STATE OF NORTH CAROLINA

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEWIDE FEDERAL COMPLIANCE AUDIT PROCEDURES

FOR THE YEAR ENDED JUNE 30, 2012

OFFICE OF THE STATE AUDITOR

BETH A. WOOD, CPA

STATE AUDITOR

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEWIDE FEDERAL COMPLIANCE AUDIT PROCEDURES

FOR THE YEAR ENDED JUNE 30, 2012

ADMINISTRATIVE OFFICERS

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AUDITOR'S TRANSMITTAL

The Honorable Pat McCrory, Governor
Members of the North Carolina General Assembly
Dr. Aldona Wos, Secretary
North Carolina Department of Health and Human Services

As part of our audit of the State of North Carolina's compliance with requirements applicable to its major federal programs, we have completed certain audit procedures at the North Carolina Department of Health and Human Services for the year ended June 30, 2012. Our audit was performed by authority of Article 5A of Chapter 147 of the *North Carolina General Statutes.* We conducted the audit 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 State Auditor expresses an opinion on the State's compliance with requirements applicable to its major federal programs in the State's *Single Audit Report*.

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

Beth A. Wood, CPA
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INDEPENDENT AUDITOR'S 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

Dr. Aldona Wos, 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, 2012, 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)

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

Early Intervention Services (IDEA) Cluster:

- CFDA 84.181 – Special Education – Grants for Infants and Families
- CFDA 84.393 – Special Education – Grants for Infants and Families, Recovery Act

Immunization Cluster:

- CFDA 93.268 – Immunization
- CFDA 93.712 – ARRA – Immunization

TANF Cluster:

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

CFDA 93.563 – Child Support Enforcement

CFDA 93.568 – Low-Income Home Energy Assistance

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 93.658 – Foster Care – Title IV-E

CFDA 93.659 – Adoption Assistance – Title IV-E

Medicaid Cluster:

- CFDA 93.720 – ARRA – State Survey and Certification Ambulatory Surgical Center Healthcare Associated Infection (ASC-HAI) Prevention Initiative

- CFDA 93.777 – State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare
- CFDA 93.778 – Medical Assistance Program

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

CFDA 93.917 – HIV CARE Formula Grants

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

Disability Insurance/SSI Cluster:

- CFDA 96.001 – Social Security – Disability Insurance (DI)

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 findings 1, 2, 5, 9, 12, 15-20, and 22 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.

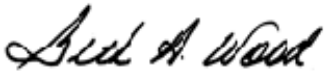
Our consideration of the internal control over compliance was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control over compliance that might be deficiencies, significant deficiencies, or material weaknesses, and 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, 15, 18, 19, and 22 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 findings 2-14, 16, 17, 20, and 21 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 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).

INDEPENDENT AUDITOR'S 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 (CONCLUDED)

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 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 5, 2013

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Management's responses are presented after each audit finding. We did not audit the responses, and accordingly, we express no opinion on them. However, *Government Auditing Standards* require that we add explanatory comments to the report whenever we disagree with an audit finding response. In accordance with this requirement and to ensure that the nature and seriousness of the findings are not minimized or misrepresented, we have provided comments to the Department's responses when appropriate.

Matters Related to Federal Compliance Objectives

VOCATIONAL REHABILITATION CLUSTER

1. ERRORS IN CLAIMS PAYMENT PROCESS

The Department made payments on behalf of Rehabilitation Services - Vocational Rehabilitation Grants to States program participants that did not comply with activities allowed and allowable cost requirements for the program. The Department erroneously made net overpayments totaling $4,370, resulting in questioned costs of $3,439, 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 different divisions - the Division of Vocational Rehabilitation and the Division of Services for the Blind. We examined a sample of 100 participant claims across both divisions and identified 31 claims that were paid in error or were not sufficiently documented. Examples of the deficiencies noted included:

- Payments using the incorrect methodology for payment or pricing.
- Insufficient or missing documentation in support of the services rendered.
- Claims paid without appropriate authorization.

Federal regulation 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 previous years.

Federal Award Information: The review for the Rehabilitation Services - Vocational Rehabilitation Grants to States program claims included federal grant awards #H126A100049, #H126A110049, #H126A120049, #H126A100050, #H126A110050, and #H126A120050 for the federal fiscal years ending September 30, 2010 to 2012.

Recommendation: The Department should continue to enhance its control procedures to improve the accuracy of the claims payment process. Services should be properly

documented and authorized in the participant's vocational rehabilitation plan prior to issuing payment. 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 agrees with the findings and recommendations and will continue to enhance its control procedures to ensure that all claims are documented, processed and paid properly.

The Department continues efforts to develop and test a replacement claims processing system that will improve accuracy and eliminate errors attributed to the inconsistent payment methodology applied to Medicaid and/or other departmental pricing policies. The replacement claims processing system will also have the functionality to ensure that services are properly authorized and documented in participants' plans before payments are issued. In addition, the Department will continue to train staff to ensure that procedures are followed and services authorized for clients match the participant's vocational rehabilitation plan.

The Department will conduct timely follow-up of the identified over and underpaid claims to ensure appropriate collection or payment.

2. DEFICIENCIES IN DOCUMENTATION OF PARTICIPANT ELIGIBILITY

The Department did not always adequately determine and document participant eligibility for the Rehabilitation Services - Vocational Rehabilitation Grants to States program. As a result, net overpayments of $136 were made on behalf of participants, with questioned costs of $107 representing 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 different divisions - the Division of Vocational Rehabilitation and the Division of Services for the Blind. We examined a sample of 100 participant files across both divisions and identified documentation deficiencies in 27 participant files. Documentation could not be located in the participant files to support:

- The timeliness of eligibility determinations and/or the agreed upon extension of time for making those determinations.
- The completion of the application with all required signatures.
- The participant's financial need assessment.
- The participant's eligibility by establishing the impairment adequately.

In addition, we noted that neither Division had adequate controls developed to ensure that eligibility determinations are made within the federally required 60-day time limit. This results in an increased risk of noncompliance in meeting the required timeframes.

Federal regulations and division policies require that documentation be maintained to support a participant's eligibility determination and complete the process within established timeframes.

Similar aspects of this finding were reported in previous years.

Federal Award Information: The review for the Rehabilitation Services - Vocational Rehabilitation Grants to States program claims included federal grant awards #H126A100049, #H126A110049, #H126A120049, #H126A100050, #H126A110050, and #H126A120050 for the federal fiscal years ending September 30, 2010 to 2012.

