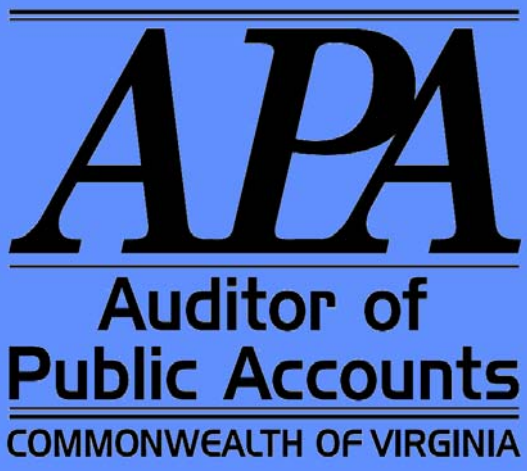
AGENCIES OF THE SECRETARY OF HEALTH AND HUMAN RESOURCES

JUNE 30, 2007



AUDIT SUMMARY

This report discusses the financial activities and performance of eleven agencies reporting to the Secretary of Health and Human Resources, which are:

- Departments of Medical Assistance Services (Medical Assistance Services)
- Department of Social Services (Social Services)
- Department of Health (Health)
- Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS)
- Departments of Rehabilitative Services (Rehabilitative Services)
- Woodrow Wilson Rehabilitation Center (Center)
- Department for the Deaf and Hard of Hearing (Deaf and Hard of Hearing)
- Department for the Blind and Vision Impaired (Blind and Vision Impaired)
- Virginia Board for People with Disabilities (Board)
- Department of Health Professions (Health Professions)
- Office of Comprehensive Services for At-Risk Youth and Families (Comprehensive Services)
- Department for the Aging (Aging)

The Secretary of Health and Human Resources oversees these agencies that provide services to Virginians with mental retardation, mental illness, substance abuse, and physical disability concerns; to low-income working families; and to the aging community. In addition, the agencies license health practitioners and ensure safe drinking water in the Commonwealth.

Approximately $1 billion or 22 percent of all Medicaid expenses support programs provided by Commonwealth agencies and institutions. Some agencies, such as DMHMRSAS, have over 30 percent of their total budget supported by Medicaid service payments. Medicaid is a program jointly funded by the federal government and the Commonwealth's General Fund. The loss or reduction of Medicaid funding would have a significant impact on many of the Commonwealth's programs.

Our audit for the year ended June 30, 2007, found:

- proper recording and reporting of transactions, in all material respects, in the Commonwealth Accounting and Reporting System and in each agency's accounting records;

- 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 "Internal Control and Compliance Findings and Recommendations" starting on page seven; and

- certain matters involving internal controls that require management's attention and corrective action; these are included in the section entitled "Internal Control and Compliance Findings and Recommendations" starting on page seven.

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MEDICAID

Medicaid is a health program for eligible low-income parents, children, seniors, and people with disabilities. The federal government and individual states jointly fund the Medicaid program at an approximate cost of $305 billion annually. Each individual state manages and administers its own program, in accordance with their statewide plan approved by the Federal government.

The Centers for Medicare and Medicaid Services (CMS) is the federal agency that oversees and monitors the state-run programs. CMS establishes minimum requirements for service delivery, quality, funding, and eligibility standards.

Each state must conform to these minimum guidelines in order to receive matching funds and grants from the federal government. The federal matching formula varies by state, depending on individual states' average per capita income. States with the highest average per capita income receive a federal match of 50 percent, while states with lower average per capita income receive a larger match. Virginia is one of 13 states with a 50 percent federal matching rate.

VIRGINIA'S MEDICAID PROGRAM

In fiscal 2007, the Commonwealth's total expenses were approximately $34.13 billion. Of that amount, Virginia's Medicaid program totaled $5.04 billion, or nearly 15 percent of total state expenses. The following schedule illustrates the portion of total state expenses that have gone to the Medicaid program since 2003.

	2003	2004	2005	2006	2007
Medicaid	3,643,148,864	3,895,466,765	4,394,414,236	4,772,677,271	5,042,199,846
Non-Medicaid	26,252,619,136	27,022,514,235	29,180,260,764	31,082,777,729	34,127,693,154
Medicaid	12%	13%	13%	13%	13%

As a percentage of total state expenses, Medicaid expenses have remained relatively constant over the past five years. This is largely a result of several cost containment strategies adopted by the state to control increases in Medicaid spending. Virginia's Medicaid expenses have increased by 38.4 percent in the last five years; this is inline with the national trends. According to CMS, national health care expenses increased by 35.3 percent over the most recent five-year period for which data is available (2001-2005).

As discussed in the previous section, Virginia's federal matching participation rate is 50 percent. That is, for every dollar the Commonwealth spends on allowable Medicaid expenses, the federal government reimburses the state 50 cents.

AGENCIES PROVIDING MEDICAID SERVICES

This section will detail the impact that Medicaid dollars have throughout Virginia government and its programs. The following table lists the relationships that Medical Assistance Services has with other state agencies and the services they provide.

Department of Medical Assistance Services' Relationship with Other State Agencies

Agency	Relationship
Department of Rehabilitative Services	• Eligibility Determinations for the Disabled
	• Medicaid Infrastructure Grant
Department of Social Services	• Eligibility Determinations for Medicaid (to include outstation employees) and SLH
	• Early and Periodic Screening, Diagnosis, and Treatment 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
	• Early and Periodic Screening, Diagnosis, and Treatment 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
	• Certificate of Public Need Approvals – Nursing Homes and Hospitals
	• Screening of Children for Lead Poison
	• Data Sharing
Attorney General's Office	• Medicaid Legal Representative
	• Medicaid Fraud 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
Department of Education	• School-Based Health Centers
	• Rehabilitative Services
	• Skilled Nursing Services
	• Psychological Services
	• Data Sharing
Department of Taxation	• DMAS uses the Tax Debt setoff on accounts that cannot be collected
JLARC	• Data Sharing
Department of Mental Health, Mental Retardation and Substance Abuse Services	• Inpatient and Community Mental Health and Mental Retardation Services
	• Nursing Home Pre-admission Screenings and Resident Reviews
	• Certification of Providers of Mental Health and Mental Retardation Case Management Services
	• Early Intervention Services for Infants and Toddlers

VCU and 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
Department of Health Professions	• Nurse Aide Certification
	• Licensure of providers
	• Investigation of Complaints (Quality of Care)
State Police	• Medicaid Drug Fraud
Virginia Employment Commission	• Access to Virginia Employment Case Management Files
Department of Accounts	• Financial Reporting
	• Compliance Audits
	• Official record of DMAS financial transactions
	• EDI – Travel Vouchers
Treasury Department	• Treasury Issues, DMAS checks, and wire transfers for vendors and providers
Department of Planning and Budget	• Oversee the agency's administrative and medical budget
Department for the Blind & Vision Impaired	• Eligibility Determinations
Office of Comprehensive Services	• Comprehensive Services Act
Library of Virginia	• Document Storage
Virginia Information Technology Agency	• Executive Summary for the VITA Transition
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

Medical Assistance Services is the state agency charged with the administration and management of the state's Medicaid program. All Medicaid funds flow through Medical Assistance Services. Medical Assistance Services uses Medicaid funds to reimburse service providers.

As stated previously, the Commonwealth's Medicaid expenses totaled $5.04 billion in fiscal 2007. Of this amount, Medical Assistance Services paid just over $1.2 billion in Medicaid funding to other state agencies and localities (Commonwealth entities) for the services they provide to individuals in the Medicaid program. The $1.2 billion represents 24 percent of Virginia's total Medicaid expenses and accordingly, the federal government reimbursed the state for about $600 million (50 percent) of that amount. Several of the internal entities in the tables below rely heavily on this Medicaid funding stream (both state and federal funding) to provide services.

The following table lists the Commonwealth entities that Medical Assistance Services pays Medicaid funding to for the services they provide to Medicaid clients.

Internal Medicaid Payments for Services

Entity	Services	Entity Provided Match	Funding from the Department of Medical Assistance Services	Total Medicaid Funding	Total Available Funding for Services	Medicaid Funding as a Percent of Total Funding for Services
DMHMRSAS	Inpatient Care, Facilities and Other	$ 27,530,014	$ 240,307,767	$ 252,307,767	$ 556,137,478	45%
Community Service Boards	Community Care Residential	-	274,172,085	274,172,085	783,348,814	35%
Comprehensive Services	Psychiatric Treatments and Utilization Management Reviews	46,805,143	46,805,143	93,610,286	316,164,675	30%
University of Virginia Health System	Patient Care	-	190,077,245	190,077,245	882,400,985	22%
VCU Medical Center	Patient Care	-	247,956,798	247,956,798	1,230,558,294	20%
Social Services, State & Local	Outreach and Eligibility Determination and Other	62,357,790	62,357,790	124,715,580	629,647,855	20%
Local School Divisions	Student Care	14,594,894	14,594,894	29,189,788	541,575,468	5%
Virginia Commonwealth University	Research	458,661	458,661	917,322	18,000,000	5%
Department of Health	Various Services, Including Outpatient Care	3,092,186	3,279,201	6,371,387	220,959,335	3%
Department of Rehabilitative Services	Eligibility Determination	987,373	987,373	1,974,746	90,755,900	2%
Woodrow Wilson Rehabilitation Hospital	Rehabilitation	-	371,476	371,476	19,903,732	2%
Department for the Aging	Medicaid Ombudsman Program	166,148	166,148	332,296	30,806,751	1%
Department of Health Professions	Nurse Aide Training and Certification Program	-	211,840	211,840	23,092,461	1%
Total		$ 155,992,209	$ 1,081,746,421	$ 1,222,208,616	$ 5,343,351,748	23%

In February 2006, the Deficit Reduction Act of 2005 became law. This legislation affected many aspects of domestic entitlement programs, including Medicare and Medicaid. The Deficit Reduction Act and other developments at the federal level aim to reduce the federal portion of costs for the entitlement programs. As the federal government tightens spending on these programs, the burden to fund these programs will shift back to individual states.

The movement to decrease costs at the federal level is forcing states to consider the impact of Medicaid spending at the individual state level. If the federal government were to cut Medicaid funding, the Commonwealth would either need to increase its contribution to the Medicaid program to maintain current levels of services, or reduce funding. The following entities rely heavily on Medicaid funding.

DMHMRSAS received about $240.3 million in Medicaid funding from Medical Assistance Services in fiscal 2007. DMHMRSAS matched funds to receive $27.5 million of those funds. The combined total of $252.3 million in Medicaid funding represents 45 percent of DMHMRSAS' total funding for services. DMHMRSAS uses Medicaid funds to provide in-patient mental health and mental retardation services at their facilities statewide.

Community Service Boards (Boards), which provide community care for mentally ill individuals and persons with disabilities, received about $783.3 million in funding in fiscal 2007. Medical Assistance Services provided about $274 million (35 percent) of the Boards' funding from the Medicaid program. Without Medicaid, the Boards would lose more than a third of their total funding stream.

Comprehensive Services transferred approximately $46.7 of its General Fund monies to Medical Assistance Services in fiscal year 2007. Medical Assistance Services, through the Medicaid program, uses the funds to match an equal amount from the federal government. The total amount, $93.4 million, was paid to private services providers for residential psychiatric treatments for foster care children that qualify for the Medicaid program. This funding arrangement allows Comprehensive Services to double 17 percent of its budgeted funding to obtain an approximately $316 million in total available funding for services.

Social Services (state and local) provided a match of about $62.4 million in fiscal 2007 to receive a one-for-one match in Medicaid funds from Medical Assistance Services. In total, Social Services received total Medicaid funding of $124.7 million to provide outreach and determine Medicaid eligibility for potential clients. Eligibility determination is an administrative cost for Social Services, and Medicaid dollars represents 20 percent of the funding for state and local Social Services' total administrative expenses ($629 million).

For the services they provide to individuals in the Medicaid program and indigent patients, the University of Virginia (UVA) Health System and the Virginia Commonwealth University (VCU) Medical Center received $190.0 million and $247.9 million in Medicaid funding respectively in fiscal year 2007. Medicaid funds represent 22 percent of the UVA Health System's, and 20 percent of the VCU Medical Center's, total revenues in fiscal 2007.

In addition to those agencies that provide services to clients, there are agencies that provide services to Medical Assistance Services. The ten agencies in the following table provide services to Medical Assistance Services, and Medical Assistance Services pays these agencies with Medicaid funds.

Entity	Services	Entity Provided Match	Funding from the Department of Medical Assistance Services	Total Medicaid Funding	Total Available Funding for Services	Medicaid Funding as a Percent of Total Funding for Services
Office of the Attorney General	Legal Services	$ 769,979	$ 3,560,311	$ 4,330,290	$ 31,032,332	14%
Department of General Services	Building Rentals, State Cars, Etc.	-	109,119	109,119	4,860,800	2%
Library of Virginia	Building Rental, Agency Meetings	-	24,625	24,625	2,017,528	1%
Department of the Treasury	Insurance Payments	-	27,677	27,677	2,782,553	1%
Auditor of Public Accounts	Audit	-	101,119	101,119	10,449,250	1%
Department of Accounts	Fiscal and Payroll Services	12,148	12,823	24,971	4,623,166	1%
Virginia Information Technologies Agency	IT Services	-	1,273,867	1,273,867	322,194,387	-
Department of Human Resource Management	Workers Compensation, Training, Etc.	-	31,702	31,702	9,326,934	-
Correctional Enterprises	Office Supplies, Furniture, Etc.	-	70,794	70,794	47,340,707	-
Department of Employee Dispute Resolution	Legal Services	-	1,350	1,350	1,369,724	-
Total		$ 782,127	$ 5,213,387	$ 5,995,514	$435,997,381	1%

Of the ten entities listed, only one receives substantial amounts of Medicaid funding in relation to their overall funding level. The Office of the Attorney General receives $3.6 million and provides a match of $769,979 for total Medicaid funding of $4.3 million. This represents 14 percent of their total funding. The Office of Attorney General receives Medicaid funding because it is responsible for investigating and prosecuting clients or companies that commit Medicaid fraud.

The remaining entities on this list either receive an immaterial amount of Medicaid funds or an immaterial amount of funds as they relate to the entity's operations, and thus they should not be substantially impacted if Medicaid funding significantly decreases.

INTERNAL CONTROL AND COMPLIANCE FINDINGS AND RECOMMENDATIONS

Findings and recommendations are listed below by agency and fall into one or more of the following categories:

- First Year Finding – items brought to the attention of management during the course of this year's audit, and management has or is developing their plans for taking corrective actions;

- Repeat Finding - corrective actions taken by management because of their prior year audit findings did not adequately reduce risk to an acceptable level;

- Risk Alert - issues beyond the corrective action of management and require the action of either another agency, outside party, or the method by which the Commonwealth conducts its operations to address the risk; and

- Efficiency Finding – areas where management should consider altering the agency's operations to make better use of state resources.

Social Services

Improve System Access Controls – Repeat Finding

Social Services should improve their Systems Access Controls in order to minimize the risks related to not maintaining the confidentiality, integrity, and availability of their information. Social Services and local agencies hired 1,253 individuals during fiscal year 2007. We reviewed the access requests forms for 133 of these individuals and found that 26 (19.5 percent) did not have supervisory approval or have the employee's signature.

In response to prior years' findings related to termination of system access Social Services implemented the Security Access Management System (SAMS) in April of 2007 to aid in the management and removal of system access. Of the 238 employees that ended their employment with Social Services after SAMS' implementation, we selected 37 system terminations for testing and found eight (21.6 percent) were not removed within 7 days.

The implementation of SAMS may address Social Services' issues; however, in order for the system to work as intended, Social Services will need to educate their managers of the functionalities of SAMS and the important rule that they, along with SAMS, play in protecting critical data. Furthermore, Social Services should develop their own internal process for monitoring and evaluating their ability to protect the Commonwealth's data effectively.

Improve Notification and Timely Reduction of Benefits When Clients are Not Cooperating with Division of Child Support Enforcement (DCSE) - Repeat Finding

Federal regulations require Social Services to reduce or eliminate a recipient's benefits in a timely manner if the recipient fails to cooperate with the Division of Child Support Enforcement (DCSE). In two out of five TANF cases tested, we found that the case files lacked a referral from DCSE for non-cooperation.

If DCSE does not properly refer non-cooperating cases to the local social service office or if the local social service office does not document the referral and take action accordingly, Social Services cannot ensure compliance with federal regulations. By not complying with federal regulations, Social Services may face federal financial penalties.

Social Services should ensure that DCSE works with the local social service offices to develop a mutually agreed upon process for properly distributing notification of non-cooperation and for providing the management at local social services offices the information they need to monitor their case workers to ensure they are acting on these notifications in a timely manner.

Define Responsibilities for Monitoring Locality Operations – Repeat Finding

Social Services has made progress in strengthening their controls over the budgeting process. They improved controls in the Budget Request System and documented the division of responsibility between budget staff and program managers within the Central Office. There is still progress that needs to occur, which includes incorporating the roles and responsibilities of the Regional Offices into the budgeting documents created as a result of last year's finding.

Furthermore, Social Services needs to determine and document who has the responsibility of monitoring and evaluating the overall total budget of each locality. Currently, Social Services is uncertain if this total budget review occurs as part of their monthly budgetary meetings or as part of the Regional Offices' reviews of localities. In addition, no one is responsible for monitoring some of the expenses localities bill to the federal government through Social Services.

Without a clear and systematic process to monitor local agencies' budgets as a whole, Social Services cannot readily identify those localities that experience dramatic variances between their original budgets and actual expenses, especially when the variance occurs among several budget line items. The lack of the "whole picture" may also prevent Social Services from noticing if a locality has inadequate budget development procedures or if they are incorrectly requesting reimbursement from Social Services.

Social Services should continue the progress they are making by further refining the roles and responsibilities each party in Social Services plays in monitoring localities, which should include determining and documenting who has the responsibility for monitoring overall budgets and expenses of the localities. Monitoring the localities as a whole and comparing the localities to each other will help Social Services to further fulfill their subrecipient monitoring responsibilities.

Align Plan for Monitoring Local Social Service Offices with Best Practices - First Year Finding

Social Services has recognized that they do not have a coordinated, system-wide approach for meeting its responsibility for monitoring localities. The state, through Social Services, is liable to the federal government for any funds that local social services offices (localities) do not spend correctly. It is Social Services responsibility to mitigate this risk by monitoring the localities. Without a formal system-wide approach, Social Services cannot provide assurance that it is adequately monitoring localities, ensuring they are achieving program objectives, or complying with the requirements that restrict program funds.

Actively monitoring localities has not been a focus of Social Services. The development of their monitoring plan represents a change in the "tone at the top" and demonstrates management's recommitment to monitoring localities.

We reviewed Social Services' actions to strengthen their sub-recipient monitoring and compared these actions to recommended practices. We noted areas where Social Services could further refine their monitoring program.

