STATE OF NORTH CAROLINA

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEWIDE FEDERAL COMPLIANCE AUDIT PROCEDURES

FOR THE YEAR ENDED JUNE 30, 2011

OFFICE OF THE STATE AUDITOR

BETH A. WOOD, CPA

STATE AUDITOR

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

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AUDITOR'S TRANSMITTAL

The Honorable Beverly Eaves Perdue, Governor
Members of the North Carolina General Assembly
Albert Delia, Acting 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 reporting entity as presented in the *Single Audit Report* for the year ended June 30, 2011. Our audit was performed by authority of Article 5A of Chapter 147 of the *North Carolina General Statutes*.

In the *Single Audit Report*, the State Auditor presents the results of tests of internal control and compliance with laws, regulations, contracts, and grants applicable to the State's major federal programs. Our audit procedures were conducted in accordance with auditing standards generally accepted in the United States of America; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; and OMB Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*.

Our audit objective was to render an opinion on the State of North Carolina's, and not the Department's, administration of major federal programs. However, the report included herein is in relation to our audit scope at the Department and not to the State of North Carolina as a whole.

The audit findings referenced in the report are also evaluated to determine their impact on the State's internal control and the State's compliance with rules, regulations, contracts, and grants. If determined necessary in accordance with *Government Auditing Standards* or the OMB Circular A-133, these findings are reported in the State's *Single Audit Report*.

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.

Beth A. Wood, CPA
State Auditor

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REPORT ON COMPLIANCE WITH REQUIREMENTS THAT COULD HAVE A DIRECT AND MATERIAL EFFECT ON EACH MAJOR PROGRAM AND ON INTERNAL CONTROL OVER COMPLIANCE IN ACCORDANCE WITH OMB CIRCULAR A-133

Albert Delia, Acting Secretary and the Audit Committee
and Management of the North Carolina Department of Health and Human Services

Compliance

As part of our audit of the State of North Carolina's compliance with the types of requirements described in the *OMB Circular A-133 Compliance Supplement* that could have a direct and material effect on each of its major programs for the year ended June 30, 2011, we have performed audit procedures at the North Carolina Department of Health and Human Services. Our report on the State of North Carolina's compliance with requirements that could have a direct and material effect on each major program and on internal control over compliance in accordance with OMB Circular A-133 is included in the State's *Single Audit Report*. Our federal compliance audit scope at the North Carolina Department of Health and Human Services included the following:

SNAP Cluster:

- CFDA 10.551 - Supplemental Nutrition Assistance Program (SNAP)
- CFDA 10.561 - State Administrative Matching Grants for the Supplemental Nutrition Assistance Program

CFDA 10.557 - Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)

CFDA 10.558 - Child and Adult Care Food Program (CACFP)

Vocational Rehabilitation Cluster:

- CFDA 84.126 - Rehabilitation Services - Vocational Rehabilitation Grants to States
- CFDA 84.390 - Rehabilitation Services - Vocational Rehabilitation Grants to States, Recovery Act

Aging Cluster:

- CFDA 93.044 - Special Programs for the Aging - Title III, Part B - Grants for Supportive Services and Senior Centers
- CFDA 93.045 - Special Programs for the Aging - Title III, Part C - Nutrition Services
- CFDA 93.053 - Nutrition Services Incentive Program
- CFDA 93.705 - ARRA - Aging Home-Delivered Nutrition Services for States
- CFDA 93.707 - ARRA - Aging Congregate Nutrition Services for States

Immunization Cluster:

- CFDA 93.268 - Immunization Grants
- CFDA 93.712 - ARRA - Immunization

TANF Cluster:

- CFDA 93.558 - Temporary Assistance for Needy Families (TANF)
- CFDA 93.714 - ARRA - Emergency Contingency Fund for Temporary Assistance for Needy Families (TANF) State Programs
- CFDA 93.716 - ARRA - Temporary Assistance for Needy Families (TANF) Supplemental Grants

CFDA 93.563 - Child Support Enforcement

CFDA 93.568 - Low-Income Home Energy Assistance

CSBG Cluster:

- CFDA 93.569 - Community Services Block Grant
- CFDA 93.710 - ARRA - Community Services Block Grant

CCDF Cluster:

- CFDA 93.575 - Child Care and Development Block Grant
- CFDA 93.596 - Child Care Mandatory and Matching Funds of the Child Care and Development Fund
- CFDA 93.713 - ARRA - Child Care and Development Block Grant

CFDA 93.658 - Foster Care - Title IV-E

CFDA 93.659 - Adoption Assistance - Title IV-E

Medicaid Cluster:

- CFDA 93.720 - State Survey and Certification Ambulatory Surgical Center Healthcare Associated Infection (ASC-HAI) Prevention Initiative
- CFDA 93.775 - State Medicaid Fraud Control Units
- CFDA 93.777 - State Survey and Certification of Health Care Providers and Suppliers
- CFDA 93.778 - Medical Assistance Program (Medicaid; Title XIX)

CFDA 93.767 - Children's Health Insurance Program (CHIP)

CFDA 93.959 - Block Grants for Prevention and Treatment of Substance Abuse

Disability Insurance/SSI Cluster:

- CFDA 96.001 - Social Security - Disability Insurance (DI)
- CFDA 96.006 - Supplemental Security Income (SSI)

The audit results described below are in relation to our audit scope at the Department and not to the State of North Carolina as a whole.

We conducted our audit of compliance in accordance with auditing standards generally accepted in the United States of America; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; and OMB Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*. Those standards and OMB Circular A-133 require that we plan and perform the audit to obtain reasonable assurance about whether noncompliance with the types of compliance requirements referred to above that could have a direct and material effect on a major federal program occurred. An audit includes examining, on a test basis, evidence about compliance with those requirements and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion. Our audit does not provide a legal determination of the Department's compliance with those requirements.

The results of our audit procedures at the North Carolina Department of Health and Human Services disclosed instances of noncompliance that are required to be reported in accordance with OMB Circular A-133 and which are described in the findings in the Audit Findings and Responses section of this report.

Internal Control Over Compliance

Management is responsible for establishing and maintaining effective internal control over compliance with the requirements of laws, regulations, contracts, and grants applicable to federal programs. In planning and performing our audit, we considered internal control over

compliance with the requirements that could have a direct and material effect on a major federal program to determine the auditing procedures for the purpose of expressing our opinion on compliance and to test and report on internal control over compliance in accordance with OMB Circular A-133, but not for the purpose of expressing an opinion on the effectiveness of internal control over compliance. Accordingly, we do not express an opinion on the effectiveness of internal control over compliance.

A *deficiency in internal control over compliance* exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance with a type of compliance requirement of a federal program on a timely basis. A *material weakness in internal control over compliance* is a deficiency, or combination of deficiencies, in internal control over compliance such that there is a reasonable possibility that material noncompliance with a type of compliance requirement of a federal program will not be prevented, or detected and corrected, on a timely basis. A *significant deficiency in internal control over compliance* is a deficiency, or combination of deficiencies, in internal control over compliance with a type of compliance requirement of a federal program that is less severe than a material weakness in internal control over compliance, yet important enough to merit attention by those charged with governance.

Our consideration of the internal control over compliance was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control over compliance that might be deficiencies, significant deficiencies, or material weaknesses, and therefore, there can be no assurance that all deficiencies, significant deficiencies, or material weaknesses have been identified. However, we consider the deficiencies described in findings 1, 5, 8-9, 12, 14, 16-17, 26-29, 31, and 35-36 in the Audit Findings and Responses section of this report to be material weaknesses in internal control over compliance, as defined above. Furthermore, we consider the deficiencies described in the remaining findings in the Audit Findings and Responses section of this report to be significant deficiencies in internal control over compliance, as defined above.

We noted certain other matters related to compliance with federal requirements or internal control over compliance that we reported to management of the North Carolina Department of Health and Human Services in a separate letter dated February 29, 2011. We also noted certain deficiencies in information systems controls that were only generally described in this report. Details about these deficiencies, due to their sensitive nature, were communicated to management in a separate letter pursuant to *North Carolina General Statute* 147-64.6(c)(18).

Management's responses to the findings identified in our audit are included in the Audit Findings and Responses section of this report. We did not audit the responses, and accordingly, we express no opinion on them.

This report is intended solely for the information and use of management, the Acting Secretary, members of the audit committee, others within the entity, the Governor, the General Assembly, and federal awarding agencies and pass-through entities and is not intended to be and should not be used by anyone other than these specified parties.

Beth A. Wood, CPA
State Auditor

March 9, 2012

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Matters Related to Federal Compliance Objectives

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

1. DEFICIENCIES IDENTIFIED IN THE MONITORING OF WIC HIGH-RISK VENDORS

The Department's monitoring activities did not sufficiently address high-risk vendors identified in the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). As a result, there is an increased risk that the Department may not perform compliance investigations for those vendors determined to have the greatest potential for program noncompliance or loss of funds.

Federal regulations require the Department to conduct compliance investigations for a minimum of five percent of authorized vendors. Additionally, federal regulations require that if the Department determines that more than five percent of authorized vendors are considered high-risk, the Department must prioritize the vendors in order to determine which ones will be subject to compliance investigations.

The Department determined that more than five percent of its authorized vendors were categorized as high-risk; however, its monitoring plan did not address the prioritization of high-risk vendors. As a result, the Department only conducted 52% (46 of 88) of the required compliance investigations for high-risk vendors.

A similar finding was written in the prior year.

Federal Award Information: This finding affects Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) grant award #5NC700705 for the federal fiscal year ended September 30, 2010.

Recommendation: The Department should strengthen controls to ensure that high-risk vendors are prioritized for review based on each entity's potential for program noncompliance or loss of funds. The Department's monitoring plan should be adjusted to ensure compliance investigations are completed for all identified high-risk vendors up to the five percent minimum federal requirement.

DHHS Response: The Department concurs with the finding and recommendation. At the time the prior year finding was identified, prompt corrective action was taken. On January 13, 2011 our revised procedure was put in place to ensure that we are properly prioritizing high-risk vendors and following federal regulations appropriately. The timing of the audits are such that the Department is halfway through the subsequent year before a finding of the previous year is identified; thus, a finding appears in two separate fiscal year reports even though prompt corrective action was taken after the first audit.

2. DEFICIENCIES IN WIC CASH MANAGEMENT PROCEDURES

The Department did not have effective controls in place to ensure the reporting of cash management activities for the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) program was in accordance with federal requirements. As a result, federal deposit and expenditure data reported were incomplete and not in compliance with the Treasury-State agreement.

The Department submits federal deposit and expenditure data to the Office of the State Controller based on its Cash Management Improvement Act (CMIA) spreadsheets. This information is tracked to improve the timing of the flow of federal reimbursements to the State for federal program expenditures. In reporting WIC program activities, the Department inadvertently excluded deposit and expenditure information for WIC breast pumps and special formula. These deposits and expenditures are subject to the same cash management requirements as WIC administrative costs. As a result, federal deposit and expenditure information was understated by $3.5 million and $1.2 million, respectively.

