State of North Carolina

Office of The State Auditor

Beth A. Wood, CPA

North Carolina Department of Health and Human Services

Raleigh, North Carolina

Statewide Federal Compliance Audit Procedures

For the Year Ended June 30, 2015

NC OSA

The Taxpayers' Watchdog

STATE OF NORTH CAROLINA
Office of the State Auditor

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AUDITOR'S TRANSMITTAL

The Honorable Pat McCrory, Governor
Members of the North Carolina General Assembly
Mr. Richard O. Brajer, 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, 2015. We conducted our audit in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Governmental 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 was performed by authority of Article 5A of Chapter 147 of the *North Carolina General Statutes*.

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 in this 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*, these findings are reported in the State's *Single Audit Report*.

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

Beth A. Wood, CPA
State Auditor

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Article V, Chapter 147 of the North Carolina General Statutes, gives the Auditor broad powers to examine all books, records, files, papers, documents, and financial affairs of every state agency and any organization that receives public funding. The Auditor also has the power to summon people to produce records and to answer questions under oath.

INDEPENDENT AUDITOR'S REPORT

STATE OF NORTH CAROLINA
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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

Richard Brajer, 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, 2015, we have performed audit procedures at the North Carolina Department of Health and Human Services. Our report on the State of North Carolina's compliance with requirements that could have a direct and material effect on each major program and on internal control over compliance in accordance with OMB Circular A-133 is included in the State's *Single Audit Report*. Our federal compliance audit scope at the North Carolina Department of Health and Human Services included the following:

- SNAP Cluster:
  - CFDA 10.551 – Supplemental Nutrition Assistance Program (SNAP)
  - CFDA 10.561 – State Administrative Matching Grants for the Supplemental Nutrition Assistance Program
- CFDA 10.557 – Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)
- CFDA 10.558 – Child and Adult Care Food Program (CACFP)
- CFDA 84.126 – Rehabilitation Services – Vocational Rehabilitation Grants to States
- Aging Cluster:
  - CFDA 93.044 – Special Programs for the Aging – Title III, Part B – Grants for Supportive Services and Senior Centers
  - CFDA 93.045 – Special Programs for the Aging – Title III, Part C – Nutrition Services
  - CFDA 93.053 – Nutrition Services Incentive Program

- CFDA 93.074 – Hospital Preparedness Program (HPP) and Public Health Emergency Preparedness (PHEP) Aligned Cooperative Agreements:
    - CFDA 93.069 – Public Health Emergency Preparedness
    - CFDA 93.889 – National Bioterrorism Hospital Preparedness Program
- CFDA 93.268 – Immunization Cooperative Agreements
- 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 93.563 – Child Support Enforcement
- CFDA 93.659 – Adoption Assistance – Title IV-E
- Medicaid Cluster:
    - CFDA 93.775 – State Medicaid Fraud Control Units
    - CFDA 93.777 – State Survey and Certification and 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

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*. The State of North Carolina arranges with local government social services agencies to perform the "intake function" to determine eligibility for the following major programs: Medicaid Cluster, Temporary Assistance for Needy Families Cluster, Special Supplemental Nutrition Program for Women, Infants and Children, Children's Health Insurance Program, and Adoption Assistance. Local government auditors audited the eligibility determination "intake function" for these major programs at the local government level. The results of these audits were furnished to us, and our opinion, insofar as it relates to the "intake function" for these programs, is based on the other auditors' results.

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 4-5, 10, 15, 17-20, 23-25, 27, and 29-33 in the Findings, Recommendations, 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, as described in the accompanying Findings, Recommendations, and Responses section, we identified certain deficiencies in internal control that we consider to be material weaknesses and significant deficiencies. We consider the deficiencies described in findings 1, 10, 13, 15, 18, 20, 23-25, 27, 29-30, and 32-33 in the Findings, Recommendations, and Responses section of this report to be material weaknesses in internal control over compliance. Furthermore, we consider the deficiencies described in findings 2-9, 11-12, 14, 16-17, 19, 21-22, 26, 28, 31, and 34-35 in the Findings, Recommendations, and Responses section of this report to be significant deficiencies in internal control over compliance.

Reporting Sensitive Information

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.

North Carolina Department of Health and Human Services' Response to Findings

The Department's responses to the findings identified in our audit are included in the Findings, Recommendations, and Responses section of this report. The Department's 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.

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.

