. Significant restricted financing sources carried forward to the next fiscal year as restricted revenue consisted of \$38.6 million and \$16.5 million in the Medicaid Benefits Trust Fund carried forward from fiscal years 2008-09 and 2007-08, respectively.

- d. Intrafund expenditure reimbursements and expenditure credits: Funding from other General Fund departments or other programs within a department to finance a program or a portion of a program that is the responsibility of the receiving department. A significant intrafund expenditure reimbursement from another General Fund department was \$37.0 million and \$33.0 million for fiscal years 2008-09 and 2007-08, respectively, from the Department of Corrections for the operation of the Center for Forensic Psychiatry. Expenditure credits for fiscal years 2008-09 and 2007-08 included \$141.9 million and \$141.7 million, respectively, from disproportionate share hospital payments received from the State psychiatric hospitals used to help finance Medicaid; \$119.4 million and \$126.9 million, respectively, from the purchase of State services contract reimbursements; and \$56.2 million and \$56.0 million, respectively, from food rebates related to the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC Program).
- e. Multi-year projects: Unexpended authorizations for work projects and capital outlay projects that are carried forward to subsequent fiscal years for the completion of the projects. Significant work projects consisted of \$7.4 million for closed site and transition costs related to the closing of the Mt. Pleasant Center in fiscal year 2008-09 and \$3.0 million for information technology services related to implementation of the Community Health Automated Medicaid Processing System (CHAMPS) in fiscal year 2007-08.
- f. Encumbrances: Authorizations carried forward to finance payments for goods or services ordered during the fiscal year but not received by fiscal year-end. These authorizations are generally limited to obligations funded by general purpose appropriations. Significant encumbrances consisted of \$2.4 million for modernizing information technology systems in fiscal year 2008-09 and \$35.9 million for the State's share of Medicaid School Based Services disallowed by the federal government in fiscal year 2007-08.
- g. Restricted revenues - not authorized or used: Revenues that, by statute, are restricted for use to a particular department program or activity. Generally, the expenditure of the restricted revenues is subject to annual legislative appropriation. Significant carry-forwards of this type are the

Medicaid Benefits Trust Fund for \$38.6 million in fiscal year 2008-09 and \$16.5 million for fiscal year 2007-08 and the Victim Services Fund for \$7.4 million in fiscal year 2008-09 and \$10.0 million in fiscal year 2007-08.

- h. Balances lapsed: DCH authorizations that were unexpended and unobligated at the end of the fiscal year. These amounts are available for legislative appropriation in the subsequent fiscal year.

Note 3 Contingencies

Specialized Pharmacy Services, Inc.

In October 2006, the Michigan Department of Attorney General signed a settlement agreement with Specialized Pharmacy Services, Inc. The settlement agreement required Specialized Pharmacy Services, Inc., to pay the State a total of \$49.0 million in several installments. The first payment for \$42.0 million was received in October 2006. DCH received additional payments in October 2006, December 2007, and December 2008. The final payment was to be received in December 2009. Approximately \$31.8 million of the \$49.0 million settlement related to a penalty arising under State law. As required by federal Medicaid law, DCH returned \$9.0 million in federal financial participation dollars in fiscal year 2006-07 related to the \$17.6 million of Medicaid funds recovered from the settlement with Specialized Pharmacy Services, Inc., but has not returned any of the penalty that arose under State law.

Beginning in late 2007, the federal Centers for Medicare and Medicaid Services (CMS) requested DCH to return an additional amount calculated as the total federal financial participation on the entire settlement agreement. In October 2008, CMS issued a letter stating its intent to recover any such federal financial participation. On January 21, 2009, CMS formally disallowed \$18.7 million. CMS alleges that \$18.7 million of the \$31.8 million penalty, arising under State law, relates to federal financial participation. DCH did not return the \$18.7 million disallowed by CMS. Instead, DCH, through the Department of Attorney General, filed a request with CMS for reconsideration of this disallowance. DCH had not yet received any response from CMS. If DCH is unsuccessful, it is reasonably possible DCH will be required to pay the disallowance of \$18.7 million to CMS.

Note 4 Quality Assurance Assessment (QAA) Tax Revenue

Beginning April 1, 2009, Section 205.93f of the *Michigan Compiled Laws* replaced the QAA tax with a use tax for health plans and community mental health providers. In addition, the American Recovery and Reinvestment Act of 2009 (ARRA) increased the federal match rate resulting in decreased QAA rates. The transition to the use tax and reduced rates resulting from the ARRA contributed to a decrease in QAA tax revenue of \$164.3 million in fiscal year 2008-09 as compared to fiscal year 2007-08.

In fiscal year 2007-08, the QAA Program began collecting a new QAA tax on outpatient disproportionate share hospitals. This resulted in a \$60.2 million increase in the QAA tax revenue for that fiscal year.

Note 5 American Recovery and Reinvestment Act of 2009 (ARRA)

The One Hundred Eleventh Congress of the United States of America passed the ARRA making supplemental appropriations for job preservation and creation, infrastructure investment, energy efficiency and science, assistance to the unemployed, and state and local fiscal stabilization.

In fiscal year 2008-09, DCH expended \$1.0 billion in ARRA funding. The vast majority of the ARRA funding (\$985.6 million) was from the U.S. Department of Health and Human Services through an increased federal match rate for Medicaid. DCH is estimating \$1.1 billion in ARRA expenditures in fiscal year 2009-10. ARRA funding is due to expire during fiscal year 2010-11.

SUPPLEMENTAL
FINANCIAL SCHEDULE

DEPARTMENT OF COMMUNITY HEALTH
Schedule of Expenditures of Federal Awards (1)
For the Period October 1, 2007 through September 30, 2009

Federal Agency/Program or Cluster	CFDA (2) Number	Pass-Through Identification Number	For the Fiscal Year Ended September 30, 2008		
			Directly Expended	Distributed to Subrecipients	Total Expended and Distributed
Financial Assistance					
U.S. Department of Agriculture					
Child Nutrition Cluster:					
Pass-Through Programs:					
Michigan Department of Education					
School Breakfast Program	10.553	330008002	\$ 45,540	\$	\$ 45,540
National School Lunch Program	10.555	330008002	71,174		71,174
Total Child Nutrition Cluster			\$ 116,714	\$ 0	\$ 116,714
SNAP Cluster:					
Pass-Through Program:					
Michigan State University					
State Administrative Matching Grants for the Supplemental Nutrition Assistance Program	10.561	61-4993H	\$ 345,120	\$	\$ 345,120
State Administrative Matching Grants for the Supplemental Nutrition Assistance Program	10.561	61-5003K			0
State Administrative Matching Grants for the Supplemental Nutrition Assistance Program	10.561	61-5050P			0
State Administrative Matching Grants for the Supplemental Nutrition Assistance Program	10.561	61-4993G	(1,757)		(1,757)
State Administrative Matching Grants for the Supplemental Nutrition Assistance Program	10.561	61-5003J	35,365		35,365
State Administrative Matching Grants for the Supplemental Nutrition Assistance Program	10.561	61-5050O			0
State Administrative Matching Grants for the Supplemental Nutrition Assistance Program	10.561	61-5050L			0
Total SNAP Cluster			\$ 378,728	\$ 0	\$ 378,728
Direct Programs:					
Special Supplemental Nutrition Program for Women, Infants, and Children	10.557		\$ 133,238,502	\$ 35,773,211	\$ 169,011,713
WIC Farmers' Market Nutrition Program (FMNP)	10.572		386,948		386,948
Senior Farmers Market Nutrition Program	10.576		235,841		235,841
WIC Grants to States (WGS)	10.578		2,458		2,458
Coordination of USDA Meetings	10.AG-3198-P-08-0017 (3)			8,907	8,907
Total Direct Programs			\$ 133,863,749	\$ 35,782,118	\$ 169,645,867
Total U.S. Department of Agriculture			\$ 134,359,191	\$ 35,782,118	\$ 170,141,309
U.S. Department of Housing and Urban Development					
Direct Programs:					
Supportive Housing Program	14.235		\$ (23,202)	\$ 1,276,065	\$ 1,252,863
Shelter Plus Care	14.238		(122,392)	3,867,065	3,744,673
Housing Opportunities for Persons with AIDS	14.241		(11,645)	670,119	658,474
Lead-Based Paint Hazard Control in Privately-Owned Housing	14.900		788,076	288,945	1,077,021
Healthy Homes Demonstration Grants	14.901		(50,503)	287,161	236,658
Total U.S. Department of Housing and Urban Development			\$ 580,334	\$ 6,389,355	\$ 6,969,689
U.S. Department of Justice					
Direct Programs:					
Crime Victim Assistance	16.575		\$ 5,648	\$ 13,098,729	\$ 13,104,377
Crime Victim Compensation	16.576		1,742,730		1,742,730
Residential Substance Abuse Treatment for State Prisoners	16.593		30,678	266,906	297,584
Edward Byrne Memorial Justice Assistance Grant Program	16.738		4,826,865	4,380,820	9,207,685
Paul Coverdell Forensic Sciences Improvement Grant Program	16.742			396,543	396,543
ARRA - Recovery Act - State Victim Compensation Formula Grant Program	16.802				0
ARRA - Recovery Act - Edward Byrne Memorial Justice Assistance Grant (JAG) Program/Grants to States and Territories	16.803				0
Total U.S. Department of Justice			\$ 6,605,921	\$ 18,142,998	\$ 24,748,919
U.S. Department of Labor					
Direct Programs:					
Senior Community Service Employment Program	17.235		\$ 70,370	\$ 3,185,388	\$ 3,255,758
ARRA - Senior Community Service Employment Program	17.235				0
Total U.S. Department of Labor			\$ 70,370	\$ 3,185,388	\$ 3,255,758

This schedule continued on next page.

For the Fiscal Year Ended September 30, 2009			Total Expended and Distributed for the Two-Year Period
Directly Expended	Distributed to Subrecipients	Total Expended and Distributed	
\$ 48,398	\$	\$ 48,398	\$ 93,938
75,487		75,487	146,661
<u>\$ 123,885</u>	<u>\$ 0</u>	<u>\$ 123,885</u>	<u>\$ 240,599</u>
\$	\$	\$ 0	\$ 345,120
(3,136)		(3,136)	(3,136)
445,144		445,144	445,144
(28,475)		(28,475)	(30,232)
(27,555)		(27,555)	7,810
68,786		68,786	68,786
451,634		451,634	451,634
<u>\$ 906,398</u>	<u>\$ 0</u>	<u>\$ 906,398</u>	<u>\$ 1,285,126</u>
\$ 130,670,702	\$ 37,682,571	\$ 168,353,273	\$ 337,364,986
398,995		398,995	785,943
253,778		253,778	489,619
		0	2,458
		0	8,907
<u>\$ 131,323,475</u>	<u>\$ 37,682,571</u>	<u>\$ 169,006,046</u>	<u>\$ 338,651,913</u>
\$ 132,353,758	\$ 37,682,571	\$ 170,036,329	\$ 340,177,638
\$ 104,906	\$ 1,411,358	\$ 1,516,264	\$ 2,769,127
(121,489)	4,419,048	4,297,559	8,042,232
13,617	679,090	692,707	1,351,181
609,895	265,061	874,956	1,951,977
49,272	168,858	218,130	454,788
<u>\$ 656,201</u>	<u>\$ 6,943,415</u>	<u>\$ 7,599,616</u>	<u>\$ 14,569,305</u>
\$ (29,395)	\$ 13,813,773	\$ 13,784,378	\$ 26,888,755
1,755,619		1,755,619	3,498,349
44,566	243,864	288,430	586,014
2,031,131	3,688,185	5,719,316	14,927,001
	315,328	315,328	711,871
355,800		355,800	355,800
124,620	2,359,772	2,484,392	2,484,392
<u>\$ 4,282,341</u>	<u>\$ 20,420,922</u>	<u>\$ 24,703,263</u>	<u>\$ 49,452,182</u>
\$ 60,002	\$ 3,387,580	\$ 3,447,582	\$ 6,703,340
2,218	213,933	216,151	216,151
<u>\$ 62,220</u>	<u>\$ 3,601,513</u>	<u>\$ 3,663,733</u>	<u>\$ 6,919,491</u>

DEPARTMENT OF COMMUNITY HEALTH
Schedule of Expenditures of Federal Awards (1)
For the Period October 1, 2007 through September 30, 2009
(Continued)

Federal Agency/Program or Cluster	CFDA (2) Number	Pass-Through Identification Number	For the Fiscal Year Ended September 30, 2008		
			Directly Expended	Distributed to Subrecipients	Total Expended and Distributed
U.S. Department of Transportation					
Highway Planning and Construction Cluster:					
Pass-Through Program:					
Michigan Department of Transportation Highway Planning and Construction	20.205	2006-0438(2)	\$ 39,508	\$ 43,100	\$ 82,608
Total Highway Planning and Construction Cluster			\$ 39,508	\$ 43,100	\$ 82,608
Highway Safety Cluster:					
Pass-Through Programs:					
Michigan Department of State Police					
State and Community Highway Safety	20.600	EM-07-01	\$ (24)	\$	\$ (24)
State and Community Highway Safety	20.600	OP-09-04			0
Total State and Community Highway Safety			\$ (24)	\$ 0	\$ (24)
Alcohol Impaired Driving Countermeasures Incentive Grants I	20.601	AL-07-04	\$	\$ 227,391	\$ 227,391
Alcohol Impaired Driving Countermeasures Incentive Grants I	20.601	AL-08-14	(2,355)		(2,355)
Alcohol Impaired Driving Countermeasures Incentive Grants I	20.601	AL-09-23			0
Total Alcohol Impaired Driving Countermeasures Incentive Grants I			\$ (2,355)	\$ 227,391	\$ 225,036
Safety Incentive Grants for Use of Seatbelts	20.604	OP-08-02	165,269		165,269
Safety Incentives to Prevent Operation of Motor Vehicles by Intoxicated Persons	20.605	EM-07-02	102,754	97,245	199,999
State Traffic Safety Information System Improvement Grants	20.610	EM-07-02	52,177		52,177
Total Highway Safety Cluster			\$ 317,821	\$ 324,636	\$ 642,457
Total U.S. Department of Transportation			\$ 357,329	\$ 367,736	\$ 725,065
U.S. Environmental Protection Agency					
Direct Programs:					
Science To Achieve Results (STAR) Research Program	66.509		\$ 28,087	\$ 91,257	\$ 119,344
TSCA Title IV State Lead Grants Certification of Lead-Based Paint Professionals	66.707		348,000		348,000
Research, Development, Monitoring, Public Education, Training, Demonstrations, and Studies	66.716				0
Total Direct Programs			\$ 376,087	\$ 91,257	\$ 467,344
Pass-Through Program:					
Wisconsin Department of Health and Family Services:					
Great Lakes Program	66.469	FAH 20307A	\$ 6,000	\$	\$ 6,000
Total Pass-Through Program			\$ 6,000	\$ 0	\$ 6,000
Total U.S. Environmental Protection Agency			\$ 382,087	\$ 91,257	\$ 473,344
U.S. Department of Education					
Special Education Cluster:					
Pass-Through Programs:					
Michigan Department of Education					
Special Education - Grants to States	84.027	080480-EOSD	\$	\$ 8,550	\$ 8,550
Special Education - Grants to States	84.027	090480-EOSD			0
Special Education - Grants to States	84.027	060450-0506	30,011		30,011
Special Education - Grants to States	84.027	080450-0708	32,057		32,057
Special Education - Grants to States	84.027	090450-0809			0
Special Education - Grants to States	84.027	080490TS	15,000		15,000
Special Education - Grants to States	84.027	090490TS			0
Total Special Education Cluster			\$ 77,068	\$ 8,550	\$ 85,618
Early Intervention Services (IDEA) Cluster:					
Pass-Through Programs:					
Michigan Department of Education					
Special Education - Grants for Infants and Families	84.181	071330/IACDCH	\$ (268)	\$	\$ (268)
Special Education - Grants for Infants and Families	84.181	081330/IACDCH	153,723		153,723
Special Education - Grants for Infants and Families	84.181	091330/IACDCH			0
Special Education - Grants for Infants and Families	84.181	08431011		10,000	10,000
Special Education - Grants for Infants and Families	84.181	09431010			0
Total Early Intervention Services (IDEA) Cluster			\$ 153,455	\$ 10,000	\$ 163,455
Direct Program:					
Safe and Drug-Free Schools and Communities - State Grants	84.186		\$ 448,821	\$ 1,883,273	\$ 2,332,094
Total Direct Program			\$ 448,821	\$ 1,883,273	\$ 2,332,094

This schedule continued on next page.

For the Fiscal Year Ended September 30, 2009			Total Expended and Distributed for the Two-Year Period
Directly Expended	Distributed to Subrecipients	Total Expended and Distributed	
\$ 59,170	\$ 108,712	\$ 167,882	\$ 250,490
\$ 59,170	\$ 108,712	\$ 167,882	\$ 250,490
\$ 155,954	\$ 0	\$ 155,954	\$ 155,930
\$ 155,954	\$ 0	\$ 155,954	\$ 155,930
\$ 0	\$ 262,439	\$ 262,439	\$ 487,475
\$ 0	\$ 262,439	\$ 262,439	\$ 487,475
		0	165,269
		0	199,999
227,720	111,562	339,282	391,459
\$ 383,674	\$ 374,001	\$ 757,675	\$ 1,400,132
\$ 442,844	\$ 482,713	\$ 925,557	\$ 1,650,622
\$ 8,657	\$ 195,261	\$ 203,918	\$ 323,262
332,005	110,869	442,874	790,874
603	26,136	26,739	26,739
\$ 341,265	\$ 332,266	\$ 673,531	\$ 1,140,875
\$ 4,000	\$ 0	\$ 4,000	\$ 10,000
\$ 4,000	\$ 0	\$ 4,000	\$ 10,000
\$ 345,265	\$ 332,266	\$ 677,531	\$ 1,150,875
\$ 0	\$ 9,937	\$ 9,937	\$ 8,550
		9,937	9,937
		0	30,011
28,440		28,440	60,497
21,662		21,662	21,662
		0	15,000
5,000		5,000	5,000
\$ 55,102	\$ 9,937	\$ 65,039	\$ 150,657
\$ 0	\$ 0	\$ 0	\$ (268)
(4)		(4)	153,719
76,012	66,797	142,809	142,809
(94)		(94)	9,906
	10,000	10,000	10,000
\$ 75,914	\$ 76,797	\$ 152,711	\$ 316,166
\$ 551,993	\$ 1,668,183	\$ 2,220,176	\$ 4,552,270
\$ 551,993	\$ 1,668,183	\$ 2,220,176	\$ 4,552,270

DEPARTMENT OF COMMUNITY HEALTH
Schedule of Expenditures of Federal Awards (1)
For the Period October 1, 2007 through September 30, 2009
(Continued)

Federal Agency/Program or Cluster	CFDA (2) Number	Pass-Through Identification Number	For the Fiscal Year Ended September 30, 2008		
			Directly Expended	Distributed to Subrecipients	Total Expended and Distributed
Pass-Through Program:					
Michigan Department of Education					
Safe and Drug-Free Schools and Communities - State Grants	84.186	Q186A060023	\$ (54,186)	\$ 13,889	\$ (40,297)
Safe and Drug-Free Schools and Communities - State Grants	84.186	Q186A070023	286,597	10,434	297,031
Safe and Drug-Free Schools and Communities - State Grants	84.186	Q186A080023	106,230		106,230
Total Pass-Through Program			\$ 338,641	\$ 24,323	\$ 362,964
Total U.S. Department of Education			\$ 1,017,985	\$ 1,926,146	\$ 2,944,131
U.S. Department of Health and Human Services					
Aging Cluster:					
Direct Programs:					
Special Programs for the Aging - Title III, Part B - Grants for Supportive Services and Senior Centers	93.044		\$ 471,013	\$ 10,974,296	\$ 11,445,309
Special Programs for the Aging - Title III, Part C - Nutrition Services	93.045		848,696	18,349,497	19,198,193
Nutrition Services Incentive Program	93.053			7,041,707	7,041,707
ARRA - Aging Home-Delivered Nutrition Services for States	93.705				0
ARRA - Aging Congregate Nutrition Services for States	93.707				0
Total Aging Cluster			\$ 1,319,709	\$ 36,365,500	\$ 37,685,209
Immunization Cluster:					
Direct Program:					
Immunization Grants	93.268		\$ 2,099,728	\$ 5,873,968	\$ 7,973,696
Total Immunization Cluster			\$ 2,099,728	\$ 5,873,968	\$ 7,973,696
Temporary Assistance for Needy Families (TANF) Cluster:					
Pass-Through Program:					
Michigan Department of Human Services					
Temporary Assistance for Needy Families	93.558	07431005	\$ (30,039)	\$	\$ (30,039)
Temporary Assistance for Needy Families	93.558	DCH-08-IA-07	18,201,330	4,313	18,205,643
Temporary Assistance for Needy Families	93.558	DCH-09-IA-02			0
Temporary Assistance for Needy Families	93.558	09431010			0
Total Temporary Assistance for Needy Families (TANF) Cluster			\$ 18,171,291	\$ 4,313	\$ 18,175,604
CCDF Cluster:					
Pass-Through Program:					
Michigan Department of Human Services					
Child Care and Development Block Grant	93.575	DCH 07-02	\$ (47,631)	\$	\$ (47,631)
Child Care and Development Block Grant	93.575	DCH 08431002		1,844,516	1,844,516
Child Care and Development Block Grant	93.575	DCH 09431004			0
Total CCDF Cluster			\$ (47,631)	\$ 1,844,516	\$ 1,796,885
Head Start Cluster:					
Pass-Through Program:					
Michigan Department of Human Services					
Head Start	93.600	DCH 08-IA-11	\$ 3,756	\$	\$ 3,756
Head Start	93.600	DCH 09-IA-01			0
Head Start	93.600	DCH 09-IA-15			0
Head Start	93.600	DCH 09-IA-18			0
Total Head Start Cluster			\$ 3,756	\$ 0	\$ 3,756
Medicaid Cluster:					
Direct Programs:					
State Survey and Certification of Health Care Providers and Suppliers	93.777		\$ 7,713,657	\$ 403,235	\$ 8,116,892
Medical Assistance Program	93.778		5,882,250,879	149,971,067	6,032,221,946
ARRA - Medical Assistance Program	93.778				0
Total Medicaid Cluster			\$ 5,889,964,536	\$ 150,374,302	\$ 6,040,338,838
Direct Programs:					
State and Territorial and Technical Assistance Capacity Development					
Minority HIV/AIDS Demonstration Program	93.006		\$ (72,686)	\$ 127,158	\$ 54,472
Special Programs for the Aging - Title VII, Chapter 3 - Programs for Prevention of Elder Abuse, Neglect, and Exploitation	93.041		(1,692)	165,411	163,719
Special Programs for the Aging - Title VII, Chapter 2 - Long Term Care Ombudsman Services for Older Individuals	93.042		368,916	121,588	490,504
Special Programs for the Aging - Title III, Part D - Disease Prevention and Health Promotion Services	93.043		(17,350)	710,814	693,464
Special Programs for the Aging - Title IV - and Title II - Discretionary Projects	93.048		134,983	492,573	627,556
Alzheimer's Disease Demonstration Grants to States	93.051		103,301	122,473	225,774

This schedule continued on next page.

For the Fiscal Year Ended September 30, 2009			Total Expended and Distributed for the Two-Year Period
Directly Expended	Distributed to Subrecipients	Total Expended and Distributed	
\$	\$	\$ 0	\$ (40,297)
178,882	13,145	192,027	489,058
124,993	1,855	126,848	233,078
<u>\$ 303,875</u>	<u>\$ 15,000</u>	<u>\$ 318,875</u>	<u>\$ 681,839</u>
\$ 986,884	\$ 1,769,917	\$ 2,756,801	\$ 5,700,932

\$	\$	\$	\$
532,143	11,298,549	11,830,692	23,276,001
971,652	19,250,462	20,222,114	39,420,307
	7,308,594	7,308,594	14,350,301
	165,236	165,236	165,236
138,516	338,734	477,250	477,250
<u>\$ 1,642,311</u>	<u>\$ 38,361,575</u>	<u>\$ 40,003,886</u>	<u>\$ 77,689,095</u>

\$	\$	\$	\$
2,106,421	6,596,121	8,702,542	16,676,238
<u>\$ 2,106,421</u>	<u>\$ 6,596,121</u>	<u>\$ 8,702,542</u>	<u>\$ 16,676,238</u>

\$	\$	\$	\$
(26,877)		(26,877)	18,178,766
18,658,489	3,110	18,661,599	18,661,599
	24,999	24,999	24,999
<u>\$ 18,631,612</u>	<u>\$ 28,109</u>	<u>\$ 18,659,721</u>	<u>\$ 36,835,325</u>

\$	\$	\$	\$
(27,354)		(27,354)	1,817,162
	1,845,127	1,845,127	1,845,127
<u>\$ (27,354)</u>	<u>\$ 1,845,127</u>	<u>\$ 1,817,773</u>	<u>\$ 3,614,658</u>

\$	\$	\$	\$
5,992		5,992	3,756
2,434		2,434	5,992
	4,800	4,800	2,434
<u>\$ 8,426</u>	<u>\$ 4,800</u>	<u>\$ 13,226</u>	<u>\$ 4,800</u>
			<u>\$ 16,982</u>

\$	\$	\$	\$
8,026,919	391,594	8,418,513	16,535,405
6,438,939,471	205,883,431	6,644,822,902	12,677,044,848
976,606,820	9,005,621	985,612,441	985,612,441
<u>\$ 7,423,573,210</u>	<u>\$ 215,280,646</u>	<u>\$ 7,638,853,856</u>	<u>\$ 13,679,192,694</u>

\$	\$	\$	\$
144,091		144,091	198,563
(541)	163,971	163,430	327,149
364,439	164,000	528,439	1,018,943
(11,685)	707,303	695,618	1,389,082
224,361	920,492	1,144,853	1,772,409
(1,722)	199,374	197,652	423,426

DEPARTMENT OF COMMUNITY HEALTH
Schedule of Expenditures of Federal Awards (1)
For the Period October 1, 2007 through September 30, 2009
(Continued)

Federal Agency/Program or Cluster	CFDA (2) Number	Pass-Through Identification Number	For the Fiscal Year Ended September 30, 2008		
			Directly Expended	Distributed to Subrecipients	Total Expended and Distributed
National Family Caregiver Support, Title III, Part E	93.052		\$ (40,215)	\$ 4,975,070	\$ 4,934,855
Innovations in Applied Public Health Research	93.061				0
Public Health Emergency Preparedness	93.069		8,657,805	19,850,873	28,508,678
Environmental Public Health and Emergency Response	93.070				0
Medicare Enrollment Assistance Program	93.071				0
Maternal and Child Health Federal Consolidated Programs	93.110		123,548	453,685	577,233
Project Grants and Cooperative Agreements for Tuberculosis Control Programs	93.116		470,153	349,243	819,396
Emergency Medical Services for Children	93.127		99,708		99,708
Cooperative Agreement, to States/Territories for the Coordination and Development of Primary Care Offices	93.130		128,583	125,297	253,880
Injury Prevention and Control Research and State and Community Based Programs	93.136		209,283	1,179,658	1,388,941
Projects for Assistance in Transition from Homelessness (PATH)	93.150		(14,101)	1,896,049	1,881,948
Coordinated Services and Access to Research for Women, Infants, Children, and Youth	93.153		2,585	1,234,442	1,237,027
Grants to States for Loan Repayment Program	93.165		734,350		734,350
Disabilities Prevention	93.184		232,748	14,188	246,936
Childhood Lead Poisoning Prevention Projects - State and Local Childhood Lead Poisoning Prevention and Surveillance of Blood Lead Levels in Children	93.197		640,086	223,036	863,122
Surveillance of Hazardous Substance Emergency Events	93.204		93,203		93,203
Family Planning - Services	93.217		869,785	6,336,547	7,206,332
Traumatic Brain Injury State Demonstration Grant Program	93.234		163,844		163,844
Abstinence Education Program	93.235		137,578	463,433	601,011
Grants for Dental Public Health Residency Training	93.236		37,980	72,247	110,227
Cooperative Agreements for State Treatment Outcomes and Performance Pilot Studies Enhancement	93.238		184,886		184,886
State Capacity Building	93.240		295,756	37,476	333,232
State Rural Hospital Flexibility Program	93.241		(16,838)	1,894,079	1,877,241
Substance Abuse and Mental Health Services - Projects of Regional and National Significance	93.243		290,352	2,685,869	2,976,221
Universal Newborn Hearing Screening	93.251		65,728	4,700	70,428
Centers for Disease Control and Prevention - Investigations and Technical Assistance	93.283		6,748,326	12,605,735	19,354,061
Small Rural Hospital Improvement Grant Program	93.301			357,800	357,800
Child Support Enforcement Demonstrations and Special Projects	93.601		(3,192)		(3,192)
Developmental Disabilities Basic Support and Advocacy Grants	93.630		1,177,245	1,824,215	3,001,460
ARRA - Survey and Certification Ambulatory Surgical Center Healthcare-Associated Infection (ASC-HAI) Prevention Initiative	93.720				0
Children's Health Insurance Program	93.767		168,690,059	2,778,631	171,468,690
Medicaid Infrastructure Grants to Support the Competitive Employment of People with Disabilities	93.768		543,856		543,856
Centers for Medicare and Medicaid Services (CMS) Research, Demonstrations and Evaluations	93.779		714,111	1,349,201	2,063,312
Alternate Non-Emergency Service Providers or Networks	93.790		3,462	20,730	24,192
Money Follows the Person Rebalancing Demonstration	93.791		273,396	2,000	275,396
Medicaid Transformation Grants	93.793		2,521,772	429,261	2,951,033
National Bioterrorism Hospital Preparedness Program	93.889		1,518,869	13,013,110	14,531,979
Grants to States for Operation of Offices of Rural Health	93.913		83,342	81,236	164,578
HIV Care Formula Grants	93.917		12,971,115	5,321,344	18,292,459
Healthy Start Initiative	93.926		67,976		67,976
Cooperative Agreements to Support Comprehensive School Health Programs to Prevent the Spread of HIV and Other Important Health Problems	93.938		5,000		5,000
HIV Prevention Activities Health Department Based	93.940		(29,202)	6,836,681	6,807,479
HIV Demonstration, Research, Public and Professional Education Projects	93.941		406,945	595,789	1,002,734
Human Immunodeficiency Virus (HIV)/Acquired Immunodeficiency Virus Syndrome (AIDS) Surveillance	93.944		85,605	1,026,001	1,111,606
Cooperative Agreements to Support State-Based Safe Motherhood and Infant Health Initiative Programs	93.946		25,385	74,141	99,526
Block Grants for Community Mental Health Services	93.958		(284,078)	14,120,445	13,836,367
Block Grants for Prevention and Treatment of Substance Abuse	93.959		(133,806)	59,608,099	59,474,293
Preventive Health Services - Sexually Transmitted Diseases Control Grants	93.977		2,462,598	403,106	2,865,704
Cooperative Agreements for State-Based Diabetes Control Programs and Evaluation of Surveillance Systems	93.988		749,791	204,468	954,259
Preventive Health and Health Services Block Grant	93.991		1,678,653	1,774,647	3,453,300
Maternal and Child Health Services Block Grant to the States	93.994		8,720,323	9,945,609	18,665,932
National Women's Health Week	93.251079 (3)			1,900	1,900
Women's Health Initiative	93.HHSP233200800257 (3)				0
Part A Ryan White HIV/AIDS Treatment Modernization Act	93.252261 (3)				0

This schedule continued on next page.

For the Fiscal Year Ended September 30, 2009			Total Expended and Distributed for the Two-Year Period
Directly Expended	Distributed to Subrecipients	Total Expended and Distributed	
\$ 188,321	\$ 4,751,712	\$ 4,940,033	\$ 9,874,888
8,000	0	8,000	8,000
8,483,899	14,499,618	22,983,517	51,492,195
8,784	37,419	46,203	46,203
	25,061	25,061	25,061
83,300	407,985	491,285	1,068,518
603,408	219,401	822,809	1,642,205
122,372	0	122,372	222,080
133,315	126,420	259,735	513,615
210,465	1,110,913	1,321,378	2,710,319
28,384	1,915,565	1,943,949	3,825,897
89,974	1,186,316	1,276,290	2,513,317
716,164		716,164	1,450,514
211,805	28,745	240,550	487,486
545,437	286,511	831,948	1,695,070
93,203		93,203	186,406
1,430,662	6,164,757	7,595,419	14,801,751
187,598		187,598	351,442
210,534	672,951	883,485	1,484,496
3,954	268,545	272,499	382,726
222,885		222,885	407,771
310,109	65,701	375,810	709,042
(261,400)	1,083,574	822,174	2,699,415
218,970	4,671,233	4,890,203	7,866,424
216,849	29,823	246,672	317,100
10,285,231	10,825,959	21,111,190	40,465,251
2,356	346,375	348,731	706,531
2,312		2,312	(880)
1,258,441	1,018,446	2,276,887	5,278,347
74,108		74,108	74,108
191,802,139	2,221,899	194,024,038	365,492,728
597,770	150,000	747,770	1,291,626
373,857	2,250,634	2,624,491	4,687,803
10,802	232,584	243,386	267,578
2,802,514	60,828	2,863,342	3,138,738
1,334,376	218,486	1,552,862	4,503,895
2,252,293	13,086,566	15,338,859	29,870,838
78,982	134,860	213,842	378,420
11,324,109	4,372,474	15,696,583	33,989,042
		0	67,976
		0	5,000
789,961	7,951,403	8,741,364	15,548,843
450,549	948,640	1,399,189	2,401,923
15,124	452,960	468,084	1,579,690
75,003	80,086	155,089	254,615
(417,699)	16,569,713	16,152,014	29,988,381
(374,892)	57,314,960	56,940,068	116,414,361
1,409,432	1,029,896	2,439,328	5,305,032
364,949	280,071	645,020	1,599,279
1,472,745	2,382,998	3,855,743	7,309,043
10,083,709	9,244,650	19,328,359	37,994,291
		0	1,900
1,500		1,500	1,500
273,058		273,058	273,058

DEPARTMENT OF COMMUNITY HEALTH
Schedule of Expenditures of Federal Awards (1)
For the Period October 1, 2007 through September 30, 2009
(Continued)

Federal Agency/Program or Cluster	CFDA (2) Number	Pass-Through Identification Number	For the Fiscal Year Ended September 30, 2008		
			Directly Expended	Distributed to Subrecipients	Total Expended and Distributed
Implementation of Uniform Alcohol & Drug Abuse Data Collection System	93.283-02-9026 (3)		\$ 124,798	\$	\$ 124,798
Mammography Quality Standards Act	93.HHSF223200740081C (3)		427,638		427,638
Genotyping TB	93.200-2003-02571 (3)		546,317		546,317
Genotyping TB	93.200-2008-28200 (3)				0
Social Security Administration - Birth Enumerations	93.SS00-08-60039 (3)		200,909		200,909
Social Security Administration - Death Records	93.SS00-08-30247 (3)		55,779		55,779
Social Security Administration - Death Records	93.SS00-09-60016 (3)				0
Vital Statistics Cooperative Agreement	93.200-20000-072222 (3)		482,562		482,562
Vital Statistics Cooperative Agreement	93.200-2007-M-19937 (3)				0
National Death Index	93.200-2007-M-21244 (3)		70,916		70,916
National Death Index	93.200-2009-M-29329 (3)				0
Healthy Start, Grow Smart	93.HHSM-500-2004-00042C (3)		20,317		20,317
Social Security Administration - Electronic Death Registration	93.SS00-05-60090 (3)		245,842	7,794	253,636
Child Maltreatment/RTI International	93.2-312-209772 (3)		95,009		95,009
Link and Analyze Data	93.200-2008-M-28096 (3)				0
PBB Reconsent	93.200-2008-M28041 (3)				0
Capacity Building Healthcare Workshop	93.HHSP233200800228M (3)				0
Total Direct Programs			\$ 225,149,917	\$ 175,917,852	\$ 401,067,769
Pass Through Programs:					
Genetic Alliance					
Maternal and Child Health Federal Consolidated Programs	93.110	20093364	\$	\$	\$ 0
University of Michigan					
Injury Prevention and Control Research and State and Community Based Programs	93.136	20092565	\$	\$	\$ 0
National Association of State Mental Health Program Directors (NASMHPD)					
Substance Abuse and Mental Health Services - Projects of Regional and National Significance	93.243	092950-01	\$	\$	\$ 0
Michigan State University					
Occupational Safety and Health Program	93.262	610405	\$ 156,669	\$	\$ 156,669
MSU Food and Waterborne Diseases	93.NO1-AI-30058 (3)	611438	\$ 36,097	\$	\$ 36,097
MSU National Children's Study Center	93.HHSN267200700034C (3)	611407MD	\$	\$	\$ 0
Wisconsin Department of Health and Family Services:					
Drug Abuse and Addiction Research Programs	93.279	X424852	\$ 44,033	\$ 18,500	\$ 62,533
Association of State and Territorial Health Officials (ASTHO)					
Centers for Disease Control and Prevention - Investigations and Technical Assistance	93.283	8220-07AST9.1	\$ 11,301	\$	\$ 11,301
Council of State and Territorial Epidemiologists (CSTE)					
Centers for Disease Control and Prevention - Investigations and Technical Assistance	93.283	20090154			0
Association of Maternal & Child Health Programs (AMCHP)					
Centers for Disease Control and Prevention - Investigations and Technical Assistance	93.283	AMCHP12/5/07	4,059		4,059
Centers for Disease Control and Prevention - Investigations and Technical Assistance	93.283	AMCHP12/23/08			0
Alzheimer's Association					
Centers for Disease Control and Prevention - Investigations and Technical Assistance	93.283	20092626			0
Total Centers for Disease Control and Prevention - Investigations and Technical Assistance			\$ 15,360	\$ 0	\$ 15,360
University of Illinois					
Cancer Cause and Prevention Research	93.393	2007-02380-01	\$ 11,909	\$	\$ 11,909
Michigan Department of Human Services					
Child Support Enforcement	93.563	09431015	\$	\$	\$ 0
Michigan Department of Human Services					
Child Abuse and Neglect State Grants	93.669	07431 008	\$ (235)	\$	\$ (235)
Child Abuse and Neglect State Grants	93.669	08431 011	40,000		40,000
Child Abuse and Neglect State Grants	93.669	09431 010			0
Total Child Abuse and Neglect State Grants			\$ 39,765	\$ 0	\$ 39,765
Minnesota Department of Health					
National Bioterrorism Hospital Preparedness Program	93.889	B-09750	\$	\$	\$ 0

This schedule continued on next page.

For the Fiscal Year Ended September 30, 2009			Total Expended and Distributed for the Two-Year Period
Directly Expended	Distributed to Subrecipients	Total Expended and Distributed	
\$ 105,517	\$	\$ 105,517	\$ 230,315
416,043		416,043	843,681
		0	546,317
539,330		539,330	539,330
243,595		243,595	444,504
		0	55,779
60,865		60,865	60,865
		0	482,562
465,804		465,804	465,804
		0	70,916
79,123		79,123	79,123
6,640		6,640	26,957
260,659		260,659	514,295
1,886		1,886	96,895
18,039		18,039	18,039
34,692		34,692	34,692
2,500		2,500	2,500
<u>\$ 253,363,357</u>	<u>\$ 170,881,878</u>	<u>\$ 424,245,235</u>	<u>\$ 825,313,004</u>
\$ 3,997	\$	\$ 3,997	\$ 3,997
\$ 7,445	\$	\$ 7,445	\$ 7,445
\$ 4,000	\$ 192,786	\$ 196,786	\$ 196,786
\$ 152,208	\$	\$ 152,208	\$ 308,877
\$ 74,636	\$	\$ 74,636	\$ 110,733
\$ 129,625	\$ 21,973	\$ 151,598	\$ 151,598
\$ 41,081	\$ 15,000	\$ 56,081	\$ 118,614
\$ 1,552	\$	\$ 1,552	\$ 12,853
19,201	69,462	88,663	88,663
		0	4,059
4,800		4,800	4,800
16,000		16,000	16,000
<u>\$ 41,553</u>	<u>\$ 69,462</u>	<u>\$ 111,015</u>	<u>\$ 126,375</u>
\$ 2,775	\$	\$ 2,775	\$ 14,684
\$ 744,895	\$	\$ 744,895	\$ 744,895
\$	\$	\$	\$ (235)
(636)		(636)	39,364
\$	40,000	40,000	40,000
<u>\$ (636)</u>	<u>\$ 40,000</u>	<u>\$ 39,364</u>	<u>\$ 79,129</u>
\$ 15,000	\$	\$ 15,000	\$ 15,000

DEPARTMENT OF COMMUNITY HEALTH
Schedule of Expenditures of Federal Awards (1)
For the Period October 1, 2007 through September 30, 2009
(Continued)

Federal Agency/Program or Cluster	CFDA (2) Number	Pass-Through Identification Number	For the Fiscal Year Ended September 30, 2008		
			Directly Expended	Distributed to Subrecipients	Total Expended and Distributed
Michigan Department of Education					
Cooperative Agreements to Support Comprehensive School Health Programs to Prevent the Spread of HIV and Other Important Health Problems Program	93.938	02770/02750 HU0708	\$ 44,599	\$	\$ 44,599
Cooperative Agreements to Support Comprehensive School Health Programs to Prevent the Spread of HIV and Other Important Health Problems Program	93.938	082750/082770 CDC2008	73,283		73,283
Cooperative Agreements to Support Comprehensive School Health Programs to Prevent the Spread of HIV and Other Important Health Problems Program	93.938	092750/092770 CDC2009			0
Total Cooperative Agreements to Support Comprehensive School Health Programs to Prevent the Spread of HIV and Other Important Health Problems			\$ 117,882	\$ 0	\$ 117,882
Illinois Department of Public Health					
Assistance Programs for Chronic Disease Prevention and Control	93.945	83285005	\$ 420	\$ 14,580	\$ 15,000
Assistance Programs for Chronic Disease Prevention and Control	93.945	93285005			0
National Association of State & Territorial Chronic Disease Program Directors (NACDD)					
Assistance Programs for Chronic Disease Prevention and Control	93.945	20092420			0
Assistance Programs for Chronic Disease Prevention and Control	93.945	20092253			0
Total Assistance Programs for Chronic Disease Prevention and Control			\$ 420	\$ 14,580	\$ 15,000
Association of Maternal & Child Health Programs (AMCHP)					
Cooperative Agreements to Support State-Based Safe Motherhood and Infant Health Initiative Programs	93.946	U65/CCU324963	\$ 5,000	\$	\$ 5,000
Research Triangle Institute (RTI) International					
RTI International Subcontract	93.8-321-0209825 (3)	8-321-0209825	\$ 86,888	\$	\$ 86,888
Wayne State University					
Surveillance, Epidemiology and End Results (SEER) Data	93.NO1-PC-35145 (3)	N01-PC-35145	\$ 76,650	\$	\$ 76,650
Northrop Grumman					
Fetal Alcohol Disorder Prevention	93.283-07-3000 (3)	7500027045	\$ 40,765	\$ 65,000	\$ 105,765
Battelle Memorial					
HPV Prevalence Study	93.200-2002-00573 (3)	213643	\$ 24,162	\$	\$ 24,162
Science Applications International Corporation					
BioSense CDC Contract	93.GS07T00BGD0028 (3)	4400151307	\$ 51,829	\$	\$ 51,829
Macro International					
CIN Surveillance	93.820040 (3)		\$	\$	\$ 0
Magna Systems					
New Freedom Initiative Financial Support	93.820027 (3)		\$	\$	\$ 0
McKing Consulting					
Genetic Services	93.200-2003-01396 (3)	2010-128	\$	\$	\$ 0
Total Pass-Through Programs			\$ 707,429	\$ 98,080	\$ 805,509
Total U.S. Department of Health and Human Services			\$ 6,137,368,735	\$ 370,478,531	\$ 6,507,847,266
U.S. Department of Homeland Security					
Pass-Through Program:					
Michigan Department of State					
Emergency Management Performance Grants	97.042	09-231-001	\$	\$	\$ 0
Michigan Department of State Police					
Emergency Management Performance Grants	97.042	20093908			0
Total U.S. Department of Homeland Security			\$ 0	\$ 0	\$ 0
Total Financial Assistance			\$ 6,280,741,952	\$ 436,363,529	\$ 6,717,105,481

This schedule continued on next page.

For the Fiscal Year Ended September 30, 2009			Total Expended and Distributed for the Two-Year Period
Directly Expended	Distributed to Subrecipients	Total Expended and Distributed	
\$	\$	\$ 0	\$ 44,599
37,716		37,716	110,999
64,322		64,322	64,322
<u>\$ 102,038</u>	<u>\$ 0</u>	<u>\$ 102,038</u>	<u>\$ 219,920</u>
\$	\$	\$ 0	\$ 15,000
16,000		16,000	16,000
20,000		20,000	20,000
13,000		13,000	13,000
<u>\$ 49,000</u>	<u>\$ 0</u>	<u>\$ 49,000</u>	<u>\$ 64,000</u>
\$ (2,566)	\$	\$ (2,566)	\$ 2,434
\$	\$	\$ 0	\$ 86,888
\$ (4,578)	\$ 75,864	\$ 71,286	\$ 147,936
\$ 2,011	\$ 227,936	\$ 229,947	\$ 335,712
\$ 24,502	\$	\$ 24,502	\$ 48,664
\$ 25,832	\$	\$ 25,832	\$ 77,661
\$ 96,812	\$	\$ 96,812	\$ 96,812
\$ 25,508	\$	\$ 25,508	\$ 25,508
\$ 95,661	\$	\$ 95,661	\$ 95,661
<u>\$ 1,630,799</u>	<u>\$ 643,021</u>	<u>\$ 2,273,820</u>	<u>\$ 3,079,329</u>
<u>\$ 7,700,928,782</u>	<u>\$ 433,641,277</u>	<u>\$ 8,134,570,059</u>	<u>\$ 14,642,417,325</u>
\$ 623,353	\$ 162,474	\$ 785,827	\$ 785,827
	60,000	60,000	60,000
<u>\$ 623,353</u>	<u>\$ 222,474</u>	<u>\$ 845,827</u>	<u>\$ 845,827</u>
<u>\$ 7,840,681,648</u>	<u>\$ 505,097,068</u>	<u>\$ 8,345,778,716</u>	<u>\$ 15,062,884,197</u>

DEPARTMENT OF COMMUNITY HEALTH
Schedule of Expenditures of Federal Awards (1)
For the Period October 1, 2007 through September 30, 2009
(Continued)

Federal Agency/Program or Cluster	CFDA (2) Number	Pass-Through Identification Number	For the Fiscal Year Ended September 30, 2008		
			Directly Expended	Distributed to Subrecipients	Total Expended and Distributed
Nonfinancial Assistance					
U.S. Department of Agriculture					
Child Nutrition Cluster:					
Direct Program:					
Michigan Department of Education					
National School Lunch Program	10.555		\$ 6,786	\$	\$ 6,786
Total Child Nutrition Cluster			\$ 6,786	\$ 0	\$ 6,786
Total U.S. Department of Agriculture			\$ 6,786	\$ 0	\$ 6,786
U.S. Department of Health and Human Services					
Immunization Cluster:					
Direct Programs:					
Immunization Grants	93.268		\$ 71,120,888	\$	\$ 71,120,888
ARRA - Immunization	93.712				
Total Immunization Cluster			\$ 71,120,888	\$ 0	\$ 71,120,888
Direct Programs:					
Centers for Disease Control and Prevention - Investigations and Technical Assistance	93.283		\$ 16,937	\$	\$ 16,937
Preventive Health Services Sexually Transmitted Diseases Control Grants	93.977		86,531		86,531
Preventive Health and Health Services Block Grant	93.991		47,553		47,553
Total Direct Programs			\$ 151,021	\$ 0	\$ 151,021
Total U.S. Department of Health and Human Services			\$ 71,271,909	\$ 0	\$ 71,271,909
Total Nonfinancial Assistance (4)			\$ 71,278,695	\$ 0	\$ 71,278,695
Total Expenditures of Federal Awards			\$ 6,352,020,647	\$ 436,363,529	\$ 6,788,384,176

(1) Basis of Presentation: This schedule presents the federal grant activity of the Department of Community Health on the modified accrual basis of accounting and in accordance with the requirements of OMB Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*. Therefore, some amounts presented in this schedule may differ from the amounts presented in, or used in the preparation of, the financial schedules.