Communication of Responsibilities

Social Services' plan will have each division develop its own program for fulfilling its responsibility for monitoring localities. Additionally, Social Services has assigned a manager in one division to coordinate and consolidate all the programs into a system-wide approach to overcome significant variability in how each division monitors sub-recipients. We believe the assigned coordinator lacks the necessary authority over the other divisions to hold them accountable when implementing the overall program.

Social Services' management should clearly articulate the sub-recipient monitoring coordinator's duties and responsibilities within the organization and this individual's ability to hold others accountable for not meeting the organization's objectives.

Communication with Localities

Social Services' plan does not address how Social Services will communicate to the localities the implementation of the sub-recipient monitoring and the process follow through when a locality has a problem. Whether it is Social Services needing to inform localities of their expectations or the localities having channels available to ask questions and gain clarification, communication is fundamental to the monitoring process.

Social Services' management should look for ways to improve their communication with localities as they work through their plans for sub-recipient monitoring. Effective communication between parties should limit the amount of misunderstandings and provide each party with information they need to perform their functions.

System-wide Risk-based Approach

There is no system-wide mechanism for identifying and reacting to changes in sub-recipients or programs, such as financial problems or funding reductions. Not having a system-wide mechanism that uses a risk-based approach may cause Social Services to fail to identify and react to changes at localities.

While Social Services plans for improving sub-recipient monitoring make mention of using a risk-based approach, we have not seen where management has completed a risk assessment. Without developing a plan using a risk-based approach to determine the programs or localities that have the highest level of risk, management can not be sure that they do not overlook an area of risk or that they are effectively focusing their resources to mitigate the risks in these areas.

In addition to using a risk-based approach to monitor localities on an ongoing basis, management should start using the risk-based approach as a tool for allocating resources during the implementation phase of their monitoring program. Furthermore, Social Services should develop a system-wide mechanism for monitoring sub-recipients that uses the risk-based approach to identify and react to changes in sub-recipients and programs.

Accountability for Deficiencies

Social Services' current plan does not address its need for establishing a consistent framework for holding localities accountable for deficiencies identified during monitoring. The framework should ensure

that Social Services is treating all localities that commit similar infractions equitably and consistently. In addition, the framework should cover imposing sanctions with regard to non-compliance as it relates to allowable costs, stewardship of funds, timeliness of annual audits, and other items, while minimizing the risk of loss by the Commonwealth.

We recommend that Social Services work to determine the types of sanctions to impose based upon the scope and severity of the deficiency. Social Services may consider imposing sanctions ranging from a warning letter to advising the localities to return improperly used funds or improve unachieved performance outcomes. We recommend Social Services make its staff and the localities aware of the policies and procedures for imposing sanctions that hold localities accountable for deficiencies. Furthermore, we recommend that Social Services apply these procedures consistently across all localities.

Establish Procedures for Controlling the Cash in the Child Support Enforcement Fund – First Year Finding

Social Services improperly transferred a total of approximately $28 million out of the Child Support Enforcement (CSE) Fund and as of June 30, 2007, still needed to recover $18 million. Over the course of four years, staff within the Fiscal Division (Fiscal) incorrectly allocated the amount of funds transferred from CSE to the federal fund. This was a result of staff using the wrong information from an internally prepared report to the Federal government. In December 2006, Fiscal found the error, discontinued the practice, and corrected their procedures. After discovering the first $16 million error, Fiscal recovered $8 million of the error in 2006, but because of lack of availability of federal funds needed to recover the remainder in fiscal year 2007.

However, Fiscal did not attempt to recover the remaining funds until the Department of Accounts raised questions. Fiscal did not institute recovery of these funds on their own, since their analysis and monitoring process failed to detect the omission.

Starting in the second quarter of fiscal year 2007, our auditors found Fiscal had begun making the same error, and during fiscal year 2007 and 2008, had again improperly transferred an amount totaling $12 million. We believe that Fiscal staff would have continued making these transfers, as management was not aware of these inaccuracies. Additionally, staff and managers did not question the accuracy of these transfers, even after they had to hold off for several weeks on making the transfers due to depleted cash sources.

There are clearly no internal controls in the Fiscal Division over these transfers, as staff with their managers lacked an understanding of the problem to bring it to the attention of management. Controls, such as reconciliations and manager oversight, in this area failed to operate. Management needs to determine if the staff and managers are capable of handling these responsibilities. Additionally, management needs to assess why these individuals failed to bring this problem to management's attention.

Systems Development Policies and Procedures Need Improvement and Updating – First Year Finding

To support its programs, Social Services maintains over 60 systems. These systems consist of internally developed, commercial off-the-shelf, and federally mandated and supplied systems. The systems operate in a diverse environment including mainframe applications and web-based systems.

In an effort to improve the information technology (IT) decision-making process, in 2001, Social Services implemented the Information Technology Investment Management methodology (ITIM). The ITIM methodology is a standard, repeatable process for prioritizing and monitoring IT initiatives. This methodology consists of the creation of various group structures and their means of communication. The

ITIM creates an investment board, steering committees, and expert panels. The Investment Board is the owner of the IT Investment Management process and is responsible for establishing, monitoring, and controlling strategic business priorities as supported by IT. The steering committees are responsible for representing the needs of their business or program area. Expert Panels support the needs of a specific Steering Committee.

Although the ITIM process is rigorous and ensures evaluation by all necessary levels within Social Services, there is no documented connection of the process to the Commonwealth's Project Management Standard. The standard categorizes projects into major and non-major based on dollar thresholds, criticality, and statewide applications and requires agencies to report both types to the Virginia Information Technologies Agency's Project Management Division (PMD). The ITIM process never specifically sites the need to comply with the standard or even the existence of the standard.

We recommend Social Services revise their policies to address the classification of a project as major or non-major per the Commonwealth Project Management Standard. The policies should also include when Social Services should direct a project to PMD for Commonwealth governance.

The Commonwealth Project Management Standard identifies the difference between maintenance and new systems activities. Although the Social Services ITIM handbook defines the differences, it does not provide guidance on what to do when operational maintenance or enhancement resulting from service requests evolve into development projects. As a result of this lack of definition, Social Services failed to report at least one recent project, ChildWINS, to PMD for approval and oversight. Social Services implemented ChildWINS in 1998. Enhancements and operational maintenance on this project never ceased and the end users never accepted the system in order to close the project. In 2005, Social Services decided to move ChildWINS to a web-based application; however, they continued to view this project as operational maintenance and did not implement appropriate Commonwealth governance as required for a major project.

Social Services should create a process to evaluate and determine when the ongoing operational costs outweigh the benefit of the system to help identify when it should replace the system altogether. Social Services should begin this process as soon as they implement new systems. The process should include determining an estimated useful life of the system and continue at regular intervals so that Social Services plans systems replacements well into the future. This process would reduce the continued investment of IT resources into the maintenance of systems requiring replacement altogether.

In addition, the Virginia Information Technologies Agency (VITA) should examine the dollar threshold used to identify projects as major and non-major as well as the definition of a project outlined in the Commonwealth Project Management Standard. The current threshold gives agencies the ability to interpret the definition to meet their needs. The project thresholds and relating criteria are specified in the Code of Virginia and VITA should consider requesting modifications to the Code once they complete their examination of alternatives.

To support the ITIM process fully, each service request goes though a standardized process, which allows Social Services to track and monitor the requests. Service requests include recurring tasks or updates, ad hoc or emergency requests, operational maintenance or enhancements, or IT development projects. The ITIM Steering Committees use the information gathered by the service request process to evaluate IT initiatives, and build and maintain their IT investment portfolios.

The Division of Information Systems initially receives a service request and forwards it to the appropriate project manager and ITIM Steering Committee Chair. The information relating to the service request is entered into the service request tracking database which is escalated through various levels of

review and then finally to the related Steering Committee for evaluation. Work on a service request begins only after approval by the Steering Committee Chair.

Social Services implemented a new service request submission and tracking process in October 2007. This new process gathers the majority of the information that PMD requires for projects classified as major or non-major; however, the process never classifies a service request as such. Of the nearly two hundred service requests submitted in fiscal year 2007, only two resulted in projects reported to PMD and both of these projects requested general fund appropriations. As was the case with ChildWINS, we believe that the old service request process was not sufficient to correctly classify a service request as maintenance or as a project. The new process has many levels of review and the auditor believes if followed with rigor, Social Services will classify service requests correctly in the future

We recommend that Social Services follow their new service request process to ensure they properly identify new systems development projects and request approval and oversight from the Chief Information Officer and the Information Technology Investment Board as required by the Commonwealth's Project Management Standard.

Once a Steering Committee approves the service request, the related work follows the Software Development Lifecycle Methodology (SDLM) manual. The SDLM Manual establishes common development methodologies. These methodologies guide all service requests so that a common understanding and project management practices are applied to all requests.

The Social Services development policies include the majority of the elements required by the Commonwealth's standard. The standard requires, at a minimum, all major IT projects complete a project proposal, project charter, executive summary, performance plan, project schedule, budget plan, risk management plan, and quality management and Independent Verification and Validation plan (IV&V). Additional documents are required for more complex projects, including but limited to, a cost benefit analysis, communications plan, procurement plan, and user acceptance documents.

Social Services does not organize their information in the same manner as the standard, but overall, Social Services accumulates the same information. Social Services lifecycle methodology is in line with industry best practices, but certain information and documents essential for project success are not required or included in the Social Services policy. Examples of documents not included are the cost benefit analysis, complete budget information, and procurement guidance. In addition, the Social Services policies include templates but do not require the completion of the project charter or project proposal.

In addition, we selected service requests at various levels of development to review for adherence to internal policies and procedures. Not all required SLDM documents exist for the service requests selected; therefore, the auditor cannot conclude that Social Services consistently follows their internal development policies and procedures. However, Social Services provided reasonable explanations as to why certain required documents were not completed; therefore, the auditor believes that opportunities exist to update procedures to reflect current practices and align procedures with best practices.

We recommend that Social Services revise their policies to ensure that the policies include all documents essential for project success and are in-line with Commonwealth Project Management Standard. Further, we recommend they implement practices necessary to ensure their policies and procedures remain up-to-date so that project managers understand what they are expected to do.

Security Risk Assurance for Infrastructure – Risk Alert

Social Services has responsibility for the security and safeguarding of all of the Commonwealth's information technology systems and information it uses. Over the past four years, the Commonwealth has moved the information technology infrastructure supporting these systems and the information they contain to VITA, who has an Information Technology Partnership (IT Partnership) with Northrop Grumman. In this environment, VITA and Social Services clearly share responsibility for the security of the Commonwealth's information technology assets, systems, and information and must provide mutual assurance of its safeguarding.

Social Services has provided VITA with all the documentation required to make a security assessment, and VITA should provide assurance that the IT Partnership will practice proper policies and procedures as outlined by Social Services. The annual review and audit of the IT Partnership infrastructure has concluded, and VITA will communicate any findings and corrective action to Social Services.

The annual review and audit has identified that the IT Partnership staff did not have formal documented procedures for job monitoring of the Multiple Virtual Storage and Unisys environments, UNIX security administration, Windows server administration, network security, or environmental security. A documented and implemented system administration process is critical in order to minimize the security risks relating to the confidentiality, integrity, and availability of the Commonwealth's information stored on the IT Partnership's hardware and infrastructure for Social Services.

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

Medical Assistance Services

Improve Controls over Leases – Risk Alert and First Year Finding

Prior to fiscal year 2006, the Department of Accounts entered all agencies' lease information into Lease Accounting System (LAS). When LAS became web-based in 2006, each agency began entering and updating its own information in LAS. Although Accounts has not updated the Commonwealth's statewide policies and procedures for the newest version of LAS, the main LAS user at Medical Assistance Services has attended adequate LAS training and received resource materials from the Department of Accounts. A second LAS user went to LAS training in October 2007.

Medical Assistance Services' LAS users have not followed Accounts instructions, and Accounts did not review any of these submissions to determine if agencies were meeting the requirements. As a result, in some instances, Medical Assistance Services has recorded its leases inaccurately in LAS causing misstated lease commitments for disclosure in the Commonwealth's Comprehensive Annual Financial Report. We found the following issues with Medical Assistance Services' methods of recording lease information in LAS. We have found similar issues at other agencies since the transition.

- Medical Assistance Services recorded improper data for executory costs for eighteen copier leases in LAS.

- Medical Assistance Services did not terminate a lease in LAS for the Roanoke office that was ending as of August 2007.

- Medical Assistance Services did not enter a new lease in LAS for the new Roanoke office or notify the Department of Accounts of the new lease and applicable commitment.

Accounts should update statewide policies and procedures, and Medical Assistance Services should adopt and incorporate this guidance in its agency specific policies and procedures to cover all aspects of entering and modifying leases into LAS. Accounts should periodically review information in LAS to determine its accuracy and work with Medical Assistance Services to ensure agency personnel have an adequate understanding and can follow the standards and principles of lease accounting. Medical Assistance Services should ask for assistance from Accounts on any areas they do not fully understand. We also recommend that Medical Assistance Services correct all copier leases active in fiscal year 2007 and beyond, terminate the old Roanoke office lease, and enter the new Roanoke lease in LAS.

Department of Mental Health Mental Retardation and Substance Abuse Services (DMHMRSAS)

Improve Monitoring Program Over Community Services Boards – First Year Finding

The Community Service Boards (Boards) are DMHMRSAS' primary mechanism of delivering community services. DMHMRSAS contracts with the Boards to provide certain services within the community and the Boards in turn agree to meet certain performance standards.

A significant portion of the funding from DMHMRSAS to the Boards comes from the Federal government through the Prevention and Treatment of Substance Abuse Block Grant, Community Mental Health Services Block Grant, and patient care billings to Medicaid. DMHMRSAS has a fundamental responsibility to ensure the proper administration of federal awards and compliance with the contractual terms of the contract with the Boards. The statewide plans for these block grants incorporate the contractual performance standards between the Boards and DMHMRSAS.

Historically, DMHMRSAS has had a two-pronged approach to Board oversight. First, each Board must have an annual financial and compliance audit conducted by an independent certified public accountant. Secondly, the various divisions within DMHMRSAS, depending on available resources and other factors, have conducted on-site reviews.

Last year, our review of DMHMRSAS' oversight of the Boards found the approach fragmented and various divisions within DMHMRSAS doing work with the Boards were unaware of what the other divisions did. Further, we found the follow-up on audit findings and on-site reviews was inconsistent. We recommended DMHMRSAS document its various approaches to overseeing the Boards and adopt a risk based approach to doing oversight.

As a result of our recommendation, DMHMRSAS consolidated the documentation of its monitoring program. We reviewed management's documented procedures, compared these procedures to recommended practices, and noted the following areas where DMHMRSAS could further refine its monitoring program.

System-wide Risk-based Approach

Management's policies and procedures for Boards monitoring do not reflect the need to conduct a system-wide risk-based assessment identifying risk factors, in order to determine which Boards to review. Without a documented risk assessment and subsequent evaluation of risk factors, management cannot determine if they have overlooked a Board at risk or they are effectively focusing their resources to mitigate the risks at these Boards.

Management should start using a risk-based approach to monitor the Boards and as a tool for allocating resources to the various areas involved in their monitoring program.

Accountability for Deficiencies

Mental Health's practice does not hold Boards accountable for correcting audit findings. According to the Office of Community Contracting, audit findings in one year are part of the following year's Performance Contract as an item for requiring corrective action. However, of the contracts we tested, we found none of the prior year audit findings part of the contract.

We recommend that the Office of Community Contracting include the corrective action that the Boards need to take in their annual contracts between DMHMRSAS and the Boards. Including these expectations, in the contract would provide DMHMRSAS some assurance that the Boards understand their responsibility and allow it to impose possible sanctions in the future if a Board fails to take adequate corrective action.

On-site Reviews

Since last year Management has made the decision to cease routine financial reviews of the Boards, opting instead to have on-site reviews prompted by material exceptions noted in the audits performed by the independent auditor. Management made this decision without requiring their staff to complete an analysis of the work done by the independent auditor as compared to DMHMRSAS' on-site review teams. An analysis would determine the amount of risk that management would accept by not completing on-site reviews.

Without an analysis, management does not know if the scope of the independent auditor provides coverage over DMHMRSAS' programs when the Boards are part of the local government. Furthermore, the analysis of DMHMRSAS' on-site review should outline how their procedures complement the work of the independent auditor and are not duplicative of their work to ensure efficient use of state resources.

Ideally, financial reviews are a supplement to the annual audits and provide operational insight into the delivery of patient services. Without timely on-site reviews, DMHMRSAS does not have a mechanism to determine if the Boards are taking corrective action to address audit deficiencies or that operations are continuing to deteriorate, thereby, creating a liability for the Commonwealth in the future. For example, Region 10's independent auditor issued a disclaimer of opinion, which may result in the Commonwealth being liable for $1.7 million in question costs.

Management should require their staff to complete an analysis of their on-site financial reviews to determine the amount of risk the Commonwealth is accepting by only completing reviews at the Boards that have material exceptions noted by their independent auditors.

Properly Complete Employment Eligibility Verification Forms – First Year Finding

DMHMRSAS is not properly completing Employment Eligibility Verification forms (I-9) in accordance with guidance issued by the U.S. Citizenship and Immigration Services of the U.S. Department of Homeland Security in its Handbook for Employers (M-274). This guidance requires the employee complete, sign and date Section 1 of the I-9 on or before the first day of employment. Additionally, the employer or designated representative must complete, sign, and date Section 2 of the I-9 within three days of employment to show that they verified the employee's identity and employment eligibility at the point of hiring.

In our testing of 42 I-9 forms, we found that DMHMRSAS completed 31 of the forms correctly. In the remaining 11, we observed the following errors:

- five failed to have the employee sign the form by the first date of employment;
- five failed to document the first day of employment; and
- one failed to list the documents used to verify the employee's identity and employment eligibility.

We found that the errors were due to a lack of proper guidance and inadequate policy and procedures regarding the I-9 process at DMHMRSAS. Therefore, we recommend that the Human Resources Division train the human resource employees at the facilities and within the Central Office on the requirements of completing I-9s, and develop a process for continuously reviewing the Department's I-9 process. The federal government has stepped up its enforcement efforts related to hiring illegal immigrants, which makes having a good I-9 process in place more important than ever before.

Security Risk Assurance for Infrastructure – Repeat/Risk Alert

DMHMRSAS has responsibility for the security and safeguarding of all of its information technology systems and information. Over the past four years, the Commonwealth has moved the information technology infrastructure supporting these databases to the VITA, who has an Information Technology Partnership (IT Partnership) with Northrop Grumman. In this environment, VITA and DMHMRSAS clearly share responsibility for the security of DMHMRSAS' information technology assets, systems, and information and must provide mutual assurance of this safeguarding.

DMHMRSAS has provided VITA with all the documentation required to make this assessment and VITA should provide assurance that the IT Partnership will practice proper policies and procedures as outlined by the Department. The annual review and audit of the IT Partnership infrastructure has concluded and VITA will communicate any findings and corrective action to DMHMRSAS.