Federal Award Information: This finding affects Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) federal grant award #5NC700705 for the federal fiscal years ending September 30, 2010 and 2011.

Recommendation: The Department should strengthen controls to ensure all WIC deposit and expenditure transactions are reported to the Office of State Controller in compliance with the Treasury-State Agreement.

DHHS Response: The Department agrees with the finding and recommendation. The Department of Health and Human Services Office of the Controller's General Accounting/Financial Management and Federal Funds/Financial Reporting Sections will meet to review the individual account numbers associated with the Women, Infants, and Children (WIC) program to confirm all applicable expenditures and revenues are reported on the Cash Management Improvement Act (CMIA) reports. The Grant Master file will continue to be reviewed for accuracy on a quarterly basis. Anticipated completion date is June 30, 2012.

3. INADEQUATE PROGRAM CHANGE CONTROLS

We identified deficiencies in the Department's segregation of duties for program changes for the Aid to Counties system, specifically the duties involved in moving application changes from the test environment into production. The lack of segregation of duties increases the risk that unauthorized or unintentional changes could occur and go undetected.

The Aid to Counties system is used to setup each county subrecipient's annual budget allotment/allocation. The State puts in the allocation amounts and the counties input their actual expenditures to request reimbursement for their administrative costs. During our

procedures, we noted that the same analysts were able to perform all program change functions for the system.

Adequate segregation of duties involves assigning responsibilities such that the duties of one employee automatically provide a cross-check on the work of other employees. All changes relating to infrastructure and applications within the production environment, including emergency maintenance and patches, should be formally managed in a controlled manner. As such, changes (including those to procedures, processes, and system and service parameters) should be logged, assessed and authorized prior to implementation and reviewed against planning outcomes following implementation. It should be noted that upon notification of the problem, the Department implemented procedural changes to address the identified concerns.

Federal Award Information: This finding affects Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) grant award #5NC700705 for the federal fiscal year ended September 30, 2010.

Recommendation: The Department should ensure proper segregation of duties exists for program changes made to the Aid to Counties system.

DHHS Response: The Department agrees with the finding and recommendation. Stakeholders for the Aid to Counties application, including Division of Public Health (DPH) Business Office and Information Technology (IT) Branch, Department of Health and Human Services (DHHS) Office of the Controller, and DHHS Division of Information Resources Management (DIRM) reviewed the audit finding and mutually developed a process and technical solution that addresses the segregation of duties. All business-related program change requests are initiated via an enhancement request or support from a single point from the DPH Business Office. Program development makes the changes in a development environment and then moves them to a test environment where the users review and approve the changes. After approval, a different developer from the one who made the changes or an IT supervisor provides a secondary approval of the changes. This secondary approval moves the program changes from the test environment into the live production environment. As of October 14, 2011, the program changes to the Aid to Counites system have already been implemented.

VOCATIONAL REHABILITATION CLUSTER - REHABILITATION SERVICES - VOCATIONAL REHABILITATION GRANTS TO STATES

4. CLAIM PAYMENT ERRORS FOR THE REHABILITATION SERVICES - VOCATIONAL REHABILITATION GRANTS TO STATES PROGRAM

The Department made payments on behalf of Rehabilitation Services - Vocational Rehabilitation Grants to States program participants that did not comply with the activities allowed and allowable cost requirements for the program. The Department erroneously made net overpayments totaling $281, resulting in questioned costs of $221,

which represents the federal share of the overpayments. We believe that it is likely that questioned costs exceed $10,000 in the population.

The Department administers the Rehabilitation Services - Vocational Rehabilitation Grants to States program through two divisions - the Division of Vocational Rehabilitation and the Division of Services for the Blind. We examined a sample of 100 client claims across both divisions and identified eight claims that were paid in error or not sufficiently documented. Examples of the deficiencies noted included payments using the incorrect methodology for payment or pricing for pharmacy claims, insufficient or missing documentation in support of the funded services, and a payment where required vendor documentation was not complete.

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.

Similar aspects of this finding were reported in the prior year.

Federal Award Information: The review for the Rehabilitation Services - Vocational Rehabilitation Grants to States program claims included federal grant awards #H126A090049, #H126A100049, #H126A110049, #H126A090050, #H126A100050, and #H126A110050 for the federal fiscal years ending September 30, 2010 and 2011.

Recommendation: The Department should continue to enhance its control procedures to improve the accuracy of the claims payment process. Procedures should ensure that the services authorized for clients match the developed rehabilitation plan. Payment methodologies should be updated to be consistent with Medicaid or other departmental pricing policies. Identified over or underpaid claims should be followed up for timely and appropriate collection or payment.

DHHS Response: The Department concurs with the finding and recommendation. The Department will continue to strengthen internal controls to ensure all claims are documented, processed and paid properly. Training will be facilitated at each of the unit offices to ensure procedures are followed and services authorized for clients match the client's developed rehabilitation plan. The Division of Vocational Rehabilitation will also continue to work and foster communication with the Division of Medical Assistance to make sure all reimbursement rates and methodologies are received and implemented in a timely manner.

More importantly, the Division has been developing a replacement claims processing system that is anticipated to eliminate claims pricing errors which are attributed to incorrect payment methodology. The anticipated date for the system implementation is October 19, 2012.

5. DEFICIENCIES IN DOCUMENTATION OF CLIENT ELIGIBILITY

There were deficiencies related to the documentation of client eligibility in the Rehabilitation Services - Vocational Rehabilitation Grants to States program. As a result, there is an increased risk of noncompliance related to client eligibility.

The Department administers the Rehabilitation Services - Vocational Rehabilitation Grants to States program through two divisions - the Division of Vocational Rehabilitation and the Division of Services for the Blind. We examined a sample of 100 client files across both divisions and identified documentation deficiencies in 25 client files. Documentation could not be located in the client files to support:

- The timeliness of eligibility determinations and/or the agreed upon extension of time for making those determinations.
- The application has the required parent/guardian signature.
- The client's financial need assessment.

Federal regulations and division policies require that documentation be maintained to support a client's eligibility determination as well as establish timeframes in which the process should be completed.

A similar finding was reported in the prior year.

Federal Award Information: The review for the Rehabilitation Services - Vocational Rehabilitation Grants to States program claims included federal grant awards #H126A090049, #H126A100049, #H126A110049, #H126A090050, #H126A100050, #H126A110050, and #H390A090049 (ARRA) for the federal fiscal years ending September 30, 2010 and 2011.

Recommendation: The Department should strengthen internal controls to ensure that all applicable eligibility forms are obtained when required, that financial needs forms are completed and documented before cost services are provided, and that the eligibility determination process occurs within required timeframes.

DHHS Response: The Department concurs with the finding and recommendation. The Division of Vocational Rehabilitation (DVR) will continue to strengthen internal controls to ensure proper documentation is maintained to support a client's eligibility determination.

Quality Development Specialists are also providing training to each unit office to make sure all eligibility determinations and/or the agreed upon extension of time for making those determinations are made within required timeframes.

In addition, the Department will stress the importance of obtaining the required signatures and assessing the client's financial need with accuracy and completeness. Anticipated date of completion is June 30, 2012.

6. DEFICIENCIES IN MONITORING PROCEDURES FOR THE COMMUNITY REHABILITATION PROGRAM CONTRACTS

We identified deficiencies in the Department's monitoring procedures for the Community Rehabilitation Program contracts. As a result, there is an increased risk that noncompliance at the vendor level could occur and not be detected in a timely manner.

A Community Rehabilitation Program can directly provide, or facilitate the provision of, one or more vocational rehabilitation services to individuals with disabilities to enable those individuals to maximize their opportunities for employment. The Department contracts with vendors across the State that provide individuals with disabilities access to the Community Rehabilitation Program. According to the contract terms, the Department is to perform two programmatic monitoring visits annually for each vendor.

We examined a sample of 17 contracts and identified three where the Department performed only one of the two required programmatic reviews. A tracking mechanism was not in place to help ensure the required monitoring visits were scheduled and to document that the visits actually occurred.

Federal Award Information: The review for the Rehabilitation Services - Vocational Rehabilitation Grants to States program claims included federal grant awards #H126A090049, #H126A100049, and #H126A110049 for the federal fiscal years ending September 30, 2010 and 2011.

Recommendation: The Department should strengthen internal controls over monitoring procedures to ensure that contract requirements are met.

DHHS Response: The Department concurs with the finding and recommendation. A tracking system is being developed which will allow the Division of Vocational Rehabilitation (DVR) to schedule monitoring, review monitoring in progress, and certify the monitoring visits have been completed and documented according to the Community Rehabilitation Program contracts. These efforts should ensure all vendors receive the two programmatic monitoring visits annually as required per contract terms. Anticipated date of completion is June 30, 2012.

7. STATE PROCUREMENT POLICIES NOT FOLLOWED

The Department did not comply with statewide procurement policies when executing two service contracts in the Rehabilitation Services - Vocational Rehabilitation Grants to States program. As a result, there is an increased risk that contracts will be entered into that do not achieve the best value possible for the program and the State. The two contracts related to the following transactions:

- One vendor was paid for performing payroll services for program participants operating their own food service or vending facilities. The vendor was paid $64,084, with the federal share totaling $50,434.

- One vendor was paid for repair and maintenance services for vending machines related to the same program participants noted above. The vendor was paid $45,471, with the federal share totaling $35,786.

Federal regulations require states to follow the same policies and procedures it uses for procurements from its non-federal funds to procure goods and services using federal funds. Those policies and procedures require bids and contract documentation for service contracts over $25,000.

Federal Award Information: The review for the Rehabilitation Services - Vocational Rehabilitation Grants to States program claims included federal grant awards #H126A100050 and #H126A110050 for the federal fiscal year ending September 30, 2011.

Recommendation: The Department should strengthen internal controls to ensure appropriate procurement policies are followed and to ensure contracts entered into are in the best interest of the program and the State.

DHHS Response: The Department concurs with the finding and recommendation. The Division will reiterate the policies and procedures which require bids and contract documentation for service contracts over $25,000. Approved guidelines will be used to ensure contracts entered into are in the best interest of the Department as well as provide the maximum benefit for program participants. Anticipated date of completion is June 30, 2012.

8. DEFICIENCIES IN CASH MANAGEMENT PROCEDURES

The Department did not have controls in place to ensure that the drawdown of funds for the Rehabilitation Services - Vocational Rehabilitation Grants to States program was in accordance with federal requirements. As a result, drawdowns occurred that were not in compliance with federal requirements and the Treasury-State agreement.

The Department administers the Rehabilitation Services - Vocational Rehabilitation Grants to States program through two different divisions - The Division of Vocational Rehabilitation and the Division of Services for the Blind. We examined a sample of 56 requests for federal funds across both divisions and identified documentation deficiencies and noncompliance in 34 requests. Examples of the deficiencies noted include requests that failed to meet the federal requirements to minimize the time elapsing between the receipt of federal funds and their disbursement, requests that failed to follow approved drawdown methods included in the Treasury-State Agreement, and requests that were not supported by adequate documentation.

Federal and state regulations require the development of procedures to ensure compliance with federal funds request methods and to minimize the time between the drawdown of federal funds from the federal government and their disbursement.