(2) CFDA is defined as *Catalog of Federal Domestic Assistance*.

(3) CFDA number is not available. Number derived from federal agency number and federal contract or grant number.

(4) Basis of Nonfinancial Assistance:

CFDA Number	
10.555	U.S. Department of Agriculture Food Distribution Recipient Entitlement Balance Report
93.268	Notice of Grant Award and Centers for Disease Control and Prevention's National Immunization Program Vaccine System
93.283	Notice of Grant Award
93.712	Centers for Disease Control and Prevention's National Immunization Program Vaccine System
93.977	Notice of Grant Award
93.991	Notice of Grant Award

For the Fiscal Year Ended September 30, 2009			Total Expended and Distributed for the Two-Year Period
Directly Expended	Distributed to Subrecipients	Total Expended and Distributed	
\$ 6,443	\$ 0	\$ 6,443	\$ 13,229
\$ 6,443	\$ 0	\$ 6,443	\$ 13,229
\$ 6,443	\$ 0	\$ 6,443	\$ 13,229
\$ 72,769,851	\$	\$ 72,769,851	\$ 143,890,739
703,364		703,364	703,364
\$ 73,473,215	\$ 0	\$ 73,473,215	\$ 144,594,103
\$	\$	\$ 0	\$ 16,937
93,758		93,758	180,289
		0	47,553
\$ 93,758	\$ 0	\$ 93,758	\$ 244,779
\$ 73,566,973	\$ 0	\$ 73,566,973	\$ 144,838,882
\$ 73,573,416	\$ 0	\$ 73,573,416	\$ 144,852,111
\$ 7,914,255,064	\$ 505,097,068	\$ 8,419,352,132	\$ 15,207,736,308

INDEPENDENT AUDITOR'S REPORTS ON
INTERNAL CONTROL AND COMPLIANCE



STATE OF MICHIGAN
OFFICE OF THE AUDITOR GENERAL
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THOMAS H. MCTAVISH, C.P.A.
AUDITOR GENERAL

Independent Auditor's Report on Internal Control Over Financial Reporting and on Compliance and Other Matters

Ms. Janet Olszewski, Director
Department of Community Health
Capitol View Building
Lansing, Michigan

Dear Ms. Olszewski:

We have audited the financial schedules of the Department of Community Health for the fiscal years ended September 30, 2009 and September 30, 2008, as identified in the table of contents, and have issued our report thereon dated June 28, 2010. We conducted our audit in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States.

Internal Control Over Financial Reporting

In planning and performing our audit, we considered the Department's internal control over financial reporting as a basis for designing our auditing procedures for the purpose of expressing our opinion on the financial schedules, but not for the purpose of expressing an opinion on the effectiveness of the Department's internal control over financial reporting. Accordingly, we do not express an opinion on the effectiveness of the Department's internal control over financial reporting.

Our consideration of internal control over financial reporting was for the limited purpose described in the preceding paragraph and would not necessarily identify all deficiencies in internal control over financial reporting that might be significant deficiencies or material weaknesses. However, as discussed in the next paragraph, we identified certain deficiencies in internal control over financial reporting that we consider to be significant deficiencies.

A control deficiency exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent or detect misstatements on a timely basis. A significant deficiency is a control deficiency, or combination of control deficiencies, that adversely affects the entity's ability to initiate, authorize, record, process, or report financial data reliably in accordance with generally accepted accounting principles such that there is more than

a remote likelihood that a misstatement of the entity's financial schedules that is more than inconsequential will not be prevented or detected by the entity's internal control. We consider the deficiencies described in Findings 1 through 5 in the accompanying schedule of findings and questioned costs to be significant deficiencies in internal control over financial reporting.

A material weakness is a significant deficiency, or combination of significant deficiencies, that results in more than a remote likelihood that a material misstatement of the financial schedules will not be prevented or detected by the entity's internal control.

Our consideration of internal control over financial reporting was for the limited purpose described in the first paragraph of this section and would not necessarily identify all deficiencies in internal control that might be significant deficiencies and, accordingly, would not necessarily disclose all significant deficiencies that are also considered to be material weaknesses. However, of the significant deficiencies described in the third paragraph of this section, we consider Finding 1 to be a material weakness.

Compliance and Other Matters

As part of obtaining reasonable assurance about whether the Department's financial schedules are free of material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the determination of financial schedule amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*.

The Department's responses to the findings identified in our audit are described in the accompanying corrective action plan. We did not audit the Department's responses and, accordingly, we express no opinion on them.

This report is intended solely for the information and use of the Governor, the Legislature, management, others within the Department, federal awarding agencies, and pass-through entities and is not intended to be and should not be used by anyone other than these specified parties. However, this report is a matter of public record and its distribution is not limited.

AUDITOR GENERAL

June 28, 2010



STATE OF MICHIGAN
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THOMAS H. MCTAVISH, C.P.A.
AUDITOR GENERAL

Independent Auditor's Report on Compliance With
Requirements Applicable to Each Major Program
and on Internal Control Over Compliance in
Accordance With OMB Circular A-133

Ms. Janet Olszewski, Director
Department of Community Health
Capitol View Building
Lansing, Michigan

Dear Ms. Olszewski:

Compliance

We have audited the compliance of the Department of Community Health with the types of compliance requirements described in the U.S. Office of Management and Budget (OMB) *Circular A-133 Compliance Supplement* that are applicable to each major federal program for the two-year period ended September 30, 2009. The Department's major federal programs are identified in the summary of auditor's results section of the accompanying schedule of findings and questioned costs. Compliance with the requirements of laws, regulations, contracts, and grants applicable to each major federal program is the responsibility of the Department's management. Our responsibility is to express an opinion on the Department's compliance based on our audit.

We conducted our audit of compliance in accordance with auditing standards generally accepted in the United States of America; the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States; and OMB Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*. Those standards and OMB Circular A-133 require that we plan and perform the audit to obtain reasonable assurance about whether noncompliance with the types of compliance requirements referred to in the preceding paragraph that could have a direct and material effect on a major federal program occurred. An audit includes examining, on a test basis, evidence about the Department's compliance with those requirements and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion. Our audit does not provide a legal determination of the Department's compliance with those requirements.

As described in Findings 9, 12 through 27, 29, 31, 33, and 35 in the accompanying schedule of findings and questioned costs, the Department did not comply with requirements regarding activities allowed or unallowed; allowable costs/cost principles; eligibility; matching, level of effort, and earmarking; reporting; and special tests and provisions that are applicable to its Immunization Cluster, Children's Health Insurance Program, Medicaid Cluster, and Block Grants for Prevention and Treatment of Substance Abuse. Compliance with such requirements is necessary, in our opinion, for the Department to comply with the requirements applicable to those programs.

In our opinion, because of the effects of the noncompliance described in the preceding paragraph, the Department of Community Health did not comply in all material respects, with the requirements referred to in the first paragraph that are applicable to the Medicaid Cluster and Block Grants for Prevention and Treatment of Substance Abuse. Also, in our opinion, except for the noncompliance described in the preceding paragraph, the Department of Community Health complied, in all material respects, with the

requirements referred to in the first paragraph that are applicable to each of its other major federal programs for the two-year period ended September 30, 2009. The results of our auditing procedures also disclosed other instances of noncompliance with those requirements, which are required to be reported in accordance with OMB Circular A-133 and which are described in the accompanying schedule of findings and questioned costs as Findings 6 through 12, 15, 19 and 32 through 35.

Internal Control Over Compliance

The management of the Department is responsible for establishing and maintaining effective internal control over compliance with the requirements of laws, regulations, contracts, and grants applicable to federal programs. In planning and performing our audit, we considered the Department's internal control over compliance with requirements that could have a direct and material effect on a major federal program in order to determine our auditing procedures for the purpose of expressing our opinion on compliance, but not for the purpose of expressing an opinion on the effectiveness of internal control over compliance. Accordingly, we do not express an opinion on the effectiveness of the Department's internal control over compliance.

Our consideration of internal control over compliance was for the limited purpose described in the preceding paragraph and would not necessarily identify all deficiencies in the Department's internal control that might be significant deficiencies or material weaknesses as defined below. However, as discussed below, we identified certain deficiencies in internal control over compliance that we consider to be significant deficiencies and others that we consider to be material weaknesses.

A control deficiency in an entity's internal control over compliance exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent or detect noncompliance with a type of compliance requirement of a federal program on a timely basis. A significant deficiency is a control deficiency, or combination of control deficiencies, that adversely affects the entity's ability to administer a federal program such that there is more than a remote likelihood that noncompliance with a type of compliance requirement of a federal program that is more than inconsequential will not be prevented or detected by the entity's internal control. We consider the deficiencies in internal control over compliance described in the accompanying schedule of findings and questioned costs as Findings 6 through 13 and 15 through 35 to be significant deficiencies.

A material weakness is a significant deficiency, or combination of significant deficiencies, that results in more than a remote likelihood that material noncompliance with a type of compliance requirement of a federal program will not be prevented or detected by the entity's internal control. Of the significant deficiencies described in the preceding paragraph, we consider Findings 9, 12, 13, 15, 16, 26, 28, 33, and 35 to be material weaknesses.

The Department's responses to the findings identified in our audit are described in the accompanying corrective action plan. We did not audit the Department's responses and, accordingly, we express no opinion on them.

This report is intended solely for the information and use of the Governor, the Legislature, management, others within the Department, federal awarding agencies, and pass-through entities and is not intended to be and should not be used by anyone other than these specified parties. However, this report is a matter of public record and its distribution is not limited.

AUDITOR GENERAL

June 28, 2010

SCHEDULE OF FINDINGS AND QUESTIONED COSTS

Section I: Summary of Auditor's Results

Financial Schedules

Type of auditor's report issued: Unqualified*

Internal control* over financial reporting:

Material weaknesses* identified? Yes

Significant deficiencies* identified that are not considered to be material weaknesses? Yes

Noncompliance or other matters material to the financial schedules? No

Federal Awards

Internal control over major programs:

Material weaknesses* identified? Yes

Significant deficiencies* identified that are not considered to be material weaknesses? Yes

Type of auditor's report issued on compliance for major programs:

Unqualified for all major programs except:

Adverse*

Medicaid Cluster

Block Grants for Prevention and Treatment of Substance Abuse

Qualified*

Immunization Cluster

Children's Health Insurance Program

Any audit findings disclosed that are required to be reported in accordance with U.S. Office of Management and Budget (OMB) Circular A-133, Section 510(a)?

Yes

* See glossary at end of report for definition.

Identification of major programs:

<u>CFDA Number</u>	<u>Name of Federal Program or Cluster*</u>
10.557	Special Supplemental Nutrition Program for Women, Infants, and Children
	<u>Aging Cluster:</u>
93.044	<ul style="list-style-type: none"> • Special Programs for the Aging - Title III, Part B - Grants for Supportive Services and Senior Centers
93.045	<ul style="list-style-type: none"> • Special Programs for the Aging - Title III, Part C - Nutrition Services
93.053	<ul style="list-style-type: none"> • Nutrition Services Incentive Program
93.705	<ul style="list-style-type: none"> • ARRA - Aging Home-Delivered Nutrition Services for States
93.707	<ul style="list-style-type: none"> • ARRA - Aging Congregate Nutrition Services for States
93.069	Public Health Emergency Preparedness
	<u>Immunization Cluster:</u>
93.268	<ul style="list-style-type: none"> • Immunization Grants
93.712	<ul style="list-style-type: none"> • ARRA - Immunization
93.283	Centers for Disease Control and Prevention - Investigations and Technical Assistance
	<u>Temporary Assistance for Needy Families (TANF) Cluster:</u>
93.558	<ul style="list-style-type: none"> • Temporary Assistance for Needy Families
93.767	Children's Health Insurance Program
	<u>Medicaid Cluster:</u>
93.777	<ul style="list-style-type: none"> • State Survey and Certification of Health Care Providers and Suppliers
93.778	<ul style="list-style-type: none"> • Medical Assistance Program
93.778	<ul style="list-style-type: none"> • ARRA - Medical Assistance Program

* See glossary at end of report for definition.

93.917	HIV Care Formula Grants
93.959	Block Grants for Prevention and Treatment of Substance Abuse
93.994	Maternal and Child Health Services Block Grant to the States

Dollar threshold used to distinguish between type A and type B programs: \$30,000,000

Auditee qualified as a low-risk auditee*? No

Section II: Findings Related to the Financial Schedules

FINDING (3911001)

1. Internal Control

The Department of Community Health's (DCH's) internal control was not sufficient to ensure the accuracy of its financial accounting and reporting and its compliance with direct and material federal requirements. Also, DCH did not effectively use its biennial internal control evaluation (ICE) process to monitor its system of internal control. As a result, we identified significant deficiencies related to financial accounting and reporting and all 11 major federal programs audited as part of this Single Audit*.

Internal control is a process, effected by those charged with governance, management, and other personnel, designed to provide reasonable assurance about the achievement of the entity's objectives with regard to the reliability of financial reporting, effectiveness and efficiency of operations, and compliance with applicable laws and regulations. Internal control is made up of the control environment, risk assessment, policies and procedures, information and communication, and monitoring. The ICE process is an important component of monitoring. Section 18.1485 of the *Michigan Compiled Laws* requires the head of each principal department to establish and maintain an internal accounting and administrative control system.

* See glossary at end of report for definition.

Our review disclosed:

- a. DCH's internal control over financial reporting and federal program compliance needs improvement.

Findings 1.b. through 5 of this audit report identify DCH's need to improve internal control over its accounting and financial reporting, third party service organizations (TPSOs), cash management, and prepaid inpatient health plans (PIHPs) and community mental health services programs (CMHSPs) contract payments.

Findings 6 through 13 and 15 through 35 of this audit report identify DCH's need to improve internal control over compliance with federal requirements. Findings 6 through 35 present significant deficiencies related to all 11 major programs audited during this Single Audit. Findings 9, 12, 13, 15, 16, 26, 28, 33, and 35 represent internal control deficiencies that were material to their respective programs. The internal control deficiencies resulted in qualified and adverse opinions on DCH's compliance with federal requirements for 2 and 2, respectively, of the 11 major programs.

We noted the same condition in our prior two Single Audits. DCH stated in its corrective action plan in the prior Single Audit that it developed corrective action for the applicable findings referenced in the prior audit report. DCH indicated that it did not comply with the condition because of key staffing changes in the Accounting Division during fiscal years 2007-08 and 2008-09.

- b. DCH's efforts to monitor the effectiveness of its system of internal control using the biennial ICE process needs improvement. Properly completed, the ICE can be an important tool in DCH's monitoring and assessing of the effectiveness of its system of internal control.

Section 18.1485 of the *Michigan Compiled Laws* requires the head of each principal department to provide a biennial report on the evaluation (which is known as an ICE report) of the department's internal accounting and administrative control system. The report is provided to the Governor, the Auditor General, the Senate and House Appropriations Committees, the Senate and House Fiscal Agencies, and the director of the Department of Technology, Management & Budget (DTMB). Section 18.1485 of the

Michigan Compiled Laws also requires the ICE report to include a description of any material weakness discovered in connection with the evaluation of the department's controls and plans and a time for correcting the weakness.

DTMB developed guidance, entitled *Evaluation of Internal Controls - A General Framework and System of Reporting* (Framework), for use by the principal departments in preparing the ICE report. The Framework identifies specific roles and responsibilities of the department's management, internal control officer (ICO), and other department personnel for establishing, maintaining, and evaluating the adequacy and effectiveness of its internal control system. In addition, the Framework provides guidance for the process of assessing the risks of critical department activities, evaluating the existing control environment, and preparing the ICE report. Using an evaluation work sheet, DCH's assessable units report their self-evaluations to the ICO, who coordinates and prepares the ICE report as part of DCH's efforts to monitor its internal control. DCH's biennial report was due on May 1, 2009 and was based on an evaluation of the system as of October 1, 2008. The Framework holds the ICO responsible for ensuring that adequate documentation is maintained to support conclusions reached in the evaluation process.

Our review of DCH's ICE process and report disclosed:

- (1) DCH did not maintain a complete inventory of its information technology (IT) systems.

The State of Michigan Financial Management Guide (FMG) requires that each department maintain an inventory of its IT systems. DCH identified and created an inventory of 134 IT systems in the preparation of its ICE report. However, we identified 3 additional IT systems used by DCH that were not included in its inventory. As a result, DCH did not ensure that it assessed the criticality of all IT systems.

- (2) DCH did not include all of its critical IT systems in its ICE report.

The FMG requires DCH to include critical IT systems in its ICE report, assess and evaluate each critical IT system's controls, and determine appropriate reporting of identified system weaknesses.

DCH identified 24 IT systems as critical to its operations. However, we identified 3 additional IT systems included in DCH's inventory that DCH used in its operations or to maintain vital records that we believe were critical. DCH did not include the DCH Data Warehouse, the Remittance Processing System, and the Habilitation Support Waiver Database as critical IT systems in its ICE report and did not assess the controls of these systems. Our review of the systems disclosed:

- (a) DCH uses the DCH Data Warehouse to maintain data including claims paid to providers on behalf of eligible beneficiaries enrolled in federal programs such as Medicaid; utilization data, which is used to calculate the rates paid to managed care organizations; and suppressed hospital claims, which DCH used to cost settle with hospitals that receive Medicaid interim payments. The information stored in the Data Warehouse for fiscal year 2007-08 indicated that there were more than 1.4 million beneficiaries who had medical claims submitted by more than 50,000 fee-for-service providers. The Data Warehouse also contained utilization data pertaining to more than 1.2 million beneficiaries who had medical services provided by more than 28,000 providers that participated in managed care. The Data Warehouse information supported payments of more than \$8.2 billion for fiscal year 2007-08.
- (b) DCH uses the Remittance Processing System to record payments from health care providers to the State. DCH recorded approximately \$1 billion in such payments in fiscal year 2007-08.
- (c) DCH uses the Habilitation Support Waiver Database to track Habilitation Support Waiver Program enrollees qualified under Section 1915c of the Social Security Act. DCH made payments of \$396.4 million for these enrollees in fiscal year 2007-08.

Failure to include all critical systems in the ICE report reduces DCH's assurance that it can identify and correct deficiencies in controls over its IT systems, such as access to the systems and completeness and accuracy of data entered into the systems.

- (3) DCH did not have a process in place to document the ICO's disposition of material weaknesses identified by its assessable units. As a result, DCH could not support that it considered each material weakness identified and developed a corresponding corrective action plan.

The assessable units have the most accurate perspective of the materiality of weaknesses they identify. Therefore, if the assessable units consider an internal control weakness to be material, such information should be provided to the ICO for review and, if in agreement that the weakness is material, a corrective action plan should be implemented. Our review of DCH's assessable units' self-evaluations disclosed 4 material weaknesses. However, the material weaknesses were not contained in the ICE report. Consequently, DCH did not develop corrective action plans to address the material weaknesses. Development and implementation of corrective action plans could help DCH ensure that controls were developed to address the material control weakness.

- (4) DCH did not submit its most recent ICE report on a timely basis. DCH submitted the ICE report, which was due on May 1, 2009, on July 9, 2009. DCH's delay in completing the ICE report could prevent it from timely completing and implementing corrective actions to improve internal control.

We noted the same condition in our prior two Single Audits. DCH stated in its corrective action plan in the prior Single Audit that it implemented steps to require assessable units to identify and address material weaknesses, including those from external and non-audit sources. DCH also indicated that the disposition of material findings would be documented and that the ICE would be submitted on a timely basis. DCH indicated that it did not comply with the condition because of key staffing changes during fiscal years 2007-08 and 2008-09.

RECOMMENDATIONS

FOR THE THIRD CONSECUTIVE AUDIT, WE RECOMMEND THAT DCH IMPROVE ITS INTERNAL CONTROL TO ENSURE THE ACCURACY OF ITS FINANCIAL ACCOUNTING AND REPORTING AND ITS COMPLIANCE WITH DIRECT AND MATERIAL FEDERAL REQUIREMENTS.

FOR THE THIRD CONSECUTIVE AUDIT, WE ALSO RECOMMEND THAT DCH IMPROVE ITS EFFORTS TO MONITOR THE EFFECTIVENESS OF ITS INTERNAL CONTROL USING THE ICE.

FINDING (3911002)

2. Accounting and Financial Reporting

DCH's internal control did not prevent and detect certain accounting and reporting errors. As a result, errors occurred in DCH's financial schedules and schedule of expenditures of federal awards (SEFA).

Internal control is a process, effected by those charged with governance, management, and other personnel, designed to provide reasonable assurance about the achievement of the entity's objectives with regard to the reliability of financial reporting, effectiveness and efficiency of operations, and compliance with applicable laws and regulations. Further, Section 18.1485 of the *Michigan Compiled Laws* requires DCH to establish and maintain an internal accounting and administrative control system that includes a system of authorization and recordkeeping procedures to control assets, liabilities, revenues, and expenditures; qualified personnel that maintain a level of competence; and internal control techniques that are effective and efficient.

We reviewed DCH's internal control over accounting and financial reporting:

a. Our review of DCH's internal control over accounting disclosed:

- (1) DCH had not established internal control to ensure the completeness or accuracy of the tobacco products tax revenue recorded on DCH's financial schedules. As a result, DCH might not prevent or detect related financial schedule misstatements.

The Tobacco Products Tax Act (Act 327, P.A. 1993, as amended) sets specific requirements for licensing, stamping, collecting, and disbursing tobacco products taxes. The proceeds derived from the payment of taxes, fees, and penalties are deposited with the State Treasurer and disbursed to various funds, including the Healthy Michigan Fund and the Medicaid Benefits Trust Fund (subfunds of the General Fund). Revenues

in these funds are used to support DCH's mission to protect, preserve, and promote the health and safety of the people of Michigan.

According to the Department of Treasury, the Healthy Michigan Fund and the Medicaid Benefits Trust Fund received 3.6% and 34.1% of tobacco products tax revenue, respectively, for fiscal year 2007-08. According to the State's accounting system, DCH received tobacco products tax revenue totaling \$403.8 million and \$416.7 million in fiscal year 2008-09 and fiscal year 2007-08, respectively. However, our review also disclosed that DCH had not implemented internal control procedures to ensure that the tobacco products tax revenue received by DCH and recorded on DCH's financial schedules was complete and accurate.

For example, in fiscal year 2007-08, the monthly tobacco products tax revenue transferred to DCH generally ranged from \$30.8 million to \$38.9 million. However, our review disclosed that December 2007 tobacco products tax revenue was only \$12.8 million and that June 2008 revenue was \$50.2 million. DCH accounting staff stated that they were unaware of these variances and had not performed any analysis to ensure that the correct amount of monthly tobacco products tax revenue was transferred to DCH. Internal control that ensures the accuracy of the financial schedules would help DCH detect the existence and evaluate the reasonableness of significant variances in the monthly revenue deposited into these funds.

- (2) DCH had not established internal control to ensure the accuracy of its accounting and financial reporting and its compliance with Medicaid Cluster direct and material federal requirements.

Until May 2008, DCH's procedure required that a supervisor review and approve journal entries recorded in the State's accounting system, including Medicaid journal entries. The procedure outlined responsibilities for persons who enter and approve journal entries, which might pertain to various Medicaid transactions, such as payments or expenditure reclassifications.

A May 2008 employee departure left an accounting supervisory position vacant for a two-month time period. During this two-month time period,

DCH temporarily changed its procedure regarding approval of Medicaid journal entries. The temporary procedure allowed for two nonsupervisory accounting staff members to approve each other's Medicaid journal entries. The temporary procedure stated that these journal entries would be subject to a subsequent review after DCH filled the vacant supervisory position.

However, DCH did not ensure that the new supervisor performed the subsequent review of the Medicaid journal entries, which included expenditure entries totaling \$384.9 million. As a result, DCH could not ensure that Medicaid journal entries in the State's accounting system were accurate, complete, adequately supported, or in compliance with federal laws and regulations.

- (3) DCH had not established internal control to ensure the completeness or accuracy of Adult Home Help (AHH) Program expenditures recorded on DCH's financial schedules (see Finding 24.b.).
 - (4) DCH did not ensure that it encumbered all commitments related to unperformed contracts in accordance with Section 1700.128 of the *Codification of Governmental Accounting and Financial Reporting Standards*, published by the Governmental Accounting Standards Board. Because DCH did not encumber these funds, DCH recorded the funds as lapsed. In addition, DCH did not perform the required review of lapses as required by the FMG. As a result, DCH's financial schedules understated encumbrances and overstated lapses by \$4.0 million for fiscal year 2008-09. DCH's financial schedules reported encumbrances and lapses of \$2.9 million and \$61.1 million, respectively, for fiscal year 2008-09.
- b. Our review of DCH's internal control over financial reporting disclosed that DCH did not ensure that DCH prepared its SEFA in accordance with OMB Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*, and State financial management policies.

OMB Circular A-133 requires that DCH identify, in its accounts, all federal awards received and expended. OMB Circular A-133 also requires that DCH's SEFA report total federal awards expended for each individual federal program, the value of federal awards expended in the form of non-cash

assistance, and the amounts provided to subrecipients*. In addition, the FMG requires that the SEFA include the portion of federal assistance that was expended directly by the department or distributed to subrecipients.

Our review of DCH's SEFA preparation process disclosed:

- (1) DCH's accounting records did not support the expenditures as presented on the SEFA. DCH included \$167.9 million on the SEFA for fiscal years 2007-08 and 2008-09 related to certified public expenditures claimed under the government provider disproportionate share hospital (DSH) pools and expenditures commonly referred to by DCH as "gross-up" expenditures. DCH indicated that federal revenues associated with certified public expenditures claimed under the government provider DSH pools and "gross-up" expenditures were used by DCH to fund other expenditures; however, the accounting records lacked grant information to support which expenditures were funded. As a result, DCH's SEFA for fiscal years 2007-08 and 2008-09 was as much as \$167.9 million (1.2%) greater than amounts supported by the State's accounting records. DCH reported Medicaid Cluster expenditures totaling \$13.7 billion on its SEFA for fiscal years 2007-08 and 2008-09 combined.
- (2) DCH's internal control did not ensure that DCH included all non-cash assistance on the SEFA. We noted that DCH did not include non-cash assistance related to the Immunization Cluster (vaccines) for fiscal year 2008-09. As a result of our audit, DCH corrected the SEFA to include \$73.5 million of non-cash assistance related to the Immunization Cluster.
- (3) DCH overstated amounts "Directly Expended" and understated amounts "Distributed to Subrecipients" by \$14.3 million and \$887,000 for fiscal years 2007-08 and 2008-09, respectively.

DCH prepares its SEFA based on coded payment information contained in the State's accounting system. The coded payment information is entered into the State's accounting system based on determinations by program staff as to whether the entity to be paid is a vendor or a

* See glossary at end of report for definition.

subrecipient. During our audit period, DCH did not always use the proper codes when entering payment information into the State's accounting system.

- (4) DCH's internal control did not ensure that recipients of federal funds were properly classified as a vendor or a subrecipient. As a result, DCH understated amounts "Directly Expended" and overstated amounts "Distributed to Subrecipients" by \$5.3 million and \$1.8 million for fiscal years 2007-08 and 2008-09, respectively.

We noted similar conditions in our prior two Single Audits. DCH stated in its corrective action plan in the prior Single Audit that it established policies and procedures to monitor and train staff to ensure proper coding for subrecipients. DCH indicated that it did not comply with the condition because of key staffing changes during fiscal years 2007-08 and 2008-09.

RECOMMENDATION

FOR THE THIRD CONSECUTIVE AUDIT, WE RECOMMEND THAT DCH IMPROVE ITS INTERNAL CONTROL OVER ACCOUNTING AND FINANCIAL REPORTING TO PREVENT AND DETECT ACCOUNTING AND REPORTING ERRORS.

FINDING (3911003)

3. Third Party Service Organizations (TPSOs)

DCH, in conjunction with the Department of Technology, Management & Budget (DTMB), did not evaluate the sufficiency of third party service organization (TPSO) internal control assurance audits. As a result, DCH cannot ensure that TPSOs have established effective internal control over transactions and services provided on behalf of DCH.

The FMG (Part VII, Chapter 1, Section 1000) requires agencies to ensure that TPSOs have an adequate internal control system when TPSOs perform services on behalf of the State. According to the FMG, State agencies may obtain required assurances by contracting for an independent audit, typically performed in accordance with Statement on Auditing Standards No. 70, *Service Organizations* (SAS 70 audit). The FMG requires the manager responsible for oversight of the

TPSO to document the method of assessing internal control at the TPSO and the conclusions about the internal control identified.

For example, DCH contracts with a vendor to perform services on behalf of the MICHild Program, a subprogram of the Children's Health Insurance Program. The vendor obtained SAS 70 audits of its internal control environment, including its information system, for both years of our audit period. However, DCH informed us that, although it reviewed the results of the two SAS 70 audits that were performed on the vendor during our audit period, DCH did not document the results of its review. To gain an understanding of the vendor's control environment and information system, we assessed the content of the vendor's SAS 70 audit report for the period July 1, 2008 through June 30, 2009. Specifically, we determined:

- a. DCH did not evaluate the significance of the vendor's use of subservice organizations to the MICHild Program's internal control or obtain other assurances about the effectiveness of internal control at the subservice organizations.

The vendor contracts with subservice organizations for certain administrative and information technology (IT) functions, such as mail house services, records management, and tape backup and storage, which will likely have an impact on the effectiveness of the MICHild Program's internal control over beneficiary eligibility and premium collection. The vendor's SAS 70 audit did not evaluate internal control at the subservice organizations. Therefore, DCH cannot ensure that appropriate internal control has been established.

- b. DCH, in conjunction with DTMB, did not ensure that the SAS 70 audit included a technical description of the vendor's IT architecture. Without a technical description, DCH cannot properly evaluate the service auditor's coverage of general controls and, consequently, DCH may not be aware of potential risks to the information system and data.

For example, the report does not describe the major hardware components, operating system, database management system, and access paths.

- c. DCH, in conjunction with DTMB, did not evaluate the sufficiency of the service auditor's tests of controls.

For example, we noted that DCH did not ensure that the vendor's service auditor fully identified or tested general controls pertaining to operating system access and security and changes to the operating system configuration. As a result, DCH cannot ensure that its vendor has implemented effective internal control over its information system and MICHild Program data.

RECOMMENDATION

We recommend that DCH, in conjunction with DTMB, evaluate the sufficiency of TPSO internal control assurance audits.

FINDING (3911004)

4. Cash Management

DCH needs to improve its internal control over its compliance with State and federal cash management requirements. As a result, DCH did not request federal reimbursement on a timely basis for two federal programs, resulting in lost interest to the State of approximately \$110,000. Also, DCH's cash management controls allowed DCH to request and obtain federal funds prematurely for the Maternal and Child Health Services Block Grant to the States (MCH Block Grant) Program, resulting in lost interest to the federal government of \$22,543.

The DTMB Administrative Guide and the federal Cash Management Improvement Act of 1990 (CMIA) require DCH to request funds from the federal government as close as possible to actual cash outlays for federal programs. Also, the CMIA requires states to comply with procedures, which have been agreed to by the federal government, for timely drawing of federal revenue on applicable major programs. The agreement with the federal government can be revised annually.

Our review of DCH's cash management practices disclosed:

a. DCH did not request and obtain federal funds on a timely basis for two major federal programs reviewed, resulting in lost interest to the State of approximately \$110,000:

(1) In the HIV Care Formula Grants Program, we noted that cumulative payments exceeded cumulative federal revenue draws for 682 (93%) of 731 days of the audit period, including 357 consecutive days with an

average excess of payments over federal revenue draws of \$1.7 million and 14 consecutive days with an average excess of payments over federal revenue draws of \$5.3 million. The excess of payments over federal revenue draws resulted in lost interest to the State of approximately \$87,000.

(2) In the MCH Block Grant Program, we noted that cumulative payments exceeded cumulative federal revenue draws for 362 (50%) of 731 days of the audit period, which resulted in lost interest to the State of approximately \$23,000.

b. DCH requested and obtained federal funds prematurely for the MCH Block Grant Program. We noted that the cash draw of federal revenue preceded the immediate need for funding for 369 (50%) of 731 days of the audit period, which resulted in lost interest to the federal government of \$22,543.

Cash managers need to adhere to appropriate and detailed procedures and controls, including management oversight. Effective cash management efforts should include consideration of the timing of program payments relative to federal revenue draw requests. Because DCH received \$15 billion in federal funds during the audit period, it is critical that DCH develop and adhere to effective cash management procedures for each of its federal programs.

We noted the same condition in our prior Single Audit. DCH stated in its corrective action plan in the prior Single Audit that it would take corrective action by September 30, 2009 and that it hired a Grants Accounting Section manager, in September 2008, whose tasks included reviewing current procedures and recommending standardized reconciliation procedures to eliminate draw and expenditure errors.

RECOMMENDATION

WE AGAIN RECOMMEND THAT DCH IMPROVE ITS INTERNAL CONTROL OVER ITS COMPLIANCE WITH STATE AND FEDERAL CASH MANAGEMENT REQUIREMENTS.

FINDING (3911005)

5. PIHP and CMHSP Contract Payments

DCH's internal control over contract payments to prepaid inpatient health plans (PIHPs) and community mental health services programs (CMHSPs) did not ensure that payments were in compliance with federal regulations and State laws. As a result, DCH made payments to PIHPs and CMHSPs before approved contracts, contract extensions, or contract amendments were in place. We estimated that DCH made Medicaid and State-funded payments during the audit period totaling approximately \$1.8 billion to the 18 PIHPs and primarily State-funded payments totaling \$219.0 million to the 46 CMHSPs prior to obtaining an approved contract, contract extension, or contract amendment.

Appendix A, section C(1)(j) of OMB Circular A-87, *Cost Principles for State, Local, and Indian Tribal Governments* (Title 2, Part 225 of the *Code of Federal Regulations* [CFR]), requires that costs charged to a federal program be supported by adequate documentation. Also, Section 330.1232 of the *Michigan Compiled Laws* (Act 258, P.A. 1974, as amended) provides that CMHSP eligibility for State financial support is contingent upon an approved contract.

For our two-year audit period, DCH made payments of \$3.6 billion to 18 PIHPs to manage and provide mental health and substance abuse services and support, such as inpatient psychiatric hospital services or substance abuse rehabilitation services. Payments to PIHPs are from federal Medicaid funds and State General Fund/general purpose funds. DCH also made payments of \$888.5 million to 46 CMHSPs to manage and provide mental health services to eligible persons who were not covered by Medicaid or to fund a portion of the cost of mental health services when Medicaid funds have been exhausted. Payments to CMHSPs are primarily from State General Fund/general purpose funds.

We tested 4 of the 18 PIHPs contracts entered into and paid during our audit period having payments totaling \$1.1 billion from Medicaid (\$464.0 million General Fund/general purpose). We also tested 5 of the 46 CMHSPs contracts entered into during our audit period having payments totaling \$346.7 million.

We determined that DCH did not ensure that contracts and contract amendments were signed by all parties prior to issuing payments for the contracts. Specifically, we noted, for the fiscal year 2007-08, that DCH made payments totaling

\$281.5 million to the 4 PIHPs tested and payments totaling \$85.7 million to the 5 CMHSPs tested before a contract or a contract extension was signed by DCH and the PIHP or CMHSP, as applicable. For fiscal year 2008-09, DCH obtained contract approvals from each of the 9 organizations tested. However, DCH made payments totaling \$4.6 million under a new rate schedule that took effect during fiscal year 2008-09 before the contract amendment incorporating the new rate schedule was signed by DCH and the 4 PIHPs tested. Consequently, the portions of the payments that resulted from the rate changes were inappropriate.

We noted the same condition in our prior Single Audit. DCH stated in its corrective action plan in the prior Single Audit that by September 30, 2009 it would implement changes to the contracting process intended to ensure that fully executed agreements are in place prior to payment.

RECOMMENDATION

WE AGAIN RECOMMEND THAT DCH CONTINUE TO IMPROVE ITS INTERNAL CONTROL OVER CONTRACT PAYMENTS TO PIHPs AND CMHSPs TO ENSURE THAT THE PAYMENTS ARE IN COMPLIANCE WITH FEDERAL REGULATIONS AND STATE LAWS.

The status of the findings related to the financial schedules that were reported in prior Single Audits is disclosed in the summary schedule of prior audit findings.

Section III: Findings and Questioned Costs* Related to Federal Awards

FINDING (3911006)

6. Special Supplemental Nutrition Program for Women, Infants, and Children, CFDA 10.557

U.S. Department of Agriculture	CFDA 10.557: Special Supplemental Nutrition Program for Women, Infants, and Children
Award Number: 2005IW101142 2006IW101142 2007IW101442 2007IW101142 2007IW500342 2008IW100342 2008IW100642 2008IW500342 2009IW100342 2009IW100642 2009IW101142 2009IW500342	Award Period: 09/16/2005 - 09/30/2008 09/30/2006 - 09/30/2010 09/30/2007 - 09/30/2011 04/09/2007 - 09/30/2008 03/30/2007 - 09/30/2008 10/01/2007 - 09/30/2008 10/01/2007 - 09/30/2008 03/12/2008 - 09/30/2009 10/01/2008 - 09/30/2009 10/01/2008 - 09/30/2009 06/30/2009 - 09/30/2010 10/01/2008 - 09/30/2009
	Known Questioned Costs: \$0

DCH's internal control over the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC Program) did not ensure compliance with federal laws and regulations regarding subrecipient monitoring.

Internal control that does not ensure compliance with federal laws and regulations could result in sanctions, disallowances, and/or future reductions of WIC Program awards.

The WIC Program provides supplemental nutritious foods, nutrition education, and health care referrals for low-income persons. DCH contracts with local agency subrecipients to certify applicants' eligibility for WIC Program benefits and deliver such benefits to eligible beneficiaries. Local agency subrecipients provide these services at their primary facilities and associated clinics.

* See glossary at end of report for definition.

Federal regulation 7 *CFR* 246.19(b)(3) requires DCH to ensure that each local agency subrecipient's financial records related to the WIC Program are reviewed at least once every two years. The reviews of local agency subrecipient financial records are performed by DCH or a public accounting firm responsible for conducting local agency subrecipient Single Audits.

Federal expenditures for the WIC Program by DCH totaled \$337.4 million for the two-year period ended September 30, 2009, including \$73.5 million that was distributed to 48 local agency subrecipients.

For the two-year period ended December 31, 2008, we determined that the required review of financial records was not performed for 21 (44%) of 48 local agency subrecipients, which received \$28.5 million during the audit period.

We noted the same condition in our prior Single Audit. DCH stated in its corrective action plan in the prior Single Audit that it would investigate a means to accomplish the required financial management systems reviews by March 31, 2009. DCH stated that it investigated a means to accomplish the required reviews, but staff furlough days and the significant time required for one agency's review hampered progress at completely correcting the condition.

RECOMMENDATION

WE AGAIN RECOMMEND THAT DCH IMPROVE ITS INTERNAL CONTROL OVER THE WIC PROGRAM TO ENSURE COMPLIANCE WITH FEDERAL LAWS AND REGULATIONS REGARDING SUBRECIPIENT MONITORING.

FINDING (3911007)

7. Aging Cluster, CFDA 93.044, 93.045, 93.053, 93.705, and 93.707

U.S. Department of Health and Human Services	<p>Aging Cluster:</p> <p>CFDA 93.044: Special Programs for the Aging - Title III, Part B - Grants for Supportive Services and Senior Centers</p> <p>CFDA 93.045: Special Programs for the Aging - Title III, Part C - Nutrition Services</p> <p>CFDA 93.053: Nutrition Services Incentive Program</p> <p>CFDA 93.705: ARRA - Aging Home-Delivered Nutrition Services for States</p> <p>CFDA 93.707: ARRA - Aging Congregate Nutrition Services for States</p>
<p>Award Number:</p> <p>08AAMIT3SP</p> <p>08AAMINSIP</p> <p>09AAMIT3SP</p> <p>09AAMINSIP</p> <p>09AAMIC1RR</p> <p>09AAMIC2RR</p>	<p>Award Period:</p> <p>10/01/2007 - 09/30/2008</p> <p>10/01/2007 - 09/30/2008</p> <p>10/01/2008 - 09/30/2009</p> <p>10/01/2008 - 09/30/2009</p> <p>03/17/2009 - 09/30/2010</p> <p>03/18/2009 - 09/30/2010</p>
	Known Questioned Costs: \$0

DCH's internal control over the Aging Cluster did not ensure compliance with federal laws and regulations regarding subrecipient monitoring.

Internal control that does not ensure compliance with federal laws and regulations could result in sanctions, disallowances, and/or future reductions of the Aging Cluster awards.

DCH's Office of Services to the Aging administers State and federal funds and manages grants for aging services provided by 16 area agencies on aging and their contracted service providers. Funded services for seniors aged 60 and older include care management, community-based services such as transportation and health promotion, elder abuse prevention services, legal assistance, meals in group settings, and delivery of meals to homebound seniors.

Federal expenditures for the Aging Cluster totaled \$77.7 million for the two-year period ended September 30, 2009, including \$74.7 million that was distributed to 16 subrecipients.

Federal regulation 45 *CFR* 92.40 and OMB Circular A-133, section 400(d)(3) require DCH to monitor the operations of its subrecipients to ensure compliance with applicable federal program requirements.

DCH's efforts to monitor its subrecipients included acquisition of subrecipient annual program outcome and compliance assessments, observations of subrecipient program activities, and attendance at administrative board meetings. However, DCH did not review documentation that supports the expenditures reported by its subrecipients, which is necessary for effective monitoring of allowable costs/cost principles and matching of federal funds requirements. Also, DCH did not document its monitoring activities to ensure subrecipient compliance with federal requirements. Although DCH implemented a control requiring field services representatives to review quarterly financial status expenditure reports from its 16 subrecipients, DCH did not document its reviews of 11 (69%) reports for the third quarter and 9 (56%) reports for the fourth quarter, respectively, of fiscal year 2008-09.

RECOMMENDATION

We recommend that DCH improve its internal control over the Aging Cluster to ensure compliance with federal laws and regulations regarding subrecipient monitoring.

FINDING (3911008)

8. Public Health Emergency Preparedness, *CFDA* 93.069

U.S. Department of Health and Human Services	<i>CFDA</i> 93.069: Public Health Emergency Preparedness
Award Number: 5U90TP517018-08 5U90TP517018-09 5U90TP517018-10 1U90TP000218-01 1H75TP000353-01	Award Period: 08/31/2007 - 08/09/2008 08/10/2008 - 08/09/2009 08/10/2009 - 08/09/2010 09/30/2008 - 09/29/2010 07/31/2009 - 07/30/2010
	Known Questioned Costs: \$0

DCH's internal control over the Public Health Emergency Preparedness (PHEP) Program did not ensure compliance with federal laws and regulations regarding subrecipient monitoring.

Internal control that does not ensure compliance with federal laws and regulations could result in sanctions, disallowances, and/or future reductions of PHEP Program awards.

The PHEP Program assists state, local, and other health agencies in developing emergency-ready public health departments by upgrading, integrating, and evaluating state and local public health jurisdictions.

Federal regulation 45 *CFR* 92.40 and OMB Circular A-133, section 400(d)(3) require DCH to monitor the operations of its subrecipients to ensure compliance with applicable federal program requirements.

Federal expenditures for the PHEP Program totaled \$51.5 million for the two-year period ended September 30, 2009, including \$34.4 million that DCH distributed to 133 subrecipients.

DCH did not monitor its subrecipients' compliance with federal requirements. DCH primarily utilized site visits for determining if subrecipients were in compliance with program requirements and applicable laws and regulations. However, DCH's site visits did not include a review of the documentation that supported expenditures reported by its subrecipients, which is necessary for effective monitoring of allowable costs/cost principles, cash management, and period of availability of federal funds requirements.

RECOMMENDATION

We recommend that DCH improve its internal control over the PHEP Program to ensure compliance with federal laws and regulations regarding subrecipient monitoring.

FINDING (3911009)

9. Immunization Cluster, CFDA 93.268 and 93.712

U.S. Department of Health and Human Services	Immunization Cluster: CFDA 93.268: Immunization Grants CFDA 93.712: ARRA - Immunization
Award Number: H23/CCH522556-05 H23/CCH522556-05-1 H23/CCH522556-05-2 2H231P522556-G6 5H231P522556-07	Award Period: 01/01/2007 - 12/31/2007 01/01/2007 - 12/31/2007 01/01/2007 - 12/31/2007 01/01/2008 - 12/31/2008 01/01/2009 - 12/31/2009
	Known Questioned Costs: \$28,155

DCH's internal control over the Immunization Cluster did not ensure compliance with federal laws and regulations regarding special tests and provisions, period of availability of federal funds, and subrecipient monitoring. Our review disclosed material weaknesses in internal control and material noncompliance* with federal laws and regulations regarding special tests and provisions. As a result, we issued a qualified opinion on compliance with federal laws and regulations for the Immunization Cluster. We also reported known questioned costs* totaling \$28,155.

Noncompliance with federal laws and regulations could result in sanctions, disallowances, and/or future sanctions of Immunization Cluster awards.

Federal financial expenditures for the Immunization Cluster totaled \$16.7 million for the two-year period ended September 30, 2009. DCH expended federal financial assistance under only the Immunization Grants Program (CFDA 93.268), one of the two programs included in the cluster. Also, the Centers for Disease Control and Prevention (CDC) provided \$144.6 million in vaccines to local health departments (LHDs) and medical providers as directed by DCH during the two-year period ended September 30, 2009.

* See glossary at end of report for definition.

Our exceptions, by compliance area, are as follows:

a. Special Tests and Provisions

DCH did not ensure that LHDs and medical providers effectively controlled and accounted for CDC vaccines. As a result, DCH could not ensure that CDC vaccines were distributed, safeguarded, and administered in accordance with federal laws and regulations.

The CDC pays vaccine manufacturers to provide vaccines to the states for immunization of eligible children. DCH reviews and approves vaccine requests by LHDs and medical providers. DCH subsequently places all vaccine orders with the CDC. Upon approval of DCH's vaccine order by the CDC, a CDC-contracted distributor ships vaccines directly to DCH, LHDs, and medical providers. The CDC provided vaccines to DCH, 45 LHDs, and 3,318 medical providers during the audit period.

Federal regulation 45 *CFR* 92.20(b)(3) requires DCH to maintain effective control and accountability for all grant and subgrant assets. For the Immunization Cluster, assets include nonfinancial assistance, such as vaccine doses that are obtained and stored by DCH, LHDs, and medical providers.

DCH monitors the CDC vaccines provided to LHDs and medical providers using an electronic vaccine management system. LHDs and medical providers are responsible for updating the system for activities such as vaccine usage, spoilage, shrinkage, and inventory results. DCH site visits of LHDs, and LHDs' site visits of medical providers, include reviews of vaccine storage and handling procedures. However, the reviews do not include a comparison of reported versus actual vaccine quantities on hand.

We noted a similar condition in our prior Single Audit. DCH stated in its corrective action plan in the prior Single Audit that it moved to a Web-based inventory system to monitor the vaccine inventory levels. However, DCH did not conduct physical inventories of the vaccine levels to ensure the accuracy of the computer system. DCH has subsequently stated that, since the prior audit, it has undertaken several initiatives to increase the accountability of vaccines distributed and has worked with the CDC to determine the appropriate level of inventories.

b. Period of Availability of Federal Funds

DCH improperly charged subrecipient expenditures incurred during the Immunization Cluster funding period ended December 31, 2009 to the funding period ended December 31, 2008. As a result, we reported known questioned costs of \$28,155.

