STATE OF NORTH CAROLINA

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

RALEIGH, NORTH CAROLINA

STATEWIDE FEDERAL COMPLIANCE AUDIT PROCEDURES

FOR THE YEAR ENDED JUNE 30, 2013

OFFICE OF THE STATE AUDITOR

BETH A. WOOD, CPA

STATE AUDITOR

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

RALEIGH, NORTH CAROLINA

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FOR THE YEAR ENDED JUNE 30, 2013

ADMINISTRATIVE OFFICERS

DR. ALDONA WOS, SECRETARY

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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, 2013. 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
State Auditor

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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

Report on 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, 2013, 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 84.126 – Rehabilitation Services – Vocational Rehabilitation Grants to States

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 93.568 – 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

CFDA 93.667 – Social Services Block Grant

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 (Medicaid; Title XIX)

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.

Management's Responsibility

Management is responsible for compliance with laws, regulations, contracts, and grants applicable to federal programs.

Auditor's Responsibility

Our responsibility is to express an opinion on compliance for each of the State of North Carolina's major federal programs based on our audit of the types of compliance requirements referred to above, which we issue in the State's *Single Audit Report*. 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. However, our audit does not provide a legal determination of the Department's compliance with those requirements.

Opinion on Each Major Federal Program

As stated above, our opinion on compliance for each of the State of North Carolina's major federal programs is included in the State's *Single Audit Report*.

Other Matters

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 – 3, 6, 8, 11 – 13, and 15 in the Audit Findings and Responses section of this report.

Report on Internal Control Over Compliance

Management is responsible for establishing and maintaining effective internal control over compliance with the types of compliance requirements referred to above. In planning and performing our audit of compliance, we considered internal control over compliance with the types of requirements that could have a direct and material effect on a major federal program to determine the auditing procedures that are appropriate in the circumstances for the purpose of expressing an opinion on compliance for each major federal program 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 material weaknesses or significant deficiencies, and therefore, material weaknesses or significant deficiencies may exist that were not identified. However, we consider the deficiencies described in findings 1, 6, 11 – 13, and 15 in the Audit Findings and Responses section of this report to be material weaknesses in internal control over compliance. Furthermore, we consider the deficiencies described in findings 2 – 5, 7 – 10, and 14 in the Audit Findings and Responses section of this report to be significant deficiencies in internal control over compliance.

Purpose of Report on Internal Control Over Compliance

The purpose of this report on internal control over compliance is solely to describe the scope of our testing of internal control over compliance and the results of that testing based on the requirements of OMB Circular A-133. Accordingly, this communication is not suitable for any other purpose.

Management's Responses to Audit Findings

Management's responses to the findings identified in our audit are included in the Audit Findings and Responses section of this report. The responses were not subjected to the auditing procedures applied in the audit of compliance or consideration of internal control over compliance, and accordingly, we express no opinion on them.

Beth A. Wood, CPA
State Auditor

Raleigh, North Carolina

March 14, 2014

Matters Related to Federal Compliance Objectives

SNAP CLUSTER – SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM

1. FEDERAL FUNDING ACCOUNTABILITY TRANSPARENCY ACT REPORTING NOT COMPLETED TIMELY

   The Department did not report on state administration subaward obligations within the required time frame, and therefore, did not comply with the Federal Funding Accountability and Transparency Act (FFATA) reporting requirements. These obligations totaled approximately $74 million.

   Federal regulations require states to report subaward actions obligating $25,000 or more in federal funds, excluding American Recovery and Reinvestment Act funds, no later than the end of the month following the month in which the obligation was made. The Department did not submit the subaward obligations for federal fiscal year 2013 until one year after the due date. There were some functionality problems with the federal reporting system, but the Department would have been able to upload the majority of the required data.

   Federal Award Information: This finding affects State Administrative Matching Grants for the Supplemental Nutrition Assistance Program for the federal fiscal year ended September 30, 2013.