Recommendation: The Department should strengthen internal controls to ensure that the eligibility determination process occurs within required timeframes, that all eligibility forms are completed with the proper signatures as required by policy, that financial needs forms are completed and documented before cost services are provided, and all applicable eligibility information is maintained to adequately support eligibility determinations made.

DHHS Response: The Department agrees with the findings and recommendations. The case files identified during the audit will be investigated and appropriately resolved.

The Department will continue to strengthen internal controls to ensure that applicable eligibility information is maintained to support eligibility determinations, including evidence of required signatures.

Timeliness of eligibility determinations and/or the agreed upon extension of time for making those determinations will continue through yearly internal audits of 60 day eligibility. The policy section will present findings of these reviews to the State and Regional Directors to allow regional management the opportunity to take appropriate action with staff in areas of concern.

Procedures for the completion of the application including all required signatures, which primarily involves missing parental signatures from the Vocational Rehabilitation (VR) applications of minor (under age 18) transition students applying for services, has been updated. In March 2013, a revised casework policy clarifying use of the "Parental Consent Letter" will be put into effect. Additionally, the replacement case management system will require client and counselor signature before the application will progress in the system.

Financial need assessment will be addressed during the Department's annual one-day training session on Determination of Financial Need and Comparable Benefits in July and August of 2013. This training will be held for all casework service delivery staff.

Additionally, the Department will develop and implement self-directed training modules to be posted online for staff to access, learn, and obtain refreshers on the essential components of determining a client's financial need.

To establish the client's impairment adequately, the Department has made very significant efforts statewide to strengthen eligibility determinations since 2005 with revision of the policy in Chapter 3 of Volume I - 3-6-3: Eligibility for VR Services based upon a Physical Disability. The revised policy provides greater guidelines and criteria for determining when impairments are chronic and how to rule out acute-type impairments that should not be serviced. The Department's position is that these current issues in eligibility are isolated and confined within certain areas of the state. This issue will be addressed with the regional management.

The replacement case management system will assist with the need for controls to ensure that eligibility determinations are made within the federally required 60-day time limit, required documentation is maintained to support a participant's eligibility determination and to complete the process within established timeframes; in accordance with policy.

3. NONCOMPLIANCE WITH CASH MANAGEMENT REQUIREMENTS

The Department did not comply with federal cash management requirements and the Treasury-State Agreement for the Rehabilitation Services - Vocational Rehabilitation Grants to States program.

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 77 requests for federal funds across both divisions and identified noncompliance with 14 requests. The requests were related to drawdowns for estimated payroll expenditures rather than actual disbursements as required in the Treasury-State Agreement. When comparing actual payroll expenditures to the requested drawdown amounts for our sample items, we identified $483,947 in overdraws and $612,580 in underdraws.

The Department does not use actual data because the necessary details are not readily available in the payroll system. The Department is pursuing revisions to the Treasury-State Agreement to allow the current procedure, but no such changes have been approved.

Federal and state regulations require the development of procedures to ensure compliance with approved federal funds request methods.

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 #H126A100049, #H126A110049, #H126A120049, #H126A100050, #H126A110050, and #H126A120050 for the federal fiscal years ending September 30, 2010 to 2012.

Recommendation: The Department should review the Treasury-State Agreement to determine whether the Agreement should be amended or the process for drawing down payroll expenditures should be revised.

DHHS Response: The Department agrees with the finding and recommendation. The Treasury State Agreement (TSA) was revised and submitted to the Office of State Controller (OSC) for approval on June 26, 2012. The funding technique for the Rehabilitation Services – Vocational Rehabilitation Grants to States program was changed to the pre-issuance basis. This allows for the amount of the request to be the amount the State expects to disburse. The amendment to the TSA was approved by the United States Department of the Treasury on November 26, 2012.

CFDA 93.658 – FOSTER CARE - TITLE IV-E

4. SUBRECIPIENT MONITORING PROCESS NEEDS IMPROVEMENT

The Department did not monitor county subrecipients in the Foster Care Title IV-E program in accordance with its monitoring plan. As a result, there is an increased risk that funding could be spent on unallowable expenditures.

The Department's monitoring plan states that IV-E Foster Care subrecipients will be monitored at least once every three years, and the Department maintains a log to track the counties monitored each year. Our review of the logs for the last three years revealed that the Department failed to monitor nine counties during the period. Those counties received federal Foster Care funds totaling $1,077,636, $738,554, and $710,010, respectively, over the three years.

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 Foster Care Title IV-E federal grant award #1201NC1401 for the federal fiscal year ended September 30, 2012.

Recommendation: The Department should strengthen internal control over its subrecipient monitoring for the Foster Care Title IV-E program to ensure that subrecipients are monitored in accordance with the Department's monitoring plan.

DHHS Response: The Department agrees with the finding and recommendation. The Child Welfare monitoring team utilizes PQA reports to establish the schedule to monitor and track county departments of social services' use of Title IV-E funding. The reports provide a listing of children in foster care, the current placement of the child, and the funding source but are limited in scope and do not reflect actual Title IV-E Foster Care expenditures. To determine the county's actual usage of Title IV-E Foster Care, the Child Welfare monitoring team began in February 2013 to use a report provided by the Division of Social Services' budget team; which identifies actual county expenditures of Title IV-E funding. The Department's use of this report will ensure that the subrecipients are monitored in accordance with the Department's monitoring plan.

The nine counties identified in the audit as not having been monitored have now been scheduled for monitoring visits and Title IV-E expenditures are being tracked.

MEDICAID CLUSTER

5. ERRORS IN 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 Medicaid Program. The Department erroneously made net overpayments of $24,707 to Medicaid providers, resulting in questioned costs of $16,068, which represents the federal share of the overpayments.

We examined a sample of 281 Medicaid claims and identified 44 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, failure to timely recoup charges subject to retroactive rate adjustments, and no consideration of the participants' private insurance prior to payment. The majority of the errors related to the medical record documentation to support services provided and the charges incurred.

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

Similar aspects of this finding were reported in previous years.

Federal Award Information: This finding affects Medical Assistance Program federal grant awards #05-1105NC5MAP and #05-1205NC5MAP for the federal fiscal years ended September 30, 2011 and 2012, respectively.

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 agrees with the recommendation to 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. In addition, the Department will continue to implement our new MMIS system which will improve our ability to implement and track

system changes. As part of our process to improve internal operations we will continue to improve our accountability and compliance monitoring.

