STATE OF NORTH CAROLINA

RESULTS OF

STATEWIDE FINANCIAL AUDIT PROCEDURES AT THE

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

FOR THE YEAR ENDED JUNE 30, 2005

OFFICE OF THE STATE AUDITOR

LESLIE W. MERRITT, JR., CPA, CFP

STATE AUDITOR

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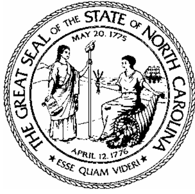
STATE OF NORTH CAROLINA
Office of the State Auditor



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March 31, 2006

The Honorable Michael F. Easley, Governor
Members of the North Carolina General Assembly
Ms. Carmen Hooker Odom, Secretary,
North Carolina Department of Health and Human Services

We have completed certain audit procedures at the North Carolina Department of Health and Human Services related to the State of North Carolina (Department) reporting entity as presented in the *Comprehensive Annual Financial Report (CAFR)* and *Single Audit Report* for the year ended June 30, 2005. Our audit was performed by authority of Article 5A of Chapter 147 of the *North Carolina General Statutes.*

The results of these audit procedures, as described below, yielded audit findings and recommendations for the Department related to the State's financial statements and federal financial assistance programs that may have required disclosure in the aforementioned reports. These findings are included in the findings and recommendations section contained herein. Our recommendations for improvement and management's response follow each finding.

The accounts and operations of the North Carolina Department of Health and Human Services are an integral part of the State's reporting entity represented in the *CAFR* and the *Single Audit Report*. In the *CAFR*, the State Auditor expresses an opinion on the State's financial statements. In the *Single Audit Report,* the State Auditor presents the results of tests of internal control and compliance with laws, regulations, contracts, and grant agreements applicable to the State's financial statements and to its federal financial assistance programs. Our audit procedures were conducted in accordance with auditing standards generally accepted in the United States of America, *Government Auditing Standards* issued by the Comptroller General of the United States, and Office of Management and Budget Circular A-133 as applicable. Our audit scope at the North Carolina Department of Health and Human Services included the following:

<u>State of North Carolina's Financial Statements</u>

General Fund, excluding the Division of Mental Health, Developmental Disabilities and Substance Abuse Services

State of North Carolina's Administration of Federal Financial Assistance Programs

Aging Cluster:

- Nutrition Services Incentive Program
- Special Programs for the Aging – Title III, Part B – Grants for Supportive Services and Senior Centers
- Special Programs for the Aging – Title III, Part C – Nutrition Services

Block Grants for Prevention and Treatment of Substance Abuse

Center for Disease Control & Prevention

Child and Adult Food Program

Child Support Enforcement

Disability Insurance/SSI Cluster

Food Stamp Cluster:

- Food Stamps
- State Administrative Matching Grants for Food Stamp Program

Foster Care – Title IV-E

Low-Income Energy Assistance

Medicaid Cluster

- Medical Assistance Program
- State Survey and Certification of Health Care Providers and Suppliers

Rehabilitation Services – Vocational Rehabilitation Grants to States

Social Services Block Grant

Special Supplemental Nutrition Program for Women, Infants, and Children

State Children's Insurance Program

Temporary Assistance for Needy Families

Our audit procedures at the North Carolina Department of Health and Human Services were less in scope than would be necessary to report on the financial statements that relate solely to the Department or its administration of federal programs. Therefore, we do not express such conclusions.

North Carolina General Statutes require the State Auditor to make audit reports available to the public. Copies of audit reports issued by the Office of the State Auditor may be obtained through one of the options listed in the back of this report.

Leslie W. Merritt, Jr., CPA, CFP
State Auditor

AUDIT FINDINGS AND RECOMMENDATIONS

Matters Related to Financial Reporting or Federal Compliance Objectives

The following findings and recommendations were identified during the current audit and discuss conditions that represent significant deficiencies in internal control and/or noncompliance with laws, regulations, contracts, or grant agreements. Findings 1-4, 7-9, 11-17, 22, and 23 were also reported in the prior year.

DIVISION OF MEDICAL ASSISTANCE

1. FINAL COST-SETTLEMENTS NOT SETTLED

   As noted in prior years, the Division of Medical Assistance had not completed the final cost-settlements for Disproportionate Share Hospital (DSH) payments to State-owned and non-State owned hospitals since the 1997 State fiscal year. The DSH program is a program designed to provide additional payments to hospitals that serve a large number of Medicaid recipients and uninsured patients. The Medicaid State Plan previously required DSH payments to be adjusted or cost settled within 12 months of receipt of the completed cost report to ensure that payments do not exceed the State aggregate upper limits for such payments (cost of care). An amendment to the State Plan, with an effective date of January 1, 2004, eliminated language requiring the settlement of DSH and Supplemental Payments and established a prospective based settlement process going forward from that date. However, the requirement remains that the Division cost-settle the DSH payments through the 2003 fiscal year cost reports. By not completing the cost settlements, the State does not know whether DSH payments made by the State exceeded the total costs of providing inpatient and outpatient services to Medicaid and uninsured patients.

   In an effort to address this issue, the Division submitted a plan to the Center for Medicaid and Medicare Services of the U.S. Department of Health and Human Services to settle this and other DSH issues. The Division has contracted with two vendors who are in the process of performing desk reviews and audits of hospital cost reports and determining cost settlement amounts; however, no cost settlements have actually been made with providers. In addition, a second State plan amendment was approved clarifying language concerning DSH payments and cost settlements.

   Recommendation: The Division of Medical Assistance should continue to establish and maintain an internal control system designed to reasonably ensure compliance with federal laws, regulations, and the Medicaid State Plan. As the Division continues its discussions and negotiations to resolve the DSH issues, it should continue its efforts to gather information required to cost-settle DSH payments with all hospital providers for 2003 and prior as required by the approved State Plan in effect prior to January 1, 2004.

Agency's Response: The Division of Medical Assistance (DMA) has been in active communication with the Center for Medicare and Medicaid Services (CMS) on this issue, and the Division has submitted a proposal which would successfully resolve this issue. We are hopeful to receive an affirmative response from CMS in the near future. Our discussions with the federal government have focused not only on the language and intent of the Plan, but also on the application of our payment plans. DMA has argued consistently that these payment plans are prospective in nature and should not be subject to cost settlements except in the aggregate with respect to the Medicare Upper Payment Limit (UPL) as discussed below. Until these discussions and negotiations are concluded with CMS, the State cannot identify what, if any, DSH overpayments may have occurred.

The Division and its contractor, Myers and Stauffer, are both confident that payments were not made in excess of the UPL. If payments were not made in excess of the UPL, settlements of supplemental payments for the years 1997 through 2002 are not required. However, should the State's final agreement with CMS result in a finding that payments were made in excess of the UPL, only at that time could any settlement amount be calculated and individual hospitals be approached to reimburse the State for excess payments.

2. PROVIDER BILLING AND PAYMENT SYSTEM ERRORS

Our tests disclosed several weaknesses with the processing of claims payments.

We uncovered errors in 16 claims from a sample of 270 Medicaid claims tested.

a. One error was due to improper medical coding by the provider that resulted in an unallowable amount of $402.

b. For two claims there were insufficient medical records or other evidence to indicate that billable services were provided resulting in an unallowable amount of $28.

c. One claim was found in error due to a violation of Medicaid Policy. Medical records indicated that the drug identification number on the submitted claim did not concur with the number recorded by the prescriber. Although the $90 claim was found to be paid correctly, the provider should be informed of the error to prevent future instances.

d. Seven claims were in error due to improper documentation in the medical records resulting in an unallowable amount of $3,302.

    1) Six claims did not have the required "plan for services" showing that the treatment was medically necessary.

    2) One claim was found to be in error as there was insufficient documentation of the policy followed by the physician's office for the renewal of medications.

e. One claim was in error because the provider improperly coded services and improper documentation. The provider overbilled for services and the services provided/billed

exceeded the number of hours allowed per the prior approval for services. The unallowable amount was $548.

f. One claim was found to be paid incorrectly due to a system error. The system was updated with a 30 units per service date maximum instead of the approved 50 units per service date maximum. There was an underpayment of $44.

g. Three claims were noted as errors because third party insurances were not billed properly. As Medicaid is the payer of last resort, all insurances are to be billed before the claim can be paid by Medicaid. Each of the recipients were noted as having insurance at the time the claim was paid; however, there was no indication that insurance was billed before the payments by Medicaid. Total claims paid of $6,498 are deemed unallowable.

The errors in the sampled claims totaled a net of $10,734. The federal share of $6,782 is considered to be questioned costs.

It was noted in our prior year audit that a system programming error added an extra day to the day outlier calculation.

A change to correct this programming error was entered in the system on November 17, 2004. We tested all claims identified as having a day outlier calculation prior to this date for potential errors. There were 59 claims that met this criterion that were found to be in error for a total overpayment of $66,425. The federal share of $41,739 is considered to be questioned costs.

During our current fiscal year testwork, we identified an additional programming error related to a non-surgical limitation of 50 units per date of service per recipient. The system was not properly updated and continued to use a per date of service limitation of 30 versus the updated 50 units. A file was obtained of all claims that were paid during the 2005 State fiscal year for the affected procedure codes. There were 1,203 errors noted for a total underpayment of $57,496.