   Recommendation: The Department should ensure FFATA reports are submitted timely in accordance with federal requirements.

   Department Response: In June 2012, the Department reported to the federal service desk the functionality problems with the federal reporting system and did not report subaward information until the issues were resolved in December 2013. All required subaward information was reported in the FFATA Subaward Reporting System (FSRS) on January 10, 2014. To ensure that FFATA reports are submitted timely, the Department will enter required data into FSRS as the system allows and will maintain periodic contact with federal partners to resolve any system issues.

2. NONCOMPLIANCE WITH SNAP REQUIREMENTS

   Deficiencies in the Department's procedures related to participants' certification periods in the North Carolina Families Accessing Services through Technology (NCFAST) system resulted in noncompliance with Supplemental Nutritional Assistance Program (SNAP) regulations. NCFAST is the new system that is used to determine eligibility and authorize benefits for SNAP. Deficiencies identified included:

- The system was not set up to prevent county case workers from establishing certification periods for longer than the participant was entitled. County case workers were given the ability to modify the certification period because of a defect in the system. After auditor inquiry, the Department provided a report of 1,683 cases that contained errors in the certification periods. The certification period for these cases ranged from 12 - 36 months while the normal certification period is 6 months.
- The system allowed county case workers to reopen cases closed by the system due to failure of the participant to recertify; however, there was no review of system overrides for appropriateness. We identified five instances in a sample of 40 where the case worker reactivated the case even though the participant did not submit the required recertification paperwork timely. By overriding the closed case, the participant received benefits for ineligible periods for total known questioned costs of $2,694 and likely questioned costs greater than $10,000 in the population. Federal regulation 7 CFR section 273.10(a)(2) states that if a participant submits an application after the certification period has expired, that application shall be considered an initial application and benefits for that month shall be prorated.
- In addition, sufficient documentation was not present to support testing of system changes in accordance with Department standard procedures. These standard procedures require a minimum of performance testing, functional testing, and user acceptance testing for major and minor releases. While evidence was present that some testing was performed on fixes to system defects, there was no evidence that user acceptance testing was performed. Changes that are not thoroughly tested can potentially result in improper system functionality, which could cause noncompliance with federal regulations.

Federal Award Information: This finding affects the Supplemental Nutritional Assistance Program for the federal fiscal year ended September 30, 2013.

Recommendation: The Department should (1) follow up on the known cases with incorrect certification periods and take appropriate action; (2) establish internal controls to identify system overrides and determine the effect on case eligibility; and (3) ensure that user acceptance testing is performed and specifically documented before system changes are put into production.

Department Response: The Department has initiated the following actions:

1. The majority of the cases identified with incorrect certification periods were converted from the legacy Food Stamp Information System. As of December 6, 2013, the cases identified with incorrect certification periods were corrected and clients were mailed recertification forms. In addition, a hard stop validation edit was added to the system to prevent workers from extending the certification period beyond 12 months for regular Food Nutrition Service.

2. Based on the results of the evaluation, the appropriate change requirements will be submitted to North Carolina Families Accessing Services through Technology (NC FAST) to ensure system controls are in place to identify system overrides and the effect on case eligibility. The ability to reopen a case was designed in the system based on the business requirement to provide a method to reopen a closed case unit. The Department will evaluate the reopen process.
3. NC FAST program has defined User Acceptance Procedures (UAT) in place that included business stakeholder acceptance before any system change can be released into production. NC FAST has implemented additional steps based on these findings to clearly provide documented business stakeholder approval.

CFDA 84.126 – REHABILITATION SERVICES – VOCATIONAL REHABILITATION GRANTS TO STATES

3. ERRORS IN CLAIMS PAYMENT PROCESS

The Department made payments on behalf of Rehabilitation Services – Vocational Rehabilitation Grants to States (VR) program participants that did not comply with activities allowed and allowable costs requirements for the program. The Department erroneously made net overpayments totaling $2,623, resulting in questioned costs of $2,064, 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 VR program through two different divisions – the Division of Vocational Rehabilitation Services and the Division of Services for the Blind. We examined a sample of 100 participant claims across both divisions and identified 28 claims that were paid in error or were not sufficiently documented. Examples of the deficiencies noted include:

- Comparable benefits were not appropriately verified and/or applied.
- Payments were made using incorrect methodology for payment or pricing.
- Insufficient documentation was maintained in support of the services rendered.

