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, 2006

OFFICE OF THE STATE AUDITOR

LESLIE W. MERRITT, JR., CPA, CFP

STATE AUDITOR

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State Auditor

March 28, 2007

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, 2006. 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:

State of North Carolina's Financial Statements

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

Center for Disease Control & Prevention

Child and Adult Care Food Program

Child Care Development Fund Cluster:

- Child Care and Development Fund Block Grant
- Child Care Mandatory and Matching Funds of the Child Care and Development Fund

Child Support Enforcement

Food Stamp Cluster:

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

Foster Care – Title IV-E

Maternal and Child Health Services Block Grant to the States

Medicaid Cluster:

- Hurricane Katrina Relief
- Medical Assistance Program (Medicaid; Title XIX)
- State Medicaid Fraud Control Units
- State Survey and Certification of Health Care Providers and Suppliers

Rehabilitation Services – Vocational Rehabilitation Grants to States

Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)

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.

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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. Similar findings were reported in the prior year for numbers 2 - 4, 9, 12 – 16.

FOOD – FOOD STAMP CLUSTER

1. IMPROPER ACCESS TO THE FOOD STAMPS INFORMATION SYSTEM

   We identified deficiencies in the Division of Social Service's oversight and management of employee access to the Food Stamp Information System (FSIS). Improper levels of access to the FSIS system were identified for two employees that serve as Social Service Regional Representatives. In addition, it was noted that periodic security reviews were not being performed for the FSIS.

   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 enhance its prescribed procedures for documenting security access privileges for the FSIS. Periodic security reviews should be conducted to ensure that access is restricted to authorized users and employee user access rights should be systematically evaluated to ensure privileges granted are appropriate for the necessary job requirements.

   DHHS Response: The Department agrees with this finding. Access for the two employees identified as having inappropriate access has been revoked. The Economic Services Section Chief or designee will request a periodic listing of section employees and their system access profile for all applicable automated data systems. This will ensure that employees have the appropriate level of access according to their responsibilities. This practice will begin the first calendar quarter of 2007.

CFDA 10.557 - SPECIAL SUPPLEMENTAL NUTRITION PROGRAM FOR WOMEN, INFANTS, AND CHILDREN (WIC)

2. FAILURE TO PROPERLY ACCOUNT FOR THE DISPOSITION OF FOOD INSTRUMENTS FOR THE WIC PROGRAM WITHIN THE DESIGNATED TIMEFRAME

In the prior year, we identified that the Division of Public Health was not properly accounting for the disposition of all valid food instruments because it was not resolving unmatched redemptions from the Unmatched Redemption reports and was not calculating the non-reconciliation rate. The reports were completed by local WIC agencies; however, the reports were being filed without appropriate follow-up on the responses. As a result, the Division was unable to calculate its non-reconciliation rate for redeemed food instruments and account for all food instruments within the established timeframe of 150 days.

This finding is partially resolved. The Division of Public Health implemented procedures for following up on responses from the local WIC agencies via the Unmatched Redemption Report during the last quarter of the State fiscal year. In addition, the Division of Public Health started calculating the non-reconciliation rate for redeemed food instruments. However, due to the timing of implementing these procedures, it was unable to adequately account for redeemed food instruments within 150 days of the food instruments' first valid date for participant use for the 2006 State fiscal year.

Per 7 CFR Section 246.12(q), the State agency must account for the disposition of all food instruments within 150 days of the food instruments first valid date for participant use.

Recommendation: The Division of Public Health should continue to refine its processes to ensure timely follow-up on the disposition of food instruments within the timeframe established by the federal guidelines.

DHHS Response: The Department concurs with this finding. This food instrument job function transferred from the DHHS Controller's Office to the WIC Program in June 2006. As of August 2006, the WIC Program staff have completed all reconciliation activities.