6. DEFICIENCIES IN THE ELIGIBILITY SYSTEM INTERFACE PROCESS

The Department did not monitor the interface of private insurance data in the Medicaid eligibility system to the Medicaid claims processing system. As a result, there is an increased risk that the Medicaid program paid claims for participants that should have been covered by other insurance.

North Carolina's federally-approved Medicaid plan requires that the Medicaid program be the "payer of last resort" in all cases that involve other insurance coverage. The Department maintains participant private insurance coverage data in the Medicaid eligibility system.

The eligibility system is interfaced with the Department's claims processing system on a daily basis. The Department is responsible for monitoring and correcting errors in the interface; however, the Department has not implemented a review of private insurance data. Errors could include failure to assign policies entered in the eligibility system to a participant, which would prevent the policies from transferring during the interface.

The claims processing system relies on the accuracy of private insurance data for the claims adjudication process. Without accurate data, claims could be paid by the system that should be denied because of other insurance coverage.

Federal Award Information: This finding affects Medical Assistance Program federal grant awards #05-1105NC5MAP and #05-1205NC5MAP for the federal fiscal years ended September 30, 2011 and 2012, respectively.

Recommendation: The Department should modify its interface monitoring procedures to include private insurance data to ensure errors are identified and corrected in a timely manner.

DHHS Response: The Department agrees with the finding and recommendation. The Division of Medical Assistance (DMA) currently has a contract with Health Management Services (HMS) to perform periodic reviews of the private insurance data entered into the system by the county Departments of Social Services. As part of DMA's monitoring process, DMA will work with HMS to ensure reviews are performed regularly for compliance and accuracy. Any errors identified will be corrected immediately.

7. DEFICIENCIES IN CASH MANAGEMENT PROCEDURES

The Department did not consistently ensure that drawdowns for Medicaid program funds were in accordance with federal requirements. The Treasury-State agreement requires that the amount of the request be the amount the State expects to disburse. It also

specifies that grantees disburse rebates and refunds before requesting additional cash payments.

Our review of a sample of 107 Medicaid federal funds requests noted four deficiencies. The deficiencies included a lack of proper approval, a calculation error, and two errors of receiving reimbursement from the wrong federal program account.

Additionally, the Department did not follow federal and departmental policies related to the return of drug rebates for the months of July 2011 and June 2012. The Department performs a revenue clearing procedure at the end of each month that adjusts the drawdown estimates to actual to ensure that there are no accumulations of federal overdrawn amounts throughout the year. Drug rebates are part of the revenue clearing process and any federal share of drug rebate amounts not returned by reducing a previous drawdown request would be returned during this process. During July 2011 an $11 million drug rebate balance was not considered in reducing requested drawdown amounts. A $56 million balance for June 2012 was delayed for revenue clearing until July 2012 to ensure that sufficient funds were available to pay medical claims. This was necessary due to state budget shortfalls for state fiscal year 2012.

Undispositioned refunds received represent an additional area where the federal share, if any is identified, could reduce the drawing of federal funds. Undispositioned refunds are refunds of expenditures received for which the corresponding receivable account is not readily determinable. The federal share of these receipts is not identified and returned until the receivable account is identified, which could take a month or more. The Department's policies and procedures do not adequately address the handling of unidentifiable cash receipts in a timely manner.

Similar aspects of this finding were reported in previous years.

Federal Award Information: This finding affects Medical Assistance Program federal grant awards #05-1105NC5MAP and #05-1205NCMAP, and Medicaid Administrative Payments federal grant awards #05-1105NC5ADM and #05-1205NC5ADM, for the federal fiscal years ended September 30, 2011 and 2012, respectively.

Recommendation: The Department should strengthen and consistently apply internal controls over federal funds requests. Additionally, the Department should continue to enhance drawdown procedures for drug rebate credits and address any state budget shortfalls to ensure compliance with the Treasury-State agreement. Procedures to timely identify and return the federal share of unidentified cash receipts should be implemented.

DHHS Response: The Department agrees with the findings and recommendations. As noted by the auditors, the Treasury-State Agreement (TSA) requires that the draw be based on the expected amount of disbursements. Therefore, the TSA indicates that the draw will be an estimate. As such, it is subject to some amount of inaccuracy when compared to the actual amount of disbursements. Mitigating controls such as the revenue clearing process ensure that the estimates are reconciled with the actual disbursements.

The Department will continue to ensure that controls over the federal draw requests are operating effectively. In addition, the Department will enhance and perform procedures to ensure proper application of drug rebate credits and identification of unidentifiable cash receipts in a timely and efficient manner. The Department has effective procedures in place to ensure the timely dispositioning once cash receipts have been identified. The issue of drug rebate credits will be refunded as directed by state and federal law effective this budget year.

8. DEFICIENCIES IN MONITORING PROCEDURES OVER PROVIDER ELIGIBILITY AND TERMINATION PROCESS

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

The Department contracts with a service provider to perform enrollment, credentialing, and verification activities for provider participation in the Medicaid program. The Department is responsible for monitoring the activities of the service provider to ensure established business rules and desk review procedures are followed during the provider eligibility determination process and that all provider sanctions are properly handled. We examined 60 departmental monitoring files and noted a lack of adequate documentation to support the monitoring procedures performed on these activities in five files.

In addition, the contracted service provider is responsible for monitoring professional licensing board notifications of sanctioned and suspended providers and terminating such providers from the Medicaid program. During our testing of the Medical Board, Dental Board, Pharmacy Board, and the Division of Health Service Regulation licensing actions, we noted exceptions in which the provider was not properly terminated from the Medicaid program. There were eight Medical Board licensees that had a temporary, indefinite, or voluntarily suspended license due to Medical Board disciplinary action who were not properly end-dated or terminated from the Medicaid program computer systems. Also, one provider failed to meet the health and safety requirements as determined by the Division of Health Service Regulation and was not properly terminated from the Medicaid program computer systems.

Similar aspects of this finding were reported in previous years.

Federal Award Information: This finding affects Medical Assistance Program federal grant awards #05-1105NC5MAP and #05-1205NC5MAP for the federal fiscal years ended September 30, 2011 and 2012, respectively.

Recommendation: The Department should continue to improve and implement adequate monitoring controls over 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 agrees with the finding and recommendation. The Department has identified and isolated the cause of the lack of adequate documentation to support the monitoring procedures performed on the activities cited. As a result of increased internal monitoring measures, the development of a monitoring and oversight plan is in process.

