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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REPORT SUMMARY

Performance Audit

Center for Forensic Psychiatry (CFP) and Related Bureauwide Reimbursement Activities

Bureau of Hospitals, Centers, and Forensic Mental Health Services

Department of Community Health (DCH)

Report Number: 39-210-03

Released: April 2005

CFP's mission is to provide quality forensic mental health services to individuals and the Michigan court system. CFP conducts diagnostic evaluations on issues related to competency to stand trial and other issues and provides psychiatric treatment for criminal defendants adjudicated incompetent to stand trial and/or acquitted by reason of insanity. CFP, like other DCH facilities, is responsible for seeking reimbursement from various parties to recover its treatment delivery costs. For facilities that are certified by the Centers for Medicare and Medicaid Services (CMS), these parties include Medicare and Medicaid. CFP is not CMS-certified.

Audit Objective:
To assess the effectiveness of CFP's and related Bureauwide reimbursement activities.

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Audit Conclusion:
We concluded that CFP's and related Bureauwide reimbursement activities were somewhat effective.

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Material Condition:
DCH's CMS-certified facilities did not seek reimbursement from Medicare for bad debt resulting from the unpaid deductibles and coinsurances of Medicare enrolled patients. We estimate that DCH's four CMS-certified facilities serving adults with mental illness could have collected additional Medicare reimbursements totaling at least $4 million for Medicare Part A covered services delivered during fiscal years 1998-99 through 2003-04 and additional lesser reimbursements for the Medicare Part B covered services delivered during the same period. (Finding 1)

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Reportable Conditions:
CFP had not conducted a comprehensive analysis to determine if it would be cost-effective to obtain CMS certification. We estimate that CFP could generate $2.44 million in Medicare Part A reimbursements initially and $1.15 million annually thereafter; $500,000 in Medicare Part B reimbursements annually; and other significant reimbursements if it obtained CMS certification. Some or all of these reimbursements may be offset by costs to obtain and retain certification. CFP had not quantified these costs. (Finding 2)

CFP and other DCH facilities did not ensure that eligible patients retained enrollment in Medicare Part B after the discontinuance of their Social Security benefits. To enroll in

Part B, most eligible individuals pay a monthly premium through a deduction from these benefits. We estimate that the facilities could have increased their total Part B reimbursements by at least $800,000 annually by retaining these enrollments. For CFP to obtain these reimbursements, it would have to enhance the documentation of the covered services that it provides. (Finding 3)

CFP and other DCH facilities did not charge counties for their full share of the facilities' costs to deliver services to county residents. As of April 30, 2004, counties had not been charged for their 10% share ($6.8 million) of $68.3 million in delinquent accounts from an extended number of years. (Finding 4)

DCH did not provide CFP with the staffing needed to complete its reimbursement responsibilities in a timely manner. As a result, CFP did not timely bill patients, counties, and other responsible parties for its patients' cost of care. (Finding 5)

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Agency Response:
Our audit report contains 5 findings and 7 corresponding recommendations. DCH's preliminary response indicated that it agrees with all of our recommendations and has taken or will take steps to comply with them.

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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

April 15, 2005

Ms. Janet Olszewski, Director
Department of Community Health
Lewis Cass Building
Lansing, Michigan

Dear Ms. Olszewski:

This is our report on the performance audit of the Center for Forensic Psychiatry and Related Bureauwide Reimbursement Activities, Bureau of Hospitals, Centers, and Forensic Mental Health Services, Department of Community Health.

This report contains our report summary; description of agency; audit objectives, scope, and methodology and agency responses; comments, findings, recommendations, and agency preliminary responses; and a glossary of acronyms and terms.

The agency preliminary responses were taken from the agency's responses subsequent to our audit fieldwork. 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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BUREAU OF HOSPITALS, CENTERS,
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Description of Agency

The Center for Forensic Psychiatry (CFP) was created by Act 266, P.A. 1966, and operates under the jurisdiction of the Bureau of Hospitals, Centers, and Forensic Mental Health Services, Department of Community Health. CFP's mission* is to provide quality forensic mental health services to individuals and the Michigan court system.