CFDA 84.126 – REHABILITATION SERVICES – VOCATIONAL REHABILITATION GRANTS TO STATES

3. BASIC SUPPORT CLAIMS WERE NOT PROPERLY PAID

There were weaknesses in the Department's controls over the payment of basic support claims in the Rehabilitation Services – Vocational Rehabilitation Grants to States program. The Basic Support Grant is administered by both the Division of Vocational Rehabilitation (DVR) and the Division of Services for the Blind (DSB). An examination of 244 client files revealed the following:

a. Seven drug claims were paid using an incorrect methodology for payment. Six claims were for DVR and one claim was for DSB. Effective December 2001, a State Maximum Allowable Cost (SMAC) rate was initiated for use in determining the lowest price for certain drugs. The SMAC price was not considered when pricing these claims. Also, the dispensing fee for four of the DVR claims was overpaid based on the medicaid set dispensing fee for the drugs. This oversight and overpayment of the dispensing fee resulted in an overpayment for DVR of $102 and for DSB of $4.

b. Three DVR inpatient claims were paid using an incorrect methodology. The claims were not paid with the rates that were in effect on the date of discharge resulting in an overpayment of $4,467.

c. Six DVR outpatient claims were paid incorrectly due to the use of an incorrect rate while pricing the claim that resulted in a total underpayment of $2,011.

d. One DVR inpatient claim was paid incorrectly due to the use of an incorrect rate while pricing the claim that resulted in an underpayment of $184.

e. Four DVR claims were paid in error based on keying errors by agency personnel resulting in a total overpayment of $11,087.

The Department paid claims in error totaling a net overpayment of $13,465. Because the actual questioned costs for the grant exceed $10,000, we are questioning the federal share of $10,597.`

In addition, we noted weaknesses in the Department's controls over the development of the Individualized Plan for Employment (IPE):

a. One DVR client file included an IPE that was unsigned by the client. The signature of both the counselor and the client are required.

b. One DVR client file did not have an IPE included. The services for this client were not appropriately agreed upon by the client and the counselor in order to reach an acceptable employment outcome. The total amount paid to the client was $465 of which the federal share of $366 is questoned costs.

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 Department 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 Divisions' payment procedures. Also, the Divisions should ensure that payment calculations are updated regularly in accordance with Medicaid payment methodology. The Divisions should perform an analysis to determine the total impact of the errors and require reimbursement from providers for overpayments.

DHHS Response: The Department concurs with the finding. Having the correct rates available for Claims Processing staff to use in accurately paying the Division's invoices depends upon several steps being executed properly and in a timely manner. Rate changes must be shared by Division of Medical Assistance (DMA) and its fiscal agent and programmed by the Division of Information Resource Management (DIRM) staff. The State Maximum Allowable Cost (SMAC) rate identified as not being used in our pricing methodology for drug claims is now being received. However, the format shared does not include critical data required by the VR payment system.

In all cases in which an overpayment was made, the provider has been contacted and a refund has been requested. Additional payments have been made to providers who were underpaid.

The Division continues to pursue every opportunity available to comply with the statutory requirement and will:

- Continue working with DIRM staff to seek an automated solution in updating SMAC rates for drug claims.
- Continue to hold frequent joint meetings with staff from the Controller's Office, DMA and DIRM, to improve communication and be informed of rate updates.
- Review and discuss with DMA and the Controller's Office, the feasibility of DMA's Fiscal Agent paying all the Division's medical claims as an add-on to DMA's contract.

We concur with the exception regarding the unsigned Individual Plan of Employment (IPE). The Division will follow-up with monitoring and oversight by managers to ensure that IPEs are completed when required and that the individual signs and agrees with the IPE.

Regarding the DVR file in which no IPE was included in the case, the case was in Status 30 (Eligible and in Comprehensive Needs Assessment). This status does not require an IPE because the service provided is an assessment. The case had not been moved to Status 12 in which an IPE is required. The delay in moving the case into Status 12 is justified since an assessment is required in order to identify services that will meet the rehabilitation needs of the individual. No corrective action is required in this case and the $465 payment should not be questioned.

Auditor Comment: We stand by the original recommendation and questioned costs.

4. 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 244 client files revealed cases in which eligibility was not determined in a timely manner 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 three clients.

  Title 34 CFR section 361.41 and the Division of Vocational Rehabilitation'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.