The annual review and audit has identified that the IT Partnership staff did not have formal, documented procedures for backup operations, operating system security, or for system security monitoring. Additionally, there was evidence of insufficient logical access controls for administrator accounts. A documented and implemented backup procedure, system security administration process, and system monitoring process is critical in order to minimize the security risks relating to the confidentiality, integrity, and availability of DMHMRSAS' information stored on the IT Partnership's hardware and infrastructure.

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

Improve Security Awareness Training Documentation – Repeat Finding

Employees typically acknowledge their responsibilities for maintaining the security of the IT systems and data by signing a form after completing their annual security awareness training. We requested the acknowledgement and IT security awareness training forms for 182 of the DMHMRSAS's employees and management could only provide signed forms for 69 (38 percent) individuals.

The signed acknowledgment form provides management some assurance that employees understand their responsibility, and allow them to take appropriate action when an employee fails to protect systems and data. We therefore recommend that management dedicate the necessary resources to ensure that new and existing employees acknowledge receipt, in a retrievable format, of the IT security awareness training and their responsibilities.

Improve Contingency and Disaster Recovery Planning – Repeat Finding

Agencies which provide critical services need to have plans on how to continue to operate on an interim basis should IT systems and support fail. We requested the plans for continuing operations for the critical functions of financial processing and pharmacy services from four of the DMHMRSAS's facilities. Three of the four facilities did not provide plans for continuing operations of pharmacy services, and we received no plans for financial operation.

Inadequate planning increases the risk that the DMHMRSAS will fail to provide services to its population successfully if they lose their mission critical IT systems. Developing procedures for maintaining interim operations will align the DMHMRSAS's contingency planning with the requirements of the Commonwealth's information security standards. Therefore, we recommend the DMHMRSAS develop and document procedures for maintaining operations in the absence of its mission critical IT systems.

Implement an Efficient Timekeeping System – Efficiency/First Year Finding

Between fiscal years 1999 and 2000, seven facilities with funding implemented an electronic timekeeping system. In the eight years since this implementation DMHMRSAS has not been able to secure the funds necessary to obtain an electronic timekeeping system for its remaining nine facilities.

The facilities without the electronic system have thousands of wage employees preparing paper timesheets, which then require manual review, compiling and extensive clerical work to properly pay these employees. While the new system will not reduce staff, it should at the least reduce the amount of time and effort that employees, supervisors, and payroll staff spend processing payroll and allow them to use this time elsewhere.

We recommend that DMHMRSAS develop a strategy for implementing an electronic timekeeping system at all facilities. The staff hours saved from operating an efficient system could provide services to clients or offset the of cost implementation.

Health

Update and Expand Security Awareness Training – First Year Finding

Health should update its Security Awareness Training and provide system users with regular updates to minimize the risks of not maintaining the confidentiality, integrity, and availability of information. Health operates a Security Awareness Training with outdated materials that do not address the risks of protecting

Health's data. Additionally, Health does not require users to receive regular refresher training to update their Security Awareness. Updates help ensure that users are aware of new policies, procedures, or risks to Health's information.

Health should evaluate and update the content of its Security Awareness Training and develop a process for providing system users with regular refreshers courses. Health should annually review the content of its Security Awareness Training to ensure it addresses any new risks.

Improve Contingency and Disaster Recovery Planning – First Year Finding

Health does not have adequate contingency and disaster recovery plans for some of its sensitive and mission critical applications. In our sample of seven of the eighteen mission critical applications identified by Health as very sensitive and mission critical, we found three systems with untested or no plans.

Inadequate analysis, planning, and testing of Health's contingency and disaster plans places the confidentiality, integrity, and availability of the Commonwealth's sensitive and mission critical information at risk. The Commonwealth's information security standards require that agencies develop business impact analysis, risk assessments, continuity of operations plans, and disaster recovery plans for sensitive and mission critical applications. Additionally, agencies must perform annual tests of these plans.

Health should apply the Commonwealth's information security standards consistently to all applications housing sensitive and mission critical information. Health should start this process by dedicating the necessary resources to review and remediate the risks to their sensitive and mission critical applications.

Properly Complete Employment Eligibility Verification Forms – First Year Finding

Health is not properly completing Employment Eligibility Verification forms (I-9) in accordance with guidance issued by the US Citizenship and Immigration Services of the US Department of Homeland Security in its Handbook for Employers (M-274). The guidance requires the employee complete, sign, and date Section 1 of the I-9 on or before the first day of employment. Additionally, employer or designated representative must complete, sign, and date Section 2 of the I-9 within three days of employment.

Furthermore, Section 2 contains spaces for the employer to lists the documents they verified from Lists A **or** B and C. For US Citizens, the employer must verify one document from List A. If no documentation from List A is available for the US Citizen, the employee must provide one document from List B and one from List C, which the employer verifies and records on the I-9. For foreign nationals authorized to work in the United States, the employer only needs to verify and list the employee's unexpired foreign passport and a current, unexpired INS authorization to work on the I-9.

In our sample of twenty I-9 forms completed in fiscal year 2007, we only found four I-9 forms correctly completed by Health. In the remaining sixteen, we observed deviations from the guidance issued by the federal government.

Based upon the number of errors and that our findings are similar to the results found and reported by Health's Internal Audit's review of Employment Verification Forms in fiscal year 2006, we considered this finding to be a significant internal control weakness over compliance.

We recommend that the Human Resources Division train human resource employees on the requirements of completing I-9s and then develop a process for continuously reviewing Health's I-9 process. The federal government has stepped up its enforcement efforts related to hiring illegal immigrants, which

makes having a good I-9 process in place more important than ever before. Furthermore, we recommend that Health be cautious in the amount of documents it requests from each employee because employers requesting more than the minimum amount of documentation from employees could be subject to fines and penalties, as the Department of Homeland Security considers it a form of harassment.

Security Risk Assurance for Infrastructure – Risk Alert/Repeat Finding

Health has responsibility for the security and safeguarding of all of the Department's information technology systems and information. Over the past four years, the Commonwealth has moved the information technology infrastructure supporting these databases to the VITA, who has an Information Technology Partnership (IT Partnership) with Northrop Grumman. In this environment, VITA and Health clearly share responsibility for the security of the Department's information technology assets, systems, and information and must provide mutual assurance of this safeguarding.

Health has provided VITA with all the documentation required to make this assessment and VITA should provide assurance that the IT Partnership will practice proper policies and procedures as outlined by Health. The annual review and audit of the IT Partnership infrastructure has concluded and VITA will communicate any findings and corrective action to Health.

The annual review and audit has identified that the IT Partnership staff did not have formal, documented procedures for security administration, backup operations, desktop support administration, change control, and system monitoring. A documented and implemented system administration process, change control process, and system monitoring process is critical in order to minimize the security risks relating to the confidentiality, integrity, and availability of Health's information stored on the IT Partnership's hardware and infrastructure.

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

Rehabilitative Services

Update and Expand Security Awareness Training – First Year Finding

Rehabilitative Services should update its Security Awareness Training and provide system users with regular training to minimize the risks of not maintaining the confidentiality, integrity, and availability of information. Rehabilitative Services operates a Security Awareness Training program that does not address the risks of protecting the Department's data. Additionally, Rehabilitative Services does not require users to receive regular refresher training to update their Security Awareness. Updates help ensure that users are aware of new policies, procedures, or risks to Rehabilitative Services' information.

Rehabilitative Services should evaluate and update the content of its Security Awareness Training and develop a process for providing system users with regular refreshers courses. Rehabilitative Services should annually review the content of its Security Awareness Training to ensure it addresses any new risks.

Improve Data Protection – First Year Finding

Rehabilitative Services exchanges data between two systems that does not adequately protect the data. Inadequate data protection of Rehabilitative Services' mission critical data places the confidentiality, integrity, and availability of the Commonwealth's information at risk. The Commonwealth's information security standards require that agencies encrypt data before the transmission of sensitive information in order to minimize the risk of compromising the sensitive data.

Rehabilitative Services should apply the Commonwealth's information security standards consistently to all applications housing sensitive and mission critical information. Rehabilitative Services should start this process by dedicating the necessary resources to review and remediate the risks to their sensitive and mission critical applications.

Limit CIPPS Access for Woodrow Wilson Rehabilitation Services Employees – First Year Finding

We found four employees, who do not have responsibility for processing payroll, having the ability to process payroll in the Commonwealth Integrated Payroll Personnel System (CIPPS). These employees work at the Woodrow Wilson Rehabilitation Center (Center). Rehabilitative Services now processes the Center's payroll, thus eliminating the need for these employees to have this access.

Permitting these employees to maintain this level of access allows for them to process and approve payroll outside of the normal course of operations. Rehabilitative Services and the Center should consider the necessity of this access. The Center should consider changing all employee access types to view only access.

Remove an Employee's Ability to Create and Approve Payroll Payments – First Year Finding

An employee at Rehabilitative Services has the ability to create and approve payroll payments. At Rehabilitative Services' recommendation, the Department of Accounts granted this employee two separate passkeys to the CIPPS. The combination of functions associated with these passkeys allows this employee to circumvent the controls designed into CIPPS.

Rehabilitative Services processes payroll for all six Disability Service Agencies. This employee has the ability to create and approve payroll payments for all six agencies. Rehabilitative Service's payroll staff averages between three and four employees and processes payroll for about 1,700 employees. Currently, Rehabilitative Services' policy of not allowing this individual to create and approve the payroll payments for the same agency is the only control limiting their functionality.

Rehabilitative Services and Accounts should consider the risk of allowing one employee both types of access, and should consider removing one of their access types.

Security Risk Assurance for Infrastructure – Risk Alert/Repeat Finding

Rehabilitative Services has responsibility for the security and safeguarding of all of their information technology systems and information. Over the past four years, the Commonwealth has moved the information technology infrastructure supporting these databases to VITA, who has an Information Technology Partnership (IT Partnership) with Northrop Grumman. In this environment, VITA and Rehabilitative Services clearly share responsibility for the security of Rehabilitative Services' information technology assets, systems, and information and must provide mutual assurance of this safeguarding.

Rehabilitative Services has provided VITA with all the documentation required to make this assessment and VITA should provide assurance that the IT Partnership will practice proper policies and procedures as outlined by Rehabilitative Services. The annual review and audit of the IT Partnership infrastructure has concluded, and VITA will communicate any findings and corrective action to Rehabilitative Services.

The annual review and audit has identified that the IT Partnership staff did not have formal, documented procedures for security administration, backup operations, change control, and system monitoring. Having these implemented is critical in minimizing the security risks relating to the confidentiality, integrity, and availability of Rehabilitative Services' information stored on the IT Partnership's hardware and infrastructure.

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

UPDATE ON PRIOR YEAR MANAGEMENT RECOMMENDATIONS AND RISK ALERTS

Complete and proper solutions to some prior findings may take time. Due to the size of the agency involved and/or the complexity of some of the issues highlighted in prior findings, we cannot reasonably expect some agencies to fully implement and evaluate their corrective action plan before the conclusion of this year's audit. In such instances, we followed up with the respective management of the agency; reviewed their revised policies, procedures, and other items related to the corrective actions taken; and evaluated their progress. From this review, we determined that management is making adequate progress through their corrective action plans.

Due to the long-term commitment required to implement, monitor, and evaluate management's corrective actions for these findings, we have provided updates on the progress that management is making below. We will continue to provide updates on these findings in future reports until management has had enough time to fully implement their corrective actions and have them evaluated for sustainability.

From our review of the prior findings listed below, we determined that management is making adequate progress through their corrective action plans or modifying their plans to react to changing situations properly.

Social Services and Medical Assistance Services

Evaluate the Adequacy of the Eligibility Determination Process-Risk Alert

Medical Assistance Services and Social Services are working together to increase the accuracy of the Medicaid eligibility determination process through a collaborative Eligibility Review Project (ERP). They have established, through an external review by an independent audit firm, an eligibility error rate based upon a statewide sample of Medicaid cases over a three-month period. Additionally, they established an eligibility analyst position and filled this position in May 2007. The eligibility analyst's primary responsibilities include providing oversight of case reviews and corrective action plans, acting as a liaison between the agencies, and serving as the contract monitor for the ERP.

Social Services developed corrective action plans to address the Medicaid eligibility determination errors identified during the external review. In addition, the agencies are working together to close the identified cases so that ineligible recipients stop receiving Medicaid coverage. Medical Assistance Services also developed training designed to target the root causes of the errors identified. After Social Services' employees complete this training, the agencies plan to conduct a second independent review in the second quarter of fiscal 2008. At the completion of the second review, the agencies will prepare another report summarizing their results, which management will use to evaluate their progress and develop future trainings.

From this review, we determined that management is making adequate progress through their corrective action plans.

Social Services

Establish Adequate Controls over the Payroll and Human Resources Functions

Social Services has revised their policies and procedures related to payroll and human resources functions for all areas indicated in the prior year finding. They have also been conducting training on Human Resource and Payroll processes for all of the various divisions.

Follow Established Policies over the SPCC Program

Social Services has revised the Small Purchase Charge Card (SPCC) policies and procedures to address the issues identified in the prior audit. They have also conducted training for all cardholders and the cardholder's supervisors. The Program Administrator is in the process of preparing a manual for all cardholders that includes the SPCC Policies and Procedures and all pertinent procurement documents. The Program Administrator is also generating monthly reports to review cardholder activity and ensure adherence to the procedures.

Improve Usage of IEVS and Case File Documentation

Social Services has emphasized to local agencies the importance of case record documentation and the need to respond the Income Eligibility Verification System (IEVS) matches. Social Services has also conducted training targeted to the specific weakness' identified in the prior audit. In addition, they are incorporating these issues in the development Social Services' overall strategy for sub-recipient monitoring.

Establish Control Mechanisms for Foster Care & Adoption Payments

Social Services has a long-term plan for establishing automated control mechanisms for Foster Care and Adoption Payments, which includes developing a new web based system. The current projected implementation date for the new system is October of 2009. In the interim before implementation of the new system, we recommended that management take steps to ensure that the local social service offices are verifying that only individuals determined eligible and in the current case management system are receiving foster care and adoption assistance payments. Additionally, we recommended that they require localities to investigate and report any discrepancies noted during their verification reviews.

During our review, we noted that Social Services now requires all localities to certify semi-annually that the individuals in the case management system agree to payments made for the applicable month. In addition, for the most recent certification Social Services requires localities to document any discrepancies they find. At this time, Social Services does not have any assurance that the localities have corrected these discrepancies. As a result, Social Services plans to change their process to require localities to certify to Social Services that they have corrected the discrepancies. Social Services also plans to implement a monitoring team, part of the team's responsibilities will be to review discrepancies and determine if localities are correcting their errors.

Maintain Local Employee Tracking System (LETS)

Social Services implemented a certification process in which they send a report of all employees in the Local Employee Tracking System (LETS) to each locality every month along with a report that shows individuals that have access to state systems and are not currently in LETS. The localities are then required to certify that all employees in LETS are active employees and correct any discrepancies identified.

The certification process has been sluggish to get going as the Central Office has had to educate the local employees on the importance of the process as well as train them on how to complete the certification process. In August and September with the creation of the LETS team there are now individuals dedicated solely to the maintenance of LETS. There is now a position dedicated to getting the certifications from the local agencies. Social Services is in the process of hiring an additional person to help with this responsibility.

Medical Assistance Services

Implementation of a System-wide Strategy for Utilization Units

As we reported in fiscal year 2006, Medical Assistance Services is adequately progressing through its plan for developing a system-wide strategy for its utilization units. Management is working with divisions to address issues through a combination of risk assessments, unit reorganizations, developing performance expectations, policy and procedure revisions, retraining of staff, outsourcing selective data mining and audit services, adding software to enhance claim edits, and improving relationship with the Medicaid Fraud Control Unit.

Efforts also include the evaluation of contractor results and the award of new contracts to conduct compliance audits for home health, home infusion services, pharmacy, durable medical equipment, and other services. Both Program Integrity and Long Term Care have increased the number of reviews completed, as well as recoveries since fiscal year 2005. Management also created a Program Integrity Workgroup, crossing over divisions, that meet regularly to review issues and make training recommendations.

Targeted for fiscal year 2009, Medical Assistance Services is planning to continue to monitor strategies, update provider agreements, and develop a database to include an agency-wide tracking system for recoveries, including fiscal settlements.

Address Findings in Internal Audit Report

Management is adequately addressing the findings in Medical Assistance Services Internal Audit report on the Operating Environment and Information Security Business Processes issued in May of 2006, improving their security documentation and strengthening certain security processes.

SECRETARY OF HEALTH AND HUMAN RESOURCES

Agencies in the Health and Human Resources secretariat are responsible for service delivery and management of responses to the most critical human resource issues that Virginians face. According to the 2007 Executive Budget document, the Secretariat's priorities are to promote self-sufficiency and independence, assure access to affordable quality health care, strengthen families, improve care and treatment for individuals who are mentally or physically impaired, increase awareness and accessibility of long-term care, and improve the quality of life for older Virginians. Additionally, the Secretariat's agencies ensure safety for citizens through inspection programs for food safety, environmental health, hospitals and nursing homes, as well as the oversight of certain health care professionals such as doctors, nurses, and counselors.

The following table details each agency in the Secretariat and its total 2007 expenses.

Agency	Expenses
Department of Medical Assistance Services	$ 5,336,830,388
Department of Social Services	1,650,616,090
Department of Mental Health, Mental Retardation and Substance Abuse Services	890,638,521
Department of Health	525,618,469
Department of Rehabilitative Services	136,318,333
Department for the Aging	47,471,487
Department for the Blind and Visually Impaired	35,324,810
Woodrow Wilson Rehabilitation Center	29,247,400
Department of Health Professions	21,132,077
Department for the Deaf and Hard-of-Hearing	5,892,414
Virginia Rehabilitation Center for the Blind and Visually Impaired	2,271,472
Virginia Board for People with Disabilities	1,945,427
Total Fiscal Year 2007 Expenses - Secretary of Health and Human Resources	$ 8,683,306,888

Source: 2007 CARS Expenditure Summaries

The secretariat's agencies had over $8.60 billion in expenses in fiscal year 2007. Of this amount, the Medicaid program accounted for about $5.04 billion or 58 percent of total expenses. The agencies listed above administer the programs that carry out the mission of the secretariat. These agencies accounted for about 25 percent of the Commonwealth's total expenses.

Social Services

Social Services administers over 40 programs that provide benefits and services to low-income families, children, and vulnerable adults. Both the state and local governments share in the administration of social service programs. Social Services is comprised of a Central Office, five regional offices, eight licensing offices, and 21 support enforcement offices. There are also 120 locally operated social service offices across the state, which report to the local governments, but receive direction and support from Social Services.

The Central Office has primary responsibility for the proper administration of all federal and state-supported social service programs. The Central Office establishes policies and procedures that ensure adherence to federal and state requirements, which local offices implement. Both Central Office and regional

offices enforce these policies and procedures by monitoring the local offices. The Central and regional offices often provide technical assistance to local offices and the regional offices serve as a liaison between the Central and local offices. In addition, the Central Office distributes benefits to eligible households and vendors under the Temporary Assistance for Needy Families (TANF), Food Stamp, and Energy Assistance programs.