Federal regulation 45 *CFR* 92.23 states that where the federal awarding agency specifies a funding period, a grantee may only charge costs to the award resulting from obligations that occurred during the funding period.

We noted a similar condition in our prior Single Audit. DCH stated in its corrective action plan in the prior Single Audit that it agreed to establish policies and procedures for the appropriate reporting of grant expenditures by March 31, 2009. DCH stated that it does not agree that the deficiency continues to exist.

c. Subrecipient Monitoring

DCH did not monitor or sufficiently document its monitoring of its subrecipients' compliance with federal requirements.

DCH performs site visits of the LHDs that administer vaccines to review various compliance and operational areas regarding client eligibility, immunization records, and vaccine storage and handling procedures. Similarly, the LHDs review their medical providers for the same compliance and operational areas and report their site visit results to DCH. DCH distributed financial assistance of \$12.5 million to 51 subrecipients for the two-year period ended September 30, 2009.

Our review of DCH's monitoring of Immunization Cluster subrecipients disclosed:

- (1) DCH did not review documentation that supports the expenditures reported by its subrecipients, which is necessary for effective monitoring of allowable costs/cost principles and period of availability of federal funds requirements.

Federal regulation 45 *CFR* 92.40 and OMB Circular A-133, section 400(d)(3) require DCH to monitor the operations of its subrecipients to

ensure compliance with applicable federal program requirements. Effective monitoring of subrecipients can be accomplished using various methods, depending on the nature and timing of the compliance requirement.

- (2) DCH did not document its monitoring of its subrecipients' compliance with federal suspension and debarment requirements.

Federal regulation 45 *CFR* 92.35 prohibits DCH and its subrecipients from contracting with, or making subawards to, any party that is suspended or debarred. Federal regulation 2 *CFR* 180.300 requires DCH and its subrecipients to meet this requirement by collecting a certification from medical providers that administer vaccines, adding a clause or condition to the contract that the party is not suspended or debarred, or checking the federal Excluded Parties List System.

DCH stated that LHDs did not collect a certification from the medical providers that distributed vaccines and did not add a pertinent clause or condition to the contract. Also, while DCH asserted that it annually verified that each provider was not suspended, debarred, or otherwise excluded, DCH did not consult the federal Excluded Parties List System.

We noted a similar condition in our prior Single Audit. DCH stated in its corrective action plan in the prior Single Audit that it agreed to follow subrecipient monitoring guidelines established by the newly formed DCH local subrecipient monitoring work group. In addition, DCH agreed to add a line in the annual enrollment form to ensure that providers were not suspended or debarred from distributing vaccines. DCH stated that when the subsequent monitoring plan was implemented, it did not include expenditure testing. DCH also stated that it initially believed that the use of the State Web site for suspended and debarred physicians was more inclusive. However, DCH subsequently acknowledged that this did not meet the requirement to check the federal Excluded Parties List System.

RECOMMENDATION

WE AGAIN RECOMMEND THAT DCH IMPROVE ITS INTERNAL CONTROL OVER THE IMMUNIZATION CLUSTER TO ENSURE COMPLIANCE WITH

FEDERAL LAWS AND REGULATIONS REGARDING SPECIAL TESTS AND PROVISIONS, PERIOD OF AVAILABILITY OF FEDERAL FUNDS, AND SUBRECIPIENT MONITORING.

FINDING (3911010)

10. Centers for Disease Control and Prevention - Investigations and Technical Assistance, CFDA 93.283

U.S. Department of Health and Human Services	CFDA 93.283: Centers for Disease Control and Prevention - Investigations and Technical Assistance
Award Number: 5U55DP521948 U90/CCU517018 5U58DP522826 U50/CCU523806 1 U59 EH000213 U58/CC522826-04-04 1U58DP000812 1U58DP000854 IU51PS000872 1U58DP001441 1U58DP001439 1U58DP001386 5UR3DD000419 1U58DP001536 1U58DP001973 1U38GD000054 U59/CCU517742 U60/CCU07277 U60/CCU07277 U50/CCU313903 5UR3DD525181 5U59EH000213-03 1U59EH000525-01 U50DP00718-03 5U58DP000854-03 5U58DP001441-02 5U58DP001439-02 5U58DP001386-02	Award Period: 09/30/2002 - 06/29/2008 08/31/1999 - 08/30/2010 06/30/2003 - 03/29/2009 06/01/2004 - 12/31/2009 09/01/2006 - 08/30/2009 06/30/2006 - 06/30/2007 06/30/2007 - 06/29/2012 07/01/2007 - 06/30/2012 11/01/2007 - 10/31/2012 06/30/2008 - 06/29/2012 06/30/2008 - 06/29/2013 06/30/2008 - 06/29/2013 07/01/2008 - 06/30/2011 07/31/2008 - 07/30/2013 03/29/2009 - 03/28/2014 09/30/2008 - 09/29/2011 08/01/2000 - 09/29/2006 07/31/2008 - 09/30/2008 10/01/2008 - 05/31/2009 06/01/2007 - 11/30/2007 07/01/2005 - 06/30/2008 09/01/2008 - 08/31/2009 09/01/2009 - 08/31/2014 06/30/2009 - 06/29/2010 07/01/2009 - 06/30/2010 06/30/2009 - 06/29/2010 06/30/2009 - 06/29/2010 06/30/2009 - 06/29/2010
	Known Questioned Costs: \$0

DCH's internal control over the Centers for Disease Control and Prevention - Investigations and Technical Assistance (CDC Program) did not ensure compliance with federal laws and regulations regarding subrecipient monitoring.

Internal control that does not ensure compliance with federal laws and regulations could result in sanctions, disallowances, and/or future reductions of CDC awards.

The CDC Program assists state, local, and other health agencies in controlling communicable diseases and disorders and other preventable health conditions.

Federal expenditures for the CDC Program totaled \$40.6 million for the two-year period ended September 30, 2009, including \$23.5 million that was distributed to 118 subrecipients.

Federal regulation 45 *CFR* 92.40 and OMB Circular A-133, section 400(d)(3) require DCH to monitor the operations of its subrecipients to ensure compliance with applicable federal program requirements. Effective monitoring of subrecipients can be accomplished using various methods, depending on the nature and timing of the compliance requirement.

DCH did not monitor its subrecipients' compliance with federal requirements. DCH's site visits, upon which DCH primarily relied for determining if the subrecipients were in compliance with program requirements and applicable laws and regulations, did not include a review of the documentation that supported expenditures reported by its subrecipients, which is necessary for effective monitoring of allowable costs/cost principles, cash management, and period of availability of federal funds requirements.

We noted the same condition in our prior Single Audit. DCH stated in its corrective action plan in the prior Single Audit that it would follow departmental guidelines established by its local subrecipient monitoring work group. DCH stated that a subrecipient monitoring plan was developed and implemented that did not include expenditure testing.

RECOMMENDATION

WE AGAIN RECOMMEND THAT DCH IMPROVE ITS INTERNAL CONTROL OVER THE CDC PROGRAM TO ENSURE COMPLIANCE WITH FEDERAL LAWS AND REGULATIONS REGARDING SUBRECIPIENT MONITORING.

FINDING (3911011)

11. Temporary Assistance for Needy Families (TANF) Cluster, CFDA 93.558

U.S. Department of Health and Human Services	Temporary Assistance for Needy Families (TANF) Cluster: CFDA 93.558: Temporary Assistance for Needy Families
Award Number: DCH-08-IA-07 DCH-09-IA-02	Award Period: 10/01/2007 - 09/30/2008 10/01/2008 - 09/30/2009
Pass-Through Entity: Michigan Department of Human Services	Known Questioned Costs: \$0

DCH's internal control over the TANF Cluster did not ensure compliance with federal laws and regulations regarding eligibility.

Internal control that does not ensure compliance with federal laws and regulations could result in sanctions, disallowances, and/or future reductions of TANF Cluster awards.

DCH administers the TANF Cluster's Family Support Subsidy Program as a subrecipient of the Department of Human Services (DHS). The Family Support Subsidy Program provides cash assistance (benefits) to families of children with severe disabilities. These families visit their local community mental health services programs (CMHSPs) to apply for the TANF Cluster's Family Support Subsidy Program benefits.

CMHSPs determine applicant eligibility through the verification of applicant eligibility requirements to supporting documentation. CMHSPs forward the completed applications to DCH and retain the supporting documentation. DCH reviews the applications for completeness and, if all sections were properly completed, initiates monthly TANF Cluster payments to the applicant.

Federal expenditures for the TANF Cluster totaled \$36.8 million for the two-year period ended September 30, 2009. DCH expended federal assistance under only the Temporary Assistance for Needy Families Program (*CFDA* 93.558), one of the four programs included in the cluster.

Our review of DCH's controls over compliance with eligibility requirements disclosed:

- a. DCH's internal control for monitoring each CMHSP did not provide DCH with reasonable assurance regarding each CMHSP's compliance with eligibility requirements.

DCH has separate agreements with each of the 46 CMHSPs, which make each CMHSP responsible for compliance with applicable federal and State laws. The agreements also make DCH responsible for monitoring each CMHSP to help ensure that each CMHSP complies with the terms of the agreement. DCH's internal control to assess the compliance of each CMHSP included monthly tests of a sample of eligibility determinations. The monthly sample was selected from a population of all eligibility cases from 5 CMHSPs.

DCH reviewed a total of 115 eligibility determinations during the current audit period, which equates to 2.5 eligibility determinations per CMHSP over the two-year period. For the 115 eligibility determinations reviewed by DCH during the audit period, DCH found that 36 (31%) were deficient. DCH's testing for some individual CMHSPs found deficiencies in 100% of the determinations. Deficiencies included missing documentation, such as Michigan income tax returns, birth certificates, and school documentation certifying the child's eligibility category and programming, and incomplete applications.

Reasonable assurance can be obtained with a test of a sufficient size, which depends on how confident DCH wishes to be of coming to the correct conclusion and the rate of compliance the tester requires. For example, if DCH wishes to be 90% confident that a CMHSP has properly determined and documented the eligibility of that CMHSP at least 95% of the time, it should test 47 eligibility determination files of the CMHSP. DCH might choose to be more or less than 90% confident and might require more or less compliance than 95%, which would impact test sizes.

However, DCH's internal control for monitoring CMHSP eligibility determinations needed improvement. DCH had not established guidelines to determine the amount of testing needed to ensure reasonable compliance for each individual CMHSP. During the two-year audit period for any of the 46 CMHSPs, the largest number of case files tested by DCH for a single CMHSP was 3. For example, during the two-year audit period, DCH tested only 2 recipients for eligibility determinations for a single CMHSP that had a monthly average of 1,156 monthly recipients. Without properly planned sample sizes for each CMHSP, DCH cannot obtain reasonable assurance regarding each CMHSP's compliance with applicable federal and State laws.

- b. DCH did not ensure that CMHSPs obtained accurate eligibility determination documentation from TANF applicants.

Federal regulation 45 *CFR* 263.2(b)(3) states that a family must be financially eligible according to the appropriate income and resource standards established by the state and contained in its TANF plan. Also, Section 330.1157 of the *Michigan Compiled Laws* requires verification that the taxable income for the family met eligibility requirements. *Michigan Administrative Code* R 330.1656 requires the applicant to submit a copy of the family's most recent Michigan income tax return to help ensure the applicant's compliance with eligibility requirements. If the applicant did not file a Michigan income tax return, DCH accepts other less authoritative documentation, such as a copy of the applicant's most recently filed federal income tax return, a recent check stub, or a signed handwritten note from the applicant attesting to no taxable income.

We reviewed 62 TANF applicant files and determined that 17 (27%) applicants provided income documentation other than a Michigan income tax return. However, DCH did not verify that the 17 TANF applicants did not file Michigan income tax returns. In 4 of the 17 cases, the eligibility determinations were based upon handwritten notes.

RECOMMENDATION

We recommend that DCH improve its internal control over the TANF Cluster to ensure compliance with federal laws and regulations regarding eligibility.

FINDING (3911012)

12. Children's Health Insurance Program, CFDA 93.767

U.S. Department of Health and Human Services	CFDA 93.767: Children's Health Insurance Program
Award Number: 05-0805MI5021 05-0905MI5021	Award Period: 10/01/2007 - 09/30/2008 10/01/2008 - 09/30/2009
	Known Questioned Costs: \$2,417

DCH's internal control over the Children's Health Insurance Program (CHIP) did not ensure compliance with federal laws and regulations regarding allowable costs/cost principles, eligibility, and subrecipient monitoring. Our review disclosed material weaknesses in internal control and material noncompliance with federal laws and regulations regarding allowable costs/cost principles and eligibility. As a result, we issued a qualified opinion on compliance with federal laws and regulations for CHIP. We also reported known questioned costs totaling \$2,417 and known and likely questioned costs* totaling \$68.9 million. Known and likely questioned costs were based on documentation provided to us by DCH during our audit fieldwork. However, it is possible that DCH could obtain additional documentation that would reduce the amount of known and likely questioned costs. Therefore, the financial risk to the State is indeterminable.

Noncompliance with federal laws and regulations could result in sanctions, disallowances, and/or future sanctions of CHIP awards.

CHIP initiates and expands health care coverage primarily to certain uninsured, low-income children and adults. CHIP consists of the Adult Benefits Waiver (ABW) Program, MIChild Program, Healthy Kids Medicaid Expansion (HKME), and Maternity Outpatient Medical Services (MOMS).

CHIP eligibility requirements are similar to Medicaid eligibility requirements. Services provided to CHIP beneficiaries under the ABW Program, HKME, and MOMS might be eligible for funding under Medicaid. However, DCH receives a higher (enhanced) funding rate from the federal government for CHIP beneficiaries as compared to the standard Medicaid funding rate. DCH charges expenditures to CHIP based on health care coverage costs attributed to the specific beneficiaries

* See glossary at end of report for definition.

identified by DCH as meeting the ABW Program, MICHild Program, HKME, or MOMS requirements. DCH relies on DHS, a subrecipient, to determine eligibility for ABW Program and HKME populations.

During the audit period, DCH expended federal funds totaling \$365.5 million to provide monthly health care coverage to approximately 47,000 children and 63,000 adults. During the audit period, DCH expended federal funds totaling \$253.7 million for the ABW Program, \$60.4 million for the MICHild Program, \$30.5 million for MOMS, and \$19.7 million for HKME.

Our exceptions, by compliance area, are as follows:

a. Allowable Costs/Cost Principles

DCH's internal control did not prevent noncompliance with allowable costs/cost principles. We identified questioned costs totaling \$716 (see Findings 15 and 19 and related recommendations).

b. Eligibility

DCH's internal control did not ensure compliance with federal laws and regulations relating to beneficiary eligibility for CHIP services and did not evaluate the sufficiency of third party service organization (TPSO) internal control assurance audits.

Our review of DCH's beneficiary eligibility determination efforts disclosed:

- (1) DCH's internal control did not ensure compliance with federal laws and regulations relating to eligibility of beneficiaries.

Title XXI of the Social Security Act, enacted in 1997 by the Balanced Budget Act, authorizes federal grants to states for provision of child health assistance to uninsured, low-income children. Within broad federal rules, each state decides who can be eligible, the types and ranges of services that can be provided, and the payment levels for benefit coverage and develops administrative and operating procedures.

DCH has developed policies and procedures to establish eligibility requirements. DHS, through an interagency agreement, is responsible for determining client eligibility for the ABW Program and HKME in

accordance with eligibility requirements defined in jointly approved DCH and DHS policies.

To ensure that individuals meet requirements for CHIP, federal regulation 42 *CFR* 457.965 requires DCH to maintain case file documentation to support the agency's decision on eligibility, such as a signed request for assistance application (DHS-1171). If case file documentation is not maintained, DCH cannot demonstrate that it is in compliance with established eligibility policies and procedures and, therefore, DCH cannot ensure that payments were made on behalf of eligible individuals.

To support our conclusion regarding DCH's compliance with federal eligibility requirements, we selected a sample of 87 case files. DCH could not locate 3 (3%) of the 87 case files. Our review of the remaining 84 case files noted that DCH and DHS did not maintain documentation, such as a written application requesting services, for 23 (27%) of the CHIP case files. DCH expenditures for the 87 cases totaled \$17,755, and DCH expenditures relating to the 3 missing files and 23 case files missing documentation for our sampled dates of service totaled \$3,359 (19%). We reported the federal share of these amounts as known questioned costs of \$2,417 and known and likely questioned costs totaling \$68.9 million. Known and likely questioned costs were based on documentation provided to us by DCH during our audit fieldwork. However, it is possible that DCH could obtain additional documentation that would reduce the amount of known and likely questioned costs. Therefore, the financial risk to the State is indeterminable.

- (2) DCH did not evaluate the sufficiency of its TPSO internal control assurance audits for CHIP. As a result, DCH cannot ensure that the TPSO established effective internal control over CHIP transactions and services provided on behalf of DCH.

DCH contracts with a TPSO to make a preliminary eligibility determination for the MICHild Program. Preliminary eligibility determinations for the program include verification that the applicant is not currently on Medicaid; review of the reported income; and review of the applicant's residency, citizenship, and social security number for eligibility. The service provider processes the applicant data in the software system and

makes the preliminary eligibility determination (see Finding 3 and related recommendation).

c. Subrecipient Monitoring

DCH did not monitor DHS's eligibility determinations for the ABW Program or HKME and did not ensure that it obtained complete and accurate information from DHS regarding beneficiaries who are eligible for HKME.

OMB Circular A-133 requires DCH to monitor its subrecipients' compliance with program requirements and applicable laws and regulations. Effective monitoring of subrecipients by DCH can be accomplished by various methods, depending on the nature and timing of the compliance requirement.

Our review of DCH's monitoring of DHS disclosed:

- (1) DCH did not monitor DHS's eligibility determinations for the ABW Program or HKME. Also, although DCH's interagency agreement with DHS provided for DHS to make eligibility determinations for HKME, the interagency agreement did not specify DHS's responsibilities for making eligibility determinations for the ABW Program. The agreement also did not specify the federal and other requirements with which DCH expects DHS to comply. In addition, the agreement did not specify that DHS must allow DCH to monitor DHS's compliance with the agreement.

Specifying compliance requirements, monitoring rights, and sanctions for noncompliance within the agreement would help DCH ensure that subrecipients comply with federal and other requirements.

We noted a similar condition in our two prior Single Audits. DCH stated in its corrective action plan in the prior Single Audit that it would develop a crosswalk for selected items in the interagency agreement to DHS's Program Eligibility Manual. DCH has subsequently stated that, during the audit period, its staff began reviewing the interagency agreement to identify possible changes needed. DCH stated that it was not able to complete the review because of its need to allocate staff resources to its transition to the Community Health Automated Medicaid Processing System (CHAMPS), implementation of DHS's Bridges eligibility

determination system, and efforts regarding the American Recovery and Reinvestment Act (ARRA).

- (2) DCH did not verify that the amount of HKME expenditures, which was based on DHS-determined HKME beneficiary data, was complete and accurate.

DCH was to obtain reimbursement from the federal government based on actual HKME expenditures. As of April 2010, DCH has not performed an analysis to determine the accuracy of the number of federal HKME-eligible beneficiaries determined by DHS and associated federal HKME expenditures. DCH informed us that its transition to the new information system (CHAMPS) has kept DCH from performing this type of assessment.

We noted a similar condition in our prior Single Audit. DCH stated in its corrective action plan in the prior Single Audit that DHS's new eligibility determination system (Bridges Integrated Automated Eligibility Determination System*) would improve its ability to systematically identify children who qualify for HKME. During the current audit period, DCH did not perform an analysis to determine the accuracy of the number of HKME beneficiaries because of DCH's transition to CHAMPS.

RECOMMENDATIONS

We recommend that DCH improve its internal control over CHIP to ensure compliance with federal laws and regulations regarding allowable costs/cost principles and eligibility.

FOR THE THIRD CONSECUTIVE AUDIT, WE RECOMMEND THAT DCH IMPROVE ITS INTERNAL CONTROL OVER CHIP TO ENSURE COMPLIANCE WITH FEDERAL LAWS AND REGULATIONS REGARDING SUBRECIPIENT MONITORING.

* See glossary at end of report for definition.

FINDING (3911013)

13. Medicaid Cluster, CFDA 93.777 and 93.778, Eligibility

U.S. Department of Health and Human Services	Medicaid Cluster: CFDA 93.777: State Survey and Certification of Health Care Providers and Suppliers CFDA 93.778: Medical Assistance Program CFDA 93.778: ARRA - Medical Assistance Program
Award Number: 05-0605MI5028 05-0705MI5028 05-0805MI5028 05-0905MI5028 05-0605MI5048 05-0705MI5048 05-0805MI5048 05-0905MI5048 05-0905MIARRA	Award Period: 10/01/2005 - 09/30/2006 10/01/2006 - 09/30/2007 10/01/2007 - 09/30/2008 10/01/2008 - 09/30/2009 10/01/2005 - 09/30/2006 10/01/2006 - 09/30/2007 10/01/2007 - 09/30/2008 10/01/2008 - 09/30/2009 10/01/2008 - 09/30/2009
	Known Questioned Costs: \$8,276

DCH's internal control over the Medicaid Cluster did not ensure compliance with federal laws and regulations regarding eligibility. Because of the significant deficiencies in internal control and the noncompliance noted in this finding, in Findings 14 through 31, and in Finding 35 were collectively material to the Medicaid Cluster, we issued an adverse opinion on compliance with federal laws and regulations for the Medicaid Cluster.

Internal control that does not ensure compliance with federal laws and regulations could result in sanctions, disallowances, and/or future reductions of Medicaid Cluster awards.

Federal expenditures for the Medicaid Cluster totaled \$13.7 billion for the two-year period ended September 30, 2009.

Title XIX of the Social Security Act, enacted in 1965, authorizes federal grants to states for medical assistance to low-income persons who are age 65 or over, blind, disabled, or members of families with dependent children or qualified pregnant women or children. Within broad federal rules, each state decides Medicaid-eligible groups, types and range of services, payment levels for services, and administrative and operating procedures. DCH has developed policies and

procedures to establish eligibility requirements for these eligible groups. DCH has an interagency agreement with DHS, which contains the specific responsibilities of each agency. DHS is responsible for determining client eligibility in accordance with eligibility requirements defined in jointly approved DCH and DHS policies.

In addition to determining eligibility in accordance with developed policies and procedures, federal regulation 42 *CFR* 435.913 requires that case file documentation be maintained to support the eligibility decision, such as a signed request for assistance application (DHS-1171). If case file documentation is not maintained, DCH cannot demonstrate that it is in compliance with established eligibility policies and procedures and, therefore, DCH cannot ensure that payments were made on behalf of eligible individuals.

DCH did not ensure or demonstrate compliance with federal laws and regulations relating to beneficiary eligibility for Medicaid services. Eligibility documentation, such as a written application requesting services, for 7 (17%) of 41 Medicaid case files reviewed was not maintained by DCH and/or DHS. Expenditures for the 41 cases reviewed totaled \$72,600. Expenditures related to the 7 case files, for our sampled dates of service, totaled \$14,188 (20%). We reported the federal share of these amounts as known questioned costs that totaled \$8,276 and known and likely questioned costs totaling \$2.7 billion. Known and likely questioned costs were based on documentation provided to us by DCH during our audit fieldwork. However, it is possible that DCH could obtain additional documentation that would reduce the amount of known and likely questioned costs. Therefore, the financial risk to the State is indeterminable.

RECOMMENDATION

We recommend that DCH improve its internal control over the Medicaid Cluster to ensure compliance with federal laws and regulations regarding eligibility.

FINDING (3911014)

14. Medicaid Cluster, CFDA 93.777 and 93.778, Special Tests and Provisions - Provider Agreements and Certifications

U.S. Department of Health and Human Services	Medicaid Cluster: CFDA 93.777: State Survey and Certification of Health Care Providers and Suppliers CFDA 93.778: Medical Assistance Program CFDA 93.778: ARRA - Medical Assistance Program
Award Number: 05-0605MI5028 05-0705MI5028 05-0805MI5028 05-0905MI5028 05-0605MI5048 05-0705MI5048 05-0805MI5048 05-0905MI5048 05-0905MIARRA	Award Period: 10/01/2005 - 09/30/2006 10/01/2006 - 09/30/2007 10/01/2007 - 09/30/2008 10/01/2008 - 09/30/2009 10/01/2005 - 09/30/2006 10/01/2006 - 09/30/2007 10/01/2007 - 09/30/2008 10/01/2008 - 09/30/2009 10/01/2008 - 09/30/2009
	Known Questioned Costs: \$354,473,800

DCH did not ensure compliance with federal laws and regulations regarding special tests and provisions pertaining to provider agreements with Medicaid's Adult Home Help (AHH) Program providers and Medicaid-funded disproportionate share hospital (DSH) payments for a State psychiatric hospital.

Noncompliance with federal laws and regulations could result in sanctions, disallowances, and/or future reductions of Medicaid Cluster awards.

Section 1902(a)(27) of the Social Security Act requires that states provide for agreements with every person or institution providing services under the state plan. DCH's Medicaid State Plan states that these requirements have been met. Also, the memorandum of understanding between DCH and DHS related to the AHH Program states that DCH will ensure that each provider of home help services enters into a provider agreement that meets State and federal requirements. In addition, federal regulation 42 *CFR* 482.1(a)(5) requires that hospitals obtain Centers for Medicare and Medicaid Services (CMS) certification to qualify for Medicaid payments.

Federal expenditures for the Medicaid Cluster totaled \$13.7 billion for the two-year period ended September 30, 2009. We reported known questioned costs totaling \$354,473,800.

Our review of the Medicaid Cluster relating to provider agreements and hospital certification during the audit period disclosed:

- a. DCH did not require or enter into provider agreements with AHH Program providers during the audit period. As a result, we reported known questioned costs totaling \$308,428,900.

The AHH Program paid \$502.3 million to approximately 61,550 providers during the audit period to provide personal care services, such as assistance with eating, bathing, medication, and housework, to approximately 69,690 Medicaid-eligible beneficiaries who were blind, disabled, or otherwise functionally disabled. These personal care services helped enable beneficiaries to live independently. As the designated Medicaid Single State Agency, DCH is responsible for the overall administration and supervision of the Medicaid Cluster, including the AHH Program. DCH entered into a memorandum of understanding with DHS, making DHS responsible for certain administrative functions such as case management, assessment of need, determination of service plan, and determination of AHH Program eligibility and verification of provider qualifications.

- b. DCH made Medicaid-funded DSH payments of \$77.9 million to the Center for Forensic Psychiatry (CFP) during our audit period. However, unlike other State psychiatric hospitals, CFP had not received the required CMS certification. As a result, we identified the federal portion of these payments as known questioned costs that totaled \$46,044,900.

We noted the same condition in our two prior Single Audits. In its corrective action plan for both prior Single Audits, DCH disagreed that it made ineligible DSH payments to CFP. DCH stated that it has consistently been DCH's position that federal requirements give the State substantial discretion in establishing criteria for DSH eligibility and that CFP qualified for DSH funding under the federal requirements.

Because CFP had not obtained the required certification, DCH needs to obtain clarification and resolution from the federal government regarding eligibility for Medicaid-funded DSH payments for CFP.

RECOMMENDATIONS

We recommend that DCH ensure compliance with federal laws and regulations for the Medicaid Cluster special tests and provisions requirements pertaining to provider agreements with Medicaid's AHH Program providers.

FOR THE THIRD CONSECUTIVE AUDIT, WE RECOMMEND THAT DCH ENSURE COMPLIANCE WITH FEDERAL LAWS AND REGULATIONS REGARDING SPECIAL TESTS AND PROVISIONS PERTAINING TO DSH PAYMENTS FOR STATE PSYCHIATRIC HOSPITALS.

WE ALSO AGAIN RECOMMEND THAT DCH OBTAIN CLARIFICATION AND RESOLUTION FROM THE FEDERAL GOVERNMENT REGARDING ELIGIBILITY FOR MEDICAID-FUNDED DSH PAYMENTS FOR CFP.

FINDING (3911015)

15. Medicaid Cluster, CFDA 93.777 and 93.778, Allowable Costs/Cost Principles - Allowability of Medical Services

U.S. Department of Health and Human Services	CFDA 93.767: Children's Health Insurance Program
Award Number: 05-0805MI5021 05-0905MI5021	Award Period: 10/01/2007 - 09/30/2008 10/01/2008 - 09/30/2009
	Known Questioned Costs: \$716

U.S. Department of Health and Human Services	Medicaid Cluster: <i>CFDA 93.777: State Survey and Certification of Health Care Providers and Suppliers</i> <i>CFDA 93.778: Medical Assistance Program</i> <i>CFDA 93.778: ARRA - Medical Assistance Program</i>
Award Number: 05-0605MI5028 05-0705MI5028 05-0805MI5028 05-0905MI5028 05-0605MI5048 05-0705MI5048 05-0805MI5048 05-0905MI5048 05-0905MIARRA	Award Period: 10/01/2005 - 09/30/2006 10/01/2006 - 09/30/2007 10/01/2007 - 09/30/2008 10/01/2008 - 09/30/2009 10/01/2005 - 09/30/2006 10/01/2006 - 09/30/2007 10/01/2007 - 09/30/2008 10/01/2008 - 09/30/2009 10/01/2008 - 09/30/2009
	Known Questioned Costs: \$12,129

U.S. Department of Health and Human Services	<i>CFDA 93.994: Maternal and Child Health Services Block Grant to the States</i>
Award Number: 6 B04MC07777-01-06 1 B04MC08892-01-00 6 B04MC08892-01-01 6 B04MC08892-01-02 6 B04MC08892-01-03 6 B04MC08892-01-04 6 B04MC08892-01-05 1 B04MC11171-01-00 6 B04MC11171-01-01	Award Period: 10/01/2006 - 09/30/2008 10/01/2007 - 09/30/2009 10/01/2007 - 09/30/2009 10/01/2007 - 09/30/2009 10/01/2007 - 09/30/2009 10/01/2007 - 09/30/2009 10/01/2007 - 09/30/2009 10/01/2008 - 09/30/2010 10/01/2008 - 09/30/2010
	Known Questioned Costs: \$73

DCH's internal control over the Children's Health Insurance Program (CHIP), Medicaid Cluster, and Maternal and Child Health Services Block Grant to the States (MCH Block Grant) Program did not ensure compliance with federal laws and regulations regarding allowable costs/cost principles.

Internal control that does not ensure compliance with federal laws and regulations could result in sanctions, disallowances, and/or future reductions of federal awards.

Appendix A, section C(1)(j) of OMB Circular A-87 (federal regulation 2 *CFR* 225) requires that costs charged to a federal program be supported by adequate documentation.

We reviewed 141 payments across three federal programs: CHIP, the Medicaid Cluster, and the MCH Block Grant Program. Our review disclosed:

- a. Seventeen (35%) of 48 CHIP payments were not properly supported. Specifically, we identified 5 (10%) payments for which there was no supporting documentation and 12 (25%) payments for which there was not adequate supporting documentation. In addition, according to the supporting documentation that was provided for 4 (8%) payments, the services provided were not medically necessary. We reported the federal share of these exceptions as known questioned costs that totaled \$716 and known and likely questioned costs totaling \$19.7 million. Known and likely questioned costs were based on documentation provided to us by DCH during our audit fieldwork. However, it is possible that DCH could obtain additional documentation that would reduce the amount of known and likely questioned costs. Therefore, the financial risk to the State is indeterminable.

In addition, we sent confirmations to the applicable CHIP beneficiaries for 35 of the 48 sampled medical services. Of the 10 responses received, 2 (20%) CHIP beneficiaries indicated that they did not receive the medical service. We subsequently determined that records were inadequate to support the services provided to 1 of the 2 beneficiaries. CHIP paid for the beneficiary's prescription drugs; however, DCH's records did not indicate the pharmacy that dispensed the prescription drugs.

- b. Thirteen (16%) of 83 Medicaid payments were not properly supported. Specifically, we identified 3 (4%) payments for which there was no supporting documentation and 9 (11%) payments for which there was not adequate supporting documentation. In addition, according to the supporting documentation provided for 3 (4%) payments, the services provided were not medically necessary. We reported the federal share of these exceptions as known questioned costs that totaled \$12,129 and known and likely questioned costs totaling \$1.0 billion. Known and likely questioned costs were based on documentation provided to us by DCH during our audit fieldwork. However, it is possible that DCH could obtain additional documentation that would reduce the amount of known and likely questioned costs. Therefore, the financial risk to the State is indeterminable.

In addition, we sent confirmations to the applicable Medicaid beneficiary for 52 of the 83 sampled medical services. Of the 24 responses received, 2 (8%) Medicaid beneficiaries indicated, respectively, that he/she did not receive the service paid by Medicaid and that he/she received the service but not by the provider indicated by DCH records. In the first instance, we subsequently determined that provider records did not exist for the medical service. Medicaid paid for the beneficiary's prescription drugs; however, the prescribing provider indicated that the beneficiary was not a patient. In the second instance, we subsequently determined that provider records were inadequate to support the services provided. DCH's records indicated that Medicaid paid a provider for a beneficiary's vision care, but the provider indicated that the beneficiary was not a patient.

- c. One (10%) of 10 MCH Block Grant payments was not properly supported by adequate documentation for the payment. We reported the federal share of these exceptions as known questioned costs that totaled \$73 and known and likely questioned costs totaling \$464,800. Known and likely questioned costs were based on documentation provided to us by DCH during our audit fieldwork. However, it is possible that DCH could obtain additional documentation that would reduce the amount of known and likely questioned costs. Therefore, the financial risk to the State is indeterminable.

Without adequate supporting documentation, DCH cannot ensure that it made CHIP, Medicaid Cluster, and MCH Block Grant Program payments for allowable costs.

RECOMMENDATION

We recommend that DCH improve its internal control over CHIP, the Medicaid Cluster, and the MCH Block Grant Program to ensure compliance with federal laws and regulations regarding allowable costs/cost principles.

FINDING (3911016)

16. Medicaid Cluster, CFDA 93.777 and 93.778, Allowable Costs/Cost Principles - ARRA Prompt Pay Requirements

U.S. Department of Health and Human Services	Medicaid Cluster: CFDA 93.777: State Survey and Certification of Health Care Providers and Suppliers CFDA 93.778: Medical Assistance Program CFDA 93.778: ARRA - Medical Assistance Program
Award Number: 05-0605MI5028 05-0705MI5028 05-0805MI5028 05-0905MI5028 05-0605MI5048 05-0705MI5048 05-0805MI5048 05-0905MI5048 05-0905MIARRA	Award Period: 10/01/2005 - 09/30/2006 10/01/2006 - 09/30/2007 10/01/2007 - 09/30/2008 10/01/2008 - 09/30/2009 10/01/2005 - 09/30/2006 10/01/2006 - 09/30/2007 10/01/2007 - 09/30/2008 10/01/2008 - 09/30/2009 10/01/2008 - 09/30/2009
	Known Questioned Costs: \$4,957,725

DCH's internal control over the Medicaid Cluster did not ensure compliance with federal laws and regulations regarding allowable costs/cost principles.

Internal control that does not ensure compliance with federal laws and regulations could result in sanctions, disallowances, and/or future reductions of Medicaid Cluster awards.

Section 5001 of the American Recovery and Reinvestment Act of 2009 (ARRA) provides eligible states an increase in their respective federal medical assistance percentage (FMAP), which determines the amount of federal funds available to states for Medicaid expenditures. For fiscal year 2008-09, the normal FMAP was 60.27% of eligible Medicaid expenditures and the increased FMAP was 70.68% of eligible ARRA Medicaid expenditures.

Section 5001(f)(2) of the ARRA provides that increased FMAP is not available for any claim received by a state from a practitioner for such days during any period in which the state has failed to pay claims in accordance with the timely processing of claims standards as referenced at Section 1902(a)(37) of the Social Security Act. This section of the Social Security Act requires states to pay or reject 90% of

claims processed within 30 days and to pay or reject 99% of claims processed within 90 days.

DCH developed, but did not officially implement, a reporting system that would enable DCH to monitor its compliance with the ARRA prompt pay requirements. DCH indicated that reports that DCH provided to us for our review were from a period of time sampled by DCH and were in draft form. However, DCH also stated that it was comfortable with the accuracy of the reports.

During our review of the reports of DCH's sample period of time, DCH determined that it did not meet the "99% of claims processed within 90 days" requirement for 12 (86%) of 14 days during April 2009. Based on these results, DCH was not in compliance with prompt pay requirements for 12 days during the audit period and was not eligible for increased FMAP for any of the 12 days.

We estimate that, over DCH's sample period of time, DCH was not eligible to receive \$4,957,725 of increased FMAP because of noncompliance with ARRA prompt pay requirements. As a result, we reported known questioned costs totaling \$4,957,725. For the entire audit period for which prompt pay requirements were in effect, DCH received a total of \$102.0 million of increased FMAP. With an 86% error rate, known and likely questioned costs totaled \$87.5 million.

RECOMMENDATION

We recommend that DCH improve its internal control over the Medicaid Cluster to ensure compliance with federal laws and regulations regarding allowable costs/cost principles.

FINDING (3911017)

17. Medicaid Cluster, CFDA 93.777 and 93.778, Allowable Costs/Cost Principles - Improper Payments

U.S. Department of Health and Human Services	Medicaid Cluster: CFDA 93.777: State Survey and Certification of Health Care Providers and Suppliers CFDA 93.778: Medical Assistance Program CFDA 93.778: ARRA - Medical Assistance Program
Award Number: 05-0605MI5028 05-0705MI5028 05-0805MI5028 05-0905MI5028 05-0605MI5048 05-0705MI5048 05-0805MI5048 05-0905MI5048 05-0905MIARRA	Award Period: 10/01/2005 - 09/30/2006 10/01/2006 - 09/30/2007 10/01/2007 - 09/30/2008 10/01/2008 - 09/30/2009 10/01/2005 - 09/30/2006 10/01/2006 - 09/30/2007 10/01/2007 - 09/30/2008 10/01/2008 - 09/30/2009 10/01/2008 - 09/30/2009
	Known Questioned Costs: \$329,581

DCH's internal control over the Medicaid Cluster did not ensure compliance with federal laws and regulations regarding allowable costs/cost principles.

Internal control that does not ensure compliance with federal laws and regulations could result in sanctions, disallowances, and/or future reductions of Medicaid Cluster awards.

Section 1902 of the Social Security Act requires each state to develop a plan that describes the nature and scope of the Medicaid Program. DCH's Medicaid State Plan specifies that AHH Program services are provided to address the physical assistance needs and to enable individuals to remain in their home by avoiding or delaying the need for long-term care services. The Medicaid State Plan also specifies that AHH Program services are to be furnished to individuals who are not currently residing in a hospital, nursing facility, intermediate care facility for persons with developmental disabilities, or institutions for mental illness.

The Medicaid State Plan requires that Medicaid providers and beneficiaries meet certain eligibility requirements in order to provide and receive medical services. Appendix A, section C of OMB Circular A-87 (federal regulation 2 *CFR* 225)

requires costs charged to federal programs to be reasonable in nature and amount, which includes restraints or requirements imposed by laws and regulations, sound business practices, and terms and conditions of the federal award. Reasonable costs include costs made to and on behalf of eligible Medicaid providers and beneficiaries, respectively.

Our review of Medicaid expenditures disclosed:

- a. DCH did not establish controls to verify that each AHH Program beneficiary continued to be Medicaid eligible prior to Medicaid payments on their behalf. As a result, DCH improperly paid \$2,033,571 (\$835,502 General fund/general purpose) during our audit period on behalf of 2,862 Medicaid AHH Program beneficiaries who were not Medicaid-eligible according to DCH's Medicaid eligibility database file. We reported known questioned costs totaling \$1,198,069, which are questioned in Finding 14.
- b. DCH did not establish controls to prevent or detect and correct payments to providers who were deceased prior to the date the medical service was provided. As a result, DCH improperly paid \$299,057 (\$122,060 General Fund/general purpose) during our audit period to 158 Medicaid providers who were deceased prior to the date the medical service was provided. Also, DCH improperly paid providers \$706,617 (\$288,406 General Fund/general purpose) during our audit period on behalf of 1,705 deceased Medicaid beneficiaries. Subsequent to our identification of these improper payments, DCH stated that it had recovered \$193,954 (\$79,162 General Fund/general purpose) from providers. We reported known questioned costs of \$480,416 and known and likely questioned costs of \$2,119,030, of which \$150,835 are questioned in Finding 14.
- c. DCH improperly issued Medicaid AHH Program payments on behalf of individuals who were currently residing in a long-term care facility or inpatient hospital setting. Our analysis showed that DCH issued AHH Program payments of \$791,664 during the audit period for a total of 60,056 days on behalf of 4,353 individuals who were currently residing in a long-term care facility or inpatient hospital setting. For example, DCH paid \$8,888 for AHH Program services over a consecutive 12-month period on behalf of a single individual, although DCH also paid for the individual's residence at a long-term care facility for the same time period. As a result, we reported the federal

share of these expenditures as known questioned costs totaling \$468,546 (\$323,118 General Fund/general purpose), which are questioned in Finding 14.

RECOMMENDATIONS

We recommend that DCH improve its internal over the Medicaid Cluster to ensure compliance with federal laws and regulations regarding allowable costs/cost principles.

We also recommend that DCH continue its efforts to recover improper payments from providers.

FINDING (3911018)

18. Medicaid Cluster, CFDA 93.777 and 93.778, Allowable Costs/Cost Principles and Special Tests and Provisions - Managed Care

U.S. Department of Health and Human Services	Medicaid Cluster: <i>CFDA 93.777</i> : State Survey and Certification of Health Care Providers and Suppliers <i>CFDA 93.778</i> : Medical Assistance Program <i>CFDA 93.778</i> : ARRA - Medical Assistance Program
Award Number: 05-0605MI5028 05-0705MI5028 05-0805MI5028 05-0905MI5028 05-0605MI5048 05-0705MI5048 05-0805MI5048 05-0905MI5048 05-0905MIARRA	Award Period: 10/01/2005 - 09/30/2006 10/01/2006 - 09/30/2007 10/01/2007 - 09/30/2008 10/01/2008 - 09/30/2009 10/01/2005 - 09/30/2006 10/01/2006 - 09/30/2007 10/01/2007 - 09/30/2008 10/01/2008 - 09/30/2009 10/01/2008 - 09/30/2009
	Known Questioned Costs: \$0

DCH's internal control over the Medicaid Cluster did not ensure compliance with federal laws and regulations regarding allowable costs/cost principles and special tests and provisions pertaining to managed care.

Internal control that does not ensure compliance with federal laws and regulations could result in sanctions, disallowances, and/or future reductions of Medicaid Cluster awards.

Section 1115 of the Social Security Act allows a state to obtain a waiver of statutory requirements in order to develop a system that more effectively addresses the health care needs of its population, including programs of managed care. Federal regulation 42 *CFR* 438.66 requires that DCH have procedures for monitoring Medicaid health plans' (MHPs') operations. Appendix A, section C of OMB Circular A-87 (federal regulation 2 *CFR* 225) requires costs charged to federal programs to be reasonable in amount, which includes considering the restraints or requirements imposed by sound business practices. DCH pays MHPs a capitated amount, or rate, per month per eligible Medicaid beneficiary for the health care services that it provides to each enrolled Medicaid beneficiary, regardless of the frequency, extent, or kind of services provided to each Medicaid beneficiary. Federal regulation 42 *CFR* 438.6 requires that capitation rates be actuarially sound.

After obtaining a federal managed care waiver, DCH contracted with 14 MHPs to carry out DCH's managed care program and issued federally funded payments to the plans totaling \$4.1 billion during the two-year audit period. In accordance with these contracts, the MHPs have the responsibilities for ensuring compliance with federal laws and regulations.

The federal waiver and the MHP contracts stated that DCH would perform annual on-site reviews to evaluate MHP compliance for program integrity, information to beneficiaries, grievance, timely access, capacity, coordination and continuity of care, coverage and authorization, provider selection, and quality of care. DCH developed a monitoring tool consisting of 59 criteria to document its monitoring efforts of each MHP. The MHP contracts stated that DCH would establish findings of pass, incomplete, fail, or deemed status for each criteria included in the monitoring tool.

DCH contracted with an actuary to develop capitation rates that DCH used to pay MHPs for enrolled Medicaid beneficiaries. DCH received fee-for-service claim data from providers and encounter data from MHPs and stored the data in its Data Warehouse. DCH provided its actuary with the stored data so that the actuary could develop the capitation rates that DCH used to make capitated payments to

MHPs. DCH provided 58.4 million encounter data claims to its actuary and made Medicaid capitated payments of \$6.3 billion to 14 MHPs during the audit period.

Our review disclosed:

- a. In fiscal year 2008-09, DCH did not review 439 (53%) of 826 criteria contained within the monitoring tools for the 14 MHPs, including 1 MHP having 42 (71%) of 59 unreviewed criteria.

Also, for the fraud and abuse section of the monitoring tool, we noted that DCH's monitoring primarily consisted of reviews of reports electronically submitted by the MHPs. However, as stated in Finding 26, DCH's review did not include tests of details to ensure that reports were accurate. For example, DCH accepted profiling reports containing specific detailed analysis and outcomes to support the MHPs' compliance with utilization requirements. However, DCH did not review underlying support to verify that the reports were accurate.

- b. DCH stated that it ensured that the encounter data provided to the actuary was accurate by subjecting submitted encounter data to electronic edits and through its contractual requirement that MHPs provide DCH with a sample of encounter data and related medical records upon request. However, contrary to sound business practices, DCH did not request any records and, therefore, did not test encounter data that it provided to the actuary. As a result, DCH did not ensure that the data used by the actuary was accurate, that the capitation rates were actuarially sound, and, consequently, that the amounts paid to MHPs were reasonable in amount.

RECOMMENDATION

We recommend that DCH improve its internal control over the Medicaid Cluster to ensure compliance with federal laws and regulations regarding allowable costs/cost principles and special tests and provisions pertaining to managed care.

FINDING (3911019)

19. Medicaid Cluster, CFDA 93.777 and 93.778, Allowable Costs/Cost Principles - Pharmacy Payments and Rebates

U.S. Department of Health and Human Services	Medicaid Cluster: CFDA 93.777: State Survey and Certification of Health Care Providers and Suppliers CFDA 93.778: Medical Assistance Program CFDA 93.778: ARRA - Medical Assistance Program
Award Number: 05-0605MI5028 05-0705MI5028 05-0805MI5028 05-0905MI5028 05-0605MI5048 05-0705MI5048 05-0805MI5048 05-0905MI5048 05-0905MIARRA	Award Period: 10/01/2005 - 09/30/2006 10/01/2006 - 09/30/2007 10/01/2007 - 09/30/2008 10/01/2008 - 09/30/2009 10/01/2005 - 09/30/2006 10/01/2006 - 09/30/2007 10/01/2007 - 09/30/2008 10/01/2008 - 09/30/2009 10/01/2008 - 09/30/2009
	Known Questioned Costs: \$0

U.S. Department of Health and Human Services	CFDA 93.767: Children's Health Insurance Program
Award Number: 05-0805MI5021 05-0905MI5021	Award Period: 10/01/2007 - 09/30/2008 10/01/2008 - 09/30/2009
	Known Questioned Costs: \$0

U.S. Department of Health and Human Services	CFDA 93.994: Maternal and Child Health Services Block Grant to the States
Award Number: 6 B04MC07777-01-06 1 B04MC08892-01-00 6 B04MC08892-01-01 6 B04MC08892-01-02 6 B04MC08892-01-03 6 B04MC08892-01-04 6 B04MC08892-01-05 1 B04MC11171-01-00 6 B04MC11171-01-01	Award Period: 10/01/2006 - 09/30/2008 10/01/2007 - 09/30/2009 10/01/2007 - 09/30/2009 10/01/2007 - 09/30/2009 10/01/2007 - 09/30/2009 10/01/2007 - 09/30/2009 10/01/2007 - 09/30/2009 10/01/2008 - 09/30/2010 10/01/2008 - 09/30/2010
	Known Questioned Costs: \$0

DCH's internal control over the Medicaid Cluster, CHIP, and the MCH Block Grant Program related to payments to DCH's pharmacy benefits manager (PBM) did not

ensure compliance with federal laws and regulations regarding allowable costs/cost principles. Also, DCH's internal control over the Medicaid Cluster and CHIP related to pharmacy rebates did not ensure compliance with federal laws and regulations regarding allowable costs/cost principles.