OMB Circular A-87 requires allowable costs to be adequately documented and program costs to be necessary and reasonable for proper and efficient administration of the grant program. Title 42 CFR section 431.107 and State Regulation 10 NCAC 26G.0107 require that medical records disclose the extent of services provided to Medicaid recipients. Additionally, the Hospital Provider Manual provides the guidance and formula for computing the day outlier amount. A Division memorandum to the fiscal agent provided for the change to the non-surgical limitation.

Recommendation: The Division of Medical Assistance should evaluate and strengthen internal controls and procedures to ensure the accuracy of the claims payment process. Management should ensure that payment edits and/or audits are working appropriately; that system changes are properly implemented; that providers are educated on the proper coding and documentation for medical services being provided; and that over or

underpaid claims are identified and appropriate collection or payment procedures are performed.

Agency's Response: A large portion of this finding was jointly developed. The Office of the State Auditor selected a sample of claims and DMA Program Integrity conducted a field review of the provider claims and supporting documentation. During 2004-05, DMA Program Integrity conducted 1,826 investigations and recouped $9.3 million as part of the DMA's compliance efforts.

While the Division of Medical Assistance (DMA) concurs with this finding, we do take note that this particular finding deals more with provider billing errors rather than with weaknesses in the DMA claims payment system. The following actions have been taken to address the issues in this finding:

- With reference to sample # 05-01-05-D-146, a recoupment letter was sent to the provider on October 4, 2005. The Controller's Office Accounts Receivable Section (AR) indicates that the provider remitted the $402 on October 29, 2005.
- With reference to sample # 05-01-03-J071 and 05-01-08-M-237, educational letters were sent to the providers on September 15, 2005 and July 6, 2005, respectively.
- With reference to sample #05-01-02-D-040, an educational letter was sent to the provider on October 18, 2005.
- With reference to sample # 05-01-02-J-041, a recoupment letter was sent to the provider on June 30, 2005. The DHHS Controller's Office Accounts Receivable Section (AR) indicates that the provider remitted $89.44 on August 2, 2005.
- With reference to sample # 05-01-04-J-109, a recoupment letter was sent to the provider. The provider appealed and the Hearing Office upheld Program Integrity Section's (PI's) decision on August 15, 2005. The Controller's Office Accounts Receivable Section (AR) indicates that the provider remitted $207.80 on September 1, 2005.
- With reference to sample # 05-01-04-J-111, a recoupment letter was sent to the provider. The provider appealed and the Hearing Office upheld PI's decision on August 25, 2005. The Controller's Office Accounts Receivable Section (AR) indicates that the provider remitted $290.92 on September 20, 2005.
- With reference to sample # 05-01-04-J-116, a recoupment letter was sent to the provider on September 23, 2005. The Controller's Office Accounts Receivable Section (AR) indicates that the provider remitted $332.48 on October 3, 2005.
- With reference to sample # 05-01-05-J-149, a recoupment letter was sent to the provider on September 23, 2005. The Controller's Office Accounts Receivable Section (AR) indicates that the provider remitted $78.26 on December 6, 2005.

- With reference to sample # 05-01-06-J-161, a recoupment letter was sent to the provider on July 13, 2005. The Controller's Office Accounts Receivable Section (AR) indicates that the provider remitted $2,303.08 on September 29, 2005.
- With reference to the one claim with insufficient documentation, on sample # 05-01-03-D-088, an educational letter was sent to the provider on October 21, 2005.
- With reference to sample # 05-01-08-J-212, a recoupment letter was sent to the provider on August 4, 2005. The Controller's Office Accounts Receivable Section (AR) indicates that the provider remitted $548 on November 8, 2005.

A Medicaid Bulletin article will be published in May 2006 reminding providers of the minimum elements required to comply with Medicaid documentation. In addition, future training offered to providers and agency staff will contain a course objective addressing documentation requirements.

The programming error related to a non-surgical limitation of 50 units per date of service per recipient has been corrected. A numbered memo (MP 06.169) to correct the inconsistency in codes and units per code was sent to EDS on September 19, 2005. User acceptance and validation of required changes occurred on January 18, 2006. A Medicaid Bulletin article will be published addressing the underpayment and asking the provider to resubmit the claim.

Although three claims bypassed Third Party Liability (TPL) edits, each claim was billed appropriately to the recipient's insurance carrier. Under a contract with the Division's TPL Section, Public Consulting Group (PCG), was able to match the three claims to the recipients' supplemental third party insurance policies. PCG then re-submitted claims to the three carriers. One claim was paid in full (05-01-06-J-166), one was denied (05-01-06-J-169) and one carrier did not respond to PCG (05-01-06-J-203).

DMA agrees with the State Auditor that third party insurances should be billed by the treating provider prior to DMA processing for payment. DMA should not resort to a "pay and chase" of claims where it is more efficient to reconcile prior to payment and to comply with CMS regulations. Based upon the State Auditor's review and our findings, DMA will evaluate whether this edit should be reinstated.

A system programming error which added an extra day to the day outlier calculation was corrected. DMA has recouped and repaid correctly day outlier claims paid prior to October 1, 2004 as of February 21, 2006. Claims that were paid between October 1, 2004 and November 17, 2004 were recouped automatically and repaid correctly as part of the DRG rate adjustments process.

3. LONG-TERM CARE FACILITY AUDITS WERE NOT TIMELY COMPLETED

The Division of Medical Assistance either did not complete, or failed to complete within required timeframes, the required long-term care facility audits for 22 of the 31 hospital based nursing facility cost reports that were due to be audited for the State fiscal year 2005.

Audits are performed to ensure that the cost reports support the rates facilities use for cost reimbursement. The failure to perform long-term care facility audits may result in the establishment of rates that under or over reimburse Medicaid providers.

The North Carolina State Plan required all cost reports of long-term care facilities to be audited within one year of the date the cost report was filed or within one year of December 31 of the fiscal year to which the report applied, whichever is later.

Recommendation: The Division of Medical Assistance should enhance controls to ensure that required long-term care facility cost report audits are completed on a timely basis. The Division should ensure that its audit section has adequate resources to complete the required audits.

Agency's Response: DMA concurs with the audit finding that 22 of 31 Hospital Based Nursing Facility Desk Audits were not completed timely per the North Carolina State Plan guidelines. Audit staff resources were focused on the successful, timely completion of 357 desk audits of FY03 free-standing nursing facilities and 60 FY03 ICFMR desk audits within the NC State Plan guidelines. DMA's Audit Section continues to take steps to ensure adequate staffing and resources are available to complete desk and field audit reviews in accordance with North Carolina State Plan guidelines. Audit staff resources were redirected and all outstanding audits were completed prior to March 2, 2006.

4. REQUIRED DISCLOSURES NOT OBTAINED AT ENROLLMENT OF PROVIDERS AND LACK OF CONTROLS IN THE PROVIDER ELIGIBILITY ENROLLMENT PROCESS

The Division of Medical Assistance failed to collect all required information from provider-applicants when they were enrolled into the Medicaid program and collected federal matching funds for these providers contrary to what is permitted in the regulations. The Division lacks the type of internal control policies and procedures needed to identify and exclude ineligible providers from participating in the Medicaid program.

Required Information Not Collected at Enrollment of Providers

We reviewed 72 different types of provider enrollment packages to determine whether the Division requested the required disclosures at enrollment of providers into the Medicaid program. Each enrollment packet was tailored to the type of provider and various forms were included in each packet. The results of this test work revealed that not all disclosures required by 42 CFR sections 455.104 through 455.106 are being

requested. The enrollment packages for 41 out of the 72 types of providers did not require the provider-applicant to disclose:

- the name and address of each person with ownership or controlling interest,
- whether the ownership, control interest, agent or managing employee had ever been convicted of a criminal offense,
- any related party arrangements.

These 41 types of providers were paid an estimated $2.44 billion this fiscal year, including matching federal funds. The payments occurred despite 42 CFR section 455.104 which requires that a provider not be approved or be terminated if the provider fails to disclose ownership. In addition, federal match is not available for payments to providers that fail to disclose the required information.

System of Enrollment of Providers Has Design Flaws

A review of the Division's system for enrolling providers, which includes all providers other than practitioners, revealed several deficiencies:

- As noted above, the Division failed to collect disclosure information from provider-applicants as required by 42 CFR part 455, related to ownership and controlling interest information, disclose of related party arrangements, or convictions of a criminal offense. In addition, an application for enrollment is not required from all providers.
- The Division does not require providers to periodically re-enroll in order to detect changes in eligibility status.
- For providers other than physicians and practitioners, the Division does not verify with the appropriate licensing organizations/boards that the license is valid. In addition, background checks are not conducted on providers prior to enrollment to ensure ineligible providers are not admitted.
- The Division has not conducted any monitoring of the contractor that was responsible for the enrollment of practitioners prior to January 1, 2005, to ensure compliance with its contract and to ensure that the enrollment process the contractor uses complies with rules and regulations for the enrollment of providers. However, as of January 1, 2005, upon expiration of the contract, a new contractor was obtained to perform this function and the Division implemented monitoring procedures.