Federal Award Information: The review for the Rehabilitation Services - Vocational Rehabilitation Grants to States program claims included federal grant awards #H126A090049, #H126A100049, #H126A110049, #H126A090050, #H126A100050, #H126A110050, and #H390A090049 (ARRA) for the federal fiscal years ending September 30, 2010 and 2011.

Recommendation: The Department should strengthen controls to ensure requests for federal funds are accurate representations of actual cash needs and to ensure monitoring of daily federal cash balances so that funds are disbursed within the required time frame. Additionally, the Department should review the Treasury-State Agreement to determine whether the Agreement should be amended or the process for drawing down expenditures should be revised.

DHHS Response: The Department agrees with the finding and recommendation. The Office of the Controller will emphasize to staff the importance of following written procedures to ensure that the receipt of federal funding is expended within the guidelines set forth in Subpart B (31 CFR 205.33). The importance of maintaining supporting documentation for each transaction, including federal draw requests, as well as the timely processing of those transactions will also be stressed. The Treasury State Agreement will be reviewed and revised as needed. The anticipated date of completion is June 30, 2012.

IMMUNIZATION CLUSTER

9. DEPARTMENTAL MONITORING OF VACCINE PROVIDERS WAS INADEQUATE

The Department's monitoring procedures were not sufficient to ensure proper oversight of vaccinating providers for the Immunization cluster. As a result, there is an increased risk that noncompliance could occur at the provider level and not be detected in a timely manner.

The federal goal is for States to perform Vaccines for Children (VFC) visits on 25% of the immunization providers. Grantees are to provide oversight of vaccinating providers to ensure proper control and accountability is maintained for vaccine, vaccine is properly safeguarded, and VFC-eligibility screening is conducted. In addition, grantees should ensure that a record of vaccine administered was made in each person's permanent medical record or in a permanent office log or file.

The Department's 2010 site visit plan, approved by the Centers for Disease Control (CDC), proposed to monitor 451 (34%) of the anticipated 1,316 vaccine providers. According to the Department's tracking records, only 214 service providers received on-site monitoring visits. This represents 16% of the immunization providers, and only 47% of the planned on-site monitoring visits. In addition, documentation supporting on-site visits that occurred during our plan year indicated that a significant number of monitoring visits identified provider noncompliance.

Federal Award Information: This grant affects the Immunization Cluster grant award #5H23IP422554-08 and #5H23IP422554-09 for federal fiscal years 2010 and 2011 respectively.

Similar aspects of this finding were reported in the prior year.

Recommendation: The Department should strengthen its controls over its provider monitoring procedures for the Immunization cluster. Procedures should be implemented to ensure adherence to the established provider monitoring plan. In addition, the Department should look to providing increased training and guidance to its providers to ensure providers are complying with the accountability and safeguarding standards.

DHHS Response: The Department concurs with the finding and recommendation. During the audit period, the Immunization Branch was short of staff due to hiring restrictions. Subsequent to the audit, the Branch has hired several staff responsible for conducting required Vaccines for Children (VFC) site visits. As a result, the Branch has not only met but exceeded its required VFC site visit quota for 2011; which has increased from 25% in 2010 to 50% in 2011.

As of December 31, 2011, the Branch has put procedures in place to provide proper oversight of vaccine providers for the Immunization Cluster. The Branch will provide oversight to ensure proper control and accountability is maintained for vaccines, vaccines are properly safeguarded, VFC-eligibility screening is conducted, and that records of vaccinations administered are maintained in each receipient's permanent medical record and/or kept in an office log or permanent file.

TANF CLUSTER - TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF)

10. DEFICIENCIES IN SUBRECIPIENT EXPENDITURES IDENTIFIED

During the year, the Office of State Budget and Management - Office of Internal Audit performed an audit on ConnectInc, a not-for-profit subrecipient in the Temporary Assistance for Needy Families (TANF) program. The audit was performed as a result of allegations of mismanagement and questionable expenditures related to its contracts with various State agencies. The audit reported questionable expenditure practices, including expenditures paid with TANF funds. ConnectInc has now ceased operations amid an ongoing investigation.

For state fiscal year 2010, an appropriation of $440,000 was directed by the General Assembly to ConnectInc from TANF Contingency funds for the Work Central activity operated by the subrecipient. Additional funding was also provided during this time period through contracts related to the TANF Subsidized Employment program. An undetermined amount of funding is in question and being reviewed by Department management in conjunction with the Attorney General's Office.

Federal regulations require the Department to monitor the activities of subrecipients as necessary to ensure that federal awards are used for authorized purposes in compliance

with laws and regulations. We noted that the Department's monitoring procedures for ConnectInc consisted of reviewing monthly reported expenditures and general correspondence. According to Division management, no monitoring visits were made during the past year since ConnectInc was not considered high risk due to the well-established entity and management.

Federal Award Information: This finding affects the Temporary Assistance for Needy Families (TANF) program federal grant awards #0902NCTANF, #1002NCTANF, #0901NCTAN2 (ARRA), and #1001NCTAN2 (ARRA) for the federal fiscal years ending September 30, 2009 and 2010.

Recommendation: The Department should continue to perform appropriate follow-up procedures to determine the extent of TANF funding provided to ConnectInc that was mismanaged or inappropriately expended. Appropriate actions should continue to be taken to recoup any monies not spent in accordance with federal guidelines. Further, the Department should review its subrecipient monitoring plan to ensure that it provides for appropriate risk assessments and other practices to ensure that effective subrecipient monitoring takes place.

DHHS Response: The Department agrees with the finding and recommendation. Monitoring encompasses a wide array of activities that do not necessarily require annual site visits, especially for established organizations that are deemed low risk as was the case for ConnectInc. ConnectInc's auditor did not detect the mismanagement of funds. As to the division monitoring process for ConnectInc, sub-recipient of Temporary Assistance for Needy Families (TANF) funds, monthly reviews were conducted of all expenditure reports. In addition to the review of expenditure reports, there were meetings in the central Division of Social Services office, emails, and telephone contacts with ConnectInc's management during the year.

The Department is currently conducting a review of the contract expenditures to determine if TANF funds were mismanaged or inappropriately expended. Action will be taken to recoup any funds that were not spent in accordance with federal guidelines.

A review of the monitoring plan for sub-recipients will be conducted and updated to ensure that appropriate risk assessments and sub-recipient monitoring takes place. It should also be noted that such risk assessments would not normally address risks associated with intentional mismanagement as indicated in this instance. The anticipated date of completion is June 30, 2012.

11. VERIFICATION OF CENTRAL CONTRACTOR REGISTRATION NOT PERFORMED

The Department did not have procedures in place to ensure that subrecipients funded by the American Recovery and Reinvestment Act (ARRA) within the Temporary Assistance for Needy Families (TANF) program were registered in the Central Contractor Registration database. The purpose of the database is to provide transparency by disclosing all recipients of ARRA funds.

The lack of review procedures being in place increases the risk that funds could be disbursed to subrecipients not in compliance with the registration requirements. However, our tests of seven subrecipients did not identify any instances of noncompliance.

Title 2 CFR section 176.50 requires recipients and their first-tier recipients to maintain current registrations in the Central Contractor Registration database at all times during which they have active federal awards funded with ARRA funds.

Federal Award Information: This finding affects the Temporary Assistance for Needy Families (TANF) program federal grant awards #0901NCTAN2 (ARRA) and #1001NCTAN2 (ARRA) for the federal fiscal years ending September 30, 2009 and 2010.

Recommendation: The Department should establish procedures to verify that subrecipients are registered and information is current in the Central Contractor Registration database.

DHHS Response: The Department agrees with the finding and recommendation. A position in the contracts office has been assigned to verify that any contracts with the American Recovery and Reinvestment Act (ARRA) funding are entered into the Central Contractor Registration database. These actions have been implemented to ensure compliance with regulations as noted in Title 2 CFR section 176.5. The anticipated date of completion is on or before June 30, 2012.

CFDA 93.563 – CHILD SUPPORT ENFORCEMENT

12. APPROPRIATE ACTION NOT TAKEN IN CHILD SUPPORT CASES

The Department did not take appropriate action within 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.

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 Department must establish an order for support, establish paternity, or document unsuccessful attempts to achieve the same. We found that 39% of open cases were not in compliance with this requirement.

We have reported a similar finding in previous years.

Federal Award Information: This finding affects Child Support Enforcement federal grant award #G1104NC4004 for the federal fiscal year ended September 30, 2011.

Recommendation: The Department performs continuous self-assessments to monitor its compliance with applicable federal guidelines. Management should continue to monitor,

evaluate, and enhance its control procedures to ensure compliance with federal child support processing requirements.

DHHS Response: The Department agrees with the finding and recommendation. Although the Child Support Program has not achieved compliance in this area, significant progress has been made. As of September 30, 2011, 60 of the 100 counties were passing this area.

As a result of ongoing corrective actions, the statewide county compliance score in Establishment has risen to 61.41% for 2011. This steady increase is significant considering that Establishment is a very difficult regulatory area in which to achieve compliance, compounded by external factors such as high caseloads, staff turnover and a significant reorganization of the administration of the Child Support Program. Federal regulations require that both paternity and support be established or that the non-custodial parent be served with court action, within 90 days of location. Unfortunately, situations occur that cause the timeframe to expire: The noncustodial parents (NCP) often schedule an appointment to discuss paternity and support and don't show up or reschedule, genetic testing may be necessary which causes a delay while the lab completes the testing, court action is often filed but the NCP cannot be located for service at his last known address, etc. Child support agents carry large caseloads ranging from 400 to 600 cases. Staff vacancies often create even larger caseloads for remaining staff. It is very difficult for an agent with a large caseload to handle each case within the 90 day timeframe, even when no delays occur.

Program Representatives work with local office supervisors to develop Corrective Action Plans annually in those offices that are out of compliance. Every quarter, Program Representatives monitor the local office Corrective Action Plans and submit monitoring reports to the Assistant Chief for Program Operations. Audit of cases will be increased. Statewide training is planned that will include onsite training and webinars. The Data Warehouse will continue to generate monthly Establishment Self-Assessment reports and make them available to local supervisors and agents. Staff are instructed to use the reports to identify and work on cases that require action in order to meet compliance standards.

Corrective Action for this area is ongoing and it is not anticipated that the Division will be in compliance in this fiscal year. The rate of improvement has ranged from 2-12% points per year. The Department's goal is to learn from past experiences what works, and continue to look for other ways to improve county employee performance in this area. Staff will focus additional attention on counties that are not meeting the compliance goal.

13. DEFICIENCIES IN FEDERAL REPORTING PROCEDURES

The Department has not implemented effective control procedures to ensure the accuracy of federal reporting for the Child Support Enforcement grant. As a result, there is an increased risk of erroneous reporting to the federal oversight agency.