Internal control that does not ensure compliance with federal laws and regulations could result in sanctions, disallowances, and/or future reductions of Medicaid Cluster, CHIP, and MCH Block Grant Program awards.

Appendix A, section C of OMB Circular A-87 (federal regulation 2 *CFR* 225) requires costs charged to federal programs to be reasonable in nature and amount, which includes restraints or requirements imposed by laws and regulations, sound business practices, and terms and conditions of the federal award. This section also requires that costs charged to a federal program be supported by adequate documentation.

Section 1927(a)(1) of the Social Security Act requires pharmaceutical companies to enter into rebate agreements with the federal government if the companies intend their drugs to be prescribed for beneficiaries of Medicaid and other programs. A rebate is payment to DCH by pharmaceutical companies for prescribed drugs provided to beneficiaries and paid for by the federal programs. Each specific drug has a specific rebate amount, which is agreed upon by the federal government and each pharmaceutical company. DCH's PBM reports which specific drugs were obtained by beneficiaries to the federal government and DCH. DCH stores the drug and beneficiary data in its Data Warehouse.

DCH contracted with its PBM to process pharmacy claims and issue payments to pharmacies. Payments to pharmacies totaled \$1.1 billion during the two-year audit period. The PBM billed DCH weekly and subsequently provided DCH with the underlying paid claims data to support the billings. To ensure that the amounts billed by the PBM were reasonable, DCH staff made reconciliation efforts, including queries of underlying paid claims files.

Also, DCH's PBM uses the agreed-upon rebate amount and drug and beneficiary data to invoice each pharmaceutical company on behalf of DCH for the rebates owed to DCH. Each pharmaceutical company subsequently remits payment to DCH. The documentation pertaining to the payment is provided to the PBM so that

the PBM can maintain control over amounts invoiced to and received from each pharmaceutical company.

DCH contracted with a pharmacy consultant, whose functions included quarterly reconciliations of pharmacy drug rebate amounts invoiced by DCH's PBM to pharmacy information contained in DCH's Data Warehouse. The reconciliations help ensure that the rebates invoiced by the PBM to drug manufacturers on behalf of DCH were reasonable. Medicaid and CHIP pharmacy rebates received by DCH totaled \$436.6 million for the two-year period ended September 30, 2009.

Our review of payments to the PBM and Medicaid pharmacy rebates disclosed:

- a. DCH policies did not require management to review or approve the query and resulting reconciliation of billed amounts to underlying claims data. Also, DCH policies did not require management to review or approve the pharmacy consultant's quarterly rebate reconciliation data queries or results.
- b. DCH did not store electronic data in a secure location.

The database that documented DCH's reconciliation of billed amounts to underlying claims data and contained confidential CMS rebate unit data and protected health information was stored in an unrestricted shared electronic directory. This allowed any of the nearly 500 users to obtain this confidential information or alter the database at any time without any accountability for such alterations.

- c. DCH did not ensure that the electronic drug volume data used to calculate drug rebate amounts was reliable.

We used DCH's reconciliation methodology to verify the drug volume information contained in DCH's pharmacy rebate reconciliations for three quarters in the audit period. Our reconciliations of drug volumes differed from DCH's reconciliations by 5.1%, 10.2%, and 12.3%. When compared to DCH's quarterly drug rebate amounts, we estimate that these drug volume differences equate to \$2.9 million, \$5.3 million, and \$6.7 million, respectively. DCH was unable to provide us with explanations for the differences.

RECOMMENDATIONS

We recommend that DCH improve its internal control over the Medicaid Cluster, CHIP, and the MCH Block Grant Program related to payments to DCH's PBM to ensure compliance with federal laws and regulations regarding allowable costs/cost principles.

We also recommend that DCH improve its internal control over the Medicaid Cluster and CHIP related to pharmacy rebates to ensure compliance with federal laws and regulations regarding allowable costs/cost principles.

FINDING (3911020)

20. Medicaid Cluster, CFDA 93.777 and 93.778, Allowable Costs/Cost Principles - Medicare Part A and Part B

U.S. Department of Health and Human Services	Medicaid Cluster: CFDA 93.777: State Survey and Certification of Health Care Providers and Suppliers CFDA 93.778: Medical Assistance Program CFDA 93.778: ARRA - Medical Assistance Program
Award Number: 05-0605MI5028 05-0705MI5028 05-0805MI5028 05-0905MI5028 05-0605MI5048 05-0705MI5048 05-0805MI5048 05-0905MI5048 05-0905MIARRA	Award Period: 10/01/2005 - 09/30/2006 10/01/2006 - 09/30/2007 10/01/2007 - 09/30/2008 10/01/2008 - 09/30/2009 10/01/2005 - 09/30/2006 10/01/2006 - 09/30/2007 10/01/2007 - 09/30/2008 10/01/2008 - 09/30/2009 10/01/2008 - 09/30/2009
	Known Questioned Costs: \$0

DCH's internal control over the Medicaid Cluster related to Medicare Part A and Part B payments did not ensure compliance with federal laws and regulations regarding allowable costs/cost principles.

Internal control that does not ensure compliance with federal laws and regulations could result in sanctions, disallowances, and/or future reductions of Medicaid Cluster awards.

Federal regulation 42 *CFR* 407.40 allows states to pay the Medicare health insurance premiums on behalf of persons who are eligible for both Medicare and Medicaid (dual eligible). Under this arrangement, Medicaid's cost per dual eligible person is limited to the Medicare insurance premium rather than the actual medical costs that may have been paid using Medicaid funding. The Medicare premium payments are an allowable cost for the Medicaid Program. In regard to Medicare Part A premiums, the amount of the payment for a beneficiary depends on the beneficiary's number of Medicare-covered quarters of employment.

CMS monthly matches its database of Medicare eligible persons against DCH's database of Medicaid-eligible persons to identify dual eligible beneficiaries. CMS then sends a database of matched dual eligible beneficiaries to DCH. DCH subsequently reviews the data for accuracy and uses the data to update its own database. CMS invoices DCH for the cost of the Medicare Part A and Part B premiums associated with dual eligible beneficiaries.

However, DCH did not ensure that invoices received from CMS for Medicare Part A and Part B premiums were reasonable. DCH did not reconcile or perform a test of reasonableness on the amount billed using the data in its own database. Although DCH reconciled CMS's database in terms of the number of dual eligible beneficiaries, DCH did not ensure the reasonableness of the CMS invoices by comparing the invoices to the underlying reconciled CMS and DCH data.

Medicaid expenditures for Medicare Part A premiums totaled \$166.3 million for the two-year period ended September 30, 2009 for approximately 16,400 eligible beneficiaries. Medicaid expenditures for Medicare Part B premiums totaled \$455.3 million for the two-year period ended September 30, 2009 for approximately 191,800 eligible beneficiaries.

We noted the same condition in our prior Single Audit. DCH stated in its corrective action plan in the prior Single Audit that it continues to investigate every beneficiary that does not match CMS's monthly file on an ongoing basis. DCH also stated that it now compares for reasonableness the CMS invoice to the beneficiary reconciliation and to the previous amounts billed by CMS on an ongoing basis. DCH indicated that it did not comply because DCH thought it had corrected the deficiency. However, after the fiscal year 2008-09 *State of Michigan Comprehensive Annual Financial Report (SOMCAFR)* audit, DCH concluded that additional procedures were necessary.

RECOMMENDATION

WE AGAIN RECOMMEND THAT DCH IMPROVE ITS INTERNAL CONTROL OVER THE MEDICAID CLUSTER RELATED TO MEDICARE PART A AND PART B PAYMENTS TO ENSURE COMPLIANCE WITH FEDERAL LAWS AND REGULATIONS REGARDING ALLOWABLE COSTS/COST PRINCIPLES.

FINDING (3911021)

21. Medicaid Cluster, CFDA 93.777 and 93.778, Allowable Costs/Cost Principles - Disproportionate Share Hospital (DSH) Pools

U.S. Department of Health and Human Services	Medicaid Cluster: CFDA 93.777: State Survey and Certification of Health Care Providers and Suppliers CFDA 93.778: Medical Assistance Program CFDA 93.778: ARRA - Medical Assistance Program
Award Number: 05-0605MI5028 05-0705MI5028 05-0805MI5028 05-0905MI5028 05-0605MI5048 05-0705MI5048 05-0805MI5048 05-0905MI5048 05-0905MIARRA	Award Period: 10/01/2005 - 09/30/2006 10/01/2006 - 09/30/2007 10/01/2007 - 09/30/2008 10/01/2008 - 09/30/2009 10/01/2005 - 09/30/2006 10/01/2006 - 09/30/2007 10/01/2007 - 09/30/2008 10/01/2008 - 09/30/2009 10/01/2008 - 09/30/2009
	Known Questioned Costs: \$0

DCH's internal control over the Medicaid Cluster related to the calculation of DSH payments to State psychiatric hospitals did not ensure compliance with federal laws and regulations regarding allowable costs/cost principles.

Internal control that does not ensure compliance with federal laws and regulations could result in sanctions, disallowances, and/or future reductions of Medicaid Cluster awards.

In the 1980s, Congress enacted changes to Medicaid that required states to increase the payments (DSH payments) made to hospitals serving a disproportionately high number of Medicaid-eligible or low-income uninsured patients. The Medicaid State Plan creates various DSH pools for these hospitals. The types of DSH pools include regular, small hospital, indigent care agreement

(ICA), managed care, indigent funds, Institute for Mental Disease, and government provider.

Federal regulations limit the amount of each hospital's DSH payments to the costs incurred by the hospital for individuals who either are eligible for medical assistance under the Medicaid State Plan or have no health insurance. To ensure that hospitals do not receive DSH payments in excess of this amount, DCH calculates an annual DSH ceiling amount for each DSH-eligible hospital. The DSH ceiling is the maximum share of DSH payments the DSH-eligible hospital can receive. To establish the DSH ceiling, DCH uses information from sources that include prior cost reports, collectibility factors, cost-to-charge ratios, and cost inflation information.

Appendix A, section C.1.j. of OMB Circular A-87 (federal regulation 2 *CFR* 225) requires that costs charged to a federal program be supported by adequate documentation.

During fiscal years 2007-08 and 2008-09, DCH claimed \$141.8 million and \$141.9 million, respectively, for the 5 hospitals in the State psychiatric hospital DSH pool. Our review disclosed:

- a. DCH could not support the collectibility factors used in State psychiatric hospital DSH calculations for fiscal years 2007-08 and 2008-09. A change in the collectibility factors could have changed the allocation of DSH payments to individual facilities.
- b. DCH did not include a collectibility factor in the calculation of the charge amounts used in the State psychiatric hospital DSH calculation for fiscal year 2008-09. Properly including a collectibility factor would have changed the allocation of DSH payments to an individual facility by as much as \$0.6 million.

Although these errors did not cause DCH to receive improper federal reimbursement, they did impact the allocation of DSH funds to the individual facilities.

We noted the same condition in our prior Single Audit. DCH stated in its corrective action plan in the prior Single Audit that it had implemented a procedure in February 2007 to help ensure the accurate calculation of DSH payments to State

psychiatric hospitals. DCH indicated that it did not comply with the condition because the prior audit dealt with DCH not including the ancillary costs and charges in its cost-to-charge ratio, which was fixed. However, DCH did not anticipate that there might be an issue with the collectibility factors.

RECOMMENDATION

WE AGAIN RECOMMEND THAT DCH IMPROVE ITS INTERNAL CONTROL OVER THE MEDICAID CLUSTER RELATED TO DSH PAYMENTS TO ENSURE COMPLIANCE WITH FEDERAL LAWS AND REGULATIONS REGARDING ALLOWABLE COSTS/COST PRINCIPLES.

FINDING (3911022)

22. Medicaid Cluster, CFDA 93.777 and 93.778, Allowable Costs/Cost Principles - Third Party Liabilities

U.S. Department of Health and Human Services	Medicaid Cluster: CFDA 93.777: State Survey and Certification of Health Care Providers and Suppliers CFDA 93.778: Medical Assistance Program CFDA 93.778: ARRA - Medical Assistance Program
Award Number: 05-0605MI5028 05-0705MI5028 05-0805MI5028 05-0905MI5028 05-0605MI5048 05-0705MI5048 05-0805MI5048 05-0905MI5048 05-0905MIARRA	Award Period: 10/01/2005 - 09/30/2006 10/01/2006 - 09/30/2007 10/01/2007 - 09/30/2008 10/01/2008 - 09/30/2009 10/01/2005 - 09/30/2006 10/01/2006 - 09/30/2007 10/01/2007 - 09/30/2008 10/01/2008 - 09/30/2009 10/01/2008 - 09/30/2009
	Known Questioned Costs: Undeterminable

DCH's internal control over the Medicaid Cluster related to third party liabilities did not ensure compliance with federal laws and regulations regarding allowable costs/cost principles.

Internal control that does not ensure compliance with federal laws and regulations could result in sanctions, disallowances, and/or future reductions of Medicaid Cluster awards.

Medicaid is required to be the payer of last resort for medical services provided to eligible beneficiaries. Medicaid should pay only after other third party sources, such as other health insurance companies or fathers of children not born to a marriage, have met their legal obligation to pay.

Federal regulation 42 *CFR* 433.138 requires DCH to develop a methodology for identifying third parties, determining the third party liabilities, and recovering reimbursement from third parties for services paid for under the Medicaid State Plan. Also, Section 722.712 of the *Michigan Compiled Laws* allows for the father of a child not born to a marriage to be charged for up to 100% of the mother's pregnancy and birthing-related Medicaid costs. In addition, Appendix A, section C of OMB Circular A-87 (federal regulation 2 *CFR* 225) requires costs to be net of all applicable credits.

DCH recovers some pregnancy and birthing-related Medicaid costs from fathers of children not born to a marriage through child support orders established by the DHS Office of Child Support. DCH receives requests for a mother's pregnancy and birthing-related Medicaid costs from, or on behalf of, the local prosecuting attorney (PA) or Friend of the Court (FOC) office responsible for establishing paternity and for seeking court-ordered child support. To complete the pregnancy and birthing-related cost requests, DCH has engaged a contractor to summarize the costs and to report these costs in both the Paternity Casualty Recovery System (PCRS) and on the cost requests. DCH stated that it reviews a certain percentage of the cost requests to ensure that the amounts are accurate. DCH subsequently returns the summarized costs for each request back to the PA or FOC office to include on the child support order.

Our review of DCH's internal control over recovering third party liabilities disclosed:

- a. DCH stated that it could not identify children not born to a marriage because DHS did not document the marital status of Medicaid beneficiaries. Although DCH's Medicaid Recipient Database was capable of storing the marital status data, DCH did not ensure that DHS obtained and entered the data into the Medicaid Recipient Database. Identifying children not born to a marriage is a critical first step in recovering reimbursements from liable fathers and in ensuring compliance with federal laws and regulations regarding allowable costs/cost principles pertaining to ensuring that costs are net of all applicable credits.

- b. DCH did not document the resolution of 40,791 cost requests received from, or on behalf of, PAs and FOCs and stored in PCRS as of September 30, 2009. Also, DCH did not document its review of the cost requests that its contractor completed or which cost requests DCH selected for review. Each cost request might result in a recovery from a father, depending, for example, on the father's ability to pay. However, because DCH did not document the resolution of the cost requests stored in PCRS and did not document its review of the cost requests, DCH did not ensure compliance with federal laws and regulations regarding allowable costs/cost principles pertaining to ensuring that costs are net of all applicable credits.
- c. DCH did not ensure that it reported pregnancy and birthing-related costs to the PA and FOC offices for all child support cases established by the DHS Office of Child Support.

Our comparison of the Judiciary's State Court Administrative Office reports with data stored in DCH's PCRS showed 28,925 Wayne County child support cases established by the Office of Child Support and 20,825 cost requests received, respectively. Each cost request might result in a recovery from a father. However, DCH did not identify which of the approximately 8,100 Wayne County child support cases filed might have Medicaid pregnancy and birthing-related costs to report to PA and FOC offices. As a result, for cases within the 8,100 cases that DCH did not identify as having Medicaid costs to report, DCH did not ensure compliance with federal laws and regulations regarding allowable costs/cost principles pertaining to ensuring that costs are net of all applicable credits.

- d. DCH did not include some pregnancy and birthing-related Medicaid costs, such as maternal support services costs, in its cost reports to the PA and FOC offices. According to DCH's PCRS, we noted that DCH reported pregnancy and birthing-related Medicaid costs of \$254.3 million to PA and FOC offices during our audit period, but it did not identify and report additional pregnancy and birthing-related Medicaid costs. As a result, DCH missed an opportunity to recover up to \$3.2 million of federal Medicaid costs (\$2.2 million General Fund/general purpose). Also as a result, DCH did not ensure compliance with federal laws and regulations regarding allowable costs/cost principles pertaining to ensuring that costs are net of all applicable credits.

We noted the same condition in our prior Single Audit. DCH stated in its corrective action plan in the prior Single Audit that by September 30, 2009 it had implemented corrective measures that include all pregnancy and birthing-related Medicaid costs for mothers with nonmarital births.

- e. DCH stated that it did not document either the dollar amount of pregnancy and birthing-related Medicaid costs that courts ordered fathers to repay or the amounts it recovered, in total or by father. As a result, DCH did not ensure compliance with federal laws and regulations regarding allowable costs/cost principles pertaining to ensuring that costs are net of all applicable credits.

RECOMMENDATION

WE AGAIN RECOMMEND THAT DCH IMPROVE ITS INTERNAL CONTROL OVER THE MEDICAID CLUSTER RELATED TO THIRD PARTY LIABILITIES TO ENSURE COMPLIANCE WITH FEDERAL LAWS AND REGULATIONS REGARDING ALLOWABLE COSTS/COST PRINCIPLES.

FINDING (3911023)

23. Medicaid Cluster, CFDA 93.777 and 93.778, Special Tests and Provisions - Sanctioned Providers

U.S. Department of Health and Human Services	Medicaid Cluster: CFDA 93.777: State Survey and Certification of Health Care Providers and Suppliers CFDA 93.778: Medical Assistance Program CFDA 93.778: ARRA - Medical Assistance Program
Award Number: 05-0605MI5028 05-0705MI5028 05-0805MI5028 05-0905MI5028 05-0605MI5048 05-0705MI5048 05-0805MI5048 05-0905MI5048 05-0905MIARRA	Award Period: 10/01/2005 - 09/30/2006 10/01/2006 - 09/30/2007 10/01/2007 - 09/30/2008 10/01/2008 - 09/30/2009 10/01/2005 - 09/30/2006 10/01/2006 - 09/30/2007 10/01/2007 - 09/30/2008 10/01/2008 - 09/30/2009 10/01/2008 - 09/30/2009
	Known Questioned Costs: \$0

DCH's internal control over the Medicaid Cluster did not ensure compliance with special tests and provisions pertaining to provider eligibility.

Internal control that does not ensure compliance with federal laws and regulations could result in sanctions, disallowances, and/or future reductions of Medicaid Cluster awards.

Federal regulation 42 *CFR* 1002.210 requires states to institute administrative procedures to exclude a provider for any reason for which the Office of Inspector General, U.S. Department of Health and Human Services (HHS), could exclude a provider under federal regulations 42 *CFR* 1001 and 42 *CFR* 1003. Michigan law specifies the actions, such as sanctions, that the DCH director may or shall take against Medicaid providers and the grounds for action.

Section 400.111d of the *Michigan Compiled Laws* grants the DCH director the authority to impose various levels of provider sanctions, including probation, suspension, or termination of participation, when a provider fails to conform to professionally accepted standards of medical practice or engages in billing practices that threaten the fiscal integrity of Medicaid. Also, Section 400.111f of the *Michigan Compiled Laws* identifies specific circumstances in which the DCH director is allowed to take emergency action to sanction a provider when the health, safety, or welfare of a beneficiary is at risk.

DCH's Medicaid Integrity Program Section is responsible for requirements established in federal regulations 42 *CFR* 455 and 42 *CFR* 456 pertaining to the establishment of a fraud detection and investigation program, as well as requirements to safeguard against unnecessary utilization of care and services and to ensure program integrity. One of DCH's primary means of identifying providers that should be sanctioned involves efforts by DCH's Medicaid Integrity Program Section, which performs audits of providers with high-risk factors, such as high Medicaid payment volumes, numerous or serious complaints, or referrals from other federal and State agencies. Also, the Medicaid Integrity Program Section reviews and oversees provider audits conducted by third party contractors (see Finding 26 and its related recommendation for our conclusions regarding DCH's efforts pertaining to utilization control and program integrity.)

DCH's Medicaid Integrity Program Section efforts contribute to the Sanctioned Providers List, which helps to track providers that are not authorized to participate

in Medicaid because of audits and investigations conducted by DCH and HHS. The list includes health professionals who had their licenses terminated or suspended by a state medical health board's disciplinary subcommittee (DSC) and health professionals who voluntarily surrendered their licenses because of DSC efforts.

Our review of DCH's processes for sanctioning providers and maintaining the Sanctioned Providers List disclosed:

- a. Although DCH has identified instances of inappropriate or questionable practices by Medicaid providers, DCH did not take appropriate actions to sanction these providers or document why the sanctioning of providers was not necessary.

During the audit period, Medicaid paid a total of 121,856 providers and the Medicaid Integrity Program Section conducted or oversaw 74 provider audits. We judgmentally selected 13 audits with high error rates or in which the Medicaid Integrity Program Section recommended a large dollar recovery and assessed the reasonableness of DCH's actions to protect Medicaid beneficiaries' health, safety, and welfare and the fiscal integrity of Medicaid. Our review disclosed:

- (1) DCH did not take action as allowed or required by State law against providers that threatened beneficiaries' health or submitted improper claims. Section 400.111e, subparts (2), (3), and (5), and Section 400.111f of the *Michigan Compiled Laws* identify specific circumstances in which the DCH director is allowed or required to take action or emergency action to sanction a provider. For example, we noted:
 - (a) DCH's analysts identified 1 of the 13 providers as a threat to beneficiaries' health, safety, and welfare. Also, for 5 additional providers, DCH's analysts questioned the medical necessity for services billed or indicated that the beneficiary received substandard care. However, DCH did not sanction any of these providers and did not document why sanctions were not necessary.

State law allows the DCH director to sanction providers that submit claims for services, supplies, or equipment that are not documented

in the recipient's medical record in the prescribed manner, that are medically inappropriate or medically unnecessary, and that are below the acceptable medical treatment standards.

- (b) DCH's analysts were unable to determine from the records of 3 of the 13 providers which beneficiaries received medical services. Also, for 1 provider, DCH's audit identified instances in which the provider of record did not bill under its own provider identification and the provider had been previously reminded of the requirement. However, DCH did not sanction any of these providers and did not document why sanctions were not necessary.

State law requires the DCH director to sanction providers that misrepresent the identity of the recipient or identity of the actual provider after receiving notice from DCH.

- (c) DCH's analysts identified 1 of the 13 providers that billed Medicaid and another source for the same service. However, DCH did not sanction the provider and did not document why sanctions were not necessary.

State law requires the DCH director to sanction providers that receive reimbursement from any other source after receiving Medicaid payment if the provider did not refund the appropriate portion of the Medicaid payment to DCH.

- (d) DCH's audits of providers' claims indicated that 2 of the 13 providers did not substantiate that services were actually provided. Specifically, for 1 provider, the audit report stated that x-rays taken after the claim's date of service did not show evidence that the beneficiary received the service. For the other provider, the analyst stated that the provider appeared to have upcoded (overcharged) the billings for the majority of services reviewed in the audit. However, DCH did not sanction either of these providers and did not document why sanctions were not necessary.

State law requires the DCH director to sanction providers that submit claims for services, supplies, or equipment that were not provided to a recipient.

We noted a similar condition in our prior Single Audit. Specifically, the prior Single Audit identified one provider that was deemed to have violated State laws during the prior audit period. However, after we issued the prior report, DCH continued to allow that provider to participate in Medicaid for the current audit period. DCH stated in its corrective action plan in the prior Single Audit that by September 30, 2009 it would review its policies and procedures, and make any changes if necessary, to help ensure that the Sanctioned Providers List included the National Provider identification number associated with a sanctioned health professional. DCH also stated that it would investigate the situation noted in the finding and initiate action, if appropriate, to disenroll the provider and its business(es) from the Medicaid Program.

DCH's records disclosed that the provider had a significant history of health, safety, and welfare and billing violations.

In January 2005, DCH's Bureau of Health Professions, in conjunction with the DSC, issued a cease and desist order that required the provider to stop delegating radiography duties to unqualified dental assistants.

In January 2006, the provider was given one year's probation, community service, and fines. The administrative complaint, to which the provider stipulated, charged the provider for various improper acts. For example, according to DCH's administrative complaint, an employee of the provider forced a 94-year-old nursing home resident to have a dental impression for dentures. The resident had been 50 years without teeth and did not want dentures. The administrative complaint stated, "Upon realizing that [the provider's employee] was taking an impression for dentures, [the resident] began to squirm and fight back: One of the men held her head in a 'hammerlock' position so she could not move. When [the resident] left the exam room, her face, neck and dress were covered with impression plaster."

The provider also stipulated to charges of writing prescriptions to his employees for controlled substances without a controlled substance license. The administrative complaint stated that "Staff informed the investigators that [the provider] gave these medications to the patients receiving treatment at the Center. The medications were dispensed to the patients in plain envelopes or paper sacks."

Additional charges included complaints of services provided by unlicensed dental assistants and billing for services not provided.

In our prior Single Audit report, we noted in a Medicaid finding that the Medicaid Integrity Program Section's October 2005 audit of the provider identified \$370,000 in improper payments (20%) of the \$1.9 million paid to the provider from 1998 through 2001 and that HHS had sanctioned the provider for program-related violations in 1994.

Subsequent to the October 2008 issuance of our prior Single Audit report, DCH completed an audit of the provider for claims submitted from January 1, 2002 through June 30, 2005. The audit identified potentially improper payments of \$1,164,883 for reasons such as those noted in parts a.(1)(a) through a.(1)(c).

DCH stated that it reported the provider to the Department of Attorney General's Medicaid Fraud Control Unit. However, DCH also stated that it did not sanction the provider because the Medicaid Fraud Control Unit did not file criminal charges against the provider and because the provider was appealing the results of the audit. However, Section 400.111e(3)(d) of the *Michigan Compiled Laws* requires action by DCH to sanction the provider.

Because the Medicaid Integrity Program Section's audit results indicated that the provider failed to conform to professionally accepted standards and threatened the fiscal integrity of Medicaid, DCH's decision not to sanction the provider was contrary to State law.

On December 13, 2009, more than two years after we used this provider as a Medicaid finding example in our prior Single Audit report, DCH's

Bureau of Health Professions issued a summary suspension* of the provider's medical license after concluding that the provider posed a risk to the public's health, safety, and welfare.

On February 11, 2010, DCH's Bureau of Health Professions suspended the provider's license for a year. According to the administrative complaint filed by the Department of Attorney General, DCH took action against the provider for a violation of duty, consisting of negligence or failure to exercise due care, incompetence, a lack of good moral character, aiding and abetting in a violation of the Public Health Code, failing to comply with a subpoena, violating the Medical Records Access (Act 47, P.A. 2004), and violating a January 2005 final order issued by the licensing board.

The summary suspension and subsequent suspension were the result of actions by DCH's Bureau of Health Professions and not a result of actions by Medicaid, as allowed or required by State law. Although Medicaid has been aware that this provider has been under investigation for several years for a variety of issues, including allegations that the health and welfare of patients were at risk, Medicaid has yet to proactively sanction this provider.

From November 1, 2000 to the end of the audit period, DCH had paid the provider \$12.7 million, including \$2.4 million, during the current audit period.

- (2) DCH had not established guidelines regarding the use of summary suspensions of Medicaid providers.

Section 400.111f of the *Michigan Compiled Laws* grants the DCH director the authority to take emergency action to protect the health, safety, or welfare of Medicaid beneficiaries or to protect the public funds of Medicaid.

For example, the law allows DCH to issue a summary suspension for circumstances that include, but are not limited to, any of the following: a

* See glossary at end of report for definition.

reasonable belief that the provider constitutes a threat to Medicaid beneficiaries' health, safety, or welfare; a reasonable belief that the provider violated the Medicaid false claims act; and a reasonable belief that, within certain parameters, a provider submitted claims for services that were unsubstantiated, were not covered, or were medically inferior or unnecessary. The law allows DCH to suspend payments to providers for pending or subsequent claims, in whole or in part, or for the summary suspension of a provider from participation in Medicaid.

We noted that DCH did not issue a summary suspension for four providers with error rates that exceeded 10% even after DCH and the provider agreed upon a settlement. The error rates ranged from 14% to 48%.

Although the Medicaid Integrity Program Section's procedure manual provided some guidance for taking action in accordance with State law, DCH had not established processes for initiating progressive sanctions against providers. Rather, DCH generally waits until a provider has been convicted before taking action to terminate the provider's participation in Medicaid.

- b. DCH had not established effective processes for ensuring the completeness of the Sanctioned Providers List.

According to the Medicaid Provider Manual, Medicaid providers, such as pharmacies, intermediate school districts, Medicaid health plans (MHPs), and prepaid inpatient health plans (PIHPs), are responsible for ensuring that they do not hire sanctioned subproviders, such as pharmacists, dentists, or physicians. The Manual states that providers are responsible for reviewing DCH's Sanctioned Providers List, and changes to the list that are periodically published in Medicaid Policy Bulletins, to identify excluded providers.

Our review of DCH's processes for maintaining the list identified three providers who were not added to the list at the time DCH issued summary suspensions or revoked the providers' licenses. State and federal laws prohibit unlicensed providers from providing services to Medicaid beneficiaries. DCH subsequently added the providers to the list when HHS notified DCH that two of the providers were excluded from participating in

Medicaid and when one provider was criminally convicted. DCH's delays in adding the providers to the list were 16 months, 14 months, and 5 months, respectively.

Also, DCH did not add to the Sanctioned Providers List eight individuals who were suspended or terminated by the Medicaid Integrity Program Section during the audit period. Our review did not identify any payments made to the providers after their suspension or termination dates.

In addition, DCH's notification process did not include providers with suspended or revoked licenses that were not current Medicaid providers. Although these providers could not be directly paid for Medicaid claims, they potentially could be a subprovider for another provider that might not be aware of gaps in the subprovider's licensing.

- c. DCH had not performed a follow-up audit of a provider who was originally charged by the Department of Attorney General with filing false Medicaid claims of \$895,000. DCH subsequently settled with the provider for \$201,389. In the settlement agreement, DCH was prohibited from performing a postaudit of the provider's claims for 180 days after the settlement date of October 20, 2006. The purpose of the 180 days was to allow the provider time to implement accounting and documentation procedures to comply with the identified deficiencies. DCH paid the provider \$849,218 during the audit period, although DCH did not ensure that the provider's new accounting and documentation procedures protected the fiscal integrity of Medicaid.

RECOMMENDATION

WE AGAIN RECOMMEND THAT DCH'S INTERNAL CONTROL OVER THE MEDICAID CLUSTER ENSURE COMPLIANCE WITH SPECIAL TESTS AND PROVISIONS PERTAINING TO PROVIDER ELIGIBILITY.

FINDING (3911024)

24. Medicaid Cluster, CFDA 93.777 and 93.778, Activities Allowed or Unallowed and Allowable Costs/Cost Principles - Omnibus

U.S. Department of Health and Human Services	Medicaid Cluster: CFDA 93.777: State Survey and Certification of Health Care Providers and Suppliers CFDA 93.778: Medical Assistance Program CFDA 93.778: ARRA - Medical Assistance Program
Award Number: 05-0605MI5028 05-0705MI5028 05-0805MI5028 05-0905MI5028 05-0605MI5048 05-0705MI5048 05-0805MI5048 05-0905MI5048 05-0905MIARRA	Award Period: 10/01/2005 - 09/30/2006 10/01/2006 - 09/30/2007 10/01/2007 - 09/30/2008 10/01/2008 - 09/30/2009 10/01/2005 - 09/30/2006 10/01/2006 - 09/30/2007 10/01/2007 - 09/30/2008 10/01/2008 - 09/30/2009 10/01/2008 - 09/30/2009
	Known Questioned Costs: \$313,988

DCH's internal control over the Medicaid Cluster did not ensure compliance with federal laws and regulations regarding activities allowed or unallowed and allowable costs/cost principles.

Internal control that does not ensure compliance with federal laws and regulations could result in sanctions, disallowances, and/or future reductions of Medicaid Cluster awards.

Appendix A, section C of OMB Circular A-87 (federal regulation 2 *CFR* 225) states that program costs must conform to any limitations or exclusions set forth in federal laws, regulations, and awards. Also, this section requires costs charged to federal programs to be reasonable in nature and amount, which includes restraints or requirements imposed by laws and regulations, sound business practices, and terms and conditions of the federal award. In addition, this section requires costs charged to federal programs to be reasonable and consistent with policies, regulations, and procedures that apply uniformly to both federal awards and other activities of the governmental unit. Further, Section 18.1485 of the *Michigan Compiled Laws* requires the head of each principal department to establish and maintain an internal accounting and administrative control system. Internal control

is a process designed to provide reasonable assurance about the achievement of the entity's objectives with regard to the reliability of financial reporting, effectiveness and efficiency of operations, and compliance with applicable laws and regulations.

Our review of Medicaid expenditures regarding activities allowed or unallowed and allowable costs/cost principles during the audit period disclosed:

- a. DCH did not complete cost settlements with Medicaid providers in a timely manner. This resulted in lost interest earnings for the State and federal governments and numerous hospitals and increased the risk that DCH will be unable to collect amounts that may have been overpaid to hospitals.

DCH issues Medicaid interim payments (MIPs) and capital interim payments (CIPs) to approximately 164 inpatient hospitals that volunteered to receive such payments as an alternative to receiving payments for actual claims received and processed by DCH weekly. DCH bases MIPs and CIPs on each hospital's most recent available annual cost data and issues the MIPs and CIPs on a biweekly basis.

After the close of each hospital's cost reporting period, which is generally one year, DCH reconciles MIPs to submitted claims during two scheduled preliminary MIP reconciliations. At final settlement, DCH again reconciles MIPs, along with CIPs, to the hospital's actual cost data. DCH approves approximately 95% of provider claims within one year of the date a medical service was provided. The final settlement determines the State's final overpayment or underpayment to each hospital by comparing the hospital's total MIPs and CIPs to actual costs as reported in the hospital's Medicaid cost report package. DCH cost settlements for some hospitals can encompass numerous annual cost reporting periods within the same State fiscal year.

As of June 2009, DCH had unsettled cost years dating back to fiscal year 2002-03. For settlements occurring during fiscal year 2007-08, DCH's settlement delay average, by hospital, ranged from 33 months to 82 months (2.8 to 6.8 years) and averaged 62 months (5.2 years). For settlements that occurred during fiscal year 2008-09, DCH's settlement delay average, by hospital, ranged from 29 months to 65 months (2.4 to 5.4 years) and averaged 50 months (4.2 years).

Our review of DCH's cost settlement process during the audit period disclosed:

- (1) During fiscal year 2007-08, DCH made 174 final settlements with 84 providers. The settlements disclosed that 53 providers owed DCH a total of \$3.2 million. Amounts owed by individual providers were as much as \$718,000 and averaged \$60,000. The settlements also disclosed that DCH owed 64 providers a total of \$6.3 million. Amounts owed to individual providers were as much as \$1.7 million and averaged \$75,000.

Delays in cost settlements resulted in net interest lost to the State and federal governments of approximately \$272,000 (approximately \$117,000 General Fund/general purpose) from 41 hospitals. As a result, we reported known questioned costs totaling \$154,957 for the one-year period ended September 30, 2008. In addition, these delays resulted in net interest lost of approximately \$738,000 by 40 hospitals that DCH identified through the settlement process as being owed additional funds.

- (2) During fiscal year 2008-09, DCH made 306 final settlements with 137 providers. The settlements disclosed that 93 providers owed DCH a total of \$9.3 million. Amounts owed by individual providers were as much as \$644,000 and averaged \$99,000. The settlements also disclosed that DCH owed 114 providers a total of \$14.9 million. Amounts owed to individual providers were as much as \$2.2 million and averaged \$109,000.

Delays in cost settlements resulted in net interest lost to the State and federal governments of approximately \$279,000 (approximately \$120,000 General Fund/general purpose) from 69 hospitals. As a result, we reported known questioned costs totaling \$159,031 for the one-year period ended September 30, 2009. In addition, these delays resulted in net interest lost of approximately \$722,000 by 63 hospitals that DCH identified through the settlement process as being owed additional funds.

Delays in identification and collection of amounts owed to the State increased the risk that DCH will be unable to collect amounts that may have been overpaid. For example, DCH may lose the ability to receive full reimbursement from bankrupt hospitals.

We noted the same condition in our prior Single Audit. DCH stated in its corrective action plan in the prior Single Audit that by September 30, 2009 it would explore options to improve the timeliness of hospital cost settlements. DCH has subsequently stated that its implementation of CHAMPS has delayed its analysis.

- b. DCH's internal control over the Medicaid Cluster's Adult Home Help (AHH) expenditures did not ensure compliance with federal laws and regulations regarding activities allowed or unallowed and allowable costs/cost principles. Also, DCH had not established internal control to ensure the completeness or accuracy of AHH Program expenditures recorded on DCH's financial schedules.

The AHH Program provides personal care services, such as assistance with eating, bathing, medication, and housework, to Medicaid-eligible beneficiaries who are blind, disabled, or otherwise functionally disabled. Through a grant from DCH, DHS was responsible for performing the administrative functions for the AHH Program, such as processing payments to providers through DHS's Model Payments System.

To generate AHH Program payments, DHS's Model Payments System interfaced monthly to the State's accounting system. DHS's Model Payments System generated \$432.8 million (86%) of the \$502.3 million recorded as AHH Program expenditures in the State's accounting system.

Although DHS was responsible for processing payments to AHH Program providers, DCH was responsible for the overall AHH Program. DCH did not implement internal control procedures, such as obtaining, analyzing, and reconciling documentation from DHS that supports the monthly AHH Program expenditures, to ensure that AHH Program expenditures were in compliance with activities allowed or unallowed and allowable costs/cost principles compliance requirements.

Also, DCH did not implement internal control procedures, such as performing analytical procedures on the amounts paid from DHS's Model Payments System, to ensure that the AHH Program expenditures recorded on DCH's financial schedules were complete and accurate. Internal control that ensures the accuracy of the financial schedules would help DCH detect the existence

and evaluate the reasonableness of significant variances in the monthly expenditures.

- c. DCH's method of reviewing inpatient hospital annual cost reports did not effectively ensure that inpatient hospital payment rates were reasonable and adequate to meet the costs incurred by inpatient hospitals.

Federal regulation 42 *CFR* 447.253 requires that DCH pay for inpatient hospital services using rates that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable State and federal laws, regulations, and quality and safety standards.

Because the cost reports are the basis for the future fees paid, it is critical that the cost reports be accurate. However, DCH only performs a variance analysis of inpatient hospital Medicaid cost reports by comparing prior year reported amounts to current year reported amounts.

DCH did not develop expectations when performing variance reviews of inpatient hospital Medicaid cost reports. Expectations are predictions of recorded amounts and are developed by identifying plausible relationships that are reasonably expected to exist based on an understanding of the entity and its industry. Total payments to inpatient hospitals during the current two-year audit period were \$2.1 billion.

Without developed expectations, DCH might inappropriately allow one-time or recurring material misstatements in prior and current years to go unnoticed. Also, considering the volatility of the health care industry, DCH might inappropriately accept an insignificant variance that should have fluctuated based on expected industry conditions.

- d. DCH needs to improve internal control over contract payments to prepaid inpatient health plans (PIHPs) (see Finding 5). DCH did not have a process to ensure that contracts and contract amendments were signed by all parties prior to issuing payments for the contracts. Also, we noted that DCH made payments under a new rate schedule during our audit period before the contract amendment incorporating the new rate schedule was signed by DCH and the PIHP.

We noted the same condition in our prior Single Audit. DCH stated in its corrective action plan in the prior Single Audit that by September 30, 2009 it would implement changes to the contracting process intended to ensure that fully executed agreements are in place prior to payment.

- e. DCH needs to improve internal control over Medicaid journal entries in the State's accounting system to ensure that the entries were accurate, complete, adequately supported, and in compliance with federal laws and regulations (see Finding 2). Subsequent to an accounting supervisory position vacancy, a temporary DCH procedure allowed for two nonsupervisory accounting staff members to approve each other's Medicaid journal entries. The temporary procedure stated that these journal entries would be subject to a subsequent review after DCH filled the vacant supervisory position. However, DCH did not ensure that the new supervisor performed the subsequent review of the Medicaid journal entries.

RECOMMENDATIONS

WE AGAIN RECOMMEND THAT DCH IMPROVE ITS INTERNAL CONTROL OVER THE MEDICAID CLUSTER TO ENSURE COMPLIANCE WITH FEDERAL LAWS AND REGULATIONS REGARDING ALLOWABLE COSTS/COST PRINCIPLES.

We also recommend that DCH improve its internal control over the Medicaid Cluster to ensure compliance with federal laws and regulations regarding activities allowed or unallowed.

FINDING (3911025)

25. Medicaid Cluster, CFDA 93.777 and 93.778, Special Tests and Provisions - Provider Eligibility and Provider Health and Safety Standards

U.S. Department of Health and Human Services	Medicaid Cluster: CFDA 93.777: State Survey and Certification of Health Care Providers and Suppliers CFDA 93.778: Medical Assistance Program CFDA 93.778: ARRA - Medical Assistance Program
Award Number: 05-0605MI5028 05-0705MI5028 05-0805MI5028 05-0905MI5028 05-0605MI5048 05-0705MI5048 05-0805MI5048 05-0905MI5048 05-0905MIARRA	Award Period: 10/01/2005 - 09/30/2006 10/01/2006 - 09/30/2007 10/01/2007 - 09/30/2008 10/01/2008 - 09/30/2009 10/01/2005 - 09/30/2006 10/01/2006 - 09/30/2007 10/01/2007 - 09/30/2008 10/01/2008 - 09/30/2009 10/01/2008 - 09/30/2009
	Known Questioned Costs: \$12,982,151

DCH's internal control over the Medicaid Cluster did not ensure compliance with federal laws and regulations regarding special tests and provisions pertaining to provider eligibility and provider health and safety standards.

Internal control that does not ensure compliance with federal laws and regulations could result in sanctions, disallowances, and/or future reductions of Medicaid Cluster awards.

Federal regulation 42 *CFR* 440.260 requires states to include in their state plan the methods and standards used to ensure that Medicaid services are of high quality. To comply with the federal regulations, DCH's Medicaid State Plan assured the federal government that all providers of medical care are licensed in compliance with State licensing requirements, as required in the Public Health Code. Also, the Medicaid State Plan requires DCH to perform on-site surveys and resurveys of health facilities, institutions, and agencies providing medical care to ensure that they are meeting State and federal standards. In addition, federal regulation 42 *CFR* 455, subpart B, requires all providers to enter into an agreement with DCH that includes certain required disclosures. Further, federal regulations 42 *CFR*

442.12 and 42 *CFR* 482.1 require nursing facilities and hospitals to meet prescribed health and safety standards in order to participate in Medicaid.

Our review of DCH's internal control over ensuring that Medicaid providers were licensed in accordance with federal, State, and local laws and regulations and had met prescribed health and safety standards disclosed:

- a. General controls over the License 2000 system and the Community Health Automated Medicaid Processing System (CHAMPS) were ineffective.

The License 2000 system and the CHAMPS provider enrollment (PE) subsystem are the two major systems that DCH uses to help ensure that it complies with federal provider eligibility requirements. DCH uses the License 2000 system to maintain data regarding the status of health professionals' licenses and to document disciplinary actions taken against health professionals. Also, DCH allows health professionals to renew their licenses through the License 2000 system instead of mailing their renewal applications.

DCH allows health professionals to have access to the PE subsystem for enrollment in Medicaid. Once enrolled, the health professionals become authorized as Medicaid providers and use the PE subsystem to update provider information, such as demographics, and make required disclosures. Also, DCH uses the PE subsystem to approve provider enrollments and manage provider information. DCH interfaces the PE subsystem daily with changes in the License 2000 system.

According to the State of Michigan Financial Management Guide (Part VII, Chapter 1, Section 900), effective general controls are necessary for reliance to be placed on application controls. Effective general controls safeguard data, protect business process application programs, and ensure continued computer operations in case of unexpected interruptions. Application controls are controls specific to an information system that ensure that information is complete, accurate, valid, and authorized. Also, application controls help agencies achieve a proper segregation of duties. However, as reported in Findings 30 and 35, we concluded that general controls over the License 2000 system and CHAMPS, including the PE subsystem, were ineffective.

Because general controls over the License 2000 system and CHAMPS were ineffective, an unauthorized individual might circumvent or improperly modify application controls. Therefore, DCH should not place reliance on the License 2000 system and CHAMPS application controls, including the PE subsystem, to ensure the integrity of the data supporting its provider eligibility processes. For example, because certain processes are completely automated and we found that general controls were ineffective:

- (1) DCH could not ensure that licenses for health professionals, including Medicaid providers, who renew their licenses on-line and make certain disclosures requiring follow-up were placed in hold status, as DCH procedure requires. The License 2000 system was designed to place a hold on the renewal application if the applicant's response to a disclosure question, such as whether the provider had ever been convicted of a felony, required follow-up. However, DCH's License 2000 system did not retain evidence of the required disclosures by health professionals who renew their licenses on-line.
- (2) DCH could not ensure that the continuing education reports generated by License 2000, which identify health professionals renewing their medical licenses, were complete and accurate. DCH's licensing personnel use the reports to select samples of health professionals for continuing education compliance audits.
- (3) DCH could not ensure the integrity of the electronic record of providers' disclosures and electronic signatures in the PE subsystem. Medicaid providers supply required demographic information and make required disclosures, such as criminal convictions and sanctions, ownership, subcontractor ownership, and office manager information, by inputting such information into the PE subsystem. Also, using the PE subsystem, Medicaid providers must electronically sign an agreement containing the terms and conditions for participation.
- (4) DCH could not ensure that the DCH Provider Enrollment Unit's enrollment staff performed their activities in accordance with management's expectations. The PE subsystem electronically captures and creates an audit trail of the enrollment staff activities, such as the validation of

provider disclosures and procedures to ensure that excluded providers are not enrolled in Medicaid.

- b. DCH made payments to medical providers whose licenses were not issued in accordance with State licensing requirements.

DCH issued licenses to 1,593 medical providers between May 1, 2006 and September 30, 2008 without first conducting a criminal history background check, as required by State law (Section 333.16174 of the *Michigan Compiled Laws*).

During the audit period, DCH made Medicaid payments totaling \$19,489,932 (\$6,565,290 General Fund/general purpose) to these improperly licensed providers. As a result, we reported known questioned costs totaling \$12,924,642.

Effective May 1, 2006, State law required applicants for initial licensure or registration to submit their fingerprints to the Michigan Department of State Police (MSP) for a criminal history background check prior to DCH's issuance of their medical licenses. DCH began requiring criminal history background checks for new licensees on October 1, 2008. However, DCH informed us that it did not request criminal history background checks for the medical providers initially licensed from May 1, 2006 through September 30, 2008 because MSP had informed DCH that MSP's internal systems could not handle the volume of background checks.

We noted the same condition in our prior Single Audit. DCH stated in its corrective action plan in the prior Single Audit that MSP had made the necessary system changes and that the Licensing Division had updated the application instructions and communicated the requirements to external stakeholders, such as educational institutions and professional associations. DCH indicated that it did not comply with the condition because it did not retroactively request criminal background checks for the medical providers initially licensed from May 1, 2006 through September 30, 2008.