These inadequate controls increase the risk of improper payments to ineligible providers or payments not adequately documented or evidencing compliance with the regulations. Our testwork for a sample of 30 provider files for required disclosures identified three instances in which the provider had not submitted the required information related to ownership and controlling interest.

The lack of adequate internal control policies and procedures increases the risk that Medicaid funds will be paid to unqualified or unscrupulous providers.

Similar deficiencies have been reported in prior year audits. During the current fiscal year, the Division's Provider Services section has been working to implement changes to bring the system into compliance with the applicable criteria. The Division has developed a uniform application, which is being reviewed and will be implemented upon approval, to address the required elements for the provider enrollment process. The Division has begun to develop procedures for sharing information internally and with agencies that have licensure or enrollment responsibilities to prevent unacceptable providers from enrolling in Medicaid. As part of developing the new Medicaid Management Information System, the Division will be implementing procedures for re-enrollment and re-verification of credentials. A new contractor has been hired to be responsible for credentialing of physicians and the performance of background checks. However, as of June 30, 2005, these proposed procedures and enhancements had not been fully implemented.

Recommendation: The Division of Medical Assistance should design and implement adequate internal controls to provide reasonable assurance ineligible medical providers are excluded from participation in the Medicaid program. The Division should continue with its efforts to implement a uniform application, to be completed by all providers, to ensure that all of the disclosures required by 42 CFR part 455 are provided. The Division should take appropriate actions to ensure that providers are re-enrolled on a regularly scheduled basis, criminal background checks are performed, and the validity of provider licenses are verified. In addition, the Division should monitor the contractor responsible for the enrollment of practitioners to ensure the contractor's compliance with required laws and regulations related to practitioner enrollment.

Agency's Response: While the Division of Medical Assistance (DMA) concurs with this finding, we note our continued efforts to develop policies and procedures to collect information and to improve the process of sharing data among other agencies with licensure or enrollment responsibilities.

In January 2005, DMA implemented a new enrollment application for physicians, chiropractors, dentists, podiatrists, osteopaths and optometrists. These six provider groups represent 68% of all enrolled Medicaid providers. The new application includes all of the required ownership and disclosure information and, through a contract with PCVS, all of this information is verified. That verification includes, but is not limited to, running a criminal background check and accessing state boards for licensure data and negative actions taken against a proposed enrollee.

The 41 enrollment packages cited by the State Auditor represent providers that are endorsed and/or surveyed by CMS or one of three sister agencies: Division of Facility Services (DFS), Division of Public Health (DPH), and Division of Mental Health, Developmental Disabilities & Substance Abuse Services (DMH). Those lead agencies

understand that they have the responsibility to collect the ownership and disclosure information as required by 42 CFR 455.104 through 106. As such, they periodically survey and/or recertify each of the 41 provider types. DMA plans to request access to their respective databases or obtain a copy of the necessary ownership information to maintain in our enrollment files.

At the time our new MMIS system (NCLeads) is operational, a new uniform application will be implemented for all providers. That application will contain ownership and disclosure information as does our current application for physicians, chiropractors, dentists, podiatrists, osteopaths and optometrists. Implementation of NCLeads will also trigger a re-verification and re-enrollment of all existing provider types and, on an ongoing basis, all provider types will be subject to a re-verification every three years. Other features of NCLeads will include online enrollment capability and the ability to access licensure and endorsement data online and in real-time.

5. DEFICIENCIES IN THE RATE SETTING PROCESS

During our testing of the State Medicaid Plan rates, we identified several deficiencies related to the rate setting process:

- Our review of the Physician Fee Schedule noted several standard methodologies used for setting the Medicaid physician fee codes, the base method being 95% of the Medicare rate or for services without the Medicare rate to use the Relative Value Unit (RVU) listing. During our recalculation process, we identified numerous exceptions to the rate computations based on the standard methodologies identified in the State Plan. For these exceptions, the methodology used for specific rate changes was not clearly documented on the rate change forms and the rate setting personnel were unable to readily identify the method used. This resulted in a trial and error process by both the audit and agency staff in determining the method and appropriateness of the rate being charged.

  Our testwork identified 20 physician codes that were not properly updated or calculated in accordance with the State Plan. Seventeen code errors had Medicare and RVU related rates but were not updated accordingly. Two code errors were incorrectly calculated. One code error was incorrectly entered into the system.

- The Rate Setting Section failed to update the Dental Services rates for the 2005 State fiscal year in accordance with the State Plan requirements.

- Two errors were noted during our testing of Inpatient Hospital rates. The errors occurred when two hospitals did not have their Inpatient rates updated using the National Hospital Market Basket Index as published by Medicare and prescribed by the State Plan. The Psychiatric and Rehab per diem rates were not updated for either hospital. In addition, the DRG rate was not updated for one of the affected hospitals.

Agency personnel were able to correlate most of the rate change calculations to the Medicare and RVU rates; however, documentation of the different methods used for computing physician fees should be available to support the rate modifications. The State Plan requirements call for the Dental Services and Inpatient Hospital rates to be updated annually. Noncompliance with the State Plan requirements could lead to the incorrect payment of filed claims.

Recommendation: The Division of Medical Assistance should implement procedures that ensure that methods used to calculate rate changes are properly documented. This may need to include the hierarchy of methods used in determining rate changes, particularly for the physician fee schedule. The Division should also implement controls to ensure consistent application of the State Medicaid Plan requirements for setting specific rates. This includes compliance with the establishment and update of rates on an annual basis.

Agency's Response: The Division of Medical Assistance (DMA) concurs with the recommendation that DMA should implement procedures to ensure that methods used to calculate rate changes are properly documented. This documentation will be in the excel worksheets used by Rate Setting staff to calculate rate changes.

DMA agrees that controls must be in place to ensure consistent application of the State Medicaid Plan requirements for setting specific rates - including compliance with the establishment and update of rates on an annual basis. We contend that such controls are already in place. Of the 10,240 Physician Fee Schedule codes presented for review, 1,304 were originally identified by the State Auditor as potentially questionable. Of those, only 20, (or 0.19%), were deemed incorrect. Those 20 have been corrected. DMA will also update the Dental Services rates in accordance with the State Plan requirements effective June 30, 2006.

The DMA rate setting personnel identified and corrected the rates for the two hospitals that did not have the rates for psychological and rehabilitation updated with the required 3.4% increase. On August 24, 2005, DMA issued numbered memoranda FO 06.057 to update the rates to the correct amount and FO 06.061 to recoup and repay any claims processed from October 1, 2004 through August 24, 2005. FO 06.057 has been completed and verified, and we are awaiting confirmation that FO 06.061 has also been completed. Neither hospital had claims paid in error since they did not present any claims for adjudication under the rates that were in error.

6. INADEQUATE COMMUNICATION OF RATE CHANGES BETWEEN DIVISIONS

The Division of Medical Assistance (DMA) has not provided rate information to other Divisions within the Department in a timely manner. Both the Division of Vocational Rehabilitation (DVR) and the Division of Services for the Blind (DSB) have had problems obtaining the necessary information from DMA. Examples of the breakdowns in communication include:

- For the 2005 State fiscal year, the outpatient rates that were provided to DVR and DSB were incorrect. The information provided was based on incomplete 2003 cost reports; whereas the actual rates used by DMA for Medicaid were based on the 2002 cost reports. The correct rates were never provided to DVR or DSB which resulted in all outpatient claims for the 2005 State fiscal year to be paid incorrectly.
- DMA also has possession of the state pharmacy rates. This information has not been provided to either DVR or DSB which has resulted in numerous pharmacy claim overpayments.
- Our current year testwork on the Basic Support Grant at both DVR and DSB has identified 21 claims being paid in error due to incorrect outpatient rates, 4 claim errors due to lacking pharmacy payments information, and 2 claim errors due to the correct pharmacy rates not being provided in a timely manner.

The lack of communication and sharing of information between Divisions has resulted in the reporting of numerous errors at both DVR and DSB.

42 CFR 438.18 provides that the Department maintain information, available to all necessary parties, that govern eligibility, provision of medical assistance, covered services, and recipient rights and responsibilities. The Medicaid State Plan has similar language that mirrors the requirement of making such information available to the necessary parties.

Recommendation: The Division of Medical Assistance should take appropriate actions to ensure that all Divisions within the Department are provided the necessary information to properly establish rates for medical claims. The information should be shared on a timely basis to help prevent the incorrect payment of claims.

Agency's Response: The Division concurs with the majority of this finding. DMA does not own nor have possession of all Medicaid pharmacy rates. Rather, these are purchased and owned by the DMA's fiscal intermediary (EDS) and changed weekly. What DMA does have in its possession, and will provide to our sister agencies, is the smaller list of drug rates contained in the State Maximum Allowable Cost drug list. New procedures were introduced for rate-setting staff such that any new or changed rate information would be shared with the DVR and DSB in a timely manner. Shortly after the new procedures were put in place, there were changes in key personnel, which caused incomplete rate information to be sent to DVR and DSB. Corrective action has been taken to ensure that:

- All current personnel have been properly trained,
- Communication has been established with DMA's counter-parts in each of our sister divisions, and;
- Both DVR and DSB have been added to the distribution lists for all rate additions and changes as well as the monthly NC State Maximum Allowable Cost drug list.