To fulfill its mission, CFP conducts diagnostic evaluations for all of the State's district and circuit criminal courts on issues related to competency to stand trial, criminal responsibility, competency to be sentenced, juvenile waiver, sentencing and pre-sentencing recommendations, dangerousness, and other issues. For fiscal year 2002-03, CFP reported that it completed 3,352 of these evaluations. CFP also provides inpatient psychiatric treatment for criminal defendants adjudicated incompetent to stand trial and/or acquitted by reason of insanity. A complement of psychiatrists, psychologists, social workers, nurses, forensic security aides, and occupational, recreational, and music therapists provides this treatment in CFP's seven inpatient units. CFP, like other DCH facilities, is responsible for seeking reimbursement from patients, insurers, and federal entitlement programs, as applicable, to recover its treatment delivery costs.

On November 1, 2000, CFP earned is first accreditation from the Joint Commission on Accreditation of Healthcare Organizations. CFP was reaccredited on January 14, 2004.

For fiscal year 2002-03, CFP expenditures totaled approximately $42.3 million. As of September 30, 2003, CFP had 224 patients and 508 employees.

* *See glossary at end of report for definition.*

Audit Objectives, Scope, and Methodology
and Agency Responses

Audit Objective

The objective of our performance audit* of the Center for Forensic Psychiatry (CFP) and Related Bureauwide Reimbursement Activities, Bureau of Hospitals, Centers, and Forensic Mental Health Services, Department of Community Health (DCH), was to assess the effectiveness* of CFP's and related Bureauwide reimbursement activities.

Audit Scope

Our audit scope was to examine the program and other records related to the Center for Forensic Psychiatry's and related Bureauwide reimbursement activities. Our audit was conducted in accordance with *Government Auditing Standards* issued by the Comptroller General of the United States and, accordingly, included such tests of the records and such other auditing procedures as we considered necessary in the circumstances.

Audit Methodology

Our audit procedures, conducted from May through July 2003 and from April through August 2004, included examination of CFP's records and activities and related reimbursement activities of other DCH facilities primarily for the period October 1, 2000 through August 27, 2004.

We conducted a preliminary review of CFP's operations to formulate a basis for developing audit objectives and defining the audit scope. Our review included interviewing CFP and DCH personnel; reviewing applicable laws, rules, regulations, policies, procedures, and other information; analyzing available records, data, and statistics; and obtaining an understanding of CFP's management control* and operational activities.

To accomplish our objective, we researched the Mental Health Code, the federal Social Security Act, federal regulations, and other resources to obtain an understanding of the reimbursements available to CFP and other DCH facilities. Also, we interviewed staff from CFP's administrative and reimbursement areas, other DCH facilities, the DCH central office, and applicable federal and private organizations. In addition, we

** See glossary at end of report for definition.*

compiled and analyzed data related to delinquent cost-of-care billings, unpaid Medicare deductibles* and coinsurances*, and Medicare Part B* enrollment at CFP and other DCH facilities serving adults with mental illness. Finally, we reviewed and tested CFP's compliance with laws, policies, and procedures related to the completion of patient financial liability determinations and its collection efforts.

Agency Responses

Our audit report contains 5 findings and 7 corresponding recommendations. DCH's preliminary response indicated that it agrees with all of our recommendations and has taken or will take steps to comply with them.

The agency preliminary response that follows each recommendation in our report was taken from the agency's written comments and oral discussion subsequent to our audit fieldwork. Section 18.1462 of the *Michigan Compiled Laws* and Department of Management and Budget Administrative Guide procedure 1280.02 require DCH to develop a formal response to our audit findings and recommendations within 60 days after release of the report.

** See glossary at end of report for definition.*

COMMENT, FINDINGS, RECOMMENDATIONS, AND AGENCY PRELIMINARY RESPONSES

EFFECTIVENESS OF
REIMBURSEMENT ACTIVITIES

COMMENT

Background: The Department of Community Health (DCH) and its facilities, including the Center for Forensic Psychiatry (CFP), are responsible for seeking reimbursement from various parties for the facilities' treatment delivery costs. These parties include patients, parents, spouses, guardians, counties, and insurers. For facilities that are certified by the Centers for Medicare and Medicaid Services* (CMS), these parties also include Medicare* and Medicaid*. CFP is not CMS-certified.

