

**AGENCIES OF THE SECRETARY OF
HEALTH AND HUMAN RESOURCES**

JUNE 30, 2010

APA

**Auditor of
Public Accounts**

COMMONWEALTH OF VIRGINIA

AUDIT SUMMARY

This report discusses the services and financial activities of the thirteen departments and agencies reporting to the **Secretary of Health and Human Resources**.

AUDIT RESULTS

Overall our audit for the year ended June 30, 2010, found the following:

- Proper recording and reporting of transactions, in all material respects, in the Commonwealth Accounting and Reporting System and in each agency's accounting records.
- Internal control matters that require management's attention and corrective action; these are included in the section entitled "Recommendations" starting on page 1.
- Instances of noncompliance with applicable laws and regulations that are required to be reported under Government Auditing Standards; these are included in the section entitled "Recommendations" starting on page 1.

DEPARTMENTS AND AGENCIES

The Secretary of Health and Human Resources report includes the following departments and agencies.

Aging
Behavioral Health and Developmental Services
Blind and Vision Impaired
Deaf and Hard of Hearing
Health
Health Professions
Medical Assistance Services
Office of Comprehensive Services for At-Risk Youth and Families
Rehabilitative Services
Social Services
Virginia Board for People with Disabilities
Virginia Rehabilitation Center for the Blind and Vision Impaired
Woodrow Wilson Rehabilitation Center

- TABLE OF CONTENTS -

	<u>Pages</u>
AUDIT SUMMARY	
RECOMMENDATIONS	1-8
SYSTEM RELATED RECOMMENDATIONS	8-15
ACCESS MANAGEMENT	8-11
SECURITY PROGRAM	11-13
INFRASTRUCTURE SECURITY RISK	14
SECURITY AWARENESS TRAINING	14-15
RECOMMENDATIONS BY AGENCY	16
RESOLVED RECOMMENDATIONS FROM PRIOR YEAR	17
STATEWIDE REPORTS	17
VIRGINIA'S MEDICAID PROGRAM	18-24
MANAGING SERVICES AND SELECTED FINANCIAL INFORMATION	25-64
AGENCIES OF THE SECRETARY HEALTH AND HUMAN RESOURCES	25-26
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES	26-31
DEPARTMENT OF SOCIAL SERVICES	31-35
DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES	35-44
DEPARTMENT OF HEALTH	44-49
COMPREHENSIVE SERVICES FOR AT-RISK YOUTH AND FAMILIES	50-54
DEPARTMENT OF REHABILITATIVE SERVICES	54-56
WOODROW WILSON REHABILITATION CENTER	56
DEPARTMENT FOR THE AGING	57-59
DEPARTMENT FOR THE BLIND AND VISION IMPAIRED	59-61
VIRGINIA REHABILITATION CENTER FOR THE BLIND AND VISION IMPAIRED	60
VIRGINIA INDUSTRIES FOR THE BLIND	61
DEPARTMENT OF HEALTH PROFESSIONS	61-62
DEPARTMENT FOR THE DEAF AND HARD-OF-HEARING	63
VIRGINIA BOARD FOR PEOPLE WITH DISABILITIES	63-64
AUDITOR'S LETTER	65-68
AGENCY RESPONSES	69-78
AGENCY OFFICIALS	79-83

RECOMMENDATIONS

SECRETARY OF HEALTH AND HUMAN RESOURCES, MEDICAL ASSISTANCE SERVICES, AND SOCIAL SERVICES

Obtain Valid Social Security Numbers

Invalid social security numbers from local departments of social services could be creating \$5 million in questioned cost each year for the Medicaid program. We found in one month that Medical Assistance Services did not receive corrected social security numbers for 1,350 individuals, which cost the program \$426,000. Medical Assistance Services relies on the Department of Social Services and local departments of social services for determining eligibility.

For the Medicaid program, social workers must accept a person's social security number on good faith if they are not able to validate the social security number during the intake process. Additionally, individuals in the Medicaid program have a year to provide a correct number to Medical Assistance Services, the Department of Social Services or local departments of social services, if the federal Social Security Administration determines that the number is invalid or does not match the name provided.

Recently Social Services reminded local social workers that they need to follow-up on all invalid numbers returned by the Social Security Administration. However, management at Medical Assistance Services and Social Services believe that they do not have the authority or the ability to hold the local departments of social services financially accountable if they do not resolve the invalid social security numbers. Additionally, Medical Assistance Services does not have a process for removing individuals from the program if their social security numbers are not correct or validated with the Social Security Administration.

To help decrease the number of invalid social security numbers, Social Services could focus its monitoring of local social services offices by targeting cases that appear to contain an error or have riskier profiles (i.e. more complicated). Currently, Social Services conduct these reviews by selecting random cases. Social Services could select specific cases from the eligibility system that are returned by the Social Security Administration.

For example, Social Services could analyze the exceptions in the cases where Medical Assistance cannot verify the social security numbers with the federal government, to determine if there is a concentration of these cases within one or more localities or with a few social workers spread across the state. However, before conducting targeted reviews, Social Services will need to gain a better understanding of the information it houses within its eligibility system and develop the skill sets needed to perform such an analysis of this information to ensure that localities, social workers, and system controls are working as intended to prevent ineligible individuals from receiving benefits.

SOCIAL SERVICES

Establish Enforcement Mechanisms for Foster Care and Adoption Payments

We first reported in 2005 that Social Services did not have a mechanism for verifying that only individuals determined eligible were receiving foster care and adoption payments. Social Services now requires localities to reconcile and certify that children and caregivers receiving payments are in the system. However, we noted that half the localities did not respond to Social Services' request for supporting documentation of their certification.

Without being able to review the localities' support for their certification Social Services is not able to assure itself that they have an active case for each Foster Care and Adoption payment. According to Social Services management, they are able to compel localities to provide the support for their certification but have not established an enforcement mechanism to hold localities accountable.

We recommend that Social Services develop an enforcement mechanism to compel localities to provide supporting documentation for foster care and adoption assistance payments. Before implementing the new policy, management should have it reviewed by the Secretary of Health and Human Resources to ensure its support.

OFFICE OF COMPREHENSIVE SERVICES

Develop Monitoring Procedures to Review Locality Statistics

The Office of Comprehensive Services (Office) does not regularly monitor locality specific expenditures and statistics. If the Office had performed some type of trend analysis or other analytical review, it would have become clear that there was a problem in Pittsylvania County, as discussed in the section "*Comprehensive Services Act in Pittsylvania County.*"

The Office collects and publishes a wealth of data on CSA expenditures and services on their website. They collect data by locality, region, and statewide. By analyzing this data and investigating outliers, the Office could have potentially identified issues similar to those in Pittsylvania County much earlier. The Office should develop monitoring procedures to review analytics and statistics regularly to look for sudden or gradual changes in a locality's standings.

Improve Guidance and Background Provided to CPA Firms

Local CPA firms audit compliance with the CSA program during the locality's annual financial audit through audit specifications developed by the Office and distributed by the Auditor of Public Accounts. However, the program is so complex that without specific training on the CSA program, auditors can easily miss inappropriate use of CSA funds similar to that found in Pittsylvania County.

We recommend that the Office, in collaboration with the Departments of Education, Social Services, and Medical Assistance Services, provide background and guidance to the CPA firms with the audit specifications that will assist the CPA firms in understanding the program. In addition,

during the annual update of the audit specifications, the Office should develop “hot topics” or “current issues” surrounding the program and service eligibility that the local CPA firms should be aware of during their audit work.

**DEPARTMENT OF ACCOUNTS,
DEPARTMENT OF PLANNING AND BUDGET, AND
MEDICAL ASSISTANCE SERVICES**

Improve Payment Transparency

Medical Assistance Services uses two different systems for processing payments, the Medicaid Management Information System (MMIS) and Oracle. Oracle is a typical agency accounting system that uploads detail payment information into the Commonwealth Accounting and Reporting System (CARS) for payments.

MMIS’s original intent was making payments to Medicaid providers through Medical Assistance Services’ fiscal agent. Additionally, MMIS has automated processes for allocating provider payments between different funding sources. Medical Assistance Services then uploads summary information for MMIS payments into its other accounting system, then CARS.

In fiscal 2010, management at Medical Assistance Services started processing administrative vendor payments through MMIS, which summarizes all the payments as a group and only produces a total allocation of the amounts. This process eliminates detailed information from the Commonwealth’s accounting and budgetary oversight systems so that oversight agencies do not have the ability to review individual vendor payments and other detailed information. Additionally, this approach does not make the information available on the Commonwealth’s public portal.

While we recognize that management made the change to create operational efficiencies; we recommend that Medical Assistance Services work with the State’s Comptroller and the Department of Planning and Budget to examine ways for MMIS payments to be more transparent, user friendly, and available to the citizens of the Commonwealth.

**DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
(BHDS)**

Properly Manage Energy Contracts and Debt

The Fiscal Director for Southwestern Virginia Training Center (SWVTC) prepaid \$1,298,216.31 on SWVTC’s energy contract. These actions potentially shift the risk of this contract away from the contractor and may void the intent of the contract.

BHDS has entered into a series of energy contracts, under which a contractor makes a number of capital improvements to various facilities to reduce overall energy costs. Further, both the contractor and BHDS agree to determine a baseline of energy cost and the savings that will pay for the contractor’s improvements. Under these arrangements, the contractor finances the energy improvements and expects BHDS to make payments from the expected savings. Normally, both

parties treat these arrangements as a form of debt and have monthly payment schedules that last more than ten years. If the energy savings do not occur, the contractor has posted a surety bond to offset the cost of the energy improvements.

While SWVTC prepayment of ten years on the contract potentially wasted \$222,472.29 in prepaying interest, which should have come out of the payments, these actions also place the program at risk by eliminating the ability to perform provisions of these contracts. Also, SWVTC is not the only facility which has prepaid some amount of these contracts. We understand that a number of facilities have made prepayments of up to a year. These other facilities are also shifting the risk of nonperformance to the Commonwealth.

BHDS should immediately stop the practice of making prepayments on its energy contracts, recover all prepaid interest, and renegotiate the contract for SWVTC or recover the prepayment. Considering the complexity of the contracts, the chances of improperly shifting risk and therefore cost from the contractor to the Commonwealth, we recommend that BHDS reconsider its oversight of these contracts both from a monitoring with their terms, but also the general financial oversight. Considering the affect that budget reductions have had on the fiscal staff at the facilities consolidation of this function may be appropriate.

Accurately Report Energy Contract Debt to the Commonwealth's Controller

BHDS did not accurately report Energy Performance information to the State Comptroller for inclusion in the Commonwealth's Comprehensive Annual Financial Report (CAFR). We found that BHDS incorrectly completed three of its five submissions for Energy Performance contracts, which contained significant errors.

The State Comptroller needs accurate energy performance information from BHDS to correctly report obligations for the state. Failure to submit accurate information by the due dates established by the State Comptroller may result in delays or errors in the CAFR.

In advance of next year's CAFR deadlines, we recommend that the State Comptroller work with BHDS's management to ensure that its staff understands how to create and produce accurate Energy Performance information.

Remove Terminated Employees Timely from Payroll

Again this year we found facilities not removing terminated employees from the payroll system. In our sample of five facilities, two facilities are not removing all terminated employees from the payroll system in a timely manner. Together, these two facilities represent over 20 percent of BHDS' payroll expenses. Not removing inactive employees from the payroll system increases the risk of inactive employees receiving payments in error.

Management uses a "pool" of hourly workers to fill temporary staffing needs. However, management has not established procedures for removing pool employees from the payroll system after it stops using an individual. Therefore, we recommend that management communicate to Payroll when a pool employee is no longer being used and that the facilities evaluate and test their

payroll certification process to ensure that Payroll and Human Resource records reconcile prior to certifying payroll each pay period.

Coordinate Independent Peer Reviews

Federal law requires that at least five percent of all entities providing mental health services in the community receive a review each year, and we have again found that BHDS' Office of Mental Health Services has still not done any independent peer reviews of Community Services Boards (Boards). Boards that provide Community Mental Health services must have the federal mandatory independent peer reviews.

The Office of Mental Health Services should coordinate these independent reviews to ensure reviewers are not reviewing their own programs. The federal regulation does not consider a review conducted as part of licensing or certification process as an independent peer review. Failure to comply with federal requirements not only increases the risk of inadequate services, but also compromises the funding to the state for Community Mental Health services.

In July 2010, the Office of Mental Health Services hired an employee to coordinate peer reviews; however, because of other priorities the Office had not completed any peer reviews as of the date of our follow-up. Management is currently in the process of developing protocols for conducting peer reviews in the future. The Office of Mental Health Services should conduct the independent peer reviews according to federal guidelines.

Use System Functionalities to Improve Payroll Processing

BHDS spent \$463.9 million in payroll costs and currently manually computes earnings for shift and weekend differentials, overtime, compensatory time and other items. BHDS is in the process of implementing a web-based KRONOS Workforce Central timekeeping system for all facilities, which includes timekeeping and attendance and scheduling modules.

KRONOS also has additional modules which may give BHDS the capability to expand the system into other payroll related areas. As with any major implementation of a modern system, there are opportunities to further enhance operations and examine the system's impact on existing internal controls and processes.

Management expects that the transition to KRONOS should improve timekeeping in the future by reducing the amount of time and effort that employees, supervisors, and payroll staff spend processing payroll and allow them to use their time elsewhere. As a result of BHDS' plans to implement KRONOS system-wide, we reviewed prior and current year findings related to payroll and noted some opportunities where we believe BHDS can improve its internal controls and possibly eliminate or reduce manual efforts and enhance operations.

While we provided management with the following listing of ideas, they will need to determine the feasibility of each idea and examine their existing internal controls and processes in light of how KRONOS operates. Finally, since KRONOS automates information and transactions, old internal controls processes may no longer work effectively and new risks may arise.

Improve Access Management

Fundamental to a sound system of internal controls are separation of duties and proper approval of transactions. Modern systems such as KRONOS rely on separating duties by restricting system access and requiring on-line approvals. Failing to restrict automated access increases the risk of fraud or error occurring or going undetected.

BHDS' management needs to develop a system-wide protocol for assigning access and on-line approval and continuously monitor access for compliance. We further recommend that management use Behavioral Health's internal auditor and information security officers to lead this development and review, since restriction of existing access may meet with some resistance because some managers may not fully comprehend the impact of their earlier access decisions.

Finally, this group should have the responsibility for developing long-term policies and procedures for granting access, reviewing access and, when necessary, terminating access. This group should consider a combination of internal and external facility reviews and assessments.

We identified specific access issues during our audit that we communicated to Behavioral Health's management so they could improve access management in KRONOS.

Use Overtime Alerts and Scheduling Module

KRONOS offers overtime alerts and a scheduling module that facilities could use to manage their labor costs. Additionally, it helps supervisors ensure employees work their hours as scheduled as it flags any deviation between the employee's approved schedule and timesheet.

Leave Tracking

Currently, BHDS uses CIPPS and KRONOS for leave tracking. Once the implementation is complete, all facilities should use one system for tracking employee leave. If implemented, there are functions that could make it easier for the Central Office to determine their leave liability at year-end.

Reassign Timekeepers

In the prior year, we recommended that Facility Directors reassign timekeepers away from Human Resources to the Office of Finance and Administration or provide a justification as to why this reporting structure does not represent a significant weakness in internal controls. Management has decided to still have Central Virginia Training Center timekeepers report to the Director of Human Resources until the completion of the KRONOS' implementation. At that time, management is expecting to reassign timekeepers to Fiscal Services.

KRONOS to CIPPS Interface

BHDS facilities already using an earlier version of KRONOS have implemented an interface between CIPPS and KRONOS, though this interface is not fully compatible. If it is economically possible, developing an interface that would recognize shift differentials would reduce or eliminate the need for the manual input into CIPPS. A fully functioning interface would allow facilities to reduce or eliminate duplicate data entry into both systems.

HEALTH

Use System Capabilities to Ensure Proper Service Delivery

Health's management is not using its eligibility system's capability to reproduce snap-shots of all eligibility profiles to monitor service delivery. Using this capability would allow management to remotely test that only eligible individuals are receiving services from the Supplemental Nutritional Program for Women, Infants, and Children (WIC), which could possibly lead to more targeted reviews that could lead to a reduction in travel and staff time.

SOCIAL SERVICES

Use System Functionalities to Improve Financial Operations

There is an opportunity for the Department of Social Services (Social Services) to use functionalities within its financial system (FAAS) to improve fiscal operations. During fiscal 2010, Social Services processed approximately 38,000 transactions valued at approximately \$2.1 billion. However, Social Services did not take advantage of some the automated features within FAAS and resorted to multiple manual processes.

As part of our audit, we conducted a review of FAAS and have noted some opportunities which we believe can improve efficiencies, eliminate or reduce manual efforts, and potentially enhance Social Service's operations. These observations include, but are not limited to the following.

- Develop automated reports to reduce staff time spent in creating manual reports.
- Develop automated edit checks to ensure compliance with period of availability requirements for federal grants so that management does not rely solely on manual reviews.
- Develop automated edit checks to enforce the type of expenses charged to each grant. If payments are coded correctly, these edit checks could lower Social Services' risk of incorrectly allocating funds.
- Implement automated system workflows to govern the approval process for accounting adjustments. Automated workflows will reduce the time that Social Services now uses to record and track all approvals through hardcopy documentation.

We recommend that all employees within the Division of Finance should work together to strengthen automated processes and eliminate manual efforts. By doing such, Social Services will be able to improve efficiencies and potentially enhance Social Service's operations. In addition, Social Services will mitigate the risk of human error and provide further assurance that it is correctly allocating funds.

REHABILITATIVE SERVICES

Improve Timeliness of Eligibility Determination

Rehabilitative Services does not enforce their policy for documenting eligibility extensions related to the Vocational Rehabilitation (VR) program within its case management system: AWARE. Section 361.41 of the Code of Federal Regulations, requires the Rehabilitative Services to determine whether an individual is eligible for VR services within a reasonable period of time, not to exceed 60 days, after the individual has submitted an application for the services unless certain exceptional and unforeseen circumstances beyond the control of the agency preclude making an eligibility determination within 60 days. In this case, the Rehabilitative Services and the client must agree to a specific extension of time.

Our review found over 1,200 cases in AWARE exceeded the 60 day eligibility determination time limit. Of those, we reviewed 25 cases, all of which had no eligibility determination extension documented.

We recommend management develop a review process to enforce the eligibility determination policies outlined in the agency's policies. Management may also wish to provide additional training to counselors to increase awareness of the new policy.

SYSTEM RELATED RECOMMENDATIONS

We have grouped system recommendations into four categories (Access Management, Security Program, Infrastructure Security Risk, and Security Awareness Training) then by agency so that managers can review common issues facing the Agencies of the Secretary of Health and Human Resources and possibly share ideas and develop joint solutions.

ACCESS MANAGEMENT

SOCIAL SERVICES

Continue Improving System Access

Social Services made improvements for the specific access management issues we identified in the prior year; however, there are still opportunities for Social Services to follow best practices across all of its systems. During our review of access management, we noted several areas in need of improvement.

Access Authorization

Management has not developed a method of approving system access that provides sufficient evidence that managers considered an employee's level of access within the system. We noted authorization forms that were generic and did not allow the supervisor to know specifically what they were authorizing. The forms either only listed the system, without indicating the level of access, or the level of access indicated on the forms did not reflect the actual capabilities within the system. Additionally, we found long-term employees where management could not locate evidence of authorization of access.