Beth A. Wood, CPA
State Auditor

Raleigh, North Carolina

March 28, 2016

FINDINGS, RECOMMENDATIONS, AND RESPONSES

Matters Related to Federal Compliance Audit Objectives

The following audit findings were identified during the current audit and describe conditions that represent deficiencies in internal control or noncompliance with laws, regulations, contracts, grant agreements, or other matters. Finding numbers 1, 3-4, 6, 9-11, 17, 19-21, 23-27, 29, and 31-35 were also reported in the prior year or multiple previous years.

1. MANAGEMENT DID NOT TAKE FULL CORRECTIVE ACTION ON PRIOR RECOMMENDATIONS

   The Department of Health and Human Services (Department) management did not take full corrective action on prior year audit findings for three major federal programs audited for the current fiscal year ended June 30, 2015.

   Because management did not implement full corrective action, the following are findings in the current year:

   ### Rehabilitation Services - Vocational Rehabilitation Grants to States

   Errors in Claims Payment Process – The Department made payments to providers that did not comply with federal cost requirements for the program. As described in current year finding #10, audit tests indicated a continuation in payment errors.

   Deficiencies in Participant Eligibility Determinations – The Department did not maintain documentation to support accurate and timely eligibility determinations for the program. As described in current year finding #11, audit tests indicated a continuation in documentation errors.

   ### Medical Assistance Program

   Deficiencies in Provider Enrollment and Termination Processes – The Department continued to inadequately monitor the contracted service provider to ensure eligible medical providers are enrolled and ineligible providers are terminated from the program. As described in current year finding #24, audit tests indicated an increase in enrollment and termination errors.

   ### Block Grants For Prevention and Treatment of Substance Abuse

   Monitoring Procedures Need Improvement – As described in current year finding #35, the Department did not ensure Local Management Entities and Managed Care Organizations complied with applicable laws and regulations.

   Failure to implement corrective action in a timely way to ensure compliance allows federal funds to potentially be used for unallowable expenditures.

   Although the Department identified corrective action plans to address these deficiencies in prior years, management did not follow through to ensure corrective actions were taken.

   OMB Circular A-133 section .300 states that auditees are responsible for following up and taking corrective action on audit findings.

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

Federal Award Information: This finding affects the following programs and awards:

CFDA #84.126 – Rehabilitation Services - Vocational Rehabilitation Grants to States

This finding affects federal grant awards H126A130049, H126A130050, H126A140049, and H126A140050 for the federal fiscal years ended September 30, 2013, and 2014, respectively.

CFDA #93.778 – Medical Assistance Program

This finding affects federal grant awards 05-1305NC5MAP and 05-1405NC5MAP for the federal fiscal years ended September 30, 2013, and 2014, respectively.

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

This finding affects federal grant awards TI010032-13 and TI010032-14 for the federal fiscal years ended September 30, 2013, and 2014, respectively.

Recommendation: The Department should ensure corrective action plans are finalized by planned completion dates.

Agency Response: See the related Department responses for findings 10, 11, 24 & 35.

2. MANAGEMENT DECISIONS WERE NOT COMMUNICATED TIMELY

The Department did not communicate management decisions[1] to subrecipients (in response to audit results) in a timely manner.

Auditors reviewed a sample of 28 annual subrecipient audit reports for the 138 governmental entities to which the Department passes through federal funds. The auditors found the following:

- For nine of the 28 (32%) subrecipient audit reports reviewed, management decisions were issued between 29 and 121 days late.
- For two of the 28 (7%) subrecipient audit reports reviewed, management decisions had not been issued at the time of audit.

[1] Management decisions clearly communicate to subrecipients whether or not the results of the audit are sustained, the reasons for the decision, and the expected subrecipient action (i.e. repay disallowed costs, make financial adjustments, or other actions).

The failure to issue a management decision on the results of the audit in a timely manner increases the risk that corrective actions will not be initiated timely by the subrecipient, including requirements to repay disallowed costs, make financial adjustments or meet other grant requirements. Delaying the implementation of the management decision increases the risk of further instances in noncompliance and allows the possible misuse of funds to continue.

According to the Department, at the end of fiscal year 2015, they underwent a significant reorganization. In preparation for and during the transition, resources were shifted and priority was not given to communicating management decisions.

Federal regulations[2] require pass-through entities to issue a management decision on the results of the subrecipient's audit within 6 months of receipt of the audit report.