Audit Objective: To assess the effectiveness of CFP's and related Bureauwide reimbursement activities.

Conclusion: We concluded that CFP's and related Bureauwide reimbursement activities were somewhat effective. Our audit disclosed one material condition*. DCH's CMS-certified facilities did not seek reimbursement from Medicare for bad debt* resulting from unpaid deductibles and coinsurances of Medicare enrolled patients (Finding 1). Our audit also disclosed reportable conditions* related to CMS certification*, Medicare Part B benefits, county cost reimbursement, and reimbursement office staffing (Findings 2 through 5).

FINDING

1. Reimbursement for Medicare Bad Debt

   DCH's CMS-certified facilities did not seek reimbursement from Medicare for bad debt resulting from the unpaid deductibles and coinsurances of Medicare enrolled patients. We estimate that DCH's four CMS-certified facilities serving adults with mental illness could have collected additional Medicare reimbursements totaling at least $4 million for the Medicare Part A* covered services delivered during fiscal years 1998-99 through 2003-04 and additional lesser reimbursements for the Medicare Part B covered services delivered during the same period.

   Medicare, a federal health insurance program for the aged and disabled, reimburses participating service providers for the service providers' cost to deliver

** See glossary at end of report for definition.*

covered services to Medicare enrolled patients, less applicable deductible and coinsurance amounts. Service providers are expected to collect the deductible and coinsurance amounts from the Medicare enrolled patients and/or others, as applicable. At the conclusion of each fiscal year, Medicare completes a reimbursement settlement with each of its service providers in which it reconciles the reimbursements it paid to the service provider with the service provider's reported costs. Medicare considers unpaid patient deductibles and coinsurances (i.e., Medicare bad debt) as reportable costs eligible for partial (the percentage varies by fiscal year) reimbursement. However, DCH facilities did not include the dollar amount of unpaid deductibles and coinsurances in their reported costs and, therefore, they did not obtain any Medicare reimbursement for them.

DCH's Revenue and Reimbursement Division informed us that it was aware that DCH facilities could have obtained reimbursement for their Medicare bad debt; however, DCH had not established a method to quantify and report the necessary information to obtain this reimbursement.

Title 42, Part 405, section 1885 of the *Code of Federal Regulations* (*CFR*) allows for a service provider to request a reopening of a completed cost settlement for three years from the date that the provider was notified of the completed cost settlement. Based upon our review of the cost settlement notification dates for DCH facilities, we determined that all of the DCH facilities can request the reopening of their completed cost settlements for fiscal year 1998-99 to date and seek reimbursement for their Medicare bad debt.

RECOMMENDATIONS

We recommend that DCH's CMS-certified facilities seek reimbursement from Medicare for bad debt resulting from the unpaid deductibles and coinsurances of Medicare enrolled patients.

We also recommend that DCH facilities request to reopen past cost settlements and seek reimbursement from Medicare for eligible Medicare bad debt.

AGENCY PRELIMINARY RESPONSE

DCH agrees and informed us that it has implemented procedures to identify and include reimbursable bad debt expense on all current and future cost reports. DCH also agrees that cost reports can be reopened as far back as fiscal year 1998-99

and informed us that it is currently working to gather the necessary information and will seek reimbursement for those previous years.

FINDING

2. CMS Certification

CFP had not conducted a comprehensive analysis to determine if it would be cost-effective to obtain CMS certification. As a result, CFP may be forgoing Medicare and Medicaid reimbursements that would significantly exceed the costs it would incur to generate them.

To participate in Medicare and/or Medicaid, service providers must meet various federal and/or State standards related to such things as staffing, medical records, and patient rights. Upon certifying that a service provider has met these requirements, Medicare and Medicaid will reimburse the provider for covered services delivered to their respective beneficiaries. Covered services include services such as general inpatient hospital care for room and board, psychotherapy, and psychiatric evaluations.

During fiscal year 2000-01, CFP and DCH central office staff conducted an analysis of the Medicare Part A reimbursements that CFP could generate if it obtained CMS certification. Based upon this analysis, CFP and DCH concluded that it would not be cost-effective for CFP to seek CMS certification. However, our review disclosed that the analysis was incomplete and, therefore, did not contain sufficient evidence to support this conclusion. Specifically, the analysis did not include an estimate of the Medicare Part A lifetime reserve days*, Medicare Part B, Medicare bad debt, and Medicaid reimbursements that CFP could generate with certification. In addition, it did not include a review of the costs associated with obtaining or retaining certification. Additional costs would likely be incurred to provide such things as increased nursing services and enhanced service related documentation.