Both DVR and DSB have current rate information and are receiving updated rate information in a timely manner.

DIVISION OF SOCIAL SERVICES

7. APPROPRIATE ACTION NOT TAKEN IN CHILD SUPPORT CASES

The Division of Social Services failed to take appropriate action or failed to take the required action in the established time periods for its child support cases. These failures exceeded the 25% error rate used by the federal government to determine substantial compliance with child support requirements.

Weaknesses identified with the Division's system of managing and bringing enforcement actions included (our testwork was performed for all open cases in the Division's Data Warehouse):

a) Federal regulations require the Division to establish paternity and support obligations for all IV-D cases that require this type of action. We found that 54% of open cases were not in compliance with this requirement.

b) Federal regulations require the Division to enforce support obligations for all cases that require this type of action. We found that 68% of open cases were not in compliance with this requirement.

c) Federal regulations require the Division to provide the appropriate child support services needed for interstate cases (cases in which the child and custodial parent live in one state and the responsible relative lives in another state). We found that 48% of open cases were not in compliance with this requirement.

Federal regulations require child support agencies to maintain an effective system of monitoring compliance with support obligations. The appropriate enforcement action must be taken within 30 days of identifying noncompliance. If service of process is necessary prior to taking an enforcement action, service must be completed within no more than 60 calendar days. Regulations require that within 90 days of locating an absent parent the Division must establish an order for support, establish paternity, or document unsuccessful attempts to achieve the same. Federal regulations also require actions to be taken on interstate cases in specified timeframes including referring cases to other states within 20 calendar days of locating an absent parent in the other states and providing services necessary as a responding state.

Recommendation: The Division of Social Services has begun performing self-assessments to review their compliance with applicable federal guidelines. Management should continue to evaluate and enhance its internal control procedures to ensure compliance with federal child support processing requirements.

Agency's Response: The Federal Office of Child Support Enforcement (OCSE) requires each state's CSE program to monitor program compliance in accordance with OCSE Action Transmittal 98-12. AT 98-12 states: "In moving towards a more results oriented review, if the State achieved a successful outcome (during the 12 month review period), the State will consider the case to be an Action case and will not evaluate required time frames for the review period for that Review Criterion." Based on this federal mandate, North Carolina's Child Support Enforcement (CSE) utilizes data warehouse technology and reviews every case quarterly in eight performance categories. For the first time this year, State auditors also used the data warehouse to evaluate the CSE Program. Instead of a sample of cases, 100% of the case population in the data warehouse was tested. We support this approach for future audits. We acknowledge these audit findings and will inform all area supervisors and local office supervisors of the findings. The audit findings will also be incorporated into CSE's program monitoring plan.

a) Establishment of Paternity and Support

We have increased our compliance percentage significantly from 29% in 2004 to 46% in 2005. In addition, CSE's scores in the Self-Assessment category of Establishment have improved each year since 2001.

CSE has taken several actions that have and will continue to increase the percentage of cases for which establishment of paternity and support is timely. In addition to certifying child support agents to take DNA samples immediately when paternity is questioned, CSE will require that state-operated local CSE offices contact non-custodial parents (NCPs) and request they sign a Voluntary Support Agreement (VSA) when paternity has been settled. When genetic testing is performed immediately and support is settled administratively with a VSA, the order for support is obtained much faster because the case does not need to be scheduled for court hearing. Increasing the number of support orders obtained via VSA will increase the number of establishment cases settled within the federal timeframes. CSE plans to modify training scripts to increase the emphasis on using the available automated supports pertaining to establishment. CSE will continue to run Self Assessment Establishment reports quarterly in order to identify cases that are out of compliance and training issues. By utilizing the data warehouse to review the entire establishment caseload, CSE provides a powerful performance management tool to local office management and field staff.

b) Enforcement

We believe that the decline in our compliance rate from 41% in 2004 (as reported by audit staff) to 32% this year (2005) is directly related to differences in the interpretation of the meaning of consistent collections and delinquency between the auditor and our assessment. As the result of our continued progress in enforcement (we have improved consistently since 2002), we believe that CSE Program improvements we have put in place are effective.

CSE utilizes an automated telecommunicator to phone NCPs and remind them that their first child support payment is due. NCPs are also called to remind them of court dates and appointments in the local child support office. CSE plans to expand the telecommunicator scripts to include calls to all delinquent NCPs. CSE provides NCP wallet cards for local offices to give new payers. These cards provide all of the information the NCP needs to pay child support, to obtain payment information and to reach customer service representatives. CSE will require that agents in state-operated CSE offices attempt to contact delinquent NCPs via telephone to discuss payment options prior to filing court action. Increasing the number on NCPs who pay their child support without court action will increase the number of cases that meet the federal timeframes for enforcement. CSE is currently conducting a pilot project in which central office staff members provide location services for NCPs whose whereabouts are unknown to the local office. Once a NCP is located, the local agent is notified and must initiate enforcement action within three (3) business days. CSE will continue to run Self Assessment Enforcement reports quarterly in order to identify cases that are out of compliance and training issues. By utilizing the data warehouse to review the entire enforcement caseload, CSE provides a powerful performance management tool to local office management and field staff.

c) Interstate

CSE's scores in the Self-Assessment category of Interstate have improved 16% since 2003; however, the Interstate cases continue to be one of the most challenging program areas. Communication between North Carolina workers and other states has improved as a result of our participation in the Federal Interstate Case Reconciliation (ICR) Project. We have increased our interstate training sessions from four (4) to nine (9) per year. We have revised the job duties of our interstate central office staff to monitor cases without an order. We have conducted multiple sessions of self assessment workshops with emphasis on documenting actions taken in ACTS.

CSE has increased our interstate training sessions from four to nine per year and is providing additional interstate training at a regional level. CSE has conducted multiple workshops for local office staff with emphasis on what Interstate actions are required and documenting those actions in the automated system. Area trainers have been given these training scripts and will continue to provide the training for each region. CSE will continue to run Self Assessment Interstate reports quarterly in order to identify cases that are out of compliance and training issues. By utilizing the data warehouse to review the Interstate caseload, CSE provides a powerful performance management tool to local office management and field staff.

Recent data shows we are on target for reaching our program goals by the year 2009 in collections, cost effectiveness, paternity establishment and percent of cases under order. Our collections goal for 2005 was 65.01%. Current data shows that we were at 64.96% at mid-fiscal year. The gross amount collected for fiscal year 2005 was $597,056,045.00. This is an all time record high reflecting a 12% increase over the past two years.

8. WEAKNESSES IN THE TEMPORARY ASSISTANCE FOR NEEDY FAMILIES PROGRAM MONITORING PROCEDURES

As noted in our prior audit, monitoring procedures in the Temporary Assistance for Needy Families (TANF) Program are not sufficiently designed to ensure that cases identified as "non-cooperative" with child support requirements are properly sanctioned. In a sample of 39 cases identified as non-cooperative, four cases were identified as not being sanctioned properly. Procedural controls were not in place to ascertain if the caseworker had reviewed the case. The Federal government could impose a penalty on the State for failure to enforce sanctions on recipients who fail to cooperate with child support requirements.

Title 45 of the Code of Federal Regulations Part 92.40 requires grantees to monitor grant and subgrant activities to ensure compliance with applicable Federal requirements and to ensure performance goals are being achieved. A reduction or elimination of assistance is required by 42 USC 608(a)(2) for recipient non-cooperation in establishing paternity or obtaining child support. Title 45 CFR 264.31 allows a reduction in the state's State Family Assistance Grant for failure to enforce penalties against recipients.

Recommendation: The Division of Social Services should implement procedures to ensure TANF sanctions are imposed and resolved timely.

Agency's Response: The Department submitted a corrective action plan to the Administration for Children and Families (ACF) detailing the corrective actions to be implemented by December 31, 2005 in order to prevent this situation from recurring. Some of the corrective actions are as follows:

- The Division has made modifications to automated reports (IV-D NONCOOP WITHOUT SANCTION) to assist the counties in identifying non-compliant cases that have not had sanctions applied.
- The Division has expanded the monitoring process for this program with regard to compliance with the regulations.
- The Division has enhanced its education/training activities within the counties to address the compliance issues identified by the auditors.
- The Division is requiring county staff to immediately process notifications from IV-D to IV-A programs.

ACF accepted the corrective action plan and agreed not to assess the Department any penalties for failure to sanction non-cooperative child support recipients prior to July 1, 2005. ACF will use the single audit for the period July 1, 2005 through June 30, 2006 to determine whether North Carolina has achieved compliance with child support enforcement requirements.

The weaknesses identified in this audit were from a sample pulled prior to implementation of the above corrective actions. The Division fully believes the actions taken as identified above will resolve the weaknesses identified in this audit.