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 the Rehabilitation Services - Vocational Rehabilitation Grants to States federal grant awards H126A110049, H126A120049, H126A130049, H126A111050, H126A120050, and H126A130050 for the federal fiscal years ended September 30, 2011 to 2013.

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.

Further, identified over or underpaid claims should be followed up for timely and appropriate collection or payment.

Department Response: The Department will continue to enhance its control procedures to ensure that all claims are documented, processed, and paid properly. Additional efforts are being made within the Department to ensure the payment tables reflect updated medical rates in the legacy claims processing system.

The Department will continue efforts to implement a replacement claims processing system, BEAM, that will improve accuracy and eliminate errors that are attributed to an 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 documented and authorized in the participants' plan before payments are issued.

In addition, collections and/or payments of the identified over and underpaid claims will be made timely and appropriately if substantiated.

4. DEFICIENCIES IN PARTICIPANT ELIGIBILITY DETERMINATIONS

The Department did not always adequately document participant eligibility determinations for the Rehabilitation Services – Vocational Rehabilitation Grant to States (VR) program, nor did it always determine eligibility timely. As a result, there was an increased risk of noncompliance related to participant eligibility.

The Department administers the VR program through two different divisions – the Division of Vocational Rehabilitation Services and the Division of Services for the Blind. We examined a sample of 100 participant files across both divisions and identified deficiencies for 39 participant files. Examples of the deficiencies noted included:

- Untimely eligibility determinations and/or the agreed upon extension of time for making those determinations.
- Lack of required signatures on the participant's application.
- Insufficient or improper eligibility documentation.
- Information used to determine financial need was not always verified.

In addition, the Department did not consistently demonstrate that it verified the participant's identity and ability to legally work. This lack of sufficient control procedures could result in ineligible participants receiving benefits.

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

Similar aspects of this finding were reported in previous years.

Federal Award Information: This finding affects the Rehabilitation Services - Vocational Rehabilitation Grants to States federal grant awards H126A110049, H126A120049, H126A130049, H126A111050, H126A120050, and H126A130050 for the federal fiscal years ended September 30, 2011 to 2013.

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

Department Response: The Department will investigate the case files identified as deficient and appropriately resolve them if substantiated.

The Department will continue efforts to strengthen internal controls to ensure that eligibility determination is made within required timeframes and all applicable eligibility information is maintained in files including evidence of required signatures. In addition, Division management will have greater accountability in monitoring the timeliness of eligibility requirements through system generated reports. During random site visits, Quality Assurance staff will conduct internal reviews focusing on the timeliness of eligibility decisions, review for applicable parent consent signatures and required eligibility documentation maintained in the case files.

The Department will implement a replacement case management system with built-in controls that will ensure eligibility forms are completed in accordance with policy and within the required timeframes.

CFDA 93.659 – ADOPTION ASSISTANCE – TITLE IV-E

5. DEFICIENCY IN SUBRECIPIENT MONITORING

The Department did not consistently complete monitoring checklists designed to verify that accurate eligibility determinations for the Adoption Assistance Title IV-E program were made at the county level. Inadequate monitoring of eligibility could result in

Adoption Assistance funds being used for children that do not meet program requirements.

We reviewed documentation of monitoring visits performed at seven counties and found that key questions related to eligibility were not answered for three of the 35 children tested. However, the monitor concluded that these children were eligible for the Adoption Assistance Title IV-E program.