Management plans to move towards an email only process for granting access. Management should develop a standard method for requesting system access for all critical systems that adequately indicates an employee's level of access within the system. The Chief Information Security Officer should then evaluate the access request relative to the employee's responsibilities before granting access. Additionally, the Chief Information Security Officer should ensure that for all employees, even long-term employees, Social Services has evidence that their access is authorized.

Access Monitoring

After Social Services performed a review of employee access to one of its systems, we found terminated employees who still had access to that system and went undiscovered by Social Services. We also noted instances of Social Services not regularly reviewing system access.

Additionally, Social Services has not turned on the auditing feature for its accounting system. Social Services has several IT employees with super user capabilities including the ability to alter their own access levels and create new users. By not having the auditing feature turned on there are no logs to track these users' activity.

The Chief Information Security Officer should develop a schedule for conducting access reviews to ensure terminated employees do not have access and that no user has inappropriate or unauthorized access. Management should communicate the responsibilities of such a review to the different groups within Social Services. Additionally, management should turn on the auditing feature for the accounting system and designate an individual without access to modify the logs the responsibility to review the logs on a routine basis.

Access Education

Social Services has not documented what the different levels of access allow the user to do or see within the system. We found no documentation for the levels of access within the local reimbursement system and only partial documentation for the eligibility system. In addition when speaking with the individuals that grant access to these two systems, we found they were not able to explain what capabilities the levels of access have. This means that individuals could be granting access without fully understanding the capabilities they are giving the user.

Subsequent to our review, management has created documentation for the local reimbursement system. The Chief Information Officer should document the system capabilities for all levels of access for Social Services' critical systems and ensure that individuals granting access understand what capabilities they are granting to users.

BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES (BHDS)

Promptly Remove Terminated Employees from Critical Systems

BHDS did not promptly remove access to critical systems for six percent of the terminated employees we tested. We found eight employees that retained their access from 49 to 369 days after their termination from BHDS. Allowing terminated employees to retain their access opens the door for disgruntled employees to jeopardize the confidentiality, integrity, and availability of BHDS' critical information.

The Commonwealth Security Standards SEC 501 Section 5.2.2.23/24 requires the prompt removal of access when employees leave the agency. We recommend that the facilities review their processes for deleting access to ensure that individuals responsible for deleting access do so promptly after an employee's termination.

REHABILITATIVE SERVICES

Improve System Application Controls

Rehabilitative Services should strengthen procedures for monitoring access to the Commonwealth Integrated Payroll/Personnel System (CIPPS), and Multi-Agency Accounting System (MAAS). CIPPS supports the processing of all payroll transactions, and MAAS is Rehabilitative Services' internal accounting system which interfaces with the Commonwealth's Accounting and Reporting System (CARS). Access control is vital to ensure the integrity of payroll and accounting transactions submitted in the identified systems above.

We identified the following issues related to system access.

- Rehabilitative Services does not have a formal procedure for documenting who is responsible for monitoring and controlling access to these applications.
- Our test of 45 CIPPS users found two individuals with access that no longer need it to perform their job functions, and two individuals with CIPPS access who terminated employment more than 18 months ago.
- Our test of 25 Multi-Agency Accounting System users found 11 users have not logged into the application in over a year, leading the auditor to believe their access may not be necessary.

We recommend Rehabilitative Services develop and implement policies addressing all aspects of system access including granting, removing, and ongoing monitoring of access. These

policies should include who has authorization to grant access, the process for granting and removing access, how often management should complete system access reviews, including CIPPS and MAAS, and the persons responsible for the review.

SECURITY PROGRAM

SOCIAL SERVICES

Improve and Comply with Information Security Program

In our prior year audit, we identified certain weaknesses in Social Services' information security program. Social Services' has improved most of the weaknesses. However, Social Services has not addressed three out of the four recommendations relating to database management.

During our review of one of Social Services' database systems that contain mission critical and confidential data, we found that Social Services still needs to improve the following security requirements.

- Password Management
- Account Management
- Activity Auditing and Monitoring

These controls contain descriptions of Social Services' security mechanisms. Therefore, we have communicated the details of these findings to management in a separate confidential document that is Freedom of Information Act Exempt under Section 2.2-3705.2 of the Code of Virginia.

We recommend that Social Services dedicate the necessary resources to develop policies and procedures that set forth management's expectations in securing information in its databases. In addition, management needs to provide training to its staff responsible for implementing these policies and procedures to ensure consistent implementation.

REHABILITATIVE SERVICES

Improve Information System Security Program

Our review found that Rehabilitative Services could not provide a current Business Impact Analysis, Risk Assessment, or Disaster Recovery Plan. The lack of adequate risk management and contingency plans results in the agency being unable to identify, analyze, prioritize, and mitigate risks that could compromise sensitive systems and data. Without IT contingency planning, Rehabilitative Services may be unable to take the immediate steps necessary to continue operations and execute recovery and restoration for IT systems in the event those systems become unavailable.

The risk management and contingency plans serve as the foundation to developing a comprehensive Information Security Program. If these plans are inadequately completed, it is difficult for Rehabilitative Services to develop a security program that contains adequate controls.

We also found the Information Security Officer does not perform all of the reviews required by the COV SEC 501 standard, stated in section 2.2.5. The Security Officer did not complete a number of the required compliance reviews on significant IT program areas during the audit period.

Security Officer Reviews are essential in determining what areas of the IT Security Program need improvements. Without periodic reviews, the security program becomes obsolete, since the Security Officer is not monitoring whether existing security controls address new and evolving risks to systems since the last review. Further, Rehabilitative Services' internal auditors identified a number of these deficiencies during the audit period; however the Security Officer did not implement many of the corrective actions.

We recommend the Security Officer prioritize the completion of risk management and contingency plans that reflect the requirements of the COV SEC 501 standard. Risk Management plans should include a Business Impact Analysis, an IT System and Data Sensitivity Classification, a Sensitive IT System Inventory and Definitions, and a Risk Assessment. Contingency Planning should include the Continuity of Operations Plan and Disaster Recovery plan which define a manual work-around for agency operations and recovery steps to restore systems in the event they go down.

We also recommend the Security Officer perform required security reviews, document the results, and retain evidence of those reviews for future reference. Further, when internal auditors inform the Security Officer of security vulnerabilities and noncompliance issues, the Security Officer should make every attempt to meet the deadlines set for remediation in their corrective action plan. While we understand that Rehabilitative Services is negotiating the scope of infrastructure security services provided by the state's IT Partnership, it is paramount that DRS assess the criticality of their business processes and supporting applications so that management obtains the appropriate level of security for their operations.

HEALTH

Improve Information Security Program

Although Health had developed a supplement to the state's information security standards, this supplement did not include agency-wide expectations regarding risk management and contingency planning. Without these expectations, the Chief Information Officer (CIO) and Information Systems Security Officer (ISO) could not hold individual divisions responsible for identifying risks and developing appropriate controls to mitigate those risks.

Health delegated the creation of its Information Security Policies and Standards, which are the responsibility of the Health Commissioner, to its CIO and ISO. The CIO and ISO are responsible for communicating these policies and standards to Health's individual divisions.

We found that different divisions within Health used their own interpretation of the Commonwealth's Security Standard when developing risk management and contingency plans for Health's systems. The lack of agency-wide risk management and contingency planning expectations resulted in divisions producing inconsistent plans; and some plans did not include all requirements of the Commonwealth's Security Standard.

Best practices suggest and security standards require that management develop an entity-wide Information Security Program to communicate expectations. While Health has an Information Security Program, we found that it did not cover all required elements of the standard, which caused some risks to go unaddressed.

We recommend that Health further develop its agency-wide expectations for developing risk management and contingency plans. The agency should do this by revising its Information Security Program to include all procedures and processes needed to meet the minimum requirements of the Commonwealth Security Standard. Finally, Health's management should use the agency-wide expectations to evaluate the actions of its divisions to ensure they are effectively identifying and mitigating Health's risks.

BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

Continue Improving IT Continuity of Operations and Disaster Recovery Plans – Follow-up

Complete and proper solutions to some prior findings may take time. Due to the long-term commitment required to implement, monitor, and evaluate management's corrective actions for this finding, we are providing this follow-up on the progress that management is making.

From our review of the prior findings, we determined that management is making adequate progress through their corrective action plans or modifying their plans to react to changing situations properly. We will continue to provide an update on this finding in future reports until management has had enough time to fully implement their corrective actions and we have evaluated them for sustainability.

In the prior year, we recommended that BHDS dedicate the necessary resources to ensure that their facilities develop plans for continuing operations and recovering IT systems that meet the Commonwealth's IT standard. Additionally, we recommended that Facility Security Officers and Central Office's ISO ensure that facilities are complying with IT standards for Continuity of Operations and Disaster Recovery plans.

BHDS concurred with our recommendations and has made progress in updating contingency plans to meet the Commonwealth's IT standard across its 16 facilities. However, due to the timing of last year's audit recommendations, the number of facilities, and the ISO not gaining authority over Facility Security Officers until May 2010, BHDS is still in the process of updating the plans across its 16 facilities. Since May 2010, the ISO has been making site visits to review facility contingency plans to ensure compliance.

We recommend that BHDS continue to update plans to meet the Commonwealth's IT Standard for its facilities, which management anticipates completing by February 28, 2011. Once developed, these plans should be tested and updated at least annually, as required by the Commonwealth's IT standard.

INFRASTRUCTURE SECURITY RISK

SOCIAL SERVICES

Finalize Responsibilities for Infrastructure Security

The Commonwealth has moved the information technology infrastructure supporting Social Services' databases to the IT Infrastructure Partnership. In this environment, the IT Infrastructure Partnership and Social Services clearly share responsibility for the security of Social Services' information technology assets, systems, and information and must provide mutual assurance of this safeguarding.

Since our finding last year, the IT Infrastructure Partnership still has not provided Social Services with a finalized memorandum of understanding and chart outlining the responsibilities of each entity. Without this information, Social Services' management cannot ensure they properly perform their duties and what services the IT Infrastructure Partnership is providing. We bring this matter to the attention of Social Services' management, so that they can properly manage their risk.

BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

Manage Infrastructure Security Risk

The Commonwealth has moved the information technology infrastructure supporting BHDS's databases to the IT Infrastructure Partnership. In this environment, the IT Infrastructure Partnership and BHDS clearly share responsibility for the security of BHDS's information technology assets, systems, and information and must provide mutual assurance of this safeguarding.

During Deloitte & Touche's review of Northrop Gumman's Information Systems Infrastructure Services for the Virginia Information Technologies Agency, the review identified certain security risks. These reviews are confidential, but VITA has communicated the results to BHDS.

Although BHDS is not responsible for correcting these findings, they should receive regular status reports from VITA on the progress the IT Partnership correction of the issues. As part of the progress reporting, VITA should provide BHDS with any interim steps they should take if the IT Partnership must delay addressing these issues. We bring this matter to the attention of BHDS, so that they can properly manage their risk and monitor corrective action.

SECURITY AWARENESS TRAINING

BEHAVIORAL HEALTH AND DEVELOPMENT SERVICES

Improve Information Security Awareness Training

BHDS does not provide information security awareness training to its employees with access to mission critical and confidential data in accordance with its training policy. Based on our last year's recommendation, BHDS developed policies and procedures to consistently provide

information security awareness training to its employees at all locations. However, we found that the Central Virginia Training Center has not provided training to 182 of 1171 (15.5 percent) employees with access to mission critical and confidential information.

While Human Resources track employees' completion of security awareness training, there is not action taken to lock the accounts for those employees that have not completed the training. Requiring security awareness training and retaining employees' acknowledgment of training provides management some assurance that employees understand their responsibilities and allows management to take appropriate action when employees fail to protect BHDS's data and systems.

For those facilities that combine HIPAA and security awareness training together this is also a potential HIPAA violation. The Commissioner has ultimate responsibility for BHDS's security program, and knowing whether employees are receiving or completing training is a requirement of the Commonwealth's Information Technology Security Standard (COV ITRM Standard SEC501-01). We recommend that BHDS dedicate the resources necessary to identify users who are not receiving their security awareness training and lock them out of the system until they have completed the training.

RECOMMENDATIONS BY AGENCY

Agency	Page
Behavioral Health and Developmental Services	
Properly Manage Energy Contracts and Debt	3-4
Accurately Report Energy Contract Debt to the Commonwealth’s Controller	4
Remove Terminated Employees Timely from Payroll	4-5
Coordinate Independent Peer Reviews	5
Use System Functionalities to Improve Payroll Processing	5-7
Promptly Remove Terminated Employees from Critical Systems	10
Continue Improving IT Continuity of Operations and Disaster Recovery Plans	13
Manage Infrastructure Security Risk	14
Improve Information Security Awareness Training	14-15
Health	
Use System Capabilities to Ensure Proper Service Delivery.....	7
Improve Information Security Program.....	12
Medical Assistance Services	
Obtain Valid Social Security Numbers.....	1
Improve Payment Transparency	3
Office of Comprehensive Services	
Develop Monitoring Procedures to Review Locality Statistics.....	2
Improve Guidance and Background Provided to CPA Firms.....	2-3
Rehabilitative Services	
Improve Timeliness of Eligibility Determination.....	8
Improve System Application Controls.....	10-11
Improve Information System Security Program	11-12
Secretary of Health and Human Resources	
Obtain Valid Social Security Number	1
Social Services	
Obtain Valid Social Security Numbers.....	1
Establish Enforcement Mechanisms for Foster Care and Adoption Payments	2
Use System Functionalities to Improve Financial Operations.....	7-8
Continue Improving System Access	8-9
Improve and Comply with Information Security Program	11
Finalize Responsibilities for Infrastructure Security	14
Department of Accounts and Department of Planning and Budget	
Improve Payment Transparency	3

RESOLVED RECOMMENDATIONS FROM PRIOR YEAR

The following agencies have taken or are taking adequate corrective action or justified why action is not warranted with respect to the following recommendations listed below:

Social Services

- Align Plan for Monitoring Local Social Service Offices with Best Practices
- Improve Information Security Officer's Authority and Independence
- Maintain Local Employee Tracking System (LETS)
- Develop Procedures for Accounting Adjustments
- Ensure Hours are Entered Correctly
- Improve Coordination between Local Eligibility Workers and the Division of Child Support Enforcement

Behavioral Health and Developmental Services

- Improve Management and Controls for Facilities
- Continue Improving Monitoring Program over Community Services Boards
- Improve Information Systems Security Program Governance
- Improve Security Awareness Training Documentation
- Improve System Access Controls
- Reinforce Reporting Requirements
- Improve Access to Timekeeping System

Health

- Improve Application and Database Management
- Improve Access Controls Patient Information
- Respond to Security Risks Associated with IT Infrastructure

STATEWIDE REPORTS

Many of the issues within this section of this report are not unique to the Secretary's agencies, as a result our Office, for the significant cycles below, has, or plans to issue statewide reports that cover the topics from the perspective of the entire Commonwealth. To view our reports or obtain electronic copies; these reports are available on our website: www.apa.virginia.gov.

Administrative Processing	Cell Phone Usage
Internal Auditors	Network Security
Performance Measures	Transparency

Managers, as they work to develop their corrective action plans, may want to review these reports to determine if there are opportunities for collaborating with other agencies to address these issues.

VIRGINIA'S MEDICAID PROGRAM

AMERICAN RECOVERY AND REINVESTMENT ACT (ARRA)

In fiscal 2010, Virginia's General Fund received \$735 million as a result of temporary changes to the funding of the Medicaid program. Historically, Virginia splits Medicaid costs 50/50 with the federal government; however, the American Recovery and Reinvestment Act (ARRA) increased the federal share to 61.59 percent from April 2009 until December 2010.

In March 2010, Congress agreed to extend the enhanced Federal Medical Assistance Percentage (FMAP) for six months, from January through June 2011, resulting in Virginia receiving \$265.6 million in estimated additional federal funds in fiscal 2011. Management believes these additional federal funds should delay some expected budget cuts until fiscal 2012. After the enhanced FMAP ends, management estimates that the General Fund will need to provide \$720 million in fiscal 2012 to maintain Virginia's Medicaid program.

MANAGING COSTS

The more than ten percent change in funding split between the state and federal government has a large impact on the General Fund because of the size of the Medicaid program. In fiscal 2010, Virginia's Medicaid program totaled \$6.55 billion, or nearly 16 percent of total state expenses, which were \$41.7 billion, as shown in the table below.

	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>	<u>2010</u>
Medicaid	4,772,677,271	5,042,199,846	5,342,630,889	5,772,295,365	6,554,598,682
Total State Expenses	35,855,455,000	39,169,893,000	38,418,200,097	41,812,984,226	41,667,745,037
% Medicaid	13%	13%	14%	14%	16%

Source: APA website, Commonwealth Data Point, Fiscal Year 2010 Statewide Expenditures

While Virginia's Medicaid program is nearly 16 percent of Commonwealth expenses, it is one of the smaller percentages when compared to other states. According to a national non-profit health policy research organization, Kaiser Family Foundation, the Commonwealth ranks fourth nationally at controlling Medicaid cost based on Medicaid expenses per capita. Virginia also ranks fourth in Medicaid enrollees as a percentage of the total state population at 11 percent, as compared to the national average of 19 percent.

In addition to cost containment strategies adopted by the state to control increases in Medicaid spending, the state has been able to control cost by not offering many of the optional services that other states are funding. Because of this and the federal government setting minimum requirements for services and redefining eligibility levels with the Healthcare Reform Act, there may be little opportunity for the Commonwealth to decrease future cost by changing services.

INTERDEPENDENCE

The Department of Medical Assistance Services (Medical Assistance Services) paid over \$1.2 billion in Medicaid funding to other state agencies and localities (Commonwealth entities) in fiscal 2010. For the services they provide, these Commonwealth entities received 19 percent of total Medicaid funding. This section details the impact that Medicaid dollars have throughout Virginia's government and its services.

The list on the following two pages shows the state agencies that have a funding relationship with Medical Assistance Services along with the services they provide using funding from Medicaid.

Medical Assistance Services' Relationship with Commonwealth Entities

Department of Rehabilitative Services

- Medicaid Eligibility Determinations for the Disabled
- Research and Consulting for the Medicaid Infrastructure Grant

Department of Social Services

- Eligibility Determinations for Medicaid and CHIP
- Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Outreach
- Identification of Recipients with Third Party Liability
- Client Medical Management Program
- Nursing Home Pre-admission Screenings
- Reimbursement of Medicaid Refugee Costs from a Federal Grant Provided to DSS
- Identification of Suspected Fraud and Non-Entitled Benefits
- Licensure for Adult Care Residence

Department of Health

- Licensure and Certification of Nursing Facilities
- EPSDT Support (Training)
- Nursing Home Pre-admission Screenings
- Resource Mothers Program - Support Persons for Indigent Young Pregnant Women
- Health Clinic Medical Services, Including Home Health Services
- Case Management Services for Pregnant Women and Children
- Teen Pregnancy Prevention Programs
- COPN Approvals - Nursing Homes and Hospitals
- Screening of Children for Lead Poison

Attorney General's Office

- Medicaid Legal Representative
- Medicaid Fraud and Control Unit

Department for the Aging

- Case Management for the Elderly
- Quality Care Assurance-Nursing Facilities
- Relocation of Residents of Nursing Homes
- Outreach for Dual Eligibles
- Research and Consulting for the Systems Transformation Grant

Department of Education

- School-Based Health Centers
- Rehabilitative Services (speech, occupational and physical therapy, and audiological screenings)
- Skilled Nursing Services
- Psychological Services

Department of Behavioral Health and Developmental Services

- Inpatient Psychiatric and Community Services for Medicaid Mental Health and Intellectually Disable Recipients
- Nursing Home Pre-admission Screenings and Resident Reviews
- Certification of Providers of Mental Health and Intellectually Disabled Case Management Services
- Early Intervention Services for Infants and Toddlers

MCV/UVA Hospitals

- Inpatient and Outpatient Care
- Nursing Home Pre-admission Screenings
- Infrastructure Grant Projects
- Revenue Maximization Support
- Medicaid Buy-In Study
- Consumer Directed Services

Supreme Court of Virginia

- Payments to Hospitals and related providers of medical and health services for individuals subject to Involuntary Mental Commitment proceedings

Office of Comprehensive Services

- Comprehensive Services Act

Virginia Commonwealth University

- Support for Revenue Maximization Project
- Personal Care Aid and Certified Nurse Assistant Training Program
- Partnership for People with Disabilities
- Area Health Education Centers Program
- Systems Transformation Grant
- Medicaid Infrastructure Grant

Several Commonwealth entities rely heavily on Medicaid funding to provide medical services, the table below list these entities, followed by an impact analysis of the matching funds used for each entity.