- c. DCH's internal control did not prevent payments to Medicaid providers that were unlicensed at the time services were rendered. State licensing

requirements do not allow licensees to practice prior to the issuance of their licenses or during the period their licenses are lapsed.

DCH made improper payments of \$88,541 (\$31,032 General Fund/general purpose) to 28 providers that were unlicensed when services were rendered. As a result, we reported known questioned costs of \$57,509.

We noted a similar condition in our prior Single Audit. DCH stated in its corrective action plan in the prior Single Audit that the new CHAMPS provider enrollment subsystem verifies that professionals are appropriately licensed prior to enrollment. DCH did not comply with the condition because DCH continued to manually update the Medicaid Management Information System (MMIS) with the changes in the providers' status and DCH continued to pay providers from MMIS. Errors in the update process allowed payments to be made to unlicensed providers.

- d. DCH discontinued its Health Professionals Credentials Verification Program in June 2008 because of, according to DCH, a lack of significant findings since the Program's implementation in 2003 and resource limitations. DCH also informed us that it has not developed alternative procedures for supervisory review and approval of new licensees. As a result, DCH could not ensure that all providers of medical services were licensed in accordance with State laws.
- e. DCH had not established effective processes to ensure that all providers of medical care were properly licensed and were not excluded from participating in Medicaid, as required by the Medicaid State Plan.

DCH contracted with certain types of providers, such as its pharmacy benefits manager (PBM), Medicaid health plans (MHPs), prepaid inpatient health plans (PIHPs), and intermediate school districts (ISDs), that utilize subproviders to provide medical services. Although DCH assigned to these providers the responsibility for credentialing and monitoring subproviders, DCH remains responsible for ensuring that it does not pay an unlicensed or excluded subprovider. We determined that DCH's oversight processes were not

sufficient to prevent payments to unlicensed or excluded providers. For example:

- (1) DCH did not require its PBM to capture information about the pharmacists (i.e., subproviders) dispensing Medicaid prescriptions. As a result, neither the provider nor DCH could verify that pharmacists dispensing prescriptions to Medicaid beneficiaries were properly licensed and not excluded from Medicaid participation. Section 333.17711 of the *Michigan Compiled Laws* requires dispensing pharmacists to be licensed.
- (2) DCH did not have effective processes to ensure that all subproviders of MHPs, PIHPs, and ISDs were properly licensed and not excluded from participation.

DCH informed us that it contracts for annual external quality reviews and it performs annual audits of MHPs and PIHPs, which include the organizations' credentialing processes. However, DCH's annual audit process of MHPs included the use of a monitoring tool that required each MHP to submit documentation for only one physician provider and only one nonphysician provider as support for the effectiveness of the MHP's credentialing processes. A test of only two subproviders did not provide DCH with a sufficient basis for forming its conclusion regarding compliance by each of the audited MHPs.

The scope of the PIHPs' external quality reviews for fiscal years 2007-08 and 2008-09 focused primarily on reviewing the content of the PIHPs' credentialing policies. Also, the reviews did not indicate the extent of testing to assess the effectiveness of the PIHPs' credentialing processes.

Also, DCH had not conducted audits of ISDs that included a review of the ISDs' provider credentialing processes during our audit period.

- f. DCH could not demonstrate that facilities, such as laboratories, hospices, and hospitals, receiving Medicaid payments received State licensing surveys in accordance with State licensing requirements.

State licensing requirements, contained in the Public Health Code (Section 333.20155 of the *Michigan Compiled Laws*), require DCH to perform surveys of health facilities.

Also, DCH informed us that because of limitations with its information systems, it could not demonstrate its identification of facilities receiving Medicaid payments that were subject to State licensing surveys. In addition, DCH indicated that although it could look up the survey dates for a particular facility, DCH could not demonstrate which facilities, except for nursing facilities, did or did not have State licensing surveys specified by State law. Furthermore, DCH informed us that it was unable to conduct some State licensing surveys, required by State law, for certain types facilities, such as laboratories and residential hospice, because of resource limitations.

- g. DCH did not require Medicaid providers to make all disclosures as required by federal regulation 42 *CFR* 455, subpart B. DCH's lack of compliance with federal regulations was reported in July 2008 in the Michigan Comprehensive Program Integrity Review conducted by the Centers for Medicare and Medicaid Services (CMS), U.S. Department of Health and Human Services (HHS). For example, CMS reported:
 - (1) DCH's provider enrollment agreement did not capture all necessary subcontractor and related owner information, such as the name and address of each person with 5% or more ownership in the disclosing entity or in a subcontractor the disclosing entity partially owns. Also, DCH's PIHP contracts did not stipulate that the PIHPs require their contracted service providers to capture the same required information.
 - (2) DCH's provider enrollment agreements and PIHP contracts did not require providers and PIHP contracted service providers to furnish information about certain business transactions with wholly owned suppliers or any subcontractor to DCH or HHS upon request.
 - (3) DCH did not ensure that all MHPs and PIHPs routinely capture required information, such as criminal convictions, on agents or managing employees in the provider enrollment process. CMS reported that 4 of 13 MHPs and several PIHPs did not capture the required information.

- (4) DCH's provider agreement and contracts with MHPs and PIHPs did not capture information on agents or managing employees for the purposes of searching for exclusions and criminal convictions.

- h. DCH did not identify and ensure that the nursing facilities and hospitals participating in Medicaid had met CMS's Conditions of Participation (CoP) standards, which are the minimum health and safety standards that providers and suppliers must meet in order to be Medicare and Medicaid certified.

Federal regulation 42 *CFR* 488.5 states that hospitals accredited by the American Osteopathic Association (AOA) or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) are deemed to have met CMS's CoP standards for Medicare. Also, federal regulations 42 *CFR* 482.1 and 42 *CFR* 483.1 require DCH to perform surveys of nursing facilities and hospitals without deemed status to determine compliance with CMS's CoP standards.

CMS uses its Automated Survey Processing Environment (ASPEN) system, which allows CMS and DCH to input and access both survey results and enforcement information, to help monitor which nursing facilities and hospitals have met CMS's CoP standards.

However, our review disclosed that DCH did not identify and ensure that the nursing facilities and hospitals participating in Medicaid had met CMS's CoP standards. DCH did not compare which nursing facilities and hospitals received Medicaid payments to CMS's ASPEN system. Also, DCH did not document the CoP standards that it reviewed during its surveys of nursing facilities and hospitals. As a result, DCH did not ensure that the nursing facilities and hospitals participating in Medicaid had met CMS's CoP standards.

DCH made Medicaid payments of \$3.1 billion to 439 nursing facilities and payments of \$2.3 billion to 948 hospitals during the audit period.

RECOMMENDATIONS

WE AGAIN RECOMMEND THAT DCH IMPROVE ITS INTERNAL CONTROL OVER THE MEDICAID CLUSTER TO ENSURE COMPLIANCE WITH FEDERAL

LAWS AND REGULATIONS REGARDING SPECIAL TESTS AND PROVISIONS PERTAINING TO PROVIDER ELIGIBILITY.

We also recommend that DCH improve its internal control over the Medicaid Cluster to ensure compliance with federal laws and regulations regarding special tests and provisions pertaining to provider health and safety standards.

We further recommend that DCH ensure that all Medicaid providers make required disclosures.

FINDING (3911026)

26. Medicaid Cluster, CFDA 93.777 and 93.778, Special Tests and Provisions - Utilization Control and Program Integrity

U.S. Department of Health and Human Services	Medicaid Cluster: CFDA 93.777: State Survey and Certification of Health Care Providers and Suppliers CFDA 93.778: Medical Assistance Program CFDA 93.778: ARRA - Medical Assistance Program
Award Number: 05-0605MI5028 05-0705MI5028 05-0805MI5028 05-0905MI5028 05-0605MI5048 05-0705MI5048 05-0805MI5048 05-0905MI5048 05-0905MIARRA	Award Period: 10/01/2005 - 09/30/2006 10/01/2006 - 09/30/2007 10/01/2007 - 09/30/2008 10/01/2008 - 09/30/2009 10/01/2005 - 09/30/2006 10/01/2006 - 09/30/2007 10/01/2007 - 09/30/2008 10/01/2008 - 09/30/2009 10/01/2008 - 09/30/2009
	Known Questioned Costs: \$0

DCH's internal control over the Medicaid Cluster did not ensure compliance with federal laws and regulations regarding special tests and provisions pertaining to utilization control and program integrity.

Internal control that does not ensure compliance with federal laws and regulations could result in sanctions, disallowances, and/or future reductions of Medicaid Cluster awards.

Federal regulations 42 *CFR* 455 and 42 *CFR* 456 pertain to requirements regarding the establishment of a fraud detection and investigation program, as well as requirements to safeguard against unnecessary utilization of care and services. Specifically, federal regulation 42 *CFR* 456.22 requires DCH to have procedures for the on going evaluation, on a sample basis, of the need for, and the quality and timeliness of, Medicaid services. Also, federal regulation 42 *CFR* 455.20 requires DCH to have a method for verifying with beneficiaries whether services billed by providers were received. In addition, federal regulation 42 *CFR* 456.23 requires that the agency have a post-payment review process that allows DCH to develop and review recipient utilization and provider service profiles so that DCH can correct misutilization practices of recipients and providers.

The responsibilities of DCH's Medicaid Integrity Program Section include helping to ensure compliance with federal laws and regulations pertaining to Medicaid utilization control and program integrity. The Section developed written procedures for performance of its duties, which included conducting Surveillance and Utilization Review System (SURS) reviews; receiving and investigating complaints of alleged Medicaid fraud, waste, and abuse from individuals, beneficiaries and providers; performing provider audits; investigating explanation of benefits (EOB) letter responses from recipients to verify services performed; performing Medicaid health plan (MHP) provider monitoring; and providing contract oversight for the inpatient hospital and pharmacy audit functions.

Our review of DCH's Medicaid utilization control and program integrity procedures disclosed:

- a. DCH did not perform sufficient monitoring of MHPs to ensure that the MHPs complied with federal laws and regulations pertaining to Medicaid utilization control and program integrity established in federal regulations 42 *CFR* 455 and 42 *CFR* 456.

DCH obtained a waiver of federal statutory requirements to implement a managed care program to more effectively address the health care needs of its population. DCH contracted with 14 MHPs to carry out its federally approved managed care waiver and issued federally funded payments to the MHPs totaling \$4.1 billion during the two-year audit period. In accordance with these contracts, the MHPs have the responsibilities pertaining to utilization control and program integrity.

The Medicaid Integrity Program Section procedures manual, the federally approved waiver, and the MHP contracts stated that DCH would perform annual monitoring of each MHP to ensure compliance with contract requirements, including requirements pertaining to utilization control and program integrity. DCH developed a fraud and abuse monitoring tool consisting of 14 criteria to document its monitoring efforts of each MHP.

However, in fiscal year 2008-09, DCH did not review 124 (68%) of 182 criteria contained within the fraud and abuse monitoring tools for 13 of the MHPs and DCH did not perform any monitoring review of 1 MHP. For example, DCH did not review the MHPs' SURS efforts to detect underutilization and overutilization of services by providers or beneficiaries for any of the 13 MHPs in fiscal year 2008-09.

Also, we noted that DCH's monitoring primarily consisted of report reviews submitted by the MHPs. However, DCH's review did not include tests of details to ensure that reports were accurate.

- b. DCH did not take steps to prevent conflicts of interest with the pharmacy audit company responsible for determining if improper Medicaid pharmacy payments were made by DCH's pharmacy benefits manager (PBM). Also, DCH did not take steps to ensure that the pharmacy audit company performed audits from the proper pharmacy claim population paid by Medicaid. As a result, DCH did not effectively comply with utilization control and program integrity requirements established in federal regulation 42 *CFR* 456.22.

DCH contracted with its PBM to process pharmacy claims and issue payments to pharmacies totaling approximately \$1.1 billion during the two-year audit period. DCH allowed the PBM to subcontract to a pharmacy audit company the PBM's obligation to maintain an ongoing pharmacy audit and monitoring program in compliance with federal regulation 42 *CFR* 456.22. Although DCH and the PBM agreed that DCH would monitor the pharmacy audit company, a conflict of interest between the PBM and the pharmacy audit company existed. The PBM hired the pharmacy audit company to audit pharmacies for improper Medicaid payments made by the PBM. Therefore, the company had an interest in both auditing pharmacies and continuing its contract with the PBM.

Also, DCH's PBM billed DCH weekly and subsequently provided DCH with the underlying paid claims data to support the billing. DCH performed reconciliations between the weekly billing and the underlying paid claims data to ensure that the PBM billing was accurate. However, rather than perform tests of the DCH-reconciled underlying paid claims data, the pharmacy audit company obtained paid pharmacy claims data directly from the PBM. As a result, DCH cannot ensure that the pharmacy audit company performed audits of pharmacy claims paid by Medicaid because DCH cannot ensure that the population of transactions tested by the pharmacy audit company was complete.

c. DCH's EOB procedures did not ensure compliance with requirements pertaining to verification with beneficiaries whether services billed by providers were received. Federal regulations require that DCH send EOB letters to Medicaid beneficiaries as part of DCH's fraud detection and investigation program. As a result, DCH did not effectively comply with utilization control and program integrity requirements established in federal regulation 42 *CFR* 455.20. Our review disclosed:

- (1) DCH did not retain and analyze undeliverable EOB letters. Instead, DCH shredded the undeliverable EOB letters, which was an ineffective practice because undeliverable EOB letters might have been used to identify improper billing by providers for falsified or nonexistent persons. Our testing of medical service payments for 180 DCH beneficiaries resulted in 25 (14%) undeliverable communications.
- (2) DCH did not require contracted MHPs and prepaid inpatient health plans (PIHPs) to send EOB letters to plan enrollees and beneficiaries for services performed by health plan participating providers. Total federally funded payments to MHPs and PIHPs were \$4.1 billion and \$2.3 billion, respectively, during the two-year audit period, which was 47% of total Medicaid Cluster federal expenditures of \$13.7 billion. Total average Medicaid beneficiaries for the two-year audit period were 2 million, of which 1.3 million (65%) were enrolled in MHPs.
- (3) DCH did not subject Medicaid Adult Home Help (AHH) Program service costs to the EOB letter verification process. Medicaid AHH Program federal expenditures totaled \$308.4 million for the two-year audit period.

- d. DCH did not perform SURS reviews in accordance with Medicaid Integrity Program Section procedures to identify misutilization practices of recipients and providers. Also, DCH's SURS process did not address all Medicaid services. As a result, DCH did not effectively comply with utilization control and program integrity requirements established in federal regulation 42 *CFR* 456.23. Our review disclosed:
- (1) DCH stated that it did not perform two episode of care SURS reviews and two profiling SURS reviews annually as required by Medicaid Integrity Program Section procedures. Instead, DCH performed one episode of care SURS review and one profiling SURS review in fiscal year 2007-08 and performed one episode of care SURS review and no profiling SURS reviews in fiscal year 2008-09.
 - (2) DCH's SURS review process did not include analysis of AHH Program expenditures or nonemergency transportation expenditures. The federally funded share of expenditures totaled \$308.4 million and \$1.3 million, respectively, during the two-year audit period. These expenditures were not included in the SURS review because the underlying support for the claims was contained in a system outside of DCH's Medicaid Management Information System (MMIS).
 - (3) DCH did not use Medicaid Integrity Program Section personnel resources to identify suspected fraud at long-term care/nursing home providers, which incurred \$1.9 billion (14%) of DCH's federal Medicaid expenditures of \$13.7 billion during the audit period. Specifically, DCH did not perform any SURS reviews of long-term care/nursing home providers and, of the 74 provider audits that the Medicaid Integrity Program Section oversaw during the audit period, none of the providers audited were long-term care/nursing home providers.

We first introduced parts a. and b. in our performance audit of the Program Investigation Section Processes to Identify Improper Payments, Medicaid Services Administration, Department of Community Health (391-0704-05). DCH's response to the findings presented in that report indicated that it generally agreed with our findings and recommendations and stated that it would take appropriate steps to remediate the reported deficiencies.

RECOMMENDATION

We recommend that DCH improve its internal control over the Medicaid Cluster to ensure compliance with federal laws and regulations regarding special tests and provisions pertaining to utilization control and program integrity.

FINDING (3911027)

27. Medicaid Cluster, CFDA 93.777 and 93.778, Special Tests and Provisions - Long-Term Care Facility Audits

U.S. Department of Health and Human Services	Medicaid Cluster: <i>CFDA 93.777: State Survey and Certification of Health Care Providers and Suppliers</i> <i>CFDA 93.778: Medical Assistance Program</i> <i>CFDA 93.778: ARRA - Medical Assistance Program</i>
Award Number: 05-0605MI5028 05-0705MI5028 05-0805MI5028 05-0905MI5028 05-0605MI5048 05-0705MI5048 05-0805MI5048 05-0905MI5048 05-0905MIARRA	Award Period: 10/01/2005 - 09/30/2006 10/01/2006 - 09/30/2007 10/01/2007 - 09/30/2008 10/01/2008 - 09/30/2009 10/01/2005 - 09/30/2006 10/01/2006 - 09/30/2007 10/01/2007 - 09/30/2008 10/01/2008 - 09/30/2009 10/01/2008 - 09/30/2009
	Known Questioned Costs: \$0

DCH's internal control over the Medicaid Cluster did not ensure compliance with federal laws and regulation regarding special tests and provisions pertaining to long-term care facility audits.

Internal control that does not ensure compliance with federal laws and regulations could result in sanctions, disallowances, and/or future reductions of Medicaid Cluster awards.

Federal regulation 42 *CFR* 447.253 requires DCH to provide for periodic audits of the financial and statistical records of participating providers. The Medicaid State Plan specifies that the cost report submitted by each long-term care facility is verified for completeness, accuracy, reasonableness, and consistency through a

desk audit and/or a computer check. The Medicaid State Plan also specifies that on-site audits will be conducted no less than once every four years.

DCH records show that 18 (5%) of the 387 long-term care facilities that were subject to a field audit did not have a field audit completed in the last four years. Total long-term care payments to the 387 facilities totaled \$1.1 billion and \$1.2 billion in fiscal years 2007-08 and 2008-09, respectively. Of these amounts, payments to the 18 long-term care facilities that did not have field audits totaled \$36.8 million (3%) and \$39.5 million (3%) in fiscal years 2007-08 and 2008-09, respectively.

RECOMMENDATION

We recommend that DCH improve its internal control over the Medicaid Cluster to ensure compliance with federal laws and regulations regarding special tests and provisions pertaining to long-term care facility audits.

FINDING (3911028)

28. Medicaid Cluster, CFDA 93.777 and 93.778, Subrecipient Monitoring

U.S. Department of Health and Human Services	Medicaid Cluster: CFDA 93.777: State Survey and Certification of Health Care Providers and Suppliers CFDA 93.778: Medical Assistance Program CFDA 93.778: ARRA - Medical Assistance Program
Award Number: 05-0605MI5028 05-0705MI5028 05-0805MI5028 05-0905MI5028 05-0605MI5048 05-0705MI5048 05-0805MI5048 05-0905MI5048 05-0905MIARRA	Award Period: 10/01/2005 - 09/30/2006 10/01/2006 - 09/30/2007 10/01/2007 - 09/30/2008 10/01/2008 - 09/30/2009 10/01/2005 - 09/30/2006 10/01/2006 - 09/30/2007 10/01/2007 - 09/30/2008 10/01/2008 - 09/30/2009 10/01/2008 - 09/30/2009
	Known Questioned Costs: \$0

DCH's internal control over the Medicaid Cluster did not ensure compliance with federal laws and regulations regarding subrecipient monitoring.

Internal control that does not ensure compliance with federal laws and regulations could result in sanctions, disallowances, and/or future reductions of Medicaid Cluster awards. Also, because of the internal control weaknesses identified in the finding, DCH could not ensure that Medicaid payments were only being made to eligible clients.

OMB Circular A-133, section 400(d)(3) requires DCH to monitor its subrecipients' compliance with program requirements and applicable laws and regulations. Effective monitoring of subrecipients by DCH can be accomplished by using various methods, depending on the nature and timing of the compliance requirement.

Through a grant from DCH, DHS was responsible for determining client eligibility for Medicaid. DCH entered into an interagency agreement with DHS, which contained the specific requirements of each agency. Federal regulations also require states to operate a Medicaid Eligibility Quality Control (MEQC) system to help ensure the propriety of eligibility determinations using requirements established by the Centers for Medicare and Medicaid Services (CMS). DCH's interagency agreement with DHS required DHS to have an MEQC system to assess the accuracy of DHS eligibility determinations. DHS's Office of Quality Assurance (OQA) developed a sampling plan as part of its MEQC system to assess DHS eligibility determinations.

The sampling plan required OQA to test a sample of DHS caseworker-determined Medicaid-eligible and Medicaid-ineligible cases. The interagency agreement required DHS to calculate and provide eligibility error rate information to CMS that was based on the results of the samples tested.

CMS compares the mispayment rate calculated by OQA to the federal mispayment tolerance of 3% when it determines whether to sanction DCH for excessive mispayment rates. DCH's monitoring of the accuracy of the DHS-calculated mispayment rate could help ensure that CMS bases its conclusions on accurate information. Also, by determining accurate reasons for mispayment rate fluctuations, DCH and DHS might improve their ability to formulate an effective corrective action plan to reduce future mispayment rates.

DCH and DHS develop an analysis of the MEQC mispayment rate that they submit to CMS. CMS reviews the analysis and may request that DCH provide additional

information and/or perform other actions. For example, in response to one CMS request, DCH, with DHS, implemented a corrective action plan to reduce eligibility errors and mispayment rates. However, to ensure that the corrective action plan is effective, DCH should periodically evaluate the impact of the plan on eligibility errors and mispayment rates.

Our review disclosed the following related to the monitoring of subrecipient efforts to ensure the eligibility of Medicaid clients:

- a. DCH did not monitor whether its subrecipient (DHS) followed the CMS-approved sampling plan.

Because DCH did not monitor whether DHS followed the approved sampling plan, DCH could not ensure that reports to CMS were accurate.

- b. DCH did not monitor the propriety and accuracy of the MEQC Medicaid mispayment rate calculations and did not determine the cause of periodic mispayment rate fluctuations.

Mispayment rates reported by DHS to CMS can fluctuate significantly. The fluctuations might indicate that the mispayment rates were inaccurately calculated or that selected DHS local offices or employees require eligibility determination training.

- c. DCH did not evaluate the impact of corrective action plans on reducing the mispayment rate.

Corrective action efforts can significantly disrupt operations. Such disruptions improve or worsen conditions. By evaluating the impact of DHS's corrective action plans on mispayment rates, DCH can increase the extent of effective corrective action efforts and modify or stop ineffective corrective action plan efforts.

We noted the same condition in our prior three Single Audits. DCH stated in its corrective action plan in the prior Single Audit that it asked DHS to include monitoring of the sampling plan in the DHS Single Audit. DCH also stated that it had begun to evaluate the impact of corrective action plans on reducing the mispayment rate. In addition, DCH stated that by December 1, 2008, DCH would

hire a contractor to conduct independent eligibility audits of both Medicaid and Children's Health Insurance Program (CHIP) programs to fulfill federal requirements outside of MEQC requirements. DCH has subsequently indicated that it felt that the joint DCH/DHS Medicaid Error Review Committee that met three times per month to review each error individually was sufficient to monitor MEQC results. However, DCH stated that the meetings did not effectively address all of the reported conditions.

RECOMMENDATION

FOR THE FOURTH CONSECUTIVE AUDIT, WE RECOMMEND THAT DCH IMPROVE ITS INTERNAL CONTROL OVER THE MEDICAID CLUSTER TO ENSURE COMPLIANCE WITH FEDERAL LAWS AND REGULATIONS REGARDING SUBRECIPIENT MONITORING.

FINDING (3911029)

29. Medicaid Cluster, CFDA 93.777 and 93.778, Reporting

U.S. Department of Health and Human Services	Medicaid Cluster: CFDA 93.777: State Survey and Certification of Health Care Providers and Suppliers CFDA 93.778: Medical Assistance Program CFDA 93.778: ARRA - Medical Assistance Program
Award Number: 05-0605MI5028 05-0705MI5028 05-0805MI5028 05-0905MI5028 05-0605MI5048 05-0705MI5048 05-0805MI5048 05-0905MI5048 05-0905MIARRA	Award Period: 10/01/2005 - 09/30/2006 10/01/2006 - 09/30/2007 10/01/2007 - 09/30/2008 10/01/2008 - 09/30/2009 10/01/2005 - 09/30/2006 10/01/2006 - 09/30/2007 10/01/2007 - 09/30/2008 10/01/2008 - 09/30/2009 10/01/2008 - 09/30/2009
	Known Questioned Costs: (\$539,523)

DCH's internal control over the Medicaid Cluster did not ensure compliance with federal laws and regulations regarding reporting.

Internal control that does not ensure compliance with federal laws and regulations could result in sanctions, disallowances, and/or future reductions of Medicaid Cluster awards.

Federal regulation 42 *CFR* 431.16 requires DCH to submit its quarterly statement of expenditures (CMS-64 report) for the Medical Assistance Program, which reports expenditure types, such as inpatient hospital services, nursing facility services, and payments to managed care organizations.

DCH uses an internal journal voucher (IJV) system for compiling Medicaid expenditure data for use in preparation of the CMS-64 report. The IJV system, which is separate from the State's accounting system, serves as a tracking and reconciliation tool for Medicaid expenditures.

DCH's internal control requires DCH grant accountants, who prepare the IJVs, to review each other's IJV entries. These reviews help DCH ensure that its grant accountants completely and accurately prepare the entries. Also, DCH stated that prior to May 2008, the grant accountants' supervisor performed a periodic review of IJV entries.

During the two-year audit period, DCH prepared 449 IJVs with a net value of \$12.5 billion. We tested 40 IJV entries totaling \$238.0 million that DCH used to prepare the CMS-64 report. Our review of DCH's process for preparing the CMS-64 report disclosed:

- a. DCH did not document that 11 (28%) of the reviews totaling \$161.4 million were performed by the other grant accountants and did not document that any of the reviews were performed by someone at a supervisory level prior to May 2008.

Also, for the 17 months of our audit period after April 2008, DCH did not have supervisory level controls in place over IJV entries. A change in supervisory positions occurred in May 2008, after which time DCH supervision did not resume periodic reviews of IJV entries.

We noted a similar condition in our prior Single Audit. DCH stated in its corrective action plan in the prior Single Audit that it added a new task to the CMS-64 Preparation Task List to verify that all internal journal vouchers were

initialed by both the employee who created the document and the employee who reviewed it. However, DCH did not completely correct the deficiency due to key staffing changes in fiscal years 2007-08 and 2008-09.

- b. DCH did not properly calculate the necessary CMS-64 report adjustment for one of our sample items. As a result, we reported known negative questioned costs totaling \$539,523.

DCH established an IJV entry to return federal funds related to a nursing home provider's closure. Subsequently, DCH established two additional IJV entries in an attempt to make corrections to the original IJV entry. However, DCH improperly calculated one of the two correcting IJV entries, which resulted in DCH not receiving proper federal reimbursement.

- c. DCH did not accurately report Medicaid payments recovered from providers for services covered by Medicare. During the audit period, DCH's CMS-64 reports identified only \$3.4 million in Medicare recoveries, although DCH's Third Party Liability Division activity report showed that it had recovered \$12.2 million.

Federal regulation 42 *CFR* 433.138 requires DCH to establish a third party liability process to determine the legal liability of third parties, such as Medicare or private health insurance companies, that are liable to pay for medical services furnished under the Medicaid State Plan. Third party recoveries are included on the CMS-64 report.

We noted the same condition in our prior Single Audit. DCH stated in its corrective action plan in the prior Single Audit that it reviewed and corrected the queries that generate the Medicare claim adjustment amounts for reporting purposes. DCH also stated that it would adjust a subsequent CMS-64 report to ensure that the amount is appropriately recorded. In addition, DCH stated that by March 2009 it would also develop reconciliation procedures to ensure that subsequent CMS-64 reports are verified against DCH accounting records. However, DCH did not correct the deficiency due to key staffing changes in fiscal years 2007-08 and 2008-09.

RECOMMENDATION

WE AGAIN RECOMMEND THAT DCH IMPROVE ITS INTERNAL CONTROL OVER THE MEDICAID CLUSTER TO ENSURE COMPLIANCE WITH FEDERAL LAWS AND REGULATIONS REGARDING REPORTING.

FINDING (3911030)

30. Medicaid Cluster, CFDA 93.777 and 93.778, Special Tests and Provisions - CHAMPS

U.S. Department of Health and Human Services	Medicaid Cluster: CFDA 93.777: State Survey and Certification of Health Care Providers and Suppliers CFDA 93.778: Medical Assistance Program CFDA 93.778: ARRA - Medical Assistance Program
Award Number: 05-0605MI5028 05-0705MI5028 05-0805MI5028 05-0905MI5028 05-0605MI5048 05-0705MI5048 05-0805MI5048 05-0905MI5048 05-0905MIARRA	Award Period: 10/01/2005 - 09/30/2006 10/01/2006 - 09/30/2007 10/01/2007 - 09/30/2008 10/01/2008 - 09/30/2009 10/01/2005 - 09/30/2006 10/01/2006 - 09/30/2007 10/01/2007 - 09/30/2008 10/01/2008 - 09/30/2009 10/01/2008 - 09/30/2009
	Known Questioned Costs: \$0

DCH, in conjunction with the Department of Technology, Management & Budget (DTMB), did not establish effective general controls over the Community Health Automated Medicaid Processing System (CHAMPS). Without effective general controls, DCH cannot ensure the CHAMPS application and data have been properly secured against unauthorized access or modification.

In March 2006, the State of Michigan contracted to replace its existing Medicaid Management Information System (MMIS). During our audit period, DCH completed the development and implementation of CHAMPS. During the development of CHAMPS, the contractor had the primary responsibility for most CHAMPS general controls. DCH informed us that it was in the process of transitioning the responsibility for general controls from the contractor to DTMB.

Because of the amount of Medicaid expenditures (\$13.7 billion during our audit period), it is critical that DCH implement effective general controls within CHAMPS

to help ensure compliance with all applicable direct and material federal compliance requirements.

Our review of selected general controls disclosed:

- a. DCH, in conjunction with DTMB, did not update the CHAMPS information system security plan, initially prepared by the CHAMPS contractor, to reflect changes in the CHAMPS information technology (IT) control environment.

Information system security plans are the primary means for State agencies to communicate the status of an information system's security controls to federal oversight agencies. The National Institute of Standards and Technology (NIST) is responsible for establishing federal IT security standards and best practices and is recognized by the State of Michigan as a source of professional guidance for securing the State's information systems. According to NIST, information system security plans should be reviewed and updated, if appropriate, at least annually to ensure that the security plan reflects current conditions.

- b. DCH, in conjunction with DTMB, did not require the CHAMPS contractor to implement security and access controls over CHAMPS development servers that align with State of Michigan and industry best practices.

DTMB Administrative Guide policy 1340.00 requires State agencies to ensure that contractors comply with all State of Michigan IT policies. For example, the contractor's security policy for password parameters and for sharing administrative accounts did not meet State of Michigan and industry best practices. As a result, DCH increased the risk that CHAMPS data or program code could be inappropriately modified.

- c. DCH, in conjunction with DTMB, had not fully developed and documented application change control procedures for CHAMPS.

The State's framework for IT governance and control, Control Objectives for Information and Related Technology* (COBIT), states that management should establish formal change control procedures to ensure all changes are handled in a standardized manner.

* See glossary at end of report for definition.

For example, DCH and DTMB had not documented procedures for authorizing changes, documenting user acceptance test plans and results, and monitoring for unauthorized changes. In addition, DCH had not documented its procedures for managing changes to configuration parameters, such as the edit disposition. Without documented procedures, there is a risk that inadvertent or intentional changes may adversely impact the CHAMPS application or the integrity of the Medicaid data.

RECOMMENDATION

We recommend that DCH, in conjunction with DTMB, establish effective general controls over CHAMPS.

FINDING (3911031)

31. Medicaid Cluster, CFDA 93.777 and 93.778, Allowable Costs/Cost Principles and Special Tests and Provisions - CHAMPS Other

U.S. Department of Health and Human Services	Medicaid Cluster: CFDA 93.777: State Survey and Certification of Health Care Providers and Suppliers CFDA 93.778: Medical Assistance Program CFDA 93.778: ARRA - Medical Assistance Program
Award Number: 05-0605MI5028 05-0705MI5028 05-0805MI5028 05-0905MI5028 05-0605MI5048 05-0705MI5048 05-0805MI5048 05-0905MI5048 05-0905MIARRA	Award Period: 10/01/2005 - 09/30/2006 10/01/2006 - 09/30/2007 10/01/2007 - 09/30/2008 10/01/2008 - 09/30/2009 10/01/2005 - 09/30/2006 10/01/2006 - 09/30/2007 10/01/2007 - 09/30/2008 10/01/2008 - 09/30/2009 10/01/2008 - 09/30/2009
	Known Questioned Costs: \$0

DCH's internal control over the Medicaid Cluster did not ensure compliance with federal laws and regulations regarding allowable costs/cost principles and special tests and provisions.

Internal control that does not ensure compliance with federal laws and regulations could result in sanctions, disallowances, and/or future reductions of Medicaid Cluster awards.

Federal regulation 42 *CFR* 433, subpart C, provides for 90% federal financial participation (FFP) for design, development, or installation and 75% FFP for operation of state mechanized claims processing and information retrieval systems. For costs generated from the system to be allowable, the costs must meet requirements outlined in Appendix A, section C of OMB Circular A-87 (federal regulation 2 *CFR* 225) and must also meet other special test and provision compliance requirements unique to the Medicaid Cluster.

MMIS is the automated management and control system for Medicaid that was in place for nearly all of the current audit period. The primary functions of MMIS included claims processing, recipient eligibility, provider enrollment, third party liability, and reference files. In March 2006, DCH began the MMIS replacement project known as the Community Health Automated Medicaid Processing System (CHAMPS). The provider enrollment subsystem of CHAMPS was implemented in March 2008. DCH stated that the eligibility, prior authorization, claims and encounter data, and contracts management CHAMPS subsystems were implemented in September 2009, during the last two weeks of the current two-year audit period, at which time DCH ceased utilization of MMIS.

DCH had not completed a functioning data warehouse to store paid claims and encounter data when CHAMPS was implemented in September 2009. Many DCH federal compliance responsibilities rely upon various queries or reports generated from paid claims data. In our discussions with DCH, DCH has stated that implementation of CHAMPS without a functioning data warehouse for storage of paid claims data has negatively impacted DCH's compliance with federal laws and regulations as follows:

- a. DCH could not send explanations of benefits (EOBs) to Medicaid beneficiaries for claims paid through CHAMPS. Federal regulation 42 *CFR* 433.116 requires DCH to provide individual notices within 45 days of the payment of the claims to all or a sample group of the persons who received services. As of April 30, 2010, DCH was 184 days delinquent with EOB mailing requirements. As a result, DCH was not in compliance with federal laws and regulations regarding special tests and provisions.

- b. DCH could not produce reports from the Management and Administrative Reporting System (MARS) for claims paid through CHAMPS. MARS reports provide analysis of recipient participation rates, expenditure rates, and medical service usage. As a result, DCH could not ensure compliance with federal laws and regulations for allowable costs/cost principles, which require costs to be reasonable and necessary for proper and efficient performance and administration of the Medicaid Cluster. Specifically:
- (1) The County Maintenance Payback MARS Report, which is used to determine accurate monthly billings to counties as required by Section 400.109 of the *Michigan Compiled Laws*, has not been completed since CHAMPS was implemented in September 2009. DCH sent estimated county billings totaling \$3.3 million for the period December 2009 through March 2010.
 - (2) DCH is unable to claim federal matching funds for State regional center approved claim activity for January 2009 through September 2009 dates of service as these claims were approved in CHAMPS. DCH was unable to estimate this amount upon our request. We estimated that the federal share of such claims for this period were \$10.1 million.
- c. DCH could not perform certain recalculations and reconciliations required by DCH's Medicaid State Plan. As a result, DCH could not ensure compliance with federal laws and regulations for allowable costs/cost principles, which require costs to be reasonable and necessary for proper and efficient performance and administration of the Medicaid Cluster. Specifically:
- (1) DCH could not perform quarterly recalculations of Medicaid interim payments (MIPs) to actual claims and could not complete annual MIP reconciliations to actual claims for long-term care providers, which included nursing homes, county medical care facilities, and hospital long-term care unit providers as required by DCH's Medicaid State Plan.

DCH issued MIPs of \$186.0 million in fiscal year 2008-09 to approximately 50 long-term care providers that volunteered to receive such payments as an alternative to receiving payments for actual claims received and processed by DCH weekly. Without performance of required MIP recalculations and reconciliations to actual claims, DCH

could not ensure that Medicaid expenditures were proper. DCH typically performs MIP recalculations on a quarterly basis and MIP reconciliations annually, generally 90 calendar days after the end of the provider's fiscal year. As of April 30, 2010, DCH was at least 180 days behind in MIP recalculations and at least 30 days behind in MIP reconciliations.

- (2) DCH could not complete annual nursing facility quality assurance supplement (QAS) reconciliations for the fiscal year ended September 30, 2009.

The Quality Assurance Assessment (QAA) Program provides a QAS to nursing facility reimbursement rates incorporating funds from the QAA tax. Effective October 1, 2005, nursing facilities receive a monthly payment as part of the QAA Program. During fiscal year 2008-09, DCH made QAS payments to nursing facilities totaling \$298.3 million.

DCH states in its Medicaid Provider Manual that it will complete an annual reconciliation of QAS payments to actual Medicaid approved days of care for each facility. If the reconciliation shows that QAS payments exceed approved Medicaid days, the provider pays the difference to DCH and if QAS payments are less than approved Medicaid days, DCH remits the difference to the facility. Without timely performance of QAS reconciliations, DCH could not timely ensure that Medicaid expenditures were proper.

- d. DCH could not bill all liable third parties for all paid claims that were the responsibility of third parties. Federal regulation 42 *CFR* 433.138 requires DCH to take reasonable measures to determine the legal liability of the third parties who are liable to pay for services furnished under the plan.

Prior to implementation of CHAMPS, DCH accessed paid claims data on a daily basis to perform functions to ensure compliance with federal laws and regulations regarding liabilities of third parties. In anticipation of implementation of CHAMPS, DCH ceased third party recoupment on July 29, 2009. For the six and one-half month period from August 2009 through mid-February 2010, DCH could not initiate provider claims adjustments or gross adjustments to recover Medicaid funds from liable third parties. For

example, DCH Medicare recoveries totaled \$8.4 million in fiscal year 2007-08; however, Medicare recoveries dropped to \$3.8 million in fiscal year 2008-09.

- e. DCH could not perform data matches to determine if DCH improperly issued payments on behalf of deceased beneficiaries.

Prior to implementation of CHAMPS, DCH stated that post-payment recoveries of payments made on behalf of deceased beneficiaries were processed on a monthly basis. However, DCH had not performed a data match to determine if DCH made payments on behalf of deceased beneficiaries since November 2009.

RECOMMENDATION

We recommend that DCH improve its internal control over the Medicaid Cluster to ensure compliance with federal laws and regulations regarding allowable costs/cost principles and special tests and provisions.

FINDING (3911032)

32. HIV Care Formula Grants, CFDA 93.917

U.S. Department of Health and Human Services	CFDA 93.917: HIV Care Formula Grants
Award Number: 6 X07HA00044-17-01 6 X07HA00044-17-02 6 X07HA00044-17-03 2 X07HA00044-18-00	Award Period: 04/01/2007 - 03/31/2008 04/01/2007 - 03/31/2008 04/01/2007 - 03/31/2008 04/01/2008 - 03/31/2009
	Known Questioned Costs: \$0

DCH's internal control over the HIV Care Formula Grants Program did not ensure compliance with federal laws and regulations regarding matching, level of effort, and earmarking and subrecipient monitoring.

Internal control that does not ensure compliance with federal laws and regulations could result in sanctions, disallowances, and/or future reductions of the HIV Care Formula Grants awards.

The HIV Care Formula Grants Program funds health care and support services for individuals with HIV/AIDS (human immunodeficiency virus/acquired immunodeficiency syndrome) and their families through care consortia in a home or community-based setting and provides assistance to ensure the continuity of health insurance coverage for individuals with HIV.

Federal expenditures for the HIV Care Formula Grants Program totaled \$34.0 million for the two-year period ended September 30, 2009, including \$9.7 million that was distributed to 19 subrecipients.

Our exceptions, by compliance area, are as follows:

a. Matching, Level of Effort, and Earmarking

DCH's internal control did not ensure that DCH timely sought and obtained a waiver for noncompliance with earmarking requirements.

Title 42, section 300ff-22(e) of the *United States Code* and Public Law 109-415, Section 2612(e) require DCH to use grant funds for health and support services to infants, children, youth, and women with HIV/AIDS in percentage amounts not less than the ratio of these groups to the general HIV/AIDS population. In addition, the federal laws allow the U.S. Department of Health and Human Services (HHS) to grant a waiver of the earmarking requirement if DCH demonstrates that the population is receiving HIV-related health services through other State or federal programs.

HHS required expenditures of 26.82% or \$4,276,239 and 26.92% or \$4,259,574 of grant funds to be allocated to infants, children, youth, and women for fiscal years 2007-08 and 2008-09, respectively. However, DCH reported grant expenditures of 23.44% or \$3,736,809 and 23.39% or \$3,701,121 for fiscal years 2007-08 and 2008-09, respectively. DCH submitted the retrospective earmarking waiver requests on September 30, 2008 and August 31, 2009 for the grant years ended March 31, 2008 and March 31, 2009, respectively.

After we brought the issue of no written approval to DCH's attention, DCH sought and received written approval for the earmarking waivers for the grant years ended March 31, 2008 and March 31, 2009 on February 3, 2010.

b. Subrecipient Monitoring

DCH did not monitor its subrecipients' compliance with federal requirements.

Federal regulation 45 *CFR* 92.40 and OMB Circular A-133, section 400(d)(3) requires DCH to monitor the operations of its subrecipients to ensure compliance with federal program requirements. Effective monitoring of subrecipients can be accomplished using various methods, depending on the nature and timing of the compliance requirement.

DCH stated that it primarily relied on site visits of its HIV subrecipients for monitoring of direct and material federal requirements applicable to subrecipient activities. However, DCH did not conduct any of these site visits during the two-year period ended September 30, 2009.

RECOMMENDATION

We recommend that DCH improve its internal control over the HIV Care Formula Grants Program to ensure compliance with federal laws and regulations regarding matching, level of effort, and earmarking and subrecipient monitoring.

FINDING (3911033)

33. Block Grants for Prevention and Treatment of Substance Abuse, *CFDA* 93.959

U.S. Department of Health and Human Services	<i>CFDA</i> 93.959: Block Grants for Prevention and Treatment of Substance Abuse
Award Number: B1MISAPT-07-3 3B08TI010026-08S4 3B08TI010026-09S3	Award Period: 10/01/2006 - 09/30/2008 10/01/2007 - 09/30/2009 10/01/2008 - 09/30/2010
	Known Questioned Costs: \$116,414,361

DCH's internal control over Block Grants for Prevention and Treatment of Substance Abuse (SAPT) did not ensure compliance with federal laws and regulations regarding matching, level of effort, and earmarking; subrecipient monitoring; and special tests and provisions. Our review disclosed material weaknesses in internal control and material noncompliance with federal laws and regulations regarding matching, level of effort, and earmarking. As a result, we issued an adverse opinion on compliance with federal laws and regulations for SAPT.

Internal control that does not ensure compliance with federal laws and regulations could result in sanctions, disallowances, and/or future reductions of SAPT awards.

During our audit period, DCH awarded SAPT funds to 18 subrecipients who, in turn, distributed the funds to 357 treatment providers. During fiscal year 2008-09, the treatment providers admitted and provided services, such as detoxification and counseling, to approximately 70,000 substance abusers.

Federal expenditures for SAPT totaled \$116.4 million for the two-year period ended September 30, 2009, including \$116.9 million that was distributed to the 18 subrecipients. We reported known questioned costs totaling \$116,414,361.

Our exceptions, by compliance area, are as follows:

a. Matching, Level of Effort, and Earmarking

DCH did not comply with SAPT level of effort requirements.

Federal regulation 45 CFR 96.134(a) requires the State to maintain aggregate State expenditures at a level not less than the average level of expenditures for the State's two fiscal years preceding the fiscal year for which the State is applying for the grant. Also, federal regulation 45 CFR 96.124(c)(3) requires the amount of expenditures for Women Services be equal to or greater than the amount expended for Women Services in fiscal year 1993-94 which, for DCH, was \$5,622,440.

For fiscal years 2007-08 and 2008-09, DCH did not record expenditures to the proper program codes. Therefore, DCH could not demonstrate that it complied with federal level of effort requirements for the aggregate State expenditures and the Women Services expenditures. As a result, we reported known questioned costs totaling \$116,414,361.

b. Subrecipient Monitoring

DCH did not perform adequate monitoring of its SAPT subrecipients.

OMB Circular A-133, section 400(d)(3) requires DCH to monitor its subrecipients' compliance with program requirements and applicable laws and regulations. Effective monitoring of subrecipients by DCH can be

accomplished using various methods, depending on the nature and timing of the compliance requirement.

DCH can use the subrecipients' Single Audits to help ensure that subrecipients used funds in compliance with federal laws and regulations if the subrecipients' Single Audits were performed during the audit period and SAPT was audited as a major program as part of the Single Audit. Otherwise, federal regulations require DCH to perform other monitoring activities to ensure that the subrecipients used funds in compliance with federal laws and regulations.

DCH stated that it relied on Single Audits of its SAPT subrecipients for monitoring of direct and material federal requirements applicable to subrecipient activities. DCH also stated that it augments its reliance on Single Audits through periodic site visits of subrecipients. However, DCH's site visits did not include a review of the documentation that supported expenditures reported by its subrecipients, which is necessary for effective monitoring of activities allowed or unallowed, allowable costs/cost principles, cash management, period of availability of federal funds, reporting, subrecipient monitoring, and special tests and provisions. Our review of DCH efforts to monitor its 18 subrecipients identified 4 SAPT subrecipients that did not have SAPT audited as a major federal program as part of the Single Audit. Expenditures to the 4 subrecipients were \$18.6 million (16%) of the \$116.9 million distributed to subrecipients during the audit period.

We noted the same condition in our prior Single Audit. DCH stated in its corrective action plan in the prior Single Audit that the DCH Office of Audit would notify program staff if the SAPT program was not tested as a major program for two consecutive years so program management could implement alternative monitoring procedures if deemed appropriate. However, DCH has subsequently concluded that notification after one year of not being tested as a major program would ensure more timely action.

c. Special Tests and Provisions

DCH could not document that treatment providers' services were independently reviewed, as required by federal regulations.

Federal regulation 45 *CFR* 96.136 requires the states to provide for independent peer reviews to assess the quality, appropriateness, and efficacy of treatment providers' services. To comply with the federal regulation, DCH requires that treatment providers acquire accreditation from one of five applicable accreditation bodies, such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

DCH stated that during its site visits to subrecipients, DCH visited two of each subrecipient's treatment providers to verify that the treatment providers are accredited as DCH requires.

However, during our review of DCH's site visits to 7 subrecipients and 14 corresponding treatment providers, we noted that DCH did not document whether 4 (29%) of the 14 treatment providers were accredited.

We noted the same condition in our prior Single Audit. DCH stated in its corrective action plan in the prior Single Audit that it had added verification of appropriate accreditation to its fiscal year 2007-08 coordinating agency and provider treatment monitoring protocols. However, DCH subsequently concluded that documentation requirements needed to be reiterated to staff.

RECOMMENDATIONS

We recommend that DCH improve its internal control over SAPT to ensure compliance with federal laws and regulations regarding matching, level of effort, and earmarking.