The Department reports the amounts collected and disbursed for child support to the federal oversight agency quarterly. The Office of Child Support Enforcement (OCSE) uses this information to calculate and issue quarterly federal grant awards and annual incentive payments to the state agencies administering the Child Support Enforcement program. For the majority of the state fiscal year, the Department did not have someone other than the preparer involved in the submission of the OCSE-34A report to the federal oversight agency. The lack of an independent review increases the risk that errors may occur and not be detected. It should be noted that our tests of the OCSE-34A reports found no material errors.

Federal Award Information: This finding affects Child Support Enforcement federal grant award # G1104NC4004 for the federal fiscal year ended September 30, 2011.

Recommendation: The Department should strengthen internal control to ensure adequate review and verification of the amounts reported on the OCSE-34A reports for the Child Support Enforcement grant. Reported information should be agreed to supporting documentation and the overall report reviewed for reasonableness prior to submission to the federal oversight agency.

DHHS Response: The Department agrees with the finding and recommendation. As of the quarter ended March 31, 2011, the Office of Child Support Enforcement (OCSE) implemented internal control procedures to ensure the accuracy of the OCSE-34A report. The revised procedures include a second level review, and verification/signature of supporting documentation prior to submission to the federal oversight agency.

14. DEFICIENCIES IN SUBRECIPIENT MONITORING PROCEDURES

We identified deficiencies in the Department's monitoring procedures for the Child Support Enforcement grant. As a result, there is an increased risk that noncompliance at the subrecipient level will occur and not be detected in a timely manner.

Our review of subrecipient monitoring activities for a sample of 20 counties noted:

- Monitoring tools were not accurately completed for 13 counties.
- Corrective actions were not proposed to address identified deficient areas for 18 counties.
- Three counties were not monitored quarterly in accordance with the plan. In addition, sufficient follow-up did not occur to ensure corrective actions were performed regarding identified deficient areas.

In addition, we noted that the Department failed to communicate all the appropriate compliance objectives, specifically those related to allowable/unallowable activities, to its subrecipients at the time of award.

Federal regulations require the Department to monitor the activities of subrecipients as necessary to ensure that federal awards are used for authorized purposes in compliance with laws and regulations and that performance goals are achieved.

Federal Award Information: This finding affects Child Support Enforcement federal grant award #G1104NC4004 for the federal fiscal year ended September 30, 2011.

Recommendation: The Department should strengthen internal control over its subrecipient monitoring for the Child Support Enforcement grant. All applicable compliance requirements should be communicated to subrecipients at the time of award. Procedures should be enhanced to ensure that subrecipients are monitored in accordance with the established plan and federal requirements, monitoring documents are complete, and corrective action plans for noted deficiencies are appropriately addressed.

DHHS Response: The Department agrees with the finding and recommendation. Monitoring tools for 13 counties cited as deficient have been completed. Corrective action plans for deficiencies identified in 18 counties have been amended. Due to a change in program area reassignment, three counties were not monitored per the quarterly schedule. Monitoring has now been completed for all three counties. A designated folder on the Child Support server will contain all monitoring activities. The Assistant Chief of Program Operations will monitor the folder to ensure Program Representatives are completing activities as required by the established plan and federal requirements.

The Child Support Program recognizes the need for increased monitoring of the program activities. Increased monitoring is planned for the remainder of this fiscal year and into the new fiscal year. A position was filled effective February 1, 2012, for the purpose of conducting additional monitoring.

Compliance objectives regarding allowable and unallowable expenses will be added to the Division of Social Services Fiscal Manual. A Dear County Director letter will be issued to communicate these requirements to local child support offices. Quarterly reviews will continue to be conducted per the schedule. Monitoring activities are ongoing, with some actions as described herein already completed. All other corrective actions, with exception of ongoing corrective actions, will be completed by June 30, 2012.

CFDA 93.568 – LOW-INCOME HOME ENERGY ASSISTANCE

15. DEFICIENCY IN FEDERAL REPORTING PROCEDURES

The Department did not have someone other than the preparer review the *Annual Report on Households Assisted by LIHEAP* prior to submission. The report identifies (1) the

number and income levels of the households assisted for each component (heating, cooling, crisis, and weatherization), and (2) the number of households served that contained young children, elderly, or persons with disabilities in the Low Income Energy Assistance Program (LIHEAP). The lack of an independent review increases the risk that errors may occur and not be detected. However, our tests of the annual report revealed no material errors.

The U.S. Administration for Children and Families uses the report data in analyzing LIHEAP funding levels and calculating performance measures and cost efficiencies.

Federal Award Information: This finding affects the Low Income Energy Assistance Program federal grant award numbers G-09B1NCLIEA and G-11B1NCLIEA for federal fiscal years ended September 30, 2010 and 2011, respectively.

Recommendation: The Department should strengthen internal control procedures to ensure adequate review and verification of amounts reported on the *Annual Report on Households Assisted by LIHEAP*. Reported information should be agreed to supporting documentation to ensure the accuracy and reasonableness prior to submission to the federal oversight agency.

DHHS Response: The Department agrees with the finding and recommendation. As of February 1, 2012, a procedure has been implemented in which once the energy policy staff completes the Annual Report on Households Assisted by LIHEAP; and the Section Chief reviews the report for accuracy and reasonableness before submission to the U.S. Administration of Children and Families.

CSBG CLUSTER – COMMUNITY SERVICES BLOCK GRANT

16. FEDERAL AWARD NUMBER NOT COMMUNICATED TO ARRA RECIPIENTS

For Community Services Block Grant contracts funded by the American Recovery and Reinvestment Act (ARRA), the Department did not communicate the federal award number to each subrecipient at the time of the ARRA award and at the time ARRA funds were disbursed. As a result, the Department did not comply with federal requirements specific to ARRA funds. This increases the risk that subrecipients will not properly identify the ARRA awards and expenditures in their Schedule of Expenditures of Federal Awards.

Title 2 CFR section 176.210(c) requires the State to separately identify to each subrecipient, and document at the time of the subaward and disbursement of funds, the federal award number, CFDA number, and the amount of ARRA funds; and require their subrecipients to provide similar identification in their Schedule of Expenditures of Federal Awards.

We examined a sample of nine contracts for ARRA subrecipients and noted that the federal award number was not present in any of the contracts. The Department was

unable to provide evidence that the required ARRA federal award information was communicated to its subrecipients.

Federal Award Information: This finding affects Community Services Block Grant award #G-0901NCCOS2 (ARRA) for the 2009 federal fiscal year.

Recommendation: The Department should ensure the federal award number is communicated to subrecipients of ARRA funds.

DHHS Response: The Department concurs with the finding and recommendation. Since the time the finding was noted, all agencies have been notified via electronic mail and official Office of Economic Opportunity (OEO) correspondence of the federal award number. Further, OEO revised its contract cover letter to include the federal award number on all future contract correspondence. Corrective action was completed prior to the February 3rd submission to the Office of State Auditor.

17. VERIFICATION OF CENTRAL CONTRACTOR REGISTRATION NOT PERFORMED

For Community Services Block Grant contracts funded by the American Recovery and Reinvestment Act (ARRA), the Department did not ensure that subrecipients were registered in the Central Contractor Registration database. The purpose of the database is to provide transparency by disclosing all recipients of ARRA funds.

We reviewed the Central Contractor Registration database for seven subrecipients of ARRA funding and identified one subrecipient that was not listed in the database. Although the subrecipient contracts communicated the requirement that the subgrantees register with the Central Contractor Registration, the Department did not have procedures in place to ensure subrecipients of the Community Services Block Grant ARRA funds were properly registered.

Title 2 CFR section 176.50 requires recipients and their first-tier recipients to maintain current registrations in the Central Contractor Registration database at all times during which they have active federal awards funded with ARRA funds.

Federal Award Information: This finding affects Community Services Block Grant award #G-0901NCCOS2 (ARRA) for the 2009 federal fiscal year.

Recommendation: The Department should verify that subrecipients are registered and information is current in the Central Contractor Registration database.

DHHS Response: The Department concurs with the finding and recommendation. As a result of the audit finding, the Office of Economic Opportunity (OEO) corresponded with the subrecipient not registered in the Central Contractor Registration database. Although the Community Services Block Grant American Recovery and Reinvestment Act (ARRA) period has concluded, the subrecipient identified during the audit is now registered and support documentation was submitted to the Auditors via electronic mail

on February 14, 2012. OEO's internal monitoring tools (application review guide and on-site review documents) will be revised to include procedures to verify subrecipients are registered in the Central Contractor Registration database. Anticipated date of completion is June 30, 2012.

CCDF CLUSTER – CHILD CARE AND DEVELOPMENT BLOCK GRANT

18. PROCEDURES SHOULD BE ENHANCED TO ENSURE FRAUDULENT CHILD CARE PAYMENTS ARE DETECTED AND REPORTED

The Department does not have adequate procedures in place to ensure its subrecipients are reporting fraudulent payments. As a result, the Department may not be recovering payments from the party committing the fraud as required by federal guidelines.

Under current policies, subrecipients are responsible for detecting fraud and reporting it to the Department in the Subsidized Child Care Reimbursement System (SCCRS). The Department then subtracts the fraud repayment amount from the next month's regular subsidy payment to the subrecipient. The subrecipient is responsible for recovering the fraud payments from the party who committed the fraud, as required by federal program requirements. Adequate procedures are not in place to ensure that the subrecipients are identifying and reporting all fraud payments in SCCRS or collecting repayment amounts from those committing the fraud.

Subrecipients have reported fraud payments to the Department in SCCRS during our audit period; however, the lack of monitoring procedures by the Department increases the risk that subrecipients are not reporting all payments that are the result of fraud.

Federal Award Information: This finding affects Child Care Development Fund Cluster award #G110NCCCDF and #G0901NCCCD7 (ARRA)

Recommendation: The Department should update its current policies and enhance procedures to ensure that its subrecipients are reporting all fraudulent payments and collecting repayment of those amounts from those committing the fraud. Verification of compliance with this requirement should be performed as part of the on-site monitoring visit.

DHHS Response: The Division of Child Development and Early Education will modify the Subsidized Child Care Services Manual to strengthen program policy that requires all local purchasing agencies to report and record all instances of fraud in the state's system of record. The policy will also include the Division's follow-up practices to ensure all instances of fraud are reported as well as identification of the recoupment process the Local Purchasing Agent (LPA), Division or its designee will follow when recouping the fraudulent payments. The anticipated date of completion for the proposed corrective action is June 30, 2012.

CFDA 93.659 – ADOPTION ASSISTANCE - TITLE IV-E

19. DEFICIENCIES IDENTIFIED DURING SUBRECIPIENT MONITORING NOT FOLLOWED UP

The Department did not follow up to ensure corrective action took place for all deficiencies noted in its monitoring of Adoption Assistance Title IV-E subrecipients. As a result, the deficiencies may not have been properly addressed by the subrecipients.

The Department uses a log to track its monitoring activities, including whether required corrective actions occur. Monitoring efforts noted deficiencies for one of the seven subrecipients we tested; however, the Department did not perform sufficient follow-up procedures in a timely manner to ensure that deficiencies were addressed. A corrective action plan was developed for the subrecipient, but the necessary follow-up was not performed.