Internal Medicaid Payments for Services
(Dollars in Thousands)

<u>Commonwealth Entity</u>	<u>Entity Provided Match</u>	<u>Funding from the Department of Medical Assistance Services</u>	<u>Total Medicaid Funding</u>	<u>Total Available Funding for Services</u>	<u>Medicaid Funding as a Percent of Total Funding</u>
<u>Department of Behavioral Health and Developmental Services</u>					
	\$3,914	\$271,460	\$275,374	\$576,117	47.80%
<u>Community Service Boards</u>					
	-	336,164	336,164	955,124	35.20%
<u>Office of Comprehensive Services</u>					
	30,822	49,149	79,972	284,263	28.13%
<u>Department of Social Services</u>					
	62,582	62,637	125,219	760,622	16.46%
<u>UVA Health System</u>					
	-	145,017	145,017	1,008,858	14.37%
<u>Local School Divisions</u>					
	13,941	14,305	28,246	204,113	13.84%
<u>VCU Medical Center</u>					
	-	215,081	215,081	1,744,977	12.33%
<u>Department of Health</u>					
	1,064	13,937	15,000	230,158	6.52%
<u>Department of Rehabilitative Services</u>					
	991	1,356	2,347	104,519	2.25%
<u>Department of Aging</u>					
	234	234	467	31,981	1.46%
<u>Woodrow Wilson Rehabilitation Hospital/Center</u>					
	-	75	75	18,284	< 1%
Total	<u>\$113,548</u>	<u>\$1,109,633</u>	<u>\$1,223,181</u>	<u>\$5,973,148</u>	<u>20.48%</u>

Fiscal Impact of Medicaid Funding on Individual Agencies

The combined total of \$275.3 million in Medicaid funding for Department of Behavioral Health and Developmental Services (BHDS) represents 47.8 percent of its total funding for services. BHDS provides in-patient behavioral health and developmental services at its facilities statewide. Historically, BHDS has been able to generate sufficient cash through its billings to provide some of

its own General Fund match; however, as BHDS undergoes budget reductions in other areas of operation, BHDS may find it harder to regenerate the cash to provide its own match.

Over a third of Community Service Boards' (Boards) total revenues, which includes state and local funds, \$336.1 million, is from direct billings to Medicaid. The Boards provide community care for mentally ill individuals and persons with disabilities. Without matching funds, which have historically come from the Commonwealth's General Fund, the Boards could lose 35 percent of its funding.

Comprehensive Services spent \$79.9 million in Medicaid funding to provide residential psychiatric treatments for foster care children. Medicaid funding is available because Comprehensive Services transferred approximately \$30.8 million of its General Fund monies to Medical Assistance Services. Without Comprehensive Services having the general funds to transfer to Medical Assistance Services, Comprehensive Services would lose \$79.9 million or 28 percent of its funding.

Social Services agencies, both state and local, received \$62.5 million for providing outreach and determining Medicaid eligibility for potential clients. To receive these funds, state and local governments must spend an equal amount of their own general funds on these same services. The \$62.6 million in federal funding from Medical Assistance Services represents eight percent of state and local administration expenses for social services.

In total, the two state University Medical Centers listed above received \$360 million from Medicaid. They received this funding for services provided to individuals in the Medicaid program and indigent patients. Medicaid funds represent 14 percent of the UVA Health System's, and 12 percent of the VCU Medical Center's, total revenues.

As illustrated above, many of the Commonwealth's entities rely on federal and required state funds to provide services. Demands for these services and the funding that supports them is not likely to recede, as improvements to unemployment, state revenues, and Medicaid caseload growth usually lag by one or two years after a recession ends. In addition, the passing of the Health Care Reform Act will also increase the demand on state assisted medical services.

HEALTH CARE REFORM

As discussed in the previous section, demands on medical services will only increase over time, especially with the passing of the Health Care Reform Act (Act) in March 2010, which will eventually require everyone to have health care coverage. At this point, there are many uncertainties about how the Act will affect states, businesses, and individuals; however, in preparation for complying with the law, management at Medical Assistance Services has begun to make projections on enrollment, costs, and necessary changes to current processes.

One of the biggest changes that will impact Virginia is the required increase in Medicaid enrollment. The reform act expands coverage to areas of the population that are not currently eligible for Virginia's Medicaid and also provides additional services to some existing Medicaid recipients.

Beginning in 2014, childless adults, without a disability, will qualify for Virginia's Medicaid program. All former foster care children will also receive coverage up to the age of 26 regardless of income. The maximum income requirements for all groups will rise to 133 percent of the federal poverty level. The new maximum income level will only affect those classified as "elderly and disabled" or a "parent", whose current level is capped at 80 and 24 percent of the federal poverty level, respectively. All other groups are already at 133 percent or will be new to Medicaid.

In 2010, following table shows the 133 percent of the federal poverty level in Virginia.

Family Size	Gross Yearly Income
1	\$14,404
2	\$19,378
3	\$24,352
4	\$29,327
5	\$34,301
6	\$39,275
7	\$44,249
8	\$49,223

The Federal government will pay the cost of all newly eligible people between 2014 and 2016, and then Virginia's portion will gradually increase up to 10 percent in fiscal 2021.

Current projections by Medical Assistance Services estimates that Virginia's Medicaid enrollment will increase between 270,000 and 425,000 new enrollees. This projection is a 30 to 48 percent increase from June's 2010 enrollment of 878,241. New enrollees, according to Medical Assistance Services, should cost the General Fund between \$2.1 and \$2.8 billion between fiscal 2014 and 2022.

Enrollment projections above also include approximately 50,000 eligible children not signed up for services. These 50,000 children are not "new" eligibles and therefore the reimbursement for these participants will continue at the historical rate of 50/50 for Virginia. Management believes

these eligible children will start taking advantage of the Medicaid program once the requirement for all individuals to have health insurance becomes effective in 2014.

Increases in Medicaid rolls will not only increase demand for Medicaid services but demand for eligibility determination services. Currently, local departments of Social Services are responsible for determining eligibility and enrolling Medicaid recipients. Management will need to determine if the local departments of Social Services have the infrastructure and capabilities to handle an almost 50 percent increase in enrolling recipients.

To prepare Virginia for implementation of laws within the Act and anticipated federal regulations, Virginia Secretary of Health and Human Resources has established the Health Care Reform Initiative Council. The Council will manage activities related to health care reform by establishing advisory workgroups of stakeholders and interested parties to provide input and advice. The Council will assist in developing a comprehensive strategy for implementing health care reform by submitting its activities, findings, and recommendations to the Governor.

The Council, chaired by Secretary of Health and Human Resources Bill Hazel, consists of members of the General Assembly, physicians, and other health care professionals. The Council has established work groups for six key areas: Medicaid Reform; Insurance Market Reform; Delivery and Payment Reform; Capacity; Technology; and Health Care Purchasers. Work groups have seven members on each panel and will report findings and recommendations to the Council. The Medicaid Reform work group has begun by determining which mandates are relevant to Medicaid and which ones will be mandatory or optional; established a priority list based on when mandates are affective. The group has also begun developing implementation plans for upcoming mandates and estimating the cost associated with each to include in budget forecasts.

MEDICAID SECTION SUMMARY

The Medicaid program is a large part of Virginia's budget. Any changes in the federal matching rate impacts Virginia's General Fund and other agencies that are interdependent on Medicaid funding for providing services. Finally, Medical Assistance Services' management expects an increase in enrollment in the Medicaid program resulting from the Healthcare Reform Act and the Secretary of Health and Human Resources has established groups to determine how Virginia should manage these changes.

MANAGING SERVICES AND SELECTED FINANCIAL INFORMATION

AGENCIES OF THE SECRETARY HEALTH AND HUMAN RESOURCES

Managing Services

Agencies in the Health and Human Resources secretariat are responsible for managing the delivery of human services, which include social and medical services. The four largest agencies in the secretariat account for nearly 95 percent of the expenses of the Health and Human Resources agencies. Each agency is responsible for providing its own services and deploys a different management model for delivering services to eligible Virginians.

The top four agencies, at a very high-level, provide the following services:

- The **Department of Medical Assistance Services** pays medical providers for services either directly through a fee-for-service payment or a set per capita rate to managed care organizations.
- The **Department of Social Services** provides funding and guidance to local governments to operate social programs and transfers child support payments between parents.
- The **Department of Behavioral Health and Developmental Services** provides services either directly in its hospitals and training centers or indirectly through funding of Community Service Boards.
- The **Department of Health** provides health care services through its 117 local departments and operates inspection programs for food sanitation, environmental health, hospitals and nursing homes

Financial Information

Analysis of Expenses by Agency (Dollars in Thousands)

<u>Agency</u>	<u>Expenses</u>	<u>Percent</u>
Department of Medical Assistance Services	\$ 6,925,410	64.4%
Department of Social Services	1,806,954	16.8%
Department of Behavioral Health & Developmental Services	941,055	8.8%
Department of Health	528,827	4.9%
Comprehensive Services for At-Risk Youths and Families	224,990	2.1%
Department of Rehabilitative Services *	177,538	1.7%
Department for the Aging	55,671	0.5%
Department for the Blind and Vision Impaired **	47,638	0.4%
Department of Health Professions	24,687	0.2%
Department for the Deaf and Hard-of-Hearing	11,565	0.1%
Virginia Board for People with Disabilities	<u>1,530</u>	<u>< 1%</u>
Total Fiscal Year 2010 - Secretary of Health and Human Resources	\$10,745,865	100.0%

* Includes Woodrow Wilson Rehabilitation Center Expenses of \$30.7 million

** Includes Virginia Rehabilitation Center for the Blind and Vision Impaired expenses of \$2.1 million

Source: Commonwealth Accounting and Report System 1419D1 report as of June 30, 2010

The secretariat's agencies spent approximately \$10.7 billion in fiscal 2010. Of this amount, the top four accounted for about \$9.1 billion or 95 percent of total expenses. These same four agencies (Department of Medical Assistance Services, Department of Social Services, Department of Behavioral Health and Developmental Services, and Department of Health) accounted for about 23 percent of the Commonwealth's total spending in fiscal 2010.

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES **(MEDICAL ASSISTANCE SERVICES)**

Managing Services

The introductory section on Virginia's Medicaid program shows the impact of Medicaid funding and health care reform throughout state government, whereas this section will focus on issues specific to Medical Assistance Services and its management of Medicaid and other programs.

Medical Assistance Services manages the federal and state-supported health care programs for eligible persons with limited income and resources. These programs include Medicaid, Family Access to Medical Insurance Security (FAMIS), Medical Assistance for Low-Income Children (FAMIS Plus), Income Assistance for Regular Assisted Living, Involuntary Mental Commitments,

and other medical assistance services. The largest program Medical Assistance Services administers is the Medicaid program.

In many ways, Medical Assistance Services operates these programs in a manner that is similar to an insurance company. Just like an insurance company, Medical Assistance Services pays providers directly for their services to covered individuals. These fee-for-service payments to the providers will vary depending on the services provided. Additionally, for selected individuals, Medical Assistance Services contracts with Managed Care Organizations (MCO) to provide services. With a MCO relationship, Medical Assistance Services pays the MCO a set per capita rate for each individual and the MCO takes on the responsibility of providing the medical services and controlling their own costs.

Managing Risks

As discussed in the Joint Legislative Audit and Review Commission's (JLARC) October 12, 2010 *Interim Report: Fraud and Error in Virginia's Medicaid Program* Medicaid is the second largest program in Virginia, and therefore a relatively small proportion of improper payments is costly. This is why Medicaid program integrity activities seek to reduce improper payments.

Similar to an insurance company managing its risk of making an improper payment that would reduce its profits, Medical Assistance Services must scrutinize both recipients and providers. Over utilization of the program by either patients in receiving services or providers in billings will result in less resources for the Commonwealth. Some risk management activities occur before providing a service or making a payment, such as screening recipients and providers prior to allowing them into the program, while others occur after providing the service.

To recapture improper payments Medical Assistance Services operates the Program Integrity Division, which the agency reorganized in fiscal 2006 after our 2005 recommendation to implement a system-wide strategy for its utilization units. The utilization units under the Program Integrity Division perform reviews and investigations of providers and recipients after they receive services. According to JLARC, the Federal Centers for Medicare and Medicaid Services cite Medical Assistance Services' Program Integrity Division, as a best practice for state Medicaid programs.

Before recipients can receive services from the Medicaid program they must be determined eligible. Eligibility determination for the state occurs at the local social services departments, which are part of the local city or county government, and Medical Assistance Services and the state's Department of Social Services (Social Services) have limited ability to control these local departments.

In fiscal 2006 and again in this report, we issued risk alerts to both the management of Medical Assistance Services and Social Services about the need to increase and coordinate their oversight of eligibility determination. Additionally, starting in fiscal 2007 and ending in 2009, we made repeated recommendations for Social Services to implement a risk based approach to monitor the local departments. If this approach works as intended; the risk based approach will allow managers at Social Services to focus their efforts on those localities that have the largest negative impact on the state's Medicaid program.

Finally, to help localities and the state ensure that only eligible individuals receive services from the Medicaid program Social Services uses several systems to verify an applicant's information. However, as noted in our 2010 report on *Enterprise Data Standards for Human Services* there is a lack of consistency in the way information is entered and stored across the Commonwealth's systems, which creates risks that needs to be managed or removed.

Demand for Services

Medical Assistance Services, across all programs, provided funding for services to over 1,000,000 persons during fiscal 2010. General population growth in Virginia, including the growth of the aging population, and especially the growth in low-income families due to current economic conditions are all key factors affecting its consumer base. As illustrated in the Medicaid section of this report, current projections of Medicaid predict an increase in enrollment as a result of health care reform.

Financial Information

The table below summarizes Medical Assistance Services' budgeted expenses by program as compared with actual results for fiscal 2010.

Analysis of Budgeted and Actual Expense by Program - Fiscal 2010
(Amounts in Thousands)

<u>Program</u>	<u>Original Budget</u>	<u>Adjusted Budget</u>	<u>Actual Expenses</u>	<u>2011 Proposed Budget</u>
Medicaid	\$6,335,672	\$5,841,822	\$5,814,267	\$6,602,996
Medicaid - ARRA	-	746,425	734,587	-
FAMIS	149,427	132,978	131,371	160,612
Administration and support services	105,978	126,245	121,764	104,889
FAMIS (PLUS)	98,426	110,229	109,447	127,273
Involuntary Mental Commitments	10,472	13,036	12,197	13,298
Continuing Income Assistance Services	1,400	1,050	941	-
State and Local Hospitalization Program	<u>822</u>	<u>877</u>	<u>836</u>	<u>822</u>
Total	<u>\$6,702,197</u>	<u>\$6,972,662</u>	<u>\$6,925,410</u>	<u>\$7,009,890</u>

Source: Original Budget: Appropriation Act Chapter 781, from the 2009 General Assembly session; Adjusted Budget and Actual Expenses: Commonwealth Accounting and Reporting System 1419D1 report as of June 30, 2010; Fiscal 2011 Proposed Budget: Appropriation Act Chapter 874, from the 2010 General Assembly session

Medical Expenses

While Medical Assistance Services' expenses were within one percent of the adjusted budget, its expenses were 13 percent higher than the prior year's amount of \$6.1 billion. However, their expenses could have been higher. As required by the 2009 General Assembly, Medical

Assistance Services continued the practice of not paying claims for the last week of the fiscal year until the beginning of the following year. As a result of this, the Commonwealth was able to maintain its onetime savings of \$50 million. Additionally, as a result of budget cuts, the Commonwealth discontinued the State and Local Hospitalization Program, which removed \$14 million of expenses. These actions along with the continued stimulus funding that is discussed in the Medicaid section of this report allowed the state to use approximately \$799 million of General Funds elsewhere that otherwise would have been the General Fund portion of the costs to maintain the Medicaid and State and Local Hospitalization Programs.

The \$807 million increase in expenses between fiscal 2009 and 2010 largely result from the increase in Medicaid enrollment because of the economic conditions that is causing more individuals to be eligible for the program. Average monthly enrollment in the Medicaid program in fiscal 2010 was 763,745. This was an increase of 69,469 or ten percent; double the increase between fiscal 2008 and 2009 of 34,307. There was also a 13 percent enrollment increase in FAMIS Plus.

Funding Sources

The table below shows expenses by program and the funding sources Medical Assistance Services used in fiscal 2010.

Analysis of Actual Expenses by Funding Source (Amounts in Thousands)

<u>Program</u>	<u>General</u>	<u>Federal</u>	<u>ARRA</u>	<u>Virginia Health Care Fund</u>	<u>Other Special Revenue</u>
Medicaid	\$2,295,814	\$3,224,459	\$734,587	\$293,995	\$ -
FAMIS	31,552	85,753	-	-	14,066
Administration and support services	45,614	75,183	-	-	967
FAMIS (PLUS)	37,288	72,160	-	-	-
Involuntary Mental Commitments	12,197	-	-	-	-
Continuing Income Assistance Services	941	-	-	-	-
State and Local Hospitalization Program	<u>533</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>
<u>Total</u>	<u>\$2,423,939</u>	<u>\$3,457,555</u>	<u>\$734,587</u>	<u>\$293,995</u>	<u>\$15,033</u>

Source: Commonwealth Accounting and Reporting System 1419D1 report as of June 30, 2010

The Federal and ARRA funds make up approximately 61 percent of the funding for Medicaid during fiscal 2010. Continued stimulus funding for fiscal 2010 increased the federal share for the Medicaid program, which allowed the Commonwealth to use an equal amount of General Funds for other items in the state's budget. While a limited amount of ARRA finding is available in fiscal 2011, the Commonwealth does not expect to receive ARRA funds for fiscal 2012.

The Virginia Health Care Fund (Fund) is a special non-reverting fund established to support health care programs using money from tobacco taxes and the Commonwealth's allocation of a national settlement known as the Master Settlement Agreement. Additionally, the Fund also

receives General Funds returned to the Medicaid program. The amount of monies in the Fund decreased in fiscal 2010 due to a reduction in the tobacco sales, which have continued to decrease over the past three years.