The monitoring plan will be designed with more control and oversight of daily activities of each enrollment specialist as well as provide assistance for each enrollment specialist in identifying when action needs to be taken on a provider record. Management will also be able to immediately recognize and address a lack of understanding with additional training, guidance and possible disciplinary actions up to and including dismissal as necessary.

The monitoring plan will also emphasize a rigid peer review process to ensure a regular progression of knowledge transfer is maintained within the Division of Medical Assistance (DMA) and is conveyed to the service provider in a timely manner.

Additional oversight of service provider activities includes the assurance that Quality Control (QC) is reviewed throughout the month and submitted on a monthly basis.

Per the contracted service provider, the Operations Managers, Supervisors, QC/Quality Assurance (QA) Auditors, and Department Leads review daily, weekly, and monthly processing and activity reports to monitor compliance to current policies and procedures. Daily reports will be reviewed to ensure the Service Level Agreements are met throughout each month and the work is spot checked and logged.

9. INADEQUATE FOLLOW-UP ON IDENTIFIED SUBRECIPIENT ERRORS

The Department did not ensure that adequate corrective action was taken on all errors identified during 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 20 monitoring reviews and noted eight payment errors that resulted in questioned costs; however, the Department could not provide evidence that adjustments were made to account for the overpayments. The eight errors resulted in questioned costs of $23,082, 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 require adjustments in federal payments within one year of discovery whether or not a recovery has been made by the State.

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

Federal Award Information: This finding affects Medical Assistance Program federal grant awards #05-1105NC5MAP and #05-1205NC5MAP for the federal fiscal years ended September 30, 2011 and 2012, respectively.

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 should ensure that necessary adjustments are made for all identified overpayments.

DHHS Response: The Department partially agrees with this finding and recommendation. The Department's Medicaid Quality Assurance Section conducts annual quality control reviews of recipient eligibility determinations in accordance with 42 CFR 431.800 to measure, identify and prevent errors due to erroneous eligibility determinations. As a corrective action to address errors that were identified, counties were notified of errors and their responses were tracked. Pursuant to federal regulations at 42 CFR 431.865(e), the Centers for Medicare and Medicaid Services (CMS) calculates a State's error rate and sends a Demand letter if a federal payback is required. It should be noted that CMS has not sent such a Demand letter to the Department. In addition, North Carolina participated in an MEQC pilot project, which takes the place of the traditional MEQC reviews; and these reviews are not subject to the threshold and disallowance provisions under section 1903(u) of the Act as long as the pilot continues. The Department is committed to working with the State Auditors and CMS to ensure compliance with applicable laws and rules.

Auditor Response: Improper payments due to ineligibility are unallowable costs for federal financial participation. Under 2 CFR 225 Appendix E (F) (5), costs specifically identified as unallowable and charged to federal awards either directly or indirectly are to be refunded. Although the counties determine eligibility, the responsibility for the return of the federal share for unallowable costs remains with the Department.

In its response, the Department indicates that under the traditional MEQC program, unallowable costs are to be refunded only if the Centers for Medicare and Medicaid Services (CMS) determines that the State's error rate is excessive (exceeding three percent) and sends the State a demand letter seeking payback. In this situation, CMS uses the percentage amount greater than the threshold to project the improper payment amount for the entire population of medical assistance payments for the period. CMS then demands repayment of the full <u>projected</u> amount.

In our opinion, this process does not result in an exemption from the requirement to refund <u>actual</u> improper payments, regardless of the State's overall error rate. Under the Department's interpretation, the State could make very large improper payments that would not have to be refunded so long as the error rate is less than three percent. In our view, this would be inconsistent with the federal requirements. Furthermore, we do not believe that operating under the pilot MEQC program would alter this conclusion.

This issue was also reported in a prior year finding. The Department concurred with the finding and sought clarification from Centers of Medicare and Medicaid Services (CMS). During our audit it was confirmed that no clarification was provided by CMS.

10. DEFICIENCIES WITH PROGRAM INTEGRITY FUNCTIONS

The Department did not adequately track case investigations, consistently maintain case file documentation, and establish an effective quality assurance process over the Public Consulting Group, a post-payment review contractor. These deficiencies could result in failures in completing case investigations, identifying provider overpayments, and referring potentially fraudulent cases to the Attorney General's Medicaid Investigations Unit. Federal regulations require the establishment of procedures to identify suspected fraud cases, investigate these cases, and refer cases with sufficient evidence of suspected fraud to law enforcement officials.

The Department's Program Integrity Unit is charged with ensuring compliance, efficiency, and accountability in the Medicaid program by detecting and preventing fraud, waste, and abuse. It also works to prevent improper payments through tort recoveries, recoupments, and ongoing training of providers and recipients. The Department has partnered with various contractors to assist in examining Medicaid activities for fraud, waste, and abuse.

The Program Integrity Unit's case tracking database documents case investigations performed. The database includes when a case is closed, referred, and investigation results. Program Integrity staff did not consistently update the database for each individual case status, particularly for cases referred to the Attorney General's Medicaid Investigations Unit. The database indicated that there were six cases referred to the Attorney General during the state fiscal year; however, the listing of referred cases obtained from the Attorney General's office contained several additional cases referred by Program Integrity staff.

In addition, we examined a sample of 60 case files of the Program Integrity Unit investigations and noted the following deficiencies:

- A Home Care Review case file did not have the Section Chief's approval of the case investigation until two months after the case closure date.
- A Home Care Review case file had to be re-created with supporting documentation, and the original Program Integrity Case Tracking Form signed by the Section Chief approving the case investigation could not be located.
- One case file could not be located by the Program Integrity Unit, and the responsible section could not be identified in the case tracking database.

Finally, the Department's Program Integrity Unit did not have a standard policy implemented related to the performance of quality assurance reviews on investigations

completed by the Public Consulting Group. Differing sample sizes and methods were selected by the two Program Integrity sections performing case reviews. The lack of a consistent methodology could lead to inaccurate case investigation results and potentially fraudulent cases not referred to the Attorney General's Medicaid Investigations Unit.

Federal Award Information: This finding affects Medical Assistance Program federal grant awards #05-1105NC5MAP and #05-1205NCMAP, and Medicaid Administrative Payments federal grant awards #05-1105NC5ADM and #05-1205NC5ADM, for the federal fiscal years ended September 30, 2011 and 2012, respectively.