Federal regulations require the Department to monitor the activities of subrecipients as necessary to ensure that federal awards are used for authorized purposes in compliance with laws and regulations and that performance goals are achieved.

Federal Award Information: This finding affects Adoption Assistance Title IV-E federal grant award #1101NC1407 for the federal fiscal year ended September 30, 2011.

Recommendation: The Department should strengthen internal control over its subrecipient monitoring for the Adoption Assistance Title IV-E program. Procedures should be enhanced to ensure that subrecipients are monitored in accordance with the established plan and federal requirements, monitoring documents are complete, and corrective action plans for noted deficiencies are appropriately executed.

DHHS Response: The Department agrees with the finding and recommendation. The Adoption Assistance monitoring protocol, as developed in the Division of Social Services' monitoring plan, was reviewed with the Adoption Coordinator to ensure thorough follow-up measures are applied correctly and consistently. The monitors continue to communicate program findings to the Adoption Coordinator, Local Business Liaison, Children Program Representative and County Department of Social Services management to make sure that subrecipients are monitored in accordance with the established plan and federal requirements.

In addition, tracking logs are used more extensively to follow up on monitoring the internal procedures.

MEDICAID CLUSTER

20. ERRORS IN MEDICAID PROVIDER BILLING AND PAYMENT PROCESS

The Department made payments on behalf of program participants that did not comply with the activities allowed or allowable cost requirements for the Medical Assistance Program. The Department erroneously made net overpayments of $59,499 to Medicaid

providers resulting in questioned costs of $44,196, which represents the federal share of the overpayments.

We examined a sample of 281 Medicaid claims and identified 26 claims that were paid in error or not sufficiently documented. Examples of the deficiencies noted included insufficient or missing documentation in support of the services rendered, documentation that failed to meet the requirements established by Medicaid policy, incorrect calculations of the claim payment, failure to timely recoup charges subject to retroactive rate adjustments, duplicate charges, and lack of prior approval for services. The majority of the errors related to the medical record documentation to support services provided and the charges incurred.

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. Federal regulations require that medical records disclose the extent of services provided to Medicaid recipients.

Similar aspects of this finding have been reported in previous years.

Federal Award Information: This finding affects Medical Assistance Program federal grant awards #05-1005NC5MAP; #05-1005NCARRA; #05-1105NC5MAP; #05-1105NCARRA; and #05-1105NCEXTN for the federal fiscal years ended September 30, 2010 and 2011.

Recommendation: The Department should continue to enhance its control procedures to improve the accuracy of the claims payment process. Management should ensure the proper implementation of system changes, including effective payment edits and/or audits. Emphasis should be placed on educating providers as to proper coding and documentation standards necessary to support the medical services being provided. Identified over or underpaid claims should be followed up for timely and appropriate collection or payment.

DHHS Response: The Department concurs with the finding and recommendation. The Department will continue to enhance procedures to improve the accuracy of the claims payment process. Emphasis will be placed on educating providers as to adequate documentation to support medical necessity and services billed to Medicaid. Follow-up will be conducted on all of the 26 claims identified to be in error. The anticipated completion date for corrective action is May 30, 2012.

21. MEDICAID DISPROPORTIONATE SHARE HOSPITAL PAYMENTS TO AN INELIGIBLE HOSPITAL

The Department made $2,494,904 in disproportionate hospital share payments to an ineligible hospital. As a result, there are potential questioned costs as high as $1,850,447, which represents the federal share of the payments.

Medicaid disproportionate share hospital (DSH) payments provide financial assistance to hospitals that serve a large number of low-income patients, such as people with Medicaid and the uninsured. In our tests of DSH payments, we identified an overpayment to one hospital that appeared to be ineligible to receive those payments. Further review determined that the hospital had merged with another hospital on July 30, 2009, effectively ending its eligibility to receive DSH funding. However, the merging hospital continued to submit requests for DSH funding and received payments of $1,920,066 and $574,838, respectively, during state fiscal years 2010 and 2011.

After the Department was notified of the hospitals' merger, DSH payments were terminated and the Medicaid provider number was end-dated in the Medicaid Management Information System. The Department is in the process of settling and recouping DSH payments sent to the provider in error.

OMB Circular A-87 requires that to be allowable under a grant program, costs must be necessary and reasonable for proper and efficient administration of the grant program and allowable costs must be adequately documented.

Federal Award Information: This finding affects Medical Assistance Program federal grant awards #05-0905NC5028, #05-0905NCARRA, #05-1005NC5MAP; #05-1005NCARRA; #05-1105NC5MAP; #05-1105NCARRA; and #05-1105NCEXTN for the federal fiscal years ended September 30, 2009, 2010 and 2011.

Recommendation: The Department should work with the merged hospital to recoup those amounts that were incorrectly paid. In addition, management should review and enhance its control procedures over provider eligibility to ensure that disproportionate hospital share payments are made only to eligible hospitals.

DHHS Response: The Department concurs with the finding and recommendation. Medicaid Disproportionate Share Hospital (DSH) payments provide financial assistance to hospitals that serve a large number of low-income patients, such as people with Medicaid and the uninsured. The auditors identified an overpayment to one hospital that appeared to be ineligible to receive those payments. The auditors review determined that the hospital had merged with another hospital on July 30, 2009, effectively ending its eligibility to receive DSH funding.

During the SFY 2011 audit, the Division of Medical Assistance (DMA), Finance Management Team identified to the Audit Team the merger of the hospital in question, thus becoming a single entity. DMA Finance Management became aware of the merger when a single 2009 cost report was submitted for both facilities to the division.

Since the DSH payment model is based upon cost reports that are two years old, it is very important that DMA Finance Management is notified of provider changes in a timely manner. Finance Management has discussed with the Provider Enrollment Section of DMA about receiving notices timely for any enrollments, terminations, change in ownership, or any other event that would affect the payment to a North Carolina

provider. There is continued open communication between the two units in order to avoid inappropriate payments to providers.

The Audit Team identified approximately $2,494,904 in over payments as a result of the merger. However, DMA performed additional procedures that would more accurately account for the correct calculation combining the two hospitals into one cost calculation. The Division has identified the overpayments to calculate a net overpayment of $980,085. On December 28, 2011, DMA issued a recoupment letter to the identified hospital requesting a recoupment of $980,085.

On February 2, 2012, the hospital issued an appeal letter contesting the recoupment amount. The documents submitted by the hospital imply that an underpayment of $138,801 occurred rather than an overpayment. The appeal is currently under review.

22. DEFICIENCIES IN CASH MANAGEMENT PROCEDURES FOR THE MEDICAID PROGRAM

The Department did not have adequate controls in place to ensure that the drawdown of Medicaid program funds was in accordance with federal requirements. As a result, there is an increased risk of drawing down excessive federal funds and noncompliance with the Treasury-State agreement.

Federal requirements specify that when advance payment procedures are used for cash management, grantees should establish procedures to minimize the time elapsing between the transfer of funds from the federal treasury and their disbursement by grantees. It also specifies that grantees disburse rebates and refunds before requesting additional cash payments. The Treasury-State agreement requires that the amount of the request be the amount the State expects to disburse.

Our review of a sample of 109 Medicaid drawdown requests noted 10 drawdowns, from October to December 2010, that were miscalculated by using the incorrect federal matching percentage, resulting in the overdraw of $9,297,475 in federal funds. Two additional calculation errors were identified in our sample that resulted in the overdraw of $148,084 in federal funds.

In addition, during our comparison of monthly drawdowns for the payment of buy-in premiums expenditures to available drug rebate credits, we noted that there were three drawdowns during the state fiscal year where there were large balances of drug rebate credits ranging from $10 to $20 million that could have been considered in reducing the requested drawdown amount. To address this concern, the Department implemented new procedures to incorporate drug rebate credits into the drawdown process effective May 2011.

The Department performs a revenue clearing procedure at the end of each month that adjusts the drawdown estimates to actual; therefore, there are no accumulations of federal overdrawn amounts throughout the year.

A similar finding was reported the previous three years.

Federal Award Information: This finding affects Medical Assistance Program federal grant award #05-1105NC5MAP, Medicaid Administrative Payments federal grant award #05-1005NC5ADM, and Health Information Technology Administrative Implementation federal grant award #05-1105NCIMP for the federal fiscal years ended September 30, 2010 and 2011.

Recommendation: The Department should monitor and reinforce their controls over the drawdown process to ensure accurate calculations are made and minimize the amount of federal funds drawn in error. Additionally, the Department should continue to ensure the implementation of their controls over the consideration of drug rebate credits prior to requesting additional federal funds.

DHHS Response: The Department agrees with the finding and recommendation. Due to miscommunication with the Centers for Medicare and Medicaid (CMS), an incorrect Federal matching rate was used. To avoid future miscommunication, the Department now uses the current rates as published in the Federal Register.

Federal draws for all Medicaid checkwrites were based on estimates, as detailed data was not available from the fiscal agent. Draws based on estimates were reconciled to actual monthly expenses incurred and any resulting liability was repaid in the following month via monthly revenue clearing settlement. Effective November 2010, the Department began using actual expenses in an enhanced model to calculate draws more accurately. To strengthen controls further, the Department began, in June 2011, to include negative adjustments to reduce the federal draw. Because legislation and the implementation of new program rate changes required many recoupments/repayments within the fiscal agent system, the negative adjustments became a material amount during the fiscal year. Prior to this time, these adjustments were not considered significant and were not considered in the calculation of the request for federal funds. Implementation of this factor is expected to facilitate more accurate calculations of federal funds earned.

Before May 2011, the Department used estimates of drug rebates because the actual information was not received in time to adjust the federal draws. After May 2011, the Department began using actual drug rebates to adjust federal draws. Overdrawn amounts have declined significantly; however, there will always be a variance due to the fact that the Department receives the largest portion of drug rebates after the last checkwrite of the month.

The Department has enhanced communication between the Office of the Controller's General Accounting/Financial Management Section and the Division of Medical Assistance (DMA) to ensure there is adequate oversight of all elements of the federal draw calculations. As a result, variances have decreased significantly.

23. DEFICIENCIES IN MONITORING PROCEDURES OVER THE PROVIDER ELIGIBILITY AND TERMINATION PROCESSES

The Department did not effectively monitor the Medicaid provider enrollment and re-verification process administered by a contract service provider. This increases the risk that ineligible providers may have been enrolled in the Medicaid program.

The Department contracts with a service provider to handle the responsibilities for enrollment, credentialing, and verification activities for provider participation in the Medicaid program. We determined that the service provider did not consistently apply final review controls implemented during the 2011 state fiscal year to ensure that all information necessary to document the eligibility determination for providers-applicants was acquired and maintained. We examined a sample of 60 group and individual provider files and noted the following exceptions:

- Eight files did not include the finisher coordinator checklist used to verify that all credentialing information was obtained and the eligibility decision was appropriate.
- One file contained the finisher coordinator checklist, however the file did not include evidence to support that the proper license was submitted or verified for this provider. Further review found this provider to be eligible for participation in the program and having the proper licensing credentials.