OMB Circular A-133 requires pass-through entities to monitor the activities of subrecipients as necessary to ensure that federal awards are used for authorized purposes in compliance with laws, regulations, and the provisions of grant agreements. The State authorizes the counties to determine eligibility of the Adoption Assistance Title IV-E program. This monitoring should include ensuring that eligibility determinations made by the counties are adequate and made within the requirements imposed by the federal regulations for the program.

Federal Award Information: This finding affects Adoption Assistance – Title IV-E federal grant award 1301NC1407 for the federal fiscal year ended September 30, 2013.

Recommendation: The Department should ensure that the Adoption Assistance monitoring tools be completed for each child to document federal eligibility requirements. The monitoring tools should be reviewed prior to sending the results to the county to ensure the documentation matches the conclusion.

Department Response: The Department will identify an independent existing position to assume the responsibility of providing quality assurance for the eligibility monitoring process. All monitoring tools will be reviewed to ensure they are complete and adequately documented to support the federal eligibility requirements prior to sending results to the county departments of social services.

MEDICAID CLUSTER

6. ERRORS IN PROVIDER BILLING AND PAYMENT PROCESS

The Department made payments on behalf of program participants that did not comply with federal activities allowed or allowable cost requirements for the Medicaid Program. The Department erroneously made net overpayments of $439,851 to Medicaid providers, resulting in questioned costs of $287,925, which represents the federal share of the overpayments.

We examined a sample of 280 Medicaid claims and identified 65 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 policy, improper billing of services by providers, payment methodologies or rates that were inconsistent with the effective state

plan or policies, 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 were related to medical record documentation to support services provided and charges incurred, which is the providers' responsibility to maintain.

Federal regulation requires allowable costs to be adequately documented and program costs to be necessary and reasonable for proper and efficient administration of the program. Federal regulations also require that medical records disclose the extent of services provided to Medicaid participants.

Similar aspects of this finding were reported in previous years.

Federal Award Information: This finding affects Medical Assistance Program federal grant awards 05-1205NC5MAP and 05-1305NC5MAP for the federal fiscal years ended September 30, 2012 and 2013, 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.

Further, identified over and underpaid claims should be followed up for timely and appropriate collection or payment.

Department Response: The Department understands that the sample of claims reviewed were processed by the legacy MMIS system that was replaced effective July 1, 2013.

The Department's Division of Medical Assistance (DMA) will investigate the sixty-five (65) claims cited to determine which claims were paid in error and which claims can be resolved by obtaining additional documentation from providers. DMA will also follow-up on any over and underpaid claims to ensure appropriate collection or payment is made.

DMA will enhance its efforts to educate providers about proper documentation to support the medical necessity and coding of services billed to Medicaid. DMA will implement a training module for providers to ensure proper coding and required documentation. DMA will provide ongoing communication via Medicaid Bulletins and other communication venues to enhance education and training.

DMA will evaluate proposed amendments to G.S. 108C to strengthen requirements for providers to submit documentation to support medical necessity and coding of services billed to Medicaid.

7. DEFICIENCIES IN THE ELIGIBILITY SYSTEM INTERFACE PROCESS

The Department did not monitor the conversion of private insurance data in the Medicaid eligibility system to the Medicaid claims processing system. As a result, there was an increased risk that the Medicaid program paid claims for recipients that should have been covered by other insurance. However, only two of the 280 Medicaid claims we examined did not have updated private insurance coverage.

North Carolina's federally-approved Medicaid plan requires that the Medicaid program be the "payer of last resort" in all cases that involve 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 daily. The Department maintains responsibility for monitoring and correcting errors in the interface; however, the interface procedures do not include a review of private insurance data. Errors could include failure to identify data that was previously interfaced from the eligibility system and subsequently deleted, which would prevent the policies from transferring during the interface. The interface procedures reviewed were for the two legacy systems that are scheduled to be replaced in the subsequent state fiscal year.

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

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

Federal Award Information: This finding affects Medical Assistance Program federal grant awards 05-1205NC5MAP and 05-1305NC5MAP for the federal fiscal years ended September 30, 2012 and 2013, respectively.

