DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General
Office of Audit Services

Region VII
601 East 12th Street
Room 284A
Kansas City, Missouri 64106

June 20, 2005

Report Number: A-07-05-04049

Carmen Hooker Odom, Secretary
Department of Health and Human Services
Adams Building
101 Blair Drive
Raleigh, North Carolina 27603

Dear Secretary Odom:

Enclosed are two copies of the U.S. Department of Health and Human Services, Office of Inspector General (OIG), final report entitled "Medicaid Hospital Outlier Payments in North Carolina – Compliance." A copy of this report will be forwarded to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters in the report. We request that you respond to the HHS action official within 30 days. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

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Please refer to report number A-07-05-04049 in all correspondence.

Sincerely,

James P. Aasmundstad,
Regional Inspector General
for Audit Services

Enclosures

Direct Reply to HHS Action Official:

Rose Crum-Johnson
Regional Administrator
Centers for Medicare & Medicaid Services
Atlanta Federal Center
61 Forsyth Street, S.W. Suite 4T20
Atlanta, Georgia 30303-8909

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICAID HOSPITAL OUTLIER PAYMENTS IN NORTH CAROLINA - COMPLIANCE

DANIEL R. LEVINSON
Inspector General

JUNE 2005
A-07-05- 04049

Office of Inspector General

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OAS FINDINGS AND OPINIONS

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed as well as other conclusions and recommendations in this report represent the findings and opinions of the HHS/OIG/OAS. Authorized officials of the awarding agency will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

North Carolina Medicaid Payments

The State of North Carolina (State) pays hospitals a predetermined per-discharge rate referred to as diagnosis related groups (DRG). While DRG payments vary by category of inpatient Medicaid cases, the payments for each category of cases are fixed. Under this system, hospitals have a financial incentive to avoid extremely costly cases. To counter this incentive and promote access to hospital care for these extremely costly patients, the State makes additional payments, called cost outlier payments. Outlier payments can be viewed as insurance for hospitals against the large losses that could result from extremely expensive cases.

Outlier Formula

The cost outlier payment amount is equal to 75 percent of the difference between the total estimated cost for the stay (billed charges multiplied by the cost-to-charge ratio) and the DRG-specific threshold amount. The cost outlier threshold is the greater of $25,000 or the mean cost for the DRG plus 1.96 standard deviations.

The State contracted with Myers and Stauffer, L.C. to calculate the cost-to-charge ratio and cost outlier thresholds. The Medicaid State Plan requires the factors used to calculate the outlier payments to be updated effective October 1 of each year.

OBJECTIVE

Our objective was to determine if the State correctly calculated the cost outlier payments for all DRGs from State fiscal years (FY) 2000 through 2003.

SUMMARY OF FINDINGS

The State did not correctly calculate cost outlier payments for certain DRGs. The State's contractor used a 1.94 standard deviation factor in computing the threshold amount rather than the 1.96 factor required by the Medicaid State Plan and State regulations. In addition, while the State effectively updated the factors used to calculate the DRG base and cost outlier payment in 3 out of 4 years that we reviewed, the State did not update the factors effective October 1, 2002 on a timely basis. The errors occurred because the State neither adequately monitored the outlier payment calculation nor ensured factors used to calculate the DRG base and outlier payments were updated in a timely manner.

As a result of errors in calculating the outlier thresholds, the State overpaid seven hospitals $775,354 ($476,533 Federal share) for State fiscal years (FY) 2000 through 2003. The State also overpaid the seven hospitals an additional $368,251 ($226,326 Federal share) because it did not ensure the factors used to calculate the DRG base and cost outlier payments were updated in a timely manner. The State may have overpaid other hospitals due to similar errors.

RECOMMENDATIONS

We recommend the State:

1. collect $775,354 for cost outlier overpayments to the seven hospitals due to the use of the incorrect threshold factor (and refund the Federal share of $476,533 to the Centers for Medicare & Medicaid Services (CMS));

2. reprocess the improperly paid claims to the seven hospitals due to not updating the payment factors effective October 2002 in a timely manner. For the claims associated with a cost outlier payment, collect $368,251[1] for Medicaid base and outlier overpayments and underpayments (and refund the federal share of $226,326 to CMS). For the remaining Medicaid base claims, calculate the effect of the error and remit the Federal share of any overpayment to CMS;

3. calculate the effect of the errors for the remaining Medicaid hospitals and remit the Federal share of any overpayments to CMS; and

4. develop and implement policies and procedures to more closely monitor outlier payments. Specifically, ensure that the outlier threshold amount is correctly calculated for future outlier payments. In addition, on an ongoing basis, review factors used in the DRG base and outlier calculation to ensure accuracy and timeliness of future payments.