In addition, the contracted service provider did not have a control in place to monitor professional licensing board notifications of sanctioned and suspended providers and the subsequent termination from the Medicaid program. This increases the risk that unlicensed and sanctioned providers will still be enrolled in the program. Although the service provider was responsible for processing e-mail communications from the licensing organizations, it did not have a process in place to monitor the proper handling and timely completion of the notifications for the entire state fiscal year.

During the testing of the Medical Board, Dental Board, Pharmacy Board, and the Division of Health Services Regulation licensing actions, we noted exceptions in which the provider was not properly handled for termination from the Medicaid program. Eight Medical Board licensees had a temporary or indefinite suspended license due to Medical Board disciplinary action; however, the provider was not properly end-dated or terminated from the Medicaid program computer systems.

Similar deficiencies have been reported in prior year audits.

Federal Award Information: This finding affects Medical Assistance Program federal grant awards #05-1005NC5MAP; #05-1005NCARRA; #05-1105NC5MAP; #05-1105NCARRA; and #05-1105NCEXTN for the federal fiscal years ended September 30, 2010 and 2011.

Recommendation: The Department should continue with its efforts to improve and implement adequate monitoring controls over the Medicaid provider enrollment and termination processes to ensure that only eligible, licensed medical providers are allowed participation in the Medicaid program.

DHHS Response: The Department concurs with the finding and recommendation. The Division of Medical Assistance (DMA) implemented new procedures to provide improved controls over the reinstatement of inactive providers that coincide with the re-verification process. The on-going re-credentialing of existing Medicaid providers will be conducted a minimum of every 3 years to ensure all provider information is accurate and up-to-date. Effective November 1, 2011, Computer Sciences Corporation (CSC) began re-credentialing 100 providers as part of a 1-month project and will re-credential 11,000 providers every 6 months thereafter. The re-credentialing process includes a thorough examination of a provider's background, credentials, and qualifications to ensure the provider continues to meet North Carolina's Medicaid participation guidelines. The process should reduce fraud by ensuring a provider's record is current and accurately reflects all adverse actions taken against the provider.

The Office of Medicaid Management Information Systems (OMMIS) continues to review the fiscal agent CSC's written policies and procedures to ensure compliance with applicable laws and regulations and to ensure the completeness and accuracy of the provider enrollment approval, denial, re-verification, and re-certification processes. Written procedures were developed to provide uniform guidance in the Enrollment, Verification, and Credentialing processes for existing and new hire staff. Procedures were also developed for ongoing Verifications and License Verifications to ensure providers fulfilled licensing requirements for continued participation in the Medicaid Program. Effective July 15, 2011, CSC began the on-going Verifications and License Verifications of providers.

The existing CSC Quality Control Desk Procedure is currently being revised to include the addition of the Quality Control (QC) Auditor, effective October 1, 2011, as well as additional checks added since the procedure was last updated. The revised QC procedure was submitted January 26, 2012, and is currently in the final review stages prior to publishing/implementation. All activities outlined in the procedure have been followed since the creation of the QC process by either the area Lead/Supervisor or now the QC Auditor with the exceptions of the Ongoing Verification QC audits which began December 13, 2011, and the Re-Credentialing QC audits which began January 16, 2012.

The QC Auditor currently performs random monthly checks on the following areas/processes using current desk procedures, checklists and business rules to ensure compliance:

Mail Room Document Preparation
Scanning
MMIS Data Entry
Credentialing

Ongoing Verifications
Re-Credentialing
NC Medicaid E-mail
Termination & Denial Letter/Processing

Current procedures are in place for the following: (1) Tracking and reporting provider sanctions notification and terminations for enrolled providers, (2) Validation of current provider licensure and ownership information, (3) Supervision and monitoring of e-mail history completeness, access, retention and deletion tracking, (4) Validation of data entry team supervision and the monitoring process for quality control, and (5) Supervision of provider validation for licensing, credentialing, reverification, enrollment changes and end-dating. The anticipated date of completion for full corrective action, including publishing the revised QC procedures is June 1, 2012.

24. INADEQUATE FOLLOW-UP ON IDENTIFIED SUBRECIPIENT ERRORS

The Department did not ensure that adequate corrective action was taken on all errors identified through Medicaid subrecipient monitoring. As a result, adjustments were not made for questioned costs that occurred at the subrecipient level.

The Department's Medicaid Quality Assurance section conducts annual quality control monitoring of recipient eligibility determinations in the Medicaid program to measure, identify, and prevent errors due to erroneous eligibility determinations. We examined a sample of 45 monitoring reviews and noted that four instances of questioned costs as a result of payment errors were identified; however, appropriate follow-up of questioned costs did not occur. The Department could not provide evidence that adjustments were made to account for the Medicaid overpayments at the subrecipient level. The four errors resulted in questioned costs of $4,615, which represents the federal share of the overpayments.

Federal requirements disallow the federal share of overpayments that have been made by a State to a person or other entity, and requires adjustments in federal payments within one year of discovery whether or not a recovery has been made by the State.

Federal Award Information: This finding affects the Medicaid Administrative Payments federal grant awards #05-1005NC5ADM and #05-1105NCADM for the federal fiscal years ending September 30, 2010 and 2011.

Recommendation: The Department should enhance its annual quality control monitoring procedures for Medicaid to ensure that appropriate corrective action is taken on errors identified by the Medicaid Quality Assurance section. Procedures implemented should ensure that any necessary adjustments are made to the State's accounting records for all identified overpayments.

DHHS Response: The Department concurs with the finding and recommendation. The Department requested clarification from Centers for Medicare and Medicaid Services

(CMS) regarding disallowance of the federal share of overpayments identified in cases reviewed for the Medicaid Eligibility Quality Control pilots and the Payment Error Rate Measurement reviews. The Department will take appropriate action based upon the CMS response. The anticipated date of completion for full corrective action is December 31, 2012.

25. DEFICIENCIES IN INTERNAL CONTROL TO PREVENT UNAUTHORIZED USER ACCESS TO THE MEDICAID MANAGEMENT INFORMATION SYSTEM

We identified deficiencies in the Department's control procedures over user access to the Medicaid Management Information System (MMIS). Improper access to computer systems can result in both intentional and unintentional security breaches that place the confidentiality and integrity of information at risk.

The MMIS is the claims processing system for the Medicaid program, which also supports coordination of benefits, surveillance and utilization review, federal and management reporting, and case management.

The Department began performing a user access security review in December 2009, but could not provide documentation to support the performance of the review. As of June 30, 2011, the Department was still working on finalizing the security review of all MMIS active users. Failure to timely monitor user access rights could place the integrity of MMIS data at risk. Results of further audit testing indicated that seven of 43 separated employees were not removed from the MMIS active user list during state fiscal year 2011. In addition, further concerns were separately communicated to the Department to address identified user access issues that are not included herein to protect system security.

Statewide information technology standards specify that system access be controlled and prescribe procedures such as documented reviews of users' rights and immediate termination of user access upon leaving employment. 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.

A similar finding was reported the previous four years.

Federal Award Information: This finding affects Medical Assistance Program federal grant awards #05-1005NC5MAP; #05-1005NCARRA; #05-1105NC5MAP; #05-1105NCARRA; and #05-1105NCEXTN for the federal fiscal years ended September 30, 2010 and 2011.

Recommendation: The Department should improve internal control over access to the Medicaid Management Information System. Reviews of user access should be performed quarterly as established by Department policy. Changes and updates as a result of the reviews should be handled timely, and the review process should be adequately

documented. In addition, the Department should take appropriate action to address other identified user access issues separately communicated to the Department.

DHHS Response: The Department concurs with the finding and recommendation. The Division of Medical Assistance (DMA) Information Technology (IT) and the Health Insurance Portability and Accountability Act (HIPAA) Section is currently working on developing a new intranet website which will host a link to the Automated Access and Resource Management System (AARMS) now in development. The new intranet website is being completed in phases. This AARMS system will be a Structured Query Language (SQL) database using Hyper Text Markup Language (HTML), front end forms and automated workflow processes. It will have auditable, password validated authorization, steps built in that will ensure these notifications are accomplished and accesses are revoked in the specified time frame allotted for each system, application or network. The data used to populate personnel records in AARMS will directly feed the information to security officials in DMA's Recipient and Provider Services section who will use the Division of Information Resources Management's (DIRM's) electronic Information Resource Access Authorization Form (e-IRAAF) (Eligibility Information System (EIS), Online Verification (OLV), IEVS, etc). Currently the Division uses e-IRAAF system as mandated by the Department of Health Human Services (DHHS) Privacy and Security Office (PSO) to track all system access.

The AARMS tool is currently in the final stages of development and an initial test phase has been set to begin on April 2, 2012. Based on test results, a go live date has been tentatively set for July 1, 2012.

Upon receipt of testing details from the auditors, the Department will confirm access was revoked for the seven separated employees identified during the audit.

The Department is committed to adhering to all HIPAA requirements with regard to controlling personnel access to information and information systems. A manual process is currently used to accomplish these tasks. The Department will reiterate to DMA personnel managers to need to comply with the existing exit procedures in place. Additionally, the Department will confirm periodic reporting of terminated personnel is forwarded to qualified IT personnel to verify cessation of access to the MMIS in a timely manner.

CFDA 93.767 – CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

26. ERRORS IN PROVIDER BILLING AND PAYMENTS

The Department made payments on behalf of Children's Health Insurance Program participants that did not comply with the activities allowed or allowable cost requirements for the program. The Department made erroneous or improperly documented payments with a net amount of $22,482 to medical providers, resulting in questioned costs of $16,940, which represents the federal share of the overpayments.

We examined a sample of 120 medical claims and identified 61 claims that were paid in error or not sufficiently documented. Examples of the deficiencies noted included insufficient or missing documentation to support the services rendered, documentation that failed to meet established policy requirements, providers not submitting documentation for review, inability to contact the providers due to bad addresses, service provided that was not covered by policy, failure to obtain prior approval for services, rates used for payment that were not verifiable, and duplicate charges. The majority of the errors related to the medical record documentation to support services provided and the charges incurred.

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.

A similar finding has been reported in previous years.

Federal Award Information: This finding affects the Children's Health Insurance Program federal grant awards #05-1005NC5021 and #05-1105NC5021 for the federal fiscal years ending September 30, 2010 and 2011.

Recommendation: The Department should continue to enhance its control procedures to improve the accuracy of claims payments. Emphasis should be placed on educating providers as to proper coding and documentation standards necessary to support the medical services being provided. Identified over and underpaid claims should be followed up for timely and appropriate collection or payment.

DHHS Response: The Department concurs with the finding and recommendations and will continue to enhance its controls procedures to improve the accuracy of the North Carolina Health Choice (NCHC) claims. Since the July 1, 2010 transfer of the administrative function from the State Employee Health Plan to the Department, the Department continues to identify over and underpaid claims for timely review and follow up. The Department is also working to ensure only providers meeting the NC Medicaid/Health Choice Standards are enrolled and credentialed to provide services. The Department anticipates standardization of the enrollment and billing processes as well as the inclusion of NC Health Choice in the Medicaid Billing guide and monthly Medicaid Bulletins.