Recommendation: The Department should ensure that interface monitoring procedures are developed for the new eligiblity system and claims processing system to ensure errors are identified and corrected in a timely manner.

Department Response: As noted above, the sample of claims reviewed were processed by the legacy MMIS system that was replaced effective July 1, 2013.

The Department will review the process by which private insurance data is transferred from the eligibility system to the claims processing system. The Department will document the measures taken to ensure that the data is reviewed on an on-going basis and that Medicaid is the payer of last resort.

8. MEDICAID DISPROPORTIONATE SHARE HOSPITAL PAYMENTS MADE INCORRECTLY

The Department made disproportionate share hospital (DSH) payments that were not in accordance with approved methodologies and calculations. This resulted in payment errors to individual hospitals.

Medicaid disproportionate share hospital payments provide financial assistance to hospitals that serve a large number of low-income patients, such as people with Medicaid and the uninsured. We noted deficiencies in the overall DSH calculations and individual hospital payment amounts. The deficiencies found included:

- An incorrect payment was made for uncompensated care DSH expenditures caused by an update in information that was not properly included in the calculation of payments. This resulted in an overpayment of $3,768, with resulting questioned costs of $2,243, which represents the federal share of the overpayment.
- Incorrect payments of various types of DSH expenditures were noted for 15 hospitals. The payment errors were caused by an incorrect calculation in the distribution of funds, the exclusion of one hospital that became eligible, and not updating a change in status for another hospital. These errors resulted in hospitals receiving under and overpayments of funds. The net impact is an underpayment of $89,515.

OMB Circular A-87 requires that to be allowable under a grant program, costs must be adequately documented and consistent with policies, regulations, and the state plan.

Federal Award Information: This finding affects Medical Assistance Program federal grant awards 05-1205NC5MAP and 05-1305NC5MAP for the federal fiscal years ended September 30, 2012 and 2013, respectively.

Recommendation: The Department should enhance procedures to identify incorrect payments and review hospital documentation in a timely manner and correct the payment calculations accordingly. Identified over and underpaid amounts should be followed up for timely and appropriate collection or payment.

Department Response: The Department's Division of Medical Assistance (DMA) reviewed issues identified during the audit for the State Fiscal Year (SFY) 2013 DSH model and made the appropriate corrections during the first quarter of SFY 2014.

DMA will enhance current procedures as necessary to ensure that hospital documentation is reviewed timely and ensure accurate DSH calculations and payments. The DSH model will be reviewed periodically and adjusted as necessary.

9. DEFICIENCIES WITH PROGRAM INTEGRITY FUNCTIONS

The Department did not adequately track and review case investigations. These deficiencies could result in failures in completing case investigations, reaching accurate conclusions, identifing provider overpayments, and referring potentially fraudulent cases to the Attorney General's Medicaid Investigations Unit.

The Department's Program Integrity Unit is charged with ensuring compliance, efficiency and accountability for 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. All cases identified as potentially fraudulent are referred to the Attorney General's Medicaid Investigations Unit for further investigation.

The Program Integrity Unit uses a case tracking database to document case investigations. The database includes when a case is opened, referred, closed, and case results. Program Integrity staff does not consistently update the database for each individual case status, particularly for cases that were closed when an investigation was not initiated and for cases referred to the Attorney General's Medicaid Investigations Unit.

We selected a sample of 60 case files identified as closed and noted six cases that did not have proper supervisory review as required by Departmental policy. These cases were completed by a contracted vendor and were related to investigations of claim payments for services provided after the death of a recipient.

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

Federal Award Information: This finding affects Medical Assistance Program federal grant awards 05-1205NC5MAP and 05-1305NC5MAP for the federal fiscal years ended September 30, 2012 and 2013, respectively.

Recommendation: The Department should review procedures and computer systems to enhance the tracking of case investigations. In addition, the Department should ensure that review procedures are consistently applied.