NORTH CAROLINA'S COMMENTS

The State concurred with our findings and recommendations. The full text of the State's comments is included as an appendix.

[1]Of the seven hospitals, one hospital was underpaid $1,296, and the remaining hospitals were overpaid a total of $369,547.

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INTRODUCTION

BACKGROUND

Medicaid Program

Medicaid was established in 1965 under Title XIX of the Social Security Act as a joint Federal and State program. Medicaid provides medical assistance to low-income persons who are age 65 or over, blind, disabled, or members of families with dependent children or qualified pregnant women or children. Each State administers its Medicaid program in accordance with a Medicaid State Plan approved by Centers for Medicare & Medicaid (CMS), which is responsible for the program at the Federal level. Within broad Federal rules, each State decides eligible groups, types and range of services, payment levels for services, and administrative and operating procedures. The Division of Medical Assistance administers the State of North Carolina's (State) Medicaid program.

The State pays hospitals for Medicaid inpatient stays using a prospective payment system that includes a pre-established amount for each discharge based on a diagnosis related group (DRG) code. Although a hospital's cost can vary significantly among patients within a specific DRG, the DRG payment is fixed. To compensate hospitals when they incur significantly high costs, the State pays hospitals outlier payments to help cover those extra costs. The outlier policy promotes access to care for extremely costly patients who would otherwise be financially unattractive.

The State established Medicaid outlier payments for situations in which the cost of care is extraordinarily high in relation to the average cost of treating comparable conditions or illnesses. Because hospitals cannot calculate costs for each admission, the State must convert billed charges to costs, using an established cost-to-charge ratio to determine if a claim qualifies as an extraordinary high-cost case. The cost-to-charge ratio is calculated by dividing the hospital's total estimated costs by its total charges and is adjusted for direct medical education costs. Total charges are derived from claims a hospital submitted to the State during the calendar year. The State calculates the estimated costs using factors from the hospital's cost report.

Outlier Formula

The cost outlier payment amount is equal to 75 percent of the difference between the total estimated cost for the stay (billed charges multiplied by the cost-to-charge ratio) and the DRG-specific threshold amount. The cost outlier threshold is the greater of $25,000 or the mean cost for the DRG plus 1.96 standard deviations.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine if the State correctly calculated the cost outlier payments for all DRGs from State fiscal year (FY) 2000 through 2003.

Scope

This audit is one of a series of audits of State Medicaid agencies' outlier payments.

During North Carolina State FYs 2000 through 2003, the State paid $2.5 billion in DRG base payments to hospitals for inpatient services. During the same period, the State paid $228.7 million in cost outlier payments to hospitals for inpatient services and made total Medicaid payments of $2.8 billion to hospitals paid under the DRG system. Total Medicaid payments include DRG base payments, day outlier payments, cost outlier payments, and disproportionate share payments. We reviewed claims from seven hospitals that received a high percentage of outlier payments for State FYs 2000 through 2003 and showed high growth in the outlier payments.

We did not perform a detailed review of the State or hospital internal controls because audit objectives did not require us to perform such tests. The State provided the Medicaid payment data used in this report. We reconciled 120 electronic claims from the State to detailed claim documentation at 4 hospitals to validate the accuracy of this data.

We performed our fieldwork at the North Carolina Division of Medical Assistance in Raleigh, NC, and at four of the selected North Carolina inpatient hospitals. We also interviewed and obtained documentation from officials at Myers and Stauffer, L.C., the State's consultant, in Leawood, KS.

Methodology

We identified seven hospitals that received a high percentage of outlier payments from a list provided by the State, which also included DRG base and outlier payments for each hospital for State FYs 2000 through 2003. We interviewed State officials and reviewed documentation in order to determine how the State calculated and monitored outlier payments. We also reviewed electronic claims, provided by the State, for the seven hospitals in order to evaluate the accuracy of the cost outlier payments.