27. NONCOMPLIANCE WITH PROCUREMENT, SUSPENSION, AND DEBARMENT REQUIREMENTS

The Department did not ensure that vendors for the Children's Health Insurance Program were not suspended or debarred prior to executing contracts. The failure to comply with these requirements increases the risk that the Department may contract with suspended or debarred parties.

We examined contract documentation for two significant vendors for the Children's Health Insurance Program representing $302.5 million in costs. Required federal

assurance certifications were not found in the documentation for the original contract or the subsequent contract amendment. In addition, one of the vendors was a non-profit organization and the required conflict of interest and federal tax exempt letter were not on file. Further audit procedures revealed that neither of these vendors were suspended or debarred from doing business with the State of North Carolina.

The *OMB Circular A-133 Compliance Supplement* requires a non-federal entity that enters into a covered transaction with an entity at a lower tier to verify that the entity is not suspended or debarred or otherwise excluded. Departmental policy states that federal assurances must be on file with each contract, including contract amendments.

Federal Award Information: This finding affects the Children's Health Insurance Program federal grant awards #05-1005NC5021 and #05-1105NC5021 for the federal fiscal years ending September 30, 2010 and 2011.

Recommendation: The Department should strengthen internal controls to ensure compliance with the federal procurement, suspension and debarment requirements.

DHHS Response: The Department concurs with the finding and recommendation. The Division of Medical Assistance (DMA) Contracts Unit implemented new monitoring procedures to ensure compliance with federal procurement, suspension and debarment requirements. Prior to the execution of a contract with a new vendor, contract monitors check federal and state debarment lists and include printed screen shots in the file as, documentation the required verification occurred. Furthermore, DMA will check all current contractors on a monthly basis against the debarment lists to ensure continued compliance with federal requiremetns. The monthly checks are tracked and documented by contract monitors. To date, approximately half of the existing contracts have been fully reviewed for debarment/suspensions. New contracts are fully monitored for compliance from their inception. The anticipated completion date for full corrective action is December 31, 2012.

28. DEFICIENCIES IN MONITORING PROCEDURES FOR THE CHILDREN'S HEALTH INSURANCE PROGRAM

The Department has not developed or implemented a monitoring plan to ensure local government subrecipients are accurately performing eligibility determination activities for the Children's Health Insurance Program. As a result, there is an increased risk that health insurance benefits could be provided on behalf of ineligible participants.

The Department's Quality Assurance and Medicaid Eligibility sections have oversight responsibilities for reviewing for eligibility payment errors, recommending corrective action as appropriate, and tracking the status of those corrective actions. A review of Children's Health Insurance Program cases was performed during the 2011 state fiscal year to determine if denied applicants were accurately processed at the subrecipient level. However, this review was designed as a special project and was not part of an overall

monitoring plan designed to review cases for ineligible participants and potential unallowable costs.

Federal requirements specify that grantees monitor subrecipient activities to ensure compliance with applicable rules and those performance goals are met.

This finding was also reported in the prior year.

Federal Award Information: This finding affects the Children's Health Insurance Program federal grant awards #05-1005NC5021 and #05-1105NC5021 for the federal fiscal years ending September 30, 2010 and 2011.

Recommendation: The Department should further develop and enhance its monitoring procedures to ensure that subrecipient eligibility determination processes for the Children's Health Insurance Program are performed in compliance with applicable rules and regulations.

DHHS Response: The Department concurs with the finding and recommendation. A monitoring plan was implemented by the Department's Quality Assurance Section in December 2011. The plan monitors cases in the Children's Health Insurance Program (CHIP) known as North Carolina Health Choice (NCHC). Errors identified by quality assurance reviews are referred to the counties and the appropriate Medicaid Program Representative (MPR) for follow-up to ensure corrective action is taken and provide training as needed in the counties audited.

CFDA 93.959 – BLOCK GRANTS FOR PREVENTION AND TREATMENT OF SUBSTANCE ABUSE

29. MONITORING PROCEDURES NEED IMPROVEMENT

We identified deficiencies in the monitoring procedures for the Block Grants for Prevention and Treatment of Substance Abuse program. As a result, there is an increased risk that noncompliance at the subrecipient level could occur and not be detected in a timely manner.

The Department is responsible for monitoring the Local Management Entities (LMEs) and non-governmental units providing program services. Our review of the monitoring efforts identified the following deficiencies:

- Fiscal monitoring reviews were not completed during fiscal year 2010-11 related to non-unit cost reimbursement expenditures. These expenditures are "grant-like," as opposed to payments made for particular services at specified rates.
- The Department's fiscal monitoring policies need further enhancement. Procedures should be developed to ensure subrecipients are monitored for the allowable cost and allowable activities compliance objectives. In addition, the

fiscal settlement review policies currently do not address appropriate corrective actions necessary to remedy deficiencies noted during the fiscal monitoring of the LMEs.

- The Department should take steps to reconcile the overall population of substance abuse service providers to ensure the completeness of its provider monitoring plan. We identified variances in the LMEs' reported provider lists and the actual providers receiving reimbursements.
- The monitoring tools should be reviewed to ensure their completeness. We noted instances where tools were not completed for certain program areas despite receiving funding for that program type. In addition, some of the developed monitoring tools do not fully address all of the necessary eligibility requirements.

Federal and departmental guidelines require the monitoring of subrecipient activities to provide reasonable assurance that subrecipients are complying with applicable laws and regulations.

A similar finding related to the enhancement of the subrecipient monitoring activities has been reported the past three years.

Federal Award Information: This finding affects Block Grants for Prevention and Treatment of Substance Abuse federal grant award 10BINCSAPT and 11BINCSAPT for the federal fiscal year ended September 30, 2010 and 2011.

Recommendation: The Department should continue to enhance its monitoring plans for the Block Grants for Prevention and Treatment of Substance Abuse program. Comprehensive policies should address all aspects of the monitoring efforts, including the plan for programmatic and fiscal monitoring activities, documentation of the monitoring procedures performed and monitoring tools to be used, and the appropriate follow-up of corrective action plans. The Department should perform appropriate reconciliations to ensure that its monitoring activities encompass all providers of substance abuse services within the LME system.

DHHS Response: The Department agrees with the finding and recommendation. The Division of Mental Health/Developmental Disabilities/Substance Abuse Services has initiated a comprehensive review of the policies and procedures currently used by the program monitoring and fiscal auditing staff. The combined efforts of the staff are to develop a consistent process for the documentation of activities, including monitoring subrecipients for allowable cost and allowable activities, and the follow-up of corrective action plans. The modification of policies and procedures, assuring every step is documented as part of the enhancements to the Block Grants for Prevention and Treatment of Substance Abuse programs monitoring and auditing tools, may be necessary to assure compliance with applicable laws and regulations. The anticipated completion date of this project is December 31, 2012.

30. DEFICIENCIES IN INTERNAL CONTROL OVER CONTRACTING

The Department's controls over contracting in the Block Grants for Prevention and Treatment of Substance Abuse program have not operated effectively to ensure compliance with departmental contracting policies. As a result, there is an increased risk that inappropriate costs could be incurred on contracts for services.

During our review of subrecipient expenditures, we identified the following deficiencies in the Department's contracting procedures:

- We noted that four Local Management Entities (LMEs) received payments totaling $1.7 million prior to the final execution of their contract amendments with the Department.
- We noted that no contract was in place to support reported disbursements of $213,000 between one LME and a provider service organization.

Contracts define the scope of work and establish guidelines and expectations for the work to be performed by way of contract terms. The Department's contract administration policy states that all appropriate approvals must be obtained prior to the effective date of a contract and payments may not be made until the contract is fully executed.

Federal Award Information: This finding affects Block Grants for Prevention and Treatment of Substance Abuse federal grant award 10BINCSAPT and 11BINCSAPT for the federal fiscal year ended September 30, 2010 and 2011.

Recommendation: The Department should strengthen internal control to ensure contract agreements are properly executed in accordance with departmental contracting policies.

DHHS Response: The Department agrees with the finding and recommendation. The Division of Mental Health/Developmental Disabilities/Substance Abuse Services is reviewing the policies for contract development and related implementation criteria. The annual contracts identified within the audit are for delivery of community services by the Local Management Entities (LMEs). The main objective of the LME contract is to outline the various performance measures to be reported to the Division. In accordance with the General Statute, the Division is authorized to allocate funding to the LMEs for delivery of behavioral health services. To ensure compliance with departmental contracting policies, the Division will complete the contracting process prior to implementation and the release of funding. The Division anticipates completion of this process by December 31, 2012.

31. FEDERAL AWARD INFORMATION NOT PROPERLY COMMUNICATED TO SUBRECIPIENTS

The Department did not communicate all the necessary federal award information to its Local Management Entities (LMEs) receiving funding through the Block Grants for Prevention and Treatment of Substance Abuse program. As a result, there is an increased

risk that LMEs may not correctly identify federal award information in their records or be made aware of applicable compliance requirements.

Per federal OMB Circular A-133 regulations, the State is responsible for identifying to the subrecipient the federal award information (Catalog of Federal Domestic Assistance (CFDA) number and title, award number and name, and name of federal agency) and applicable compliance requirements. The performance contract between the Department and the LMEs does not include all of the required elements.

Federal Award Information: This finding affects Block Grants for Prevention and Treatment of Substance Abuse federal grant award 10BINCSAPT and 11BINCSAPT for the federal fiscal year ended September 30, 2010 and 2011.

Recommendation: The Department should ensure that required federal award information is communicated to all subrecipients and subsequent pass-through entities for all federal funding programs.

DHHS Response: The Department agrees with the finding and recommendation. The Division of Mental Health/Developmental Disabilities/Substance Abuse Services will modify the annual allocation letters sent to the Local Management Entities (LMEs) to include all necessary federal award information for subrecipients and subsequent pass-through entities. The Division anticipates completion of this process by December 31, 2012.

DISABILITY INSURANCE/SSI CLUSTER

32. INTERNAL CONTROL OVER PAYMENTS FOR PROVIDER CONSULTATIVE EXAMINATIONS NEEDS IMPROVEMENT

Internal control over payments for provider consultative examinations in the Social Security - Disability Insurance program do not effectively ensure that the Department only pays for medically necessary services and that invoices for services are accurate. As a result, there is an increased risk of payments for unauthorized services or unallowable costs.

Disability Determination Services (DDS) receives applications from Social Security offices across the State and is responsible for determining eligibility for social security disability and supplemental security income disability payments. To assist in the eligibility determination process, DDS pays medical service providers to perform consultative examinations of disability claimants to verify the accuracy of the disability determination. Consultative examinations are scheduled by DDS for the claimant and a *DD-6 Consultative Exam Authorization and Claim for Payment* form is completed, which identifies the medical services that the provider is authorized to perform.

In a sample of 60 payment transactions, we noted 15 invoices where payment was made for procedures that differed from those originally approved as medically necessary.