9. ERRORS IN THE FOSTER CARE AND ADOPTION ASSISTANCE FINANCIAL REPORT

Amounts reported in and deemed to be critical information in the ACF-Title IV-E-1, Foster Care and Adoption Assistance Financial Report were misstated. The amount reported on line 8 was understated by $231,000. Misstatements could result in costs incorrectly charged to the federal program. The error was due to incorrect data from subsystem reports being entered on the agency prepared worksheet used to accumulate the amounts for the federal report.

Good internal controls dictate that amounts reported on federal reports be accurate and agree with the supporting accounting records.

Recommendation: The Division of Social Services should implement review procedures to ensure that amounts reported on the federal reports are accurate and agree to the supporting accounting records. Review procedures should include recalculations and periodic comparison to supporting documentation.

Agency's Response: During the period under review, the Child Welfare Waiver Demonstration Project (IV-E Waiver) was in transition through agreement with federal agency Administration of Children and Families. The errors identified were miscalculations resulting from a formula error in the spreadsheet that is used to calculate the cost neutrality status of the demonstration project. At the time, the Division had one person completing all aspects of reporting expenditures associated with this demonstration project. Currently, the Division has two positions reviewing these calculations. A data entry person makes the initial entries into the spreadsheets, and a manager reviews the data for accuracy. The ACF-Title IV-E-1, Foster Care and Adoption Assistance Financial Report containing the misstatement of $231,000 on line 8 was corrected and resubmitted November 2005.

In July 2004, the Division began implementation of phase II of the demonstration project which includes contracting with an outside evaluator to track outcomes and costs under the demonstration project. This effort will allow the Division to implement more stringent review procedures to cross-check calculations and expenditures. The Division will also be collaborating with the DHHS Office of the Controller to develop a streamlined reporting process for the demonstration project that utilizes more system generated reports and relies less on human calculations. When fully implemented, the Division believes these changes will establish stronger internal controls for project reporting.

10. IMPROPER ACCESS TO THE ELIGIBILITY INFORMATION SYSTEM

We identified deficiencies in the Division of Social Service's oversight and management of employee access to the Eligibility Information System (EIS). We identified six employees, from a random sample of 60, with improper levels of access to the EIS system. Improper access to computer systems can result in both intentional and unintentional security breaches. Maintaining proper access controls over computer systems helps to protect the confidentiality and integrity of information by preventing alteration, unauthorized use, or loss of data.

Statewide Information Technology Standards specify that system access be controlled and prescribe procedures such as documented reviews of users' rights and immediate termination of access upon severance or leaving employment.

Recommendation: The Division of Social Services should review its prescribed procedures for documenting security access privileges for the EIS. Periodic security reviews should be conducted to ensure that access is restricted to authorized users. Access privileges should be removed for terminated employees in a timely manner. Employee user access rights should be systematically evaluated to ensure privileges granted are appropriate for the necessary job requirements.

Agency's Response: The Department concurs with the finding that security access procedures need to be more rigorously implemented for the EIS.

Of the six instances in which employees had unnecessary access to EIS, the inappropriate access has been revoked. Each affected office has proposed corrective action to prevent recurrence of this issue.

The Department revised its policy effective June 15, 2005, which reiterates the division and office responsibilities regarding granting, modifying or terminating access to automated systems owned by DHHS. This is a formal process whereby authorization is approved and a record of what resources the individual is allowed to access is kept on file. Divisions/offices are required to have written authorization for granting or modifying access to automated systems. A new request will be submitted if there are any changes to the stated conditions of access. The authorization request, if in hardcopy format, must be signed by the applicant and approved by the supervisor or manager assigned. The authorization request, if electronic, must identify the supervisor or manager making the request. Access Authorization is established or reviewed whenever a new employee is hired, the worker transfers to another area resulting in job function changes, employment for the worker terminates, the worker requires additional functions or access to fulfill a specific duty, or the worker no longer requires access. Requests for modifying user accounts (i.e., to grant or disallow additional permissions) must be accomplished by submitting a new request. The documentation of the approval/denial/change/termination must be maintained in accordance with Record Retention Laws.

The policy requires the system owner of each information system to ensure that all user accounts are reviewed and access rights evaluated at least once per quarter. Discrepancies must be investigated and corrected. Audit documentation must be maintained as specified by the DHHS Security policy for Records Management.

The DHHS Security Officer who acts as the Department expert for issues related to information technology security will review and approve the Divisions/Offices security corrective action plans submitted as a result of this audit finding and provide technical assistance as needed.

11. WEAKNESSES IN CONTROL OVER PHYSICAL INVENTORY OF FIXED ASSETS

Weaknesses were noted in the Division of Social Services' internal control over fixed assets, which increased the risk of loss, damage, or theft of the Division's equipment. Inaccurate information in the fixed asset system could also result in the misstatement of financial statements.

- The Division's own tracking system revealed that of the 121 child support enforcement locations, 11 locations failed to turn in annual inventory reports and one location submitted its report after June 30, 2005. Also, inventory packages were received from four locations that were not updated in the Department's fixed asset records. Incomplete or missing inventory packets prevent the Department from updating fixed asset records with current information.
- Fixed asset records are incomplete. A scan of current fixed asset records identified asset items without proper asset descriptions, acquisition dates, location assignment, serial numbers, etc. In addition, we noted assets purchased in prior years that continue to be assigned temporary fixed asset numbers.
- Fixed assets records were not updated to reflect the disposition or transfer of asset items. Our tests identified asset items that were either sent to State Surplus Property or transferred to other Divisions that were still accounted for within the Division of Social Services records.
- Based on our review of fixed asset records for Child Support Enforcement, the Federal and State cost percentage of assets is not readily determinable by documentation provided.

Title 45 CFR section 74.34 requires the recipient to take a physical inventory of equipment and reconcile the results with equipment records at least once every two years. Any differences between quantities determined by the physical inspection and those shown in the accounting records should be investigated to determine the causes of the difference. The recipient is required to maintain a control system to insure adequate safeguards exist to prevent loss, damage, or theft of equipment. In addition, section (f)(iv) within the same CFR requires information to be maintained that allows for the calculation of the Federal share of the cost of equipment.

Recommendation: The Division of Social Services should ensure that all completed inventory worksheets are submitted in a timely manner, that equipment records are changed to correctly reflect the results of the physical inventory, and that all equipment purchases are entered into the fixed asset system. The Division should take appropriate steps to ensure that the fixed asset system captures Federal participation percentages for the cost of equipment.

Agency's Response: The Department concurs with this finding. The Division notifies the local child support offices of the inventory requirement and the due date. In addition to the initial notification, the offices with the missing inventory reports were contacted by phone and then via email in an attempt to have the inventory reports returned.

The inventory reports for the four locations that initially were not keyed have been provided to the DHHS Office of the Controller for entry into the Fixed Assets System (FAS).

Regarding assets without serial numbers, location assignment, etc., the Division continues to work cooperatively with staff in the DHHS Office of the Controller who key asset information into the FAS to ensure that this situation is resolved.

The auditor identified nine assets that were purchased in 2003 and still have temporary asset numbers. Of the nine assets that were assigned temporary numbers, four have been assigned permanent numbers. We determined that three of the remaining five did not require permanent numbers. We will continue to work with the DHHS Office of the Controller to obtain information for the remaining two assets.

The Department is also exploring how to capture and retain the Federal and state shares of equipment.

DIVISION OF CENTRAL ADMINISTRATION

12. BASIC SUPPORT CLAIMS NOT PROPERLY PAID

There were weaknesses in the Department's controls over the payment of basic support claims for both the Division of Vocational Rehabilitation and the Division of Services for the Blind related to the Rehabilitation Services - Vocational Rehabilitation Grants to States program. An examination of 225 client files revealed:

For the Division of Vocational Rehabilitation:

- The Department paid two vendors $1,864 without the required vendor signatures.
- One inpatient claim was paid as an outpatient claim, resulting in an underpayment of $2,635.

- The amount paid for one invoice was less than the recalculated amount based on the documentation available, resulting in an underpayment of $15,613.
- Four claims were paid in error based on agency keying errors, resulting in an underpayment of $3,213.

For the Division of Services for the Blind:

- Supporting documentation for one claim could not be located. The total amount of the claim was $144.
- One claim was paid in error based on agency keying errors resulting in an overpayment of $70.

The Department paid claims in error totaling a net underpayment of $19,383. The claim overpayment errors totaled $2,078. Because the projected questioned costs exceed $10,000, we are questioning the related federal share of $1,636 of overpayments.

Section 1-11 of the Division of Vocational Rehabilitation internal policies manual requires that invoices for inpatient and outpatient hospital services be paid at the Medicaid rate and requires that invoice information include vendor signature. In addition, costs must be adequately documented in accordance with OMB Circular A-87.

Recommendation: The Department should strengthen internal control to ensure that all invoices are properly processed and paid. Also, the Department should ensure that all applicable rates are properly incorporated into its payment procedures.

The Department should perform an analysis to determine the total impact of the errors and require providers to reimburse the Department for all overpayments.

The Department should strengthen internal control to ensure that vendor signatures and adequate documentation are obtained for all invoices before payment is made in accordance with both federal and internally required procedures.