CFP and DCH informed us that they did not complete a comprehensive cost analysis because they believed that the costs to obtain and retain certification would have easily exceeded the reimbursements that could have been generated. In addition, CFP and DCH did not include the potential Medicare bad debt

* *See glossary at end of report for definition.*

reimbursements in the analysis because no other DCH facilities were seeking such reimbursement (see Finding 1). Furthermore, as a mental health services provider, CFP generally would not be eligible for Medicaid reimbursement for services delivered to individuals between the ages of 22 and 65.

However, using patient Medicare eligibility data from the fiscal year 2000-01 analysis and CFP's fiscal year 2003-04 billing rate, we estimate that CFP could generate $2.44 million in Medicare Part A reimbursements initially and $1.15 million annually thereafter. Also, CFP could generate one-time Medicare Part A reimbursements of up to $6,900 per patient for those patients who approve the use of their lifetime reserve days. In addition, we estimate that CFP could generate Medicare Part B reimbursements totaling $500,000 annually. Further, although we did not attempt to estimate the Medicare bad debt and Medicaid reimbursements that CFP could generate, we believe that the amounts would be significant.

Because our analysis demonstrates that CFP could generate a significant amount of Medicare and Medicaid reimbursements if it obtained CMS certification, CFP should fully quantify its potential reimbursements and compare them against its quantified costs to obtain and retain certification.

RECOMMENDATION

We recommend that CFP conduct a comprehensive analysis to determine if it would be cost-effective to obtain CMS certification.

AGENCY PRELIMINARY RESPONSE

DCH agrees that it has not conducted a comprehensive cost-benefit analysis to determine whether it would be cost-effective for CFP to obtain CMS certification. DCH will conduct a more thorough analysis to determine if it should pursue certification and will maintain documentation supporting the results of the analysis. If the analysis demonstrates that it is cost-effective, DCH will pursue certification subject to any statutory or other budgetary approvals that may be required.

FINDING

3. Medicare Part B Benefits

CFP and other DCH facilities did not ensure that eligible patients retained enrollment in Medicare Part B after the discontinuance of their Social Security

benefits. We estimate that the facilities could have increased their total Part B reimbursements by at least $800,000 annually by retaining these enrollments.

Medicare Part B reimburses DCH facilities for various medical services delivered to Part B enrollees. To enroll in Part B, most eligible individuals pay a monthly premium through a deduction from their Social Security benefits. However, the Social Security Administration discontinues providing monthly benefits to many individuals when they begin receiving court-ordered treatment at CFP or other DCH facilities. In most instances, these individuals simultaneously lose their Part B enrollment because they lack other financial resources to pay the Part B premiums. To preserve the enrollment of these individuals in Part B, DCH facilities can apply to have Medicaid pay the monthly premiums. Alternatively, the facilities can pay the premiums for the individuals who do not qualify for Medicaid.

For calendar years 2003 and 2004, Medicare Part B's monthly premiums were approximately $59 and $67 per patient, respectively. Based on our review, the facilities could have easily offset the cost of these premiums with the additional Part B reimbursements that they would have generated. For example, for the three-month period ended April 2003, we estimate that DCH facilities received, or expected to receive, an average $369 in monthly Part B reimbursements for each enrolled patient. This exceeded the monthly cost of the Part B premium for each individual by approximately $310.

One DCH facility informed us that it had been paying the Medicare Part B premiums for its patients, when necessary, but it was now using Medicaid for this purpose. Other DCH facilities informed us that they had not attempted to have Medicaid pay patients' Part B premiums or had not paid the Part B premiums themselves, when necessary, because DCH did not allow the facilities to fund the monthly premiums with the additional Part B reimbursements that they would have generated.

For CFP to obtain Medicare Part B reimbursements, it would have to enhance the documentation of the covered services that it provides.