Child Support Enforcement is a state-administrated and operated program. Child support offices process custodial parent information, help locate non-custodial parents, establish paternity, enforce both administrative and court orders, and collect and distribute child support monies.

Licensing offices regulate licensed child and adult care programs including the following programs: certified preschools, child day centers, family day homes, child placing agencies, and children's residential facilities. They also regulate adult day care centers and assisted living facilities.

In fiscal 2007, the Central, regional, child support, and licensing offices spent approximately $993 million (60 percent) of Social Services' total funding. This amount includes benefit assistance amounts paid directly to individuals.

Local social service offices deal directly with consumers. They perform a variety of functions including eligibility determination, case management, and "service" program administration such as Foster Care, Child/Adult Daycare, Adoption, and Child/Adult Protective Services. Local offices also provide information to consumers transitioning from dependency to independence. In fiscal 2007, Social Services paid over $657 million (40 percent) of its total funding to local social service offices.

Financial Information

Tables 1 and 2 summarize Social Services' budgeted revenues and expenses compared with actual results for the fiscal year ended June 30, 2007.

Analysis of Budgeted and Actual Funding by Funding Source

Table 1 - Financial Information
Analysis of Budgeted and Actual Funding by Funding Source

	Original Budget	Final Budget	Actual Funding
Federal	$ 754,035,600	$ 763,303,707	$ 633,669,813
Special	633,132,488	634,978,952	615,109,480
General	361,611,315	380,375,740	380,375,740
Total	$1,748,779,403	$1,778,658,399	$1,629,155,033

Source: Original budget - Appropriation Act Chapter 3, Adjusted Budget CAFR 1419D1 report as of 6/30/07, Actual Funding - CARS 402

Social Services' increased its original budget by about $29.9 million in fiscal year 2007. Despite the increase, Social Services' actual funding was about $119.6 million lower than its original funding. The differences between budgeted and actual funding for federal funds and special funds caused the overall difference. Social Services projected the base budget for the 2006 to 2008 biennium in fiscal year 2006; assuming revenue related to these activities would continue to increase. However, revenue did not continue to increase.

Although the Food Stamp Program is Social Services fourth largest source of federal funding, the amounts reported for this program do not include the Food Stamp benefits that recipients receive as direct benefits. The individual benefits are 100 percent federally funded and go directly from the federal government to the Commonwealth's electronic benefits transfer contractor, J.P. Morgan. During fiscal year 2007, J.P. Morgan disbursed approximately $544 million in Food Stamp benefits, which are not part of Social Services' revenues shown above or expenses shown below.

Analysis of Budgeted and Actual Expenses by Program

Table 2 - Analysis of Budgeted and Actual Expenses by Program

Program Name	Budget	Actual	Difference
Financial Assistance for Self-Sufficiency Program	$ 353,428,103	$ 310,102,119	$ (43,325,984)
Financial Assistance for Local Social Services Staff	319,931,909	283,907,201	(36,024,708)
Financial Assistance for Supplemental Assistance Services	62,276,784	50,600,868	(11,675,916)
Financial Assistance to Community Human Services	34,476,286	24,005,024	(10,471,262)
Child Support Enforcement Services	685,132,384	677,754,665	(7,377,719)
Program Management Services	37,914,385	30,793,862	(7,120,523)
Administrative and Support Services	70,740,836	66,825,433	(3,915,403)
Adult Programs and Services	44,360,491	40,680,818	(3,679,673)
Child Welfare Services	156,623,361	153,772,030	(2,851,331)
Regulation of Public Facilities	13,773,860	12,174,070	(1,599,790)
Total	$1,778,658,399	$1,650,616,090	$(128,042,309)

Source: CARS and FATS

Social Services' expenses exceeded their actual funding from revenues due to how the State Comptroller accounts for pass-through funds in the Commonwealth Accounting and Reporting System (CARS). Medical Services receives federal funds as part of its actual funding from revenues and then transfers the money to Social Services, which budgets and spends the funds. During fiscal 2007, Social Services received transfers in the amount of $65 million in federal funds for determining eligibility for the Medicaid and FAMIS programs.

Social Services' actual expenses were about $128 million less than budgeted. Four programs accounted for 83 percent ($106.3 million) of the variance.

Expenses in the Financial Assistance for Self-Sufficiency Programs were about $43.3 million less than budgeted. A decreased caseload in the TANF program resulted in benefit expenses $12 million less than appropriated. Employment services and childcare expenses for TANF were $11 million below their appropriation because of the decreased caseload as well. Additionally, federal funding for Non-VIEW Childcare declined and consequently, expenses were $16 million less than budgeted.

Social Services' Financial Assistance for Local Social Services Staff programs' expenses were about $36 million below budget. This decrease occurred because of changes in federal reimbursement policies. Due to the changes, the amounts of reported locality expenses reimbursable by federal funds were lower than originally projected and budgeted.

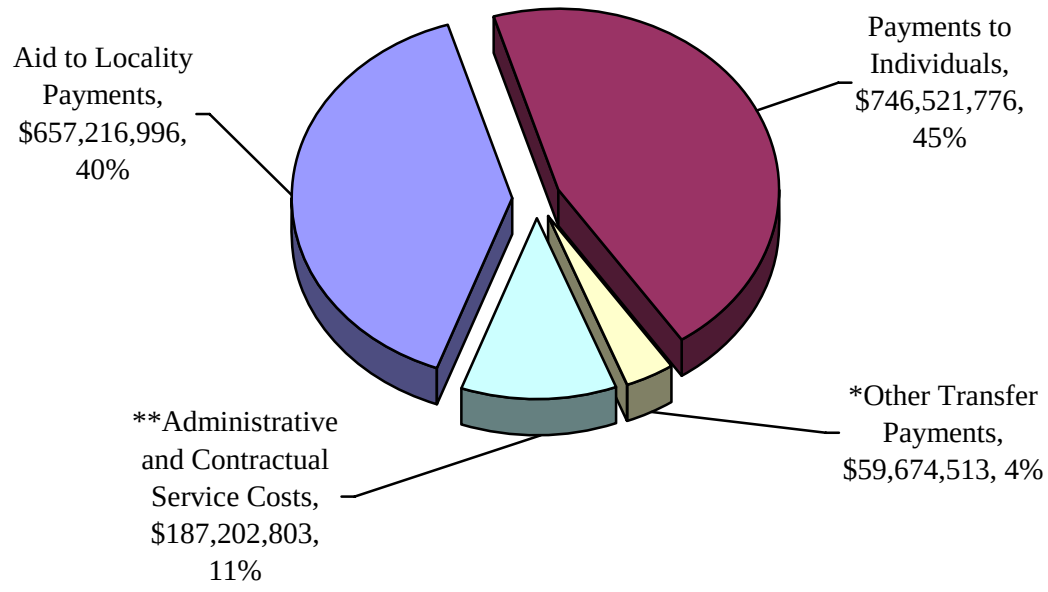
Actual expenses in the Financial Assistance for Supplemental Assistance Services program were about $11.7 million less than budgeted. Social Services received a supplemental federal award of $10 million

in fiscal 2007. Social Services requested an increased appropriation from Planning and Budget, which Planning and Budget granted. However, Social Services expended $6.8 million of this amount in a cash transfer to another state agency. Social Services did not need an appropriation for funds they would transfer to another agency; therefore, the budgeted appropriation is higher than actual expenses. A similar situation occurred in the Financial Assistance to Community Human Services program for $4.9 million. The remaining variance between budgeted and actual expenses resulted because the federal government kept funding for federal grants in this program level, when they had historically increased.

Social Services has the following sources of funding: 22 percent General Funds, 38 percent special revenue, which includes child support enforcement funds, and 40 percent federal grants. General Fund expenses include state matching dollars spent in order to receive federal funds.

The figure below summarizes Social Services' expenses by type for the fiscal year ended June 30, 2007.

Expenses by Type



*Includes payments to nongovernental and intergovernental organizations and community service agencies

**Includes payments for personal services, supplies, rent, equipment, property and improvements

Approximately 89 percent of Social Services' expenses are transfer payments to local governments, individuals, and other organizations. Payments to individuals, financial assistance for individuals and family and child support enforcement, comprise about 57 percent of Social Services' total transfer payments. In fiscal 2007, Social Services paid more than $657 million (approximately 40 percent of total expenses) to local social service agencies and $746 million (approximately 45 percent of total expenses) to individuals as direct benefits. Administrative and contractual service costs are 11 percent of total expenses. Social Services spent almost $96 million on personal service expenses and roughly $80 million on contractual services.

Table 4 summarizes the aid to locality payments by subprogram for the fiscal year ended June 30, 2007.

Aid to Locality Expenses by Subprogram

Benefit programs administration	$166,937,751
Direct social services	115,018,537
Day care (non-TANF)	78,667,885
Foster care	80,572,772
Financial assistance for child and youth services	61,679,843
Individual and family economic independence services through day care support (TANF)	53,229,160
Individual and family economic independence services through employment assistance services	58,683,481
Supplemental income assistance to the aged, blind, and disabled	22,941,430
Other	19,486,138
Total	$657,216,997

Source: CARS

Of the $657 million paid to the localities, 43 percent of the funds are for local social service agency benefits programs administration and direct social services. These programs include administrative and other allocable costs, pass-through funds, and locality contractual services. Foster care expenses include maintenance payments to foster care families, foster parent and staff training, and additional foster care administrative costs. Adoption incentive payments, special needs adoption expenses, and adoption-related contracts are included in Financial Assistance for Child and Youth Services subprogram. Other aid to locality expenses include: regional and area-wide assistance administration, general relief payments, resettlement assistance, emergency assistance, Comprehensive Services Act administration, financial assistance for employment services, non-public assistance child support payments, and other purchased services.

Table 5 summarizes the payments to individuals by subprogram for the fiscal year ended June 30, 2007.

Payments to Individuals by Subprogram

Nonpublic assistance child support payments	$589,216,201
Temporary Assistance for Needy Families (TANF)	105,522,293
Emergency assistance	39,912,880
Other	11,870,403
Total	$746,521,777

Source: CARS

Of the $746 million paid directly to individuals, approximately 79 percent is non-public assistance child support payments. These payments are to custodial parents from the child support special revenue fund. Once Social Services has collected the child support payment from the non-custodial parent, Social Services redistributes the money to the custodial parent.

TANF payments represent nearly 14 percent of Social Services' payments to individuals. These are cash payments made directly to eligible families to help meet basic monthly needs.

Emergency assistance payments account for just over five percent of Social Services' payments made to individuals. Historically, these payments have been limited to the Low Income Home Energy Assistance Program. Under the home energy assistance program, Social Services pays energy vendors and individuals directly. Other payments to individuals include expenses related to unemployed parent supplements and public assistance child support collections.

Follow-up to Prior Year's Special Review of Information Security in the Commonwealth of Virginia

Social Services has made measurable progress in response to the initial Senate Joint Resolution 51 study conducted during 2006. At the conclusion of that study, Social Services received a grade of "INADEQUATE." Since that time, Social Services has designated an Information Security Officer and placed the position high enough in the organization to be effective.

Social Services has enhanced their authentication process and now require authentication of all users without exception. They have enhanced the physical access security to the computer room and restricted access to only those personnel with an identified need and they are monitoring all of their systems to determine whether access is appropriate. In addition, Social Services has implemented a new Security Access Monitoring System (SAMS) to track user access. They should continue the rollout of SAMS to ensure that they will be fully compliant with the new Commonwealth Security Standard, which required compliance as of September 28, 2007.

Special Review of Systems Development

Social Services does not use the Commonwealth's system development standard but instead have developed their own policies and procedures that they believe provide adequate controls and include the essence of the standard. Therefore, the objective of this part of the audit was to assess Social Services over arching development methodology and compare it to the standard to ensure their methodology is adequate. In addition, our objective was to determine whether the components critical to successful development exist within the Social Services development methodology.

We are continuously monitoring systems development efforts and project management at Social Services, but our initial review covered the period July 2007 through October 2007. Our audit included reviewing documents submitted to the PMD, reviewing documents used to manage service requests, reviewing polices and procedures relating to systems development and information technology (IT) management, and interviewing personnel involved in the management and governance of IT projects. In addition, we reviewed service requests at various levels of development for compliance with internal policies and procedures.

As a result of our audit of Social Services' systems development methodology, we have noted areas for improvement and updating, and we have shared our recommendations with management. These recommendations are entitled Systems Development Policies and Procedures Need Improvement and Updating and can be found under Social Services in the section entitled "Internal Control and Compliance Findings and Recommendations".

Medical Assistance Services

Medical Assistance Services administers the Commonwealth's 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), the Indigent Health Care Trust Fund, Income Assistance for Regular Assisted Living, Involuntary Mental Commitments, the Virginia Health Care Trust Fund, and other medical assistance services such as HIV assistance and state and local hospitalization.

Medical Assistance Services provided services to over 1,000,000 persons during fiscal year 2007. General population growth in Virginia and especially the growth of the aging population are key factors affecting its customer base. Projections forecast that the number of Virginians age 65 and older will increase dramatically over the next ten years – over five times faster than the state's total population growth. An aging population within the state will place increased demands for services on Medicaid, especially in the areas of long-term care and waiver services. Access to medical care for uninsured children has been a priority of Medical Assistance Services.

Table 1 summarizes Medical Assistance Services' budgeted expenses by program as compared with actual results for the year ended June 30, 2007.

Analysis of Budgeted and Actual Expenses by Program – Fiscal Year 2007

Program	Original Budget	Adjusted Budget	Actual Expenses
Medicaid	$5,029,321,523	$5,153,917,545	$5,042,199,846
Administration and support services	98,050,828	113,951,676	111,572,269
FAMIS	90,049,514	85,238,843	84,038,246
FAMIS (Plus)	67,154,269	69,304,509	67,820,518
Medical assistance services (Non-Medicaid)	14,222,481	14,886,934	13,293,929
Appellate processes	10,180,391	9,737,494	9,654,181
Indigent health care trust fund	9,285,831	9,285,866	7,291,101
Continuing income assistance services	1,400,000	1,400,000	960,297
Total resources	$5,319,664,837	$5,457,722,867	$5,336,830,387

Medical Assistance Services adjusted its original general and federal fund budgets primarily as a result of Medicare Part D, which now covers prescription drugs for individuals eligible for Medicare and Medicaid (dual eligibles). Prior to Medicare Part D, Medicare did not cover prescription drugs for dual eligibles. Although the administration of these drugs have transferred from Medicaid to Medicare, the state is required to continue its funding for its share of the costs of these drugs in what is commonly referred to as a "clawback payment" to the federal government. The clawback payments during the year were higher than what Medical Assistance Services had expected to pay for these drugs through its Medicaid program.

Centers for Medicaid and Medicare implemented Medicare Part D in the third quarter of fiscal year 2006 and costs of $47.7 Million resulted in that year. The program was in effect all of fiscal year 2007 and expenses totaled $151.6 million. The remaining increase is driven primarily by several provider rate increases as mandated by the 2007 Appropriation Act, continued significant growth in the utilization of mental health services, continued significant growth in the utilization of dental services following the implementation of

Virginia's Smiles for Children dental program, and the expansion of the number of slots under the Home and Community Based Care waiver. Medical Assistance Services' actual budget was less than three percent higher than its original budget.

Table 2 summarizes Medical Assistance Services' actual program expenses by fund source for the year ended June 30, 2007.

Analysis of Expenses by Program Funding Source – Fiscal Year 2007

Program	Federal Funds	General Funds	Virginia Health Care Fund	Other Special Revenue
Medicaid	$2,456,304,548	$2,297,753,964	$288,141,334	$ -
Administration and support services	73,508,250	37,298,797	-	765,222
FAMIS	54,757,404	15,215,279	14,065,563	-
FAMIS (Plus)	44,087,722	23,732,796	-	-
Medical assistance services (non-Medicaid)	-	11,386,623	-	1,907,306
Appellate processes	-	9,654,181	-	-
Indigent health care trust fund	-	4,285,446	-	3,005,655
Continuing income assistance services	-	960,297	-	-
Total	$2,628,657,924	$2,400,287,383	$302,206,897	$5,678,183

Source: CARS 1419D1 Report

Virginia Health Care Fund

The Virginia Health Care Fund is a special non-reverting fund established to support health care programs using money from tobacco taxes and 40 percent of the Commonwealth allocation of a national settlement known as the Master Settlement Agreement between the states and tobacco companies. The Fund also consists of all recoveries received during a fiscal year resulting from expenses incurred in the Medicaid program during a prior fiscal year or years to the extent that such amounts represent recoveries of state funds that would otherwise be deposited to the General Fund. Between fiscal years 2006 and 2007 the Fund only experienced a $3.5 million decrease in revenues, $288.7 million to $285.2 million. This reduction is due to prior year Medicaid recoveries and occurred because of the implementation of Medicare Part D as Medical Assistance Services received lower pharmacy rebates.

Tobacco taxes in fiscal year 2007 provided the Fund with a majority of its funding (83 percent), a two percent increase over last year.

Total Medical Assistance Services' expenses for all programs amounted to $5.3 billion in fiscal 2007, approximately six percent higher than the previous fiscal year. Approximately 97 percent of total expenses represent medical expenses attributable to the Medicaid, FAMIS, and FAMIS Plus programs. Another 2.1 percent of the total amount represents administrative expenses for these three programs.

Medicaid

Medical Assistance Services spent $5.04 billion on Medicaid services. The following table shows total medical expenses for the Medicaid program by provider type. Enrollment trends show slower growth in Medicaid with an actual decline in enrollment in fiscal year 2007. The implementation of federal Deficit Reduction Act citizenship and identity requirements of 2006 is the cause of the decline. The trends, by fiscal year, in enrollment growth are as follows: 9.1 percent in 2004; 7.6 percent in 2005; 4.9 percent in 2006; and a decrease of 0.4 percent in 2007.

Medicaid Expenses by Provider Type – Fiscal Years 2005-2007

Service Category	2005	2006	2007
Managed Care	$ 963,613,776	$1,091,040,018	$1,190,959,577
Nursing Facility	657,532,982	697,984,269	718,375,124
Community-Based Waiver Services	446,686,043	517,767,803	600,169,213
Inpatient Hospital	531,970,281	553,129,491	547,650,686
Mental Health	267,196,363	352,128,633	395,562,682
Pharmacy	611,762,513	458,755,750	228,301,049
Public ICF/MR Facilities	190,114,299	197,872,439	201,079,045
Medicare Premiums	133,111,555	176,132,821	194,307,374
All Other Services	164,206,641	175,044,363	179,022,939
Medicare Part D Clawback Payments	-	47,704,174	151,605,379
Physician Services	155,452,122	153,891,820	143,310,705
Enhanced DSA - UVA and MCV	111,561,611	92,198,332	141,026,423
Outpatient	126,275,548	115,024,648	105,546,509
Dental	13,750,693	55,624,772	80,698,293
Transportation Services	55,167,599	63,166,758	67,054,128
Public MH Facilities	44,384,328	50,553,407	48,862,334
Regular DSA - General Hospital and Rehabilitation	-	44,046,764	47,648,530
Private ICF/MR Facilities	34,036,235	40,532,655	43,526,395
Other Long-Term Care	3,640,322	3,312,742	5,142,146
Home Health	4,555,784	5,018,912	4,787,051
Supplemental Drug Rebates	(10,796,161)	(13,732,363)	(2,088,208)
Drug Rebates	(109,808,297)	(104,520,939)	(50,347,527)
Total	$4,394,414,237	$4,772,677,269	$5,042,199,847

Source: Department of Medical Assistance Services Statistical Report

Administrative Expenses

In addition to medical assistance services, Medical Assistance Services spent $111.6 million on administrative costs. The tables below summarize the administrative expenses.