WE AGAIN RECOMMEND THAT DCH IMPROVE ITS INTERNAL CONTROL OVER SAPT TO ENSURE COMPLIANCE WITH FEDERAL LAWS AND REGULATIONS REGARDING SUBRECIPIENT MONITORING AND SPECIAL TESTS AND PROVISIONS.

FINDING (3911034)

34. Maternal and Child Health Services Block Grant to the States, CFDA 93.994

U.S. Department of Health and Human Services	CFDA 93.994: Maternal and Child Health Services Block Grant to the States
Award Number:	Award Period:
6 B04MC07777-01-06	10/01/2006 - 09/30/2008
1 B04MC08892-01-00	10/01/2007 - 09/30/2009
6 B04MC08892-01-01	10/01/2007 - 09/30/2009
6 B04MC08892-01-02	10/01/2007 - 09/30/2009
6 B04MC08892-01-03	10/01/2007 - 09/30/2009
6 B04MC08892-01-04	10/01/2007 - 09/30/2009
6 B04MC08892-01-05	10/01/2007 - 09/30/2009
1 B04MC11171-01-00	10/01/2008 - 09/30/2010
6 B04MC11171-01-01	10/01/2008 - 09/30/2010
	Known Questioned Costs: \$22,543

DCH's internal control over the Maternal and Child Health Services Block Grant to the States (MCH Block Grant) Program did not ensure compliance with federal laws and regulations regarding cash management and subrecipient monitoring.

Internal control that does not ensure compliance with federal laws and regulations could result in sanctions, disallowances, and/or future reductions of MCH Block Grant awards.

The MCH Block Grant Program's goal is to provide funds for improvement of the health of all mothers and children consistent with applicable health status goals and national health objectives established under the Social Security Act. DCH's primary internal control was its review of MCH Block Grant subrecipients' financial status reports to determine if the subrecipients were in compliance with program requirements and applicable laws and regulations.

Federal expenditures for the MCH Block Grant Program totaled \$38.0 million for the two-year period ended September 30, 2009, including \$19.2 million provided to 71 subrecipients.

Our exceptions, by compliance area, are as follows:

a. Cash Management

DCH needs to improve its internal control over its compliance with State and federal cash management requirements pertaining to the MCH Block Grant Program. DCH requested and obtained federal funds prematurely for the MCH Block Grant Program. As a result, we reported known questioned costs totaling \$22,543 (see Finding 4.b. and related recommendation).

b. Subrecipient Monitoring

DCH did not monitor its subrecipients' compliance with certain federal requirements. The financial status report reviews, and DCH's other efforts to monitor subrecipient compliance, did not include a review of documentation that supports the expenditures reported by its subrecipients, which is necessary for effective monitoring of allowable costs/cost principles, cash management, and period of availability of federal funds requirements.

OMB Circular A-133, section 400(d)(3) requires DCH to monitor its subrecipients to ensure compliance with applicable federal program requirements. Effective monitoring of subrecipients by DCH can be accomplished by using various methods, depending on the nature and timing of the compliance requirement.

We noted the same condition in our prior two Single Audits. DCH stated in its corrective action plan that it disagreed that internal control was not in place to ensure compliance with federal laws and regulations regarding subrecipient monitoring but also stated that DCH implemented risk assessment tools and conducted site visits as necessary. DCH subsequently indicated that it developed and implemented a subrecipient monitoring plan. However, the site visits and the subrecipient monitoring plan did not include testing of detailed transactions.

RECOMMENDATIONS

FOR THE THIRD CONSECUTIVE AUDIT, WE RECOMMEND THAT DCH IMPROVE ITS INTERNAL CONTROL OVER THE MCH BLOCK GRANT PROGRAM TO ENSURE COMPLIANCE WITH FEDERAL LAWS AND REGULATIONS REGARDING SUBRECIPIENT MONITORING.

We also recommend that DCH improve its internal control over the MCH Block Grant Program to ensure compliance with federal laws and regulations regarding cash management.

FINDING (3911035)

35. **Automated Data Processing (ADP) Security Program**

U.S. Department of Agriculture	CFDA 10.557: Special Supplemental Nutrition Program for Women, Infants, and Children
Award Number: 2005IW101442 2006IW101442 2007IW101442 2007IW101142 2007IW500342 2008IW100342 2008IW100642 2008IW101442 2008IW450342 2008IW500342 2009IW100342 2009IW100642 2009IW101442 2009IW500342	Award Period: 09/16/2005 - 09/30/2008 09/30/2006 - 09/30/2010 09/30/2007 - 09/30/2011 04/09/2007 - 09/30/2008 03/30/2007 - 09/30/2008 10/01/2007 - 09/30/2008 10/01/2007 - 09/30/2008 06/02/2008 - 09/30/2009 04/07/2008 - 09/30/2008 03/12/2008 - 09/30/2009 10/01/2008 - 09/30/2009 10/01/2008 - 09/30/2009 06/30/2009 - 09/30/2010 10/01/2008 - 09/30/2009
	Known Questioned Costs: \$0

U.S. Department of Health and Human Services	Temporary Assistance for Needy Families (TANF) Cluster: CFDA 93.558: Temporary Assistance for Needy Families
Award Number: DCH-08-IA-07 DCH-09-IA-02	Award Period: 10/01/2007 - 09/30/2008 10/01/2008 - 09/30/2009
Pass-Through Entity: Michigan Department of Human Services	Known Questioned Costs: \$0

U.S. Department of Health and Human Services	CFDA 93.767: Children's Health Insurance Program
Award Number: 05-0805MI5021 05-0905MI5021	Award Period: 10/01/2007 - 09/30/2008 10/01/2008 - 09/30/2009
	Known Questioned Costs: \$0

U.S. Department of Health and Human Services	Medicaid Cluster: CFDA 93.777: State Survey and Certification of Health Care Providers and Suppliers CFDA 93.778: Medical Assistance Program CFDA 93.778: ARRA - Medical Assistance Program
Award Number: 05-0605MI5028 05-0705MI5028 05-0805MI5028 05-0905MI5028 05-0605MI5048 05-0705MI5048 05-0805MI5048 05-0905MI5048 05-0905MIARRA	Award Period: 10/01/2005 - 09/30/2006 10/01/2006 - 09/30/2007 10/01/2007 - 09/30/2008 10/01/2008 - 09/30/2009 10/01/2005 - 09/30/2006 10/01/2006 - 09/30/2007 10/01/2007 - 09/30/2008 10/01/2008 - 09/30/2009 10/01/2008 - 09/30/2009
	Known Questioned Costs: \$0

U.S. Department of Health and Human Services	CFDA 93.917: HIV Care Formula Grants
Award Number: 6 X07HA00044-17-01 6 X07HA00044-17-02 6 X07HA00044-17-03 2 X07HA00044-18-00	Award Period: 04/01/2007 - 03/31/2008 04/01/2007 - 03/31/2008 04/01/2007 - 03/31/2008 04/01/2008 - 03/31/2009
	Known Questioned Costs: \$0

U.S. Department of Health and Human Services	CFDA 93.994: Maternal and Child Health Services Block Grant to the States
Award Number: 6 B04MC07777-01-06 1 B04MC08892-01-00 6 B04MC08892-01-01 6 B04MC08892-01-02 6 B04MC08892-01-03 6 B04MC08892-01-04 6 B04MC08892-01-05 1 B04MC11171-01-00 6 B04MC11171-01-01	Award Period: 10/01/2006 - 09/30/2008 10/01/2007 - 09/30/2009 10/01/2007 - 09/30/2009 10/01/2007 - 09/30/2009 10/01/2007 - 09/30/2009 10/01/2007 - 09/30/2009 10/01/2007 - 09/30/2009 10/01/2008 - 09/30/2010 10/01/2008 - 09/30/2010
	Known Questioned Costs: \$0

DCH had not established a comprehensive ADP security program over its information systems. As a result, DCH cannot demonstrate that it has implemented effective controls to ensure the integrity, availability, and confidentiality of its information systems and, as a consequence, cannot ensure

that DCH complies with applicable direct and material federal compliance requirements, such as the Medicaid Cluster ADP special tests and provisions requirement.

Federal regulations 45 *CFR* 95.621 and 7 *CFR* 277.18 make state agencies responsible for the security of all information systems used to administer federal programs. The regulations require state agencies to implement and maintain a comprehensive ADP security program. The primary goal of a comprehensive ADP security program is to ensure the integrity, availability, and confidentiality of state agencies' information systems and data.

According to the federal regulations, a comprehensive ADP security program includes categorization of information systems to determine the appropriate security requirements; establishment of a security plan, including provisions for disaster recovery; and performance of periodic risk assessments and system security reviews. In addition, an effective security program requires State agencies to assign the responsibility for information technology (IT) security to an individual with the appropriate level of authority to carry out security related tasks.

The State of Michigan Financial Management Guide (FMG) recommends that State agencies and the Department of Technology, Management & Budget (DTMB) use a service level agreement to clearly communicate IT roles and responsibilities. The service level agreement between DCH and DTMB states that DTMB is responsible for general controls and requires DCH to adequately communicate to DTMB its security requirements.

We assessed selected general controls over 23 information systems, including MMIS, CHAMPS, and the License 2000 System, that we determined to be significant to the administration of DCH's federal programs, such as the Medicaid Cluster, CHIP, the WIC Program, the TANF Cluster, the HIV Care Formula Program, and the MCH Block Grant Program. During the audit period, DCH's expenditures for these programs were \$13.7 billion, \$365.5 million, \$337.4 million, \$36.8 million, \$34.0 million, and \$38.0 million, respectively. Our review disclosed:

- a. DCH had not performed a security categorization for 20 (87%) of 23 information systems. As a result, DCH cannot ensure that its information systems have been appropriately secured based on defined risk levels.

- b. DCH, in conjunction with DTMB, did not complete risk assessments for 21 (91%) of 23 information systems. For the remaining 2 information systems, DTMB had completed a partial risk assessment as part of its security plan development (DIT-170). Without an effective risk assessment process, DCH cannot ensure that appropriate, cost-effective controls have been established to mitigate risks to DCH applications and data.
- c. DCH, in conjunction with DTMB, did not prepare an information system security plan for 17 (74%) of 23 significant information systems. Without documented security plans, DCH cannot demonstrate that appropriate security safeguards have been implemented to mitigate potential risks that could result in unauthorized disclosure, modification, or destruction of sensitive information stored or processed on DCH's information systems.
- d. DCH, in conjunction with DTMB, did not prepare and test disaster recovery plans for 13 (57%) of 23 information systems. DCH and DTMB had a partial or draft plan for 6 (26%) of 23 information systems. Without documented and tested disaster recovery plans, DCH cannot ensure that its information systems and data will be completely recovered in the event of a disruption.
- e. DCH, in conjunction with DTMB, did not adequately assess the security of its information systems. As a result, DCH cannot demonstrate that sufficient controls and security measures are in place to identify and remediate general control weaknesses such as those identified by recent Office of the Auditor General, DTMB, and third party reviews of general controls over DCH's information systems.

The reviews identified numerous and significant general control weaknesses pertaining to security management, access, configuration management, and contingency planning. Collectively, the general control weaknesses identified contributed to the Single Audit's conclusion that the auditors could not plan the audit to support a low assessed level of control risk for numerous compliance requirements as required by OMB Circular A-133. Consequently, we expanded our testing of compliance to ensure that we had a sufficient basis for our conclusions.

Federal regulations require DCH, no less than biennially, to assess information system security. The regulations require that DCH assess, at a minimum,

physical and data security, operating procedures, and personnel practices. In addition, the federal regulations require DCH to maintain reports of its reviews along with supporting documentation for on-site review by the federal oversight agencies.

- f. DCH's information security officer did not report directly to DCH's executive management team. Instead, DCH placed the security officer function in its Medical Services Administration. As a result, the security officer may find it difficult to effectively implement and enforce DCH's security policies and procedures across the entire organization. Also, there is an increased risk that DCH's other programs and information systems may not get the level of attention and resources needed to ensure that their information systems have been properly secured.

RECOMMENDATION

We recommend that DCH establish a comprehensive ADP security program over its information systems.

The status of the findings related to federal awards that were reported in prior Single Audits is disclosed in the summary schedule of prior audit findings.

OTHER SCHEDULES

DEPARTMENT OF COMMUNITY HEALTH
Summary Schedule of Prior Audit Findings
As of June 28, 2010

PRIOR AUDIT FINDINGS RELATED TO THE FINANCIAL SCHEDULES

Audit Findings That Have Been Fully Corrected:

Audit Period: October 1, 2005 through September 30, 2007
Finding Number: 3910805
Finding Title: Advance Payments

Finding: The Department of Community Health (DCH) did not obtain prior approval to make \$30.2 million in advance payments to providers.

Agency Comments: DCH has corrected the deficiency noted.

Audit Findings Not Corrected or Partially Corrected:

Audit Period: October 1, 2001 through September 30, 2003
Finding Number: 390402
Finding Title: Internal Control Over Financial Reporting and Accounting

Finding: DCH's internal control did not prevent certain reporting and accounting errors:

- a. DCH's internal control over financial reporting did not ensure that its schedule of expenditures of federal awards (SEFA) was accurately prepared.
- b. DCH's internal control over accounting did not prevent errors in the reporting of intrafund expenditure reimbursements and expenditure credits, long-term deferred revenue, and one contingent liability in DCH's notes to its financial schedules.

- c. DCH's internal control over accounting did not include a reconciliation of invoices from First Health Services Corporation to the underlying claims files.
- d. DCH's internal control over accounting did not properly account for federal funds passed through to the Department of Corrections.
- e. DCH's internal control over accounting did not prevent DCH from recording numerous accounting transactions during the audit period that needed adjustment.

Agency Comments: DCH has corrected the deficiencies noted in parts b. through e.

For part a., DCH will develop a process for ensuring that appropriate coding is used for future payments.

Audit Period: October 1, 2003 through September 30, 2005

Finding Number: 3910603

Finding Title: Schedule of Expenditures of Federal Awards (SEFA)

Finding: DCH's internal control over financial reporting did not ensure that DCH prepared its SEFA in accordance with U.S. Office of Management and Budget (OMB) Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*, and State financial management policies:

- a. DCH was unable to provide procedures for reconciling the specific expenditure transactions in the State's accounting records to the Medicaid and State Children's Insurance Program (SCHIP) federal program expenditures presented in its SEFA.
- b. DCH did not have adequate procedures to ensure that subrecipient expenditures reported on its SEFA accurately

reflected the expenditures recorded in the State's accounting records.

- c. DCH's internal control did not ensure that expenditures recorded in the State's accounting records were adequately reported in the SEFA as payments to subrecipients or payments to vendors.
- d. DCH's internal control did not ensure that federal expenditures were accurately reported under the appropriate *Catalog of Federal Domestic Assistance (CFDA)* number on its SEFA.

Agency Comments: DCH has corrected the deficiencies noted in parts a., b., and d.

For part c., DCH will develop a process for ensuring that appropriate coding is used for future payments.

Audit Period: October 1, 2005 through September 30, 2007
Finding Number: 3910801
Finding Title: Internal Control

Finding: DCH's internal control was not sufficient to ensure the accuracy of its financial accounting and reporting and its compliance with direct and material federal requirements. Also, DCH did not effectively use its biennial internal control evaluation (ICE) process to monitor its system of internal control:

- a. DCH's internal control over financial reporting and federal program compliance needs improvement.
- b.(1) DCH did not require its assessable units to assess the materiality of the weaknesses identified by their evaluation work sheets, which the designated senior official used to prepare the ICE.

b.(2) DCH did not have a process in place to document the designated senior official's disposition of material weaknesses identified by external sources (e.g., Office of the Auditor General reports).

b.(3) DCH did not submit its most recent ICE on a timely basis.

Agency Comments: DCH has corrected the deficiencies noted in parts b.(1) and b.(2).

For part a., please refer to the responses for Findings 3910801.b. through 3910823.

For part b.(3), DCH expects to submit its ICE on a timelier basis; however, DCH did not meet the May 1 deadline this reporting cycle. Subsequent to submission of the ICE this cycle, the responsibilities for completion of ICE reporting transferred to the Accounting Division.

Audit Period: October 1, 2005 through September 30, 2007

Finding Number: 3910802

Finding Title: Accounting and Financial Reporting

Finding: DCH's internal control did not prevent and detect certain accounting and reporting errors:

a.(1) DCH needs to improve internal control over disproportionate share hospital (DSH) payments (see Finding 3910816).

a.(2) DCH needs to improve its internal control over pharmacy rebates recovered from drug manufacturers by its pharmacy benefits manager (PBM) (see Finding 3910817).

- a.(3) DCH needs to improve internal control over invoices received from the Centers for Medicare and Medicaid Services (CMS) for Medicare Part A and Part B premiums (see Finding 3910818).
- a.(4) DCH needs to improve internal control over recoveries from providers for medical services (see Finding 3910819).
- b.(1)(a) DCH inappropriately included certified public expenditures claimed under the government provider DSH pool and expenditures commonly referred to by DCH as "gross-up" expenditures.
- b.(1)(b) DCH overstated amounts "Directly Expended" and understated amounts "Distributed to Subrecipients" by \$97.9 million and \$34.2 million for fiscal years 2005-06 and 2006-07, respectively.
- b.(1)(c) DCH's internal control did not ensure that recipients of federal funds were properly classified as a vendor or a subrecipient.
- b.(2) DCH's internal control over financial reporting did not ensure that DCH would identify accounting events that may require disclosure under generally accepted accounting principles.

Agency Comments: DCH has corrected the deficiency noted in part b.(2).

For parts a.(1) through a.(4), please refer to the responses for Findings 3910816 through 3910819.

For part b.(1)(a), DCH will explore the feasibility of coding these direct expenditures of DCH with grants for fiscal year 2009-10 and going forward.

For part b.(1)(b), DCH will develop a process for ensuring that appropriate coding is used for future payments.

For part b.(1)(c), DCH will develop a process for ensuring that recipients are appropriately classified for future grant periods.

Audit Period: October 1, 2005 through September 30, 2007

Finding Number: 3910803

Finding Title: Cash Management

Finding: DCH needs to improve its internal control over its compliance with State and federal cash management requirements:

- a. DCH did not request federal funds for two federal programs until the audit brought the missed federal funds to DCH's attention.
- b. DCH did not request and obtain federal funds on a timely basis for 3 of the 11 federal programs reviewed.

Agency Comments: DCH has corrected the deficiency noted in part a.

For part b., DCH has made significant improvements since the prior audit cycle and will continue to seek opportunities to make draws as accurately as possible.

Audit Period: October 1, 2005 through September 30, 2007

Finding Number: 3910804

Finding Title: PIHP and CMHSP Contract Payments

Finding: DCH's internal control over contract payments to prepaid inpatient health plans (PIHPs) and community mental health services programs (CMHSPs) did not ensure that payments were in compliance with federal regulations and State laws.

Agency Comments: For fiscal year 2008-09, DCH had fully executed contracts for all 46 CMHSPs before payments were made. DCH's legacy Medicaid Management Information System (MMIS) did not allow for the withholding of payment for a single vendor; therefore, DCH could not delay payments to all 18 PIHPs because 2 had not completed their necessary public hearings. DCH will continue to implement improvements in the contracting process that will guarantee that fully executed agreements are in place prior to the initial payment. In addition, DCH will pursue contract language or changes in the contracting process that will expedite execution of rate modifications, contract amendments, or contract extensions.

Audit Period: October 1, 2003 through September 30, 2005

Finding Number: 3910604

Finding Title: Receivables System (RS) Database

Finding: DCH's internal control did not ensure the completeness and accuracy of its RS Database, which is used to record past due amounts owed to DCH by Medicaid providers:

- a. DCH's Medicaid Collections Unit did not periodically reconcile the RS Database with receivables referred to the Unit from other DCH units and other State agencies.
- b. The Unit did not ensure that its review and approval of postings to the RS Database were complete, accurate, and timely.
- c. The Unit did not have procedures for identifying and documenting MQ-774 (the gross adjustment details report) receivables to be posted to the RS Database.

Agency Comments: DCH has corrected the deficiencies noted in parts a. and c.

For part b., the MAIN and Medical Support Section (MMSS) continues to strive to complete the receivable error checklist for all postings; however, staffing continues to be an issue.

Audit Period: October 1, 2005 through September 30, 2007

Finding Number: 3910806

Finding Title: Receivables System (RS) Database

Finding: DCH's internal control did not ensure the completeness and accuracy of its postings to the RS Database:

- a. DCH's Medicaid Collections Unit did not periodically reconcile the RS Database with receivables referred to the Unit from other DCH units and other State agencies.
- b. The Unit did not document its review and approval of postings to the RS Database.
- c. The Unit did not post all the Hospital and Health Plan Reimbursement Division's receivables from the gross adjustment details report (MQ-774 report) to the RS Database.

Agency Comments: DCH has corrected the deficiency noted in part a.

For part b., MMSS continues to strive to complete the receivable error checklist for all postings; however, staffing continues to be an issue.

For part c., MMSS continues to strive to post receivables on a timelier basis; however, staffing continues to be an issue.

PRIOR AUDIT FINDINGS RELATED TO FEDERAL AWARDS

Audit Findings That Have Been Fully Corrected:

Audit Period: October 1, 2001 through September 30, 2003

Finding Number: 390409

Finding Title: Immunization Grants, *CFDA* 93.268

Finding: DCH's internal control over the Immunization Grants Program did not ensure compliance with federal laws and regulations regarding allowable costs/cost principles and subrecipient monitoring. Also, in some instances, DCH did not document certain subrecipient monitoring activities:

- a. DCH's internal control did not prevent noncompliance with allowable cost/cost principle provisions related to payroll costs.
- b.(1) DCH did not have adequate procedures to monitor subrecipient compliance with federal allowable cost requirements.
- b.(2) DCH procedures did not ensure that DCH reconciled subrecipient inventory reports to DCH inventory records and did not ensure that subrecipients submitted their inventory reports in a timely manner.
- b.(3) DCH did not document its monitoring activities to ensure subrecipient compliance with federal guidelines regarding client vaccinations and eligibility.
- b.(4) DCH did not document its monitoring activities to ensure that subrecipients complied with federal requirements regarding vaccination fees charged to clients.

Agency Comments: DCH has corrected the deficiencies noted.

Audit Period: October 1, 2003 through September 30, 2005
Finding Number: 3910606
Finding Title: Injury Prevention and Control Research and State and Community Based Programs (IPP), *CFDA* 93.136

Finding: DCH's internal control over IPP did not ensure compliance with federal laws and regulations regarding allowable costs/cost principles and period of availability of federal funds:

- a. DCH authorized an IPP subrecipient to expend federal funds for an equipment purchase that exceeded allowable federal limits.
- b. DCH's internal control did not ensure compliance with federal period of availability requirements.

Agency Comments: DCH has corrected the deficiencies noted.

Audit Period: October 1, 2005 through September 30, 2007
Finding Number: 3910821
Finding Title: Centers for Medicare and Medicaid Services (CMS) Research, Demonstrations and Evaluations (CMS Research), *CFDA* 93.779

Finding: DCH's internal control over the CMS Research Program did not ensure compliance with federal laws and regulations regarding period of availability of federal funds.

Agency Comments: DCH has corrected the deficiencies noted.

Audit Findings Not Corrected or Partially Corrected:

Audit Period: October 1, 2001 through September 30, 2003
Finding Number: 390412
Finding Title: Medicaid Cluster, *CFDA* 93.778, Subrecipient Monitoring

Finding: DCH's internal control over the Medicaid Cluster did not ensure compliance with federal laws and regulations regarding subrecipient monitoring:

- a. DCH did not document how and whether it resolved Medicaid Eligibility Quality Control (MEQC) error cases.
- b. DCH did not monitor the propriety of MEQC non-error assessments.
- c. DCH did not monitor the propriety and accuracy of the MEQC Medicaid mispayment error rate.

Also, the interagency agreement, which was last updated in 1996, did not include federal award information required by OMB Circular A-133.

Agency Comments: DCH has corrected the deficiencies noted in parts a. and b. and in the last item related to the interagency agreement.

For part c., DCH meets on a regular basis with MEQC staff to review each identified error for accuracy as it applies to the error rate calculations. The Medicaid Error Review Committee, which meets three times per month, reviews each error individually with representatives of DCH, the Department of Human Services (DHS) central office, and local DHS offices. In reviewing the errors, corrections are made, suggestions are considered, and training needs are identified. DCH feels that these activities are sufficient and that further action, such as the recalculation of the error rate, is not warranted.

Audit Period: October 1, 2001 through September 30, 2003

Finding Number: 390413

Finding Title: Medicaid Cluster, *CFDA* 93.778, Reporting and Special Tests and Provisions

Finding: DCH's internal control over the Medicaid Cluster did not ensure compliance with federal laws and regulations regarding reporting and special tests and provisions:

- a. DCH submitted reports to the federal government that misclassified expenditures among categories by as much as \$719 million. The aggregate of the overstatements and understatements netted to zero.
- b.(1) DCH did not establish and maintain a program for conducting a biennial risk assessment of the Medicaid Management Information System (MMIS), as required by federal regulations.
- b.(2) DCH did not have controls in place to ensure that it did not make Medicaid payments to medical providers who had not renewed their State medical licenses.

Agency Comments: DCH has corrected the deficiencies noted in parts a. and b.(1).

For part b.(2), DCH expects this issue to be addressed by the new Community Health Automated Medicaid Processing System (CHAMPS).

Audit Period: October 1, 2003 through September 30, 2005

Finding Number: 3910605

Finding Title: Residential Substance Abuse Treatment for State Prisoners (RSAT), *CFDA* 16.593

Finding: DCH's internal control over RSAT did not ensure compliance with federal laws and regulations regarding subrecipient monitoring:

- a. DCH did not have adequate procedures to monitor subrecipient compliance with federal allowable costs/cost principles requirements.

- b. DCH could document only 1 of 10 RSAT subrecipient site visits that were required by DCH's procedures.

Agency Comments: DCH has corrected the deficiency noted in part b.

For part a., DCH will document any monitoring of subrecipients during future site visits. This program was transferred to the Michigan Department of State Police pursuant to Executive Order No. 2009-42, effective October 26, 2009.

Audit Period: October 1, 2003 through September 30, 2005

Finding Number: 3910608

Finding Title: State Children's Insurance Program (SCHIP), *CFDA* 93.767

Finding: DCH's internal control over SCHIP did not ensure compliance with federal laws and regulations regarding eligibility, reporting, and subrecipient monitoring:

- a. DCH's internal control did not prevent it from enrolling ineligible children into the MICHild Program. Also, DCH did not refer eligible children to the Medicaid Program.
- b. DCH's internal control did not ensure compliance with federal laws and regulations regarding reporting.
- c. DCH's internal control over SCHIP did not ensure compliance with federal laws and regulations regarding subrecipient monitoring.

Agency Comments: DCH has corrected the deficiencies noted in parts a. and b.

For part c., DCH still expects to develop a crosswalk for selected items in the interagency agreement to DHS's Program Eligibility Manual. DCH will attempt to work with DHS to add language to the interagency agreement that allows DCH to monitor DHS's compliance.

Audit Period: October 1, 2003 through September 30, 2005
Finding Number: 3910610
Finding Title: Medicaid Cluster, *CFDA* 93.777 and 93.778, Procurement and Suspension and Debarment and Subrecipient Monitoring

Finding: DCH's internal control over the Medicaid Cluster did not ensure compliance with federal laws and regulations regarding procurement and suspension and debarment and subrecipient monitoring:

- a. DCH and Medicaid health plan payment controls did not prevent Medicaid payments for services provided by sanctioned providers.
- b.(1) DCH did not monitor whether DHS followed the CMS-approved sampling plan.
- b.(2) DCH did not monitor the propriety of MEQC non-error assessments.
- b.(3) DCH did not monitor the propriety and accuracy of the MEQC Medicaid mispayment error rate calculations and did not determine the cause of sizable periodic error rate fluctuations.
- b.(4) DCH did not specify within its agreement with DHS potential monetary sanctions against DHS for noncompliance with the agreement.

Agency Comments: DCH has corrected the deficiencies noted in parts a. and b.(2).

For part b.(1), DCH will conduct an overview of samples, to the extent staff time permits, to provide the assurance that the sampling plan is adhered to.

For part b.(3), DCH meets on a regular basis with MEQC staff to review each identified error for accuracy as it applies to the error rate calculations. The Medicaid Error Review Committee, which

meets three times per month, reviews each error individually with representatives of DCH, the DHS central office, and local DHS offices. In reviewing the errors, corrections are made, suggestions are considered, and training needs are identified. DCH feels that these activities are sufficient and that further action, such as the recalculation of the error rate, is not warranted.

For part b.(4), DCH has been composing a list of necessary changes to the interagency agreement. DHS sanctions are part of this list.

Audit Period: October 1, 2003 through September 30, 2005
Finding Number: 3910611
Finding Title: Medicaid Cluster, *CFDA* 93.777 and 93.778, Special Tests and Provisions

Finding: DCH's internal control over the Medicaid Cluster did not ensure compliance with federal laws and regulations regarding special tests and provisions:

- a.(1) DCH made Medicaid-funded DSH payments of \$95.8 million to the Center for Forensic Psychiatry during the audit period and payments of \$68.7 million during fiscal year 2000-01 through fiscal year 2002-03.
- a.(2) DCH made Medicaid-funded DSH payments of \$32.7 million to the Huron Valley Center during fiscal year 2000-01.
- b. DCH made payments of \$49,723 to 22 unlicensed providers during the audit period, of which \$28,198 was federally funded and is reported as known questioned costs.

Agency Comments: DCH has corrected the deficiencies noted in part a.(2).

For part a.(1), DCH continues to believe that its actions with respect to these payments were appropriate. However, DCH has obtained the necessary support to seek Medicare certification. A written provider agreement has been established.

For part b., DCH expects CHAMPS to correct this issue.

Audit Period: October 1, 2003 through September 30, 2005

Finding Number: 3910613

Finding Title: Maternal and Child Health Services Block Grant to the States, *CFDA* 93.994

Finding: DCH's internal control over the Maternal and Child Health Services Block Grant to the States did not ensure compliance with federal laws and regulations regarding subrecipient monitoring.

Agency Comments: DCH has made significant strides since the audit period toward correcting subrecipient monitoring deficiencies. The Public Health Administration will work with the DCH Office of Audit to implement a procedure for testing a sample of expenditures from high-risk agencies. If, however, an agency that is deemed high risk has a specific program selected as major in its most recent Single Audit, DCH will rely on the results of that audit group and forgo any expenditure testing.

Audit Period: October 1, 2005 through September 30, 2007

Finding Number: 3910807

Finding Title: Special Supplemental Nutrition Program for Women, Infants, and Children (WIC Program), *CFDA* 10.557

Finding:

DCH's internal control over the WIC Program did not ensure compliance with federal laws and regulations regarding allowable costs/cost principles and subrecipient monitoring:

- a.(1) DCH's internal control did not ensure that it retained supporting documentation for redeemed WIC Program coupons.
- a.(2) DCH's internal control over the WIC Program coupon redemption process did not always ensure that the Michigan Department of Information Technology maintained adequate control over redeemed coupons submitted by retailers.
- b.(1) DCH did not ensure that it, or a public accounting firm, reviewed its local agency subrecipients' financial records at least once every two years.
- b.(2) DCH did not ensure that it completely examined all significant compliance requirements during its on-site monitoring visits and communicated areas of noncompliance to the local agency subrecipients.

Agency Comments:

DCH has corrected the deficiencies noted in all parts of the finding, except for part b.(1).

For part b.(1), after the requirement to conduct the fiscal reviews at least once every two years on each subrecipient was brought to DCH's attention during the last Single Audit, DCH began investigating means to accomplish the required reviews on a two-year cycle. DCH will continue to work toward accomplishing the required financial management systems reviews at least once every two years on each subrecipient. Further reductions to audit scopes, additional audit staffing, and reliance on subrecipients' Single Audits if the WIC Program is tested as a major program are items being considered to meet compliance.

Audit Period: October 1, 2005 through September 30, 2007
Finding Number: 3910808
Finding Title: Injury Prevention and Control Research and State and Community Based Programs (IPP), *CFDA* 93.136

Finding: DCH's internal control over IPP did not ensure compliance with federal laws and regulations regarding allowable costs/cost principles, period of availability of federal funds, and subrecipient monitoring:

- a. DCH's internal control did not ensure that it initially obtained a semiannual certification for one employee who reportedly worked solely on IPP.
- b. DCH improperly liquidated obligations for two subprograms incurred during the final funding period with payments that were 46 days and 65 days, respectively, beyond the 90-day requirement.
- c.(1) DCH did not adequately monitor and document its subrecipients' compliance with requirements pertaining to activities allowed or unallowed.
- c.(2) DCH did not monitor its IPP subrecipients' compliance with requirements pertaining to allowable costs/cost principles, cash management, and period of availability of federal funds.
- c.(3) DCH did not monitor its subrecipients for compliance with requirements pertaining to subrecipient monitoring.

Agency Comments: DCH has corrected the deficiencies noted in parts a. and b.

For parts c.(1) through c.(3), the Public Health Administration has made great strides in subrecipient monitoring since the last Single Audit in which DCH was found to be lacking in this area. The Public Health Administration will work with the DCH Office of Audit to implement a procedure for testing a sample of

expenditures from high-risk agencies. If, however, an agency that is deemed high risk has a specific program selected as major in its most recent Single Audit, DCH will rely on the results of that audit group and forgo any expenditure testing.

Audit Period: October 1, 2005 through September 30, 2007
Finding Number: 3910809
Finding Title: Immunization Grants, *CFDA* 93.268, Special Tests and Provisions

Finding: DCH's internal control over the Immunization Grants Program did not ensure compliance with federal laws and regulations regarding special tests and provisions (control, accountability, and safeguarding of vaccines):

- a. DCH did not ensure that local health departments (LHDs) effectively controlled and accounted for vaccines distributed to them.
- b. DCH did not document its periodic physical inventories of vaccines stored by DCH and did not have someone who was independent of the process complete the inventories.

Agency Comments: DCH has corrected the deficiencies noted in part b.

For part a., since the last audit, DCH has moved to an electronic vaccine accountability system built into the Michigan Care Improvement Registry. DCH continues to refine its processes at the LHDs since the implementation of this new system.

Audit Period: October 1, 2005 through September 30, 2007
Finding Number: 3910810
Finding Title: Immunization Grants, *CFDA* 93.268, Period of Availability and Subrecipient Monitoring

Finding:

DCH's internal control over the Immunization Grants Program did not ensure compliance with federal laws and regulations regarding period of availability of federal funds and subrecipient monitoring:

- a. DCH improperly charged personal service costs incurred by subrecipients during the Immunization Grants Program funding period ended December 31, 2005 to the funding period ended December 31, 2006.
- b.(1) DCH did not review documentation that supports the expenditures reported by its subrecipients, which is necessary for effective monitoring of allowable costs/cost principles and period of availability of federal funds requirements.
- b.(2) DCH did not document its monitoring activities to ensure subrecipient compliance with requirements pertaining to client vaccination and eligibility documentation.
- b.(3) DCH did not document its monitoring activities to ensure subrecipient compliance with federal suspension and debarment requirements.

Agency Comments: DCH has corrected the deficiency noted in part b.(2).

For part a., DCH continues to believe that expenditures were appropriate because they were obligated to the grantee prior to the end of the grant period.

For part b.(1), the Public Health Administration will work with the DCH Office of Audit to implement a procedure for testing a sample of expenditures from high-risk agencies. If an agency that is deemed high risk has a specific program selected as a major in its most recent Single Audit, DCH will rely on the results of the audit group and forgo any expenditure testing.

For part b.(3), DCH will be adding a clause in the provider enrollment form for the Vaccines for Children (VFC) Program that the provider is not suspended or disbarred.

Audit Period: October 1, 2005 through September 30, 2007
Finding Number: 3910811
Finding Title: Centers for Disease Control and Prevention - Investigations and Technical Assistance, *CFDA* 93.283

Finding: DCH's internal control over the Centers for Disease Control and Prevention - Investigations and Technical Assistance (CDC Program) did not ensure compliance with federal laws and regulations regarding subrecipient monitoring.

Agency Comments: The Public Health Administration will work with the DCH Office of Audit to implement a procedure for testing a sample of expenditures from high-risk agencies. If an agency that is deemed high risk has a specific program selected as a major in its most recent Single Audit, DCH will rely on the results of the audit group and forgo any expenditure testing.

Audit Period: October 1, 2005 through September 30, 2007
Finding Number: 3910812
Finding Title: Temporary Assistance for Needy Families (TANF), *CFDA* 93.558

Finding: DCH's internal control over TANF did not ensure compliance with federal laws and regulations regarding eligibility:

- a. DCH did not ensure that CMHSPs obtained and maintained case file documentation to support the recipients' eligibility for TANF.
- b. DCH did not monitor the appropriateness of eligibility determinations made by the CMHSPs for the first 22 months of the audit period.

Agency Comments: For part a., DCH will work with the CMHSPs so that appropriate supporting documentation is obtained/maintained for all Family Support Subsidy Program cases.

For part b., DCH is working on a revised sampling methodology for CMHSPs to take into account CMHSPs with larger volumes of Family Support Subsidy Program cases.

Audit Period: October 1, 2005 through September 30, 2007

Finding Number: 3910813

Finding Title: State Children's Insurance Program (SCHIP), *CFDA* 93.767

Finding: DCH's internal control over SCHIP did not ensure compliance with federal laws and regulations regarding allowable costs/cost principles and subrecipient monitoring:

- a. DCH did not base its claim for federal reimbursement of Healthy Kids Medicaid Expansion (HKME) expenditures on only actual expenditures, as required by federal regulation.
- b.(1) DCH did not monitor DHS's eligibility determinations for the Adult Benefits Waiver (ABW) Program or HKME.
- b.(2) DCH did not determine the reasonableness of the decrease of federal expenditures that DCH attributed to SCHIP's HKME-eligible beneficiaries.

Agency Comments: DCH has corrected the deficiency noted in part a.

For part b.(1), DCH still expects to complete a crosswalk for selected items in the interagency agreement to the Program Eligibility Manual. DCH will continue to work with DHS in an attempt to get language added to the interagency agreement which allows DCH to monitor DHS's compliance.

For part b.(2), DHS's new eligibility determination system (the Bridges Integrated Automated Eligibility Determination System, known as Bridges) will more systematically identify children who qualify for HKME. When the system has been fully implemented, a final and more definitive outcome on this issue will occur.

Audit Period: October 1, 2005 through September 30, 2007
Finding Number: 3910814
Finding Title: Medicaid Cluster, *CFDA* 93.777 and 93.778, Special Tests and Provisions

Finding: DCH did not ensure compliance with federal laws and regulations regarding special tests and provisions pertaining to Medicaid-funded DSH payments for State psychiatric hospitals:

- a. DCH made Medicaid-funded DSH payments of \$67.5 million to the Center for Forensic Psychiatry (CFP) during the audit period.
- b.(1) DCH issued licenses to 308 medical providers without conducting a criminal history background check, as required by State law, for Medicaid providers who were granted a license on or after May 1, 2006.
- b.(2) DCH made Medicaid payments to medical providers that had not renewed their State medical licenses.

Agency Comments: For part a., DCH continues to believe that its actions with respect to these payments were appropriate. Nevertheless, it has established a provider agreement with CFP and is still in the process of seeking CMS certification.

For part b.(1), DCH began conducting criminal history background checks as of October 1, 2008. DCH will check with the Department of Attorney General to determine the legality of conducting criminal history background checks on the professionals that were licensed prior to the Michigan

Department of State Police having the capacity to begin the background checks for DCH.

For part b.(2), DCH expects CHAMPS to correct this issue.

Audit Period: October 1, 2005 through September 30, 2007
Finding Number: 3910815
Finding Title: Medicaid Cluster, *CFDA* 93.777 and 93.778, Allowable Costs/Cost Principles - Omnibus

Finding: DCH's internal control over the Medicaid Cluster did not ensure compliance with federal laws and regulations regarding allowable costs/cost principles:

- a. DCH did not complete cost settlements with Medicaid providers in a timely manner.
- b. DCH's process for maintaining the Medicaid Sanctioned Providers List did not ensure that it contained all providers having past and current associations with health professionals and other providers that were shown to have threatened the fiscal integrity of Medicaid.
- c. DCH needs to improve internal control over contract payments to prepaid inpatient health plans (PIHPs).

Agency Comments: For part a., as hiring/budget allows, the Hospital and Health Plan Reimbursement Division will be requesting additional positions to accomplish this goal. Without additional staff, the status will remain the same. Due to the policy of using filed cost reports to reimburse providers for multiple programs, DCH has implemented additional desk reviews. This will not only delay the processing of filed cost reports, but also requires an amended filed cost report for prior years. All of these steps take staff time that would normally be used to process final settlements.

For part b., DCH will review available options and will implement additional procedures as deemed necessary.

For part c., DCH will continue to implement improvements in the contracting process that will guarantee that fully executed agreements are in place prior to the initial payment. In addition, DCH will pursue contract language or changes in the contracting process that will expedite execution of rate modifications, contract amendments, or contract extensions.

Audit Period: October 1, 2005 through September 30, 2007

Finding Number: 3910816

Finding Title: Medicaid Cluster, *CFDA* 93.777 and 93.778, Allowable Costs/Cost Principles - Disproportionate Share Hospital (DSH) Pools

Finding: DCH's internal control over the Medicaid Cluster related to DSH pools did not ensure compliance with federal laws and regulations regarding allowable costs/cost principles:

- a. DCH inappropriately billed and received federal reimbursement from the government provider DSH pool.
- b. DCH's internal control did not prevent errors in the calculation of DSH payments to State psychiatric hospitals.
- c. DCH's internal control did not ensure compliance with the Medicaid State Plan for payments from the indigent care agreement (ICA) DSH pool.

Agency Comments: DCH has corrected the deficiencies noted in parts a. and c.

For part b., DCH will continue to update its procedures to ensure that DSH payments are appropriately calculated.

Audit Period: October 1, 2005 through September 30, 2007
Finding Number: 3910817
Finding Title: Medicaid Cluster, *CFDA* 93.777 and 93.778, Allowable Costs/Cost Principles - Pharmacy Rebates

Finding: DCH's internal control over the Medicaid Cluster and SCHIP related to pharmacy rebates did not ensure compliance with federal laws and regulations regarding allowable costs/cost principles:

- a. DCH did not have procedures in place to ensure that rebates billed by the PBM to drug manufacturers on behalf of DCH were reasonable.
- b.(1) During fiscal year 2005-06, DCH incorrectly distributed pharmacy rebates attributable to SCHIP to the Medicaid Cluster.
- b.(2) During fiscal year 2006-07, DCH incorrectly distributed pharmacy rebates between Medicaid Cluster program cost accounts.

Agency Comments: DCH has corrected the deficiencies noted in part b.

For part a., DCH continues to complete the quarterly procedure that validates the reasonableness of the invoiced amounts to provide assurance that DCH is maximizing allowable rebates. Updates are made as necessary.

Audit Period: October 1, 2005 through September 30, 2007
Finding Number: 3910818
Finding Title: Medicaid Cluster, *CFDA* 93.777 and 93.778, Allowable Costs/Cost Principles - Medicare Part A and Part B

Finding: DCH's internal control over the Medicaid Cluster related to Medicare Part A and Part B did not ensure compliance with

federal laws and regulations regarding allowable costs/cost principles.

Agency Comments: In February 2010, DCH initiated additional reasonableness review procedures. DCH continues to review available options and will implement additional procedures as deemed appropriate.

Audit Period: October 1, 2005 through September 30, 2007

Finding Number: 3910819

Finding Title: Medicaid Cluster, *CFDA* 93.777 and 93.778, Allowable Costs/Cost Principles - Third Party Liabilities

Finding: DCH's internal control over the Medicaid Cluster related to third party liabilities did not ensure compliance with federal laws and regulations regarding allowable costs/cost principles:

a. DCH made excessive recoveries from providers for medical services.

b. DCH did not have sufficient controls in place to ensure that Medicaid was the payer of last resort, as reported in the performance audit of the Court Originated Liability Section (COLS), Medical Services Administration, Department of Community Health (391-0702-05). The audit reported the following control deficiencies, all of which were considered to be material conditions:

b.(1) The COLS's Paternity Unit did not coordinate with applicable State and local offices to ensure that the Wayne County Friend of the Court requested and sought reimbursement for the pregnancy and birthing-related Medicaid costs for Wayne County recipients involved in child support actions.

b.(2) The COLS's Paternity Unit did not include some pregnancy and birthing-related Medicaid costs for mothers

with nonmarital births on the reports provided to the governmental agencies involved in recovering the costs for Medicaid from the children's fathers.

- b.(3) The COLS's Paternity Unit did not have controls to ensure that it answered the requests of local prosecuting attorney and Friend of the Court offices for selected Medicaid recipients' pregnancy and birthing-related Medicaid costs.
- b.(4) The COLS's Paternity Unit did not coordinate with the applicable State and local offices to end the practice of establishing countywide limits on the amount of court-ordered reimbursement sought for pregnancy and birthing-related Medicaid costs.
- b.(5) The COLS's Casualty Unit did not use State motor vehicle and workers' compensation files to identify recipients with Medicaid costs related to injuries sustained in motor vehicle accidents or at work.
- b.(6) The COLS's Casualty Unit did not have a sufficient basis for accepting partial payments from some third parties as full payment of their Medicaid liabilities. Also, the Unit did not identify some accident-related Medicaid costs for recipients when pursuing recovery from other liable third parties.

Agency Comments: DCH has corrected the deficiencies noted in parts a., b.(1), b.(4), b.(5) and b.(6).

For part b.(2), changes were made subsequent to the audit. Additional changes were made during CHAMPS implementation and with the ongoing implementation of the Paternity Casualty Recovery System (PCRS). COLS continues to review the process and make changes as necessary.

For part b.(3), the Third Party Liability Division will review all requests carried over from the previous system and appropriately resolve all requests brought over as part of the conversion to PCRS.

Audit Period: October 1, 2005 through September 30, 2007
Finding Number: 3910820
Finding Title: Medicaid Cluster, *CFDA* 93.777 and 93.778, Reporting and Subrecipient Monitoring

Finding: DCH's internal control over the Medicaid Cluster did not ensure compliance with federal laws and regulations regarding reporting and subrecipient monitoring:

- a.(1) DCH did not document that the controls established to ensure the accuracy of the internal journal voucher entries were operating.
- a.(2) DCH's internal control did not ensure accurate reporting of Medicaid payments recovered from providers for services covered by Medicare.
- b.(1) DCH did not monitor whether its subrecipient (DHS) followed the CMS-approved sampling plan.
- b.(2) DCH did not monitor the propriety and accuracy of the MEQC Medicaid mispayment rate calculations and did not determine the cause of periodic mispayment rate fluctuations.
- b.(3) DCH did not evaluate the impact of corrective action plans on reducing the mispayment rate.
- b.(4) DCH did not sufficiently monitor DHS's compliance with federal requirements pertaining to subrecipient monitoring of allowable costs/cost principles and eligibility for the Medicaid Adult Home Help Program, which is an example

of a Medicaid Cluster program for which DHS determines client eligibility.

Agency Comments: For part a.(1), during a brief period when supervisory approval was not available, DCH allowed some peer-to-peer review. Current Accounting Division policy requires approval of all journal vouchers by supervisors.

For part a.(2), the DCH Accounting Division will work with the Third Party Liability Division to develop a process for ensuring that Medicare recoveries are accurately reported on the statement of expenditures (CMS-64 report).

For part b.(1), DCH meets on a regular basis with MEQC staff to review each identified error for accuracy as it applies to the error rate calculations. The Medicaid Error Review Committee, which meets three times per month, reviews each error individually with representatives of DCH, the DHS central office, and local DHS offices. In reviewing the errors, corrections are made, suggestions are considered, and training needs are identified. DCH feels that these activities are sufficient and that further action, such as the recalculation of the error rate, is not warranted.