RECOMMENDATION

We recommend that DCH facilities ensure that eligible patients retain enrollment in Medicare Part B after the discontinuance of their Social Security benefits.

AGENCY PRELIMINARY RESPONSE

DCH agrees and will expand the system used at the Caro Center to its other certified hospitals and centers to ensure that eligible patients retain their enrollment in Medicare Part B after discontinuance of their Social Security benefits. CFP will participate in Part B should it seek and obtain CMS certification. If it is determined that CMS certification is not feasible, CFP will explore whether it is cost-effective to enhance the documentation of the covered services that would be required to participate in Part B.

FINDING

4. County Cost Reimbursement

CFP and other DCH facilities did not charge counties for their full share of the facilities' costs to deliver services to county residents. As a result, DCH facilities did not obtain all applicable county cost reimbursements.

Section 330.1302 of the *Michigan Compiled Laws* states that a county is financially liable for 10% of the net cost of any service that a DCH facility delivers to a resident of that county, excluding county residents acquitted of a criminal charge by reason of insanity or determined incompetent to stand trial, during their initial 60-day period of evaluation. "Net cost" is defined as the operating cost of delivering a service less that amount of the operating cost paid for by federal and private funds and reimbursements received from the insurers and individuals who are financially liable for the cost of the service.

When calculating the net cost to provide a service, DCH facilities reduced their operating costs to provide the service by the amounts billed to insurers and financially liable individuals (e.g., patients, parents, and spouses). However, if the amount that the financially liable individuals reimbursed the facilities was less than the amount that the facilities billed them, the facilities did not increase their net cost by the amount of the underpayment and bill the counties for their 10% share of the difference.

DCH facilities attempted to collect amounts that financially liable individuals owed to them using various collection methods. After exhausting these collection methods, DCH facilities referred uncollectible accounts to the Michigan Department of Treasury for it to pursue collection on their behalf. During the three-year period

ended September 30, 2003, these referrals totaled approximately $7.7 million. However, based upon our review, the Department of Treasury collected only a limited dollar amount and percentage of the referred accounts. For example, CFP had referred approximately $2.3 million (30%) of the aforementioned uncollectible accounts to the Department of Treasury. However, as of August 13, 2004, the Department of Treasury had collected only $23,989 (1%) of these referrals. DCH facilities could charge the applicable counties for their 10% share of uncollectible accounts upon referring them to the Department of Treasury and then refund the counties for their share of any subsequent collections.

As of April 30, 2004, the Department of Treasury was attempting to collect approximately $68.3 million from over 7,200 individuals for uncollectible accounts from an extended number of years ranging from less than $100 to more than $666,000. If DCH facilities had billed the counties for their 10% share of these accounts, the facilities would have generated approximately $6.8 million in additional county cost reimbursements. In the absence of the county funding, DCH funded the unreimbursed costs in their entirety.

RECOMMENDATIONS

We recommend that DCH facilities charge counties for their full share of the facilities' costs to deliver services to county residents.

We also recommend that DCH facilities charge counties for their 10% share of the uncollectible accounts previously referred to the Department of Treasury, as determined to be economically feasible.

AGENCY PRELIMINARY RESPONSE

DCH agrees that counties are financially liable, with some limited exceptions, for 10% of the net cost of services provided by DCH facilities. DCH also agrees that it did not separately bill the counties for any first and third party reimbursements that proved to be uncollectible. DCH informed us that it is in the process of analyzing and making changes to its billing system in response to changes in Medicare. As a result of these changes and issues raised by the audit, DCH intends to completely review its procedures relating to how it calculates the net cost of providing services to determine the cost-benefit of any changes necessary to ensure that first and third party payers and the counties meet their financial obligation.

FINDING

5. Reimbursement Office Staffing

DCH did not provide CFP with the staffing needed to complete its reimbursement responsibilities in a timely manner. As a result, CFP did not timely bill patients, counties, and other responsible parties for its patients' cost of care. Timely billing is important because it increases the likelihood of collection and improves the State's cash flow.