- One client did not have appropriate documentation of the individual's financial status. The file did not have the completed form nor the documentation of the individual's SSI/SSDI status as specified in the Division of Vocational Rehabilitation's policies. Since proof of financial need was not determined, the client would not be eligible for cost services to be provided. The client was paid $859 resulting in questioned costs of the federal share of $676.

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.

DHHS Response: The Department concurs with part of this finding. The Division will continue to track the error reports on the Case Management System in order to identify cases that are at risk for going beyond the 60 day limit. Unit managers will be required to submit reports regarding timeliness of eligibility decisions on a quarterly basis. The Division will also institute training on the Timeliness of Eligibility Decision Policy which counselors will complete online.

The part of the finding that addresses the case in which no financial needs test was completed does not represent a deficiency. The identified service was a diagnostic service that was provided in Status 02 (Application Status) prior to eligibility determination. A financial needs test was not required. Therefore, the $859 in client payments should not be questioned.

Auditor Comment: We stand by the original recommendation and questioned costs.

5. CASH MANAGEMENT WEAKNESSES FOR THE VOCATIONAL REHABILITATION PROGRAM

The Department failed to maintain adequate documentation to support cash drawdown requests. In addition, drawdowns were made where the federal portion of the drawdown was calculated incorrectly. Errors were noted in our sample of 41 test items as follows:

- For drawdowns of $9,149 requested on February 16, 2006, and $68,427 requested on December 29, 2005, the Department did not have all or part of the cash requirements expenditure reports to support the drawdown amounts. In addition, the amounts drawn down were incorrect.
- For drawdowns of $18,981 requested on September 8, 2005, and $2,988 requested on April 6, 2006, the federal portion of the expenditure was calculated using an incorrect federal funds participation rate for a particular federal reporting code.

The Treasury-State agreement requires that program and administrative costs be funded on a pre-issuance basis, but funds should not be drawn down more than three business days prior to the day of disbursement.

Recommendation: The Department should enhance controls related to the federal funds drawdown process to ensure accuracy in the calculation of federal amounts and the maintenance of adequate documentation to support the process.

DHHS Response: The Department agrees with this finding. We have procedures in place for drawing funds and maintaining adequate documentation. We have discussed this with staff and reiterated the importance of following these procedures.

93.558 – TEMPORARY ASSISTANCE FOR NEEDY FAMILIES

6. INSUFFICIENT FOLLOW-UP OF WORK FIRST PROGRAM MONITORING RESULTS

TANF monitoring procedures are not sufficiently designed to ensure that all cases which have been identified as ineligible due to County Responsible Overpayments (CROP) are properly closed and overpayments are recouped. The Work First Monitoring Plan requires that information from all program area monitoring activities be entered into the departmental monitoring database by the current Program Compliance Monitor. Monitoring data is periodically entered into the database after all County appeals are resolved and a year-end report is completed subsequent to the fiscal year after all County monitoring documentation has been entered into the database.

The Enterprise Program Integrity Control System (EPICS) produces a monthly report for the Program Benefit Payment Section showing CROP entries. CROP amounts on this report require that the claim has been appropriately closed-out on the EPICS Referral Detail screen. From a sample of ten County monitoring files and 199 monitored cases, two counties with one case each were identified as not closed or resolution of noncompliance issues pending. These two cases were identified and corrected during our testing procedures. However, we expanded our testwork to include a query of all CROP cases in EPICS, but not yet closed-out. An additional 837 cases were identified dating from August 1992 through February 2007, with overpayments totaling $268,946. It does not appear that controls were in place to ensure that proper follow-up procedures were performed to verify that corrective actions were fully implemented.

In addition, the original sample errors did not have a written corrective action plan in the monitoring file. The Work First Monitoring Plan states that monitoring tools, corrective action plans, and follow-up results will be maintained.

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. Additionally, the Department EPICS manual requires proper case closure. The failure to properly follow-up on cases identified as ineligible due to CROPS has resulted in the failure to recoup overpayments totaling $268,946, which are considered to be questioned costs.

Recommendation: The Division of Social Services should implement procedures to ensure outstanding adjustments are corrected and appropriate corrective action occurs for identified noncompliance.