Recommendation: The Department should strengthen internal controls over the tracking of case investigations and ensure case file documentation is maintained. In addition, the Department should implement and continue to enhance its newly created policy for quality assurance reviews over Public Consulting Group case investigations.

DHHS Response: The Department agrees with the finding and recommendations. The Program Integrity (PI) case tracking database is an Access database created six years ago that now contains 50,000 records. Due to the volume of records contained in the PI case tracking system, it is extremely unstable and has weekly issues. In addition, the 2008 Centers for Medicare and Medicaid Services (CMS) audit cited the Division of Medical Assistance for not maintaining an effective fraud and abuse case tracking system. PI continues in its effort to procure an effective PI case tracking system to ensure case file documentation is maintained. In the interim, PI conducts monthly quality assurance reviews for all contractors performing case investigations to ensure the quality assurance review process is strengthened.

11. DEFICIENCIES IN ACCESS CONTROL OVER THE MEDICAID MANAGEMENT INFORMATION SYSTEM

We identified deficiencies with the Department's protocols and procedures over user access to the legacy Medicaid Management Information System (MMIS). The nature of the deficiencies was separately communicated to the Department. 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. Statewide information technology standards specify that systems must be adequately controlled to prevent unauthorized access. 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.

Similar aspects of this finding were reported in previous years.

Federal Award Information: This finding affects Medical Assistance Program federal grant awards #05-1105NC5MAP and #05-1205NC5MAP for the federal fiscal years ended September 30, 2011 and 2012, respectively.

Recommendation: The Department should take appropriate action to address identified user access issues that were separately communicated to the Department.

DHHS Response: The Department agrees with the finding and recommendation. The Division of Medical Assistance (DMA) has added additional security to the legacy Medicaid Management Information System (MMIS). The modifications bring the security requirements in compliance with the statewide information technology standards. This added security is included in the new MMIS set to go live on July 1, 2013.

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

12. ERRORS IN PROVIDER BILLING AND PAYMENT PROCESS

The Department made payments on behalf of Children's Health Insurance Program participants that did not comply with activities allowed or allowable cost requirements for the program. The Department erroneously made net overpayments of $329 to medical providers, resulting in questioned costs of $249, which represents the federal share of the overpayments. We believe that it is likely that questioned costs exceed $10,000 in the population.

We examined a sample of 125 medical claims and identified nine claims that were paid in error or were not sufficiently documented. Examples of the deficiencies noted include calculated payments not in accordance with established policies, payment for services for an ineligible participant, insufficient or missing documentation in support of the services rendered, and the failure to consider third party insurance prior to payment.

The Department also failed to reconcile paid claims data from Blue Cross Blue Shield, the Department's claims processor, to payments made to Blue Cross Blue Shield to cover the benefits. Due to the difficulties encountered while attempting the reconciliation, the Department determined that it was not cost effective to resolve the issue since the processing contract was transitioning to Hewlett-Packard Enterprise Services. The lack of a reconciliation process increases the risk of the Department over or under paying for services. Upon the transition to Hewlett-Packard Enterprise Services, a monthly reconciliation was completed for those paid claims.

Federal regulation 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 previous years.

Federal Award Information: This finding affects Children's Health Insurance Program federal grant awards #05-1105NC5021 and #05-1205NC5021 for the federal fiscal years ended September 30, 2011 and 2012, respectively.

Recommendation: The Department should continue to enhance its control procedures to improve the accuracy of the claims payment process. Emphasis should be placed on educating providers as to proper coding and documentation standards necessary to support the medical services being provided. Identified overpaid claims should be followed up for timely and appropriate collection. The Department should continue the reconciliation process started with the new claims processing contractor, Hewlett-Packard Enterprise Services.

DHHS Response: The Department agrees with the findings and recommendations. The Department will continue to enhance procedures to improve the accuracy of the claims payment process. Emphasis will continue to be placed on educating providers as to adequate documentation to support the medical necessity and services billed to the Children's Health Insurance Program. Identified overpaid claims will be followed up for timely and appropriate collection. In addition, the Department will ensure the new claims processing contractor will continue to perform scheduled reconciliations of the paid claims data.

13. DEFICIENCIES IN CASH MANAGEMENT PROCEDURES

The Department did not consistently ensure drawdowns for the Children's Health Insurance Program were reviewed, approved, and accurately calculated. As a result, there is an increased risk of drawing down excessive federal funds and noncompliance with the Treasury-State agreement. The Treasury-State agreement requires that the amount of the request be the amount the State expects to disburse.

A test of 67 drawdown requests for the Children's Health Insurance Program resulted in the following:

- One request was not reviewed and approved prior to the requesting of federal funds.
- Two requests were incorrectly calculated based on supporting expenditure documentation. One request resulted in a $46,084 overdraw and the other request resulted in a $50,000 underdraw of federal funds.
- One request used the incorrect federal matching percentage to calculate the federal share, which resulted in a $32 underdraw.

Federal Award Information: This finding affects Children's Health Insurance Program federal grant awards #05-1105NC5021 and #05-1205NC5021 for the federal fiscal years ended September 30, 2011 and 2012, respectively.

Recommendation: The Department should ensure that controls over the review and approval of federal drawdown requests are consistently and effectively applied.

DHHS Response: The Department agrees with the findings and recommendations. The Department's review of the errors identified above which resulted in an underdraw of federal funds prove these to be isolated occurrences and not representative of daily operating controls and practices. The Department will continue to ensure that controls over the federal draw requests are operating effectively.

14. DEFICIENCIES IN SUBRECIPIENT MONITORING PROCEDURES

The Department did not have a subrecipient monitoring plan for the Children's Health Insurance Program in place throughout the year and did not ensure that corrective action was taken on all errors identified through subrecipient monitoring. As a result, there is an increased risk that health insurance benefits were provided on behalf of ineligible participants and adjustments were not made for questioned costs that occurred at the subrecipient level.

The Department developed a monitoring plan to ensure that subrecipients make proper eligibility determinations; however, the monitoring plan was not in place for the first four months of the state fiscal year. Also, the Department has not implemented control procedures to ensure that subrecipient errors identified through monitoring procedures are sufficiently addressed by corrective actions. As a result, all federal funds paid in error may not be recouped and returned to the federal oversight agency as required.

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

Similar aspects of this finding were reported in previous years.