To compute the net overpayments, we recalculated all cost outlier payments made by the State to the seven hospitals for State FYs 2000 through 2003 as of July 15, 2004. In the recalculations, we computed the outlier payment threshold with the 1.96 standard deviation figure in lieu of the 1.94 standard deviation figure used by the State. In addition, we used the appropriate weight table and cost-to-charge ratios that should have been in effect as of October 1, 2002. The reduced outlier payment may have caused a change to the disproportionate share payment a hospital may have received. However, we did not consider this in our overpayment calculation.

We performed our audit in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

The State did not correctly calculate cost outlier payments for certain DRGs. The State's contractor used a 1.94 standard deviation factor in computing the threshold amount rather than the 1.96 factor required by the Medicaid State Plan and State regulations. In addition, the factors

used to calculate the DRG base and cost outlier payment were not updated effective October 1, 2002. The errors occurred because the State neither adequately monitored the outlier payment calculation nor ensured factors used to calculate the DRG base and outlier payments were updated in a timely manner.

As a result of errors in calculating the outlier thresholds, the State overpaid seven hospitals $775,354 ($476,533 Federal share) for State fiscal years (FY) 2000 through 2003. The State also overpaid the seven hospitals an additional $368,251 ($226,326 Federal share) because it did not ensure the factors used to calculate the DRG base and cost outlier payments were updated in a timely manner. The State may have overpaid other hospitals due to similar errors.

State Requirements

The Medicaid State Plan and State regulations[2] provide that a cost threshold is the greater of $25,000 or mean cost for the DRG plus 1.96 standard deviations.

The Medicaid State Plan Amendment[3] states:

> *The Division of Medical Assistance (Division) shall use the DRG assignment logic of the Medicare Grouper to assign individual claims to a DRG category. Medicare revises the Grouper each year in October. The Division shall install the most recent version of the Medicare Grouper implemented by Medicare to be effective October 1 of each rate year.*[4]

Outlier Thresholds Incorrectly Calculated

The State's consultant incorrectly calculated the cost outlier thresholds by multiplying the standard deviation of costs attributed to each DRG by 1.94 standard deviations rather than 1.96 as required by the Medicaid State Plan. This resulted in an overpayment of all outlier payments with a threshold greater than $25,000. For example, by using the 1.94 standard deviations rather than the 1.96 factor, the State overpaid hospital F by $1,043 for one DRG 483 (Tracheotomy) claim in October 2002. (See Table 1.)

[2]North Carolina State Plan Attachment 4.19-A (g)(3) effective January 1995 and North Carolina Administrative Rules, subchapter 22G, section .0202 effective March 1995.

[3]North Carolina State Plan Amendment 4.19-A (b) effective January 1995.

[4]The Medicare Grouper is the software used to assign individual claims to a DRG category. The Division of Medical Assistance uses the Medicare Grouper program in the assignment of inpatient hospital claims.

Table 1: Illustration of Outlier Threshold Calculation Error

	Formula Details	Sample Claim Inaccurate Threshold Calculation	Sample Claim Accurate Threshold Calculation	Difference
Charges	Value A	$478,951	$478,951	
Cost-to-Charge Ratio	Value B	0.6697	0.6697	
Calculated Costs	C = A * B	320,753	320,753	
DRG Specific -				
Average Cost	Value D	75,904	75,904	
Standard Deviation	Value E	69,495	69,495	
Threshold				
Inaccurate Calculation	F = Greater of D + (1.94*E) or $25,000	210,724		
Accurate Calculation	F = Greater of D + (1.96*E) or $25,000		212,114	
Outlier Payment	G = C - F *.75	$82,522	$81,479	$1,043

Factors Not Updated In A Timely Manner

The Medicaid State Plan required the factors used to calculate the DRG base and outlier payments to be updated effective October 1 of each year. While the State updated these payment factors on a timely basis effective October 1, 1999, October 1, 2000, and October 1, 2001, the State did not update these factors effective October 1, 2002. Consequently, the State did not ensure the appropriate weight table and cost-to-charge ratio were used when calculating the DRG base and outlier payments effective October 1, 2002. Instead, some claims were paid based on factors from the prior year until the factors were updated effective November 2, 2002. Therefore, these payments were overstated or understated depending upon the DRG and the hospital. Further, the State did not retroactively adjust the payments that were made in error. For example, by using the prior year's weight table and cost-to-charge ratio for one DRG 408 (Myeloproliferative Disorders) claim with an October 2002 discharge, the State overpaid hospital E by $31,633 for the outlier portion of the payment and by $1,932 for the DRG base portion of the payment (for a total overpayment of $33,565). (See Table 2.)