DHHS Response: The Department concurs with this finding. The Auditor's report cited insufficient follow-up of Work First program monitoring results with reference to agency error claims left open in the EPICS system thereby preventing the state from recouping

funds on those claims. The Division of Social Services Work First Representatives (WFR) will meet with counties and address with them their responsibility to follow policy, procedures and timeframes for resolving overpayments as indicated in Section 263 (Financial Responsibility) of the Work First Manual. Counties with outstanding recoupments will be instructed to enter the appropriate County Responsibility Overpayments (CROPS) amount, date of entry and closure, and reference number and provide the data to their WFR who will forward that information to the appropriate Program Compliance Monitor for placement in the county's monitoring file.

A protocol has been established to address the finding. The Division of Social Services Performance Management team developed a query that is now available to Work First Representatives (WFR) in the Client Services Data Warehouse (CSDW) system for the purpose of monitoring Agency Error (AE) claims with a balance greater than zero on Active Work First cases. The WFR will review the query no less than every 6 months to ensure overpayments are recouped timely.

Counties with monitoring findings causing agency errors/overpayments are required to enter the appropriate County Responsible Overpayments (CROPS) amounts into the EPICS system. The County will forward the CROP amount, date of entry and closure, and EPICS reference number to their WFR. The above information will be placed in each county's Monitoring file along with the written corrective action plan developed by the county.

CCDF – CHILD CARE DEVELOPMENT FUND CLUSTER

7. INSUFFICIENT DOCUMENTATION TO SUPPORT ADJUSTMENT RECLASSIFICATIONS

During our testwork for the Child Care Development Fund Cluster, we identified that adjustments were being recorded that lacked sufficient documentation to support the purpose and amount of transactions posted. Many of these adjustments were being prepared in the final quarter of the federal fiscal year.

Such adjustments change financial data reported within the accounting system. Adequate documentation should be maintained to support the purpose and methodology for these changes as well as the authorization for these changes to occur.

Recommendation: We recommend that adequate documentation be maintained to support the calculation and purpose for adjustments made to the accounting records.

DHHS Response: The Department agrees with this finding. We agree that requests from the Department of Child Development (DCD) staff to the Controller's Office for adjustments to CCDF expenditures lacked consistent documentation to support the need and amount of the transactions. We are aware of the importance of having justification for reclassifications and have implemented a more formal structure that will create a paper trail.

8. IMPROPER ACCESS TO THE SUBSIDIZED CHILD CARE REIMBURSEMENT SYSTEM

We identified deficiencies in the Division of Child Development's oversight and management of employee access to the Subsidized Child Care Reimbursement System (SCCRS). Seven employees that are classified as Technology Support Analysts have the ability to change financial data in the SCCRS. Division of Child Development personnel stated that it was necessary for the Technology Support Analyst to have unlimited access (including the ability to change financial data) in the SCCRS to assist employees at the County level to solve system problems. However, there are no compensating controls in place to ensure that financial data is not compromised by activities performed by these employees.

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.

Recommendation: The Division of Child Development should review its prescribed procedures for documenting security access privileges for the SCCRS. Periodic security reviews should be conducted to ensure that access is restricted to authorized users and employee user access rights should be systematically evaluated to ensure privileges granted are appropriate for the necessary job requirements. If it is determined that the Technology Support Analyst position requires this level of access, compensating reviews should be implemented to ensure that the integrity of the data is not compromised.

DHHS Response: The Department agrees with the finding. The Division of Child Development (DCD) acknowledges the Infrastructure, Operations, and Systems Management (IOSM) Customer Support Services staff, Technology Support Analysts, did have data entry access level to the Subsidized Child Care Reimbursement (SCCR) System. The Division of Child Development requested that the SCCR System programming supervisor, the Customer Support Services manager, and the IOSM director immediately change the access levels of the IOSM Customer Support Services staff, Technology Support Analysts, from data entry to inquiry only for the production environment. This change has been completed as of March 12, 2007.

93.563 – CHILD SUPPORT ENFORCEMENT

9. 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 of Social Service'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 of Social Services to establish paternity and support obligations for all IV-D cases that require this type of action. We found that 42% of open cases were not in compliance with this requirement.

b) Federal regulations require the Division of Social Services 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 36% 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. Regulations require that within 90 days of locating an absent parent the Division of Social Services 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 is 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.