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

- 10.551 – Supplemental Nutrition Assistance Program
- 10.561 – State Administrative Matching Grants for the Supplemental Nutrition Assistance Program
- 10.557 – Special Supplemental Nutrition Program for Women, Infants, and Children
- 93.044 – Special Programs for the Aging Title III, Part B Grants for Supportive Services and Senior Centers
- 93.045 – Special Programs for the Aging Title III, Part C Nutrition Services
- 93.053 – Nutrition Services Incentive Program
- 93.268 – Immunization Cooperative Agreements
- 93.558 – Temporary Assistance for Needy Families
- 93.563 – Child Support Enforcement
- 93.659 – Adoption Assistance
- 93.714 – ARRA – Emergency Contingency Fund for Temporary Assistance for Needy Families (TANF) State Program
- 93.767 – Children's Health Insurance Program
- 93.778 – Medical Assistance Program
- 93.959 – Block Grants for Prevention and Treatment of Substance Abuse

Recommendation: The Department should assure that priority is given to communicating management decisions timely to subrecipients.

Agency Response: The Department agrees with the finding and will ensure management decision letters are issued in a timely manner.

[2] OMB Circular A-133 Subpart D section 405(d)

SNAP CLUSTER – SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM

3. SNAP ELIGIBILITY DETERMINATIONS AND BENEFIT CALCULATIONS NOT PERFORMED ACCURATELY

The Department had numerous deficiencies in the Supplemental Nutrition Assistance Program (SNAP) eligibility determination and benefit calculation processes. During state fiscal year 2015, the SNAP eligibility system (NC FAST) processed $2.4 billion for 1.2 million households. The net underpayments identified were $4,672.

During the audit, auditors identified the following errors in the eligibility determination and benefit calculation process:

- In 21 out of 294 (7%) cases[3] the eligibility system did not calculate income or deductions correctly. These errors resulted in net underpayments of $4,672.

  The 21 cases contained the following types of errors in the components used to calculate benefit amounts, with some cases having multiple types of errors:

  - In 10 cases, the shelter deduction[4] was not calculated correctly.
  - In three cases, the household composition was incorrect. Two cases did not include all eligible participants. One case included an ineligible participant.
  - In three cases, the participant benefits were not updated to include the new federal rates effective October 1, 2014.
  - In three cases, the incorrect household income was used in the benefit calculation. Two cases did not use the updated income as shown in the system. In one case, the system counted the income twice.
  - In two cases, the system did not correctly calculate the prorated amount for participants in their first month of benefits.
  - In addition, auditors also noted that in four cases, the system showed documentation had been deleted from the case. Without the documentation, the auditors were unable to verify the accuracy of eligibility and benefit system calculations.
- In 12 out of 227 (5%) households, notices were not sent to participants communicating major changes in their case status such as eligibility or benefit calculations.
- The auditors performed a system validation test and determined that the eligibility system does not deny benefits to secondary education students when they do not meet the federal work requirements. Specifically, the auditors entered hours less than the federal requirement into a test environment and validated that the system did not deny eligibility.

[3] Cases represent individual households. The household could have multiple cases throughout the year.

[4] Shelter deduction is the calculation of expense related to your home used to offset income. Expenses include rent, mortgage, utilities, telephone, and taxes.

As a result, the Department made improper payments to households which could result in eligible participants not receiving the necessary amount of nutrition assistance. Additionally, the Department could incur additional administrative costs to reprocess the benefit underpayments and in determining improper payments made to secondary education students.

According to the Department, the issues were caused by processing errors in the eligibility system that were not detected. Also, case workers deleted information from the eligibility system that prevented auditors from determining the accuracy of the eligibility and benefit system calculations.

Federal regulations[5] require state agencies to maintain an efficient and effective food stamp system. State agencies are also required to determine household eligibility and benefit levels accurately. This determination should include all federally required criteria including, but not limited to specific household income and deductions, household composition, and new federal rates.

Federal regulations for the SNAP program also include the following:

- Federal regulations require[6] the eligibility system to "notify the certification unit (or generate notices to households) of cases requiring Notices of (A) Case Disposition, (B) Adverse Action and Mass Change, and (C) Expiration."
- Federal regulations[7] require students to "be employed for a minimum of 20 hours per week and be paid for such employment or, if self-employed, be employed for a minimum of 20 hours per week and receiving weekly earnings at least equal to the Federal minimum wage multiplied by 20 hours" or meet qualified exemptions to be eligible for the SNAP program.