Administrative Expenses

In addition to medical services, Medical Assistance Services spent \$121 million on administrative and support services, which represents a \$16 million or 15 percent increase between original budget and actual expenses. This increase was a result of transitioning between fiscal agents to process Medicaid claims. When Medical Assistance Services prepared the original budget, they were still in negotiations with the new fiscal agent establishing milestone payments for fiscal 2010 and were therefore not included in the original budget. The new fiscal agent, Affiliated Computer Services (ACS) took over managing the Medicaid Management Information System at the beginning of fiscal 2011.

The table below summarizes the administrative expenses by major categories for fiscal 2010 and 2009.

Administrative Expenses - Fiscal Year 2009 - 2010
(Dollars in Thousands)

	Expenses	
	2010	2009
Contractual Services	\$ 89,361	\$ 76,802
Personal Services	28,911	30,150
Continuous Charges	2,837	2,323
Supplies and Materials	379	399
Transfer Payments	166	151
Equipment	110	163
Total	<u>\$121,764</u>	<u>\$109,988</u>

Source: Commonwealth Accounting and Reporting System

Contractual services includes fees for processing claims, FAMIS eligibility determination, recipient and provider enrollment, prior authorization of medical services, cost settlement and audit reviews, managed care enrollment, actuarial services, and reimbursement to K-12 schools for Medicaid and FAMIS administrative costs.

Medical Assistance Services uses a number of contractors to help manage and carry out the requirements of the Medicaid program. The key contractual relationship for Medical Assistance Services is with its fiscal agents, previously First Health, now ACS, who have the main duties of processing claims payments and enrolling providers.

Administrative Contractual Service
(Dollars in Thousands)

	Expenses	Percent
First Health Services Corp	\$21,208	23.7%
Affiliated Computer Services, Inc	14,654	16.4%
Kepro, Inc	8,990	10.1%
Virginia Public Schools	8,697	9.7%
Public Partnerships, LLC	7,889	8.8%
Combined Other Contracted Vendors	7,879	8.8%
Clifton Gunderson, LLP	7,545	8.4%
Other Contracted Services	12,499	14.0%
Total	\$89,361	99.9%

Source: Commonwealth Accounting and Reporting System

As illustrated in the table above, First Health was the largest contractor during fiscal 2010 with over \$21 million in expenses, 23 percent of total contractual expenses. ACS accounted for 16 percent of contractual expenses for FAMIS enrollment and processing; and milestone payments for the fiscal agent take-over. Kepro handles preauthorization of medical services. Virginia Public Schools are reimbursed for their administrative costs for providing medical services to Medicaid and FAMIS recipients.

DEPARTMENT OF SOCIAL SERVICES
(SOCIAL SERVICES)

Managing Services

Social Services’ administers over 40 programs, which we grouped into four major categories: Benefit Programs, Family Services, Child Support Enforcement, and Licensing. Social Services also operates Child Support Enforcement and Licensing services from their own offices located throughout the state; eight licensing offices and 21 Child Support Offices.

Conversely, for Benefit Programs and Family Services, Social Services does not directly provide these services. Instead, Social Services depends on 120 locally operated social services offices across the state to provide these services. These local offices receive direction and support from Social Services, but the local governments manage these offices. To aid in the oversight of local offices, Social Services operates five regional offices that are an extension of the state’s Central Office.

Local social service offices deal directly with consumers. They perform a variety of functions but their main two functions are determining eligibility for benefit programs and case management for family services. The local governments’ ability to determine eligibility is very important to the state and federal government. In this capacity, the local offices are acting as the “gatekeeper” for benefit programs, which includes: Medicaid, Supplemental Nutrition Assistance

Program (SNAP), and Temporary Assistance for Needy Families (TANF). In other words, the local governments are controlling who can access over \$4 billion in total annual benefits.

The Central Office and other state agencies, such as Medical Assistance Services, that rely on the local offices for determining eligibility have primary responsibility for who is receiving benefits from their programs. However, the state does not manage or control the local social services offices. To help the local offices, the Central Office establishes policies and procedures for adhering to federal and state requirements, which local offices implement. Both the Central Office and regional offices monitor the local offices for compliance with these policies and procedures. The Central and regional offices often act in an advisory role by providing technical assistance to local offices and do not impose sanctions.

Demands for eligibility determination and case management services are at record highs because of the economic decline. In addition, management is anticipating that demand for these services will increase dramatically when the provisions of Healthcare Reform cause more individuals to become eligible for Medicaid.

Financial Information

The below table entitled *Analysis of Budgeted and Actual Expenses by Funding Source* summarizes Social Services' budgeted revenues and expenses compared with actual results for fiscal 2010.

Analysis of Budgeted and Actual Expenses by Funding Source
(Dollars in Thousands)

<u>Funding Source</u>	<u>Original Budget</u>	<u>Adjusted Budget</u>	<u>Actual Expenses</u>	<u>Proposed Budget for 2011</u>
General	\$ 386,161	\$ 389,257	\$ 387,309	\$ 381,066
Special	708,937	709,616	658,299	710,667
Federal	743,449	797,450	681,152	776,961
ARRA	-	96,149	80,193	-
Total	<u>\$1,838,547</u>	<u>\$1,992,472</u>	<u>\$1,806,953</u>	<u>\$1,868,694</u>

Source: Original budget-Appropriation Act Chapter 781, Adjusted Budget and Actual Expenses – Commonwealth Accounting and Reporting System 1419D1 report as of June 30, 2010 Proposed Budget - Appropriation Act Chapter 874.

The overall budget increase of eight percent during fiscal 2010 results from new ARRA funding as well as an additional \$50 million appropriation for the Low Income Home Energy Assistance Program (LIHEAP) due to an increase in federal funds available. Not all budgetary increases resulted in new actual expenses. For example, in some cases for budgetary purposes the Commonwealth replaced existing federal program funds with ARRA funds, but did not adjust the budget for the change. In addition, Social Services historically over budgets for federal expenses because of difficulty in forecasting local expenses as a result of changes in federal reimbursement policies and varying case loads and eligibility determinations.

The table below entitled *ARRA Awards and Expenses to Date* shows the ARRA awards Social Services received and expensed from the enactment of ARRA through the end of fiscal 2010. Social Services plans to use the remaining award balances in fiscal 2011 with no more ARRA funds available thereafter.

ARRA Awards and Expenses to Date
(Dollars in Thousands)

Program	Award	Expenses
Child Support Enforcement	\$ 53,105	\$ 42,662
Child Care	37,892	15,096
Temporary Assistance for Needy Families	21,802	21,802
Community Service Block Grant	16,008	9,577
Foster Care and Adoption Assistance	12,442	10,621
Supplemental Nutrition Assistance Program	5,261	2,656
Americorps	526	398
State Victim Assistance *	-	76
Total	<u>\$147,036</u>	<u>\$102,888</u>

* This grant was awarded to Criminal Justice Services

Source: Award - www.stimulus.virginia.gov Expenses - Commonwealth Accounting and Reporting System

The majority of the programs managed by Social Services depend at least in part on federal funds. The bulk of General Fund expenses are state matching dollars spent according to agreements with the federal government. The table below entitled *Analysis of Actual Expenses by Funding Source* shows an analysis of program expenses at Social Services by funding source.

Analysis of Actual Expenses by Funding Source
(Dollars in Thousands)

Program	General	Special Revenues	Federal	ARRA	Total
Child Support Enforcement Services	\$ 3,351	\$655,157	\$ 36,975	\$25,005	\$ 720,488
Financial Assistance for Local Social Services Staff	116,741	1,378	242,311	2,617	363,047
Financial Assistance for Self-Sufficiency Programs and Services	98,867	-	143,309	36,897	279,073
Child Welfare Services	85,355	133	57,825	5,616	148,929
Financial Assistance for Supplemental Assistance Services	2,962	-	98,680	-	101,642
Administrative and Support Services	32,121	48	37,855	-	70,024
Adult Programs and Services	23,237	-	14,597	44	37,878
Financial Assistance to Community Human Services Organizations	3,895	-	23,953	9,975	37,823
Program Management Services	16,341	75	16,960	39	33,415
Regulation of Public Facilities and Services	4,439	1,508	8,687	-	14,634
Total	<u>\$387,309</u>	<u>\$658,299</u>	<u>\$681,152</u>	<u>\$80,193</u>	<u>\$1,806,953</u>

Source: Commonwealth Accounting and Reporting System 1419D1 report as of June 30, 2010.

The table below entitled *Actual Expenses by Type* shows Social Services' actual expenses for four major types of expenses. The largest type is transfers to localities, which the graph, entitled *2010 Locality Expenses*, beneath further defines. Child Support Transfers are payments to custodial parents that have been collected from noncustodial parents. Benefit payments to individuals consists of only two programs Temporary Assistance for Needy Families (TANF) (\$130 million) and Energy Assistance (\$92 Million). The Central office makes these payments directly to the individuals or vendors. The Central Office expenses include personnel services, information technology services, contractual services, supplies, rent, and equipment.

Actual Expenses by Type
(Dollars in Thousands)

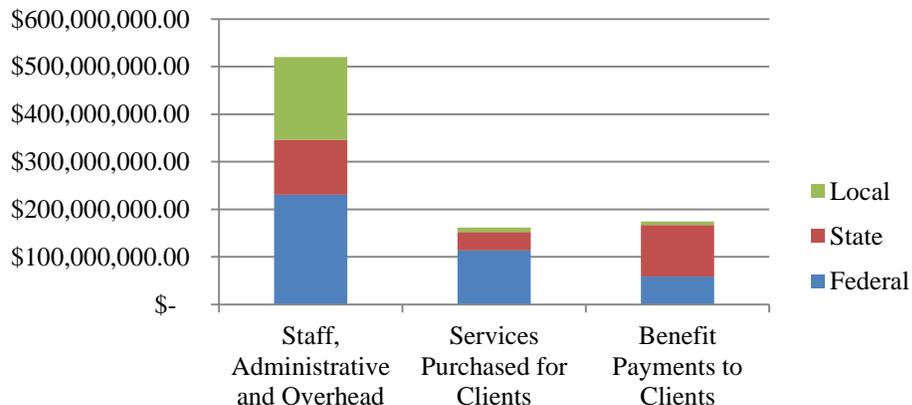
Type	Expenses	Percent
Transfers to localities	\$ 685,201	38%
Child Support Payments	623,665	35%
Benefit Payments to Individuals	222,250	12%
Central Office	210,164	11%
*Other Transfer Payments	65,673	4%
Total	<u>\$1,806,953</u>	<u>100%</u>

*Includes payments to nongovernmental and intergovernmental organizations and community service agencies

Source: Commonwealth Accounting and Reporting System

The amounts in the table above only include federal and state funds along with transfers between parents. The localities also contribute funds to social programs. A majority of these local funds cover administrative expenses, which include case management and eligibility determination. The table below shows how the localities spent the transfers they received from Social Services as well as their funding that they reported to Social Services.

2010 Locality Expenses



Source: Social Services' Local Reimbursement System

In fiscal 2012, Social Services expects to complete its implementation of a statewide system for making payments for childcare services. The new system will allow Social Services to pay for childcare services statewide directly from its Central Office. The new payment process should remove the amount of time locality staff spend administering childcare payments.

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
(DEPARTMENT)

Managing Services, the Department

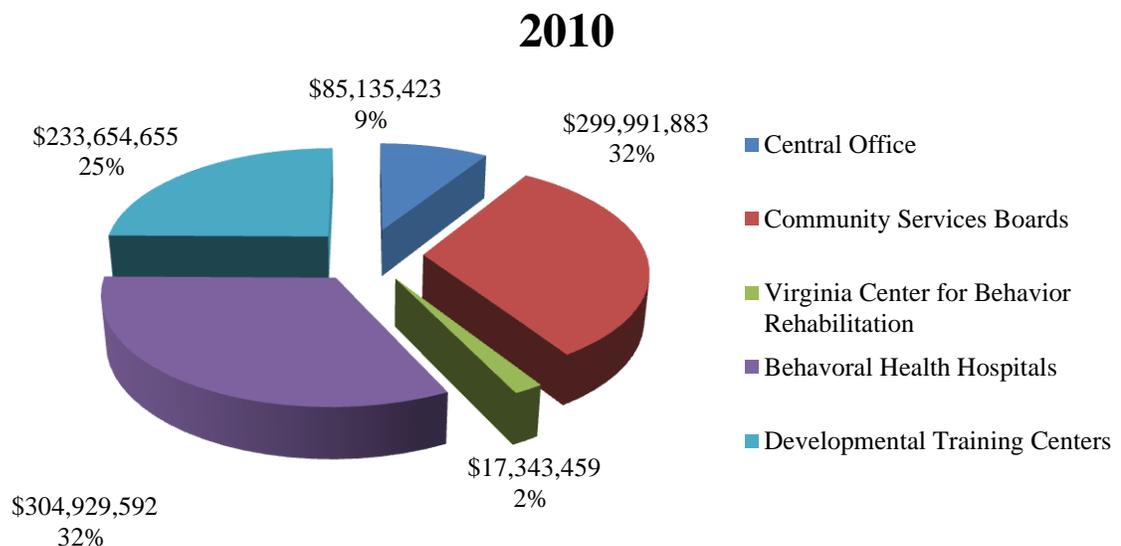
The Department funds and provides behavioral health and developmental services. The Department provides these services directly in 16 state-operated facilities and indirectly through its funding of community services throughout the Commonwealth.

The Department consists of a central office and 16 facilities. While the Central Office provides oversight to the facilities, the facilities provide most of their own administrative functions and provide all direct services to the Department’s consumers. In addition, the Central Office contracts, funds, and monitors 39 local community service boards and one behavioral health authority, collectively referred to as CSBs, that provide services within the community.

Financial Information, the Department

The chart below summarizes the Department’s expenses between the facilities (Behavioral Health Hospitals and Developmental Training Centers), the CSBs, and the Central Office. In fiscal 2010, the Department spent \$941 million, a decrease of \$23 million or 2.9 percent from the prior year. Removing the effect of capital projects, non-construction expenses decreased \$34 million or 3.7 percent from the prior year’s \$928 million.

Analysis of Expenses by Service Areas



Source: Commonwealth Accounting and Reporting System

The table below summarizes the Department's budgeted revenues and expenses compared with actual results for fiscal 2010.

Analysis of Budgeted and Actual Expenses by Fund - Fiscal Year 2010
(Dollars in Thousands)

	<u>Original Budget</u>	<u>Adjusted Budget</u>	<u>Actual Expenses</u>	<u>Proposed Budget For 2011</u>
General	\$574,361	\$524,100	\$522,076	\$528,868
Special	307,774	315,269	299,918	318,572
Federal	71,786	71,786	66,764	71,942
ARRA	-	<u>5,540</u>	<u>3,927</u>	-
Total	<u>\$953,921</u>	<u>\$916,696</u>	<u>\$892,684</u>	<u>\$919,382</u>

*Source: Commonwealth Accounting and Reporting System 1419D1 report as of June 30, 2010;
Proposed Budget for 2011 - Chapter 874, the Appropriation Act*

As a result of budget reductions; the Department's General Fund budget decreased \$50 million or 8.75 percent during fiscal 2010. The reductions occurred in the following areas: \$37.5 million from Hospital and Training Center facilities; \$11.4 million from CSBs; and \$2.8 million from the Central Office. Offsetting these reductions was a slight increase of \$1.1 million for Virginia Center for Behavioral Rehabilitation. Management achieved these reductions by eliminating filled and vacant positions, program efficiencies, reducing outside contractors, saving energy, consolidating some support services at state facilities, and reducing expenses at state facilities not associated with direct care.

While actual expenses for special funds were less than their original budget, the Department requested and received \$7.5 million in increases to spend special funds in fiscal year 2010. Of this amount, the Department received special funds of \$1 million from the Indigent Defense Fund and \$3.5 million from the Department of Criminal Justice Services to support CSBs instead of General Funds. They also received authority to spend increased collections from Medicaid, which were the result of the Department transferring General Funds to Medical Assistance Services.

Central Office

The Department's Commissioner in the Central Office has responsibility for the programmatic, financial, and administrative operations of the state facilities. However, for many operational functions the Commissioner has delegated responsibility to facility directors. The Central Office also has responsibility for monitoring and overseeing the programmatic and financial activities of the CSBs. Additionally, there is the Office of Inspector General housed within the Central Office that independently investigates and monitors human rights issues at the facilities and CSBs.

The Central Office provides oversight of the overall management and direction to the facilities, which includes: developing an overall budget, financial management policies, Medicare and Medicaid cost reports, and reimbursement rates. The Central Office also performs architectural and engineering services, administers capital outlay projects, provides internal audits and pharmaceutical services, manages the information systems and budgets, and licenses all providers of mental health, mental retardation, and substance abuse services throughout the state. Further, the Central Office provides assistance on human resource issues to the facilities.

In fiscal 2010, the total expenses of the Central Office were about \$85.1 million or nine percent of the Department's total expenses. This is an increase of 14.9 percent over the prior year, all of which is due to an \$11.8 million increase in construction expenses the Central Office pays on behalf of facilities. In fiscal 2010, the Central Office paid \$48.3 million, 41 percent of its total expenses, for construction activities at the facilities. Other expenses decreased by about \$707 thousand from the prior year.

Facilities – Hospitals and Training Centers

Managing Services

Ten behavioral health facilities, referred to as “Hospitals”, provide acute care and chronic psychiatric services to children, adults, and the elderly. There are also five developmental services facilities, referred to as “Training Centers”, that offer residential care and training in such areas as language, self-care, independent living, academic skills, and motor development.

In total, 15 facilities employ about 8,300 individuals and provide consumer care to about 2,603 individuals. As highlighted in the following Financial Information section, Personal Services Expenses, otherwise known as payroll expenses, are 80 percent of the yearly cost of providing services in the facilities.

Because managing the payroll process is the largest expense for providing services in the facilities, we focus our procedures in this area. As a result of our efforts, we provide management with recommendations for improving their managing of the payroll process in the form of Efficiency Observations within the section of this report entitled “*Findings and Recommendations*”.

The following table summarizes the composition and numbers of staff per category throughout the entire Department. Administration and Support Services, which is 13 percent of staffing includes the following categories: Commissioner, Administrative and Support, Education and Training, Public Relations and Marketing, Financial Services, General Administration, Health Care Compliance, Human Resources, Policy and Planning, Printing Technicians, Procurement, and Store and Warehouse. Analysis of the information below shows that 5,650 or 68 percent of the Departments employees are Medical/Clinical Service staff at the facilities.