DHHS Response: The Department agrees with this finding. The Department has made significant progress in all areas of Child Support Enforcement compliance. Since 2002, the North Carolina Child Support Enforcement's compliance rate in Establishment has risen by 21%, the compliance rate in Interstate has risen by 21% and the compliance rate in Enforcement has risen by 18%. The compliance rate in Enforcement is 75% which meets federal standards.

The Office of Child Support Enforcement (CSE) has recently increased the frequency of self-assessment reporting from quarterly to monthly so that action on non-compliant cases can be taken sooner. Self-Assessment reports are published in the data warehouse and shared with Regional Representatives and local offices. These reports identify cases that require processing and enable local office staff to improve performance in the areas of Establishment and Interstate. CSE will also use the reports to identify specific training needs for regional and centralized training.

CFDA 93.658 – FOSTER CARE – TITLE IV-E

10. IMPROPER ACCESS TO THE FOSTER CARE INFORMATION SYSTEMS

We identified deficiencies in the Division of Social Services' oversight and management of employee access to the Child Placement Payment System and the Foster Care Facilities Licensing Systems. Nineteen employees that are classified as Technology Support Analysts have the ability to change financial data in either of these systems. Division of Social Services personnel stated that it was necessary for the Technology Analyst to have unlimited access (including the ability to change financial data) in the systems to assist employees at the County level to solve system problems. However, there are no compensating controls in place to ensure that financial data is not compromised by activities performed by these employees.

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.

Recommendation: The Division of Social Services should review its prescribed procedures for documenting security access privileges for the Child Placement Payment System and the Foster Care Facilities Licensing System. Periodic security reviews should be conducted to ensure that access is restricted to authorized users and employee user access rights should be systematically evaluated to ensure privileges granted are appropriate for the necessary job requirements. If it is determined that the Technology Support Analyst position requires this level of access, compensating reviews should be implemented to ensure that the integrity of the data is not compromised.

DHHS Response: The Department agrees with part of this finding. The employees identified by the State auditors were the Technical Support Analysts that work on the DIRM Help Desk. After consulting with staff familiar with this issue, the general consensus is that, although it is rarely needed, staff on the DIRM Help Desk need this level of access to CPPS and FCFLS in order to help county and state staff with glitches that occasionally happen in these systems. Having this level of access allows them to look at the actual screen that staff is looking at so that they are able to troubleshoot the problem directly. In discussing this issue with DIRM, it was agreed that not everyone on the list provided by the auditor needed this access. Access has been removed for those individuals.

Additionally, the auditor was concerned that there was no review of adjustments made in these systems. Anytime there is a change in the CPPS forms (5094/5095) or the FCFLS (5015) there are turnaround forms created with the changes. When changes are made to the CPPS forms (5094/5095), monthly reports on the updates are sent to the counties and the Controller's Office for review. These updates flag potential mistakes and errors so that they can be corrected.

11. DEFICIENCIES IN THE FOSTER CARE MONITORING PROCEDURES

In reviewing the monitoring procedures for the Foster Care program, we noted that the monitoring activities were not consistently in compliance with the monitoring plan. The monitoring plan specifically spells out the timeframe for the review period to be the six-month period ending three months prior to the monitoring notice date. However, we identified that 5 of the 10 counties which were selected for our review fell outside those established parameters.

In addition, the monitoring directives state that in performing the review, the monitoring review follows the placement of the children throughout the period under review to ensure that payments are being made to eligible child care providers. For the 10 counties reviewed, we determined that the monitoring procedures were incomplete. We noted that children were moved to subsequent providers within the review period; however, the monitoring documentation did not address the new placement. Benefit payments totaling $11,654 were paid to child care institutions where this subsequent follow-up did not occur.

The guidelines for monitoring activities are established in regulations for Foster Care Program as well as the Monitoring Plan (Plan) created by the Division of Social Services' Family Support and Child Welfare Services Section. Per the Plan, the Program Compliance Monitors are responsible for monitoring Title IV-E eligibility determination and re-determination for Title IV-E maintenance payments, including eligibility for the child and the child care institution.