These 15 invoices included 18 different instances of documented authorized services not matching the services performed:

- Fourteen instances were noted where the DDS case examiners and the scheduling unit did not update the claimant's file for medical procedure changes made after initial authorization. Staff members indicated that the revised procedures were appropriate but the documentation was not updated. We noted that supervisory approval is not required for modifications to initially approved medical services.
- Four instances were noted where a doctor modified or added medical services. There are no procedures in place that require the doctor to obtain program approval prior to rendering additional or modified services.

We also noted that DDS erroneously overpaid claimants' medical expenses, resulting in questioned costs of $53. The projected questioned costs from such errors in the population exceed $10,000. One overpayment was due to a clerical billing error of $30. An additional overpayment of $23 occurred when an invoice was paid in total, although it indicated that a service included in the invoice was not actually rendered. The Department has subsequently pursued refunds of these amounts.

Federal Award Information: This finding affects Social Security - Disability Insurance federal grant award #04-11-04NCDI00 for the federal fiscal year ended September 30, 2011.

Recommendation: The Department should enhance internal control over payments for consultative examinations in the Social Security - Disability Insurance program. Modifications to pre-approved medical services should be documented and subjected to supervisory approval to ensure that medical services performed are necessary and that costs incurred are for allowable services. Further, effective procedures should be in place to ensure the accuracy of invoices and payments.

DHHS Response: The Department concurs with the finding and recommendation. When deemed necessary during case adjudication, the North Carolina Disability Determination Services (DDS) pays medical service providers to perform consultative examinations (pre-approved medical services) to assist in the eligibility determination process. Steps have been added to existing internal controls when an adjudicator requests additional studies for pre-approved medical services to ensure medical services performed are necessary and that costs incurred are for allowable services.

Supervisors and other senior level adjudicative staff are authorized to approve consultative examinations and additional studies. The disability examiner requests approval to add studies to a previously approved authorization. Once the additional studies are approved, the Consultative Examination (CE) scheduler will be notified to add the additional studies. This action will now be performed through the DDS legacy system, which will automatically create a line-item to the electronic worksheet. These actions will ensure pre-approved medical services are documented on the electronic worksheet, create a permanent case record, and allow the CE Controls Unit to notify the

Unit Supervisor when additional studies are requested without an authorized approver. To further strengthen internal controls, CE Controls will conduct quality checks to facilitate accurate payment of pre-approved services.

As an added measure to guarantee the accuracy of invoices and payments to vendors, the Office of the Controller will be advised to contact the Professional Relations Office regarding any questions. Written instructions will be sent to staff and the Office of the Controller. The anticipated date of completion is March 31, 2012.

33. DEFICIENCIES IN ENROLLMENT PROCEDURES FOR PROVIDERS OF CONSULTATIVE EXAMINATION SERVICES

We identified deficiencies in the Department's enrollment procedures for providers of consultative examination services for the Social Security - Disability Insurance program. This increases the risk that payments could be made to ineligible or nonqualified service providers.

Disability Determination Services (DDS) recruits medical providers to perform consultative examinations on behalf of disability claimants to verify the accuracy of the disability determination. Providers are approved to perform these services, but only after a verification process that includes a review of credentialing, licensure, and medical standing. A medical qualifications review is performed annually to ensure subsequent continuation in the program. For the fiscal year ending June 30, 2011, the Department paid $14.8 million for consultative examinations.

In a sample of 60 payment transactions, we identified seven instances where the providers did not have documentation on file to support their approval to participate in the program. Further review noted that all such providers were either hospitals or providers of radiology services. DDS personnel stated that hospitals and radiologists have not been required to follow the same enrollment process as other medical services providers. For hospitals and radiologists, the federal awarding agency relies on the accreditation process performed by The Joint Commission.

Federal Award Information: This finding affects Social Security - Disability Insurance federal grant award #04-11-04NCDI00 for the federal fiscal year ended September 30, 2011.

Recommendation: The Department should strengthen internal control over the enrollment process for providers of consultative examination services for the Social Security - Disability Insurance program. Approval processes for providers to participate in the program should be documented across all medical service types to ensure that all providers meet program qualifications and provide services that are allowable within the program. The Department should establish procedures that verify hospitals and radiologists have been accredited by The Joint Commission.

DHHS Response: The Department concurs with the finding and recommendation. The North Carolina Disability Determination Services (DDS) is developing a formal procedure for annual review of hospitals and radiologists as recommended during the audit process.

A database inquiry will provide a list of all hospitals and radiology groups used in the consultative examination process within the last year. The Professional Relations Office (PRO) will verify that each hospital and radiology group is not on the list of Excluded Individual/Entities by checking the United States Department of Health and Human Service, Office of Inspector General website. This will ensure there are no excluded, suspended, or barred participants in the federal or federally assisted programs. The PRO will also utilize the North Carolina Division of Health Service Regulation website to verify the hospital is currently licensed by the State of North Carolina.

Letters will be mailed initially, then annually going forward, to each hospital and radiology group requesting a signed statement certifying the appropriate State licensing or certification requirements for all support staff and that no sanctions have been imposed.

Once the initial verification is complete, a review will be performed annually to ensure providers are not excluded for improprieties in a Federal program that would prevent them from performing consultative examination services. Ongoing, these procedures will be used prior to adding any new hospital or radiology group to the consultative examination panel. The anticipated completion date is May 31, 2012.

34. DEFICIENCIES IN FEDERAL REPORTING PROCEDURES

During the state fiscal year, the Department did not have someone other than the preparer review the SSA-4514 - *Time Report of Personnel Services for Disability Determination Services* report prior to submission. Form SSA-4514 is a quarterly report of the hours charged to the federal awarding agency related to the disability determination process in the Social Security - Disability Insurance program. The lack of an independent review increases the risk that errors may occur and not be detected.

The Social Security Administration uses the information on the reports to evaluate the costs incurred by states in making the disability determinations on behalf of the federal agency. The data are also used to determine funding levels for each state's Disability Determination Services program.

Our testing of two sample SSA-4514 reports submitted during the state fiscal year determined that the reports materially agreed to the departmental supporting worksheet. However, we identified minor discrepancies in the amounts reported on the supporting worksheet and the actual employee time reporting data.

Federal Award Information: This finding affects Social Security - Disability Insurance federal grant award #04-11-04NCDI00 for the federal fiscal year ended September 30, 2011.

Recommendation: The Department should strengthen internal control to ensure adequate review and verification of the amounts reported on the SSA-4514 reports for the Social Security - Disability Insurance program. Reported information should be agreed to supporting documentation to ensure accuracy and reasonableness prior to submission to the federal oversight agency.

DHHS Response: The Department agrees with the finding and recommendation. Internal controls have been strengthened to ensure adequate review and verification of amounts reported on the SSA-4514 reports for the Social Security-Disability Insurance Program. The North Carolina Disability Determination Services (DDS) Administrator, Deputy Administrator, Chief of Administrative Services, and the Supervisor of the Budget and Planning Department will review the form for accuracy prior to submission to the Social Security Administration. This process will eliminate report errors and ensure the amounts reported on the supporting worksheets agree with the actual employee time data. The anticipated date of completion is June 30, 2012.

CENTRAL TESTS

35. FEDERAL AWARD INFORMATION NOT PROPERLY COMMUNICATED TO SUBRECIPIENTS

The Department did not communicate all the necessary federal award information to its county subrecipients receiving funding through the County Administration Reimbursement System. As a result, there is an increased risk that county subrecipients may not correctly identify federal award information in their records or be made aware of applicable compliance requirements.

Per federal OMB Circular A-133 regulations, the State is responsible for identifying to the subrecipient the federal award information (Catalog of Federal Domestic Assistance (CFDA) number and title, award number and name, and name of federal agency) and applicable compliance requirements.

The Department communicates the federal award information to its county subrecipients using a "Dear County Letter." Our review identified that all federal award information, including the CFDA number and title, were not provided for the Child Support Enforcement, Adoption Assistance, and Foster Care federal grant programs. The Department's communication of federal award information did not include these entitlement grant programs.

Federal Award Information: This finding affects the following federal programs:

- Child Support Enforcement federal grant award #G1104NC4004 for the federal fiscal year ended September 30, 2011.

- Foster Care - Title IV-E federal grant award #11001NC1401 for the federal fiscal year ended September 30, 2011.
- Adoption Assistance Title IV-E federal grant award #1101NC1407 for the federal fiscal year ended September 30, 2011.

Recommendation: The Department should ensure that required federal award information is communicated to all subrecipients for all federal funding programs.

DHHS Response: The Department agrees with the finding and recommendation. The Division of Social Services (DSS) Budget Office will work with the Department of Health and Human Services Office of the Controller's Federal Funds/Financial Reporting Branch to ensure all DSS Federal Awards are identified to the subrecipient along with the required information. A new "Dear County" letter will be sent to sub-recipients by March 29, 2012.

36. FAILURE TO PROPERLY REPORT SUBRECIPIENT PASS-THROUGH AMOUNTS ON THE SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS (SEFA)

The Department did not accurately report on its Schedule of Expenditures of Federal Awards (SEFA) the amounts provided to subrecipients. Without our audit adjustments, the SEFA could have been misleading to users of the schedule.

OMB Circular A-133 requires a pass-through entity to identify in its SEFA the total amount of funding provided to subrecipients from each federal award. The Department identified amounts provided to its subrecipients; however, we noted the following deficiencies in the amounts reported:

- For the Child Care Development Fund grant, the Department reported the subrecipient amount as $37.4 million. The audited amount totaled $263.7 million, an understatement of $226.3 million.
- For the ARRA-related activities of the Child Care Development Fund grant, the Department reported the subrecipient amount as $1.5 million. The audited amount totaled $10.1 million, an understatement of $8.6 million.
- For the Foster Care - Title IV-E grant, the Department reported the subrecipient amount as $49.4 million. The audited amount totaled $74.7 million, an understatement of $25.3 million.
- For the ARRA-related activities of the Foster Care - Title IV-E grant, the Department reported the subrecipient amount as $0. The audited amount totaled $1.4 million, which is the understated amount.

A contributing factor to the SEFA errors was inconsistencies in the Department's coding for subrecipient transactions.

Federal Award Information: This finding affects Child Care Development Fund Cluster award #G110NCCCDF and #G0901NCCCD7 (ARRA) and Foster Care Title IV-E award #1101NC1401 and #1101NC1402 (ARRA).

Recommendation: The Department should strengthen internal control over the preparation of the SEFA, and the supporting coding, to provide reasonable assurance that reported pass-through amounts are accurate and presented in accordance with federal guidelines.

DHHS Response: The Department agrees with the finding and recommendation. The Department of Health and Human Services Office of the Controller General Accounting and Financial Management Section and the Division of Social Services are working together to ensure all costs are reported accurately on the Schedule of Expenditures of Federal Awards (SEFA) as required by federal guidelines. The discrepancies in reporting were a result of misinterpretation regarding account classifications. The Department is working to ensure the correct accounts are used to record expenditures within the North Carolina Accounting System (NCAS) as well as reported correctly on the SEFA. NCAS will be updated to reflect the correct account classifications. In the interim detailed support/documentation of all subrecipient costs will be reviewed prior to reporting on the SEFA. The anticipated date of completion is June 30, 2012.

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