Agency's Response: The Department concurs with the finding and the Auditor's recommendation to strengthen internal control to ensure all invoices are properly processed and paid, applicable rates are properly incorporated into payment procedures, and adequate documentation is obtained before payment is made. The deficiencies noted by the auditors are due in part to human error resulting from inexperienced staff. Continual training, monitoring, and evaluation of staff performance has been necessary and will continue. The Division of Vocational Rehabilitation (DVR) has found that non-medical vendors are not willing to provide signatures on invoices, so as standard operating procedure signatures have not been required on non-medical invoices. DVR has drafted an internal policy revision to the vendor signature requirement. One of the invoices without a signature was for computer equipment and the signature is not required so there are no associated questioned costs.

For one invoice without the signature, the medical service provider has been contacted and the missing invoice signature obtained. Adjustment payments have been made to correct the inpatient claim paid as outpatient and the invoice paid for an amount less than the total calculated based on the documentation. Each claim exception identified within the audit is in the process of being recalculated and adjusted appropriately. The supporting documentation for the missing Services for the Blind claim is being secured.

13. INADEQUATE DOCUMENTATION AND FAILURE TO RECONCILE FIXED ASSETS

The Department failed to follow specific internal policies and to maintain adequate documentation in support of fixed assets purchased with federal funds from the Rehabilitation Services - Vocational Rehabilitation Grants to States program by the Division of Vocational Rehabilitation. Testing of fixed assets and inventory procedures revealed the following:

- The Department failed to update the fixed asset system for five missing items for which it had received the fixed asset input change form. Additionally, missing asset forms were not on file for nine items indicated as missing per the annual inventory.
- The fixed asset system was not reconciled to the North Carolina Accounting System on a monthly basis as required by the Department's Cash Management Plan.
- Documentation for disposed assets considered as surplus was not received or on file for one month. The fixed asset system was not updated for this month to remove the disposed assets.

The Division's failure to follow policies and maintain proper documentation could result in fixed assets being misstated on the financial statements. Additionally, the failure to safeguard assets, perform reconciliations and follow-up on missing assets increases the risk of misuse or theft of assets.

The Office of State Controller's fixed asset policies require agencies to safeguard assets and properly account for asset dispositions. OMB Circular A-102 Common Rule also requires that equipment records be maintained, a physical inventory of equipment be taken and reconciled to the equipment records, and an appropriate control system be used to safeguard equipment.

Recommendation: The Department should communicate the importance of following internal policies to ensure that proper documentation is maintained and assets are accurately recorded. Management should implement procedures to ensure that appropriate reconciliations are performed at both the Department and Division levels. The Department should establish the necessary communication channels between the respective Divisions to ensure all personnel understand their responsibilities for documenting and safeguarding fixed assets.

Agency's Response: The Department concurs with the finding. A new centralized filing system has been established for the fixed asset input forms. These forms remain in the

asset file for the life of the asset along with all other pertinent documentation. A monthly reconciliation procedure for fixed assets has been developed and fully implemented since August 2005. Management has communicated between the DHHS Office of the Controller and Divisions to ensure all personnel understand their responsibilities for documenting and safeguarding fixed assets. We have fully implemented these changes during fiscal year 2005-06 and continue to communicate the importance of following internal policies.

14. FIXED ASSET RECORDS INCOMPLETE/INACCURATE

Weaknesses were noted in the Department's controls over fixed asset records. The Department failed to update the fixed asset records in a timely manner for equipment purchased during the fiscal year. The records also did not contain all pertinent information. In addition, the records were not properly updated for required changes uncovered during the annual inventory.

- Fixed asset records are incomplete. A scan of current fixed asset records identified asset items without proper asset descriptions, acquisition dates, location assignment, serial numbers, etc. In addition, we noted assets purchased in prior years that continue to be assigned temporary fixed asset numbers.
- Fixed assets records were not updated to reflect the disposition or transfer of asset items. Our tests identified asset items that were either sent to State Surplus Property or transferred to other Divisions that were still accounted for within the wrong Division's fixed asset records.

In our review of fixed asset records for assets purchased with Child Support Enforcement funds, we noted:

- The Division's own tracking system revealed that of the 121 child support enforcement locations, 11 locations failed to turn in annual inventory reports and one location submitted its report after June 30, 2005.

  Also, inventory packages were received from four locations that were not updated in the Department's fixed asset records. Incomplete or missing inventory packets prevent the Department from updating fixed asset records with current information.
- Based on our review of fixed asset records for Child Support Enforcement, the Federal and State cost percentage of assets is not readily determinable by documentation provided.

Inaccurate information or the omission of information in the fixed asset system increases the risk that missing and/or stolen items will not be detected and could result in misstatement of fixed asset account balances in the financial statements.

Title 45 CFR section 74.34 requires the recipient to maintain adequate safeguards to prevent loss, damage, or theft of equipment. The recipient is required to complete a

physical inventory of equipment and reconcile any differences noted with equipment records at least once every two years. The regulation also requires that the records include a description of the equipment, the manufacturer's serial number or other identification number, acquisition date, location of equipment, unit acquisition cost, and disposition data.

Recommendation: The Department should implement a tracking system to ensure all changes noted on the inventory worksheets are made to the equipment records. The Department should also ensure that all equipment purchases are entered correctly into the system within a reasonable period. Inconsistencies or errors uncovered when updating fixed asset records should be investigated and corrected.

Agency's Response: The Department concurs with this finding. The DHHS Office of the Controller has communicated with the Division of Social Services (DSS) Fixed Asset Coordinator and other Division staff several times and stressed the importance of providing accurate and timely information related to changes in the status of assets to the Fixed Assets System. Of the nine assets that were assigned temporary numbers, four have been assigned permanent numbers. The DSS determined that three of the remaining five did not require permanent numbers. We will continue to work with Division staff to obtain information for the remaining two. The DHHS Office of the Controller will continue to work closely with DSS to ensure that fixed assets are correctly recorded and tracked.

The Department is examining the possible need to inventory the ACS leased equipment. Action will be taken when the decision as to how to treat that equipment is reached. We are also exploring how to capture and retain the Federal and state shares of equipment.

DIVISION OF VOCATIONAL REHABILITATION

15. BASIC SUPPORT CLAIMS WERE NOT PROPERLY PAID

There were weaknesses in the Division of Vocational Rehabilitation's controls over the payment of basic support claims in the Rehabilitation Services – Vocational Rehabilitation Grants to States program. An examination of 225 client files revealed the following:

a. Six outpatient claims were paid using an incorrect methodology. Lab fees were incorrectly included in the calculation for outpatient claims resulting in an overpayment of $298.

b. Twenty claims were paid at incorrect rates. Rates were not obtained and entered into the system in a timely manner, causing claims to be paid at old rates. This resulted in an overpayment of $5,235.

c. Three inpatient claims were paid incorrectly based on an incorrect formula for calculating cost outliers. This resulted in an underpayment of $523.

d. Two drug claims were paid at incorrect rates. Rates were not obtained and input into the system in a timely manner. Also, the dispensing fee for one of the claims was overpaid based on the Medicaid set dispensing fee for the drugs. These errors resulted in a net underpayment of $105.

e. Five drug claims were paid using an incorrect methodology for payment. Effective December 2001, a State Maximum Allowable Cost (SMAC) rate was initiated for certain drugs to use in determining the lowest price. The SMAC rate was not considered when pricing these claims. Also, the dispensing fee for three of the claims was overpaid based on the Medicaid set dispensing fee for the drugs. The net overpayment of these errors was $164.

f. One drug claim overpaid the dispensing fee based on the Medicaid set dispensing fee for the drugs resulting in an overpayment of $5.

g. One payment was overpaid due to the use of an incorrect rate while pricing the claim that resulted in an overpayment of $802.

h. One payment was overpaid due to Division personnel providing incorrect payment information. The bill was paid in its entirety rather than the Division's normal practice for paying claims without Medicaid rates at 65% of the billed amount. This error resulted in an overpayment of $2,100.

i. One claim was paid incorrectly based on an incorrect formula for calculating inpatient per diem claims. The current calculation does not include a Disproportionate Share (DSH payment) resulting in an underpayment of $129.

j. One claim was paid incorrectly based on an incorrect calculation for claims with an invalid DRG. The system inputs a zero value for the DRG weight causing the system to pay the claims incorrectly. This error resulted in an overpayment of $718.

The Department paid claims in error totaling a net overpayment of $8,565. Because we believe the errors will result in questioned costs exceeding $10,000, we are questioning the federal share of $7,336 related to overpayments of $9,322.

In addition, we noted that the policy of paying 65% of the billed amount when Medicaid rates are not available is not a written policy for the Division. When inquiring about supporting documentation for Item (h) above, none could be provided. There were two other items in our sample, which we have not considered as errors, that were paid using the 65% methodology.

The control weaknesses that allowed the errors to occur could, under other circumstances, cause other claims to be paid incorrectly by amounts that are significant. Section 1-11 of the Division of Vocational Rehabilitation internal policies manual requires that invoices for hospital services be paid at the Medicaid rate. The Medicaid State Plan and the Hospital Manual define the correct methodology for the payment of

lab fees, inpatient per diem calculations, and calculating cost outliers. The Medicaid Pharmacy manual defines the correct methodology for determining drug pricing.