Table 2: Illustration of Outlier Calculation for Claim Using Incorrect Factors

	Formula Details	Sample Claim Using Factors Effective Oct. 1, 2001	Sample Claim Using Factors Effective Oct. 1, 2002	Difference
Charges	Value A	$320,591	$320,591	
Cost-to-Charge Ratio	Value B	0.7027	0.6697	
Calculated Costs	C = A * B	225,279	214,700	
Threshold Used By State	Value D	38,437	70,035	
Outlier Payment	E = (C - D) *.75	140,132	108,499	$31,633
Hospital DRG Rate	Value F	4,955	4,955	
DRG Weight	Value G	2.08	1.69	
DRG Payment	H = F * G	$10,306	$8,374	$1,932

State Did Not Adequately Monitor Outlier Payments

The State did not adequately monitor outlier payments. The State neither adequately monitored the outlier threshold calculation nor ensured factors used to calculate the DRG base and outlier payments were updated in a timely manner.

The State relied on the contractor's determination of cost-to-charge ratios and thresholds. The State did not review the cost-to-charge ratio and threshold calculations for accuracy. The State was unaware of the amount of outlier payments that existed and was unable to provide clear and complete documentation on how the cost outlier payments were determined.

State Overpaid Diagnosis Related Groups and Outlier Payments

Because incorrect thresholds (based on a factor of 1.94 standard deviations instead of 1.96 standard deviations) were used to calculate the outlier payments, the State overpaid seven hospitals $775,354[5] ($476,533 Federal share) for State FYs 2000 through 2003. (See Table 3.) The State may have overpaid other hospitals due to similar errors.

[5]To compute the overpayment impact of using the incorrect cost outlier threshold, we determined, in some instances, that day outlier payments would have increased as a result of decreased or eliminated cost outlier payments. Accordingly, we reduced the cost outlier overpayment amount by the increase in day outlier payments.

Table 3: Outlier Overpayments Resulting From Incorrect Thresholds

Hospital	2000	2001	2002	2003	Total
A	$16,208	$23,024	$23,929	$23,983	$87,144
B	6,993	12,870	14,677	21,987	56,527
C	22,190	35,496	56,329	55,823	169,838
D	3,228	1,654	2,247	2,922	10,051
E	16,300	52,886	53,420	67,491	190,097
F	18,016	50,845	71,099	117,536	257,496
G	311	410	1,950	1,530	4,201
Total	**$83,246**	**$177,185**	**$223,651**	**$291,272**	**$775,354**

In addition, the State overpaid seven hospitals a total of $368,251 ($226,326 Federal share) because it did not ensure that the factors used to calculate DRG base and outlier payments were updated effective October 1, 2002. (See Table 4.)

Table 4: Overpayments Resulting From Factors Not Being Updated Timely

	FY 2003		
Hospital	**Cost Outlier**	**DRG**	**Total**
A	$38,165	$1,237	$ 39,402
B	15,861	(1,255)	14,606
C	454	256	710
D	-	-	-
E	136,602	13,315	149,917
F	169,639	(4,727)	164,912
G	(1,169)	(127)	(1,296)
Total	**$359,552**	**$8,699**	**$368,251**

RECOMMENDATIONS

We recommend the State:

1. collect $775,354 for cost outlier overpayments to the seven hospitals due to the use of the incorrect threshold factor (and refund the Federal share of $476,533 to CMS);

2. reprocess the improperly paid claims to the seven hospitals due to not updating the payment factors effective October 2002 in a timely manner. For the claims associated with a cost outlier payment, collect $368,251[6] for Medicaid base and outlier overpayments and underpayments (and refund the federal share of $226,326 to CMS). For the remaining Medicaid base claims, calculate the effect of the error and remit the Federal share of any overpayment to CMS;

3. calculate the effect of the errors for the remaining Medicaid hospitals and remit the Federal share of any overpayments to CMS; and

[6]Of the seven hospitals, one hospital was underpaid $1,296, and the remaining hospitals were overpaid a total of $369,547.