Administrative Expenses – Fiscal Year 2007

Contractual services	$ 64,203,687
Dental and medical services contract services	17,873,805
Personal Services	25,618,293
Continuous Charges	2,570,058
Equipment	808,610
Supplies and Materials	475,609
Transfer Payments	22,208
Total	$111,572,270

Source: CARS

Administrative expenses increased by about $25.1 million in fiscal 2007. Over 93 percent of the increase is due to an increase in administrative spending related to contractual services.

Administrative Contractual Service Payments – Fiscal Year 2007

Contracted Vendors	Amount
First Health Services Corp	$33,346,738
Clifton Gunderson and Co.	5,065,431
Kepro Inc	4,297,141
Affiliated Computer Services, Inc.	3,880,912
Health Management Corp.	2,188,895
Health Management Systems, Inc.	1,922,156
Combined Other Contracted Vendors	7,279,824
Other	24,096,395
Total	$82,077,492

Source: CARS

System development expenses associated with the National Provider Identifier (NPI) project are the primary reason for this increase. The federal government mandated conversion to the standard NPI identifier for all providers. This mandate required a major overhaul of the Medicaid Management Information System (MMIS). This project began in fiscal year 2006 with expenses at $271,000. Major system development work began in fiscal year 2007 resulting in approximately $15 million in expenses. Medical Assistance Services revenue maximization project resulting in an increase in the number of school districts participating in administering health care services to children eligible under Medicaid resulted in another $3.2 million in increased administrative expenses.

FAMIS AND FAMIS Plus

FAMIS' medical expenses amounted to $84 million, an increase of 5.5 percent over the prior year. Medical expenses for the FAMIS Plus amounted to $67.8 million, an increase of 16.5 percent. FAMIS and FAMIS Plus now cover ninety-eight percent of eligible children; therefore, Medical Assistance Services expects future growth in the program to be slower.

Key Initiatives

Disease State Management (DSM) Program

Medical Assistance Services implemented its DSM program, Healthy Returns Care Management Program on January 13, 2006, for persons enrolled in its fee-for-service program who have one or more of the following chronic health conditions: asthma, diabetes, congestive heart failure (CHF), or coronary artery disease (CAD), and in May 2007 expanded to cover persons with chronic obstructive pulmonary disease (COPD). In order to take advantage of new options to change benefits or impose new cost sharing requirements that were part of the Deficit Reduction Act, in fiscal year 2007, Virginia converted this program from a voluntary "opt in" to a voluntary "opt out" program.

Managed Care Expansions

Medical Assistance Services continued to increase the number of persons enrolled in managed care plans. Managed care organizations are operating in 110 localities serving 56 percent of Medicaid individuals. Statewide Medicaid enrollment as of August 1, 2007: Fee-for-Service at 255,926, MEDALLION at 51,079, and Medallion II at 383,103. Medical Assistance Services also plans to increase the different types of enrollees participating in managed care such as those in long-term care settings.

Integration of Acute Care and Long-Term Care

Medical Assistance Services developed a blueprint for integrating acute care and long-term care services for Medicaid clients. Concurrent with the development of the long-range plan, they will move forward with two models of care: (1) establishment of Program for All-inclusive Care for the Elderly (PACE) sites across Virginia; and (2) regional managed care plans that include acute and long-term care services. PACE is a capitated benefit that provides a comprehensive service delivery system and features integrated Medicare and Medicaid financing. PACE provides social and medical services in a variety of settings including adult day health care centers and the home. Individuals participating in the PACE program must be at least 55 years old, live in the PACE service area, and meet the criteria for nursing home placement. Other goals of integrated care include decreasing the number of avoidable hospital admissions and the unnecessary use of nursing home care.

Department of Mental Health Mental Retardation and Substance Abuse Services (DMHMRSAS)

DMHMRSAS provides a wide array of services to individuals in 16 state-operated facilities and in communities throughout the Commonwealth of Virginia. DMHMRSAS has a central office that provides oversight for the 16 facilities. The facilities provide most of their own administrative functions and provide all direct services to the Department's consumers. In addition, DMHMRSAS indirectly provides services through its funding and monitoring of 40 local Community Service Boards (Boards).

Central Office

The central office has direct responsibility for the programmatic, financial, and administrative operations of the state facilities. It also has responsibility for monitoring and overseeing the programmatic and financial activities of the Boards. In fiscal year 2007, the expenses of the central office were about $80.05 million, 8.8 percent of total expenses. This is an increase of 106.2 percent over the prior year, which is due to an increase in capital outlay projects that are a result of the System Transformation Initiative discussed later in this report.

The central office provides overall management and direction to the facilities. This includes developing an overall budget, financial management policies, and Medicare and Medicaid cost reports and reimbursement rates. They also provide internal audits, perform architectural and engineering services, administer capital outlay projects, and manage the information systems and budgets. Further, the central office provides technical assistance on human resource issues and billing services to the facilities and licenses all providers of mental health, mental retardation, and substance abuse services throughout the state. The Office of Inspector General, housed within the central office, independently investigates and monitors human rights issues at the facilities and Boards.

System Transformation Initiative

The central office has been working with both the facilities and the Boards as part of the state's System Transformation Initiative (Initiative). Part of the Initiative calls for Western State Hospital in Staunton, Eastern State Hospital in Williamsburg, Central Virginia Training Center in Lynchburg and Southeastern Virginia Training Center in Chesapeake to undergo major construction projects, which the Central Office will manage. DMHMRSAS expects either the Virginia Public Building Authority or the Public Private Partnership Educational Facilities and Infrastructure Act of 2002 to finance the cost of facility replacements. The estimated replacement costs represented about $290 million of the Initiative.

The table below reflects the construction projects related to the Initiative.

Facility	Location	Current Bed Capacity	Fiscal Year 2007 Average Daily Census	Planned Bed Capacity	Funding Source	Funding Approved (Millions)	Amount Spent as of February 6, 2007
Eastern State Hospital	Williamsburg						
Phase I - Hancock Geriatric Treatment Center		210	183	150	Bond	$22	$16,700,000
Phase II - Adult Mental Health Center		26	244	150	General Funds	$59	$1,300,000
Western State Hospital	Staunton	254	241	246	General Funds	$2.5*	$1,000,000
Central Virginia Training Center	Lynchburg	611	509	300	General Funds	$2.5*	$580,000
Southeastern Virginia Training Center	Chesapeake	200	187	100	General Funds	$2.5*	$500,000

* Planning only

Facilities

Sixteen facilities provide inpatient consumer care to slightly less than 3,000 individuals. Ten mental health facilities, referred to as "hospitals," provide acute care and chronic psychiatric services to children, adults, and the elderly. There are also five mental retardation 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. Finally, the Virginia Center for 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.”

The following tables summarize each hospital’s and training center’s revenues, expenses, and populations for fiscal year 2007.

COMPARISON OF FACILITY OPERATIONS
Fiscal Year 2007
Hospital Facilities

	Central State Hospital	Eastern State Hospital	Southwestern Virginia Mental Health Institute
Average resident census	240	427	151
Total resident days	87,600	155,855	55,115
Revenue:			
Adjusted General Fund appropriations	$ 43,189,556	$ 43,225,864	$ 23,573,663
Collections (third party reimbursements)	503,930	21,496,220	9,751,826
Collections for General Fund of the Commonwealth	31,692	10,656	5,989
Other revenues	1,682	3,072	-
Total revenue	43,726,860	64,735,812	33,331,478
Expenses:			
Personal services	39,504,815	51,374,647	25,812,795
Contractual services	5,060,752	2,713,614	2,117,603
Supplies and materials	625,676	8,018,551	3,814,088
Transfer payments	85,256	50,325	33,876
Continuous Charges	1,223,257	3,135,258	1,145,460
Property and Improvements	30,671		2,590
Equipment	1,097,876	703,557	83,860
Plant and Improvements	110,786		21,073
Total expenses	47,739,089	65,995,952	33,031,345
Excess (deficiency) of revenues over expenses	$ (4,012,229)	$ (1,260,140)	$ 300,133
Expenses per resident	$ 198,913	$ 154,557	$ 218,751
Expenses per resident day	$ 545	$ 423	$ 599
Revenues per resident	$ 182,195	$ 151,606	$ 220,738
Revenues per resident day	$ 499	$ 415	$ 605

Western State Hospital	Commonwealth Center for Children & Adolescents	Catawba Hospital	Northern Virginia Mental Health Institute	Piedmont Geriatric Hospital	Southern Virginia Mental Health Institute
241	34	107	122	120	69
87,965	12,410	39,055	44,530	43,800	25,185
$ 42,138,726	$ 6,724,983	$ 9,143,025	$ 24,247,715	$ 3,261,290	$ 10,556,793
4,310,669	2,041,058	10,019,920	3,180,204	17,382,617	1,721,212
908	52	45,559	-		
2,091				36,695	1,589
46,452,394	8,766,093	19,208,504	27,427,919	20,680,602	12,279,594
40,068,177	7,677,739	15,482,500	19,487,626	16,113,013	9,118,136
2,567,456	278,374	1,677,650	2,755,013	799,100	1,131,074
4,537,376	478,680	2,136,337	2,353,251	2,448,608	1,019,861
7,146	10,604	10,911	36,448	13,866	16,037
1,869,910	521,653	643,907	641,186	603,726	432,402
342		-	3,868	4,997	
225,707	19,414	232,213	205,500	736,194	97,824
		16,928		42,000	
49,276,114	8,986,464	20,200,446	25,482,892	20,761,504	11,815,334
$ (2,823,720)	$ (220,371)	$ (991,942)	$ 1,945,027	$ (80,902)	$ 464,260
$ 204,465	$ 264,308	$ 188,789	$ 208,876	$ 173,013	$ 171,237
$ 560	$ 724	$ 517	$ 572	$ 474	$ 469
$ 192,749	$ 257,826	$ 179,519	$ 224,819	$ 172,338	$ 177,965
$ 528	$ 706	$ 492	$ 616	$ 472	$ 488

COMPARISON OF FACILITY OPERATIONS
Fiscal Year 2007
Hospital Facilities

	Hiram Davis Medical Center	Total for Mental Health Facilities
Average resident census	58	1,569
Total resident days	21,170	572,685
Revenue:		
Adjusted General Fund appropriations	$ 12,438,263	$ 218,499,878
Collections (third party reimbursements)	11,981,341	82,388,998
Collections for General Fund of the Commonwealth	667	95,524
Other revenues	1,009	46,138
Total revenue	24,421,280	301,030,538
Expenses:		
Personal services	9,471,343	234,110,791
Contractual services	949,845	20,050,482
Supplies and materials	15,572,466	41,004,893
Transfer payments	2,987	267,457
Continuous Charges	181,288	10,398,047
Property and Improvements	78	42,546
Equipment	195,868	3,598,012
Plant and Improvements	8,218	199,005
Total expenses	26,382,093	309,671,233
Excess (deficiency) of revenues over expenses	$ (1,960,813)	$ (8,640,695)
Expenses per resident	$ 454,864	$ 197,369
Expenses per resident day	$ 1,246	$ 541
Revenues per resident	$ 421,057	$ 191,861
Revenues per resident day	$ 1,154	$ 526

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COMPARISON OF FACILITY OPERATIONS
Fiscal Year 2007
Training Centers

	Central Virginia Training Center	Southeastern Virginia	Northern Virginia
Average resident census	509	187	172
Total resident days	185,785	68,255	62,780
Revenue:			
Adjusted General Fund appropriation	$ 11,246,157	$ 2,796,757	$ 6,733,280
Collections (third party reimbursements)	74,148,891	22,256,266	32,969,368
Collections for General Fund of the Commonwealth	3,267	-	
Other revenues	8,091	232,542	2,959
Total revenue	85,406,406	25,285,565	39,705,607
Expenses:			
Personal services	65,634,493	18,494,348	27,178,159
Contractual services	2,213,732	1,156,571	2,790,059
Supplies and materials	8,772,270	1,365,090	2,546,400
Transfer payments	-	48,439	13,287
Continuous Charges	3,375,587	516,327	741,995
Property and Improvements			
Equipment	120,873	196,547	280,004
Plant and Improvements			
Total expenses	80,116,955	21,777,322	33,549,904
Excess (deficiency) of revenue over expenses	$ 5,289,451	$ 3,508,243	$ 6,155,703
Expenses per resident	$ 157,401	$ 116,456	$ 195,058
Expenses per resident day	$ 431	$ 319	$ 534
Revenues per resident	$ 167,793	$ 135,217	$ 230,847
Revenues per resident day	$ 460	$ 370	$ 632

Southside Virginia	Southwestern Virginia Training Center	Total for Retardation Training Centers
311	209	1,388
113,515	76,285	506,620
$ 15,541,343	$ 2,639,445	$ 38,956,982
63,987,124	22,352,472	215,714,121
1,070	-	4,337
187,614	294	431,499
79,717,151	24,992,211	255,106,939
54,644,062	18,250,309	184,201,371
3,112,154	496,467	9,768,983
6,969,323	1,188,964	20,842,047
123,621	68,938	254,285
2,843,493	977,374	8,454,776
238,812	36,908	275,720
481,236	568,066	1,646,726
4,055		4,055
68,416,756	21,587,026	225,447,963
$ 11,300,395	$ 3,405,185	$ 29,658,976
$ 219,990	$ 103,287	$ 162,426
$ 603	$ 283	$ 445
$ 256,325	$ 119,580	$ 183,795
$ 702	$ 328	$ 504

The tables show that per diem expenses range from $283 to $1,246 with an average per diem of $445 for training facilities and $541 for hospitals. Hiram Davis Medical Center accounts for the highest per diem cost due to the severe nature of its patients' physical and psychiatric conditions and the pharmacy services that it provides to clients outside of its facility.

Overall, personal services are the facilities' largest expense, which is consistent with prior years. In fiscal year 2007, the training facilities and hospitals spent over $418 million, or 78 percent, of their total expenses on personal services.

The facilities' largest source of revenue is collections from third-party payers, primarily Medicaid. In fiscal year 2007, these third-party payers accounted for approximately 53 percent of the facilities' total available resources, or roughly $298 million.

The Appropriation Act shows collected Medicaid and Medicare fees as special revenue, with amounts appropriated by facility. However, the central office can request transfers of special revenues among the individual facilities to cover other facilities whose expenses exceed revenues. Since each facility receives both General and Special Revenue funding, and the mental health facilities do not usually generate sufficient revenues to cover expenses, the central office closely monitors the income and expenses of each facility.

When it is apparent that the mental retardation facilities will generate sufficient revenues to cover their expenses, the central office transfers the excess collections to cover the shortfall in other mental health facilities. This practice allows DMHMRSAS to operate all of its facilities within its overall appropriation.

This budgetary method may have long-term critical consequences, as the federal government enacts changes to their Medicaid reimbursement policies. Additionally, this practice also tends to show a more even distribution of General Fund appropriations among all facilities, when in reality, the transfer of special fund revenue indicates that some mental retardation units could operate more independently, and other mental health facilities would need additional General Fund appropriations.

The table below provides a detailed analysis of transfer payments in fiscal year 2007 for each facility, with summary figures for comparison purposes for fiscal years 2005, 2006, and 2007.

Special Revenue Comparison

Facility	Original Appropriation	Adjusted Budget	Revenues Collected	Transfers In/Out	FY 2007 Expenses
Catawba State Hospital	$ 9,667,466	$ 11,054,751	$ 10,019,920	$ 2,050,000	$ 11,054,751
Central State Hospital	560,690	4,548,690	505,612	4,500,000	4,548,690
Community Center. for Children and Adolescents	1,651,712	2,215,111	2,041,058	-	2,215,111
Eastern State Hospital	24,647,930	22,802,844	21,496,220	1,500,000	22,792,724
Hiram W. Davis Medical Center	11,543,330	15,160,298	11,981,341	2,200,000	13,943,977
Northern Virginia Mental Health Institute	1,258,863	1,235,308	3,180,204	-	1,235,308
Piedmont Geriatric Hospital	17,037,117	17,463,519	17,345,923	750,000	17,463,519
Southern Virginia Mental Health Institute	1,487,189	1,487,189	1,719,624	(300,000)	1,257,189
Southwestern Va. Mental Health Institute	8,407,031	9,444,071	9,751,826	1,000,000	9,444,018
Western State Hospital	3,385,271	7,135,209	4,310,669	4,000,000	7,134,944
FY 2007 Total	$ 79,646,599	$ 92,546,990	$ 82,352,397	$ 15,700,000	$ 91,090,231
FY 2006 Total	$ 77,990,481	$ 89,613,782	$ 81,533,369	$ 5,548,236	$ 88,338,319
FY 2005 Total	$ 77,990,481	$ 81,224,844	$ 75,279,549	$ 12,056,972	$ 81,343,914
Central Virginia Training Center	$ 66,886,670	$ 68,888,916	$ 74,154,395	$ (7,827,146)	$ 68,887,626
Northern Virginia Training Center	31,278,968	26,816,625	32,969,368	(3,700,000)	26,816,625
Southeastern Virginia Training Center	64,362,570	19,418,222	22,256,266	(1,000,000)	19,052,114
Southside Virginia Training Center	18,025,702	52,876,239	64,174,178	(7,050,000)	52,875,556
Southwestern Virginia Training Center	20,969,787	19,215,340	22,352,671	850,000	19,215,278
FY 2007 Total	$201,523,697	$187,215,342	$ 215,906,878	$(18,727,146)	$ 186,847,199
FY 2006 Total	$175,983,994	$191,752,059	$ 209,928,235	$(8,309,123.00)	$ 191,714,681
FY 2005 Total	$175,983,994	$179,462,936	$ 195,228,788	$ (14,413,43)	$ 179,438,723

Virginia Center for Behavioral Rehabilitation

The Virginia Center for Behavioral Rehabilitation (Center) opened in October 2003 in response to an immediate need to accommodate individuals who would be civilly committed as sexually violent predators following their criminal sentences. The state needed a facility to provide individualized rehabilitation services in a secure environment. The immediacy of the need resulted in DMHMRSAS retrofitting an existing building on their Petersburg complex to accommodate an operating capacity of 36. The average daily census was 28 in fiscal 2006 and 35 in fiscal 2007.

The table below shows the high Per Diem cost of the current facility, caused by a small patient population and the large number of employees needed to both operate the center and achieve appropriate security levels and program effectiveness.