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

Federal Award Information: This finding affects the Supplemental Nutrition Assistance Program for the federal fiscal years ended September 30, 2014, and September 30, 2015.

Recommendations: The Department should implement system enhancements to ensure the eligibility system is accurately processing and calculating household eligibility and participant benefits.

The Department should prohibit case workers from deleting information that was used in system calculations.

The Department should also ensure notices are properly sent to participants.

[5] 7 CFR 273.9, 7 CFR 273.10, 7 CFR 272.10, and 7 CFR 273.12

[6] 7 CFR 272.10(b)(1)(iv)

[7] 7 CFR 273.5(b)(5)

Agency Response: The Department is committed to administering the SNAP program in accordance with Federal requirements and State. The Department reviewed all 21 cases noted and agrees that 16 of the cases contained errors, though not all errors were caused by the system as indicated. The Department agrees that errors in shelter deduction amounts were noted for 10 cases, participant benefits were not calculated on new rates for 3 cases, prorated amounts were incorrect for 2 cases and 1 case contained an error in the household composition. Additional documentation was available in the system to determine the Department's disagreement with the 2 household composition and 3 household income errors noted.

Additionally, the Department agrees that evidence was mistakenly deleted for 4 cases, notices were not sent to 12 households and benefits were not denied for secondary education students who did not meet Federal work requirements.

The Department will take appropriate action to reduce the opportunity for the errors to reoccur.

4. CHANGES MADE TO CASES RESULT IN PAYMENTS MADE OUTSIDE OF CERTIFICATION PERIOD

The Department did not discontinue Supplemental Nutrition Assistance Program (SNAP) benefit payments to participants after the end of their certification period. During state fiscal year 2015, the SNAP eligibility system (NC FAST) processed $2.4 billion in SNAP benefit payments for 1.2 million households.

Auditors identified the following errors:

Auditors reviewed a sample of 117 out of 2,076 cases[8] where participants received a payment subsequent to their certification period. Six (5%) of the cases received benefits after the case was closed. Total questioned costs were $1,102.

In addition, auditors reviewed a sample of 72 out of 44,911 cases that changed from a closed status to another status[9]. Three (4%) closed cases were reopened by case workers. Two cases resulted in payments for ineligible periods and one case resulted in an underpayment. Total questioned costs were $221.

As a result, the Department made at least $1,323 of benefit overpayments to households, increasing the overall costs to the program. If tests were extended to the entire population, questioned costs could be significant to the program.

Case workers are allowed to manually close and reopen closed cases, but no review is performed to ensure that the changes are appropriate.

[8] Cases represent individual households. The household could have multiple cases throughout the year.

[9] Cases status types include, but are not limited to Active, Approved, Open, etc.

Federal regulations[10] require the eligibility system to "Provide for an automatic cutoff of participation for households which have not been recertified at the end of their certification period."

In addition, federal regulations[11] also state that "If a household submits an application after the household's certification period has expired, that application shall be considered an initial application and benefits for that month shall be prorated." Cases should not be reopened in these instances.

Similar aspects of this finding were reported in previous years.

Federal Award Information: This finding affects the Supplemental Nutrition Assistance Program for the federal fiscal years ended September 30, 2014, and September 30, 2015.

Recommendation: The Department should develop a review process to ensure cases that change from a closed status are reopened appropriately.

Agency Response: The Department is committed to administering the SNAP program in accordance with Federal requirements and State policy and very pleased to report significant progress in this area. Accordingly, the Department is pleased to note that while similar aspects of this finding were reported in the prior year, the error rate for inappropriately re-opened cases dropped from 10% for SFY2014 to 4% for this SFY2015 audit. Likewise, the error rate for payments made after a certification period declined significantly from 71% in SFY2014 to 5% for this SFY2015 audit.

The NC FAST system experienced a system processing error which caused the 6 pending payments to be held in transition. In an effort to deliver the benefits to the recipients in a timely manner, several workers closed the cases and generated new cases which processed payments properly and recipients received their benefits. Unfortunately, when the system processing error was resolved, the payments which were held in transition on the closed cases unexpectedly processed resulting in duplicate payments being issued. This error was identified prior to the audit review and efforts have been put in place to recoup the overpayments by reducing future benefit payment amounts. The payments appeared to be made subsequent to the certification period because the closed date on the previous case had to be set for the month prior to the certification period in order to rekey the case and issue the benefits timely.