The failure to perform monitoring procedures in accordance with the established Plan could result in payments being made to child care institutions that did not meet the eligibility requirements per the regulations.

Recommendation: The Division of Social Services should review its current Plan to ensure that it adequately addresses its planned monitoring activities. To ensure the appropriateness of the Title IV-E eligibility determination and re-determination for maintenance payments are correct, the monitoring efforts should document the children's placement throughout the review period.

DHHS Response: The Division of Social Services' Program Compliance Monitors will ensure that the case sample selection correctly reflects the review period according to the established protocol for determining the review period. As well, the process for determining the review period will be more definitive in the monitoring plan. The reported failure to follow the child's placement during the review was the result of incomplete documentation in some county records. Counties have been advised to develop stronger internal communication plans to ensure that all required documentation for determining eligibility is maintained in case files. This internal communication plan will be reviewed by the Children's Programs Representative (CPR) to determine if it is adequate.

In addition, the Children's Programs Representative (CPR) for each county will conduct periodic record reviews and training to ensure all program requirements and policy are met, including ensuring that a log is maintained in each child's record which outlines the child's placement history, dates of these placements, as well as specific reasons for the move(s) and matches. Training will also focus on ensuring that the child's placement log matches information on the child's 5094 form that tracks the child's placement payment history. Training will also address accuracy in the completion of the 5094 form.

Each of the placements that were not initially monitored have subsequently been determined to have been in licensed facilities, therefore, benefit payments totaling $11,654 were appropriate. The monitoring questions on licensure and safety corroborate eligibility of the foster care facility but in no way should be construed as eligibility re-determination for the foster care facility.

MED – MEDICAID CLUSTER

12. 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. During the 2006 State fiscal year, the Division of Medical Assistance continued to contract with two vendors who are performing hospital cost report audits to address the issue of cost settlements. Also, State Plan Amendment 04-002 was approved August 10, 2005, with an effective date of January 1, 2004, that clarified the language concerning DSH payments and cost settlements. However, this issue remained unresolved at year end.

As of August 17, 2006, the North Carolina Department of Health and Human Services, on behalf of the Division of Medical Assistance, entered into a settlement agreement with the United States Department of Justice, on behalf of the Center for Medicare and Medicaid Services (CMS) to repay $151.5 million for unallowed DSH payments. An initial payment of $106.5 million was made in September 2006, with the balance to be paid over the next three fiscal years. A portion of the amount due to CMS represents a recoupment from the hospitals. This settlement covers State fiscal years 1997-2002. Resolution has not occurred for the 2003 State fiscal year.

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. Also, the Division of Medical Assistance should continue its efforts to cost-settle DSH payments with all hospital providers for the 2003 FFY as required by the approved State Plan in effect prior to January 1, 2004.

DHHS Response: The Department agrees with this finding. As noted above, the Division has reached settlement of the DSH payments for FFY 1997–2002. Currently, the settlement for DSH payments made under the payment plan for FFY 2003 is being calculated. The target for completion of this settlement is June 30, 2007.

13. PROVIDER BILLING AND PAYMENT SYSTEM ERRORS

Our tests disclosed several weaknesses with the processing of claims payments. Errors were noted in 28 claims from a sample of 270 Medicaid claims tested.

a. One error was due to there being no medical records to support the services provided. The claim totaled $15, the total amount being unallowable. The federal share of $10 is questioned costs.

b. Nine claims were found to be in error due to insufficient documentation. The claims totaled $9,847 of which $4,013 was deemed as unallowable. The federal share of $2,549 is questioned costs.

   1) Four errors were due to insufficient documentation to support the actual services rendered.

   2) One error was due to insufficient documentation to support the quantity of services rendered.

   3) Two errors were due to insufficient documentation of diagnosis as this was not included in the medical records.

   4) One error was due to insufficient documentation to support the service dates within the period billed.

   5) One error was due to insufficient documentation in that the claim was not properly signed.

c. Three claims were found to be in error due to a violation of Medicaid Policy. The claims totaled $537 of which $216 was deemed as unallowable. The federal share of $137 is questioned costs.