Federal Award Information: This finding affects Children's Health Insurance Program federal grant awards #05-1105NC5021 and #05-1205NC5021 for the federal fiscal years ended September 30, 2011 and 2012, respectively.

Recommendation: Now that a monitoring plan is in place, the Department should enhance monitoring procedures to ensure corrective actions identified are appropriate and tracked to ensure completion in a timely manner. Procedures implemented should ensure that any necessary adjustments are made for all identified overpayments.

DHHS Response: The Department partially agrees with the findings and recommendations. The Department's current understanding is that there is no Federal requirement for monitoring eligibility in the Children's Health Insurance Program (CHIP), except through the Payment Error Rate Measurement (PERM) program. The Medicaid Quality Control Section implemented a review of CHIP in FFY 2012 to ensure proper eligibility determinations. Since there is no federal requirement to monitor this program under MEQC, there is no federal disallowance requirement. In addition, 42 CFR 457.628 references the regulations applicable to CHIP, and 45 CFR 92 is not

referenced. The Department will continue to work with the State Auditors and CMS to clarify the federal requirements and their applicability to CHIP.

Auditor Response: The federal Department of Health and Human Services made the general monitoring requirements described in 45 CFR 92 applicable to the Children's Health Insurance Program with *Federal Register*, 68 FR 52843-52844, dated September 8, 2003. The purpose of this provision was to bring the administration of entitlement and non-entitlement programs under a "common rule." 45 CFR 92.40 requires grantees to monitor subgrant supported activities to assure compliance with applicable federal requirements.

Improper payments due to ineligibility are unallowable costs for federal financial participation. Under 2 CFR 225 Appendix E (F) (5), costs specifically identified as unallowable and charged to federal awards either directly or indirectly are to be refunded. Although the counties determine eligibility, the responsibility for the return of the federal share for unallowable costs remains with the Department.

CFDA 93.917 – HIV CARE FORMULA GRANTS

15. DEFICIENCIES IN CASH MANAGEMENT PROCEDURES

The Department inappropriately drew down funds in the HIV CARE Formula Grant program and also inappropriately advanced funds to subrecipients in the program. Federal requirements specify that when a reimbursement basis is used for cash management, program costs must be paid for by the grantee before reimbursement is requested.

We examined a sample of 46 requests for federal funds and identified noncompliance in two requests, resulting in overdraws of $8,663,710. When correcting variances between reported actual program expenditures and actual federal funds received, the Department requested $8,662,710 in excess of the amount needed for program expenditure reimbursement. Upon realizing this amount was overdrawn, the Department returned some of the federal funds; however, $522,871 was held to cover subsequent program expenditures within the next two days. In another instance, the request for reimbursement was $1,000 more than paid expenditures.

Additionally, the Department advanced $317,571 of federal funds to subrecipients without federal approval. Federal program requirements do not allow advance payments for HIV CARE Formula Grant funds. The Department provided advances to select subrecipients due to a concern with their ability to fund the first month of program expenditures without an advance. Our examination of monthly subrecipient expenditure reports noted that the subrecipients were receiving an advance at the beginning of the project period, and for subsequent months the Department would reimburse the actual monthly expenditures. This allowed the subrecipients to maintain the initial advance until the last month of the project period. It was also noted for the majority of the

program year, the monthly subrecipient expenditures were less than the amount of the initial advance provided.

Federal Award Information: This finding affects HIV CARE Formula Grant awards #2X07HA00051-21-00 and #2X07HA00051-22-00 for the grant awards ending March 31, 2012 and 2013, respectively.

Recommendation: The Department should strengthen internal controls to ensure that they only request federal funds when actual expenditures have been made to support the requests. In addition, procedures should be developed and implemented to ensure HIV CARE Formula Grant funds are not used to make advance payments to subrecipients.

DHHS Response: The Department agrees with the findings and recommendations. Although an error in the draw was made, existing internal controls detected the error the next day. The Department self-corrected the error before any negative impact to federal cash management reporting or to the Department's accounting records could occur. The Department will continue to monitor and utilize internal controls to ensure that federal draws are only requested to fund actual expenditures.

As to advance payments, the Department had previously received approval from the Federal awarding agency to grant advances in 1999 and again in 2010 and had received no notice of change in the awarding agency's position. However, the Department will modify procedures to reflect current Federal policy regarding advance payments for the HIV CARE Formula Grant. Unless specific approval is received from the Federal authority, advance payments to subrecipients will no longer be made.

Auditor Response: In relation to the $8.7 million overdraw, the Department indicates that the error was detected by "existing internal controls." We agree the error was caught by an employee and corrected; however, the error was not detected by a procedure that is regularly and consistently applied, and therefore, there continues to be a deficiency in internal control.

16. DEFICIENCIES IN ELIGIBILITY DETERMINATIONS

The Department did not adequately determine and document eligibility for participants that receive Human Immunodeficiency Virus (HIV) or Acquired Immunodeficiency Syndrome (AIDS) treatments, as funded by the HIV CARE Formula Grant. As a result, benefits were delivered to ineligible participants and $21,549 of federal questioned costs were identified for the program.

To be eligible to receive treatment assistance, a participant must meet financial and medical criteria, including a requirement that the participant not be enrolled in the Medicaid program. We examined a sample of 71 participant case files and identified the following deficiencies in 10 case files:

- The financial eligibility application and authorization request were both missing in three participants' case files.
- There were four participants enrolled in Medicaid that were approved to receive services.
- The eligibility determinations for three participants were correctly determined based on the initial application; however, during the authorization period the participants became eligible for Medicaid and should have been removed from the program.

Federal Award Information: This finding affects HIV CARE Formula Grant award #2X07HA00051-21-00 for the grant award ended March 31, 2012.

Recommendation: The Department should strengthen internal controls to ensure that eligibility determination documentation is maintained and that only eligible participants receive services.

DHHS Response: The Department agrees with the findings and recommendation. A random sampling of 50 records will be reviewed every quarter in order to assure all required information is maintained in client files. If errors are found in the first 50 records reviewed, an additional 20 records will be randomly sampled to search for commonalities. The results of the quarterly sampling will be maintained.

The Department will conduct periodic meetings with program staff to determine and assess if the best process is currently being utilized to determine when a client's eligibility status changes. The Department will modify the current process if necessary to ensure that eligibility determination documentaion is maintained and that only eligible particpants receive services.