4. develop and implement policies and procedures to more closely monitor outlier payments. Specifically, ensure that the outlier threshold amount is correctly calculated for future outlier payments. In addition, on an ongoing basis, review factors used in the DRG base and outlier calculation to ensure accuracy and timeliness of future payments.

AUDITEE'S COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

The State concurred with our findings and recommendations. We commend the State for taking steps to identify and collect overpayments. We also commend the State for revising its policy and procedures to ensure Medicaid base and outlier payments are accurately calculated. The State's response is included in its entirety as an appendix.

APPENDIX

North Carolina Department of Health and Human Services
2001 Mail Service Center •Raleigh, North Carolina 27699-2001
Tel 919-733-4534 •Fax 919-715-4645

Michael F. Easley, Governor

Carmen Hooker Odom, Secretary

May 24, 2005

Report Number: A-07-05-04049

Mr. James P. Aasmundstad
Regional Inspector General for Audit Services
US DHHS Office of Audit Services
601 East 12th Street, Room 284A
Kansas City, Missouri 64106

Dear Mr. Aasmundstad:

We have received your April 15, 2005 letter and draft report entitled, *Medicaid Hospital Outlier Payments in North Carolina - Compliance.* We are also appreciative of the additional time allowed NC DHHS to respond to the draft report.

NCDHHS Response to Report Findings

The report indicated an overpayment to various hospitals across the State resulting from incorrect payments of certain claims for outlier claims. The total of these hospital overpayments was $1,143,605. We have reviewed and agree with the OIG audit report. We are providing the following specific comments relative to the four audit report recommendations.

OIG Audit Recommendation #1: Collect $775,354 for cost outlier payments to the seven hospitals due to the use of the incorrect threshold factor (and refund the federal share of $476,533 to the Centers for Medicare & Medicaid Services (CMS))

NC DHHS agrees with the audit finding that the contractor inadvertently and incorrectly used 1.94 standard deviations instead of the appropriate 1.96 standard deviations when establishing the Cost Outlier thresholds for rate period of October 1, 2002 through September 30, 2003. Further, the State intends to recover the amount of the identified error, either from the providers or from the contractor and thereby refund the amounts, making the Federal Government whole as to the FFP incorrectly claimed.

However, there are different means and approaches to accomplishing this goal and the Department has not yet determined the optimal method to accomplish this recoupment, but is in the process of doing so. This is targeted for completion during the fourth calendar quarter of 2005; however, the State of North Carolina is in the process of changing Medicaid fiscal

intermediaries. This change requires a substantial system conversion and a system freeze to allow parallel testing; we currently expect this freeze to begin during the fourth calendar quarter of 2005. If the system freeze prevents completion of the recoupment from providers in 2005, the recoupment will be accomplished under the new intermediary after July 2006. We will do our utmost to get it done before the system freeze.

Once this error was brought to our attention during the OIG audit, we have reinforced with our current rate contractor, Clifton Gunderson, the State Plan requirement of using 1.96 standard deviations when calculating the cost outlier threshold to ensure that the error does not recur.

OIG Audit Recommendation #2: Reprocess the improperly paid claims to the seven hospitals due to not timely updating the payment factors effective October 2002. For the claims associated with a cost outlier payment, collect $368,251 for Medicaid base and outlier overpayments and underpayments (and refund the federal share of $226,326 to CMS). For the remaining Medicaid base claims, calculate the effect of the error and remit the Federal share of any overpayment to CMS.

The Department agrees with the OIG audit finding that incorrect grouper versions were used in the instances identified. Further, the State intends to recover the amount of the identified error either from the providers or from the contract fiscal agents (EDS) and thereby make the Federal Government whole as to the FFP incorrectly claimed.

As background information, the Division of Medical Assistance annually updates to the most current grouper version in effect as of October 1. Because the most current grouper versions are not always approved by CMS prior to October 1, the new rates and grouper versions are updated as soon as CMS gives their approval. If the rates are approved after October 1, then instructions are given to the contract fiscal agent to update the rates, recoup payment differences for all claims paid with the old grouper rates after October 1 with patient discharge dates on or after October 1.