Recommendation: The Division of Vocational Rehabilitation should strengthen internal controls to ensure that all invoices are properly processed and paid. Rate changes should be obtained in a timely manner and properly incorporated into the Division's payment procedures. Also, the Division should ensure that payment calculations are updated regularly in accordance with Medicaid payment methodology. The Division should perform analysis to determine the total impact of the errors and require reimbursement from providers for overpayments.

Agency's Response: The Department concurs with the finding. Each claim exception identified within the audit is in the process of being recalculated and adjusted appropriately. All vendors that received overpayments will be billed for the overpayment amount by April 1, 2006. The Division of Vocational Rehabilitation (DVR) must adhere to published Division of Medical Assistance (DMA) rate schedules because of the General Statute requirement that DMA established rates for medical services not be exceeded by any state agency. Due to various mitigating factors, such as: complexity of rate determination, DMA outsourced bill-paying process and the lack of access afforded DVR to these rate changes in a timely manner; DVR encounters continuing difficulty in applying rates/fees retroactively and gaining full insight to the DMA rate structure. In order to avoid service interruption for clients, DVR must process claims in a timely manner and cannot hold payments in anticipation of retroactive rate changes, which can cause the incorrect rate to be applied.

The Division continues to pursue every opportunity available to comply with the General Statute and will:

- Continue to attend meetings with the DHHS Office of the Controller, DMA, and Division of Information Resource Management (DIRM), to work towards improving communications and updates in a timely manner.
- Obtain access to the DMA information memoranda on-line rate change alert system to ensure the Division's compliance with adhering to DMA published rate schedules.
- To seek appropriate computer program changes to facilitate timely implementation of DMA retroactive rate changes in concert with DIRM and the DHHS Office of the Controller.
- Revise policy to reflect the use of the DVR's customary practice of paying claims at 65% of the billed amount when the Medicaid rates are unavailable.
- Continue to review and discuss with DMA and DHHS Office of the Controller the feasibility of the DMA Fiscal Agent paying all DVR medical claims as an add-on to the DMA contract.

16. CONTROL WEAKNESSES OVER DETERMINATION AND DOCUMENTATION OF CLIENT ELIGIBILITY

There were control weaknesses related to the determination of client eligibility and completion of financial needs documentation in the Rehabilitation Services – Vocational Rehabilitation Grants to States program. Our examination of 225 client files revealed cases in which eligibility was not determined in a timely manner, eligibility determination forms were not completed and included in the client's case file, and the individual financial needs documentation was not completed according to the specifications in federal requirements.

- Required Agreement to Extend Eligibility Decision forms were not obtained or were not obtained in a timely manner for seven clients.

  Title 34 CFR section 361.41 and the Division's internal policies manual require that the eligibility extension forms be filed if eligibility cannot be determined within 60 days. Since clients were later determined eligible, there are no questioned costs.

- Required Certificates of Eligibility forms were not completed and included in the client's file for five clients as required by section 3-7-6 of the internal policy manual. The payments to these clients totaled $31,575. Since proof of eligibility could not be determined and likely errors exceed $10,000, the federal share of $24,849 is being questioned.

- Two clients did not have appropriate documentation of the individual's financial status. Neither file had the completed form nor the documentation of the individual's SSI/SSDI status as specified in the Division's policies. Since proof of financial need was not determined, the clients would be ineligible for cost services to be provided. The clients were paid $10,901 resulting in questioned costs of the federal share of $8,579.

These weaknesses increase the risk of paying costs related to ineligible participants or for unapproved services.

Recommendation: The Division of Vocational Rehabilitation should strengthen internal controls to ensure that all applicable eligibility forms are obtained when required and that financial needs forms are completed before cost services are provided in accordance with the requirements specified in federal regulations.

Agency's Response: The Department concurs with the finding. DVR will continue to strengthen the eligibility determination process. Areas to be emphasized include eligibility documentation, financial needs testing, lack of adequate documentation, and timeliness of the eligibility determination.

Regarding eligibility extension forms, DVR will train Regional Directors, managers and counselors to increase the effective use of the error report that enables managers to monitor cases approaching the 60 day limit. In addition, managers will review the error

report once a quarter and provide a report to the Regional Director. The DVR Director will review these reports quarterly with Regional Directors.

DVR will increase random monitoring for eligibility documentation. If a pattern of errors is identified, a developmental plan for performance in the specific areas will be developed. In addition, changes will be implemented with the automated case management system that will ensure that the form is completed and printed prior to case activation. The five cases in question during this audit were reviewed and deemed to meet eligibility criteria; therefore, there was no overpayment. The required Eligibility Decision form will be added to each case file.

The requirements for the financial need test are more complex. When an individual is an applicant, DVR may authorize diagnostic services in order to determine eligibility for treatment services. After being determined eligible for treatment services, only certain services require the financial need test. Thus, an eligible individual may receive a number of services which do not require a financial need test. In one of the cases pulled for review, after the authorized diagnostic services were performed the applicant was found not eligible for treatment services. DVR appropriately paid for diagnostic services in this case and there was no overpayment. The second case was determined eligible and a service that requires a financial need test was added to the Individual Plan for Employment (IPE); however, after the diagnostic service was performed it was determined that the client was unable to participate in the authorized service requiring a financial need test. No services provided to this individual were subject to the financial need test; therefore, there was no overpayment. Training will be provided in each Unit Office regarding the requirement that only services for which the individual is eligible and financial need, if required, has been determined are included on the IPE. In addition, an automated edit and/or reminder will be implemented in the case management system to ensure accurate completion of the financial needs form prior to the authorization/expenditure of funds for services subject to the needs test.

17. CONTROLS OVER FIXED ASSETS NEED IMPROVEMENT

The Division of Vocational Rehabilitation failed to follow specific internal policies related to fixed assets documentation and the safeguarding of assets purchased with Rehabilitation Services - Vocational Rehabilitation Grants to States program funds. Testing of fixed assets and inventory procedures revealed the following:

- The Division failed to timely submit missing asset forms for nine items listed as missing during the annual inventory.
- In our testwork of asset dispositions, we noted that the Division did not submit documentation for one month in which assets were sold/disposed through State Surplus Property. The disposed assets were not removed from the fixed asset system.

The Division's failure to follow policies and maintain proper documentation could result in fixed assets being misstated on the financial statements.

The Office of State Controller's fixed asset policies require agencies to safeguard assets and properly account for asset dispositions. OMB Circular A-102 Common Rule also requires that equipment records be maintained, a physical inventory of equipment be taken, and an appropriate control system be used to safeguard equipment.

Recommendation: The Division of Vocational Rehabilitation should ensure all personnel understand their responsibilities for documenting, recording, and safeguarding fixed assets and the importance of following internal policies.

Agency's Response: The Department concurs with the finding. The missing asset forms referenced above were subsequently found. DVR will reinforce policies for more timely submission of asset forms which will aid in proper recording, deleting and editing of assets. DVR will work in conjunction with the DHHS Office of the Controller to ensure procedures are complete for proper recording, deleting and editing of assets in a timely manner. DVR will conduct regional training on the procedures relating to the documentation, recording and safeguarding of fixed assets.

DIVISION OF PUBLIC HEALTH

18. FAILURE TO PERFORM TIMELY MONITORING OF LOCAL AGENCIES FOR THE SPECIAL SUPPLEMENTAL NUTRITION PROGRAM FOR WOMEN, INFANTS, AND CHILDREN (WIC)

The Division of Public Health failed to perform on-site monitoring visits for the required number of local agencies for the WIC program. The Division's monitoring plan provided for 41 visits to local agencies to be performed for the 2005 federal fiscal year. A management decision was made not to perform the monitoring visits for two counties due to an imbalance of reviews for one region.

The number of local agencies reviewed did not meet 7 CFR Section 246.19(b)(3) that requires that the State agency conduct monitoring reviews of each local agency at least once every two years. State agencies are required to establish an on-going management evaluation system for monitoring local agencies operations including planned on-site visits.

Recommendation: The Division of Public Health should adhere to its policies and procedures for performing monitoring of local agencies in accordance with its established management evaluation system for the WIC program. All local agencies should be monitored timely, at least once every two years.

Agency's Response: The Department concurs with this finding. WIC Program staff made changes to the WIC Monitoring Schedule without receiving approval from the Branch Head. The changes were made to accommodate staff scheduling needs and an

excessive number of reviews in two quarters of the year. Staff acknowledges the error and no changes will be made in the future without written approval from the Branch Head. The review schedule is now generated for the Federal Fiscal Year calendar and all scheduled reviews have been completed.

19. FAILURE TO PROPERLY ACCOUNT FOR THE DISPOSITION OF FOOD INSTRUMENTS FOR THE WIC PROGRAM

The Division of Public Health has not properly accounted for the disposition of all valid food instruments as required by 7 CFR Section 246.12(q). The Division is required to identify all food instruments as either issued or voided, and those issued as redeemed or unredeemed. This accounting must occur within 150 days of the food instruments' first valid date for participant use. This goal is achieved by requesting the local WIC agencies to review and resolve the items listed on the Unmatched Redemption reports. These reports are reviewed by the local agencies and returned to the Division; however, the reports are being filed without appropriate follow-up on the responses.