Comparison Of Facility Operations

Behavioral Rehabilitation Facility	Virginia Center for Behavioral Rehabilitation
Average resident census	35
Total resident days	12827
Revenue:	
Adjusted General Fund Appropriations*	$ 6,652,546
Fund 100-General Fund, other revenue	331
Fund 600-Internal Service Fund, sales of	-
Total revenue	$ 6,652,877
Expenses:	
Personal services	$ 4,740,643
Contractual services	650,016
Supplies and materials	535,972
Transfer payments	10,034
Continuous charges	116,995
Property and improvements	6,323
Equipment	267,562
Total expenses	$ 6,327,545
Excess (deficiency) of revenues over expenses	$ 325,332
Expenses per resident	$ 180,787
Expenses per resident day	$ 493
Revenues per resident	$ 190,082

The Center's occupancy will increase dramatically based upon an imposed change in the screening criteria for facility placement. DMHMRSAS is currently overseeing the construction of a $62 million, 300-bed facility in Nottoway County. As of December 2007, construction expenses amounted to approximately $40.5 million. Management expects to open phase one of the new center in February 2008.

Community Service Boards

Community Service Boards (Boards) are the single point of entry into the Commonwealth's Mental Health, Mental Retardation, and Substance Abuse Services system, which includes providing access to state mental health and mental retardation facilities, as well as community programs. Individuals who seek services from a Board receive an intake evaluation to determine the type and duration of services needed. The Boards provide pre-admission screening and discharge planning services for consumers entering or leaving state facilities.

In addition, the Boards function as providers of services (directly or contractually), advisors to their local government, client advocates, community educators, and planners on issues related to mental health, mental retardation, and substance abuse. In contrast to hospitalization, the Boards provide services by drawing on community resources and support systems, such as the family and friends of patients. During fiscal year 2007, DMHMRSAS transferred $277 million (about 30.8 percent of its total budget) to the Boards.

The Boards access medications for eligible consumers through the Community Resource Pharmacy, located within the Hiram Davis Medical Center in Petersburg. They provide medications for individuals who have been discharged or diverted from state facilities and have Medicaid or cannot pay for medications to treat or prevent a recurrence of their condition. Each year, DMHMRSAS provides the Boards with a capped amount of state-funded medication. DMHMRSAS bases these amounts on the historical costs of covering prescription drugs for those individuals who are unable to pay. The Boards direct individuals eligible for Medicare Part D benefits to outside pharmacies.

Initiatives in the public Mental Health, Mental Retardation, and Substance Abuse Services industry stress the benefits of community-based care for this population of citizens. As these initiatives reduce state facility capacity and increase demand on community services, DMHMRSAS' ongoing and collaborative efforts with Boards and other stakeholders is vital to the success of the transformation.

DMHMRSAS monitors this transformation through various implementation committees. The Facility Capital Replacement Project has the responsibility of coordinating the planning for each of the state facility projects. In addition, DMHMRSAS is using the following committees to ensure that the transformation from state facilities to community-based care is effective and efficient:

- Service Development Group: The Service Development Group is responsible for coordinating the development of regional and Board-specific plans and for the implementation of these plans.

- Training and Education Committee: The Training and Education Committee is responsible for developing a program of peer and project providers.

- Data Outcome Measures Group: The Data Outcome Measures Group is responsible for coordinating the development of outcome measures and the identification of the data.

Health

Health seeks to achieve and maintain personal and community health by emphasizing health promotion, disease prevention, bio-terrorism preparedness, and environmental protection. Health administers the state's system of public health.

The State Board of Health, appointed by the Governor, provides planning and policy development to enable Health to implement coordinated, prevention-oriented programs that promote and protect the health of the Commonwealth's citizens. In addition, the Board serves as the advocate and representative of citizens in health issues.

Health operates through a central office and 35 health districts that operate 119 local health departments. Local health departments work with Health through agreements between the state and participating local governments. These agreements define the health services funded by the localities in the health districts. Programs offered include communicable disease control, and prevention and health education. In addition to patient visits, local health departments are responsible for inspecting restaurants and drinking water, and issuing permits for sewage systems, wells, and waterworks operations. Additionally, most local health departments provide a variety of non-mandated healthcare services for persons who cannot otherwise afford them.

Financial Operations

Health expended $525.6 million throughout thirteen programs in fiscal year 2007. The following tables summarize Health's original and adjusted budgets to actual expenses for the fiscal year. Six of the thirteen programs account for 89 percent of Health's total expenses.

Analysis of Budget to Actual Expenses by Program

Program	Original Budget	Adjusted Budget	Actual Expenses
Community Health Services	$220,959,335	$228,579,365	$218,895,567
State Health Services	98,978,581	104,012,343	99,929,808
Communicable and Chronic Disease Prevention and Control	46,624,833	46,464,699	43,411,807
Emergency Preparedness	33,882,053	46,116,752	42,939,760
Emergency Medical Services	28,384,800	40,203,361	35,616,992
Drinking Water Improvement	36,422,690	34,027,982	27,171,380
Administrative and Support Services	14,748,841	13,998,876	13,086,775
Financial Assistance to Community Human Services Organizations	12,116,296	14,315,225	11,513,743
Health Research/Planning/Coordination	12,120,743	12,695,039	11,148,071
Environmental Health Hazards Control	7,086,907	8,453,192	7,479,427
Medical Examiner and Anatomical Services	7,182,695	7,329,960	7,279,724
Vital Records & Health Statistics	6,969,168	6,969,168	5,397,456
Higher Education Student Financial Assistance	1,808,196	2,198,290	1,747,959
Total	$527,285,138	$565,364,252	$525,618,469

Source: Original Budget - Appropriation Act, Chapter 3; Adjusted Budget and Actual Expenses – CARS

The $38 million increase in the original budget occurred for several reasons. About $19 million of the increase (50 percent) stems from costs associated with salary and benefit increases included in the past

biennium. Health also received an additional $11.3 million to purchase antiviral medications and treatments through a federal program.

Additionally, $4 million of the increase is due to the addition of the Richmond City Health Department, formerly operated by the city, in fiscal 2007. The locality's inclusion created an additional 120 state positions.

Other Financial Activities

Health receives funding primarily from three sources; federal grant awards, the general fund, and through the collection of special revenue. Health collected about $218.5 million in federal revenue, received $165.2 in general fund appropriations, and generated special revenue of about $150.9 million in fiscal year 2007.

During fiscal year 2007, four sources accounted for $108.4 million of the special revenue collected by Health. About $51.6 million represents the localities' share of funding towards operating costs of local health departments. Approximately $20.7 million comes from patient collections for services at the local health departments. The Department of Motor Vehicles collected a "4 for Life" vehicle registration fee and transferred the collections to Health, which accounted for $25.2 million. Health uses the"4 for Life" funding to support, train, and provide grants to local rescue squads. About $10.9 million represents monies that Health collected for vital statistics (birth and death certificates). The remaining special revenue consists of fines, penalties, interest, and permit fees for septic systems, wells, and campgrounds.

Management spends the majority of Health's funding on payroll and related fringe benefit costs ($218.9 million) and to support localities and their emergency medical services ($22.7 million). These two expense categories constitute nearly 46 percent of Health's total expenses.

Information Systems

Management processes federal programs and financial activities on a variety of information systems. Below is a brief description of these information systems.

- F&A: a financial and administrative system that records initial transactions so that management can upload information into the Commonwealth's Accounting and Reporting System (CARS).

- WICNet: a client-server application that allows for automated tracking of WIC check issuance at the 35 local health districts.

- HIV Aids Drug Assistance Program (ADAP): provides utilization and demographic data for program reporting requirements.

- Virginia Immunization Information System (VIIS): referred to as the Immunization Registry, gathers and reports on immunization activities across the Commonwealth.

- Safe Drinking Water Information System (SDWIS): a repository of Virginia's public drinking water supply information necessary for routine monitoring and regulatory activities.

We tested controls over the systems including user access, change management, disaster recovery and business continuity, server and database administration controls, and Health's general security environment. Our findings are in the section entitled, "Internal Control and Compliance Findings and Recommendations."

Rehabilitative 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 consists of the following primary divisions: Vocational Rehabilitation Services, the Community Rehabilitation Program, Disability Determination Services, and Agency Support Activities. In fiscal years 2006 and 2007, these divisions spent about $131 million and $136 million, respectively.

The following tables summarize Rehabilitative Services' original and adjusted budget and actual expenses for state fiscal years 2006 and 2007.

2006 Budgeted vs. Actual Expenses

Program	Original Budget	Adjusted Budget	Actual Expenses
Rehabilitation Assistance Services	$ 85,799,471	$ 88,695,323	$ 86,316,145
Continuing Income Assistant Services	35,511,635	36,290,816	35,871,654
Administrative and Support Services	8,204,982	10,947,288	9,061,348
Total	$129,516,088	$135,933,427	$131,249,147

Sources: CARS budget/actual summary prepared by Data Analysis; proposed budget bill and supporting reports; FATS system (DPB)

2007 Budgeted vs. Actual Expenses

Program	Original Budget	Adjusted Budget	Actual Expenses
Rehabilitation Assistance Services	$ 90,755,900	$ 91,770,371	$ 90,563,525
Continuing Income Assistant Services	35,436,635	35,537,684	35,532,674
Administrative and Support Services	8,806,093	10,569,270	10,222,134
Total	$134,998,628	$137,877,325	$136,318,333

Sources: CARS budget/actual summary prepared by Data Analysis; proposed budget bill and supporting reports; FATS system (DPB)

During both fiscal years under audit, Rehabilitative Services was within three percent of both their original and adjusted budgets. The increase in the original fiscal year 2006 budget is attributable to costs associated with the salary and benefit increases. The increase in fiscal 2007 is attributable to an increase in Administrative and Support Services. This increase resulted from expenses related to information systems, including the development of an integrated case management project.

The following table summarizes Rehabilitative Services' total expenses in fiscal years 2006 and 2007. Transfer payments represent 42.3 and 43.5 percent, respectively, of Rehabilitative Services' expenses. Transfer payments go to both state and non-state entities, such as disability service boards and Community Service Boards.

Expenses

	2006	2007
Transfer payments	$ 55,566,273	$ 59,393,586
Personal services	48,468,229	50,848,539
Contractual services	19,363,745	17,831,297
Continuous charges	4,828,964	5,043,224
Equipment	1,391,135	1,267,488
Supplies and materials	1,544,037	1,784,277
Plant and improvements	86,745	149,557
Property and improvements	19	365
Total	$131,249,147	$136,318,333

Source: CARS 2006 & 2007 Expenditure Summaries

Woodrow Wilson Rehabilitation Center (Center)

Rehabilitative Services transferred $15.4 million and $14.7 million to the Woodrow Wilson Rehabilitation Center (Center) in fiscal years 2006 and 2007, respectively. The transfers from Rehabilitative Services represent 80.1 percent of the Center's revenues for the two-year period. The Center also receives third party medical reimbursements from insurers, such as Medicare, Medicaid, and private insurance carriers, and private funds and student financial aid assistance.

The Center is one of nine comprehensive rehabilitation facilities in the country and primarily serves individuals with multiple service needs. The Center operates a Vocational Rehabilitation Program, a Post Secondary Education Transition Program, and a Comprehensive Outpatient Rehabilitation Program. According to the Center's annual report, the Center admitted about 2,700 clients in fiscal year 2006. Rehabilitative Services refers about 75 percent of the Center's clients.

The following table summarizes the Center's expenses in fiscal years 2006 and 2007. In fiscal years 2006 and 2007, personal services comprised 66 percent and 61 percent of the Center's total expenses, respectively.

Expenses		
	2006	2007
Personal services	$17,779,357	$17,909,864
Contractual services	5,263,742	7,734,556
Supplies and materials	2,288,884	2,004,497
Continuous charges	977,877	1,143,990
Equipment	489,214	412,680
Transfer payments	33,694	36,432
Property and improvements	641	5,382
Total	$26,833,409	$29,247,401

Source: CARS 2006 & 2007 Expenditure Summaries

Blind and Vision Impaired

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.

The following table summarizes Blind and Vision Impaired's total expenses for fiscal years 2006 and 2007. Blind and Vision Impaired's two largest expenses in fiscal 2007 were supplies and materials (39 percent) and personal services (34 percent).

Expenses		
	2006	2007
Supplies and materials	$14,522,982	$13,801,499
Personal services	12,497,644	12,019,817
Contractual services	2,839,405	3,408,950
Transfer payments	2,944,346	2,890,073
Equipment	1,293,020	1,579,418
Continuous charges	1,046,940	1,105,573
Plant and improvements	295,406	513,531
Property and improvements	2,450	5,950
Total	$35,442,193	$35,324,811

Source: CARS 2006 & 2007 Expenditure Summaries

Virginia Industries for the Blind (Industries)

The Virginia Industries for the Blind (Industries), the business enterprise division of Blind and Vision Impaired, 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. Industries has manufacturing locations in Charlottesville and Richmond. Products manufactured by Industries include mattresses, writing instruments, mop heads and handles, and physical fitness uniforms. Industries also has 14 satellite operations across Virginia with ten self-service supply stores serving military and other federal organizations. Additionally, Industries provides staffing for administrative office services.

Virginia Rehabilitation Center for the Blind and Vision Impaired (Blind and Vision Impaired Center)

The Virginia Rehabilitation Center for the Blind and Vision Impaired (Blind and Vision Impaired Center) is a sub-agency of Blind and Vision Impaired that provides comprehensive adjustment 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 students in evaluation and training. The average length of stay at the Blind and Vision Impaired Center is three to four months.

Deaf and Hard-of-Hearing

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 administers programs through the following divisions: Telecommunications Relay Services; Interpreter Services Requests; Quality Assurance Screening; Technology Assistance Program; and Outreach, Information, and Referral.

The following table summarizes Deaf and Hard of Hearing's expenses in fiscal years 2006 and 2007. The increase in Deaf and Hard of Heaing's expenses is attributable to the approximate $4.5 million increase in contractual services. In fiscal 2007, Deaf and Hard of Hearing and the Virginia Information Technology Agency (VITA) jointly entered into contracts with both Sprint and the AT&T Corporation to open, staff, and operate a telecommunications Relay Center in Norton, Virginia. The Relay Center provides telecommunication relay services for deaf and hearing-impaired citizens across the Commonwealth.

Expenses		
	2006	2007
Contractual services	$ 312,736	$4,879,179
Personal services	676,743	632,244
Equipment	241,304	265,743
Continuous charges	103,134	108,024
Supplies and materials	12,565	7,213
Transfer payments	345,804	11
Total	$1,692,286	$5,892,414

Virginia Board for People with Disabilities (Board)

The Virginia Board for People with Disabilities (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 *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 combined expenses for fiscal years 2006 and 2007 were about $3.86 million.

Major activities of the Board include:

- Partners in Policy Making Program - provides leadership training, resource development, and advocacy skill workshops to people with developmental disabilities and parents of young children with developmental disabilities.

- Youth Leadership Forum - seeks to empower young people with disabilities to further develop their leadership skills. Rising high school juniors and seniors serve as delegates from communities throughout Virginia by participating in a wide range of activities and learning experiences during a four-day Youth Leadership Forum.

- James C. Wheat Award - recognizes individuals for outstanding service to Virginians with disabilities.

- Disability Policy Fellowship - promotes scholarly research and work by offering a graduate or doctoral student an opportunity to engage in the practice of public policy and administration and develop skills in a variety of areas.

- Developmental Disabilities Competitive Grant Program - provides federal funds to initiate major disability service innovations.

The following table summarizes the Board's expenses for fiscal years 2006 and 2007. Personal services represent the Boards largest expenses (44.5 percent). The increase in personal services for fiscal 2007 is attributable to the hiring of additional staff members and their associated salary and benefit costs. Other than personal service expenses, transfer payments represent the only other significant expense for the Board (30.9 percent). Transfer payments consist of payments to sub-recipients under the Developmental Disabilities Competitive Grant Program.

Expenses

	2006	2007
Personal services	$ 741,385	$ 866,439
Transfer payments	663,836	602,692
Contractual services	332,903	305,958
Continuous charges	147,344	139,864
Supplies and materials	15,481	17,099
Equipment	15,904	3,376
Total	$1,916,853	$1,945,428

Source: CARS 2006 & 2007 Expenditure Summaries

Health Professions

Health Professions, the Board of Health Professions (Board), and Virginia's 13 health regulatory boards have responsibility for ensuring the safe and competent delivery of healthcare services through the regulation of the health professions. The Board recommends policy, reviews the Health Profession's budget matters and monitors its activities, adopts standards to evaluate the competency of the professions and occupations, and certifies compliance with those standards. The Board has one member from each of the 13 health regulatory boards and five citizen members. The Governor appoints all members, who may serve two, four-year terms.

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

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

Each of the health regulatory boards determines which applicants meet the necessary requirements for licensure, certification, and registration. Licensure or certification typically requires the completion of a board-approved professional education program and the passage of approved examination in the professional field.

FINANCIAL INFORMATION

Health Profession 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 schedule summarizes the Health Profession's budgeted expenses compared with actual results for fiscal year 2007.

Analysis of Budgeted and Actual Expenses by Program and Funding Source

Program	Program Expenses			Expenses by Funding Source	
	Original Budget	Final Budget	Actual Expenses	Special Revenue	Federal
Higher education student financial assistance	$ 65,000	$ 65,000	$ 52,060	$ 52,060	$ -
Regulation of professions and occupations	22,815,937	23,368,985	21,080,016	20,794,340	285,676
Total uses	$22,880,937	$23,433,985	$21,132,076	$20,846,400	$285,676

Comprehensive Services

The Comprehensive Services administers the Comprehensive Services Act for At-Risk Youth and Families (CSA), which provides services and funding to address the needs of emotionally and behaviorally disturbed youth and their families. CSA 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) governs the Office and 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 two employees in the central office to process CSA disbursements. The Office has 12 employees that are employees of Social Services.

Program delivery under CSA 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." CSA uses three teams to manage collective efforts among 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 (CPMT) serves as the community's liaison to the Office. The CPMTs coordinate long-range, community-wide planning, which ensures the development of resources and services needed by children and families in its community. It is their duty to establish policies governing referrals and reviews of children and families to the Family Assessment and Planning Teams. Each CPMT establishes and appoints one or more Family Assessment and Planning teams based on the needs of the community. CPMTs also authorize and monitor the disbursement of funds by each Family Assessment and Planning Team.

Family Assessment and Planning Team

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

Financial Information

Comprehensive Services received funding from the Commonwealth's General Fund and federal grants. In fiscal year 2007, funding increased more than three and a half percent from fiscal year 2006 due to the increased cost of serving children mandated for care under CSA. In fiscal year 2007, the Office served 17,128 children. The following table summarizes 2007 budget and actual activity.

Analysis of Budget and Funding Sources

Funding Source	Original Budget	Adjusted Budget	Actual Expenses	Proposed Budget for 2008
General Fund appropriations	$210,691,140	$169,881,225	$169,568,429	$239,329,274
Federal grants	54,419,998	9,419,998	9,419,998	52,607,746
Total	$265,111,138	$179,301,223	$178,988,427	$291,937,020

Source: CARS

The variance between the original and adjusted budgets arises from transfers to the Medical Assistance Services for the Medicaid portion of CSA costs. These transfers amounted to $46.6 million in general funds and $45 million in federal funds for fiscal year 2007.