The Department reviewed the 3 cases that were deemed to be reopened inappropriately and agrees that one of the cases was in fact reopened when it should not have been. A detailed review of the other 2 cases revealed that they were reopened in accordance with the Department's SNAP Policy Manual; however, workers did not clearly document the reason for reopening the cases.

[10] 7 CFR 272.10(b)(iii)
[11] 7 CFR 273.10(a)(2)

5. DUPLICATE PAYMENTS MADE TO SNAP PARTICIPANTS

The Department made duplicate payments to participants enrolled in the Supplemental Nutrition Assistance Program (SNAP) program. During the state fiscal year 2015, the SNAP eligibility system (NC FAST) processed $2.4 billion in SNAP benefit payments for 1.2 million households. The identified overpayments and questioned costs totaled $352,613.

In a week in April 2015, the Department encountered a system error resulting in a large volume of duplicate payments to recipents. Total questioned costs from these duplicate payments were $272,127.

In addition, auditors also identified the following:

- During the audit period, we identified 359 benefit payments where the participant received duplicate benefit payments for the same month on the same case[12]. Specifically, two of these cases received 12 authorizations for the same month. Total identified questioned costs were $80,331.
- In a sample of 74 out of 60,771 participants receiving benefits on two or more cases, auditors identified three errors where the cases overlapped from two days to one month. Total identified questioned costs were $155. Even though the sample results identified only $155 in questioned costs, if tests were extended to the entire population, questioned costs would likely exceed $10,000. Federal regulations[13] require auditors to report known questioned costs when likely questioned costs are greater than $10,000.

As a result, the Department made at least $352,613 of benefit overpayments to households, increasing the overall costs to the program.

According to the Department, it installed a software update in April 2015. After installation, the Department detected a system problem that resulted in a large number of duplicate payments. The Department immediately put in a system correction. Subsequent to the fiscal year end, the Department communicated the occurrence to the United States Department of Agriculture and has begun the process to recoup the overpayments. The process of identifying how many and who received overpayments plus the recoupment effort will cost the Department additional agency resources and administrative costs.

Additionally, the system did not have a process with preventive edit checks in place to detect duplicate payments before being issued to participants.

[12] Cases represent individual households. The household could have multiple cases throughout the year.
[13] OMB A-133 Section .510(a)(3)

Federal regulations[14], state "Each State agency shall establish a system to assure that no individual participates more than once in a month, in more than one jurisdiction, or in more than one household within the State in the Food Stamp Program. To identify such individuals, the system shall use names and social security numbers at a minimum, and other identifiers such as birth dates or addresses as appropriate. If the State agency detects a large number of duplicates, it shall implement other measures, such as more frequent checks or increased emphasis on prevention."

Federal Award Information: This finding affects the Supplemental Nutrition Assistance Program for the federal fiscal years ended September 30, 2014, and September 30, 2015.

Recommendations: The Department should implement system validations or edits to ensure that duplicate benefits are not provided for the same participant and/or the same period before issuing monthly benefits.

The Department should continue its efforts to recoup benefit overpayments.

Agency Response: The Department agrees with the finding and will implement an appropriate corrective action plan to meet the intent of the recommendations.

6. DEFICIENCIES IN SYSTEM ACCESS CONTROLS

The results of our audit disclosed deficiencies considered reportable under generally accepted *Government Auditing Standards*. These deficiencies regard security, which due to their sensitivity, are reported to the Department by separate sensitive letter. Pursuant to *North Carolina General Statute 132-6.1(c)*, the sensitive letter including your responses will not be publicly released.

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

Federal Award Information: This finding affects Supplemental Nutrition Assistance Program for federal fiscal years ended September 30, 2014, and September 30, 2015.

Agency Response: The Department is committed to maintaining adequate information security and system access controls. The Department has designed and/or implemented corrective actions to address the risks identified in this audit. These corrective actions have been detailed in a response separately submitted to the State Auditor. Security risks are given the highest priority by the Department and corrective actions will be monitored by senior leadership.

7. DEFICIENCIES IN NC FAST PROGRAM CHANGE CONTROLS

There were NC FAST change requests for the Supplemental Nutrition Assistance Program (SNAP) that did not have approvals before implementation. All NC FAST changes affecting compliance for the SNAP program were tested for evidence of approvals before implementation. Of the 31 changes, there were five (16%) that did not have evidence of the designated program expert's approval.