Department Response: The Department's Division of Medical Assistance's Program Integrity Unit (PI) will review its case tracking database procedures with staff to ensure accurate tracking of case investigations. In addition, PI will continue to conduct monthly quality assurance reviews of case tracking. The existing case tracking system will be upgraded to allow for more comprehensive tracking of cases and reporting.

10. DEFICIENCIES IN PROVIDER ENROLLMENT AND TERMINATION PROCESSES

The Department did not have sufficient policies and procedures in place to ensure the accuracy and completeness of the Medicaid provider enrollment and termination

processes administered by a contracted service provider. These issues increase 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.

Our review of 60 group and individual provider files noted that the contract service provider did not consistently acquire and/or maintain all required information necessary to document the eligibility determination for provider-applicants of Medicaid services for five providers.

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 licensing actions, we noted exceptions in which the provider was not properly terminated from the Medicaid program. There were four 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.

Similar aspects of this finding were reported in previous years.

Federal Award Information: This finding affects Medical Assistance Program federal grant awards 05-1205NC5MAP and 05-1305NC5MAP for the federal fiscal years ended September 30, 2012 and 2013, 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 and provider files are maintained.

Department Response: The Department will investigate the errors noted by the auditors to determine the potential root causes. The Department will continue to implement monitoring controls over Medicaid provider enrollment and termination processes utilized by the service provider to ensure that only eligible providers are allowed to participate in the Medicaid Program.

CFDA 93.767 CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

11. 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 $1,358 to medical providers, resulting in questioned costs of $1,030, 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 28 claims that were paid in error or were not sufficiently documented. Examples of the deficiencies noted include lack of sufficient documentation to support billed services, payment for ineligible participants due to misclassification within the eligibility category, payment methodology was inconsistent with the effective state plan or policies, payment based on the incorrect rate for the claim date of service, provider not providing documentation to support services rendered, and insufficient signatures on medical documentation. The majority of the errors were related to the payment of claims based on incorrect rates and payment methodologies, which is the responsibility of the Department to ensure an accurate claims payment process.

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 05-1205NC5021 and 05-1305NC5021 for the federal fiscal years ended September 30, 2012 and 2013, 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.

Further, identified overpaid claims should be followed up for timely and appropriate collection or payment.

Department Response: The Department understands that the sample of claims reviewed were processed by the legacy MMIS system that was replaced effective July 1, 2013. The Department's Division of Medical Assistance (DMA) will investigate the twenty-eight (28) claims cited to determine which claims were paid in error and which claims can be resolved by obtaining additional documentation from providers. DMA will also follow-up on any over and underpaid claims to ensure appropriate collection or payment is made.

The Division of Medical Assistance (DMA) will enhance its efforts to educate providers about proper documentation to support the medical necessity and coding of services billed to Children's Health Insurance Program. DMA will implement a training module for providers to ensure proper coding and required documentation. DMA will provide ongoing communication via Medicaid Bulletins and other communication venues to enhance the education and training.

DMA will evaluate proposed amendments to G.S. 108C to strengthen requirements for providers to submit documentation to support medical necessity and coding of services billed to Children's Health Insurance Program.

CFDA 93.917 – HIV CARE FORMULA GRANTS

12. UNTIMELY USE OF REBATES

The Department did not ensure that rebate funds for the HIV CARE Formula grant were used in accordance with federal requirements. Federal regulations require that grantees disburse rebates before requesting additional cash payments from the federal awarding agency.

The Department did not consistently use the rebate funds prior to requesting additional federal funds from the federal awarding agency. The Department accumulated $4.6 million in drug rebate funds from July 2012 to May 2013 before disbursing the funds in June 2013.

Federal Award Information: This finding affects HIV CARE Formula federal grant awards 12X07HA00051-22-00 and 12X07HA00051-23-00 for fiscal years ended March 31, 2013 and 2014, respectively.