Breakdown of Services by Employee Category

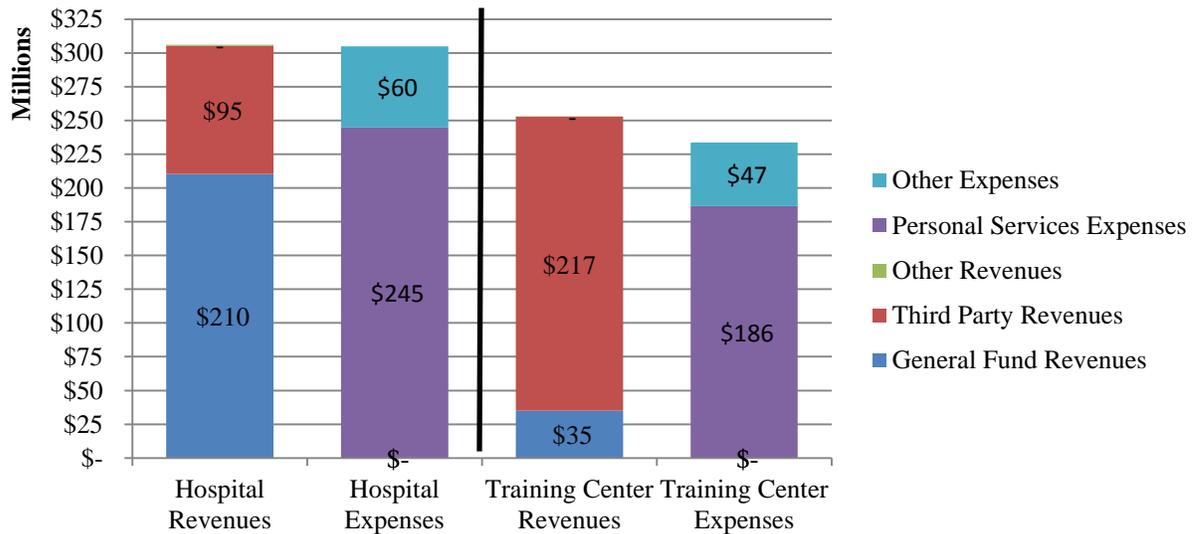
Administration and Support Services	1,104
Building and Grounds	273
Food Services	383
Housekeeping Services	448
Information Technology Services	48
Legal Services	1
Medical/Clinical Services	
Pharmacy Services	37
Physician Services	110
Dental Services	7
Health Care Techs	29
Nursing Services	
Direct Service Associates	3,676
Licensed Practical Nurses	421
Registered Nurses	838
Psychological Services	127
Social Services	183
Therapy Services	222
Program Administration and Support Services	342
Transportation Services	<u>69</u>
Total	<u>8,318</u>

Source: Department of Behavioral Rehabilitation and Developmental Services, Human Resources Department as of July 2010.

Financial Information

The following chart illustrates the major sources and uses of revenues for the Hospitals and Training Centers.

Analysis of Revenues by Funding Source and Expenses by Type



Source: Commonwealth Accounting and Reporting System

The General Fund provides \$245 million or 44 percent of the facilities' total resources, with Hospitals receiving \$210 million or 86 percent of these funds. The largest source of revenue for Training Centers is billing and collections from third-party payers, primarily Medicaid. In fiscal 2010, these third-party payers represented about \$313 million or 56 percent, of the facilities' total available resources, with Training Centers receiving \$217 million or 86 percent of their revenue from third-party payers.

As noted earlier, personal services are the facilities' single largest expense. In fiscal 2010, the Hospitals and Training Centers spent over \$431 million, or 80 percent, of their total expenses on payroll and other related expenses.

Average Daily Expenses and Patient Census

The following section analyzes the average daily expenses as reported in the Commonwealth Accounting and Reporting System and the average daily census of residents for each hospital and training center.

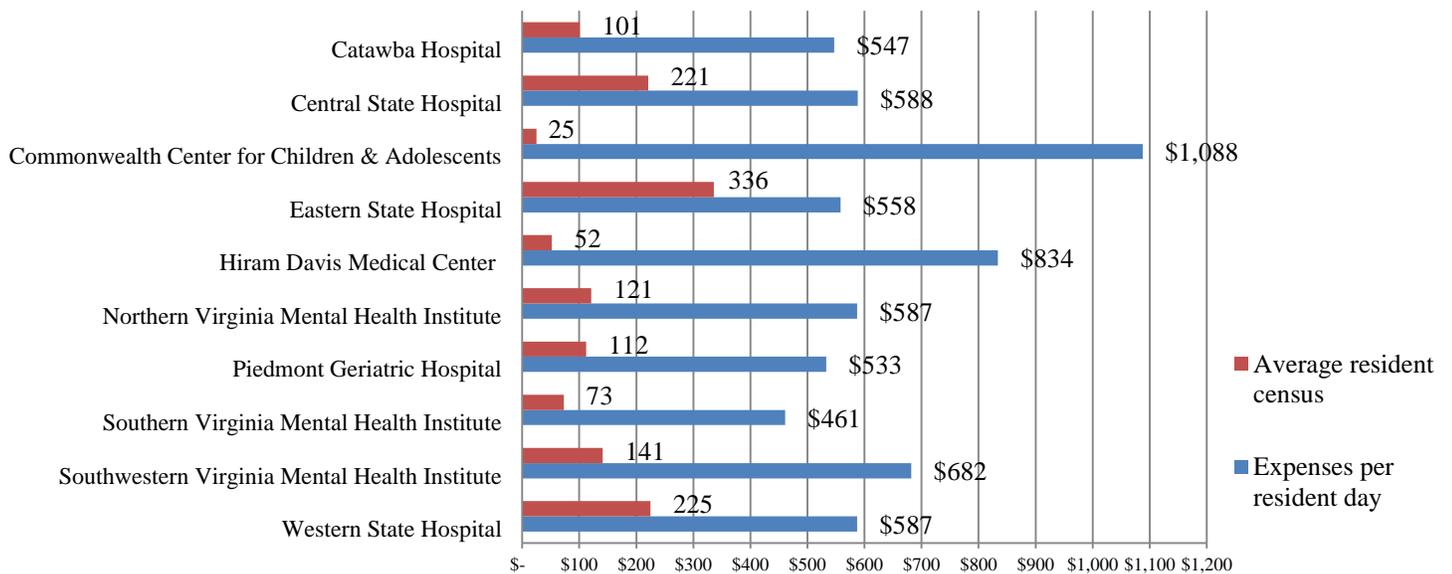
BEHAVIORAL HEALTH HOSPITALS

The Hospitals shown below have expenses per resident day ranging from \$461 to \$1,088 with an average cost per resident day of \$642, and an average daily census ranging from 25 to 336 residents with a total population of 2,814.

The Commonwealth Center for Children and Adolescents reflects the lowest average daily census at 25, down seven from the prior year, with the highest cost per patient day of \$1,088, an increase of \$237 or 28 percent. Their census, like other facilities, is decreasing as part of the System Transformation Initiative to provide more services in the community. As the census decreases, cost per day increases, since most of the costs are semi-fixed-costs associated with physically operating a facility and maintaining standards of care.

Hiram Davis Medical Center has the second highest daily cost per resident day of \$834 due to the severe nature of its residents’ physical and psychiatric conditions. Additionally, the entire pharmacy budget for the Petersburg campus, which also includes the facilities of Central State Hospital and Southside Virginia Training Center, is within Hiram Davis.

Analysis of Hospitals Census and Cost per Day



Source: Department of Behavioral Health and Developmental Services

DEVELOPMENTAL TRAINING CENTERS

Training Centers’ expenses per resident day range from \$353 to \$717 with an average cost per resident day of \$535, and an average daily census ranging from 145 to 425 residents with a total population of 1,196. As the chart below shows, Southside Virginia Training Center has the highest cost per resident day at \$717; however, this facility pays for and provides administrative support for all the other facilities at the Petersburg campus.

As a group, the total cost of Training Centers decreased by \$12 million between fiscal 2009 and 2010; however, the average cost per resident day increased from \$527 to \$535. The increase in average cost per resident day is a result of a decrease of 81 residents or 6.3 percent of the total population for Training Centers. Same as the Hospitals, their cost per day will continue to increase

even with decreasing populations since most of the costs are semi-fixed-costs associated with physically operating a facility and maintaining standards of care.

Analysis of Training Centers Census and Cost per Day



Source: Department of Behavioral Health and Developmental Services

Virginia Center for Behavioral Rehabilitation (Behavioral Rehabilitation)

Managing Services

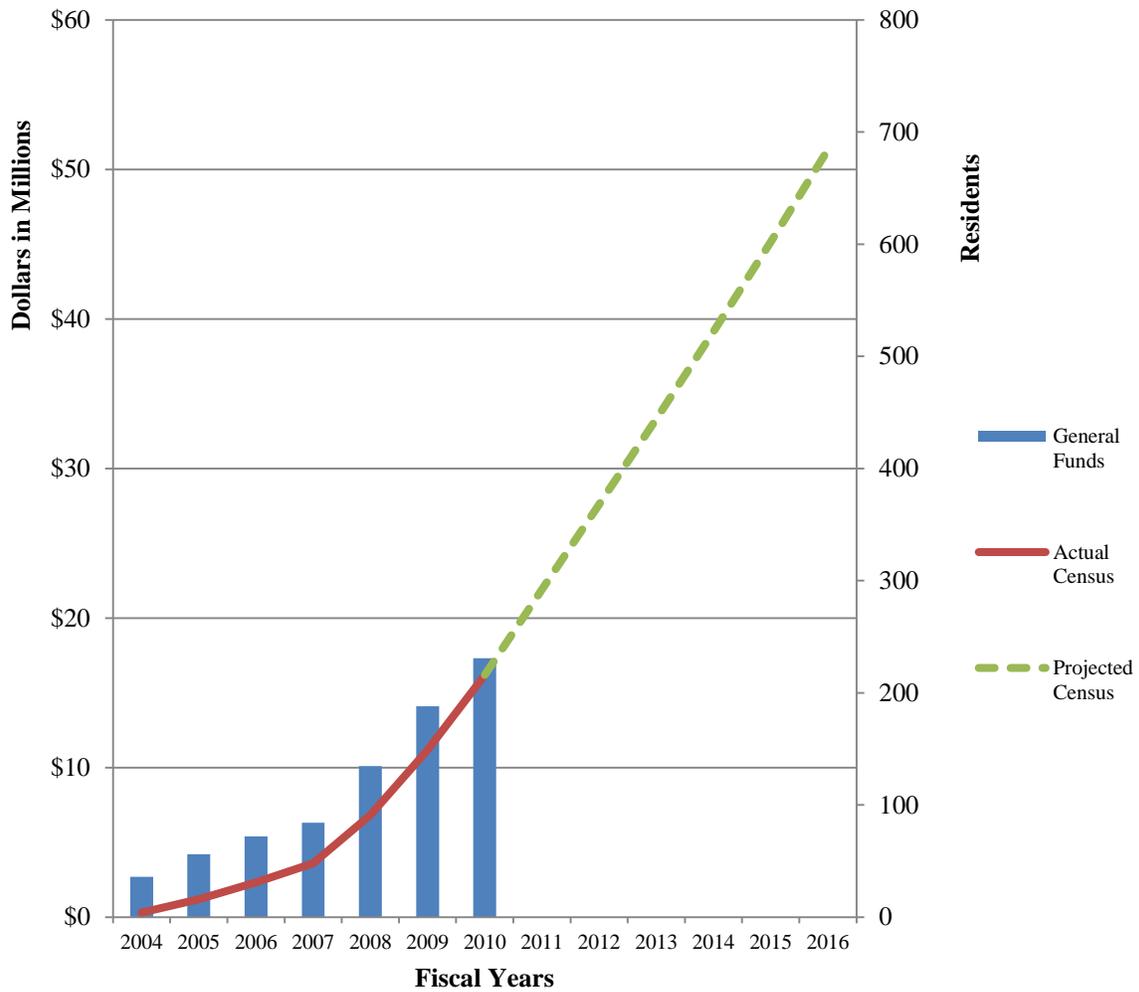
Behavioral Rehabilitation houses convicted sex offenders who are civilly committed at the end of their prison sentence if the Department of Corrections deems them “sexually violent predators”. Due to a change in the screening criteria for facility placement, the average daily census has increased. Behavioral Rehabilitation opened in October 2003 in response to an immediate need to accommodate these individuals, and could provide individualized rehabilitation services in a secure environment. The need resulted in the Department retrofitting an existing building on their Petersburg complex to accommodate an initial operating capacity of 36 individuals.

The Department completed construction of a \$62 million, 300-bed facility in Nottoway County in fiscal year 2009 in response to anticipated increase in demand for services from an imposed change in the screening criteria for facility placement. Its average daily census continued to grow to 216 during fiscal 2010. As of mid October 2010, Behavioral Rehabilitation had a weekly census of 229.

Financial Information

Behavioral Rehabilitation receives all of its funding from the General Fund. The following table trends the resident census at year end and general fund support from its inception in fiscal 2004 through 2010. In fiscal 2010, the census grew to 216 supported by a general fund appropriation of \$17 million. With the expectation of further increases in census, the Department and the Commonwealth will need to plan accordingly.

Analysis of Behavioral Rehabilitation’s Census and General Funding



Source: General Funds: Commonwealth Accounting and Reporting System and Census, Actual and Projected, the Department Behavioral Health and Developmental Services

Community Service Boards (CSB)

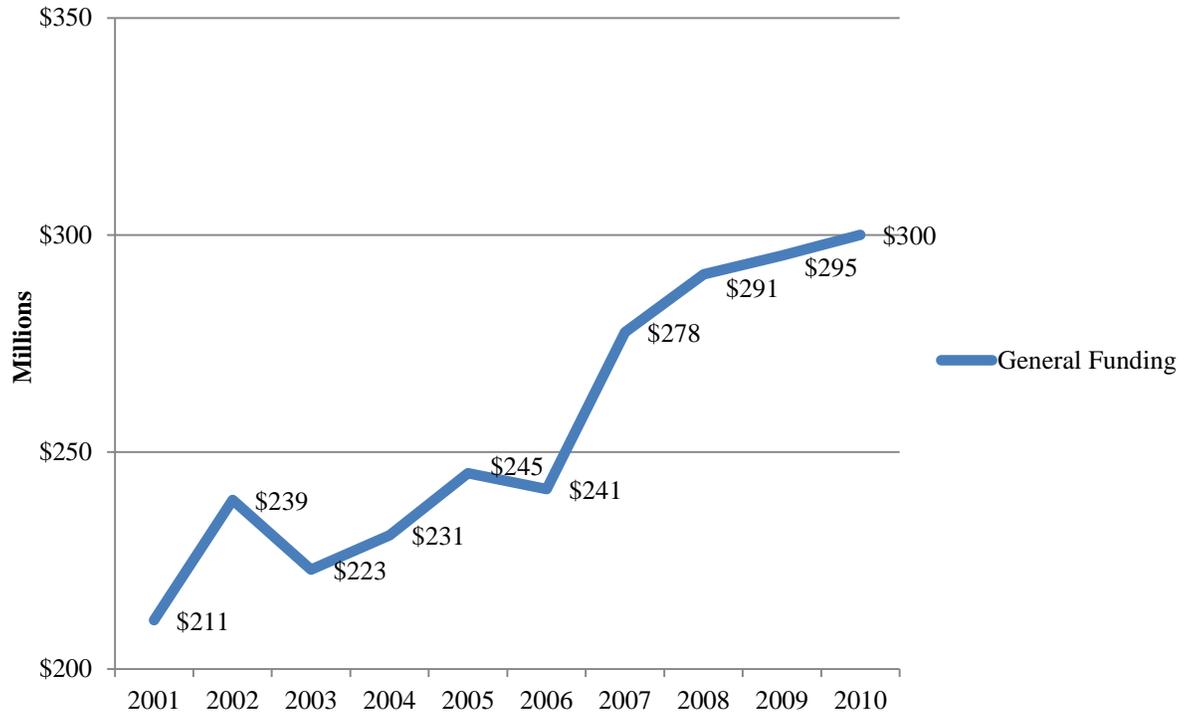
Managing Services

The Department contracts with, provides consultation to, funds, monitors, licenses, and regulates CSBs because they are the single point of entry into the Commonwealth’s behavioral health and developmental services system. The CSBs provide pre-admission screening and discharge planning services for consumers entering or leaving state facilities. Additionally, the CSBs function as advisors to their local government and are providers (directly or contractually) of community based behavioral health and developmental services.

Financial Information

During fiscal 2010, the Department transferred \$299.9 million in General Funds or about 32 percent of its total budget to the CSBs. Over the past ten years, the Commonwealth, through the Department, has consistently increased its payments to CSBs as part of its commitment to provide more services in the community.

General Funding to the Community Services Boards
Fiscal Years 2001 through 2010



System Transformation Initiative

As part of a national movement to provide more services in the community and operate smaller more efficient facilities, the Commonwealth implemented the system transformation initiative. In addition to the financial commitment to the CSBs discussed in the previous subsection, the Initiative also includes funds to rebuild, resize, relocate, and renovate existing facilities. Below is an overview of major facility projects.

- Eastern State Hospital completed the Phase I rebuilding of the facility in fiscal 2008 with Phase II scheduled for completion in the first quarter of fiscal 2011.
- The Department sold the Western State Hospital property to the City of Staunton. The Department plans to site the new hospital on approximately 60 acres of adjacent land previously owned by the City of Staunton's Industrial Development Authority. Western State Hospital will continue operating on a portion of the existing campus until the

completion of the new facility. With the completion of the replacement hospital, Western State Hospital will relocate to the new hospital and vacate the current property. A scheduled completion date is the spring of 2013.

- At Central Virginia Training Center, construction is underway to renovate existing buildings, resize and consolidate the campus, and build community housing with a completion date sometime in 2012.
- Southeastern Virginia Training Center's plans include two elements: first is the creation of homes in the community that will be dedicated to moving residents into the community and off the campus; second is downsizing the facility from its current capacity of 200 beds and rebuilding at a capacity of 75 beds. Management expects to have this completed in mid-fiscal 2011.

DEPARTMENT OF HEALTH **(HEALTH)**

Management of Services

In addition to the normal medical services that Health manages for the Commonwealth, Health was responsible for managing the state's response to and administering of vaccines for the H1N1 flu during fiscal 2010. The next subsection discusses Health's management of H1N1 vaccines followed by other services.

The H1N1 Flu Vaccines

After Health received the first shipments of the H1N1 vaccine in early October, it began a statewide media campaign and vaccination program. As part of this campaign, Health used public service television and radio announcements, and transit, internet, and cinema-based advertising. Health also created a special website to provide both information about the virus and information about available providers. Health also collaborated with retail stores in December to reach shoppers and partnered with radio stations to increase participation from young adults. Health worked with the Virginia Department of Education to establish a statewide absentee reporting system to enhance their ability to track potential cases and also posted an interactive map on its website detailing the number of reported cases within each local health district.

All 119 of Virginia's local health departments served as public vaccination sites to provide immunizations without fees. In addition, Health worked with over 3,000 different entities, including hospitals, physicians' offices, pharmacies, schools, and retail stores, to serve as vaccination sites.

By January of 2010, over 26 percent of Virginia's population received vaccination against the H1N1 flu virus, including nearly 40 percent of school age children. According to the CDC, the national median for the entire population at that point was 23.9 percent and 23 percent for Virginia's region, which includes Delaware, the District of Columbia, Maryland, Pennsylvania, and West Virginia.

During fiscal 2010 the federal government provided \$15.7 million and over 3.9 million doses of the H1N1 vaccine to Virginia. Health, through public and private providers, administered about 1.8 million doses. However, due to production issues with the federal vendor, the H1N1 vaccine was not widely available until December, after the peak of the flu season in October and November of 2009. After the 2009-2010 flu season ended, the Center for Disease Control and Prevention (CDC) recalled about 2.1 million unused doses, with an original cost of about \$18 million to the federal government.

Other Services

Health's delivery system consists of a central office and 119 local health departments grouped geographically into 35 health districts. Some health districts cover multiple localities, but for larger localities the health district has the same borders as the locality. Health districts allow for tailoring of services to meet local needs.

The local departments provide a variety of environmental services and both mandated and non-mandated community healthcare services. Health operates the local health departments under Cooperative Agreements (Agreements) between Health and local governments, which sets forth the funding participation between the state and local government and some optional services.