[14] 7 CFR 272.4 (e)(1)

Failure to approve changes before implementation could result in noncompliance with eligibility rules for the SNAP program. This could potentially adversely affect the outcomes to SNAP participants and/or payment of erroneous benefits.

The Department did not ensure that the program change approvals were being performed and documented.

The Statewide Information Security Manual, dated January 2015, standard 040405 states "adequate management of system change control processes shall require…proper authorization and approvals at all levels." The standard's guidelines include a best practice requiring formal agreements and approvals for any changes. Under standard 040203 software upgrades shall not be installed until the following conditions are met:

- "Qualified personnel certify that the upgrade has passed acceptance testing.
- Management has agreed that the desired acceptance criteria have been met."

Federal Award Information: This finding affects Supplemental Nutrition Assistance Program for federal fiscal years ended September 30, 2014, and September 30, 2015.

Recommendation: The Department should ensure that all NC FAST program changes have written documentation of business approval before implementation.

Agency Response: The Department is committed to maintaining compliance with program change control requirements as noted in the Statewide Information Security Manual. Adequate program change control procedures have been in place in the division. While division personnel consistently performed the required acceptance testing, the Department agrees that documentation of the approval was not always maintained. The Department will reemphasize the need and requirement to maintain adequate approval documentation.

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

8. DEFICIENCIES IN SYSTEM ACCESS CONTROLS

The results of our audit disclosed deficiencies considered reportable under generally accepted *Government Auditing Standards*. These deficiencies regard security, which due to their sensitivity, are reported to the Department by separate sensitive letter. Pursuant to *North Carolina General Statute 132-6.1(c)*, the sensitive letter including your responses will not be publicly released.

Federal Award Information: This finding affects the Special Supplemental Nutrition Program for Women, Infants, and Children federal grant award 5NC705W for the federal fiscal years ended September 30, 2014 and 2015.

Agency Response: The Department is committed to maintaining adequate information security and system access controls. The Department has designed and/or implemented corrective actions to address the risks identified in this audit. These corrective actions have been detailed in a response separately submitted to the State Auditor. Security risks are given the highest priority by the Department and corrective actions will be monitored by senior leadership.

CFDA 10.558 – CHILD AND ADULT CARE FOOD PROGRAM

9. MONITORING OF CHILD AND ADULT CARE FACILITIES HAD WEAKNESSES

The Department did not properly perform compliance reviews/monitoring over child and adult care facilities related to recordkeeping, meal counts, administrative costs, facility licensing, etc.[15]. During state fiscal year 2015, the Department paid $93.7 million to reimburse 729 facilities for providing healthy meals and snacks to children and adults receiving day care as a part of the Child and Adult Care Food Program (CACFP).

Auditors identified the following weaknesses in the monitoring of child and adult care facilities:

- 53 out of 79 (67%) review reports of seriously deficient[16] facilities were not reviewed by the Department. Facilities that are found to be seriously deficient require a quality review of the monitoring results to ensure that the monitoring was completed accurately.
- 12 out of 50 (24%) reviews that resulted in adjustments in the amount paid to the facility were not adjusted. The total amount of overpayments that were not adjusted was $1,620.
- 4 out of 729 (0.5%) facilities were not monitored by the Department on a three year rotation as required. One of these facilities has had no review since joining the program in fiscal year 2011.

Undetected or uncorrected noncompliance with federal guidelines could result in excess spending and increase the overall cost of the program.

According to the Department, all monitoring reviews were not performed because the annual monitoring schedule was not complete. The database used to generate annual monitoring schedules was not compared to the payments made to facilities to ensure all paid facilities were on the schedule.

Further, according to the Department, they had significant turnover. This resulted in the Department having limited ability to perform quality reviews of monitoring results or review documentation on which underpayments or overpayments would have been reported.

[15] See 7 CFR 226(m)(3) for a complete list of review content.

[16] Seriously deficient means the status of an institution or a day care home that has been determined to be non-compliant in one or more aspects of its operation of the Program (7 CFR 226(a)).

Federal regulations[17] state, "Independent centers and sponsoring organization of 1 to 100 facilities must be reviewed at least once every three years" and "new institutions that are sponsoring organizations of five or more facilities must be reviewed within the first 90 days of Program operations."

The Department's program policy[18] requires a quality review be conducted on all monitoring reviews submitted as seriously deficient. In addition, the Department's contracting policy[19] requires some form of monitoring schedule in place for each contract to determine whether the contractor will meet the terms and goals noted in the contract.