For part b.(2), DCH hired a contractor and is in the process of establishing a universe of data from which it can draw a sample to conduct audits. The implementation of Bridges has played a role in this process.

For part b.(3), DCH will continue to develop evaluative techniques that attempt to quantify correlations between corrective measures and improved performances.

For part b.(4), DCH hired a contractor during fiscal year 2007-08 to conduct monitoring of the home help program.

Audit Period: October 1, 2005 through September 30, 2007
Finding Number: 3910822
Finding Title: Block Grants for Prevention and Treatment of Substance Abuse (SAPT), *CFDA* 93.959

Finding: DCH's internal control over SAPT did not ensure compliance with federal laws and regulations regarding matching, level of effort, and earmarking; subrecipient monitoring; and special tests and provisions (independent peer reviews):

- a. DCH did not comply with SAPT earmarking requirements for the grant award that ended on September 30, 2007.
- b. DCH did not perform adequate monitoring of its SAPT subrecipients.
- c. DCH could not document that treatment providers' services were independently reviewed as required by federal regulations.

Agency Comments: For part a., DCH will develop a procedure to allocate expenditures to appropriate program codes to allow for an easier demonstration of compliance with federal level of effort and earmarking requirements. In addition, DCH will ensure that if level of effort requirements are not met, appropriate waivers will be sought.

For part b., DCH will ensure monitoring of direct and material federal requirements applicable to subrecipient activities not less often than every other year.

For part c., DCH site visit procedures call for the documentation to be noted on the protocol, obtained from the providers, and retained in files. DCH will work with staff to ensure that this occurs.

Audit Period: October 1, 2005 through September 30, 2007
Finding Number: 3910823
Finding Title: Maternal and Child Health Services Block Grant to the States
(MCH Block Grant), *CFDA* 93.994

Finding: DCH's internal control over the MCH Block Grant Program did not ensure compliance with federal laws and regulations regarding allowable costs/cost principles and subrecipient monitoring:

- a. DCH did not have a process to ensure that the system-generated refund payments to insurance carriers were accurate.
- b. DCH did not perform adequate monitoring of its MCH Block Grant Program's subrecipients.

Agency Comments: DCH has corrected the deficiency noted in part a.

For part b., DCH has made significant strides since the audit period toward correcting subrecipient monitoring deficiencies. The Public Health Administration will work with the DCH Office of Audit to implement a procedure for testing a sample of expenditures from high-risk agencies. If, however, an agency that is deemed high risk has a specific program selected as major in its most recent Single Audit, DCH will rely on the results of that audit group and forgo any expenditure testing.

DEPARTMENT OF COMMUNITY HEALTH

Corrective Action Plan

As of June 24, 2010

FINDINGS RELATED TO THE FINANCIAL SCHEDULES

Finding Number: 3911001
Finding Title: Internal Control

Management Views: Part a.: The Department of Community Health (DCH) agrees with the recommendation, but does not agree with all of the examples cited in support of the conclusion that DCH's internal control did not ensure the accuracy of its financial accounting and reporting and its compliance with direct and material federal requirements. Because all of the examples referred to in this part represent specific findings that are separately addressed in this report, the corrective action and detailed responses will not be duplicated here, but separately addressed in response to each specific finding.

Part b.: DCH agrees that there are opportunities for improving its efforts to monitor the effectiveness of its internal control process using the internal control evaluation (ICE).

Part b.(1): DCH agrees that it did not maintain a complete inventory of its information technology (IT) systems.

Part b.(2): DCH agrees that it did not include all critical IT systems in its ICE report.

Part b.(3): DCH agrees that it did not have a process to document the internal control officer's (ICO's)

disposition of material weaknesses identified by its assessable units for the last ICE cycle.

Part b.(4): DCH agrees it did not submit the last ICE report by the established deadline.

Planned Corrective Action:

Part a.: Refer to the responses to Findings 1b. through 13 and 15 through 35.

Part b.(1): DCH will work with the Department of Technology, Management & Budget (DTMB) prior to the next ICE cycle to develop a complete inventory of its IT systems.

Part b.(2): DCH will work with the system business owners to determine critical IT systems to include in its next ICE report.

Part b.(3): DCH will institute a process to document the ICO's disposition of material weaknesses identified by its assessable units for the current ICE cycle.

Part b.(4): DCH will submit the current ICE report by the established deadline.

Anticipated Completion Date:

Part a.: Refer to the responses to Findings 1b. through 13 and 15 through 35.

Part b.(1): October 1, 2010

Part b.(2): October 1, 2010

Part b.(3): October 1, 2010

Part b.(4): March 1, 2011

Responsible Individuals: Part a.: Refer to the responses to Findings 1b. through 13 and 15 through 35.

Part b.: Tim Becker and Scott Werner

Finding Number: 3911002

Finding Title: Accounting and Financial Reporting

Management Views: Part a.(1): DCH agrees that there are opportunities for improvement to ensure the completeness and accuracy of tobacco products tax revenue recorded monthly on the DCH financial statements. DCH currently analyzes annual tax collections against the published tobacco products tax revenue projections by the Department of Treasury and is aware of variances. Historically, the actual tobacco products tax revenues are very close to the Department of Treasury's revenue estimates that are prepared in December and May of the fiscal year.

Part a.(2): DCH acknowledges that during a brief two-month period, when supervisory approval was not available, DCH allowed some peer-to-peer approval of journal entries. Current Accounting Division policy requires approval of all journal entries by supervisors, and the internal control concern noted in this finding was isolated to the two-month period.

Part a.(3): DCH agrees that there are opportunities for improvement in its internal control over Adult Home Help (AHH) expenditures. The Program has undergone significant changes in fiscal year 2009-10, including a transition to a new payment system under the supervision of DCH. Controls have been instituted in the new payment system to give DCH direct control

over the payment process and greater assurance as to the accuracy of the payments.

Part a.(4): DCH agrees that there are opportunities for improvement in its internal control over the accounting for, and reporting of, encumbrances and lapses.

Part b: DCH acknowledges that there are opportunities for improvement in its schedule of expenditures of federal awards (SEFA) preparation.

Part b.(1): DCH agrees that the \$167.9 million reported on DCH's SEFA did not have associated grant information to support which expenditures were funded.

Part b.(2): DCH acknowledges that the fiscal year 2008-09 SEFA initially excluded non-cash assistance related to vaccines. DCH was aware of the total attributed to non-cash assistance, but was not aware that the federal compliance supplement required that this be included on the SEFA.

Part b.(3): DCH agrees that the proper coding was not always used when entering payment information into the State's accounting system.

Part b.(4): DCH agrees that recipients of federal funds were not always properly classified as a vendor or a subrecipient.

Planned Corrective Action:

Part a.(1): DCH accounting staff will perform a monthly analysis of tobacco products tax revenue received as compared to the Department of Treasury's revenue projections. The Department of Treasury will be contacted if any significant variances in monthly revenues are identified.

Part a.(2): Accounting Division Procedure 105.0 was amended to now require supervisory approval of all journal entries.

Part a.(3): Effective January 2010, DCH implemented a new payment system for AHH which transitioned responsibility for AHH payments from the Department of Human Services (DHS) to DCH. The AHH payments previously made from the Model Payments System at DHS are now made directly by DCH through the Adult Services Authorized Payments System (ASAP). Payments are only generated for authorized services and for beneficiaries with Medicaid eligibility.

Part a.(4): DCH Accounting and Budget will develop a process at year-end closing to ensure that appropriate entries are completed so that funds are accounted for accurately.

Part b.(1): DCH will explore the feasibility of coding these direct expenditures of the department with grants for fiscal year 2009-10 and going forward.

Part b.(2): DCH will incorporate a review of the federal compliance supplement to ensure that appropriate grant information is reported.

Part b.(3): DCH will develop a process for ensuring that appropriate coding is used for future payments.

Part b.(4): DCH will develop a process for ensuring that appropriate recipients are appropriately classified for future grant periods.

Anticipated Completion Date: Part a.(1): October 1, 2010

Part a.(2): Completed

Part a.(3): Completed

Part a.(4): October 1, 2010

Part b.(1): October 1, 2010

Part b.(2): June 30, 2010

Part b.(3): October 1, 2010

Part b.(4): October 1, 2010

Responsible Individuals: Part a.(1): Tim Becker

Part a.(2): Tim Becker

Part a.(3): Tim Becker and Debra Katcher

Part a.(4): Tim Becker and Sue Malkin

Part b.(1): Tim Becker

Part b.(2): Tim Becker

Part b.(3): Tim Becker and Kristi Broessel

Part b.(4): Tim Becker and Kristi Broessel

Finding Number: 3911003

Finding Title: Third Party Service Organizations (TPSOs)

Management Views: DCH agrees that there are opportunities for improvement in evaluating the sufficiency of third party service organization (TPSO) internal control assurance audits.

Part a.: DCH agrees that the Statement on Auditing Standards No. 70, *Service Organizations*, SAS 70 audit did not require an evaluation of the vendor's use of subservice organizations to the MICHild Program's internal control.

Part b.: DCH agrees that it did not require that a technical description of the vendor's IT architecture be included in the SAS 70 audit.

Part c.: DCH agrees that it did not conduct a detailed evaluation of the sufficiency of the service auditor's tests of controls.

Planned Corrective Action:

Part a.: DCH will define a requirement that requires that the SAS 70 audit evaluate internal control of the subservice organizations used by the vendor. These requirements will become part of the contract.

Part b.: DCH, in conjunction with DTMB, will define a requirement to include a technical description of the IT architecture in the SAS 70 audit. This requirement will become part of the contract.

Part c.: DCH, in conjunction with DTMB, will develop a process to evaluate the sufficiency of the service auditor's tests of controls.

Anticipated Completion Date: December 31, 2010

Responsible Individuals:

Part a.: Terry Geiger and Kristi Broessel

Part b.: Terry Geiger, Kristi Broessel, and Linda Myers

Part c.: Terry Geiger, Kristi Broessel, and Linda Myers

Finding Number: 3911004
Finding Title: Cash Management

Management Views: DCH acknowledges that there are opportunities for improvement in its compliance with State and federal cash management requirements. However, DCH has made significant improvements since the prior audit cycle and will continue to seek opportunities to make its draws as accurately as possible.

Planned Corrective Action: DCH will explore the potential use of subsidiary coding within its Administrative Revolving Fund (ARF) to facilitate more timely draws for expenditures in the ARF.

Anticipated Completion Date: October 1, 2010

Responsible Individuals: Tim Becker and Corey Sparks

Finding Number: 3911005
Finding Title: PIHP and CMHSP Contract Payments

Management Views: DCH acknowledges that further improvements in the contractual process are necessary. The Mental Health Code mandates provision of mental health and substance abuse services to individuals. Timely payments to the community mental health services programs (CMHSP)/prepaid inpatient health plans (PIHP) are necessary to ensure continuity of services to individuals whose health conditions are such that interruption of services could be life threatening and/or place the consumer at significant risk. DCH did implement a new rate schedule April 1, 2009, which resulted in an estimated increase in payments to the PIHPs of \$4.6 million Statewide. This new rate schedule was implemented to ensure community

placement for individuals with developmental disabilities who were placed in the community when the Mt. Pleasant Center closed. This new rate schedule was approved by the Centers for Medicare and Medicaid Services prior to payment as required by federal regulation.

Planned Corrective Action: DCH will continue to implement improvements in the contracting process that will guarantee that fully executed agreements are in place prior to the initial payment. In addition, DCH will pursue contract language or changes in the contracting process that will expedite execution of rate modifications, contract amendments, or contract extensions.

Anticipated Completion Date: October 1, 2010

Responsible Individual: Mark Kielhorn

FINDINGS RELATED TO FEDERAL AWARDS

Finding Number: 3911006
Finding Title: Special Supplemental Nutrition Program for Women, Infants, and Children, *CFDA 10.557*

Management Views: DCH agrees that subrecipients' financial records related to the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC Program) were not reviewed at least once every two years as required by federal regulation.

Planned Corrective Action: DCH will continue to investigate means to accomplish the required financial management system reviews at least once every two years on each subrecipient. Further reductions to audit scopes, additional audit staffing, and reliance on subrecipients' Single Audits if

WIC is tested as a major program are items being considered to meet compliance.

Anticipated Completion Date: September 30, 2011

Responsible Individual: Deb Hallenbeck

Finding Number: 3911007

Finding Title: Aging Cluster, *CFDA* 93.044, 93.045, 93.053, 93.705, and 93.707

Management Views: The Office of Services to the Aging (OSA) reviewed documentation that supported expenditures reported by the area agencies on aging (AAAs) during yearly compliance assessments of AAAs. OSA, however, agrees that it did not always maintain documentation evidencing the reviews of expenditure documentation. In addition, DCH agrees that it had not updated the log that evidenced its quarterly reviews of financial status expenditure reports for the third and fourth quarters of fiscal year 2008-09.

Planned Corrective Action: OSA will maintain documentation evidencing the review of documentation that supports expenditures reported by the AAAs during the yearly compliance assessments. In addition, OSA will improve the current process of completing the log that evidences quarterly reviews of financial status expenditure reports. The quarterly log will be completed by the first of the second month following the quarter-end showing the review date, reviewer's name, and any comments; this will be forwarded to the deputy director for review.

Anticipated Completion Date: September 30, 2010

Responsible Individual: Peggy Brey

Finding Number: 3911008
Finding Title: Public Health Emergency Preparedness,
CFDA 93.069

Management Views: DCH agrees that its site visits did not include a review of the documentation that supported expenditures reported by its subrecipients. The Office of Public Health Preparedness has made great strides in subrecipient monitoring since the last Single Audit in which DCH was found to be lacking in this area.

Planned Corrective Action: The Office of Public Health Preparedness will work with the DCH Office of Audit to implement a procedure for testing a sample of expenditures from high-risk agencies. If, however, an agency that is deemed high risk has a specific program selected as major in its most recent Single Audit, DCH will rely on the results of that audit group and forgo any expenditure testing.

Anticipated Completion Date: October 1, 2010

Responsible Individual: Jackie Scott

Finding Number: 3911009
Finding Title: Immunization Cluster, *CFDA* 93.268 and 93.712

Management Views: DCH generally agrees that there are opportunities for improvement to ensure compliance with federal laws and regulations.

Part a.: DCH disagrees that it did not effectively control and account for vaccines provided to local health departments and medical providers. Since the last audit, DCH has moved to an electronic vaccine accountability system built into the Michigan Care Improvement Registry. DCH has exceeded the expectations of the Centers for Disease Control and

Prevention (CDC) for vaccine accountability for all vaccines ordered and distributed using federal funds. DCH acknowledges that site visits did not include a comparison of reported versus actual quantities on hand but believes that reasonable measures have been taken to ensure that vaccines are appropriately controlled and accounted for.

Part b.: DCH disagrees that \$28,155 was improperly charged to the wrong grant period. The entire \$28,155 was obligated to the grantee for the period ended December 31, 2008 and therefore is an appropriate expenditure for the grant period.

Part c.: The Public Health Administration has made great strides in subrecipient monitoring since the last Single Audit in which DCH was found to be lacking in this area.

Part c.(1): DCH agrees that it was not reviewing documentation to support expenditures reported by its subrecipients.

Part c.(2): DCH agrees that it was not checking the federal Excluded Parties List System.

Planned Corrective Action:

Part a.: N/A

Part b.: N/A

Part c.(1): The Public Health Administration will work with the DCH Office of Audit to implement a procedure for testing a sample of expenditures from high-risk agencies. If, however, an agency that is deemed high risk has a specific program selected as major in its most recent Single Audit, DCH will rely on the results of that audit group and forgo any expenditure testing.

Part c.(2): In the future, DCH will add a clause in the provider enrollment form for the Vaccines for Children (VFC) Program that the provider is not suspended or debarred. In addition, DCH will continue to check with its licensing area for complaints or disciplinary actions against providers.

Anticipated Completion Date: Part a.: N/A

Part b.: N/A

Part c.: October 1, 2010

Responsible Individual: Robert Swanson

Finding Number: 3911010

Finding Title: Centers for Disease Control and Prevention -
Investigations and Technical Assistance,
CFDA 93.283

Management Views: DCH agrees that its site visits did not include a review of the documentation that supported expenditures reported by its subrecipients. The Public Health Administration has made great strides in subrecipient monitoring since the last Single Audit in which it was found to be lacking in this area.

Planned Corrective Action: The Public Health Administration will work with the DCH Office of Audit to implement a procedure for testing a sample of expenditures from high-risk agencies. If, however, an agency that is deemed high risk has a specific program selected as major in its most recent Single Audit, DCH will rely on the results of that audit group and forgo any expenditure testing.

Anticipated Completion Date: October 1, 2010

Responsible Individual: Betsy Pash

Finding Number: 3911011

Finding Title: Temporary Assistance for Needy Families (TANF)
Cluster, *CFDA* 93.558

Management Views: DCH agrees that there are opportunities for improvement in the monitoring of eligibility requirements.

Part a.: DCH acknowledges that the sampling methodology did not take into account the number of active cases at the CMHSPs.

Part b.: DCH agrees that a copy of the family's most recent Michigan income tax form was not always obtained; however, DCH does not necessarily agree that CMHSPs did not obtain accurate eligibility determination documentation.

Planned Corrective Action: Part a.: DCH will modify its sampling methodology to take into account CMHSPs with a larger volume of Family Support Subsidy cases, so that reasonable assurance of the accuracy of the eligibility determination and documentation is achieved.

Part b.: DCH will explore available options and request a change to the *Michigan Administrative Code* if deemed appropriate.

Anticipated Completion Date: Modification of sampling methodology: April 2010

Exploration of possible *Michigan Administrative Code* changes: December 2010

Responsible Individual: Sheri Falvay

Finding Number: 3911012
Finding Title: Children's Health Insurance Program, *CFDA* 93.767

Management Views: DCH generally agrees that there are opportunities for improvement to ensure compliance with federal laws and regulations regarding eligibility and subrecipient monitoring but does not necessarily agree with all components of the finding.

Part a.: Because the findings referred to in part a. represent specific findings that are separately addressed in this report, the corrective action and detailed responses will not be duplicated here, but separately addressed in response to each specific finding.

Part b.(1): DCH agrees that some required documents, such as the written application for the sample date selected, were missing from the case files reviewed by the Office of the Auditor General (OAG). The OAG's presumption of ineligibility was based on the absence of these documents. In the example of the application, an application was available for a subsequent period, just not for the period selected in the OAG's sample. Absence of documents is not conclusive of ineligibility. Historically, when the Medicaid Eligibility Quality Control (MEQC), process (which is a federally mandated eligibility review process) encounters missing documentation, this deficiency is noted, but the effort to validate the eligibility decision does not end at that point. As a practice, MEQC auditors investigate further, to the extent of contacting the beneficiary to obtain and validate the missing information and to make a final decision of eligibility based on those findings. It is DCH's position that although the case files may have been missing items

for the sample period selected, this does not necessarily mean the beneficiary was ineligible for Children's Health Insurance Program (CHIP)-funded services.

Part b.(2): DCH agrees there are opportunities for improvement in evaluating the sufficiency of third party service organization (TPSO) internal control assurance audits. However, DCH believes that the level of risk associated with this deficiency is minimal due to the sample testing it conducts on its contractor.

On a weekly basis, DCH tests a sample of MIChild application approvals and a sample of denials to ensure that its TPSO is processing MIChild applications correctly. These tests have consistently shown an extremely low error rate by the TPSO.

DCH also tests on a weekly basis, a sample of MIChild applications for which it validates each applicant's declaration of income. If an applicant does not provide the requested income verification, his/her case is closed. For those applicants who provide the requested information, the error rate is extremely low.

Part c.(1): DCH again disagrees that it did not monitor the Department of Human Services (DHS's) eligibility determinations for the Adult Benefits Waiver (ABW) Program or Healthy Kids Medicaid Expansion (HKME). DHS's MEQC Section includes both of these populations in its sampling plan.

DCH disagrees that the interagency agreement did not specify DHS's responsibilities for making eligibility determinations for the ABW Program or the federal and other requirements with which DCH expects DHS to comply. The agreement clearly states that all

references to Medicaid or Medicaid programs will be understood to refer to all DCH medical assistance programs and that DHS's responsibilities include: "Provide initial and annual eligibility determinations for applicants for Medicaid programs as assigned by DCH in accordance with DCH approved policy." The assignment of HKME and ABW Program eligibility determination to DHS is reflected in DHS's Bridges Eligibility Manual (BEM).

Part c.(2): DCH acknowledges the analysis has not been completed yet. This is the result of limited staff availability and resources due to implementation of the Community Health Automated Medicaid Processing System (CHAMPS).

Planned Corrective Action:

Part a.: Refer to the responses to Findings 15 and 19.

Part b.(1): DCH will work with DHS to require that MEQC staff track and report missing documentation as part of their annual review, which will allow DCH to monitor the issue and develop corrective measures if necessary.

Part b.(2): DCH will consider modifying the TPSO contract to more clearly define the requirements of the SAS 70 audit.

Part c.(1): DCH will submit a revised interagency agreement to DHS.

Part c.(2): DCH will perform an analysis when staff and resources become available.

Anticipated Completion Date:

Part a.: Refer to the responses to Findings 15 and 19.

Part b.(1): October 1, 2010

Part b.(2): January 1, 2011

Part c.(1): December 31, 2010

Part c.(2): December 31, 2010

Responsible Individuals: Part a.: Refer to the responses to Findings 15 and 19.

Part b.(1): Dan Ridge

Part b.(2): Terry Geiger

Part c.(1): Terry Geiger and Neil Oppenheimer

Part c.(2): Neil Oppenheimer

Finding Number:

3911013

Finding Title:

Medicaid Cluster, *CFDA* 93.777 and 93.778, Eligibility

Management Views:

DCH agrees that some required documents, such as the written application for the sample date selected, were missing from the case files reviewed by the OAG. The OAG's presumption of ineligibility was based on the absence of these documents. In the example of the application, an application was available for a subsequent period, just not for the period selected in the OAG's sample. Absence of documents is not conclusive of ineligibility. Historically, when the MEQC process encounters missing documentation, this deficiency is noted, but the effort to validate the eligibility decision does not end at that point. As a practice, MEQC auditors investigate further, to the extent of contacting the beneficiary to obtain and validate the missing information and to make a final decision of eligibility based on those findings. It is DCH's position that although the case files may have been missing items for the sample period selected, this does not necessarily mean the beneficiary was ineligible for Medicaid-funded services.

Planned Corrective Action: DCH will work with DHS to require that MEQC staff track and report missing documentation as part of their annual review, which will allow DCH to monitor the issue and develop corrective measures if necessary.

Anticipated Completion Date: October 1, 2010

Responsible Individual: Terry Geiger

Finding Number: 3911014

Finding Title: Medicaid Cluster, *CFDA* 93.777 and 93.778, Special Tests and Provisions - Provider Agreements and Certifications

Management Views: DCH generally agrees that there are opportunities for improvement to ensure compliance with federal laws and regulations regarding special tests and provisions pertaining to Adult Home Help (AHH) and Medicaid-funded disproportionate share hospital (DSH) payments, but does not necessarily agree with all components of the finding.

Part a.: DCH acknowledges that it had not entered into agreements with AHH providers. However, historically, the Home Help Services Statement of Employment (MSA-4676) has served as a proxy for a provider agreement. DHS uses this form to enroll AHH providers. Both the AHH provider and the Medicaid beneficiary receiving services must sign the agreement, which identifies the services to be provided, the quantity and frequency of the services, and the wages to be paid. A DHS adult services worker is actively involved in working with the provider and the beneficiary to execute the agreement. While this does not achieve the full level of a provider agreement, it is an agreement required by DCH that documents the provider's acceptance of the terms under which AHH services are to be rendered.

Despite DCH's belief that AHH providers are different from all other Medicaid providers, DCH has been working to implement a provider agreement for this population.

Part b.: DCH again strongly disagrees with the OAG's finding. The OAG issued a similar finding in the Single Audit covering fiscal years 2003-04 and 2004-05 and for fiscal years 2005-06 and 2006-07. It continues to be DCH's position that its actions to claim DSH for the Center for Forensic Psychiatry (CFP) comply with federal laws and regulations.

Federal assistance in the form of DSH payments is available to hospitals that serve a disproportionate number of low-income individuals and states have substantial discretion in establishing criteria for DSH eligibility. Section 1923(b)(4) of the Social Security Act states, "the Secretary may not restrict a State's authority to designate hospitals as disproportionate share hospitals." Section 1923(h) identifies state psychiatric hospitals as a separate entity to receive DSH payments.

It is DCH's position that the establishment of a Statewide DSH allotment by the federal government is the basis upon which it intends to limit its DSH obligation and that its intent is not to limit the ability of states, within reasonable parameters, to determine which hospitals should receive DSH payments.

Planned Corrective Action:

Part a.: Since 2006, DCH has attempted to obtain clarification from the Centers for Medicare and Medicaid Services (CMS) regarding advance directive requirements and their application to DCH's individual AHH providers and beneficiaries. DCH has also sought and obtained guidance on this subject from attorneys within DCH and the Department of Attorney

General and from other states. No clear-cut advice was available from any of these entities because of the unique nature of these providers.

In fiscal year 2005-06 and in fiscal year 2006-07, DCH initiated promulgation of a policy bulletin that presented a draft AHH provider agreement. As a result of significant concerns raised regarding the proposed forms, process, storage, and provider requirements, in both instances the policy was not finalized and the provider agreement was not implemented.

The AHH provider agreement has been finalized and will be implemented beginning July 1, 2010. Agreements will be signed by individual providers throughout the upcoming fiscal year as the required beneficiary home visits and assessments are completed. All agency providers must complete a provider agreement by October 1, 2010.

Part b.: Nevertheless, funding to obtain certification was initially included in DCH's fiscal year 2007-08 budget, and has been continued in fiscal year 2008-09 and fiscal year 2009-10. CFP is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and DCH is working toward obtaining CMS certification. CFP has submitted a CMS-855A enrollment application and is waiting for certification to take place.

Anticipated Completion Date: Part a.: October 1, 2011

Part b.: DCH dependent upon a CMS survey date.

Responsible Individuals: Part a.: Susan Yontz

Part b.: Richard Miles and Cynthia Kelly

Finding Number: 3911015
Finding Title: Medicaid Cluster, *CFDA* 93.777 and 93.778, Allowable Costs/Cost Principles - Allowability of Medical Services

Management Views: While DCH agrees that some of the payments noted in the finding were not adequately supported, the OAG's presumption that the services and payments were not appropriate was based on the absence of these documents. Absence of supporting documentation is not conclusive that the services and payments were inappropriate.

Planned Corrective Action: Nevertheless, DCH will explore options for improving providers' maintenance of appropriate documentation to support the services they provide and for which they bill.

Anticipated Completion Date: March 31, 2011

Responsible Individuals: Ed Kemp and Karen Rothfuss

Finding Number: 3911016
Finding Title: Medicaid Cluster, *CFDA* 93.777 and 93.778, Allowable Costs/Cost Principles - ARRA Prompt Pay Requirements

Management Views: DCH strongly disagrees with the OAG's finding and recommendation. It is DCH's position that not meeting the ARRA prompt pay requirements at this time represents neither an internal control weakness nor noncompliance with federal laws and regulations. DCH also strongly disagrees that it was not eligible to receive increased federal medical assistance percentage (FMAP) for the 12 days of alleged noncompliance.

The development of reporting systems to comply with the ARRA prompt pay requirements is a major work effort for the Michigan Medicaid Program for multiple reasons. First, the ARRA extends prompt pay requirements to hospitals and nursing homes and, perhaps more importantly, requires states to determine on a **daily** basis if they are compliant with the new requirements. Incorporating new provider groups and changing the periodicity to daily in combination bring a substantial level of complexity to systems development. The second special challenge to the Michigan Medicaid Program is that these new requirements were imposed in the middle of the most intensive period of developing and installing a new Medicaid Management Information System (MMIS) (known as CHAMPS). DCH has to develop separate, independent prompt pay reporting systems for the periods before and after CHAMPS implementation, which just occurred in September 2009.

When Congress was developing the ARRA legislation, Michigan and other states expressed concern about the prompt pay requirements, anticipating that the development and implementation of CHAMPS could prove problematic in achieving compliance. This concern was recognized in the ARRA legislation which provides CMS the latitude to waive the prompt pay requirements given appropriate "exigent circumstances." Michigan requested a waiver of the prompt pay requirements, but not the reporting itself, in April 2010.

CMS also recognized that State Medicaid programs did not have reporting systems in place to comply with the ARRA prompt pay requirements at the time of enactment. The original CMS guidance on the ARRA prompt pay requirements does not indicate a date by

which states must be in compliance with these new reporting requirements. The same CMS guidance states, "Further instructions on the proper reporting of expenditures related to the prompt pay provision will be provided in a separate communication." CMS has yet to issue these instructions. Consequently, it is not clear how a state can be considered out of compliance without a due date having been established by the federal government.

DCH has been working in good faith, and in partnership with CMS, to develop the appropriate reporting and has produced some draft reports. However, given that these reports are draft at this point, it is inappropriate for the OAG to base conclusions on them. It is particularly premature to assign financial consequences. The OAG observation that, "DCH also stated that it was comfortable with the accuracy of the reports", does not change the fact that they are draft and that further work is needed to ensure their accuracy.

Planned Corrective Action: DCH will continue to work in partnership with the federal government to comply with the ARRA statute, as well as federal regulations.

Anticipated Completion Date: Ongoing
Responsible Individual: Neil Oppenheimer

Finding Number: 3911017
Finding Title: Medicaid Cluster, *CFDA* 93.777 and 93.778, Allowable Costs/Cost Principles - Improper Payments

Management Views: DCH generally agrees that there are opportunities for improvement to ensure compliance with federal laws and regulations regarding allowable costs/cost principles.

Part a.: DCH agrees that it did not have controls in place during the audit period to verify that each Adult Home Help (AHH) beneficiary continued to be Medicaid-eligible prior to payment.

Part b.: DCH agrees that it made improper payments to Medicaid providers who were deceased prior to the date the medical service was provided and to providers on behalf of deceased Medicaid beneficiaries. DCH has made significant progress in this area. DCH has been in the process of implementing a new CHAMPS data warehouse. This has resulted in a temporary delay in the process it uses to identify deceased beneficiaries and in pursuing recoupment of inappropriate payments. It is DCH's expectation that once the information needed from the CHAMPS data warehouse becomes available, it will regain the progress it had made in this area. DCH routinely runs matches against death files from Michigan vital records, the Michigan license file, DCH's data warehouse, and the federal vital records to identify deceased Medicaid beneficiaries and providers. As a result of lag time in receiving these files and performing the matches, it is not always possible to stop payments through the use of front-end controls on the payment system. Consequently, DCH pursues recoupment of inappropriate payments on behalf of beneficiaries through a post-payment review process.

Part c.: DCH agrees that it needs to improve its internal control to ensure that AHH services are furnished only to individuals who are not currently residing in a long-term care facility or a hospital. DCH implemented a new payment system for the AHH Program in February 2010. Prior to this, the payments were made through DHS's Model Payment System.

Data from the new Adult Services Authorized Payments System (ASAP) will be stored in the new DCH data warehouse.

Planned Corrective Action:

Part a.: The AHH Program has undergone significant changes in fiscal year 2009-10, including transition to a new payment system under the supervision of DCH. Controls have been instituted in the new payment system to give DCH direct control over the payment process and greater assurance as to the accuracy of the payments. This new system interfaces with the Medicaid eligibility file, resulting in payments only for Medicaid-eligible beneficiaries.

Part b.: DCH has reactivated the identification and recoupment processes as the relevant areas of the CHAMPS data warehouse have been implemented.

DCH will continue to work to reduce the number of inappropriate payments and to enhance its recoupment efforts, including the establishment of a process to recoup payments made to deceased providers.

Part c.: Once the new data warehouse is operational, it is anticipated that storage of AHH data will be completed within three to six months.

After the data is moved into the DCH data warehouse, DCH will develop a query against AHH Program beneficiary data to determine if inappropriate payments have been made. If so, recoupment action will be taken according to DCH policy and procedures.

DCH will determine the appropriate action to take on any payments made for AHH services while the beneficiary was in a nursing facility or hospitalized during the audit period.

Anticipated Completion Date: Part a.: Completed
Part b.: Ongoing
Part c.: Three to six months from the new data warehouse implementation.

Responsible Individuals: Part a.: Deb Katcher
Part b.: Jay Slaughter
Part c.: Deb Katcher

Finding Number: 3911018
Finding Title: Medicaid Cluster, *CFDA* 93.777 and 93.778, Allowable Costs/Cost Principles and Special Tests and Provisions - Managed Care

Management Views: While DCH generally disagrees with the finding, it recognizes that there are opportunities for improvement to ensure compliance with federal laws and regulations regarding allowable costs/cost principles and special tests and provisions pertaining to managed care.

Part a.: DCH agrees that in fiscal year 2008-09 it did not review all of the criteria contained within the monitoring tools for all of the health plans. However, DCH believes that the modified annual on-site reviews comply with Title 42, Part 438, section 66 of the *Code of Federal Regulations (CFR)* and, thus, this is not an internal control issue.

DCH conducts annual on-site compliance reviews of the Medicaid health plans (MHPs) utilizing criteria delineated in its site visit tool.

In fiscal year 2007-08, DCH conducted MHP site reviews utilizing the entire tool. For fiscal year 2008-09 and fiscal year 2009-10, DCH conducted site reviews utilizing the entire tool over the two-year period. In fiscal year 2008-09, staff reviewed approximately half of the tool, and in fiscal year 2009-10, staff are reviewing those items not reviewed the previous year. Each year, mandatory items are reviewed, as well as those items that received a fail or incomplete at the previous year's compliance review.

Every other year CMS performs a site visit of DCH's managed care program. The report from CMS's site visit in August 2008 stated, "One of the program's strengths is the thoroughness of the State's annual onsite monitoring protocol in conjunction with the contract requirements. The State's oversight of these programs and the unique incentives arrangements is underscored by the data supporting the increased health outcomes for enrollees."

DCH agrees that its review of reports relating to the fraud and abuse section of the monitoring tool did not include tests of details to ensure that reports were accurate. However, DCH does not agree that this should be an organizational priority. MHPs are financially incentivized to prevent and detect fraud and abuse. In fact, they monitor providers who are high utilizers, even though within perfectly legal bounds. MHPs have no motivation to mislead with their reporting and would do so to their own detriment. Therefore, DCH's judgment is that given current staff constraints and other priority functions, it will continue to review reports, but will not test the details.

Part b.: DCH strongly disagrees with the conclusion that its rate setting process is contrary to sound

business practice, that it cannot ensure that its capitation rates are actuarially sound and, consequently, that payments made to its MHPs were reasonable in amount.

The rate setting process that is employed by DCH is fully compliant with requirements for actuarial soundness as specified in federal regulation 42 *CFR* 438.6 and with guidance from the Centers for Medicare and Medicaid Services (CMS) as reflected in Financial Review Documentation for At-risk Capitated Contracts Rate Setting. Furthermore, the rates that were applied to Michigan's MHPs during the audit period were certified as being actuarially sound by an actuary who is a member of the American Academy of Actuaries and meets the standards established by the American Academy of Actuaries. Finally, these rates were reviewed and approved by CMS.

DCH contracted with Milliman, an actuarial firm, to develop the reimbursement rates for the MHPs. The process for determining actuarially sound rates is complex and includes numerous factors. In addition to encounter data, the actuary considers fee-for-service data, financial data obtained from health plans and the Office of Financial and Insurance Regulation (OFIR), Medicaid fee screen data, survey data from health plans as well as Milliman Medicaid Cost Guidelines, and other Milliman proprietary data.

DCH has been engaged in a quality improvement process for encounter data for over a decade. The quality of the data has improved dramatically over that time span. Editing of the data has been increasingly rigorous as has the use of the data for various incentive arrangements embedded in the rate-setting process. DCH has a formal and consistently executed

feedback process with the health plans regarding both data completion and quality. DCH is convinced that Michigan's Medicaid encounter data is among the best in the nation in regard to both completeness and quality. Nevertheless, DCH will continue to work with health plans to improve data quality and completeness knowing that there always will be room for improvement.

As it pertains specifically to the observation that DCH did not test a sample of encounter data and related medical records, that was a conscious decision and reflected appropriate priorities in establishing actuarially sound rates. Rather than test individual records, it was deemed more important to achieve alignment between the financial reporting of health plans to OFIR and the aggregate values of the encounter data versus validating data at the micro level. DCH does not have unlimited time or resources.

Planned Corrective Action: Part a.: If staff resources expand, DCH will explore the feasibility of testing a sample of the reports related to fraud and abuse to ensure their accuracy.

Part b.: N/A

Anticipated Completion Date: Part a.: December 31, 2010

Part b.: N/A

Responsible Individual: Part a.: Karen Rothfuss

Part b.: N/A

Finding Number: 3911019
Finding Title: Medicaid Cluster, *CFDA* 93.777 and 93.778, Allowable Costs/Cost Principles - Pharmacy Payments and Rebates

Management Views: DCH agrees to improve its internal control over the Medicaid Cluster, CHIP, and the Maternal and Child Health Services Block Grant Program related to pharmacy rebates and payments to its pharmacy benefits manager to ensure compliance with federal laws and regulations regarding allowable costs/cost principles.

Part a.: DCH agrees that its policies did not require management to review or approve DCH's pharmacy consultant's quarterly reconciliation data queries or results. DCH also agrees that its policies did not require management to review or approve the query and resulting reconciliation of billed amounts to underlying claim data.

Part b.: DCH agrees that its electronic data was not stored in a restricted location.

Part c.: DCH agrees that it did not track details needed to reproduce the point-in-time reconciliation results at a later date.

Planned Corrective Action: Part a.: DCH will revise reconciliation review procedures to include and document management's review and approval of the quarterly rebate reconciliation results and the reconciliation of billed amounts to underlying claim data.

Part b.: DCH implemented changes to place further access restrictions on the internal control procedures and databases.

Part c.: DCH will modify procedures to track details needed to reproduce the point-in-time rebate reconciliation results at later dates.

Anticipated Completion Date: Part a.: Completed

Part b.: January 2010

Part c.: Completed

Responsible Individual: Trish O'Keefe

Finding Number: 3911020

Finding Title: Medicaid Cluster, *CFDA* 93.777 and 93.778, Allowable Costs/Cost Principles - Medicare Part A and Part B

Management Views: DCH acknowledges that there are opportunities for improvement in its processes to ensure that CMS billings are reasonable.

Planned Corrective Action: DCH initiated additional reasonableness review procedures. DCH continues to review available options and will implement additional procedures as deemed appropriate.

Anticipated Completion Date: February 2010

Responsible Individual: Mark West

Finding Number: 3911021

Finding Title: Medicaid Cluster, *CFDA* 93.777 and 93.778, Allowable Costs/Cost Principles - Disproportionate Share Hospital (DSH) Pools

Management Views: DCH agrees that there are opportunities for improvement in the internal control associated with DSH calculations. However, as noted by the OAG, DCH did not receive improper federal reimbursement.

Part a.: DCH agrees that it could not provide supporting documentation for the State facility collectability factors used in the calculation of fiscal year 2007-08 and fiscal year 2008-09 State psychiatric hospital DSH payments.

Part b.: DCH agrees that it did not include a collectability factor in the calculation of the charge amounts used in the psychiatric DSH calculation.

Planned Corrective Action: DCH agrees to update collectability factors on an annual basis and to ensure that estimated first party payments (charges multiplied by updated collectability factors) are applied when calculating DSH limits for State psychiatric hospitals.

Anticipated Completion Date: For DSH payments made during fiscal year 2009-10 and forward.

Responsible Individual: Dick Miles

Finding Number: 3911022

Finding Title: Medicaid Cluster, *CFDA* 93.777 and 93.778, Allowable Costs/Cost Principles - Third Party Liabilities

Management Views: DCH generally agrees that there are opportunities for improvement to ensure compliance with federal laws and regulations regarding allowable costs/cost principles pertaining to third party liabilities, but does not necessarily agree with all components of the finding. In addition, DCH maintains that its current program to recoup pregnancy and birthing-related costs meets both federal (federal regulation 42 *CFR* 433.138) and State (Michigan State Plan) requirements and that costs were reported net of all applicable credits.

Part a.: While DCH acknowledges that marital status was not entered into the Medicaid Recipient Database, capturing marital status does not identify the father who may be responsible to reimburse pregnancy and birthing-related Medicaid costs.

Part b.: DCH agrees that it did not document the resolution of the cost requests noted. The previous system for cost request records did not have the capability to document the completion date.

Part c.: It should be noted that the State Plan requires DCH to process requests that it receives from the Friend of the Court (FOC). It does not require DCH to actively pursue the FOC offices to determine if they "may" have a request that needs processing; this would require a change to Medicaid's State Plan. Since not all child support cases include Medicaid beneficiaries, DCH does not have the legal right to request information on all cases the FOC handles. Thus, a difference between the number of Wayne County child support cases stored in the Judiciary's State Court Administrative Office and the number of Wayne County cost requests supplied by DCH does not substantiate that DCH failed to report pregnancy and birthing-related costs requested by Wayne County prosecuting attorney (PA) and FOC offices.

Part d.: DCH agrees that it did not include some pregnancy and birthing-related Medicaid costs in its reports to the PA and FOC offices. However, DCH disagrees that it missed an opportunity to recover up to \$3.2 million of federal Medicaid costs. DCH reviews the appropriateness of costs selected for this process on a yearly basis and modifies accordingly.

Maternal support services costs are predominately used by DCH and are rarely reimbursed by private insurance. As DCH includes in its reports only those pregnancy and birthing-related costs that are routinely reimbursed by private insurance, few of the maternal support services costs are included.

Part e.: DCH agrees that opportunity for improvement in securing support case documents and individual payments exists. While DCH agrees that it did not document the amounts it recovered by the father, it disagrees that it did not document the amount it recovered in total.

Planned Corrective Action:

Part a.: DCH is exploring the ability to capture appropriate data from vital records that could allow identification of the father.

Part b.: DCH is in the process of updating the resolution status of all cost request records transferred to the new Paternity Casualty Recovery System in 2005, which should resolve this issue.

Part c.: DCH will consider making a change to the State Plan.

Part d.: N/A

Part e.: DCH continues to work with PA and FOC offices and DHS to improve operational protocols.

Anticipated Completion Date:

Part a.: September 30, 2011

Part b.: September 30, 2011

Part c.: December 31, 2010

Part d.: Yearly

Part e.: Ongoing

Responsible Individual: Dan Voss

Finding Number: 3911023

Finding Title: Medicaid Cluster, *CFDA* 93.777 and 93.778, Special Tests and Provisions - Sanctioned Providers

Management Views: DCH acknowledges that it did not document why sanctions were not necessary and that it may have been appropriate to sanction some of the providers referenced by the OAG. However, DCH disagrees that its lack of such documentation necessarily means sanctions were appropriate in all of the referenced cases.

Part a.: DCH disagrees with the implication that it did not actively seek to remove from the Medicaid Program the particular provider identified in the prior Single Audit. DCH worked closely with the Department of Attorney General to explore options for removing this provider from the Medicaid Program. As noted by the OAG, the U.S. Department of Health and Human Services (HHS) sanctioned the provider in 1994. However, HHS sanctioned the corporation, not the individual. In addition, as allowed by State law, DCH sought a peer review on the provider in question. The peer reviewer did not concur with the DCH audit findings, so DCH was not able to use this as a basis for sanctioning the provider. It is important to note that providers do have rights for a hearing under the State law referenced in the finding, so DCH cannot arbitrarily impose sanctions assuming no challenge from the provider.

DCH acknowledges that it needs to improve its internal communication to ensure that potential problem providers are identified in a timely manner, that information about these providers is shared with all appropriate staff, and that timely decisions are made and documented as to potential action against these providers.

Part b.: DCH agrees that it needs to improve its processes for ensuring the completeness of the Sanctioned Provider List.

Part c.: While DCH agrees it did not verify that the provider's new accounting and documentation procedures addressed the identified deficiencies, the payments it made during the audit period were not necessarily inappropriate.

Planned Corrective Action:

Part a.: DCH will establish a workgroup to determine the protocol for sharing information amongst the various offices to ensure that action is taken against providers, if appropriate.

Part b.: Staff from appropriate areas within DCH will collaborate to develop improved processes to ensure that the Sanctioned Provider List is updated on a regular basis and available to all appropriate staff.

Part c.: DCH will consider verifying that the identified deficiencies have been addressed.

Anticipated Completion Date: December 31, 2010

Responsible Individual: Karen Rothfuss

Finding Number: 3911024
Finding Title: Medicaid Cluster, *CFDA* 93.777 and 93.778, Activities Allowed or Unallowed and Allowable Costs/Cost Principles - Omnibus

Management Views: DCH generally agrees that there are opportunities for improvement to ensure compliance with federal laws and regulations regarding activities allowed or unallowed and allowable costs/cost principles but does not necessarily agree with all components of the finding.

Part a.: DCH agrees that hospital cost settlements are not always completed in a timely fashion. However, DCH disagrees with the questioned costs of \$313,988.

DCH acknowledges that delays in identifying and collecting amounts owed to the State may increase the risk that it will be unable to collect amounts that have been overpaid. However, it is DCH's position that, as a result of controls it implemented several years ago, such as Medicaid interim payment (MIP) reconciliations 15 months after a provider's fiscal year-end and quarterly analysis of utilization of interim payments, the risk of DCH being unable to collect overpayments is extremely low.

As it pertains to the interest costs associated with cost settlement delays, the OAG arbitrarily separates the costs owed to hospitals from those owed by hospitals. The reality is that the interest impact on the State of Michigan is the net of these amounts. For example, in fiscal year 2007-08, 53 providers owed DCH a total of \$3.2 million, while DCH owed 64 providers a total of \$6.3 million. Since DCH owed \$3.1 million more than it was owed, the interest impact is actually to the benefit of the State of Michigan and to the disadvantage of hospitals. It is important that DCH continue to improve its settlement timeliness to be fair

to hospitals, not because it is hurting the State of Michigan from an interest cost standpoint.

Part b.: DCH agrees that there are opportunities for improvement in its internal control over AHH expenditures. The Program has undergone significant changes in fiscal year 2009-10, including a transition to a new payment system under the supervision of DCH. Controls have been instituted in the new payment system to give DCH direct control over the payment process and greater assurance as to the accuracy of the payments.

Part c.: DCH disagrees that its method of reviewing inpatient hospital annual cost reports did not effectively ensure that inpatient hospital payment rates were reasonable and adequate to meet the costs incurred by inpatient hospitals. In order for the inpatient hospital rates to be at risk, there must be a risk for material overstatement. Given the application of a State operating limit at the average cost per discharge for all inpatient admissions within Michigan, the contention that the inpatient hospital rates are at risk of overstatement is not accurate.

DCH agrees that cost acceptance procedures are not sufficient in themselves to ensure reasonable and adequate rates. For this reason, the Hospital Rate Review Section spends in excess of one full-time equivalent (FTE) per year on rate setting in testing claims data, cost data, indirect medical education data, and Medicare audited wage data; comparing to industry norms (Medicare rates); submitting said data for public review; reviewing all appeals and responses; releasing all draft and preliminary rates to industry; and considering all public comments, including a review of the rates by health maintenance

organizations which apply the said rates as a basis for the majority of their Medicaid contracts.

As a specific example, the OAG references the following federal regulation: "Federal regulation 42 *CFR* 447.253 requires that DCH pay for inpatient hospital services using rates that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable State and federal laws, regulations, and quality and safety standards."

The Michigan Medicaid Provider Manual (Hospital Chapter, Appendix, Section 2.7) clearly indicates a limit in place holding all hospitals to the industry average cost:

"Determine the DRG [diagnosis related group] base price by:

- Calculating each hospital's limited base price. This is the lesser of the hospital specific base price or the mean of all base prices, plus one standard deviation.
- Calculating the Statewide operating cost limit. This is a truncated, weighted mean of all hospitals' limited base prices divided by base period discharges.
- The lesser of the truncated mean or the hospital specific base price then becomes the DRG base price (before the cost adjustor and incentives are added) for each hospital."