Effective March 1, 2007, the Office had to eliminate its Medicaid-supported treatment foster care services in accordance with the federal Deficit Reduction Act. This change meant that the Office had to support these services with additional general funds.

Comprehensive Services separates state and federal expenses into two funds: state pool and administrative. The Office allocates the funds based on Appropriation Act requirements. The Office classifies the majority of its funds as pool funds. The Office uses state and federal funds to reimburse localities for costs of providing private residential or day special education, foster care, and foster care prevention services for eligible children and their families.

Administrative funds offset the additional cost localities incur for implementing the CSA and represent about $1.5 million or one percent of total expenses for the year. The localities may use these funds for administrative and coordinating expenses or direct services to eligible youth and families.

Aging

Aging fosters the independence, security, and dignity of older Virginians by promoting partnerships with families and communities. Aging is the federally recognized state unit for the Older Americans Act

(Act). The Act contains objectives that address the inherent dignity of older people, and the duty and responsibility of governments of the United States to assist older Americans. The objectives cover the areas of adequate income, availability of mental and physical services, suitable housing, long-term care needs, employment opportunities, transportation, and protection against abuse, neglect, and exploitation.

Aging, in its role as state administrator of the Act, is responsible for the implementation of a plan and delivery of services that accomplishes the objectives of the Act. Aging accomplished its mission through the receipt of federal funds and General Fund appropriations. Additionally, Aging receives special revenue funds through state tax refund contributions and miscellaneous grants. For fiscal years 2007, Aging received the following revenues.

Revenues for Fiscal Years 2007

Fund Source	2007	Percent
General	$ 17,395,025	37%
Special	155,667	< 1%
Federal	29,026,341	62%
Total	$ 46,577,033	

Source: CARS

Area Agencies on Aging

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 Mental Health, Mental Retardation, and Substance Abuse Services 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 table below indicates total funds disbursed to each Area Agency in fiscal year 2007.

Disbursements to Area Agencies for Fiscal Years 2007

Area Agency on Aging	2007
Private Nonprofit Organizations	
Senior Services of Southeastern Virginia	$ 5,154,387
Senior Connections: The Capital Area Agency on Aging	3,858,051
Southern Area Agency on Aging, Inc.	2,787,760
Bay Aging	2,131,069
Mountain Empire Older Citizens, Inc.	1,968,854
Valley Program for Aging Services, Inc.	1,943,742
LOA Area Agency on Aging	1,929,044
Peninsula Agency on Aging, Inc.	1,876,496
Central Virginia Area Agency on Aging, Inc.	1,697,202
Appalachian Agency for Senior Citizens, Inc.	1,437,328
Piedmont Senior Resources Area Agency on Aging, Inc.	1,247,386
Shenandoah Area Agency on Aging, Inc.	1,244,791
Eastern Shore Agency on Aging (Community Action Agency, Inc.)	905,769
Rappahannock Area Agency on Aging, Inc.	847,695
Local Governments	
Fairfax Area Agency on Aging	2,492,233
Arlington Agency on Aging	645,088
Prince William Area Agency on Aging	496,642
Alexandria Office of Aging and Adult Services	403,481
Loudoun County Area Agency on Aging	355,424
Joint Operating Agencies	
District Three Senior Services	2,714,871
Lake County Area Agency on Aging	1,451,367
Crater District Area Agency on Aging	1,434,257
Jefferson Area Board for Aging	1,215,291
New River Valley Agency on Aging	1,070,689
Community Services Board	
Rappahannock-Rapidan CSB and AAA	1,071,095
Total area agency amount	42,380,012
Other Contractors and Service Providers	3,669,051
Total grants to organizations	$46,049,063

Source: 2007 CARS Vendor Summary Report

The Older Americans Act requires Aging to allocate 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 Bureau of the Census to perform a special tabulation of the weighted factors. The weighted factors are as follows:

Population 60+	30%
Population 60+ in Rural Jurisdictions	10%
Population 60+ in Poverty	50%
Population 60+ Minority in Poverty	10%
Total allocation	100%

The Bureau of the Census (Census) completed its special tabulation of the 2000 census in fiscal year 2005. The new tabulation revealed a significant shift in the population demographics of older Virginians since 1990 (the previous census). Until Census completed its tabulation, Aging had used the 1990 statistics to allocate funding to Area Agencies. The population shift would have resulted in allocation shortfalls for several Area Agencies, preventing them from maintaining current levels of service.

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 Census completes its special tabulation of 2010 data.

Analysis of Budgeted and Actual Expenses by Program

Aging's final budget was within 1.5 percent of its original budget.

Budgeted and Actual Expenses for Fiscal Year 2007

Program	Original	Final	Actual Expenses
Individual Care Services (455)	$ 30,806,751	$ 31,880,568	$ 29,858,425
Nutritional Services (457)	16,208,165	15,808,556	15,426,726
Admin & Support Services (499)	2,394,089	2,461,498	2,186,345
Total	$ 49,409,005	$ 50,150,622	$ 47,471,496

Source: State Budget Bills, FATS System (DPB), CARS

Approximately 95 percent of Aging's total expenses are grants to Area Agencies and other contractors and service providers. For fiscal year 2007, Aging had the following operating expenses.

Expenses for Fiscal Years 2007

Type of Expenses	2007	Percent
Transfer payments	$44,905,347	95%
Personal services	1,703,246	4%
Contractual services	646,272	1%
Continuous charges	167,306	<1%
Supplies and materials	34,406	<1%
Equipment	14,918	<1%
Total	$47,471,495	

Source: CARS Expenditure Summary

Commonwealth of Virginia

Walter J. Kucharski, Auditor

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

January 25, 2008

The Honorable Timothy M. Kaine
Governor of Virginia
State Capital
Richmond, Virginia

The Honorable Thomas K. Norment, Jr.
Chairman, Joint Legislative Audit
and Review Commission
General Assembly Building
Richmond, Virginia

We have audited the financial records and operations of the **Agencies of the Secretary of Health and Human Resources**, as defined in Audit Scope and Methodology section, for the year ended June 30, 2007. We conducted our audit in accordance with Government Auditing Standards, issued by the Comptroller General of the United States.

Audit Objectives

Our audit's primary objective was to evaluate the accuracy of 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, 2007, 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 their financial transactions in 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 controls, tested for compliance with applicable laws, regulations, contracts, and grant agreements, and if applicable reviewed their corrective actions of audit findings from prior year reports.

Audit Scope and Methodology

Management at the Agencies of the Secretary of Health Human Resources has 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 materiality and control risk in determining the nature and extent of our audit procedures. By agency, our review encompassed controls over the following significant cycles, classes of transactions, account balances and systems:

Department of Medical Assistance Services

Medicaid revenues and expenses	Operating leases
Accounts receivable	General system controls
Accounts payable	System penetration
Contract management	Oracle financial system

Department of Social Services

Federal revenues and expenses	Network security and system access
Monitoring of Local Social Services	Systems development
Capital leases	Oracle financial system

Department of Health

Payroll expenses	Payments from localities
Support for local rescue squads	Operating leases
Aid to local governments	Network security
Collection of fees for services	Financial and Accounting system

Department of Mental Health, Mental Retardation, and Substance Abuse Services

Federal revenues and expenses	Monitoring of Community Service Boards
Accounts receivable	Network security
Payroll expenses	Financial Management system
Institutional Revenues	

Department of Rehabilitative Services

Payroll expenses	System Access
Travel expenses	Multi-agency Accounting System
Revenues and expenses for Social Security Disability Determination	

The Department of Rehabilitative Services was audited for the years ended June 30, 2006, and June 30, 2007. The Department of Rehabilitation Services provides administrative services for six other agencies, they 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.

Our audit did not include the Department for the Aging, Department of Health Professions, and Comprehensive Services for At Risk Youths and Families, which we will audit and report our results under separate reports.

The Department of Social Services, along with the City of Norfolk's Department of Human Services and Norfolk State University were the subject of a special review completed by our Office in November 2007. The results of that review are not included in this report, however they can be found on our website: www.apa.virginia.gov.

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

We performed audit tests to determine whether the respective agency's 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 observations of agency's operations. We tested transactions and performed analytical procedures, including budgetary and trend analysis. 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 in addition to other financial information reported to the Department of Accounts for inclusion in the Comprehensive Annual Financial Report for the Commonwealth of Virginia. 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 and its operation and compliance with applicable laws and regulations that require management's attention and corrective action. These matters have been categorized by agency and are described in the section entitled "Internal Control and Compliance Findings and Recommendations."

The Agencies of the Secretary of Health and Human Resources have taken adequate corrective action for prior year audit findings not repeated in this report.

Exit Conference and Report Distribution

We discussed this report with management at the Agencies of the Secretary of Health and Human Resources between January 7 and 25, 2008. Management's responses have been included at the end of this report.

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/wdh

COMMONWEALTH of VIRGINIA

DEPARTMENT OF SOCIAL SERVICES

Office of the Commissioner

Anthony Conyers, Jr.
COMMISSIONER

January 28, 2008

Mr. Walter J. Kucharski
Auditor of Public Accounts
101 North 14th Street
Richmond, Virginia 23219

Dear Mr. Kucharski:

The Virginia Department of Social Services' (VDSS) response to the Auditor of Public Accounts (APA) audit report for fiscal year ended June 30, 2007 is enclosed and titled "Response to Auditor of Public Accounts Report for Fiscal Year Ended June 30, 2007." In accordance with the *Commonwealth Accounting Policies and Procedures Manual,* Topic 10205 (Agency Response to APA Audit), our response includes the cited findings and recommendations and provides the related corrective action plans, including the individuals responsible for implementation and the target dates for completion.

Please contact me at (804) 726-7011 if you require additional information.

Sincerely,

Anthony Conyers, Jr.

Enclosure
cc: Wallace G. Harris, Chief Operating Officer, VDSS
Margaret R. Schultze, Assistant Commissioner, VDSS
Nathaniel L. Young, Jr., Deputy Commissioner & Director, Child Support Enforcement, VDSS
Jack B. Frazier, Director, Director, Community & Volunteer Services, VDSS
Lynette W. Isbell, Director, Family Service Programs, VDSS
Renée Fleming Mills, Director, Human Resource Management, VDSS
F. Richard Schreiber, Director, Audit Services, VDSS
J. R. Simpson, Chief Financial Officer, VDSS
Thomas J. Steinhauser, Director, Benefit Programs, VDSS
Dorothy W. Wells, Acting Director, Information Systems, VDSS

JAN 28 '08 PM3:20

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VIRGINIA DEPARTMENT OF SOCIAL SERVICES
RESPONSE TO AUDITOR of PUBLIC ACCOUNTS AUDIT REPORT
FOR FISCAL YEAR ENDED JUNE 30, 2007

INTERNAL CONTROL & COMPLIANCE FINDINGS & RECOMMENDATIONS

Improve System Access Controls

Finding: Access approval forms for 26 of 133 state and local employees tested did not have supervisory approval and/or were not signed by the employee. In addition, system access was not terminated within seven days for eight of 238 terminations reviewed.

Recommendation: The Department should educate its managers on the functionality of the Security Access Management System (SAMS) and develop an internal process for monitoring and protecting state data.

Response (provided by Wallace G. Harris, Chief Operating Officer): The Department concurs with the discrepancies in the system access forms and issued an e-mail on January 2, 2008 to remind state and local security officers that security access forms must be signed by the employee and approved by the supervisor prior to granting system access.

The Department further agrees that eight terminated employees were not removed within seven days of termination, but would note that the exception criteria in the 2007 audit was 21 days less than that used in 2006 (seven versus 30). We would also note that the eight untimely removals cited in 2007 were all local employees. There were no exceptions related to state employees—a 100 percent improvement over the 2006 audit. Of the eight local employees not removed within seven days, one was a seasonal worker who was intentionally not removed because of the nature of the work, two occurred when the security officer was on vacation and the remaining five occurred due to untimely supervisor notification. All eight exceptions were corrected during the audit.

Although the Department requires removal of system access within three days of termination, compliance with that practice cannot be determined until two weeks later because the Personnel Management Information System (PMIS), which SAMS uses to verify state user access privileges, is only updated semi-monthly. Even though the auditor's sample for 2007 did not yield any exceptions for state employees, a testing criterion less than the PMIS update cycle could indicate nonexistent exceptions. As such, the Department feels a 15-day criterion would be more in alignment with the PMIS update cycle and will, by February 15, 2008, incorporate this fact into the "*SAMS Instruction Manual.*"

As acknowledged by the auditor, SAMS was implemented in April 2007. This means that SAMS was a new system when the audit test work was performed which, in turn, means that users were in the process of learning the system's uses and capabilities. To facilitate this learning curve, DIS provided SAMS and data protection training to state and local security officers and directors in May 2007 in accordance with DSS' practice for new systems. In addition, at the time of the auditor's test work, the Department was in the process of developing an automated tool for monitoring and evaluating the effectiveness of data protection. Security performance analysis reporting was added

to SAMS in November 2007. Security requirements are emphasized in our annual security training which every employee is required to attend; attendance is monitored and recorded in individual personnel files. The home office training was completed in October 2007; the 2007 security training videos were distributed to state and local field offices in December 2007.

Improve Notification and Timely Reduction of Benefits when Clients are not Cooperating with Division of Child Support Enforcement (DCSE)

Finding: In two of five Temporary Assistance to Needy Families (TANF) cases tested, there was no evidence that local departments of social services received notification of custodial parents' failure to cooperate with DCSE.

Recommendation: The Department should ensure the prompt delivery of non-cooperation notices.

Response (provided by Nathaniel L. Young, Jr., Deputy Commissioner & Director, Child Support Enforcement, & Thomas J. Steinhauser, Director, Benefit Programs): As a result of the 2006 audit, the Department developed and implemented an automated mechanism for communicating non-cooperation cases from APAPT to APECS; however, in researching the two findings noted in the 2007 audit, we unexpectedly learned that a program error was affecting the number of non-cooperation notices generated. Steps to correct this error were initiated immediately and completed in November 2007 as predicted. Currently, once a non-cooperation letter is generated, APECS sends non-cooperation notification to ADAPT for appropriate action by the local departments of social services. To further improve timely reduction in benefits for non-cooperation, the Division of Information Systems is working on a report that will enable regional staff to monitor local non-cooperation. The target date for completion of this report is January 31, 2008..

Define Responsibilities for Monitoring Locality Operations

Finding: Despite strengthening its budgeting controls since the previous audit, the Department had not incorporated the roles and responsibilities of regional offices into budgeting documents nor had it identified who was responsible for monitoring and evaluating the overall budget of each locality.

Recommendation: The Department should continue its progress by further refining individual roles and responsibilities for monitoring localities.

Response (provided by J. R. Simpson, Chief Financial Officer and Jack B. Frazier, Director, Community & Volunteer Services): Responsibility for the overall budget and financial reviews of local departments of social services (LDSS) including pass-thru expenses is, and was at the time of the audit, assigned to Regional Administrative Managers (RAMS) through Employee Work Profiles (EWP). Measurements for these responsibilities will be added to RAM EWPs effective November 2007. RAM responsibilities will also, by January 31, 2008, be included in the "Procedures for Local Budget Administrators" created subsequent to the 2006 audit.

Complimenting and supplementing the efforts of the RAMS are the monthly budget reviews and the sub-recipient monitoring program currently being implemented. One of the components of the sub-recipient monitoring program is the Local Review Team (LRT) which was established in April 2007 to review local claims for reimbursement. The LRT's process starts with desk reviews performed in the Central Office, obtaining and using assistance from RAMS where required, and moves to field reviews where appropriate.

To further enhance the budget review process for LDSS, the Department has restored the three RAM positions which had been vacant since 2003 because of budget reductions. The Department has also added three positions to the LRT. When these positions are filled, there will be a RAM and an analyst assigned to each of the five DSS regions.

Align Plan for Monitoring Local Social Services Offices with Best Practices

Finding:

(1) Communication of Responsibilities

The manager assigned to coordinate divisional monitoring programs into a system-wide approach did not have the authority to hold the individual divisions accountable.

(2) Communication with Localities

The Department's plan did not address how implementation will be communicated to local social services agencies or how the localities should address problems.

(3) System-wide Risk-based Approach

There was no system-wide mechanism for identifying and reacting changes in sub-recipients or programs. In addition, a risk assessment for identifying the localities and programs with the highest risk had not been developed.

(4) Accountability for Deficiencies

The Department's plan does not include a framework for holding localities accountable for deficiencies.

Recommendation:

(1) Communication of Responsibilities

Department management should define and communicate the coordinator's duties and responsibilities, including authority for accountability.

(2) Communication with Localities

Communication with localities should be improved.

(3) System-wide Risk-based Approach

The risk-based approach should be used not only for monitoring localities but for allocating resources. In addition, a system-wide mechanism for monitoring sub-recipients should be developed.

(4) Accountability for Deficiencies

The Department should determine the type of sanctions to impose for deficiencies and communicate those sanctions to the localities.

Response (provided by Wallace G. Harris, Chief Operating Officer):

(1) Communication of Responsibilities

The Department agrees in part with the auditor's recommendation. The sub-recipient monitoring plan as well as the Employee Work Profile (EWP) for the monitoring coordinator will be revised to clearly articulate the coordinator's duties and responsibilities within the organization. Because the plan calls for cross divisional coordination, the plan will be specific as to the coordinator's responsibility to report any accountability and/or implementation issues to the Chief Operating Officer, who will have the necessary authority over the other divisions to hold them accountable when implementing the program. The revisions to the plan and to the EWP will be made no later than January 31, 2008.

(2) Communication with Localities

The Department agrees with the auditor's recommendation. Once hired, the sub-recipient monitoring coordinator will develop a two-phased process to improve communications with localities. The first, in conjunction with Public Affairs, will be a general discussion of the monitoring program to explain rationale and set expectations. The second will be more detailed and procedural relative to the actual monitoring activities to take place. The communications process will be initiated within 60 days of the coordinator position being filled and beginning work.

(3) System-wide Risk-based Approach

The Department agrees with the auditor's recommendation. VDSS will cause a risk assessment to be conducted to determine a monitoring schedule that allocates resources relative to risk. That assessment and resulting schedule will be completed by September 30, 2008, or sooner, if internal resources are available to conduct the assessment.

(4) Accountability for Deficiencies

DSS management agrees in part with the auditor's recommendation. Where federal funds are involved and where the local agency's failure to follow policies and procedures results in a disallowance, DSS may have no discretion on the sanction to be levied. Where DSS has discretion, guidelines will be established and published that define appropriate sanctions and how those sanctions will be applied consistently across localities. Those guidelines will be established and published no later than June 30, 2008.

Establish Procedures for Controlling the Cash in the Child Support Enforcement Fund

Finding: The Department improperly transferred $28 million from the Child Support Enforcement (CSE) fund and, as of June 30, 2007, needed to recover $18 million.

Recommendation: The Department should assess why the controls in this area failed to operate.