Recommendation: The Department should ensure rebate funds are used in accordance with program regulations prior to requesting additional federal funds from the federal awarding agency.

Department Response: Effective March 1, 2014, the Department implemented procedures to ensure appropriate disbursement of rebates. Upon receipt of drug invoices, budget staff determines the availability of rebates as reflected in the North Carolina Accounting System (NCAS). If available, rebates are used for disbursements prior to the use of federal funds.

13. DEFICIENCIES IN ELIGIBILITY DETERMINATIONS

The Department did not adequately determine 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 $23,212 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 identified seven participant cases in a sample of 60 where the participants were enrolled in Medicaid during the authorization period and should have been removed from the HIV CARE Formula program. The evaluation of Medicaid participation occurs during the intake process and no further verification is performed thereafter.

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

Federal Award Information: This finding affects HIV CARE Formula federal grant awards 12X07HA00051-22-00 and 12X07HA00051-23-00 for fiscal years ended March 31, 2013 and 2014, respectively.

Recommendation: The Department should implement procedures to periodically verify Medicaid participation and enhance communication between divisions to ensure only eligible participants receive services.

Department Response: The Department will continue to conduct a quarterly, random sampling of records to assure that all required information is maintained in client files until the Division of Public Health and the Division of Medical Assistance have implemented a process to ensure that participants eligible for Medicaid will not receive treatments funded by the HIV CARE Formula Grant. The amount of any questioned costs will be verified and repaid to the federal agency as appropriate.

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

14. 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) 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.

- The Department is not properly completing monitoring tools during the LME annual systems reviews. We reviewed 134 monitoring tools and identified 11 that were incomplete or improperly completed. Questions related to eligibility criteria were not answered by the monitor.

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 2B08TI010032-12 and 2B08TI010032-13 for the federal fiscal years ended September 30, 2012 and 2013, 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 develop and implement procedures to review monitoring tools to ensure they are properly completed.

Department Response: The Department revised its Local Management Entities (LMEs) / Managed Care Organizations (MCOs) fiscal monitoring procedures and guidelines for conducting settlement reviews effective January 2014 to include the requirement for a corrective action plan for all deficiencies found during the LME / MCO fiscal settlement reviews. The process followed will be in accordance with the procedures and timelines in the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) Plan of Correction policy, http://www.ncdhhs.gov/mhddsas/providers/POC/poc-policy.pdf.

Staff has been informed to complete each item on all monitoring tools regardless of the eligibility criteria previously determined. In addition, the Department will implement an electronic audit tool to require monitoring worksheets to be completed before the related question on the tool will automatically rate criteria as Met or Not Met.

15. NONCOMPLIANCE WITH DUNS NUMBER REQUIREMENT

The Department did not obtain Dun and Bradstreet Data Universal Numbering System (DUNS) numbers from subrecipients of the Block Grants for Prevention and Treatment of

Substance Abuse program prior to the issuance of subawards, as required by federal regulations. After our inquiry, the Department requested subrecipients to provide DUNS numbers. Our testwork verified that the DUNS numbers provided were valid.

Federal regulations (Title 2 CFR section 25.200) 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.

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

Federal Award Information: This finding affects Block Grants for Prevention and Treatment of Substance Abuse federal grant awards 2B08TI010032-12 and 2B08TI010032-13 for the federal fiscal years ended September 30, 2012 and 2013, respectively.

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

Department Response: Effective June 1, 2013, the Department amended all LME / MCO contracts, with the exception of one, to include the requirement to obtain a valid DUNS number prior to the time of sub-award. The contract amendment between the one remaining contract and DMH/DD/SAS is currently in negotiation. The Department will continue to include the DUNS number requirement in all contracts entered into with the LME / MCOs in subsequent periods.

ORDERING INFORMATION

Copies of this report may be obtained by contacting the:

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For additional information contact:
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919-807-7513

This audit required 13,244 audit hours at an approximate cost of $1,006,544.