In addition, the application of a budget neutrality factor guarantees, along with the above stated limits, that no

hospital in Michigan is receiving full cost reimbursement for any inpatient procedure, nor have they since implementation of the budget neutrality factor in fiscal year 2004-05.

The OAG also stated the following in support of its contention of insufficient controls: "DCH did not develop expectations when performing variance reviews of inpatient hospital Medicaid cost reports. Expectations are predictions of recorded amounts and are developed by identifying plausible relationships that are reasonably expected to exist based on an understanding of the entity and its industry." The comparison to prior year cost reports is, in and of itself, a developed expectation and that application of the rate setting rules ensures appropriate cost containment when compared to all hospitals within Michigan.

Part d.: DCH acknowledges that further improvements in contractual process are necessary. The Mental Health Code mandates provision of mental health and substance abuse services to individuals. Provision of the mental health service and substance abuse services are contracted through the CMHSP/PIHP network. Timely payments to the CMHSPs/PIHPs are necessary to ensure continuity of services to individuals whose health conditions are such that interruption of services could be life threatening and/or place the consumer at significant risk. DCH did implement a new rate schedule April 1, 2009 which resulted in an estimated increase in payments to the PIHPs of \$4.6 million Statewide. This new rate schedule was implemented to ensure community placement for individuals with developmental disabilities who were placed in the community when the Mt. Pleasant Center closed. The Mt. Pleasant

Center rate schedule was approved by the CMS prior to payment as required by federal regulation.

Part e.: DCH acknowledges that during a brief two-month period, when supervisory approval was not available, DCH allowed some peer-to-peer approval of journal entries. Current Accounting Division policy requires approval of all journal entries by supervisors and the internal control concern noted in this finding was isolated to the two-month period.

Planned Corrective Action:

Part a.: DCH will meet to explore options to improve the timeliness of hospital cost settlements.

Part b.: DCH implemented a new payment system for AHH, which transitioned responsibility for AHH payments from DHS to DCH. The AHH payments previously made from Model Payments System at DHS are now made directly by DCH through the Adult Services Authorized Payments System (ASAP). Authorizations are interfaced daily from the authorized services system (ASCAP) to ASAP. Payments are only generated for authorized services and for beneficiaries with Medicaid eligibility.

Part c.: N/A

Part d.: DCH will continue to implement improvements in the contracting process that will guarantee that fully executed agreements are in place prior to the initial payment. In addition, DCH will pursue contract language or changes in the contracting process that will expedite execution of rate modifications, contract amendments, or contract extensions.

Part e.: Accounting Division procedure 105.0 was amended to require supervisory approval of all journal entries.

Anticipated Completion Date: Part a.: December 31, 2010

Part b.: January 2010

Part c.: N/A

Part d.: October 1, 2010

Part e.: Completed

Responsible Individuals: Part a.: Brenda Fezatte

Part b.: Debra Katcher and Tim Becker

Part c.: N/A

Part d.: Mark Kielhorn

Part e.: Tim Becker

Finding Number: 3911025

Finding Title: Medicaid Cluster, *CFDA* 93.777 and 93.778, Special Tests and Provisions - Provider Eligibility and Provider Health and Safety Standards

Management Views: Part a.: DCH acknowledges that there are opportunities for improvement in the special tests and provisions pertaining to provider eligibility, especially in relation to the general controls associated with the License 2000 System, MyLicense, and the CHAMPS Provider enrollment application. However, DCH views the likelihood of an unauthorized individual gaining access to circumvent or modify application controls to be a very low risk.

Part b.: DCH agrees that it did not perform criminal history background checks for applicants for initial licensure between May 1, 2006 and September 30, 2008. Although DCH was prepared to implement this

background check program, it was advised that the Michigan Department of State Police would be unable to process new applicants, as its system infrastructure could not support these background checks in addition to a significant number of additional checks resulting from other legislation passed at the same time.

DCH disagrees that licenses issued during that time were improperly issued. Although DCH was unable to fully implement the criminal background check as described in Section 333.16174 of the *Michigan Compiled Laws*, there was a substantially equivalent review process in place. Applicants for licensure during this period were required to answer a series of questions disclosing any criminal convictions, actions taken by employers or health facilities restricting their ability to practice, etc. Any affirmative answer to questions on an application was reviewed by DCH staff to determine whether the conduct would impact the issuance of the license. If the conduct was of an egregious nature, the staff could request the issuance of a Notice of Intent to Deny Licensure (NOID). This process enabled an applicant to explain the nature of the conduct and its relevance to the issuance of a license. DCH would then make the final decision as to whether a license would be granted or not. During fiscal years 2006-07 and 2007-08, a total of 6 NOIDs were issued for individuals applying for licensure as a physician based upon the information disclosed on the application form, which included conviction information.

Since implementation of the criminal background check program, individuals applying for licensure are still required to respond to the series of questions as noted above. In comparing the background check results to the information disclosed by the applicants,

there have been no instances where the background check revealed information that should have been disclosed on the application and was not. Background checks have merely supplemented what was already being disclosed by the applicant. During the past year, there have been no instances where the issuance of a NOID was based solely on the results of the background check.

It is DCH's position that the system in place during the period in question was sufficient to ensure that those individuals who received a license during that time were qualified to do so.

Part c.: DCH agrees that it made some payments to Medicaid providers who were unlicensed at the time services were rendered. These payments occurred under the previous Medicaid Management Information System (MMIS). With the implementation of CHAMPS and additional procedures that were put in place at the time of CHAMPS implementation, DCH is confident that future payments will only be made to licensed providers.

Part d.: DCH acknowledges that it discontinued the Health Professionals Credentials Verification Program. However, DCH disagrees that it was in violation of any federal regulation or State law. This was a pilot program initiated by the Bureau of Health Professions for the purpose of doing a periodic internal audit of its processes. The pilot was distinct and separate from the licensing process and the audits were conducted after the license had already been issued. The pilot had two purposes: (1) to identify instances where there was a question as to whether an individual should have been issued a license, and (2) to identify any steps in the licensing process that could be improved.

The Program was never intended to serve as a proxy for supervisory review, particularly given that the review occurred after the issuance of the license. After reviewing completed applications for five years, there were no instances in which a license had been improperly issued and no processes that needed to be changed. As this was a voluntary initiative and there were no findings that required action on the part of the Bureau, the pilot was discontinued. DCH maintains that all providers of medical services were licensed appropriately.

Part e.(1): DCH disagrees that verification of pharmacists' licensure does not occur. Upon enrollment, pharmacy providers have agreed to accept responsibility for compliance with DCH policy and procedures, including proper employee training, licensure, nonexcluded status, etc. DCH, through its pharmacy benefits manager, enrolls and reimburses pharmacies, but does not enroll or reimburse pharmacists. DCH pharmacy enrollment processing controls verify licensure, monitor for exclusions, and sufficiently prevent payment to unlicensed or excluded pharmacy providers.

Part e.(2): DCH acknowledges that it reviewed documents for one physician and one nonphysician as partial support for effective credentialing. The monitoring tool examines the current sanctioned/suspended provider list of the plans and examines screen prints to validate the exclusion databases were checked.

DCH disagrees that the scope of the PIHPs' external quality reviews (EQRs) focused primarily on reviewing the content of the PIHPs' credentialing policies and believes the EQRs were more thorough than that.

Through a contract with the PIHPs, DCH delegates the responsibility of credentialing and monitoring subproviders to ensure that payments are not made to unlicensed or excluded providers. The EQRs also address this. DCH monitors the PIHPs through biennial site reviews.

As part of the next round of EQRs, DCH will work with its EQR contractor to ensure that the effectiveness of the PIHPs' credentialing activities are adequately assessed and reported.

DCH acknowledges that there was a brief period prior to filling an audit position that it was not monitoring to ensure that the intermediate school districts (ISDs) were fulfilling their contract responsibilities in regard to making sure that staff were appropriately credentialed.

A new School Based Services (SBS) Program was implemented in July 2008. Prior to that time, DCH audit staff were required to review only the administrative outreach portion.

Part f.: DCH acknowledges that there are limitations with its information systems relating to surveying health facilities and that it did not perform some State licensing surveys. In addition, it is DCH's position that certification of some types of facilities is more stringent and more relevant than licensure.

For many types of facilities, including hospitals and hospices, to participate in Medicare, the federal CMS requires them to be certified by the State Survey Agency (DCH) or accredited by a CMS-designated third party as meeting Medicare's Conditions of Participation (CoP). DCH believes these CoP are more stringent than State licensure. DCH requires

hospitals and hospices to have Medicare certification to enroll and be paid as a Medicaid provider. All hospitals and hospices in Michigan have been accredited by a CMS-designated third party or certified by DCH.

Clinical laboratories that provide testing in Michigan and that bill Medicaid are required to have an active Clinical Laboratory Improvement Amendments (CLIA) certificate. DCH, as the State Survey Agency, is responsible for ensuring that laboratories seeking CLIA certification meet regulatory requirements. DCH believes the requirements for CLIA certification, which are more current than Michigan's laboratory licensing rules, are more relevant than State licensure.

Part g.: DCH partially agrees that it did not require Medicaid providers to make all disclosures as required by federal regulation 42 *CFR* 455, subpart B.

DCH acknowledges that during the audit period it did not ensure that its provider agreement and Medicaid health plan (MHP) and prepaid inpatient health plans (PIHP) contracts routinely captured all required information, such as criminal convictions on agents or managing employees, etc.

DCH monitors the MHP and PIHP contract requirements as part of the annual (MHP) and biennial (PIHP) site reviews.

Part h.: DCH disagrees that it did not identify and ensure that nursing homes and hospitals participating in Medicaid had met CMS's CoP.

While DCH acknowledges that it did not compare which nursing facilities and hospitals received

Medicaid payments to CMS's Automated Survey Processing Environment (ASPEN) system, it disagrees that such a comparison is necessary. DCH inspects each nursing home and Medicaid is informed of all providers that are certified or any that face decertification. Medicaid will not enroll a nursing home unless it has been notified by the Bureau of Health Systems that the facility has been certified. All Michigan hospitals have Medicare certification and, consequently, are permitted to enroll in Medicaid.

DCH disagrees that it did not document the CoPs that it reviewed during its surveys of nursing facilities and hospitals. It is DCH's standard procedure to review all of the CoP and to document only those conditions requiring corrective action.

Planned Corrective Action:

Part a.: DCH will work with the Department of Technology, Management & Budget to improve the general controls over the noted applications.

Part b.: N/A

Part c.: Completed

Part d.: N/A

Part e.(1): N/A

Part e.(2): DCH will consider performing a more in-depth analysis of MHPs' credentialing processes, should additional staffing and resources become available.

As part of the next round of EQRs, DCH will work with its EQR contractor to ensure that the effectiveness of the PIHPs' credentialing activities are adequately assessed and reported.

DCH audit staff are now checking to determine if an ISD has verified credentials in accordance with program requirements. Effective for the 2011 school year (July 1, 2010 - June 30, 2011), the Michigan Department of Education will perform a provider credential review and report the results to DCH.

Part f.: N/A

Part g.: Changes have been made to the provider agreement and MHP and PIHP contracts and this information is now being captured and utilized. To ensure the adequacy and thoroughness of the PIHPs' compliance with the contract requirements referenced in the findings, DCH will incorporate examination of these requirements in the next round of EQR.

Part h.: DCH agrees to explore options other than the ASPEN system to ensure that all appropriate parties receive notification of certifications and decertifications.

Anticipated Completion Date: Part a.: April 30, 2011

Part b.: N/A

Part c.: Completed

Part d.: N/A

Part e.(1): N/A

Part e.(2): MHP (Dependent upon staffing)
PIHP (fiscal year 2010-11)
SBS (Completed and fiscal year 2010-11)

Part f.: N/A

Part g.: MHP (Completed)
PIHP (fiscal year 2010-11)

Part h.: December 31, 2010

Responsible Individuals:

Part a.: Cynthia Edwards, Jay Slaughter, and Linda Myers

Part b.: N/A

Part c.: Teri Chamberlain

Part d.: N/A

Part e.(1): N/A

Part e.(2): MHP (Cheryl Bupp)
PIHP (Mark Keilhorn)
SBS (Linda Sowle and Pam Myers)

Part f.: N/A

Part g.: MHP (Cheryl Bupp)
PIHP (Judy Webb)

Part h.: Susan Yontz

Finding Number:

3911026

Finding Title:

Medicaid Cluster, *CFDA* 93.777 and 93.778, Special Tests and Provisions - Utilization Control and Program Integrity

Management Views:

DCH generally agrees that there are opportunities for improvement to ensure compliance with federal laws and regulations regarding special tests and provisions pertaining to utilization control and program integrity.

Part a.: DCH agrees that it did not review all Medicaid health plan (MHP) criteria in fiscal year 2008-09 and did not perform a test of details for the MHP reports to ensure their accuracy.

Although the goal of the Medicaid Integrity Program Section is to monitor all 14 of the criteria on an annual basis, due to staffing changes and limited resources, the Section focused its review of the MHPs on 3 criteria in fiscal year 2008-09. Any criteria that were incomplete the previous year were also reviewed. The MHPs were still responsible for monitoring for overutilization/underutilization in fiscal year 2008-09, even though this criteria was not reviewed by the Medicaid Integrity Program Section unless the plan did not pass the previous year.

One MHP was new in fiscal year 2008-09. Historically, the first year for an MHP has been a teaching year. All criteria were discussed with this plan, including the expectations for the following year. All 14 criteria for all MHPs will be reviewed in fiscal year 2009-10.

Part b.: DCH agrees that it did not take steps to prevent a conflict of interest with the pharmacy audit company responsible for determining if improper Medicaid pharmacy payments were made by DCH's pharmacy benefits manager (PBM). As of April 1, 2010, the PBM contract no longer requires the PBM to be responsible for postpayment auditing.

DCH disagrees that it did not ensure that the pharmacy audit company performed audits of pharmacy claims paid by Medicaid. While DCH acknowledges that it did not provide the pharmacy claims data directly to the pharmacy audit company, the PBM transmitted its adjudicated paid claims data to DCH and the pharmacy audit company at the same time. As noted by the OAG, DCH performed reconciliations between the weekly billing and the underlying paid claim data to ensure that the PBM billing was accurate.

Part c.(1): DCH agrees that it did not account for the number of undeliverable explanation of benefits (EOB) letters.

Part c.(2): DCH agrees that during the audit period, it did not require the MHPs or the PIHPs to send EOBs to their members to verify services.

Some of the MHPs had this practice in place on their own and some used other methods to verify services, but DCH acknowledges that it did not monitor these methods.

Part c.(3): While DCH acknowledges that it did not subject Medicaid AHH Program service costs to the EOB letter verification process, it utilizes other processes to help verify that services were provided. Each month, the beneficiaries sign a log verifying which services they received that month.

Part d.: DCH acknowledges that Surveillance and Utilization Review System (SURS) reviews were not completed in accordance with Medicaid Integrity Program Section procedures; however, DCH federal regulation 42 *CFR* 456.23 does not indicate the quantity or frequency for which reviews must be performed.

Part d.(1): DCH agrees that it did not perform the annual number of episode of care (EOC) and profiling SURS reviews as required by the Medicaid Integrity Program Section procedures. The major commitment of staff needed for the development, testing, and implementation of DCH's CHAMPS significantly affected the Section's ability to perform reviews.

Part d.(2): DCH agrees that its SURS review process did not include analysis of AHH Program or nonemergency transportation expenditures.

The AHH Program was transitioned to a new payment system in fiscal year 2009-10 that will provide greater assurance as to the accuracy of payments. Staff are working to make AHH payment data available in the new DCH data warehouse, and it is anticipated that this will be completed in fiscal year 2009-10.

Part d.(3): DCH acknowledges that it did not use Medicaid Integrity Program Section personnel resources to identify suspected fraud at long-term care/nursing home providers, but strongly disagrees with the implication that there is a lack of oversight by DCH of long-term care/nursing home providers. DCH takes its oversight responsibility of these providers very seriously.

DCH acknowledges that it did not perform any SURS reviews of long-term care/nursing home providers and that the Medicaid Integrity Program Section did not oversee any audits of long-term care/nursing home providers. However, this was a conscious decision resulting from a meeting of staff from various areas within DCH involved with nursing homes, as well as staff from the Department of Attorney General, to discuss oversight of nursing homes. It was decided that the combination of these areas provided sufficient oversight and that it was not necessary for the Medicaid Integrity Program Section to assign staff solely to review nursing homes. Although the Section did not oversee any audits of nursing homes, these providers are subject to regular audits by DCH's Office of Audit.

The Medicaid Integrity Program Section performs a preliminary investigation on all nursing home complaints/referrals. In addition, Section staff review other services/products that are provided in nursing homes, but are outside of the nursing homes' per diem rate, such as hospice services, durable medical equipment (DME), etc.

Planned Corrective Action:

Part a.: DCH will explore the feasibility of testing a sample of the MHP reports to ensure their accuracy. However, in a time of limited resources and competing priorities, DCH does not view this as one of the higher risk areas and will make judgments from that perspective. MHPs are paid capitated rates at full risk and, therefore, have direct financial interest in preventing fraud and making recoveries in the instances it occurs. DCH has incorporated these market principles to align financial self-interest with the overall goals of the program.

Part b.: DCH is in the process of procuring a vendor to perform this audit function and will contract directly with that entity.

Part c.(1): DCH will review the federal regulations to determine what, if any, action is required for DCH to be in compliance.

Part c.(2): The MHP contract that began in October 2009 instructs the plans to begin the process of sending EOBs to their members. DCH will develop language to include in its contract with the PIHPs to address this issue. Appropriate entities within DCH will work together to ensure requirements are met and that there is a consistent process across DCH.

Part c.(3): N/A

Part d.(1): The Medicaid Integrity Program Section has performed one EOC SURS run in fiscal year 2009-10 and anticipates performing at least one more EOC run and two profiling runs in the fiscal year.

Part d.(2): DCH will explore modifying its SURS review process to include analysis of AHH expenditures when this data becomes available. DCH does not anticipate any changes being made to the reimbursement process for nonemergency transportation that would allow analysis of expenditures through the SURS review process.

Part d.(3): DCH will explore having the Medicaid Integrity Program Section perform SURS runs for use by other areas of DCH that are responsible for oversight of long-term care/nursing home providers.

Anticipated Completion Date: Part a.: Fiscal year 2010-11

Part b.: April 1, 2010

Part c.(1): Fiscal year 2010-11

Part c.(2): MHPs (October 2009)
PIHPs (October 1, 2012)

Part c.(3): N/A

Part d.(1): September 30, 2010

Part d.(2): Fiscal year 2010-11

Part d.(3): Fiscal year 2010-11

Responsible Individuals: Part a.: Karen Rothfuss and Ruthanne Monkman
Part b.: Karen Rothfuss, Michele Warstler and James Kenyon
Part c.(1): Jackie Prokop
Part c.(2): PIHPs (Irene Kazieczko)
MHP (Cheryl Bupp)
Part c.(3): Deb Katcher
Part d.(1): Karen Rothfuss and Michele Warstler
Part d.(2): Karen Rothfuss and Michele Warstler
Part d.(3): Karen Rothfuss and Michele Warstler

Finding Number: 3911027
Finding Title: Medicaid Cluster, *CFDA 93.777* and *93.778*, Special Tests and Provisions - Long-Term Care Facility Audits

Management Views: DCH agrees that for 18 nursing facilities on-site reviews were not conducted at least once every four years. The Office of Audit completed an analysis of the 18 facilities and would like to point out that there appears to be a very low risk of any impact on Medicaid reimbursement in regard to these facilities.

Planned Corrective Action: DCH has initiated an additional step in the audit planning process to ensure that an on-site review is completed at least once every four year.

Anticipated Completion Date: Completed

Responsible Individual: Pam Myers

Finding Number:

3911028

Finding Title:

Medicaid Cluster, *CFDA* 93.777 and 93.778,
Subrecipient Monitoring

Management Views:

DCH acknowledges that there are opportunities for improvement in its monitoring of its subrecipient.

Part a.: DCH agrees that it did not monitor whether DHS followed the CMS-approved sampling plan.

Part b.: DCH disagrees that it did not monitor the propriety and accuracy of the MEQC Medicaid mispayment rate calculations. DCH meets on a regular basis with MEQC staff to review each identified error for accuracy as it applies to the error rate calculations. Also, the Medicaid Error Review Committee, which consists of representatives from DCH, DHS central office, and DHS local offices, meets three times per month to review each error. In reviewing the errors, corrections are made, suggestions are considered, and any training needs are identified.

DCH acknowledges that it did not evaluate the cause of periodic mispayment rate fluctuations. The sampling plan submitted to CMS by DCH was developed to provide a statistically accurate evaluation of eligibility error rates on an annual basis. Periodic fluctuations are not statistically reliable and are subject to anomalies that may be caused by one or several outlier errors. DCH does not consider these fluctuations reliable and sees little value in devoting scarce resources to determining the cause of these anomalies.

Part c.: DCH agrees that it did not evaluate the impact of corrective action plans.

Planned Corrective Action: Part a.: DCH will conduct an overview of samples, to the extent staff time permits, to provide the assurance that the sampling plan is adhered to.

Part b.: N/A

Part c.: While attempting to draw conclusions regarding the direct correlation between corrective actions and reducing the mispayment rate can be problematic, DCH will attempt to develop evaluative techniques that quantify such correlations.

Anticipated Completion Date: Part a.: June 30, 2011

Part b.: N/A

Part c.: June 30, 2011

Responsible Individual: Terry Geiger

Finding Number: 3911029

Finding Title: Medicaid Cluster, *CFDA* 93.777 and 93.778, Reporting

Management Views: DCH agrees that there are opportunities for improvement in the preparation of its quarterly statement of expenditures (CMS-64).

Planned Corrective Action: Part a.: DCH will modify its Journal Voucher Approval policy to incorporate management review and approval of all internal journal vouchers (IJVs).

Part b.: DCH will modify its Journal Voucher Approval policy to incorporate management review and approval of all IJVs. In addition, DCH will make an adjustment to the CMS-64 to correct the previous reporting error.

Part c.: DCH accounting staff will work with the Third Party Liability Division to develop a process for ensuring that Medicare recoveries are accurately reported on the CMS-64.

Anticipated Completion Date: Part a.: July 1, 2010

Part b.: Adjustment will be made on the third quarter 2010 (June 30, 2010) CMS-64.

Part c.: September 30, 2010

Responsible Individuals: Part a.: Tim Becker and Corey Sparks

Part b.: Tim Becker and Corey Sparks

Part c.: Tim Becker, Corey Sparks, and Mark West

Finding Number:

3911030

Finding Title:

Medicaid Cluster, *CFDA* 93.777 and 93.778, Special Tests and Provisions - CHAMPS

Management Views:

DCH, in conjunction with Department of Technology, Management & Budget (DTMB), generally agrees that there are opportunities for improvement of the general controls over the CHAMPS application.

Part a.: DCH and DTMB agree that the CHAMPS information system security plan was not updated to reflect changes in the CHAMPS information technology control environment.

Part b.: DCH and DTMB agree that they did not ensure that the CHAMPS contractor implemented security and access controls over the development servers that align with State of Michigan policy.

Part c.: DCH and DTMB agree that the application

change control procedures are not fully documented for CHAMPS.

Planned Corrective Action: Part a.: DTMB, in conjunction with DCH and the CHAMPS contractor, will update the CHAMPS security plan and complete the DIT-170 for CHAMPS.

Part b.: DTMB will work with the CHAMPS contractor to ensure that security and access controls over the development servers align with State of Michigan policy.

Part c.: DTMB, in conjunction with DCH, will develop and document appropriate change control procedures for CHAMPS.

Anticipated Completion Date: Part a.: September 30, 2010

Part b.: June 30, 2010

Part c.: June 30, 2010

Responsible Individuals: Part a.: Cynthia Edwards, Jay Slaughter, and Linda Myers

Part b.: Cynthia Edwards, Jay Slaughter, and Linda Myers

Part c.: Cynthia Edwards, Jay Slaughter, and Linda Myers

Finding Number: 3911031

Finding Title: Medicaid Cluster, *CFDA* 93.777 and 93.778, Allowable Costs/Cost Principles and Special Tests and Provisions - CHAMPS Other

Management Views: DCH generally agrees that there are opportunities for improvement to ensure compliance with federal laws and regulations regarding allowable costs and special tests and provisions.

Part a.: DCH agrees that it could not send EOBs to Medicaid beneficiaries for claims paid through CHAMPS. Since the implementation of CHAMPS, DCH has worked on converting the EOB specifications from the old MMIS to CHAMPS, including the development of a requirements document.

Part b.(1): DCH agrees that the County Maintenance Payback MARS Report has not been completed since CHAMPS was implemented in September 2009.

Part b.(2): DCH agrees that it is unable to claim federal matching funds for State Regional Center approved claim activity for January 2009 through September 2009 dates of service.

Part c.(1): DCH agrees that for selected long term care providers, it could not perform quarterly recalculations of Medicaid interim payments (MIPs) and could not complete annual MIP reconciliations.

Part c.(2): DCH agrees that it could not complete annual nursing facility quality assurance supplement (QAS) reconciliations for fiscal year 2008-09.

Part d.: DCH disagrees that it could not bill all liable third parties for all paid claims that were the responsibility of third parties. Only claims with paid dates from September 2009 through May 2010 were unavailable for billing. Billings involving claims with these pay dates have been delayed, not waived.

Although DCH agrees that it could not initiate provider claim adjustments or gross adjustments from September 2009 through May 2010, the ability to do so has been delayed, not lost.

Part e.: While DCH has performed matches since CHAMPS implementation to identify deceased beneficiaries, it agrees that it has not performed a data match to determine if it made fee-for-service payments on behalf of deceased beneficiaries since November 2009. The recoupment process for deceased beneficiaries in Medicaid health plans (MHPs) has been occurring regularly within CHAMPS.

Planned Corrective Action:

Part a.: The conversion has been completed and production of EOBs will resume in June 2010.

Part b.(1): DCH will use the report again when it becomes available.

Part b.(2): DCH intends to claim these federal funds, as appropriate, when the necessary paid claims reporting becomes available.

Part c.(1): When the necessary paid claims reporting becomes available, DCH will perform these recalculations and reconciliations.

Part c.(2): When the reports become available, DCH will complete the QAS reconciliations.

Part d.: Claim adjustment ability was restored and DCH began to process claim adjustments in February 2010. DCH anticipates gross adjustment ability will be restored in the near future.

Part e.: The recoupment process for deceased beneficiaries in MHPs has been occurring regularly within CHAMPS. Fee-for-service matches will begin again when the new data warehouse is fully operational.

Anticipated Completion Date: Part a.: June 2010

Part b.(1): Dependent upon report availability.

Part b.(2): The availability of reports from the CHAMPS data warehouse needed to complete these reconciliations is not yet known.

Part c.(1): The availability of reports from the CHAMPS data warehouse needed to complete these reconciliations is not yet known.

Part c.(2): The availability of reports from the CHAMPS data warehouse needed to complete these reconciliations is not yet known.

Part d.: Dependent upon the availability of gross adjustment capabilities.

Part e.: Dependent upon the DCH data warehouse becoming fully operational.

Responsible Individuals:

Part a.: Jackie Prokop

Part b.(1): John Donaldson and Tim Becker

Part b.(2): John Donaldson

Part c.(1): John Donaldson

Part c.(2): John Donaldson

Part d.: Tanya Lowers

Part e.: Jay Slaughter

Finding Number:

3911032

Finding Title:

HIV Care Formula Grants, *CFDA* 93.917

Management Views:

DCH generally agrees that there are opportunities for improvement to ensure compliance with federal laws and regulations regarding matching, level of effort, and earmarking and subrecipient monitoring.

Part a.: DCH acknowledges that the 2007 and 2008 waiver requests were not submitted within 120 days of the end of the grant period; however, for grant year 2007, DCH had received an extension to submit final expenditures and therefore does not believe the submission was late. For 2008, DCH disagrees that the waiver requirement was submitted late. The instructions for fiscal year 2007-08 progress reports changed the final report submission date to August 31, 2009. DCH was granted a one-week extension and submitted its final report and waiver request on September 1, 2009. For both grant periods, the federal agency approved the waiver requests without exception.

Part b.: DCH's HIV/AIDS Prevention and Intervention Section (HAPIS) conducted fiscal site visits, including a review of documentation to support subrecipients' reported expenditures, at most subrecipients in 2007. DCH, however, agrees that fiscal site visits were not conducted during the two-year period ended September 30, 2009. In addition to reviewing subrecipients' financial status reports (FSRs) and following up on concerns with subrecipients in 2008, HAPIS completed a risk assessment on each subrecipient (except local health departments) in an effort to prioritize monitoring efforts. Of the 19 subrecipients, HAPIS identified 4 as moderate or high risk. HAPIS initiated monitoring for one of the

moderate risk agencies in October 2009 and efforts to obtain documentation from the agency continue.

Planned Corrective Action: Part a.: N/A

Part b.: In January 2010, HAPIS reviewed documentation to support all October 2009 expenditures reported by two other subrecipient agencies. In May 2010, HAPIS completed new risk assessments for each subrecipient. By December 2010, HAPIS will perform fiscal site visits at agencies determined to be moderate or high risk. The fiscal site visits will include a review of documentation that support expenditures reported at agencies deemed high risk to monitor activities allowed or unallowed, allowable costs/cost principles, cash management, and eligibility.

Anticipated Completion Date: Part a.: N/A

Part b.: December 31, 2010

Responsible Individual: Deb Szwejda

Finding Number: 3911033

Finding Title: Block Grants for Prevention and Treatment of Substance Abuse, *CFDA* 93.959

Management Views: DCH generally agrees that there are opportunities for improvement to ensure compliance with federal laws and regulations regarding matching, level of effort, and earmarking; subrecipient monitoring; and special tests and provisions.

Part a.: DCH agrees that expenditure allocations between program codes were not recorded in the accounting system in fiscal years 2007-08 and

2008-09 as they had been in prior years, but does not agree that DCH could not demonstrate levels of effort for aggregate State expenditures and women services. Levels of effort for aggregate State expenditures were tracked on a DCH spreadsheet based on reports submitted by coordinating agencies (CAs) and community mental health services providers (CMHSPs). Levels of effort for women services are based on reports submitted by CAs. The source of this data is no different than the sources used to populate the accounting system. The lack of certain coding within the accounting system had no impact on DCH's ability to properly track level of effort spending.

DCH met its federal level of effort requirements for aggregate State expenditures in fiscal year 2007-08 and for women services expenditures for both fiscal years 2007-08 and 2008-09 as evidenced by reports submitted by CAs and CMHSPs. The maintenance shortfall experienced in fiscal year 2008-09 for aggregate State expenditures was anticipated by both the federal government and the State as a result of the American Recovery and Reinvestment Act. DCH identified a shortfall, based on preliminary numbers, within two months of the end of fiscal year 2008-09. A waiver, however, is expected to be approved. An informal communication with the federal government states, ". . . yes, based on our analysis so far, Michigan would meet the waiver criteria for extraordinary economic conditions for SFY 2009." A waiver request was submitted to the federal government in April 2010 with final tax revenue numbers and unemployment rates and a preliminary State spending number; the final State spending number will be submitted in June 2010. No formal time frames exist for waiver requests and there is no

indication that the date of the waiver request will jeopardize waiver approval.

Since DCH could in fact demonstrate compliance with federal level of effort requirements for aggregate State expenditures for 2008 and women services expenditures for 2008 and 2009, and a preliminary waiver for aggregate State expenditures for 2009 has been submitted and will likely be approved, the entire amount of federal expenditures for Block Grants for Prevention and Treatment of Substance Abuse (SAPT) of \$116.4 million for the two-year period ended September 30, 2009 should not be questioned.

Part b.: DCH agrees with the finding. Although the Bureau of Substance Abuse and Addiction Services (BSAAS) and the Office of Audit had developed a coordinated plan to address the finding from the prior Single Audit, in retrospect the plan did not address the condition timely.

Part c.: DCH agrees with the finding. When this condition was raised during the prior Single Audit, BSAAS immediately took steps to address the issue. BSAAS reinstated verification of accreditation on the treatment provider section of the site visit protocol and resumed on-site verification. BSAAS is confident that site visit staff did in fact verify accreditation at all providers they visited. However, documentation of this was not in the files for four providers. Site visit procedures call for the documentation to be noted on the protocol, obtained from the providers, and retained in files. Searches of accreditation body Web sites did indicate that these providers were accredited during the Single Audit time period.

Planned Corrective Action:

Part a.: DCH accounting staff will develop a procedure to allocate expenditures to the appropriate program codes to allow for an easier demonstration of compliance with federal level of effort requirements. Year-end allocations will be recorded using preliminary closeout documents from the CAs as final reports will not be submitted early enough to meet year-end closing requirements.

Part b.: DCH's corrective action will ensure monitoring of direct and material federal requirements applicable to subrecipient activities not less often than every other year. That is, no subrecipient will go more than one year in a row without the SAPT Program being subject to either major program testing in a Single Audit or BSAAS on-site monitoring activities to ensure that the subrecipients used funds in compliance with federal laws and regulations. The Office of Audit will notify BSAAS if a subrecipient's SAPT Program is not selected as a major program for the prior fiscal year (that is, for the year in which audit reports are due, audit reports are due to MDCH nine months after the close of the subrecipient's fiscal year). BSAAS will then contact the subrecipient to see if the SAPT Program has been or will be selected as a major program for the following fiscal year. If not, BSAAS will conduct a special review of that subsequent year to determine compliance with federal requirements. For example, the Office of Audit might notify BSAAS in September 2010 that a subrecipient's SAPT Program had not been selected as a major program for fiscal year 2008-09. BSAAS would then ask the agency if the SAPT Program was selected as a major program for fiscal year 2009-10. If not, BSAAS would conduct a special review in fiscal year 2010-11 of fiscal year 2009-10.

Part c.: BSAAS will adopt more detailed internal procedures regarding site visit tasks, time frames, documentation requirements, reporting, and other elements, with an emphasis on obtaining and retaining evidence of treatment provider accreditation, and will ensure that staff is made aware of expectations.

Anticipated Completion Date: Part a.: September 30, 2010

Part b.: All subrecipients not selected as major programs in fiscal year 2007-08 and fiscal year 2008-09 will be reviewed by September 30, 2010.

Part c.: June 15, 2010

Responsible Individuals: Part a.: Tim Becker and Teresa Schneider

Part b.: Mark Steinberg and Deb Hallenbeck

Part c.: Mark Steinberg

Finding Number: 3911034

Finding Title: Maternal and Child Health Services Block Grant to the States, *CFDA* 93.994

Management Views: DCH acknowledges that there are opportunities for improvement in its compliance with State and federal cash management requirements and subrecipient monitoring.

Part a.: DCH has made significant improvements since the prior audit cycle and will continue to seek opportunities to make its draws as accurately as possible.

Part b.: DCH agrees that its site visits did not include a review of the documentation that supported

expenditures reported by its subrecipients. The Public Health Administration has made great strides in subrecipient monitoring since the last Single Audit in which DCH was found to be lacking in this area.

Planned Corrective Action: Part a.: DCH will evaluate whether it would be cost effective to increase staffing so that federal draws can be completed on a daily basis.

Part b.: The Public Health Administration will work with the DCH Office of Audit to implement a procedure for testing a sample of expenditures from high-risk agencies. If, however, an agency that is deemed high risk has a specific program selected as major in its most recent Single Audit, DCH will rely on the results of that audit group and forgo any expenditure testing.

Anticipated Completion Date: October 1, 2010

Responsible Individuals: Part a.: Tim Becker

Part b.: Betsy Pash

Finding Number: 3911035

Finding Title: Automated Data Processing (ADP) Security Program

Management Views: DCH generally agrees that there are opportunities for improvement in its ADP security program over its information systems.

Part a.: DCH agrees that, for 20 of the 23 information systems, it had not completed a security categorization.

Part b.: DCH and DTMB agree that risk assessments have not been completed for 21 of the 23 information systems.

Part c.: DCH and DTMB agree that security plans have not been completed for 17 of the 23 information systems.

Part d.: DCH and DTMB agree that disaster recovery plans have not been documented and tested for 13 of the 23 information systems.

Part e.: DCH and DTMB agree that they did not adequately assess and report on the security of DCH information systems.

Part f.: DCH agrees that its security officer function is placed within the Medial Services Administration.

Planned Corrective Action:

Part a.: DCH, as part of the next internal control evaluation (ICE) process, will determine the appropriate security categorization of its information systems.

Part b.: DTMB, in conjunction with DCH, will complete a risk assessment for DCH applications still in productions.

Part c.: DTMB, in conjunction with DCH, will complete a security plan for all systems still in production.

Part d.: DTMB, in conjunction with DCH, will complete the documentation of the disaster recovery Plans and test the disaster recovery plans, after finishing the documentation.

Part e.: DTMB, in conjunction with DCH, will no less than biennially review the system security plans. A written summary of the results, including an action plan to correct security weaknesses, will be prepared. This will commence with the completion of the security plans.

Part f.: DCH will consider the recommendation of having the security officer report directly to DCH's executive management team.

Anticipated Completion Date: Part a.: December 31, 2010

Part b.: April 30, 2011

Part c.: April 30, 2011

Part d.: May 31, 2011 (documentation)
December 31, 2011 (testing)

Part e.: April 30, 2011

Part f.: April 30, 2011

Responsible Individuals: Part a.: Cynthia Edwards and Scott Werner

Part b.: Cynthia Edwards and Linda Myers

Part c.: Cynthia Edwards and Linda Myers

Part d.: Cynthia Edwards and Linda Myers

Part e.: Cynthia Edwards and Linda Myers

Part f.: Cynthia Edwards and Linda Myers

GLOSSARY

Glossary of Acronyms and Terms

AAA	area agency on aging.
ABW Program	Adult Benefits Waiver Program.
ADP	automated data processing.
adverse opinion	An auditor's opinion in which the auditor states that the audited agency did not comply, in all material respects, with the cited requirements that are applicable to each major federal program.
AHH	Adult Home Help.
AIDS	acquired immunodeficiency syndrome.
ARF	Administrative Revolving Fund.
ARRA	American Recovery and Reinvestment Act of 2009.
ASPEN system	Automated Survey Processing Environment system.
ASAP	Adult Services Authorized Payments System.
Bridges Integrated Automated Eligibility Determination System (Bridges)	An automated integrated service delivery system for Michigan's cash assistance, medical assistance, food assistance, and child care assistance program.
BSAAS	Bureau of Substance Abuse and Addition Services.
CA	coordinating agency.
CCDF	Child Care and Development Fund.
CDC	Centers for Disease Control and Prevention.

CDC Program	Centers for Disease Control and Prevention - Investigations and Technical Assistance.
<i>CFDA</i>	<i>Catalog of Federal Domestic Assistance.</i>
CFP	Center for Forensic Psychiatry.
<i>CFR</i>	<i>Code of Federal Regulations.</i>
CHAMPS	Community Health Automated Medicaid Processing System.
CHIP	Children's Health Insurance Program.
CIP	capital interim payment.
CLIA	Clinical Laboratory Improvement Amendments.
cluster	A grouping of closely related federal programs that have similar compliance requirements. Although the programs within a cluster are administered as separate programs, a cluster of programs is treated as a single program for the purpose of meeting the audit requirements of OMB Circular A-133.
CMHSP	community mental health services program.
CMIA	federal Cash Management Improvement Act of 1990.
CMS	Centers for Medicare and Medicaid Services.
CMS-64 report	quarterly statement of expenditures.
COLS	Court Originated Liability Section.

control deficiency in internal control over federal program compliance	The design or operation of a control that does not allow management or employees, in the normal course of performing their assigned functions, to prevent or detect on a timely basis noncompliance with a type of compliance requirement of a federal program.
control deficiency in internal control over financial reporting	The design or operation of a control that does not allow management or employees, in the normal course of performing their assigned functions, to prevent or detect misstatements on a timely basis.
Control Objectives for Information and Related Technology (COBIT)	A framework, control objectives, and audit guidelines published by the IT Governance Institute as a generally applicable and accepted standard for good practices for controls over information technology.
CoP	Conditions of Participation.
DCH	Department of Community Health.
DHS	Department of Human Services.
DSC	disciplinary subcommittee.
DSH	disproportionate share hospital.
DTMB	Department of Technology, Management & Budget.
DWCHA	Detroit Wayne County Health Authority.
EOB	explanation of benefits.
EQR	external quality review.
FFP	federal financial participation.

financial audit	An audit that is designed to provide reasonable assurance about whether the financial schedules and/or financial statements of an audited entity are presented fairly in all material respects in conformity with the disclosed basis of accounting.
FMAP	federal medical assistance percentage.
FMG	State of Michigan Financial Management Guide.
FOC	Friend of the Court.
Framework	<i>Evaluation of Internal Controls - A General Framework and System of Reporting.</i>
HAPIS	HIV/AIDS Prevention and Intervention Section.
HHS	U.S. Department of Health and Human Services.
HIV	human immunodeficiency virus.
HKME	Healthy Kids Medicaid Expansion.
ICE	internal control evaluation.
ICO	internal control officer.
IJV	internal journal voucher.
internal control	A process, effected by those charged with governance, management, and other personnel, designed to provide reasonable assurance about the achievement of the entity's objectives with regard to the reliability of financial reporting, effectiveness and efficiency of operations, and compliance with applicable laws and regulations.

IPP	Injury Prevention and Control Research and State and Community Based Programs.
ISD	intermediate school district.
IT	information technology.
known questioned costs	Questioned costs that are specifically identified by the auditor.
LHD	local health department.
likely questioned costs	The auditor's estimate, based on the known questioned costs, of total questioned costs.
low-risk auditee	As provided for in OMB Circular A-133, an auditee that may qualify for reduced federal audit coverage if it receives an annual Single Audit and it meets other criteria related to prior audit results. In accordance with State statute, this Single Audit was conducted on a biennial basis; consequently, this auditee is not considered a low-risk auditee.
MARS	Management and Administrative Reporting System.
material misstatement	A misstatement in the financial schedules and/or financial statements that causes the schedules and/or statements to not present fairly the financial position or the changes in financial position or cash flows in conformity with the disclosed basis of accounting.
material noncompliance	Violations of laws, regulations, contracts, and grants that could have a direct and material effect on major federal programs or on financial schedule and/or financial statement amounts.

material weakness in internal control over federal program compliance	A significant deficiency, or combination of significant deficiencies, that results in more than a remote likelihood that material noncompliance with a type of compliance requirement of a federal program will not be prevented or detected.
material weakness in internal control over financial reporting	A significant deficiency, or combination of significant deficiencies, that results in more than a remote likelihood that a material misstatement of the financial schedules and/or financial statements will not be prevented or detected.
MCH Block Grant	Maternal and Child Health Services Block Grant to the States.
MEQC	Medicaid Eligibility Quality Control.
MHP	Medicaid health plan.
MIP	Medicaid interim payment.
MMIS	Medicaid Management Information System.
MMSS	MAIN and Medicaid Support Section.
MOMS	Maternity Outpatient Medical Services.
MPHI	Michigan Public Health Institute.
MSP	Michigan Department of State Police.
MSU	Michigan State University.
NIST	National Institute of Standards and Technology.
NOID	Notice of Intent to Deny Licensure.
OAG	Office of the Auditor General.

OFIR	Office of Financial and Insurance Regulation.
OMB	U.S. Office of Management and Budget.
OOA	DHS's Office of Quality Assurance.
OSA	Office of Services to the Aging.
PA	prosecuting attorney.
pass-through entity	A nonfederal entity that provides a federal award to a subrecipient to carry out a federal program.
PBM	pharmacy benefits manager.
PCRS	Paternity Casualty Recovery System.
PE	provider enrollment.
PIHP	prepaid inpatient health plan.
PHEP	Public Health Emergency Preparedness.
QAA	quality assurance assessment.
QAS	quality assurance supplement.
qualified opinion	An auditor's opinion in which the auditor: <ul style="list-style-type: none"> a. Identifies a scope limitation or one or more instances of misstatements that impact the fair presentation of the financial schedules and/or financial statements presenting the basic financial information of the audited agency in conformity with the disclosed basis of accounting or the financial schedules and/or financial statements presenting supplemental financial information in relation to the basic financial schedules

and/or financial statements. In issuing an "in relation to" opinion, the auditor has applied auditing procedures to the supplemental financial schedules and/or financial statements to the extent necessary to form an opinion on the basic financial schedules and/or financial statements, but did not apply auditing procedures to the extent that would be necessary to express an opinion on the supplemental financial schedules and/or financial statements taken by themselves; or

- b. Expresses reservations about the audited agency's compliance, in all material respects, with the cited requirements that are applicable to each major federal program.

questioned cost

A cost that is questioned by the auditor because of an audit finding: (1) which resulted from a violation or possible violation of a provision of a law, regulation, contract, grant, cooperative agreement, or other agreement or document governing the use of federal funds, including funds used to match federal funds; (2) where the costs, at the time of the audit, are not supported by adequate documentation; or (3) where the costs incurred appear unreasonable and do not reflect the actions a prudent person would take in the circumstances.

RSAT

Residential Substance Abuse Treatment for State Prisoners.

RS Database

Receivables System Database.

RTI

Research Triangle Institute.

SAPT

Block Grants for Prevention and Treatment of Substance Abuse.

SBS

School Based Services.

SCHIP	State Children's Insurance Program.
SEFA	schedule of expenditures of federal awards.
significant deficiency in internal control over federal program compliance	A control deficiency, or combination of control deficiencies, that adversely affects the entity's ability to administer a federal program such that there is more than a remote likelihood that noncompliance with a type of compliance requirement of a federal program that is more than inconsequential will not be prevented or detected.
significant deficiency in internal control over financial reporting	A control deficiency, or combination of control deficiencies, that adversely affects the entity's ability to initiate, authorize, record, process, or report financial data reliably in accordance with generally accepted accounting principles such that there is more than a remote likelihood that a misstatement of the entity's financial schedules and/or financial statements that is more than inconsequential will not be prevented or detected.
Single Audit	A financial audit, performed in accordance with the Single Audit Act Amendments of 1996, that is designed to meet the needs of all federal grantor agencies and other financial report users. In addition to performing the audit in accordance with the requirements of auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in <i>Government Auditing Standards</i> issued by the Comptroller General of the United States, a Single Audit requires the assessment of compliance with requirements that could have a direct and material effect on a major federal program and the consideration of internal control over compliance in accordance with OMB Circular A-133.
SNAP	Supplemental Nutrition Assistance Program.
SOMCAFR	<i>State of Michigan Comprehensive Annual Financial Report.</i>

subrecipient	A nonfederal entity that expends federal awards received from another nonfederal entity to carry out a federal program.
summary suspension	An emergency action taken by the department, in conjunction with the chair of the appropriate medical board, against a provider whose actions threaten the public's health, safety, or welfare.
SURS	Surveillance and Utilization Review System.
TANF	Temporary Assistance for Needy Families.
TB	tuberculosis.
TPSO	third party service organization.
TSCA	Toxic Substances Control Act.
unqualified opinion	<p>An auditor's opinion in which the auditor states that:</p> <ol style="list-style-type: none"> a. The financial schedules and/or financial statements presenting the basic financial information of the audited agency are fairly presented in conformity with the disclosed basis of accounting; or b. The financial schedules and/or financial statements presenting supplemental financial information are fairly stated in relation to the basic financial schedules and/or financial statements. In issuing an "in relation to" opinion, the auditor has applied auditing procedures to the supplemental financial schedules and/or financial statements to the extent necessary to form an opinion on the basic financial schedules and/or financial statements, but did not apply auditing procedures to the extent that would be necessary to express an opinion on the supplemental financial schedules and/or financial statements taken by themselves; or

- c. The audited agency complied, in all material respects, with the cited requirements that are applicable to each major federal program.

USDA

U.S. Department of Agriculture.

WIC Program

Special Supplemental Nutrition Program for Women, Infants, and Children.