The Agreements cover both mandated and non-mandated health services that each local jurisdiction must provide. The Code of Virginia requires Health to fund at least 55 percent of the mandated services. Employees in 33 health districts are state employees and subject to state policies and procedures, except for Arlington and Fairfax. Health also funds a limited amount of some non-mandated services. Additionally, a locality can opt to provide services unique to its jurisdiction; local governments must fund 100 percent of any of these unique local services. In addition to services covered by the Agreements with local governments, the local offices within each district operate other programs for the state and federal government.

In two localities, Arlington and Fairfax, the local governments manage their own local health departments and health districts. The significant difference between these offices is how they control their administrative functions. Local government employees operate these two departments and follow local personnel policies. Health must reimburse these two local governments for 55 percent of the expenses incurred for mandated services.

Financial Information

Local Health Districts

At a statewide level, Health supported about \$80.8 million out of \$129.6 million in shared expenses with local governments during fiscal 2010, or roughly 62 percent. The state's percentages for shared services, which range from a minimum of 55 percent to as much as 79 percent, considers several factors including the average adjusted individual gross income for the locality.

The following table entitled *Analysis of Health District Statewide Expenses* details the expenses to administer the health districts and the funding sources that support these services, excluding Arlington and Fairfax’s local funds.

Analysis of Health District Statewide Expenses
(Dollars in Thousands)

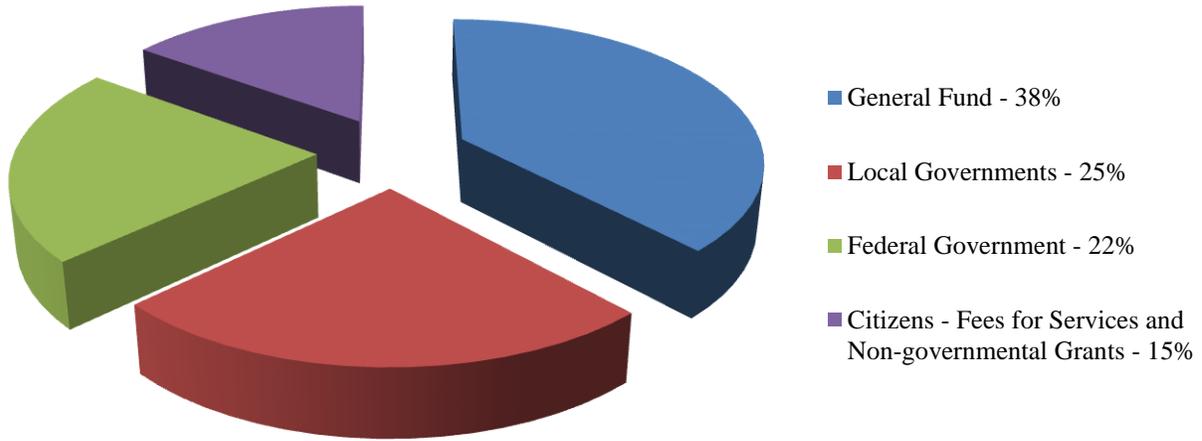
	<u>2010</u>	<u>2009</u>
Total Expenses for Local Health Districts	\$230,651	\$231,029
Cooperative Agreement Expenses	\$167,737	\$179,159
<i>State Portion of Shared Expenses</i>	81,565	88,442
<i>Localities' Portion of Shared Expenses</i>	48,085	50,647
<i>District Earned Revenue</i>	29,491	31,063
<i>100 percent Locally-funded Services</i>	8,596	9,007
Non Cooperative Agreement Expenses	\$62,915	\$51,870
<i>Federal Fund Expenses</i>	51,448	38,488
<i>General Fund Expenses</i>	6,468	7,289
<i>Special Revenue Fund Expenses</i>	4,999	6,093

Total costs to operate the 35 local health districts held steady at about \$231 million. While costs for services in the agreements between Health and local governments decreased by \$11.4 million, expenses that are not part of the Cooperative Agreements increased by \$11.1 million primarily due to the administrative costs of administering the H1N1 vaccine. Funding for the H1N1 vaccine and other programs that are not part of the Cooperative Agreements, such as the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), came primarily from federal grant funds.

The General Fund amount of \$87.3 million includes the \$80.8 million Health paid to or on behalf of local governments and an additional \$6.5 million to support other public health programs. The Local Government amount of \$57.4 million includes about \$8.6 million to provide services requested by individual localities. In addition to the federal expenses that are discussed above, fees for services paid by citizens and non-governmental grants support about 15 percent of the total expenses to operate the local health system.

The following chart shows the funding sources that supported \$231 million in local health district expenses, excluding Arlington and Fairfax’s local funds, by percentage.

Actual Sources Supporting \$231 Million in Health District Expenses - 2010



Statewide

In total, Health expended \$528.8 million throughout 13 programs in fiscal 2010. The following table summarizes Health’s original and adjusted budgets and actual expenses for fiscal 2010. Six of the 13 programs account for 88 percent of Health’s total expenses.

Analysis of Budget to Actual Expenses by Program
(Dollars in Thousands)

Program	Original Budget	Adjusted Budget	Actual Expenses
Community Health Services	\$243,533	\$230,158	\$213,492
State Health Services	120,059	109,299	97,072
Communicable and Chronic Disease Prevention and Control	50,876	54,068	53,488
Emergency Preparedness	34,958	44,830	41,888
Emergency Medical Services	36,848	36,422	31,752
Drinking Water Improvement	30,175	41,729	30,910
Financial Assistance to Community Human Services Organization	16,332	14,644	14,642
Administrative and Support Services	15,549	16,674	12,780
Health Research/Planning/Coordination	13,051	12,847	10,916
Medical Examiner and Anatomical Services	8,892	9,219	8,871
Environmental Health Hazards Control	7,779	8,259	7,009
Vital Records and Health Statistics	6,780	6,780	5,776
Higher Education Student Financial Assistance	2,008	779	232
Executive Budget Reductions	<u>(11,309)</u>	-	-
Total	<u>\$575,531</u>	<u>\$585,709</u>	<u>\$528,828</u>

Source: Original Budget: Appropriation Act Chapter 781, from the 2009 General Assembly session; Adjusted Budget and Actual Expenses: Commonwealth Accounting and Reporting System 1419D1 report as of June 30, 2010; Fiscal 2011 Proposed Budget: Appropriation Act Chapter 874, from the 2010 General Assembly session.

Health's expenses were \$46.7 million or 8.1 percent below its original budget. The entire variance is due to decreases in two programs, Community Health and State Health Services. The decrease in Community Health Services included more than \$5 million in budget reductions, a \$3 million transfer to the Emergency Preparedness program to support H1N1 activity, and a \$2.5 million transfer to support the agency's administrative and support services. The variance in actual expenses for State Health Services was also primarily due to Health's budget reduction strategies. Overall, State and Community Health Services expenses decreased by about five percent between fiscal 2009 and 2010.

Revenue

Health receives funding primarily from three sources: federal grants, the General Fund, and through the collection of special revenue. Health obtained about \$242 million in federal revenue, including about \$9.2 million in ARRA funding. Overall, federal revenue increased by more than \$23 million between fiscal 2009 and 2010. Health received \$149.3 million from the General Fund, and generated special revenue of about \$151.6 million in fiscal 2010, or a combined \$18.5 million less than in fiscal 2009. Like other agencies, Health relied on increased federal revenues to offset decreases in state funding and fee revenue to maintain service levels.

Of the \$151.6 million Health generated in special revenue, four revenue streams accounted for \$130.9 million (86 percent); locality reimbursement for health services, Department of Motor Vehicles and local court transfers, patient collections for health services, and non-medical permits, license, and fee revenue.

Analysis of Material Special Revenue Sources (Dollars in Thousands)

Revenue Type	Amount
Locality Reimbursement for Health Services	\$ 58,029
Department of Motor Vehicles Transfers	37,447
Patient Collections for Health Services	19,064
Non-medical Permits, Licenses, Fees, etc.	16,436
Vital Statistics Fees	10,229
Other Revenue (Fines, Penalties, Refunds, etc.)	5,712
Private Donations, Gifts, and Grants	<u>4,659</u>
Total	<u>\$151,576</u>

Source: 2010 Commonwealth Accounting and Reporting System Revenue Summary

Of the amounts listed above, Health does not provide direct services to citizens from the funds transferred from the Department of Motor Vehicles. The Department of Motor Vehicles transfers funds collected from the "4 for Life" vehicle registration and DUI reinstatement fees during the year for the following activities as required by the Code of Virginia.

- \$27 million to support, train, and provide grants to local rescue squads
- \$1.7 million to the Virginia State Police to support their Medical Flight Program
- \$6.8 million to award grants to qualifying trauma centers
- \$1.7 million to the General Fund as part of Health’s budget reduction strategy

Expenses

Health’s expenses consist primarily of payroll and related fringe benefit costs (\$232 million) for their roughly 3,600 employees throughout the Commonwealth, the non-payroll costs of administering its federal programs (\$172.9 million) such as benefit payments for WIC and the cost of providing HIV services, and transfers to support emergency medical services at the local level (\$28.7 million), as described above. These three expense categories constitute about 82 percent of Health’s total expenses.

Health administered 70 federal programs in fiscal 2010. Seven of the programs made up over 87 percent of the agency’s total federal expenses. Health expensed about \$9.4 million in ARRA funding, including about \$8.5 million from the Drinking Water State Revolving Fund to support drinking water improvement programs and about \$2.8 million in immunization funding to support vaccination programs. Health also received about \$2.6 million in ARRA-funded vaccines to support the state’s immunization program.

However, the large increase in federal expenses occurred in the Public Health Emergency Preparedness program, which includes \$32.7 million for H1N1 vaccines and a general increase of about \$15.7 million. We discuss the H1N1 vaccines in more detail at the beginning of this agency’s report section.

The following table entitled *Federal Program Expenses* provides expenses (federal only) for fiscal 2009 and 2010 for the seven largest federal programs managed by Health:

Federal Program Expenses
(Dollars in Thousands)

<u>Federal Program</u>	<u>2010</u>	<u>2009</u>
Special Supplemental Nutrition Program for Women, Infants, and Children	\$ 90,313	\$ 93,248
Public Health Emergency Preparedness	66,946	19,669
Immunization Grants	51,874	48,200
HIV Care Formula Grants	32,925	30,986
National Bioterrorism Hospital Preparedness Program	10,873	14,325
Maternal and Child Health Services Block Grant to the States	12,663	11,781
Capitalization Grants for Drinking Water State Revolving Funds	18,132	11,700
Other Federal Programs	<u>44,074</u>	<u>46,298</u>
Total Federal Expenses	<u>\$327,800</u>	<u>\$276,207</u>

Source: Department of Health 2009 and 2010 Schedule of Expenditures of Federal Awards

COMPREHENSIVE SERVICES FOR AT-RISK YOUTH AND FAMILIES **(OFFICE)**

Managing Services

The Office of Comprehensive Services for At-Risk Youth and Families (Office) administers the Comprehensive Services Act for At-Risk Youth and Families (Act), which provides services and funding to address the needs of emotionally and behaviorally disturbed youth and their families. The Office works to return at-risk youth back to their homes and schools through a collaborative effort of local government, private providers, and family members that address each child's and family's individual needs.

The State Executive Council (Council) oversees the Office, establishes interagency programmatic policy development and fiscal policies, identifies and establishes goals for comprehensive services, and advises the Governor on proposed policy changes. The Department of Education serves as the fiscal agent and has assigned one employee in its central office to process disbursements. The Office has thirteen employees that are all employees of the Department of Social Services.

Program delivery under the Act occurs through management of the cases at the local level and includes funding sources other than those disbursed through the Office. This report discusses other funding sources below in the section entitled, "Financial Information." The Office uses three teams to manage the collective efforts of state and local agencies.

State and Local Advisory Team

The State and Local Advisory Team makes recommendations to the Council on interagency programs and fiscal policies and advises the Council on the impacts of proposed policies, regulations, and guidelines. They also offer training and technical assistance to state agencies and localities.

Community Policy and Management Team

The Community Policy and Management Team (Community Team) serves as the community's liaison to the Office. The Community Team coordinates long-range, community-wide planning, which ensures the development of resources and services needed by children and families in the community. Its duty is to establish policies governing referrals and reviews of children and families to the Family Assessment and Planning Team. Each Community Team establishes and appoints one or more Family Assessment and Planning teams based on the needs of the community. The Community Team also authorizes and monitors the disbursement of funds for services recommended by the Family Assessment and Planning Team.

Family Assessment and Planning Team

The Family Assessment and Planning Team (Family Team) assesses the strengths and needs of troubled youth and families, and develops an individual family service plan to ensure appropriate services. The Family Team recommends services to the Community Team.

Comprehensive Services Act in Pittsylvania County

We performed a separate review of the Comprehensive Services Act program in Pittsylvania County at the request of the Office and the Virginia Department of Education. These entities performed an onsite review of the Pittsylvania County program at the request of the new Community Policy Management Board chair. This review brought to light significant issues that concerned the Office and Education, which were beyond their scope to review. Our review included 269 children who received CSA funded services during fiscal years 2008, 2009, and 2010. These services represented approximately \$19.3 million in state and local funding.

Our review found the inappropriate use of state funds and a significant lack of internal controls over the Comprehensive Services Act in Pittsylvania County. Specifically we found the following issues.

- Pittsylvania County may owe the Commonwealth \$7.7 million because they received reimbursement for ineligible students and services under the CSA program.
- Overall, Pittsylvania County does not have adequate policies, procedures, and controls over the CSA program. There is also a lack of communication and coordination between the School Board Office, the Community and Policy Management Board, and the CSA Coordinator.
- Pittsylvania County Schools and Pittsylvania County's Social Services Department do not have proper policies, procedures, and controls in place to properly contract with CSA service providers. They spent \$14.5 million and \$165,000, respectively, without written agreements with the service providers.
- Although Pittsylvania County's CSA expenses are inappropriate, the data reported to the Department of Education related to student counts for CSA are appropriate.
- The complexity of the CSA program increases the risk of misuse.

Many of the issues noted throughout this review have been ongoing in Pittsylvania County potentially since 2003 or earlier. The Office of Comprehensive Services did identify the issue in a 2004 analysis and discussed it with the County Schools. However, nothing changed at the County level because of this analysis and discussion. In 2004, the focus of the Office changed from providing both technical assistance and conducting compliance functions to that of focusing solely on technical assistance. As a result, the Office performed no other follow up with the County.

In 2009, the focus of the Office changed back to focusing on compliance and technical assistance. Since then, the Office has been working with Education to identify issues such as the improper funding of behavioral aides throughout the state. They have addressed these issues in

training provided to localities and through channels such as Superintendent memos. However, the Office failed to monitor locality specific expenditures and statistics. If the Office had performed some type of trend analysis or other analytical review, it would have become clear that there was a problem in Pittsylvania County.

The Office collects and publishes a wealth of data on CSA expenditures and services on their website. They collect data by locality, region, and statewide. By analyzing this data and investigating outliers, the Office could have potentially identified issues similar to this much earlier. The Office should develop monitoring procedures to review analytics and statistics regularly to look for sudden or gradual changes in a locality's standings.

In addition, as can be seen from the multiple eligibility requirements (eligibility vs. mandated vs. targeted), the statutes surrounding CSA funding and eligibility are very complex. The Office, in collaboration with Education, Social Services, and Medical Assistance Services, issues a CSA manual available on its website. The manual quotes the Code of Virginia with Education, Social Services, and Medical Assistance Services providing interpretation of the requirements on how to administer the CSA program in varying forms within the manual.

Local CPA firms audit compliance with the CSA program during the locality's annual financial audit through audit specifications developed by the Office and distributed by the Auditor of Public Accounts. However, the program is so complex that without specific training on the CSA program, auditors can easily miss inappropriate use of CSA funds similar to that found in Pittsylvania County.

We recommend that the Office, in collaboration with Education, Social Services, and Medical Assistance Services, provide background and guidance to the CPA firms with the audit specifications that will assist the CPA firms in understanding the program. In addition, during the annual update of the audit specifications, the Office should develop "hot topics" or "current issues" surrounding the program and service eligibility that the local CPA firms should be aware of during their audit work.

Financial Information

The Office receives funding from the Commonwealth's General Fund and federal grants. In fiscal year 2010, actual expenses increased only 0.2 percent from the prior year. The number of children receiving services decreased slightly from 17,644 in fiscal year 2009 to 17,568. The following table summarizes 2010 budget and actual activities, with analysis following.

Analysis of Budget and Funding Sources
(Dollars in Thousands)

<u>Funding Source</u>	<u>Original Budget</u>	<u>Adjusted Budget</u>	<u>Actual Expenses</u>
General Fund	\$315,841	\$242,316	\$215,570
Federal grants	53,573	9,420	9,420
 Total	 <u>\$369,414</u>	 <u>\$251,736</u>	 <u>\$224,990</u>

Source: Commonwealth Accounting and Reporting System

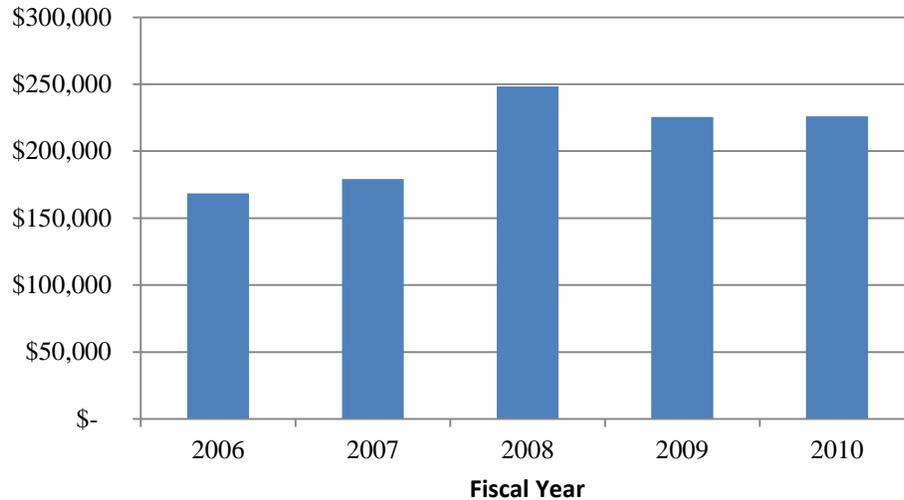
Although the Office started fiscal 2010 with a General Fund budget over \$100 million, or 46 percent, more than fiscal year 2009's actual expenses, the Office ended fiscal year 2010 with actual General Fund expenses of over \$100 million, or 46 percent less than its starting budget. The Office did not spend its entire original budget for the following reasons.

- \$33 million, as in prior years, was the transfer of a portion of the General Fund budget to the Department of Medical Assistance Services (Medical Assistance Services) that actually makes the payments for the Medicaid portion of the Act's costs.
- \$43 million were mandated budget reductions as part of the Office's reduction strategies.
- \$5 million were cuts to aid to localities that pass through the Office; to this extent, the localities had to pay for these services without receiving reimbursement.
- The remaining \$19 million in unused General Funding is attributable to two factors. The first is the fiscal stress local governments are experiencing which increases the desire to curb CSA program spending. The other factor is localities have increased use of community-based services instead of the more expensive and restrictive residential services as intended by the change in match rates discussed below.

The change in original to final budget for federal grants is the same as in prior years. The Office transferred about \$43 million of its federal budget to Medical Assistance Services for Medicaid provider claims.