Response (provided by J. R. Simpson, Chief Financial Officer): The accounting entries cited in this finding resulted in an understatement of the balance in the CSE fund, but do not represent a loss of funds. The $18M cited as not recovered as of June 30, 2007 has been fully recovered and was reflected in the CSE fund on December 14, 2007.

The next quarterly transfers related to the CSE fund will occur in late January or early February 2008. Before that transfer, the related procedures will be rewritten and the Chief Financial Officer and the Director of Child Support Enforcement will review the updated procedures with involved staff members. Going forward, these entries will be reviewed and approved by knowledgeable fiscal and program staff with appropriate action being taken where necessary to prevent recurrence.

We agree that internal controls and other warning signals failed in this case. We do not agree that no internal controls existed.

Systems Development Policies and Procedures Need Improvement and Updating

Finding:

(1) There was no documentation connecting the Department's Information Technology Investment Management (ITIM) methodology to the Commonwealth's Project Management Standard.

(2) The Department's ITIM handbook did not provide guidance for operational maintenance requests which evolve into development projects. As a result, one recent project (ChildWIN) was not reported for approval and oversight.

(3) Service requests were not classified as projects as required by VITA's Project Management Division (PMD). Of nearly 200 service requests submitted in fiscal year 2007, only two were reported to PMD.

(4) Although the Department's lifecycle methodology is in line with industry best practices, its policies did not contain certain information and documents essential for project success. In addition, not all System Development Lifecycle (SDLC) methodology documents exist.

Recommendation:

(1) The Department should revise its policies to comply with the Commonwealth's Project Management Standard on classification and governance of projects.

(2) A process to evaluate system operational costs versus benefits should be established and used to make system replacement decisions. VITA should examine the dollar threshold for defining projects and categorizing them as major and non-major.

(3) The Department should use its newly implemented service request tracking and submission process to ensure proper identification, approval and oversight in accordance with the Commonwealth's Project Management Standard.

(4) Policies should be revised and maintained current to ensure inclusion of essential documents and compliance with the Commonwealth's Project Management Standard.

Response (provided by Wallace G. Harris, Chief Operating Officer):

(1) The Department agrees with the recommendation and will modify its ITIM procedures to specifically tie the ITIM process with the identification and reporting of projects as noted in the Commonwealth's Project Management Standard. These procedures will be modified no later than January 31, 2008.

(2) The Department agrees with the intent of the recommendation and has begun discussions with the Gartner Group to develop a process which identifies systems which need to be replaced. However, we believe this is a VITA issue and that VITA should establish a statewide protocol for comparing all information technology investments that consider return on investments. We agree that VITA should examine the dollar threshold for defining projects and for categorizing them as major and non-major. We encourage the auditor to discuss both aspects of this recommendation with VITA.

(3) In conjunction with its ongoing improvement of internal processes, the Department revised its Service Request System to capture more detailed information for determining major and non-major projects. The revisions went into production as of October 15, 2007.

(4) The Department will update the current SDLC methodology and train its project managers, by February 1, 2008, on the necessity for consistency between DSS policies and procedures and those of the Commonwealth's Project Management Standard. The Department has also initiated a monthly Project Manager Roundtable to discuss issues and work on compliance with state policies and procedures.

RISK ALERT

Security Risk Assurance for Infrastructure

Finding: The IT Partnership staff did not have formal documented procedures for job monitoring of the MVS and Unisys environments, UNIX security administration, Windows server administration, network security or environmental security.

Recommendation: DSS should receive regular status reports from VITA on the progress the IT Partnership is making to correct these issues. VITA should also provide interim steps to be taken should there be an implementation delay.

Response (provided by Wallace G. Harris, Chief Operating Officer): On October 23, 2007, the Department requested that VITA Security provide quarterly status reports which detail the IT Partnership's progress in correcting outstanding security issues and which specify interim steps that DSS should take if the IT Partnership has a delay in addressing these issues. VITA agreed to provide the first such report by January 31, 2008.

****

COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

PATRICK W. FINNERTY
DIRECTOR

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January 22, 2008

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

Dear Mr. Kucharski:

We have reviewed your Report on Audit for the Year Ended June 30, 2007. We concur with your finding and will initiate corrective action.

If you have any questions, please do not hesitate to contact our Director of Internal Audit, Charles W. Lawver.

Sincerely,

Patrick W. Finnerty

COMMONWEALTH of VIRGINIA

DEPARTMENT OF
MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES

JAMES S. REINHARD, M.D.
COMMISSIONER

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January 29, 2008

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

Dear Mr. Kucharski:

Attached are the responses of the Department of Mental Health, Mental Retardation and Substance Abuse Services to the fiscal year 2007 audit. Please feel free to contact appropriate staff if you have any questions or concerns regarding the content of these responses.

Sincerely,

James Reinhard

James S. Reinhard, M.D

Cc: Ray Ratke
James Evans
Frank Tetrick
Joy Yeh
Ken Gunn

Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services
Response to Auditor of Public Accounts Fiscal Year 2007 Audit

Presented below are the official responses of the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) to the fiscal year 2007 Auditor of Public Accounts audit. We would like to officially thank APA for this opportunity to comment and for their professionalism in the conduct of the audit.

Improve Monitoring Program Over Community Services Boards

This single finding consists of three parts. Each part is addressed separately below.

System-Wide Risk Assessment

Although DMHMRSAS assesses risk when decisions regarding field site reviews are made, the assessment has not been based upon a formal, documented risk assessment framework. We agree with this recommendation and will conduct such an assessment. The lead offices will be the Office of Budget and Financial Reporting, the Office of Internal Audit and the Office of Community Services Administration.

Accountability for Deficiencies

DMHMRSAS does hold community services boards accountable for the correction of audit findings. Furthermore, DMHMRSAS, via desk review, follows up on previous year audit findings. These are considered along with current findings when we decide the extent to which follow up is needed. Our policy has always been that ***material*** audit findings become part of the performance contract. Although audit findings were noted in some of the independent audits of the community services boards, none were considered by the auditors to be material weaknesses. We, therefore, did not include them in the performance contracts.

We will continue to follow up on all audit findings of independent CPA firms relative to our community services boards.

On Site Financial Reviews

The spirit of this recommendation is more in line with that of formalizing the risk assessment process as noted previously. We will formalize this risk assessment process and use it to determine the extent to which field site reviews are required.

Implement An Efficient Timekeeping System

We agree with this recommendation and will make an effort to implement it where possible and within available resources. Unfortunately, our facilities have been subjected

to budget reductions. These reductions have had the effect of forcing our inpatient operations to rethink service delivery and to make important decisions regarding priorities related to patient care. Resources related to direct care staffing will have to be prioritized first before we are able to look at funding other important aspects of facility operations.

Complete Eligibility Verification Forms

The Department agrees with the deficiencies noted regarding the errors found on the I-9 forms and is taking appropriate steps to ensure that the state facility Human Resource Offices (HROs) receive further communication on proper completion from Central Office Human Resources. However, it should be noted that the department opines that the errors were not due to a "lack of proper guidance and inadequate policy and procedures regarding the I-9 process at DMHMRSAS" but largely due to human error in completing the forms. The Department believes that there is adequate guidance both from the federal government and state government based upon the following:

1. The I-9 form is self explanatory (even given the changes effective November, 2007).
2. The Department follows the "Handbook for Employers-Instructions for completing the Form I-9" issued by the Department of Homeland Security /U.S. Citizenship and Immigration Services.
3. The Department follows guidance issued by the Department of Human Resources Management (DHRM) which outlines employer requirements under the I-9 process. (See DHRM's Human Resource Manual, Chapter 15, page 7)
4. The state facilities develop internal policies covering documentation requirements for pre/post-employment purposes. Additionally, any changes to federal/state forms affecting all state employers is periodically communicated to the Department from DHRM and then subsequently to state facility HROs.

Security Risk Assurance for Infrastructure

We agree that VITA and Northrop Grumman Partnership have not provided the Department assurances that the IT Partnership practices proper policies and procedures as outlined by the Department and that the Partnership has not provided this.

We are undergoing "server transformation" in our agency that will correct equipment deficiencies that impact our ability to install security patches and address a number of backup and recovery issues.

Improve Security Awareness Training Documentation

We agree that the documentation of security awareness training by employees is inadequate, primarily in state facilities. Human Resources provided each facility with the

training requirements and the need to document this training. Some facilities complied and others did not.

Improve Contingency and Disaster Recovery Planning

We agree that there are inadequate interim operational procedures for financial and pharmacy services should IT systems and support fail. We also believe that,

1. These manual contingency plans should be the responsibility of the service area and not IT.
2. In the case of pharmacy services, contingency procedures do not exist and need to be developed by the customer. In the case of fiscal services, the procedures exist but the service areas are not aware of them and need training on them.

COMMONWEALTH of VIRGINIA

Department of Health

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1-800-828-1120

January 28, 2008

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, 2007.

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

Sincerely,

Karen Remley, M.D., M.B.A.
Commissioner, Virginia Department of Health

CC: Department of Accounts

Properly Complete Employment Eligibility Verification Forms – First Year Finding

Health is not properly completing Employment Eligibility Verification forms (I-9) in accordance with guidance issued by the US Citizenship and Immigration Services of the US Department of Homeland Security in its Handbook for Employers (M-274). The guidance requires the employee complete, sign and date Section 1 of the I-9 on or before the first day of employment. Additionally, employer or designated representative must complete, sign and date Section 2 of the I-9 within three days of employment.

Furthermore, Section 2 contains spaces for the employer to lists the documents they verified from Lists A **or** B and C. For US Citizens, the employer must verify one document from List A. If no documentation from List A is available for the US Citizen, the employee must provide one document from List B and one from List C, which the employer verifies and records on the I-9. For foreign nationals authorized to work in the United States, the employer only needs to verify and list the employee's unexpired foreign passport and a current, unexpired INS authorization to work on the I-9.

In our sample of twenty I-9 forms completed in fiscal year 2007, we only found three I-9 forms correctly completed by Health. In the remaining seventeen, we observed numerous errors. Based upon the number of errors and that our findings are similar to the results found and reported by Health's Internal Audit's review of Employment Verification Forms in fiscal year 2006, we considered this finding to be a significant internal control weakness over compliance.

We recommend that the Human Resources Division train human resource employees on the requirements of completing I-9s and then develop a process for continuously reviewing Health's I-9 process. The federal government has stepped its enforcement efforts related to hiring illegal immigrants, which makes having a good I-9 process in place more important than ever before. Furthermore, we recommend that Health be cautious in the amount of documents it requests from each employee because employers requesting more than the minimum amount of documentation from employees could be subject to fines and penalties, as the Department of Homeland Security considers it a form of harassment.

VDH Management Response

We concur that there were a number of forms not filled out completely or precisely.
All incomplete or imprecise entries have been corrected or annotated. A number of corrective actions have been completed and additional measures are underway to inform agency managers of I-9 requirements. Included are annual training, web based resources, sample forms, individual consultation and assignment of additional line responsibilities for quality assurance.

Health Findings and Recommendations

Security Risk Assurance for Infrastructure

The Virginia Department of Health (Health) has responsibility for the security and safeguarding of all of the Department's information technology systems and information. Over the past four years, the Commonwealth has moved the information technology infrastructure supporting these databases to the Virginia Information Technologies Agency (VITA), who has an Information Technology Partnership (IT Partnership) with Northrop Grumman. In this environment, VITA and Health clearly share responsibility for the security of the Department's information technology assets, systems, and information and must provide mutual assurance of this safeguarding.

Health has provided VITA with all the documentation required to make this assessment and VITA should provide assurance that the IT Partnership will practice proper policies and procedures as outlined by Health. The annual review and audit of the IT Partnership infrastructure has concluded and VITA will communicate any findings and corrective action to Health.

The annual review and audit has identified that the IT Partnership staff did not have formal, documented procedures for security administration, backup operations, desktop support administration, change control, and system monitoring. A documented and implemented system administration process, change control process, and system monitoring process is critical in order to minimize the security risks relating to the confidentiality, integrity, and availability of the Health's information stored on the IT Partnership's hardware and infrastructure.

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

VDH Management Response

We concur with this finding and intend to monitor corrective actions taken by the IT Partnership.

Update and Expand Security Awareness Training – First Year Finding

Health should update its Security Awareness Training and provide system users with regular updates to minimize the risks of not maintaining the confidentiality, integrity, and availability of information. Health operates a Security Awareness Training with outdated materials that do not address the risks of protecting Health's data. Additionally, Health does not require users to receive regular refresher training to update their Security Awareness. Updates help ensure that users are aware of new policies, procedures, or risks to Health's information.

Health should evaluate and update the content of its Security Awareness Training and develop a process for providing system users with regular refreshers courses. Health should annually review the content of its Security Awareness Training to ensure it addresses any new risks.

VDH Management Response

We concur with this finding. The Agency ISO will institute an agency wide formal IS system user security awareness training program no later than March 31, 2008. This program will be used for annual IT system user and new employee training and will provide formal records of who has received the training and the curriculum used.

As we are aware that specialized security awareness training is also required for IS system managers, administrators, developers, data owners and in the area of disaster recovery, the Agency CIO and Agency ISO will consult with the Agency Information Systems Security Committee to determine the specific formal IS security awareness training that will be performed under the jurisdiction of the Agency IS Security Officer, Office of Human Resource Management-New Employee Orientation and Office of the Emergency, Preparedness and Response by January 31, 2007.

Improve Contingency and Disaster Recovery Planning – First Year Finding

Health does not have adequate contingency and disaster recovery plans for some of its sensitive and mission critical applications. In our sample of seven of the eighteen mission critical applications identified by Health as very sensitive and mission critical, we found three systems with untested or no plans.

Inadequate analysis, planning, and testing of Health's contingency and disaster plans places the confidentiality, integrity, and availability of the Commonwealth's sensitive and mission critical information at risk. The Commonwealth's information security standards require that agencies develop business impact analysis, risk assessments, continuity of operations plans, and disaster recovery plans for sensitive and mission critical applications. Additionally, agencies must perform annual tests of these plans.

Health should apply the Commonwealth's information security standards consistently to all applications housing sensitive and mission critical information. Health should start this process by dedicating the necessary resources to review and remediate the risks to their sensitive and mission critical applications.

VDH Management Response

We concur with this finding. The Information Security Officer (ISO) will work with the Data Owners in each of the respective departments and insure that they correct the noted findings by March 31, 2008. In addition, the ISO will work with the Agency Security Committee to devise a plan to insure that all agency data owners are trained in the completion of Business Impact Analyses, Risk Assessments, Continuity of Operations Plans, and Disaster Recovery Plans by June 30, 2008.

COMMONWEALTH of VIRGINIA

James A. Rothrock, M.S., L.P.C.
COMMISSIONER

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January 28, 2008

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, 2007.

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

DRS's Response to: ***Update and Expand Security Awareness Training – First Year Finding***

The Department of Rehabilitative Services concurs with this recommendation and is in the process of updating its Security Awareness Training Program. The training will include, but not be limited to, protecting the Disability Service Agencies' data and minimizing risks associated with issues of confidentiality, integrity, and availability of information. The training will address Information Technology security as well as physical security.

The Department of Human Resource Management's (DHRM) Knowledge Center will be used to track employee's completion of the Security Awareness Training. The system will be used as a tool to ensure that employees are provided both the initial training as well as periodic refresher training.

DRS's Response to: ***Improve Data Protection – First year Finding***

While the Department of Rehabilitative Services (DRS) concurs with the findings of the APA, it should be noted that the Federal Department of Social Security Administration mandates that DRS use the (Virginia) Claims Processing System. This system is subject to Federal security standards. We are in contact with our Federal partners and all parties are currently working diligently to correct this system deficiency. The Agency (DRS) expects to have this issue resolved by use of secure File Transfer Protocol (FTP) no later than March 31, 2008. The Department of Rehabilitative Services will also systematically review other FTP scripts to be sure this issue does not occur with other data interfaces is the future.

DRS's Response to: ***Security Risk Assurance for Infrastructure – Risk Alert/Repeat Finding***

The Disability Service Agencies are in agreement with the APA finding that it is the Virginia Information Technology Agency's (VITA) to take corrective action in response to this finding. Further, the Department (DRS) agrees that VITA should provide regular status reports from VITA on the progress the IT Partnership is making to correct the issues. The Department of Rehabilitative Services, on behalf of all the Disability Service Agencies, has requested and will continue to request on a quarterly basis, a status report from VITA on the IT Partnership's remediation plan regarding the security issues that Deloitte and Touche noted in their review. Also, VITA was asked to provide DRS with any interim steps it should take if the IT Partnership must delay addressing the issue. DRS will work with VITA to implement any interim steps that VITA recommends.

DRS's Response to: ***Limit CIPPS Access for Woodrow Wilson Rehabilitation Center Employees – First Year Finding***

Following the loss of a key Payroll position at the Woodrow Wilson Rehabilitation Center (WWRC) in 2001, the DRS Payroll Unit assumed payroll responsibility for them. The function was transferred to DRS with the understanding that WWRC would: a) reassume the function if the increased payroll workload could not be handled by DRS; and b) retain CIPPS access types that would allow them to process payrolls in case of emergency.

While DRS did successfully assume the WWRC payroll processing, WWRC maintained their CIPPS access as a part of the Continuity of Operations Planning (COOP) effort and has maintained their ability to enter and certify payrolls at the Center should the need arise. Currently, they retain 2 positions that have data entry capability and 1 position (Fiscal Director) with type 3 access for certification of the payrolls. Although these

CIPPS access types have remained in force, to date, WWRC has not had to enter or certify CIPPS payroll data.

In light of the APA recommendation that selected Fiscal employees at WWRC should be limited to "view only" CIPPS access, and the recent hire of a fourth Payroll position at DRS, the Department will comply with the APA recommendation no later than February 10, 2008. All Fiscal staff at WWRC that now maintain a data entry or certification type CIPPS access will be changed to "view only".

DRS's Response to: ***Remove an Employee's Ability to Create and Approve Payroll Payments – First Year Finding***

As noted in the APA finding, the Department of Accounts granted this dual CIPPS access type based on the volume and number of agencies served by DRS and the limited number of Payroll staff to do the job. DRS concurs that an internal control risk exists as a result of this dual CIPPS access type; however, controls were put in place to mitigate this risk. At no time did the employee in question certify and release any payrolls that they had been responsible for processing or keying. System controls were put in place to ensure that did not occur. With the recent hire of an additional Payroll Accountant position in the DRS Payroll Unit, the need for a position to maintain dual CIPPS access types diminishes. Therefore, effective on or before March 10, 2008, the employee in question will no longer have dual access to CIPPS. This action should effectively mitigate any unnecessary risk in the Payroll area.

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

Very Truly Yours,

Philip W. Benton
DSA Financial Services Director

cc: James A. Rothrock, M.S., L.P.C., Commissioner, DRS
Joseph A. Bowman, Commissioner, DBVI
Heidi L. Lawyer, Director, VBPD
Ronald L. Lanier, Director, VDDHH
David A. Von Moll, Comptroller, DOA

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