17. DEFICIENCIES WITH THE DRUG DISCOUNT PROGRAM

The Department did not comply with federal drug pricing program requirements for the HIV CARE Formula Grant program. As a result, the Department erroneously made overpayments totaling $5,436, which represents the federal share of the questioned costs. We believe that it is likely that questioned costs exceed $10,000 in the population.

Federal regulations for the drug pricing program require grantees to properly identify and price drugs throughout the procurement process, ensure drugs are not given to ineligible participants, and ensure duplicate discounts are not applied.

We noted that the Department did not obtain the federal drug and price listing, which limited the Department's ability to monitor that the appropriate drug price was paid. Our examination of drug prescriptions dispensed and program eligibility files identified the following deficiencies:

- We tested a sample of 60 AIDS drug prescriptions dispensed and identified 21 instances where the amount paid was more than the contract price, resulting in $197 of overpayments. Within those 21 pricing errors there were eight exceptions in which the price paid was higher than the federal pricing program amount.
- We compared the drugs dispensed to the Department's program eligibility file and identified 135 unmatched records, indicating that drugs may have been dispensed to ineligible recipients. We further tested a sample of 27 unmatched records and identified three instances where drugs were provided to ineligible program participants, resulting in $5,239 of overpayments.

Federal Award Information: This finding affects HIV CARE Formula Grant awards #2X07HA00051-21-00 and#2X07HA00051-22-00 for the grant awards ending March 31, 2012 and 2013, respectively.

Recommendation: The Department should obtain the federal drug pricing program listing to use in their monitoring efforts for the HIV CARE Formula Grant program. In addition, control procedures should be enhanced to ensure proper drug pricing during the procurement process and that only eligible participants receive drug benefits.

DHHS Response: The Department agrees with the finding and recommendation. The Department is consulting with the pharmaceutical wholesale vendor to ensure the current process for checking drug pricing is strengthened. The vendor currently verifies that all contract prices are entered into the program eligibilty file on a quarterly basis. The vendor will conduct an additional internal contract price audit on a monthly basis to more efficiently capture price variations and ensure accurate pricing. The Department will also evaluate and implement methods to strengthen monthly pricing checks that are in place. The Department is working with the dispensing pharmacy vendor to ensure the internal process for Medicaid eligibility cross checks is strengthened and to improve the process for receiving reimbursement from Medicaid when Aids Drug Assistance Program clients are found to be Medicaid eligible.

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

18. 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 or corrected 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:

- The Department does not require a corrective action plan for all deficiencies it finds during the LME fiscal settlement reviews. All issues found are communicated to the LMEs but corrective action is not required unless the LME is required to repay funds. Other issues noted, including those that violate federal regulations such as the practice of advancing funds to providers, do not require a corrective action plan from the LME. Our review of the monitoring reports showed that many of the issues identified during the monitoring visits had been reported in prior reviews.
- The Department does not reconcile the overall population of substance abuse service providers to ensure the completeness of its provider monitoring population. The report used to select the 2012 providers to be monitored totaled $4.7 million, which was $9.5 million less than the amount reported on the 2011 report. The Department was unable to explain the differences even though benefits paid during the two years were comparable.
- The Department does not independently select provider cases to examine during LME monitoring visits. Instead, the Department relies on the provider to identify and select the cases.

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

Similar aspects of this finding were reported in previous years.

Federal Award Information: This finding affects Block Grants for Prevention and Treatment of Substance Abuse federal grant awards 2B08TIO10032-11 and 2B08TIO10032-12 for the federal fiscal years ended September 30, 2011 and 2012, respectively.

Recommendation: The Department should continue to enhance its monitoring process for the Block Grants for Prevention and Treatment of Substance Abuse program. Comprehensive policies should address all aspects of the monitoring efforts, including obtaining corrective action plans for all deficiencies. The Department should perform appropriate reconciliations to ensure that its monitoring activities encompass all providers of substance abuse services within the LME system. Case files to be examined should be selected by the Department's monitors, and not by the provider.

DHHS Response: The Department agrees with the finding and recommendations. The Department recognizes the important aspects of proper monitoring of both programmatic and financial operations of the Block Grants for Prevention and Treatment of Substance Abuse program. The Division of Mental Health and Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) has initiated steps to assure proper follow up of findings on questionable activities by combining the existing plan of processing corrections for Local Management Entity-Managed Care Organization (LME/MCO)

programs and providers' monitoring with the financial monitoring area of the LME/MCOs fiscal operations. The DMH/DD/SAS has also implemented a change in the methodology used in the generation of reports and the selection process for the review of providers. In addition, reconciliations will be completed to ensure all monitoring activities comprise all providers of substance abuse services within the LME system.

19. NONCOMPLIANCE WITH DUNS NUMBER REQUIREMENT

The Department did not ensure Dun and Bradstreet Data Universal Numbering System (DUNS) numbers were obtained from subrecipients for the Block Grants for Prevention and Treatment of Substance Abuse program prior to the issuance of subawards. This condition is a violation of federal regulations.

The Department had not obtained DUNS numbers from its subrecipients prior to making subawards. However, after our inquiry the Department requested subrecipients to provide DUNS numbers. Our testwork verified that the DUNS numbers provided were valid.

Federal regulations require the awarding agency, for non-ARRA first tier subawards made on or after October 1, 2010, to have the subrecipient provide a valid DUNS number before issuing the subaward.

Federal Award Information: This finding affects Block Grants for Prevention and Treatment of Substance Abuse federal grant awards 2B08TIO10032-11 and 2B08TIO10032-12 for the federal fiscal years ended September 30, 2011 and 2012, respectively.

Recommendation: The Department should implement procedures to ensure a valid DUNS number is obtained from every subrecipient prior to issuing the subaward.

DHHS Response: The Department agrees with the finding and recommendation. The Department recognizes the requirement to have a valid DUNS number on file for all sub-recipients. The Division of Mental Health and Developmental Disabilities and Substance Abuse Services has included this requirement in the revised Local Management Entity-Managed Care Organization contract.

DI/SSI CLUSTER – SOCIAL SECURITY – DISABILITY INSURANCE

20. NONCOMPLIANCE WITH CONSULTATIVE EXAMINATION COSTS

In two known cases, the Department made inappropriate payments for consultative examination services. The identified questioned cost is $235; however, we believe that it is likely that questioned costs exceed $10,000 in the population.