To encourage localities to provide more community-based treatment, which is less expensive than institutional treatment, the General Assembly lowered the locality's match rate for these services in 2008. Conversely, the locality's match rates for congregate care services have increased. The result of the changes in these match rates have lowered total comprehensive services expenses over the past two years as seen in the chart below.

**Office of Comprehensive Services
Past 5 Years Expenses
(Dollars in Thousands)**



Sources: Commonwealth Accounting and Reporting System

DEPARTMENT OF REHABILITATIVE SERVICES (REHABILITATIVE SERVICES)

Services

Rehabilitative Services helps Virginians with physical, mental, and emotional disabilities become employable, self-supporting, and independent. Rehabilitative Services uses the definition of “disabled” found in the *Americans with Disabilities Act*, which defines a disability as a physical or mental impairment that substantially limits one or more of the major life activities of an individual. Rehabilitative Services provides the following services: Vocational Rehabilitation, Social Security Disability Determination Program, Community Rehabilitation Program, and Management and Administrative Support Services.

Financial Information

The table below summarizes Rehabilitative Services’ original and adjusted budget and actual expenses for fiscal 2010.

Analysis of Budgeted to Actual Expenses by Program

(Dollars in thousands)

<u>Program</u>	<u>Original Budget</u>	<u>Final Budget</u>	<u>Actual Expenses</u>
Rehabilitation Assistance Services	\$ 96,758	\$ 104,519	\$ 92,100
Continuing Income Assistance Services	40,197	52,123	43,692
Administrative and Support Services	<u>12,817</u>	<u>13,497</u>	<u>11,014</u>
Total	<u>\$149,772</u>	<u>\$170,139</u>	<u>\$146,806</u>

Source: Commonwealth Accounting and Reporting System 1419D1 report as of June 30, 2010.

During fiscal 2010, Rehabilitative Services' final budget increased across all of its programs. The majority of the increase resulted from additional federal awards through the ARRA funding totaling \$10.4 million as well as a substantial increase to the Disability Determination Program from the Social Security Administration totaling \$11.9 million.

The following table illustrates the type of expenses Rehabilitative Services made in fiscal 2010.

Analysis of Expenses by Type

(Dollars in Thousands)

	<u>Expenses</u>	<u>Percent</u>
Transfer payments	\$ 59,873	40.8%
Personal services	57,484	39.1%
Contractual services	20,238	13.8%
Continuous charges	5,555	3.8%
Equipment	1,970	1.3%
Supplies and materials	1,561	1.1%
Plant and improvements	<u>125</u>	<u>0.1%</u>
Total	<u>\$146,806</u>	<u>100.0%</u>

Source: Commonwealth Accounting and Reporting System

Rehabilitative Services makes transfer payments to a number of state and non-state entities such as Community Services Boards, Independent Living Facilities, and Colleges and Universities. Services and programs provided by these entities assist individuals with significant disabilities to maximize their education, independence, employment, and full inclusion into society.

Woodrow Wilson Rehabilitative Center (Center)

Services

The Center, which is a sub-agency of Rehabilitative Services, provides residential, outpatient, and community based medical rehabilitation services for individuals with functional limitations and physical disabilities through the Center's comprehensive rehabilitation facility.

Financial Information

Rehabilitative Services transferred approximately \$16.2 million to the Center during fiscal 2010 to help administer the Center's Vocational and Medical Service Programs. Transfers from Rehabilitative Services account for approximately 87 percent of the Center's total revenue. Revenues collected include Third Party Medical Reimbursements from insurers, such as Medicare and Medicaid. Other revenues include charges collected from private insurance carriers, private funds, and student financial aid assistance. In addition to the revenues received from Rehabilitative Services, the Center received approximately \$5.3 million in general funds and \$280,000 in federal funds during fiscal 2010.

Additionally, Rehabilitative Services also received \$7.9 million in bond proceeds for renovations to one of its facilities. Bonds from the Virginia Public Building Authority have been the major source of funding for this project.

The table below summarizes the Center's expenses by type in fiscal 2010.

	<u>Analysis of Expenses by Type</u>	
	(Dollars in Thousands)	
	<u>Expenses</u>	<u>Percent</u>
Personal services	\$17,814	58.0%
Contractual services	9,535	31.0%
Supplies and materials	1,799	5.9%
Continuous charges	1,113	3.6%
Equipment	433	1.4%
Transfer payments	34	0.1%
Property and improvements	<u>4</u>	<u>< 0.1%</u>
Total	<u>\$30,732</u>	<u>100.0%</u>

Source: Commonwealth and Reporting System

Personal services account for approximately 58 percent of the Center's expenses. Total personal service expenses decreased by approximately two percent between fiscal 2009 and 2010. These reductions are the direct result of budget reductions. Additionally, payments for contractual services, including over \$5.8 million to various construction contractors for maintenance of facilities, make up 31 percent of expenses.

DEPARTMENT FOR THE AGING (AGING)

Managing Services

Aging contracts with 25 Area Agencies on Aging (Area Agencies) to provide services to older Virginians. The Area Agencies, directly or through their contractors, provide a variety of services including delivered meals, congregate meals, transportation, homemaker services, personal care services, care coordination, volunteer programs, disease prevention and health promotion and information and assistance, a long-term care ombudsman, and other services that foster the independence and meet the care needs of older Virginians.

Of the Area Agencies, 14 are private nonprofit corporations, five are local government units, five consist of two or more local governments that exercise joint powers to create the Area Agency, and one is part of a Community Services Board. All Area Agencies must first submit to Aging an annual “area plan” of service provision. Once Aging approves the area plan, it signs a contract with the Area Agency, which receives funding in accordance with the approved plan.

The Older Americans Act requires Aging to allocate a portion of its federal funds to the Area Agencies based on a formula that weighs several factors related to the population of older Virginians in each locality. The U.S. Administration on Aging contracts with the U.S. Bureau of the Census once every ten years to perform a special tabulation of the weighted factors. The weighted factors are as follows.

Weighting of Factors for Allocating Federal Funding
Under the Older Americans Act

Population 60+	30%
Population 60+ in Rural Jurisdictions	10%
Population 60+ in Poverty	50%
Population 60+ Minority in Poverty	<u>10%</u>
Total Allocation	<u>100%</u>

The Bureau of the Census completed its special tabulation of the 2000 census in fiscal 2005. Aging began using the 2000 census statistics to allocate funds at the beginning of the federal fiscal year 2007. The new tabulation revealed a significant shift in the population demographics of older Virginians since the previous census. To “hold harmless” those Area Agencies that would have experienced funding shortfalls as a result of the census information, the 2006 budget added \$1.2 million into Aging’s base budget which Aging provides to the affected Area Agencies. The “hold harmless” provision remains a short-term solution. If the population demographic of older Virginians continues to shift in the future, the Area Agencies will face the same issue once the special tabulation of the 2010 census is complete.

Financial Information

The table below shows an analysis of Aging's budgeted and actual expenses as well as the proposed budget for fiscal 2010. The only significant change from the original budget is an additional appropriation for ARRA funding. The final expenses were below the budgeted amount because the agency did not spend the entire ARRA award during fiscal year 2010; however, the agency does have until September of 2010 to spend the remaining funds.

Analysis of Budgeted and Actual Expenses by Funding Source (Dollars in Thousands)

	<u>Original Budget</u>	<u>Adjusted Budget</u>	<u>Actual Expenses</u>	<u>Proposed Budget 2011</u>
Federal	\$31,627	\$36,301	\$35,979	\$34,327
General	18,523	17,572	17,572	16,920
Special	160	299	198	160
ARRA	-	<u>2,967</u>	<u>1,923</u>	-
Total	<u>\$50,310</u>	<u>\$57,139</u>	<u>\$55,672</u>	<u>\$51,407</u>

Source: Original budget-Appropriation Act Chapter 781, Adjusted Budget, and Actual Expenses – Commonwealth Accounting, and Reporting System 1419D1 report as of June 30, 2010.

The table below shows an analysis of expenses by program and funding source. The majority of ARRA appropriation went to the Nutritional Services program which explains the increase from the original to the final budget and the difference between the final budget and actual expenses.

Analysis of Budgeted and Actual Expenses by Program Funding Source (Dollars in Thousands)

<u>Program</u>	<u>Original Budget</u>	<u>Final Budget</u>	<u>Actual Expenses</u>	<u>General Fund</u>	<u>Special Revenues</u>	<u>Federal Grants</u>	<u>ARRA</u>
Individual Care Services	\$30,395	\$31,981	\$31,611	\$11,649	\$198	\$19,307	\$ 457
Nutritional Services	17,212	22,278	21,273	4,783	-	15,024	1,466
Administrative and Support Services	3,050	2,879	2,788	1,140	-	1,648	-
Executive Management	<u>(348)</u>	-	-	-	-	-	-
Total	<u>\$50,309</u>	<u>\$57,138</u>	<u>\$55,672</u>	<u>\$17,572</u>	<u>\$198</u>	<u>\$35,979</u>	<u>\$1,923</u>

Source: Original budget-Appropriation Act Chapter 874; Final Budget and Actual Expenses – Commonwealth Accounting and Reporting System

As depicted in the next table, 94 percent of Aging’s total expenses are transfer payments for grants to Area Agencies and other contractors and service providers. For fiscal 2010, Aging had the following operating expenses:

Expenses by Type
(Dollars in Thousands)

<u>Type of Expenses</u>	<u>2010</u>	<u>Percent</u>
Transfer payments	\$52,526	94%
Personal services	1,950	4%
Contractual services	973	2%
Continuous charges	180	<1%
Supplies and materials	23	<1%
Equipment	<u>18</u>	<u><1%</u>
Total	<u>\$55,670</u>	<u>100%</u>

Source: Commonwealth Accounting and Reporting System

DEPARTMENT FOR THE BLIND AND VISION IMPAIRED (BLIND AND VISION IMPAIRED)

Services

Blind and Vision Impaired enables blind, deaf-blind, and visually impaired individuals to achieve their maximum level of employment, education, and personal independence. Blind and Vision Impaired provides vocational training and placement services, daily living skills instruction, orientation and mobility services, counseling, Braille, and training in the use of various types of adaptive equipment. Blind and Vision Impaired works cooperatively with the Department of Education and the public school systems to assist in the education of blind, deaf-blind, or visually impaired students. Blind and Vision Impaired provides these services and devices through a variety of entities such as Vocational Rehabilitation, Rehabilitation Teaching and Independent Living, Educational Services, Virginia Industries for the Blind, the Library and Resource Center, Randolph Sheppard Vending Program, and Virginia Rehabilitation Center for the Blind and Vision Impaired.

Financial Information

The following table summarizes Blind and Vision Impaired total expenses for fiscal 2010. As indicated in the table below, Blind and Vision Impaired spends approximately 47 percent of its funds on supplies and materials. These expenses are mostly for merchandise and manufacturing supplies used in the enterprise division, Virginia Industries for the Blind.

Analysis of Expenses by Type

(Dollars in Thousands)

	<u>Expenses</u>	<u>Percent</u>
Supplies and materials	\$21,374	46.9%
Personal services	12,356	27.1%
Transfer payments	4,204	9.2%
Contractual Services	3,244	7.1%
Continuous charges	2,071	4.5%
Plant and Improvements	1,676	3.7%
Equipment	639	1.4%
Property and Improvements	<u>4</u>	<u><0.1%</u>
Total	<u>\$45,568</u>	<u>100.0%</u>

Source: Commonwealth Accounting and Reporting System

Virginia Rehabilitation Center For The Blind And Vision Impaired (Blind And Vision Impaired Center)

Services

The Blind and Vision Impaired Center is a sub-agency of Blind and Vision Impaired that provides comprehensive services to severely visually impaired Virginians. The Blind and Vision Impaired Center provides a program of evaluation, adjustment, and prevocational training, which enables students to learn skills necessary for greater independence and efficiency and safety on the job, at home, and in social settings.

The Blind and Vision Impaired Center provides specialized training and evaluation in computer technology, Braille technology, and customer service representative training. The Blind and Vision Impaired Center has cooperative programs with other community agencies to meet the needs of the students in evaluation and training. A 40-bed dormitory is available to students who are receiving services at the Blind and Vision Impaired Center, with several rooms adapted to accommodate individuals with physical limitations.

Financial Information

Personal services and contractual services made up approximately 90 percent of all expenses during fiscal 2010. Personal services expenses increased by about \$120 thousand while contractual services decreased by \$281 thousand. Plant and improvement expenses decreased from \$1.2 million in 2009 to \$0 in 2010 due to the Center's completion of a new Dormitory in 2009.

The table below summarizes the Blind and Vision Impaired Center's expenses for fiscal 2010.

Analysis of Expenses by Type
(Dollars in Thousands)

	Expenses	Percent
Personal services	1,516	73.3%
Contractual services	336	16.3%
Continuous charges	159	7.7%
Supplies and materials	56	2.7%
Equipment	3	0.1%
Total	2,070	100.0%

Source: Commonwealth Accounting and Reporting System

VIRGINIA INDUSTRIES FOR THE BLIND (INDUSTRIES)

Services

Industries works in conjunction with the Division for Services at Blind and Vision Impaired and the Virginia Rehabilitation Center for the Blind and Vision Impaired to provide employment, training, and other vocational services to blind individuals across the Commonwealth. Services provided by Industries include vocational evaluation, work adjustment, on-the-job training, skill enhancement, and cross training, placement counseling, and a summer work program.

Industries' is a self-supporting division that manufactures and sells items to military bases and government offices. Currently, Industries has manufacturing locations in Charlottesville and Richmond and sixteen satellite operations across Virginia, including 11 self-service and base supply stores that serve military and other federal employees. Products manufactured by Industries include gloves, mattresses, writing instruments, mop heads and handles, and physical fitness uniforms. Industries also operates a full service mail handling service.

DEPARTMENT OF HEALTH PROFESSIONS (HEALTH PROFESSIONS)

Managing Services

Health Professions provides administrative services, coordination, and staff support to the following regulatory boards.

Audiology and Speech Pathology	Optometry
Counseling	Pharmacy
Dentistry	Physical Therapy
Funeral Directors and Embalmers	Psychology
Long-term Care Administrators	Social Work
Medicine	Veterinary Medicine
Nursing	

The Board of Health Professions (Board) supervises the staff of the agency. The Board consists of one member from each of the 13 health regulatory boards above and five citizen members. The Board recommends policy and reviews budget matters and monitors agency activities whereas each of the regulatory boards adopts standards to evaluate the competency of their respective professions and then certifies compliance with those standards. For all boards, the Governor appoints their members, who may serve up to two four-year terms.

Systems Security

On April 30, 2009, Health Professions experienced a cyber attack on their Prescription Monitoring Program (PMP). Although the attack caused significant disruption to the agency’s operations, it does not appear that there was any data lost and, as far as the agency is aware, no individual whose information was in the PMP database suffered a loss as a result of the system breach. Since the attack, Northrop Grumman has redesigned the program’s infrastructure and has relocated operations to the Commonwealth Enterprise Solution Center (CESC) in Chester. Agency staff have upgraded the program software to provide 24/7 access to the system’s registered users and to provide greater security. The attack remains under active investigation by the Federal Bureau of Investigation and the Virginia State Police.

Financial Information

Health Professions uses a dedicated special revenue fund to account for the daily operations of the agency. The largest source of revenue comes from licensing application and renewal fees. The following table summarizes Health Professions’ budgeted expenses compared with actual results for fiscal 2010.

Analysis of Budgeted and Actual Expenses by Program and Funding Source
(Dollars in Thousands)

<u>Service Area</u>	<u>Original Budget</u>	<u>Final Budget</u>	<u>Actual Expenses</u>
Regulation of Professions and Occupations	\$27,316	\$27,316	\$24,603
Higher Education Student Financial Assistance	<u>65</u>	<u>95</u>	<u>84</u>
Total	<u>\$27,381</u>	<u>\$27,411</u>	<u>\$24,687</u>

Source: Original budget-Appropriation Act Chapter 781, Adjusted Budget, and Actual Expenses – Commonwealth Accounting and Reporting System 1419D1 report as of June 30, 2010.

DEPARTMENT FOR THE DEAF AND HARD-OF-HEARING (DEAF AND HARD-OF-HEARING)

Services

Deaf and Hard-of-Hearing works to reduce communication barriers between individuals who are deaf or hard-of-hearing, their families, and the professionals who serve them. All of Deaf and Hard of Hearing’s programs deal with communication, both as a service (through interpreters, technology, and other modes) and as a means of sharing information for public awareness (through training and education). Deaf and Hard of Hearing provides services through the following programs: Relay Services; Interpreter Services Coordination; Quality Assurance Screening; Technology Assistance Program; and Outreach, Information, and Referral. Deaf and Hard of Hearing receives’ special revenue funds from the State Corporation Commission from earmarked tax collections.

Financial Information

The table below summarizes Deaf of Hard of Hearing’s expenses for fiscal 2010. Contractual services make up approximately 91 percent of Deaf of Hard of Hearing’s fiscal 2010 expenses. Sprint and AT&T receive approximately ninety five percent of contractual services payments for the Relay Center in Norton. The Relay Center provides telecommunication relay services for the deaf and hearing-impaired population across the Commonwealth. Deaf and Hard of Hearing serves as the oversight agency for the operation of the telecommunications relay services in the state.

Analysis of Expenses by Type
(Dollars in Thousands)

	<u>Expenses</u>	<u>Percent</u>
Contractual services	\$10,525	91.0%
Personal services	692	6.0%
Equipment	227	2.0%
Continuous charges	117	1.0%
Supplies and materials	<u>5</u>	<u><0.1%</u>
Total	<u>\$11,566</u>	<u>100.0%</u>

Source: Commonwealth Accounting and Reporting System

VIRGINIA BOARD FOR PEOPLE WITH DISABILITIES (BOARD)

Services

The Board serves as the Developmental Disabilities Planning Council for addressing the needs of people with developmental disabilities as established under the federal *Developmental Disabilities Assistance and Bill of Rights Act* and the State’s *Virginians with Disabilities Act*. The Board advises the Secretary of Health and Human Resources and the Governor on issues related to people with disabilities in Virginia. The Board’s total expenses for fiscal 2010 were \$1.5 million.

Financial Information

The Board receives the majority of its funding through State General Funds and federal grants. In addition, the Board also receives periodic donations through the Youth Leadership Forum.

Expenses of the Board consist mainly of personal services and transfer payments to run the boards programs including, but not limited to the Partners in Policy Making Program, Youth Leadership Forum, Disability Policy Fellowship, and Developmental Disabilities Competitive Grant Program.

The table below summarizes the Board's expenses for fiscal 2010.