   1) Two claims were found to be in error because medical records indicated that the DEA number on the claims submitted did not concur with the number recorded by the prescriber. The claims totaled $321 and were found to have been paid correctly; however, the providers need to be made aware of the errors to help prevent future similar errors.

   2) One claim was found to be in error because the services were rendered against DMA policy. The claim totaled $216, the entire amount found to be unallowable. The federal share of $137 is questioned costs.

d. Three claims were found to be in error due to duplicate billing of the claims.

   1) Two claims totaling $3,607 were found to be in error due to being billed twice. The system caught the error and paid the bill only once. The claims were found

to have been paid correctly; however, the providers need to be made aware of the errors to help prevent future similar errors.

2) One claim was found to be in error because the pharmacy submitted a duplicate claim for additional units of a patient's medication. The claim totaled $6,406 of which $1,468 was deemed unallowable. The federal share of $932 is questioned costs.

e. Ten claims were found to have improper coding or diagnosis based on medical records or other evidence provided. The claims totaled $132,870 of which $22,684 was found to be unallowable. The federal share of $14,447 is questioned costs.

f. Two claims were found to be in error for both insufficient documentation and duplicate billing. The claims totaled $3,819 of which $2,238 was found to be unallowable. The federal share of $1,424 is questioned costs.

The actual sampled claims errors totaled $30,634. As actual questioned costs are in excess of $10,000, the federal share of $19,499 is considered to be questioned costs.

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.

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.

DHHS Response: As is in years' past, a large portion of this finding was jointly developed. The Office of State Auditor selected a sample of claims and DMA's Program Integrity Section conducted a field review of provider claims and supporting documentation. During SFY 2005-06, the Program Integrity staff conducted in excess of 9,000 reviews and investigations and recouped $10.3 million as a part of DMA's overall compliance efforts.

The Department concurs with the finding that 28 of 270 claims contained errors, but noted that that this particular finding dealt primarily with provider billing errors, not payment errors made by the Division and/or its contractors. All of the errors have been resolved, recoupment/repayments completed, and educational letters have been sent to affected providers. The Division will continue to take corrective action to further educate providers on appropriate coding and documentation requirements to achieve more correct claims filing.

14. 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 of Medical Assistance 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 of Medical Assistance 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 40 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.

These 40 types of providers were paid an estimated $4.1 billion this fiscal year, including matching federal funds, representing 51% of the total amount paid to providers for the 2006 State fiscal year. 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.

Several of the 40 enrollment package types noted as errors were for provider types that are certified/endorsed by other Divisions within the Department including the Division of Facility Services, Division of Public Health, and Division of Mental Health. In these situations, the delegated Divisions request the disclosure information; however, the Division of Medical Assistance (DMA) does not have the ability to access or verify the accuracy of information obtained.

Test Results for Provider Files

From a sample of 45 providers, our tests revealed 12 providers where the provider's file was missing disclosure documentation, manager's signature of approval, or licensure verification. Details of the errors are as follows:

- One missing both ownership and criminal offense;
- Two missing the signature of approval from the DMA manager;
- Five missing the disclosure of ownership;
- One missing the business transactions disclosure;
- One missing licensure verification;
- One missing both licensure verification and criminal offense disclosure;
- One missing signature of DMA manager, licensure verification, and ownership, criminal offense and business transaction disclosures.

Test of Provider Sanctions

We also reviewed a list of sanctions given by the North Carolina Dental Board to determine if the agency had received notification from the Board and whether appropriate action had been taken to update the Medicaid Management Information System (MMIS) in accordance with the sanctions. For 17 sanctions filed by the Dental Board during SFY 2006, there were six providers with errors related to either a lack of documentation or inappropriate action following a sanction.

- Two errors were instances in which Provider Services had received a Notification of Disciplinary Action for the sanctions but failed to end-date the provider in MMIS.
- One provider's status was noted as being updated in MMIS; however, documentation was not on file to support the sanction.
- Documentation was not on file for three providers identified on the sanction list; nor were the sanctions reflected in the MMIS.

The lack of adequate internal control policies and procedures increases the risk that improper payments will be made to unqualified providers or that appropriate action may not be taken by the Division of Medical Assistance to recoup payments made in error.