Within the Department, 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 the following deficiencies:

- One payment was made at a higher rate than the normal hospital rate for that service. The hospital was paid $82, $54 more than the rate it should have received if the documented rate had been used. We consider the $54 to be questioned cost.
- One payment was made for services that were added by the physician but were never entered in the Department's examination scheduling system. The cost of these added services was $181, which we consider to be questioned cost.

Federal Award Information: This finding affects Social Security - Disability Insurance federal grant award #04-12-04NCDI00 for the federal fiscal year ended September 30, 2012.

Recommendation: The Department should continue to enhance internal controls over payments for consultative examinations to ensure that proper rates are used, medical services performed are necessary, and payments are not made unless the service is approved. The Department should seek to recoup the questioned costs from the providers.

DHHS Response: The Department agrees with the findings and recommendations. As an exception to regular practice, the Department had a verbal agreement with a medical service provider to reimburse at a flat fee of $82.32 for the cited examination rather than the regular Medicaid/Medicare reimbursement rate. As of March 1, 2012, the Department has eliminated this practice with the provider. All service providers will be charged the normal Medicaid/Medicare reimbursement rate. In addition, the Department will take action to recoup the questioned cost from the service provider overpaid.

In February 2012 the Department implemented procedures to strengthen internal controls regarding authorization changes to consultative examinations.

The finding cited in this year's audit occurred on an exam scheduled for November 11, 2011, which was prior to implementation of the strengthened procedures. The Department will take action to recoup the cited cost from the appropriate consultative provider.

21. DEFICIENCIES IN MAINTAINING VENDOR FILE

The Department did not effectively maintain its file of vendors eligible to perform consultative examinations for Disability Insurance and Supplemental Security Income

claimants. As a result, there is an increased risk that an unapproved vendor could perform services and receive payment for those services.

During a three month period, the Department identified 53 physicians that needed to be deleted from the authorized vendor listing; however, we found that nine of these physicians remained on the list. We determined that six of the nine did not receive additional payments after the month they should have been deleted from the vendor listing. We were unable to determine whether or not the remaining three physicians continued receiving payments because they were part of a group medical practice and payments were sent to the group as a whole rather than the individual physicians.

Federal Award Information: This finding affects Social Security - Disability Insurance federal grant award #04-12-04NCDI00 for the federal fiscal year ended September 30, 2012.

Recommendation: The Department should strengthen internal controls over the vendor file to ensure that only approved vendors will be selected to perform services and receive payment for those services.

DHHS Response: The Department agrees with the finding and recommendation. The Department utilizes the Vendor File to request medical evidence of record and schedule consultative examinations with selected providers. During case adjudication, providers are selected from the vendor file to perform consultative examinations for Disability Insurance and Supplemental Security Income claimants.

The Department is in the process of cleaning and purging the Vendor File due to its anticipated expansion. Disability Determination Services staff members are working in collaboration with the Division of Information Resource Management (DIRM) to check and correct all classifications of vendor providers in the file to ensure only approved vendors will be selected to perform services and receive payment for those services. In the interim, the Department will implement additional internal controls to prevent scheduling with providers who are no longer on the consultative examinations panel.

In addition, the deficiencies noted during the audit will be reviewed.

CENTRAL TESTS

22. FAILURE TO PROPERLY REPORT 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 program expenditures and 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 that the schedule shall provide total federal awards expended for each individual federal program. Also, the circular requires a pass-through entity to identify in its SEFA the total amount of funding provided to subrecipients from each federal award. We noted the following variances in the amounts reported:

- For the Block Grants for Prevention and Treatment of Substance Abuse program, the Department reported the grant's expended amount as $25.8 million. The audited amount totaled $40.6 million, an understatement of $14.8 million. In addition, the Department reported the subrecipient amount as $25.3 million. The audited amount totaled $38.8 million, an understatement of $13.5 million. The understatements were caused by a prior period adjusting journal entry that erroneously impacted the current year expenditures.
- For the Temporary Assistance for Needy Families (TANF) grant, the Department reported the subrecipient amount as $169.3 million. The audited amount totaled $184.1 million, an understatement of $14.8 million.
- For the Foster Care - Title IV-E grant, the Department reported the subrecipient amount as $70.5 million. The audited amount totaled $75 million, an understatement of $4.5 million.
- For the Adoption Assistance grant, the Department reported the subrecipient amount as $400,000. The audited amount totaled $2.7 million, an understatement of $2.3 million.

A contributing factor to the SEFA errors in the subrecipient amounts was inconsistency in the Department's interpretation of the appropriate coding for subrecipient transactions.

Federal Award Information: This finding affects the following:

- Block Grants for Prevention and Treatment of Substance Abuse federal grant awards 2B08TIO10032-11 and 2B08TIO10032-12 for the federal fiscal years ended September 30, 2011 and 2012, respectively.
- Temporary Assistance for Needy Families (TANF) federal grant awards #1102NCTANF, #G1102NCTANF, and #1202NCTANF, for the federal fiscal years ended September 30, 2011 and 2012.
- Foster Care Title IV-E federal grant award #1201NC1401, for the federal fiscal year ended September 30, 2012.
- Adoption Assistance federal grant award #1201NC1407, for the federal fiscal year ended September 30, 2012.

Recommendation: The Department should strengthen internal control over the preparation of the SEFA, and the supporting coding, to provide reasonable assurance that amounts provided to pass-through entities are accurate and presented in accordance with federal guidelines. Journal entries should be reviewed to ensure that their impact is reported in the proper period.

DHHS Response: The Department agrees with the finding and recommendations. Expenditures to both subrecipients and direct recipients are recorded in the North Carolina Accounting System (NCAS) using 5361XX accounts. Currently, the NCAS account structure does not readily differentiate between subrecipient expenditures and direct recipient expenditures. The Controller's Office will confer with the Office of the State Controller to gain an understanding of the types of reports available to better identify subrecipient expenditures. The data available from these reports will be used to identify subrecipient expenditures for the State Fiscal Year (SFY) 2013 Schedule of Expenditures of Federal Awards (SEFA).

Each year during the SEFA preparation, the SFY expenditures and revenues are reconciled to NCAS. However, a reclass of prior year federal expenditures to state expenditures for the Substance Abuse Prevention and Treatment Block Grant significantly decreased the amount of expenditures reported on the SEFA. All journal entries including prior year expenditure adjustments will be reviewed to ensure their impact is reported properly on the SEFA.

ORDERING INFORMATION

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This audit required 16,411 audit hours at an approximate cost of $1,181,592. The cost represents 0.0096% of the Department's total federal awards expended and subjected to audit.