Federal regulations[20] require the disallowance of any portion of claims that are incorrect and recover any payment to an institution this is not properly payable.

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

Federal Award Information: This finding affects the Child and Adult Care Food Program federal grant awards 5NC300N1099 and 5NC300N2020 for the federal fiscal years ended September 30, 2014, and 2015, respectively.

Recommendations: The Department should ensure the database used to generate annual monitoring review schedules is compared to the payments made to facilities to ensure all paid facilities are on the schedule.

The Department should ensure that priority is given to reviewing the results of monitoring reviews and documentation of under/overpayments.

Agency Response: The Department agrees with the findings identified in the area of subrecipient monitoring of the Child and Adult Care Food Program (CFDA # 10.558). The Nutrition Services Branch (NSB) is committed to providing quality nutrition services to the citizens of North Carolina. We will implement corrective actions to help minimize the risks identified in this audit.

CFDA 84.126 - REHABILITATION SERVICES – VOCATIONAL REHABILITATION GRANTS TO STATES

10. ERRORS IN CLAIMS PAYMENT PROCESS

The Department processed more than 103,000 payments for vocational rehabilitation services totaling more than $55 million during state fiscal year 2015. One hundred seven (107) of 226 (47%) payments tested contained errors. The total errors identified resulted in net overpayments of $104,277 and federal questioned costs of $82,066.

[17] 7 CFR 226

[18] Division of Public Health's Administrative Reviews Policy date June 2015

[19] Chapter 1 – General Contracting Requirements within the Division's Procurement and Contract Services Policies and Procedures dated October 2005

[20] 7 CFR 226.14(a)

Examples of the errors detected included:

- Payment amount was calculated incorrectly and/or paid at the wrong rate for 104 claims totaling $88,397.
- Inadequate documentation to support the payment for 10 claims totaling $25,394.
- Payment amount did not apply available third party benefits first for 3 claims totaling $8,214
- Provided service was not on the individual's plan of employment for 1 claim totaling $3,432.

Some claims payments had numerous errors detected.

In accordance with OMB Circular A-133 Section .510(a)(3), auditors must report known questioned costs when likely questioned costs are greater than $10,000. Therefore, the overpayments of $104,277 (federal share $82,066) are being questioned. The estimated errors in the population are $4.77 million, +/- 4%.

As a result, the Department made improper payments of program funds that could have been used to provide additional rehabilitation services to other eligible clients, or reduce program cost.

Implementation of a new claims processing system (BEAM) occurred during the year under audit. According to the Department, they delayed updating Medicaid rates in the new system until the completion of the NCTracks/BEAM interface. This delay in rate updates resulted in payments made based upon incorrect rates. Correcting these errors will result in additional cost to the Department.

In addition to the rate calculation errors, the benefit determinations / claims authorizations made by counselors and the supporting documentation did not receive adequate supervisory review to detect errors and omissions in a timely manner.

Federal regulations[21] require costs to be adequately documented; authorized; necessary and reasonable; and be consistent with program regulations that apply to the federal award.

Significant 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 H126A130049, H126A130050, H126A140049, H126A140050, H126A150049, H126A150050 for the federal fiscal years ended September 30, 2013 to 2015.

Recommendations: The Department should ensure the rates in the claim processing system are timely and consistently updated with the most current rates to ensure payments are calculated accurately. Further, the Department should ensure all third-party benefits are appropriately applied where applicable.

[21] OMB Circular A-87

The Department should ensure payments are made only for authorized services and are supported by documentation.

Agency Response: The Department agrees with the errors noted for SFY2015. As of July 1, 2015, the division acquired access to NCTracks and began manually pricing claims until the NCTracks/BEAM interface was complete. On November 1, 2015, the interface was fully functional and the correct rates are being paid for medical, pharmaceutical, and institutional goods and services. Third-party benefits are appropriately applied except when the division, in accordance with 34 CFR 361.53, elects to waive the determination of the benefits to avoid a delay in achieving an individual's employment outcome. The Department will reemphasize the need to maintain adequate documentation to support the payment of claims.

11. DEFICIENCIES IN PARTICIPANT ELIGIBILITY DETERMINATIONS

The Department did not make eligibility determinations in accordance with timeframes established by the regulatory guidelines and some determinations lacked required documentation. Eligibility determinations were made for approximately 24,800 participants during the audit period.