Similar deficiencies have been reported in prior year audits and the Division of Medical Assistance's Provider Services section has been working to implement changes to bring the system into compliance with the applicable criteria. The Division of Medical Assistance is working to address the disclosure of information as required per 42 CFR 455 subpart B (information related to ownership, business transactions, and criminal convictions) by developing a uniform application for all providers that includes the required elements. As of September 1, 2006, Provider Services updated several of its enrollment packages to include new enrollment applications that address the disclosure requirements. As part of the development of the new Medicaid Management Information System, providers will be re-enrolled and periodic re-enrollment or re-verification of credentials will be established to detect changes in eligibility status.

Recommendation: The Division of Medical Assistance should continue with its efforts to improve and implement adequate internal controls over the provider enrollment process to ensure that only eligible medical providers are allowed participation in the Medicaid program. In addition, the Division of Medical Assistance should work to enhance controls related to provider sanctions to ensure that provider status is updated timely and supported by adequate documentation.

DHHS Response: The Department concurs with this finding. We note the past and continuing efforts of the Division of Medical Assistance (DMA) to develop policies and procedures to collect the required information from providers and to improve the process of sharing data among other agencies with licensure and enrollment responsibilities.

Corrective action efforts have been and will include:

- DMA continues to contract with an outside credentialing agency to credential all individual practitioners before enrollment occurs.
- DMA continues to use the application form for individual providers to reflect all disclosures required by 42 CFR Part 455.
- All organizations and individuals on the OIG Exclusion list are being reviewed and compared to the provider enrollment file on a continuing basis.
- DMA has added ownership information to all new applications such as Community Intervention Service (CIS) Providers. We will also add ownership information to existing applications where appropriate.

DMA acknowledges the need for re-enrollment of existing providers. The Division continues to work closely with sister agencies as well as create policies and procedures to prevent unacceptable providers from enrolling in Medicaid for all provider types.

Additionally, the new MMIS system will include the use of a new uniform application for all providers. It will also have the functionality to trigger re-verification and re-enrollment of all existing provider types automatically. Other features will include on-line enrollment and the ability to access licensure and endorsement data on-line and in real time.

15. INADEQUATE COMMUNICATION OF RATE CHANGES BETWEEN DIVISIONS

As identified in the prior year, we continued to note instances whereby 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. DMA is in possession of the state pharmacy rates which are needed by the DVR and DSB to accurately price claims. During the current year, we noted seven claims that were in error due to the State rate for pharmacy payments information not being shared with either DVR or DSB.

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

42 CFR 431.18 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 continue to 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.

DHHS Response: The Department concurs with this finding. We note that new procedures were introduced for rate-setting staff such that any new or changed rate information would be shared with the Division of Vocational Rehabilitation (DVR) and the Division of Services for the Blind (DSB) in a timely manner. Corrective action has been taken to ensure that:

- All current personnel have been properly trained;
- Communication has been established with DMA's counterparts in each of our sister divisions;
- 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.

We believe the inadequate communication cited in this year's audit occurred just prior to the implementation of our corrective action plan. Both DVR and DSB have current rate information and are receiving updated rate information in a timely manner.

FINANCIAL STATEMENT ISSUE

16. IMPROPER ACCESS TO THE ELIGIBILITY INFORMATION SYSTEM

During the prior year, we identified deficiencies in the Division of Social Service's oversight and management of employee access to the Eligibility Information System (EIS). Improper levels of access to the EIS system were identified for six employees during the prior year. Follow-up procedures were performed during the current year, particularly for those employees. We noted that one employee identified in the prior year continued to have the same improper access. There was a change in the Security Officer position during the year which apparently contributed to this oversight.

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 continue to enhance 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 and employee user access rights should be systematically evaluated to ensure privileges granted are appropriate for the necessary job requirements.

Division Response: The Department agrees with this finding. The DHHS Privacy and Security Office investigated the security profile of the individual employee during the month of October 2006, and revoked the access that is not required for this employee to perform job duties. The DIRM technical support will continue to review the RACF Violation Log on a periodic basis.

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