Department of Legislative Services
Office of Legislative Audits

Department of Human Resources – Local Department Operations (LDO)

Report Dated July 24, 2015

Presentation to the Joint Audit Committee

Thomas J. Barnickel III, CPA
Joshua S. Adler, CPA, CFE

November 3, 2015

Audit Overview

- Local Department Operations (LDO) is one of seven budgetary units in the Department of Human Resources (DHR). It consists of funds for activities (e.g., Temporary Cash Assistance) administered by the 24 local departments of social services (LDSS).
- The LDO's fiscal year 2014 expenditures totaled approximately $2.2 billion, which included $1.7 billion in assistance program expenditures and $500 million in operating expenditures (primarily employee salaries and benefits).
- State law requires DHR to audit each LDSS every three years. Audits are performed by DHR's Office of the Inspector General (OIG). OLA reviewed this work and concluded that it could be relied upon, and thus we did not conduct audits of the LDSSs.
- The prior OLA audit report contained 6 findings, and our current audit disclosed that 1 was satisfactorily addressed by DHR. The remaining 5 findings, are repeated in this report as Findings 1, 4, 5, 7 and 8, based on our review of OIG's LDSS audits.

Key Audit Issues

- The audit reports issued by the OIG indicated that the LDSSs continued to have a significant number of audit deficiencies in critical areas of operations, including a number of repeat findings.

- DHR's executive management had not established a formal process to provide oversight and monitoring to help ensure that the findings were corrected.

- The OIG's corrective action monitoring process was not effectively followed to help ensure that findings were corrected.

- The OIG did not distribute its LDSS reports to all appropriate governing authorities and to local oversight boards, as required by State law.

OIG Audit Findings and Oversight

DHR executive management had not established a formal process to provide oversight and monitoring of LDSS corrective actions, which if in place, could help ensure that audit findings are addressed. **(Finding 1)**

The 24 LDSSs OIG audit reports issued as of December 2014 contained a significant number of deficiencies in five critical areas (see Page 5), including a number of repeat findings.

- OIG audit reports collectively contained 299 findings, including 89 deemed to be repeat conditions from the preceding OIG reports. The number of findings in each report ranged from 5 (two LDSS) to 30 (one LDSS), with five reports containing at least 20 findings.

- While the number of findings has decreased (from 373) since our preceding audit report, the number deemed by the OIG to be repeated has increased (from 77).

OIG's Corrective Action Monitoring Process

The OIG had a corrective action monitoring process for the LDSS findings, but it was not effectively followed to help ensure that corrective actions were taken and that DHR executive management was provided periodic LDSS progress reports, as required. **(Finding 2)**

- Our review of the actions taken by 5 LDSSs to address 106 findings in the related OIG audit reports disclosed that for 36 findings the OIG either determined that the finding had been resolved based on insufficient evidence or did not adequately follow-up to obtain information when not provided by the LDSS.

LDSS Audit Report Distribution

The OIG did not distribute the LDSS audit reports to all appropriate parties. (**Finding 3**)

- The OIG generally distributed its audit reports within DHR and to the applicable LDSS directors; however, the reports were not distributed to the members of the applicable City or county council and to the LDSS oversight boards, as required by State law.

- Although the LDSSs administer programs that provide essential services using considerable public funding, the OIG's audit reports were not available to the public through DHR's website. Public issuance is not required nor precluded by law and OLA believes that public reporting would provide greater transparency, potentially resulting in increased accountability by the LDSSs.

- DHR management advised that providing public reports would result in additional resources and increased costs, such as to enhance a quality review process.

Overview of OIG Audit Findings

Overview of the 299 OIG Findings by Functional Area
(Reports Issued as of December 2014)

Functional Area	Number of	
	LDSSs	Findings
Fiscal Management (e.g., bank accounts and procurement)	23	97
Family Investment Administration (e.g., Supplemental Nutrition Assistance Program)	22	70
Social Services Administration (e.g. out of home placement program)	19	63
Computer Systems Security (e.g., access to benefit systems)	21	40
Other (e.g., Medicaid eligibility determinations)	16	29

LDSS Audit Findings by Critical Area

Fiscal Management

The OIG reports for 23 LDSSs contained 97 findings pertaining to fiscal management such as bank accounts, procurement and prepaid gift cards. **(Finding 4)** For example:

- Bank accounts maintained by the LDSSs to pay for certain administrative and program expenditures were not reconciled timely and had outstanding checks for extended periods.