In the specific case of grouper version 20, the Division provided the fiscal agent the grouper rates on October 22, 2002 under the numbered memo FO 03.136. On November 6, 2002 under numbered memo FO 03.149, the fiscal agent was given the North Carolina specific DRG Weight Table for the version 20 grouper. These specific changes would include updating each DRG weight, average length of stay (ALOS), the cost outlier threshold and the day outlier threshold. Also on November 6, 2002, numbered memo FO 03.150 was issued to the fiscal agent by the Division updating each hospital's specific rates which includes their DRG unit value, Psychiatric services per diem rates, Rehabilitation services per diem rates, and the ratio of cost to charges (RCC) used in the outlier calculations.

As a result of changes to the version 20 grouper, the Division's contractor, Myers & Stauffer, reissued the weight table data. On January 28, 2003, numbered memo FO 03.258 was issued to the fiscal agent with the instructions to update grouper version 20 with the changes and recoup

previously paid claims with dates of service on or after October 1, 2002 and repay those same claims with the new rates as applied to the DRG weight table using grouper version 20. The fiscal agent issued CSR NC011471 to comply with the Division's instructions. The process to recoup previous payments and repay the claims using the new rates and grouper version 20 was done on or about April 8, 2003.

The OIG audit has identified about 75 claims that were not correctly recouped and repaid under grouper version 20. The Division concurs with OIG that the identified accounts were not properly paid. Upon the Division's investigation, it appears that these accounts were not included in the recoup/repay process by the fiscal agent under CSR NC011471 because the patient admit dates were before October 1, 2002 and thus fell out of the CSR beginning and ending date range. It was the intent of the Division that all claims with the discharge date on or after October 1, 2002 are paid using the new rates and grouper version 20. The Division is issuing instructions to the fiscal agent that the 75 claims are to be recouped and repaid under the correct grouper version 20 and payment rates.

OIG Audit Recommendation #3: Calculate the effect of the errors for the remaining Medicaid hospitals and remit the Federal share of any overpayments to CMS.

The Department agrees with the recommendation to calculate the effect of errors noted above for the remaining hospitals and remit the Federal share of any overpayments to CMS. For additional overpayments, if any, resulting from recalculation of the cost outlier threshold at 1.96, the Department intends to recoup the amount of the identified error, either from the providers or from the contractor. The Department has not yet determined the optimal method to accomplish this recoupment, and is in the process of doing so. For additional overpayments, if any, resulting from DRG payments using the incorrect grouper, the Department is issuing instructions to the fiscal agent to recoup and repay claims using the correct grouper version 20 and payment rates. The threshold recalculation and recoup/repayment of claims are targeted for completion during fourth calendar quarter 2005. As stated above, a system freeze associated with a change to a new fiscal intermediary may present complications which would not allow recoupment from providers to occur until after July 2006. Again, we will try to get this accomplished before the system freeze.

OIG Audit Recommendation #4: Develop and implement policies and procedures to more closely monitor outlier payments. Specifically, ensure that the outlier threshold amount is correctly calculated for future payments. In addition, on an ongoing basis, review factors used in the DRG base and outlier calculation to ensure accuracy and timeliness of future payments..

The Department has policies and procedures to monitor payments. The Department agrees with the recommendation that these policies and procedures need to be enhanced to address outlier payments, specifically as to threshold amounts, DRG base calculations and outlier payment calculations. Development and implementation of the revised policies and procedures is targeted for completion during the fourth calendar quarter of 2005.

We trust that the foregoing response addresses the various report recommendations. If additional information is needed, please contact Dan Stewart, Assistant DHHS Secretary (Acting) at (919) 715-4170 or Dan.Stewart@ncmail.net . Lastly, we would like to compliment Ms. Debra Keasling and Mr. Dan Bittner and staff that worked on this project. They were very professional in defining and gathering information, listening to our comments, objective in writing the report and granted extra time to the Division for providing a response to these issues.

Sincerely,

Carmen Hooker Odom

CHO:ds

Cc: Dan Stewart, CPA
Mark Benton
Eddie Berryman, CPA
Laketha Miller, CPA
Allyn Guffey, CPA
Honorable Les Merritt, CPA, CFE