An employee of Northville Psychiatric Hospital (NPH) was responsible for completing CFP's reimbursement responsibilities until NPH's closure in May 2003. Upon NPH's closure, DCH reassigned the employee to its central office but did not make alternative arrangements for another individual to complete CFP's reimbursement responsibilities. In March 2004, CFP hired its own reimbursement staff person. However, by this date, CFP had already accumulated a significant reimbursement-related work backlog. For example, CFP informed us that as of May 26, 2004, it had a backlog of approximately 350 financial liability determinations dating back to May 2003. The financial liability determination establishes the amount owed by each patient or other responsible party and must be completed before the amount owed by the patient's county of residence can be calculated and billed. Sections 330.1817 - 330.1819 of the *Michigan Compiled Laws* require that CFP complete a financial liability determination for each of its patients as soon as practical after admission, again upon the patient's 61st day of admission, and annually thereafter.

Because DCH's billing system necessitates that CFP generate all billings for a given month's services at the same time, the backlog of financial liability determinations prevented it from billing for any of the services that it had delivered since April 2003. In addition, from July 7, 2003 through June 8, 2004, CFP had not generated any follow-up billings for amounts that it had previously billed to patients or other responsible parties that remained unpaid by them. DCH's billing and collection policy requires that billings be sent out during the calendar month following the month that services were provided and monthly thereafter. In fiscal year 2001-02, CFP's patient and county reimbursements totaled $2.5 million.

RECOMMENDATION

We recommend that DCH provide CFP with the staffing needed to complete its reimbursement responsibilities in a timely manner.

AGENCY PRELIMINARY RESPONSE

DCH agrees that for a period of time its billing functions were not being performed in a timely manner. DCH informed us that it has now centralized its billing responsibilities for all of its hospitals and centers. DCH also informed us that the backlog of financial liability determinations has been caught up and the determinations are now current. In addition, DCH informed us that it has and will continue to make progress to improve its timeliness regarding its billing responsibilities.

GLOSSARY

Glossary of Acronyms and Terms

bad debt	The Medicare deductible and coinsurance amounts that are deemed uncollectible from Medicare beneficiaries after reasonable collection efforts have been made.
Centers for Medicare and Medicaid Services (CMS)	An agency within the federal Department of Health and Human Services that administers Medicare. In addition, the agency works with individual states to administer Medicaid.
certification	The designation given to a health care provider that has demonstrated, through inspection, that it meets the participation requirements of Medicare and Medicaid. Medicare and Medicaid cover only care delivered by certified providers.
CFP	Center for Forensic Psychiatry.
coinsurance	A fixed percentage of the total amount paid for a health care service that can be charged to a beneficiary on a per service basis.
DCH	Department of Community Health.
deductible	The amount a beneficiary must pay for health care before Medicare begins to pay, either for each benefit period for Part A or for each year for Part B.
effectiveness	Program success in achieving mission and goals.
lifetime reserve days	Sixty days that Medicare will pay for when a beneficiary is in a hospital for more than 90 days. These 60 reserve days can be used only once during a beneficiary's lifetime. For each lifetime reserve day, Medicare pays all covered costs except for a daily coinsurance.

management control	The plan of organization, methods, and procedures adopted by management to provide reasonable assurance that goals are met; resources are used in compliance with laws and regulations; valid and reliable data is obtained and reported; and resources are safeguarded against waste, loss, and misuse.
material condition	A reportable condition that could impair the ability of management to operate a program in an effective and efficient manner and/or could adversely affect the judgment of an interested person concerning the effectiveness and efficiency of the program.
Medicaid	A federal and state-funded health care entitlement program for certain individuals and families with low incomes and limited resources.
Medicare	A federal health insurance program for people 65 years of age or older, certain younger people with disabilities, and people with end-stage renal disease.
Medicare Part A	Hospital insurance that provides coverage for inpatient care.
Medicare Part B	Medical insurance that provides coverage for doctor's services and outpatient hospital care, including physical and occupational therapists and some home health care.
mission	The agency's main purpose or the reason that the agency was established.
NPH	Northville Psychiatric Hospital.
performance audit	An economy and efficiency audit or a program audit that is designed to provide an independent assessment of the performance of a governmental entity, program, activity, or function to improve public accountability and to facilitate

decision making by parties responsible for overseeing or initiating corrective action.

reportable condition A matter that, in the auditor's judgment, represents either an opportunity for improvement or a significant deficiency in management's ability to operate a program in an effective and efficient manner.

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