	<u>Expenses</u>	<u>Percent</u>
Personal services	\$ 812	53.1%
Contractual services	323	21.1%
Transfer payments	204	13.4%
Continuous charges	145	9.5%
Equipment	26	1.7%
Supplies and materials	<u>19</u>	<u>1.3%</u>
Total	<u>\$1,529</u>	<u>100.0%</u>

Source: Commonwealth Accounting and Reporting System



Commonwealth of Virginia

Walter J. Kucharski, Auditor

Auditor of Public Accounts
P.O. Box 1295
Richmond, Virginia 23218

December 14, 2010

The Honorable Robert F. McDonnell
Governor of Virginia

The Honorable Charles J. Colgan
Chairman, Joint Legislative Audit
and Review Commission

We have audited the financial records and operations of the **Agencies of the Secretary of Health and Human Resources**, as defined in the Audit Scope and Methodology section below, for the year ended June 30, 2010. We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Audit Objectives

Our audit's primary objective was to evaluate the accuracy of the Agencies of the Secretary of Health and Human Resources financial transactions as reported in the Comprehensive Annual Financial Report for the Commonwealth of Virginia for the year ended June 30, 2010 and test compliance for the Statewide Single Audit. In support of this objective, for those agencies with significant cycles, as listed below, we evaluated the accuracy of recording financial transactions on the Commonwealth Accounting and Reporting System, their accounting systems, and other financial information they reported to the Department of Accounts, reviewed the adequacy of their internal control, tested for compliance with applicable laws, regulations, contracts, and grant agreements, and reviewed corrective actions of audit findings from prior year reports.

Audit Scope and Methodology

Management of the Agencies of the Secretary of Health and Human Resources have responsibility for establishing and maintaining internal control and complying with applicable laws and regulations. Internal control is a process designed to provide reasonable, but not absolute, assurance regarding the reliability of financial reporting, effectiveness and efficiency of operations, and compliance with applicable laws and regulations.

We gained an understanding of the overall internal controls, both automated and manual, sufficient to plan the audit. We considered significance and risk in determining the nature and extent of our audit procedures. Our review encompassed controls over the following significant cycles, classes of transactions, account balances, and systems.

Department of Medical Assistance Services

Medicaid revenues, expenses, and compliance	Contract management
Accounts receivable	System access controls
Accounts payable	Unitization units
Adjusting journal entries	

Department of Social Services

Federal revenues, expenses, and compliance for:	Budgeting and cost allocation
Temporary Assistance for Needy Families (TANF)	Network security and system access
Child Care and Development Block Grant	Payroll expenses
Child Support Enforcement	Monitoring of Local Social Services
Adoptions Assistance	Oracle financial system
Community Services Block Grant	Adjusting journal entries
	Contract Administration

Department of Behavioral Health and Developmental Services

Federal revenues, expenses, and compliance for:	Monitoring of Community Service Boards
Early Intervention Services	Payroll expenses
Accounts receivable	Institutional revenues
Adjusting journal entries	Network security
Energy contracts	Financial Management System

Department of Health

Federal revenues, expenses, and compliance for:	Cooperative agreements between Health and local government, which includes:
Special Supplement Nutrition Program for Women, Infants, Children (WIC)	Aid to local governments
Immunization Cluster	Allocation of costs
HIV Care Formula Grants	Reimbursement from local governments
Support for local rescue squads	Payroll expenses
Collection of fees for services	Network security
	Financial and Accounting system

Comprehensive Services for At Risk Youth and Families

Administrative controls at the
Department of Education

Revenues and expenses

Department of Rehabilitative Services

Payroll expenses and controls
Financial and case management
controls
Information system security controls

Federal revenue, expenses, and compliance for:
Vocational Rehabilitation including
ARRA
Social Services Disability Determination

Our Office, for certain business processes, which are listed below in alphabetical order, has or is planning to issue statewide reports that cover these topics from the perspective of the entire Commonwealth. To view these reports or request electronic copies as they come available go to: www.apa.virginia.gov.

Administrative Processing
Internal Auditors
Performance Measures

Cell Phone Usage
Network Security
Transparency

The Department of Rehabilitative Services was audited for the years ended June 30, 2009, and June 30, 2010.

At the request of the Department of Medical Assistance Services' management, we completed penetration testing of its information systems in fiscal year 2010. Given the sensitive nature of these results, they are not included in this report; however, detailed results were provided to management in a separate report.

Our audit did not include the Department of Aging, which we will audit and report on our results under a separate report. Audits and reports for the Department of Rehabilitative Services includes analytical reviews of the activities of six agencies it provides administrative services for, which are: Woodrow Wilson Rehabilitation Center, Department for the Blind and Vision Impaired, Virginia Industries for the Blind, Virginia Rehabilitation Center for the Blind and Vision Impaired, the Department for the Deaf and Hard-of-Hearing, and the Virginia Board for People with Disabilities. Additionally, Comprehensive Services for At Risk Youth and Families receives administrative services from the Department of Education, which were audited and reported on under a separate report.

We performed audit tests to determine whether the Agencies' controls were adequate, had been placed in operation, and were being followed. Our audit also included tests of compliance with provisions of applicable laws and regulations. Our audit procedures included inquiries of appropriate personnel, inspection of documents, records, contracts, reconciliations, board minutes, and the Code of Virginia, and observation of the Agencies' operations. We tested transactions and performed analytical procedures, including budgetary and trend analyses. Where applicable, we compared an agency's policies to best practices and Commonwealth standards.

Conclusions

We found that the Agencies of the Secretary of Health and Human Resources properly stated, in all material respects, the amounts recorded and reported in the Commonwealth Accounting and Reporting System and in other financial information reported to the Department of Accounts for inclusion in the Comprehensive Annual Financial Report for the Commonwealth of Virginia. The Agencies record their financial transactions on the cash basis of accounting, which is a comprehensive basis of accounting other than accounting principles generally accepted in the United States of America. The financial information presented in this report came directly from the Commonwealth Accounting and Reporting System or from the Agencies.

We noted certain matters involving internal control, compliance with applicable laws and regulations, and agency operations that require management's attention. These matters are described in the section entitled "Recommendations". The internal control and compliance matters that require corrective action are individually entitled "Obtain Valid Social Security Numbers", "Establish Enforcement Mechanisms for Foster Care and Adoption Payments", "Develop Monitoring Procedures to Review Locality Statistics", "Improve Guidance and Background Provided to CPA Firms", "Improve Payment Transparency", "Properly Manage Energy Contracts and Debt", "Accurately Report Energy Contracts to the Commonwealth's Controller", "Remove Terminated Employees Timely from Payroll", "Coordinate Independent Peer Reviews", "Improve Timeliness of Eligibility Determination", "Continue Improving System Access", "Promptly Remove Terminated Employees from Critical Systems", "Improve System Application Controls", "Improve and Comply with Information Security Program", "Improve Information System Security Program", "Improve Information Security Program", "Continue Improving IT Continuity of Operations and Disaster Recovery Plans – Follow-up", "Finalize Responsibilities for Infrastructure Security", "Manage Infrastructure Security Risk", and "Improve Information Security Awareness Training". The operational matters that management needs to evaluate are individually entitled: "Use System Functionalities to Improve Payroll Processing", "Use System Capabilities to Ensure Proper Service Delivery", and "Use System Functionalities to Improve Financial Operations".

The Agencies have taken adequate corrective action with respect to audit findings reported in the prior year that are not repeated in this report as summarized in the section *Resolved Recommendations from Prior Year*.

Exit Conference and Report Distribution

We discussed this report with management at the Agencies of the Secretary of Health and Human Resources as we completed our work on each agency. Management's responses have been included at the end of this report. We did not audit management's responses and, accordingly, we express no opinion on them.

This report is intended for the information and use of the Governor and General Assembly, management, and the citizens of the Commonwealth of Virginia and is a public record.


AUDITOR OF PUBLIC ACCOUNTS

GDS/clj



COMMONWEALTH of VIRGINIA
Department of Medical Assistance Services

GREGG A. PANE, MD, MPA
DIRECTOR

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800/343-0634 (TDD)
www.dmas.virginia.gov

January 7, 2011

Mr. Walter J. Kucharski
The Auditor of Public Accounts
P. O. Box 1295
Richmond, Virginia 23218

Dear Mr. Kucharski:

We have reviewed your Report on Audit for the Fiscal Year Ended June 30, 2010. We concur with your findings and will initiate corrective action as indicated below.

Obtain Valid Social Security Numbers

DMAS accepts and understands its role as the responsible state agency for the Virginia Medicaid program. We will work with the Department of Social Services to develop a corrective action plan to address the timely resolution of unverified SSNs. We envision the establishment of a joint DMAS/DSS work group consisting of DSS, localities, DMAS staff and other subject matter experts. We will work with State DSS to develop an education and training plan to obtain Valid SSN's and to ensure compliance with data already resident in the MMIS system. A review of Valid SSN's in Adapt and ultimately in MMIS is also recommended to be included as part of a Medicaid Eligibility Quality Control (MEQC) pilot. To the extent systems changes are required to fully comply with SSN validation efforts, DMAS will work closely with DSS to support changes needed between the two systems. We found that this type of joint work group has improved the DSS compliance rate when applied to other errors in the past and therefore, expect positive results. However, in spite of our good faith and diligent efforts DMAS has no authority to enforce or sanction locally-operated DSS offices.

Responsible Persons: Steve Ford, Director, Policy and Research Division; Tom Edicola, Director, Program Operations Division

Estimated Implementation Date: 06/30/2011. This date is tentative and will be extended if there are any system changes needed by either DMAS or DSS. It would be

difficult to project a date for full implementation before assembling the joint workgroup to determine scope of effort on both sides and next steps.

Improve Payment Transparency

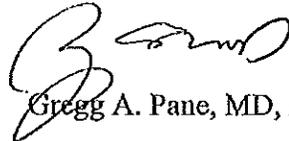
We concur with your observation of the Department's processing of vendor payments. To address the transparency issue, the Department will publish the details of these administrative payments on the DMAS website. This information is readily available and can be provided to the APA and DOA to publish on their respective websites as well. Although publishing the required information on said websites is not the optimal solution, DMAS believes that it addresses the transparency issue cited because the information would be readily available to the public and would be referenced between websites. It is the agency's intent to provide information sufficient to address the need for transparency and accessibility of agency expenditures to the public. In addition, the Department will explore the feasibility and cost effectiveness of system changes needed to provide details of administrative payments in CARS.

Responsible Person: Karen Stephenson, Controller, Fiscal and Purchases Division

Expected Implementation Date: 03/31/11

If you have any questions, please do not hesitate to contact our Director of Internal Audit, Paul Kirtz.

Sincerely,



Gregg A. Pane, MD, MPA



COMMONWEALTH of VIRGINIA

DEPARTMENT OF SOCIAL SERVICES

Office of the Commissioner

Martin D. Brown
COMMISSIONER

January 7, 2011

Mr. Walter J. Kucharski
Auditor of Public Accounts
P.O. Box 1295
Richmond, VA 23218

Dear Mr. Kucharski:

We have reviewed your Report on Audit for the year ended June 30, 2010. We concur with your findings and have initiated corrective actions.

Please contact J. R. Simpson, Chief Financial Officer, if additional information is required or desired.

Sincerely,

A handwritten signature in black ink that reads "Martin D. Brown".

Martin D. Brown

MDB/jrs

cc: VDSS Leadership Team



COMMONWEALTH of VIRGINIA

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

Post Office Box 1797
Richmond, Virginia 23218-1797

JAMES W. STEWART, III
COMMISSIONER

Telephone (804) 786-3921
VOICE/TDD (804) 371-8977
www.dbhds.virginia.gov

January 6, 2011

Mr. Walt Kucharski
Auditor of Public Accounts
101 North 14th Street
Monroe Office Building
Richmond, Virginia 23219

Dear Mr. Kucharski:

Presented below are the responses to audit findings attributable to the annual audit of the Department of Behavioral Health and Developmental Services.

Properly Manage Energy Contracts and Debt

DBHDS concurs with the finding. Our approach will be to recoup the interest savings associated with the prepayment.

Responsible Party: Southwestern Virginia Training Center Chief Financial Officer

Implementation Date: Immediately

Accurately Report Energy Contract Debt to the Commonwealth's Comptroller

Although three of five submissions from our facilities did contain errors, the effect of these errors was not material to the Comprehensive Annual Financial Report (CAFR) of the Commonwealth of Virginia for the fiscal year ended June 30, 2010. In total the errors from these three submissions amounted to what would have been an overstatement of \$543,000 to the Commonwealth's installment purchase liability of over \$215 million. This is not a material difference.

We do accept the spirit of the recommendation and will work to improve the process as part of the fiscal year 2011 year end close and financial reporting cycle.

Responsible Party: Facility Chief Financial Officers

Implementation Date: June 30, 2011 as applied to the fiscal year end close

Remove Terminated Employees from the Payroll

This finding involved a total of eight exceptions at Central State and Eastern State Hospitals. Resolution of this issue will continue to be a part of the performance standards of the Facility Directors at each of these facilities.

Responsible Party: CSH and ESH Facility Directors

Implementation Date: Immediately

Coordinate Independent Peer Reviews

In response to this concern DBHDS requested clarification from the US DHHS Substance Abuse and Mental Health Services Administration, Center for Mental Health Services (the MH Block Grant administering authority at the Federal level). Their response to DBHDS is presented below.

“ The MHBG Program does not hold states accountable for meeting the requirement for “peer review” which is mentioned in the BG statute. The MHBG program regards the State’s total quality improvement/management program as the state’s effort to address peer review and the QA/QM Program is reviewed during the time of the State’s on site monitoring visit.”

As a result of the above interpretation from the Federal regulatory authority, DBHDS considers itself to be in compliance with the peer review requirements outlined by Federal authority. DBHDS performs field site reviews of the MH Block Grant as part of its overall Federal sub-recipient monitoring program.

Use System Functionalities to Improve Payroll Processing

DBHDS has already made the commitment to implement the KRONOS system at all facilities. All preparations have been made including training of staff and appropriate payment to KRONOS for services delivered to date. We have established a test environment at the Petersburg site and testing is underway at the 5 new KRONOS sites. Training to staff and application testing at all sites is underway. Despite this progress, we continue to wait for a hardware quote. We are told that as of January 5, 2011 the issue has been moved to NG contracting to be processed. Final processing must occur at VITA and this is not expected until at least January 13, 2011.

Although DBHDS concurs with the recommendation, no estimated time frame can be offered at this time due to the problems associated with VITA/NG and its delivery of the hardware quote noted above. The DBHDS Commissioner and all staff involved are doing everything possible to move this process along appropriately.

Properly Remove Terminated Employees from Critical Systems

This issue relates to access to our AVATAR system. The Central Office AVATAR Coordinator must be informed by the Facility AVATAR Coordinator when access is to be terminated. In the case of the six individuals not terminated timely proper notification did not occur.

DBHDS concurs that facilities need to review their processes for deleting access, specifically with regard to informing Central Office Information Technology Services of terminated employees who no longer need access to AVATAR.

Responsible Party: Facility AVATAR Coordinators

Implementation Date: Immediately

Continue Improvement of Continuity of Operations and Disaster Recovery Plans

DBHDS concurs and the process is ongoing.

Manage Infrastructure Security Risk

DBHDS concurs. This is an issue completely in the hands of VITA. We will make every effort to ensure that they report any potential risk to us.

Responsible Party: VITA/NG Partnership

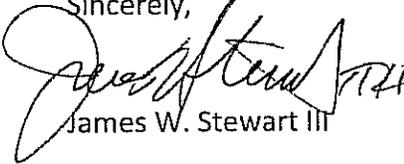
Implementation Date: Immediately

Improve Information Security Awareness Training

Procedures and controls to ensure that security awareness training is completed currently exist in our system. At Central Virginia Training Center, however, 182 of 1,171 employees did not either document receipt of or receive security awareness training. DBHDS will make this a performance standard of the Facility Director.

Responsible Party: CVTC Facility Director

Implementation Date: Immediately

Sincerely,

James W. Stewart III

pc: Joy Yeh
Ken Gunn
Sanford Hostetter
John Willinger
Jim Martinez



COMMONWEALTH of VIRGINIA

Karen Remley, MD, MBA, FAAP
State Health Commissioner

Department of Health
P O BOX 2448
RICHMOND, VA 23218

TTY 7-1-1 OR
1-800-828-1120

January 5, 2011

The Auditor of Public Accounts
P.O. Box 1295
Richmond, Virginia 23218

Dear Sir:

We are providing this letter in response to your report on audit of the financial records of the Virginia Department of health for the fiscal year ended June 30, 2009.

We confirm that we have reviewed the findings, conclusions and recommendations and have prepared a response and corrective action plan which is attached.

Sincerely,

A handwritten signature in blue ink, appearing to read "Karen Remley".

Karen Remley, M.D., M.B.A., FAAP
State Health Commissioner

CC: Department of Accounts



COMMONWEALTH of VIRGINIA

James A. Rothrock
COMMISSIONER

Department Of Rehabilitative Services

8004 FRANKLIN FARMS DRIVE
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EMAIL: drs@drs.virginia.gov

December 10, 2010

Mr. Walter J. Kucharski
Auditor of Public Accounts
James Monroe Building
101 N. 14th Street
Richmond, Virginia 23219

Dear Mr. Kucharski:

The Agencies Serving Virginians with Disabilities appreciates the opportunity to respond to the findings and recommendations contained in your audit report of the Agencies' financial activities administered by the Department of Rehabilitative Services (DRS) for the fiscal year ended June 30, 2010.

Presented below are the responses to the internal control findings specific to the Department of Rehabilitative Services.

DRS's Response to: Improve Information System Security Program

The department concurs with this finding we are currently completing Business Impact Analysis and IT system Data Sensitivity Classification for each Division of the Disability Service Agencies. Our Risk Management plans will include a Business Impact Analysis, an IT System and Data Sensitivity Classification, a Sensitivity IT System Inventory and Definition, and a Risk Assessment. Contingency Planning documents will include the Continuity of Operations Plan and Disaster Recovery plan. We have documented and tested the manual processes necessary to recover our in-house fiscal system. Employees were notified in the BIA training and previously in the COOP training, that manual procedures must be documented and available in cases of emergencies and when systems are down. DRS is in the process of hiring staff to assist the ISO in performing compliance reviews, documentation of results and improved response to remediation of corrective actions.

DRS's Response to: Improve Timeliness of Eligibility Determination

In response to this audit finding, the Department will take actions to re-train VR counselors on the VR eligibility extension regulations and policy and how to properly document eligibility extensions in the AWARE client data base. Documentation of eligibility extensions will continue to be reviewed by the Department's VR Quality Assurance staff in their VR case audit reviews with notice given to counselors and their managers of non-compliance. DRS will institute procedures to notify VR counselors of pending expiration of the 60-day eligibility timeframe as a means of notifying counselors of the need for extension documentation if necessary, and conduct periodic reviews of compliance with this policy.

DRS's Response to: Improve System Application Controls

The department concurs with this finding therefore we will establish policies addressing, granting and removing access to CIPPS and MAAS to strengthen systems access. We utilize the information technology listing of separated employees to remove system access for separated employees. The instances of employees not being removed after separation were due to the staff person responsible for system security being reassigned to other duties. Additionally, we use the semi-annual CIPPS Access/Security listing to confirm system access for fiscal staff. The listing is then forwarded to Human Resources to confirm system access for leave coordinators.

Again, thank you for the opportunity to respond. Please contact me should you require further information.

Sincerely,



John W. Thaniel
DSA Chief Financial Officer

cc: James A. Rothrock, Commissioner, DRS
Raymond E. Hopkins, Commissioner, DBVI
Heidi L. Lawyer, Director, VBPD
Ronald L. Lanier, Director, VDDHH
David A. Von Moll, Comptroller, DOA

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as of June 30, 2010

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Alan G. Saunders, Chief Operating Officer

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The Honorable John S. Edwards	Joseph Paxton
Michael Farley	Karen Remley, MD, MBA, FAAP
L. Michael Gilmore, Ph. D	Jim Stewart

Patricia I. Wright, Ed. D.

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DEPARTMENT FOR THE DEAF AND HARD-OF-HEARING

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