- State procurement regulations were not always followed. For example, payments were made to vendors without written contracts and formal procurement processes were circumvented.

- Accountability of prepaid gift cards (provided to recipients in urgent need of support) was not established, as physical inventories of gift cards were not documented.

LDSS Audit Findings by Critical Area (continued)

Family Investment Administration (FIA)

The OIG reports for 22 LDSSs contained 70 findings related to FIA programs including the Supplemental Nutrition Assistance Program (SNAP) and Temporary Cash Assistance (TCA). **(Finding 5)** For example:

- Critical duties were not properly segregated for the electronic debit cards used by recipients to access SNAP and TCA benefits. As a result, there was a lack of assurance that the benefits were being used by the intended recipient(s).

- The required number of public assistance case files were not subject to supervisory review, in accordance with FIA quality assurance policies. These reviews help ensure the accuracy and the propriety of assistance payments and reduce errors.

FY 2014 SNAP disbursements were $1.2 billion (federal) and TCA payments were $203 million (federal and State).

LDSS Audit Findings by Critical Area (continued)

Social Services Administration (SSA)

The OIG reports for 19 LDSSs contained 63 findings related to SSA activities, primarily related to the out-home-placement and adoption programs. **(Finding 6)** For example:

- Out-of-home placement program case files did not always have documentation that a caseworker had monthly contact with the child, as required, so there was a lack of assurance that all services were provided. The program provides short-term care and support to children who are unable to live at home because of abuse/neglect.
- Adoptions expenses were paid without any documented support justifying the expenditure and without obtaining partial reimbursement from federal funding.

As of June 2014, there were 5,339 children in the out-of-home placement program and 337 adoption cases, and FY 2014 expenditures totaled $303 million.

LDSS Audit Findings by Critical Area (continued)

Computer Systems Security

OIG reports for 21 LDSSs contained 40 findings related to computer systems security for critical systems, such as the system used to record, authorize, and disburse SNAP and TCA benefits. **(Finding 7)** For example:

- Controls over granting of user access to critical systems needed improvement, as documents authorizing employee access were missing or not completed, and certain employees had access capabilities that were not required for their duties.
- Employees' assigned access capabilities were not properly monitored. Logonids of certain former employees were not deleted and employee access was not periodically reviewed for appropriateness.

Based on these conditions, assurance was lacking that employee access was necessary and appropriate and unnecessary system access could result in unauthorized changes to data without detection.

Medicaid Eligibility Determinations

Medicaid eligibility determinations for long-term care recipients were not always proper. **(Finding 8)**

- Through an interagency agreement between DHR and the Department of Health and Mental Hygiene, the LDSSs perform the eligibility determination for the majority of Medicaid recipients.

- The OIG conducted a review of the Medicaid long-term care eligibility determinations at the Anne Arundel County, Baltimore City, Baltimore County, and Prince George's County LDSSs.

- In its July 2014 report, the OIG noted that cases could not be located, eligibility documentation was missing, and real property searches were not conducted to assist in determining whether financial resources were within the limits established by State regulations. For example, OIG's review of 42 case files disclosed 12 cases with inadequate eligibility determinations or lien documentation.

Conclusions

DHR, including the Office of the Secretary and the management of the DHR administrations, as applicable, should:

- establish a process to actively monitor corrective actions taken to address OIG audit findings;
- ensure that the OIG's corrective action monitoring process is effectively followed;
- distribute the OIG audit reports to all appropriate parties;
- ensure that the LDSSs establish appropriate accountability and controls over their financial processes and information systems;
- ensure that the LDSSs comply with all FIA and SSA program requirements; and
- ensure that the LDSSs properly perform Medicaid long-term care eligibility determinations.