We noted instances where the local agencies responded in a manner that did not adequately meet the federal requirement for disposition. As a result, the Division has not been calculating its non-reconciliation rate for redeemed food instruments.

The Division's food instrument disposition process is not in compliance with established federal requirements. The failure to perform proper follow-up and reconciliation procedures increases the risk that food instruments may be used inappropriately.

Recommendation: The Division of Public Health should establish and implement procedures that provide assurance that the disposition of all food instruments is accounted for and proper follow-up occurs for identified discrepancies reported at the local agency level. In addition, the Division should establish procedures to ensure that the non-reconciliation rate is calculated and assessed for appropriateness.

Agency's Response: The Department concurs with this finding. This task was overlooked during the transition of staff assigned to the WIC Program and the DPH Budget Office. Staff from the WIC Program and the DHHS Controller's Office have agreed to jointly complete the task of reviewing/reconciling the Unmatched Redemption Reports for the 2004 and 2005 fiscal years by April 30, 2006. WIC Program staff and the DHHS Controller's Office staff will jointly develop procedures outlining tasks and responsible parties to ensure that the task is completed in the future. The procedures will cover computation of the monthly reconciliation rate and the annual rate. The annual non-reconciliation rate will be assessed for appropriateness. WIC Program staff will be responsible for the calculation of the monthly non-reconciliation rate and the annual rate.

20. INADEQUATE SUBRECIPIENT MONITORING FOR CENTER FOR DISEASE CONTROL AND PREVENTION PROGRAM

The Division of Public Health did not adequately monitor grants made under the Center for Disease Control and Prevention – Investigations and Technical Assistance program. As a result, there is an increased risk that funds were spent for improper purposes.

There are several different activities that take place under the Center for Disease Control and Prevention – Investigations and Technical Assistance program, including activities to control and prevent bioterrorism and chronic disease. To a large extent, these activities are carried out independently of one another.

For grants to subrecipients related to bioterrorism, the Division reviews activity reports from subrecipients called "quarterly narratives" to monitor program activity. We found that for 18 of the 23 subrecipient reporting periods selected, quarterly narrative reports were either missing or the quarter to which they applied was not noted on the report, thus making it unclear as to whether a report had been filed for the selected period.

Also, the Division did not have a subrecipient monitoring plan for the chronic disease control and prevention activity known as "Well Integrated Screening and Evaluation for Women Across the Nation" program. There was some monitoring ongoing, but with no structured procedures.

OMB Circular A-133 requires pass-through entities to monitor subrecipient activities to ensure that federal awards are used in accordance with federal laws and regulations. Subrecipients received $14.7 million of grant funds for bioterrorism activities and $1.1 million for the Well Integrated Screening and Evaluation for Women Across the Nation program during the year ended June 30, 2005.

Recommendation: The Division of Public Health should implement procedures to ensure that all required subrecipient activity reports are filed and reviewed by appropriate personnel. The Division should also ensure that all significant subrecipient grant activity is subjected to adequate monitoring procedures.

Agency's Response: The Division of Public Health (DPH) has always been cognizant of its subrecipient monitoring responsibilities. DPH did not have a staff position dedicated to perform this function for the Bioterrorism related Center for Disease Control and Prevention (CDC) grant component. For the Bioterrorism related CDC grant component, a subrecipient monitoring position was filled effective June 26, 2004. Since that time, the Bioterrorism Program subrecipient monitor has developed and implemented a web-based reporting process effective October 2005 for the required quarterly narrative reports which improves the reporting process and includes a date field to capture the quarter being reported. In addition to this improvement, since October 2004 this position has reviewed all records and reports related to this grant for 85 local health departments (LHD); maintained meticulous files on each LHD; and, monitored the receipt of the quarterly narrative reports. This position had conducted onsite reviews for all but 2 of

the 85 LHDs by August 2005. The position also had developed and implemented a new method for the required Expenditure Monitoring Reporting and trained the LHDs on the method from October 2004 to January 2005. Monitoring reviews of LHDs that demonstrate a lack of compliance with the required reports has resulted in a LHD reduction of funds from this grant source.

Regarding the Well Integrated Screening and Evaluation for Women Across the Nation (WISEWOMAN) related CDC grant component, the subrecipient monitoring activity was ongoing; however, the monitoring process was not well documented. Developing more structured monitoring procedures is a priority for the WISEWOMAN Program. The Division of Public Health Monitoring plan will be updated by April 30, 2006 to include program-specific monitoring requirements and tools for WISEWOMAN.

21. INSUFFICIENT DOCUMENTATION OF PROGRAM CHANGES AND AUTHORIZATION FOR SYSTEM USERS FOR THE NC CARES PROGRAM

NC CARES is a packaged web-based system that allows the Division of Public Health to account for documentation from participating institutions and to provide for claim reimbursements for the Child and Adult Care Food Program. During the audit, we identified documentation deficiencies to support the testing of program changes for the NC CARES system as well as inadequate documentation to support the authorization and approval of system users. Inadequate documentation to support program changes could result in insufficient testing of program updates prior to their implementation. Inadequate documentation to support authorization and approval of system users could result in unauthorized users being given access to the system.

Best practices provide for appropriate information technology (IT) procedures to be in place and compliance standards enforced by management. Documented results of system testing should be retained. In addition, documentation should be available to provide for system security and accountability.

Recommendation: The Division of Public Health should develop and implement adequate documentation standards to support the testing of program changes and the authorization and approval of users of the NC CARES system.

Agency's Response: The Department concurs with this finding. The Division of Public Health in the past has conducted tests of NC CARES Program changes as well as providing training and documentation for issuance of NC CARES passwords and system access. However, due to staff turnover in the Information Technology Unit of Nutrition Services, we agree that inadequate documentation was maintained to support the testing of program changes and authorization/approval of system users. Effective February 21, 2006, new policies and procedures were implemented regarding system access and user IDs for the NC CARES system. New policies and procedures regarding documenting, authorizing and testing changes to the NC CARES system were also

implemented on February 27, 2006. The NC CARES Manual will be updated by June 30, 2006 to reflect the new policies and procedures.

DIVISION OF SERVICES FOR THE BLIND

22. BASIC SUPPORT CLAIMS WERE NOT PROPERLY PAID

There were weaknesses in the Division of Services for the Blind's controls over the payment of basic support claims in the Rehabilitation Services – Vocational Rehabilitation Grants to States program. An examination of 225 client files revealed the following:

- One outpatient claim was paid using an incorrect methodology. Lab fees were incorrectly included in the calculation for outpatient claims resulting in an overpayment of $11.
- Three claims were paid at incorrect rates. Rates were updated using incorrect information causing claims to be paid at incorrect rates. This resulted in an overpayment of $495.

The Division overpaid claims by $506. Because the projected amount of questioned costs for the grant exceeds $10,000, we are questioning $399, which represents the federal share of the overpayment.

The Division's internal policies require that invoices for hospital services be paid at the Medicaid rate. The Medicaid State Plan and the Hospital Manual define the correct methodology for the payment of lab fees.

Recommendation: The Division of Services for the Blind should strengthen internal controls to ensure that all applicable rate changes are received in a timely manner and properly incorporated into its payment procedures. Also, the Division should ensure that payment calculations are updated regularly in accordance with Medicaid payment methodology. The Division should perform analysis to determine the total impact of the errors and require reimbursement from providers for overpayments.

Agency's Response: The Department concurs with the finding. The Division of Services for the Blind (DSB) management will continue to review check write vouchers weekly. Invoices that are paid at what appears to be a very high or very low amount based on our experience will be questioned through Claims Processing and needed corrections will be made; however, DSB is not in a position to identify invoices paid at an inaccurate amount through this review. DSB along with the Division of Vocational Rehabilitation, the DHHS Controller's Office, the Division of Medical Assistance and the Division of Information Resource Management, will work together to define a procedure that will ensure accurate and timely payments to providers. The DHHS Office of the Controller staff are initiating action to recoup the questioned costs by June 30, 2006.

23. MAINTENANCE OF EFFORT NOT MET

The Division of Services for the Blind did not have controls in place to ensure that the required maintenance of effort was provided for a grant award in the Rehabilitation Services – Vocational Rehabilitation Grants to State program.

Our tests revealed that as of June 30, 2005, the Division provided $80,066 less for the 2003 grant than it was required to provide. We are questioning the $80,066 maintenance of effort deficit incurred by the Division as of June 30, 2005.

Federal regulation 34 CFR section 361.62 requires federal funding to be reduced by the amount that a grantee fails to maintain the level of effort provided by the grantee two years prior to the grant.

Recommendation: The Division of Services for the Blind should establish controls to ensure that the required maintenance of effort is maintained. Also, the Division should seek resolution to the issue through its oversight federal funding authority.

Agency's Response: The Department concurs with this finding. The DHHS Office of the Controller and DSB have implemented additional control procedures to ensure that the required maintenance of effort is provided. The Federal funding agency, Rehabilitation Services Administration, has not made a determination on how to handle the MOE questioned costs identified by the State Auditor.

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