Out of a sample of 214, 12 (5.6%) files contained the following errors:

- 6 (2.8%) client files did not contain documentation to prove that the Department verified participant's financial need. However, we determined that these six participants were eligible for the program.
- 6 (2.8%) eligibility decisions were not made within the required 60 days or within the extension period agreed to by the participant and the Department.

As a result, there is an increased risk that federal funds could be provided to ineligible individuals, an eligible individual could be denied services, or an individual's rehabilitative needs are not met in a timely manner to obtain employment.

According to the Department, the errors occurred and were not detected because there is limited supervisory review of the counselors' determinations.

Federal regulations[22] require the agency to maintain documentation for each individual determined to be eligible. Further, regulations also require that the agency must determine whether an individual is eligible for services within a reasonable period of time, not to exceed 60 days after the individual has submitted an application for the services unless the agency and the individual agree to a specific extension of time.

Significant 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 H126A130049, H126A130050, H126A140049, H126A140050, H126A150049, H126A150050 for the federal fiscal years ended September 30, 2013 to 2015.

[22] 34 CFR 361

Recommendation: The Department should strengthen the supervisory review of counselors' eligibility determinations to ensure determinations are appropriately documented and made in accordance with timeframes established by the regulatory guidelines.

Agency Response: The Department agrees with the errors noted and is pleased with the improvement made over the last two years. During the Single Audit for SFY 2013 an error rate of 39% was identified from a sample of 100 cases. For SFY 2015 the error rate has been drastically reduced to 5.6% in a larger sample of 214 cases. The Department credits the improvement to the implementation of structured statewide monitoring procedures employed during SFY 2014. The Department will continue to improve its documentation to substantiate its verification of participant's financial need to ensure compliance with the federal regulations.

12. DEFICIENCIES IN SYSTEM ACCESS CONTROLS

The results of our audit disclosed deficiencies considered reportable under generally accepted *Government Auditing Standards*. These deficiencies regard security, which due to their sensitivity, are reported to the Department by separate sensitive letter. Pursuant to *North Carolina General Statute 132-6.1(c)*, the sensitive letter including your responses will not be publicly released.

Federal Award Information: This finding affects the Rehabilitation Services – Vocational Rehabilitation Grants to States federal grant awards H126A130049, H126A130050, H126A140049, H126A140050, H126A150049, and H126A150050 for the federal fiscal years ended September 30, 2013 to 2015.

Agency Response: The Department is committed to maintaining adequate information security and system access controls. The Department has designed and/or implemented corrective actions to address the risks identified in this audit. These corrective actions have been detailed in a response separately submitted to the State Auditor. Security risks are given the highest priority by the Department and corrective actions will be monitored by senior leadership.

13. DEFICIENCIES IN BEAM PROGRAM CHANGE CONTROLS

The Department failed to properly manage system changes for the BEAM eligibility system.

The Department implemented 96 change requests for enhancements or new components during state fiscal year 2015 and a random sample of 20 (20%) change requests was tested. Documentation of user acceptance testing (UAT) verification was not available for five (25%) of the 20 change requests sampled.

Failure to properly manage program changes increase the risk of noncompliance with eligibility rules and could result in improper payment amounts from BEAM.

The Department did not ensure user acceptance testing verification was being documented before implementation.

The Statewide Information Security Manual, dated January 2015, standard 040405 states "Adequate management of system change control processes shall require…successful testing of updates and new programs prior to their being moved into a live environment."

Additionally, the BEAM Release Management process dated July 24, 2014 states that "UAT will occur…to unit test each individual ticket" and "these tickets will be verified or rejected as appropriate."

Federal Award Information: This finding affects the Rehabilitation Services – Vocational Rehabilitation Grants to States federal grant awards H126A130049, H126A130050, H126A140049, H126A140050, H126A150049, and H126A150050 for the federal fiscal years ended September 30, 2013 to 2015.

Recommendation: The Department should ensure documentation of user acceptance testing verification occurs during their formal program change management process.

Agency Response: The Department agrees with the recommendation and is committed to maintaining compliance with program change control requirements as noted in the Statewide Information Security Manual. The divisions are in the process of implementing a multi-step solution, some of which has been partially implemented.

14. DEFICIENCIES IN PARTICIPANT PLAN FOR EMPLOYMENT DOCUMENTATION

The Department did not consistently complete program participants' plans to gain employment or improve their employment status within 90 days as required by the Rehabilitation Services – Vocational Rehabilitation Grants to States program.

Individualized Plans of Employment (IPE)[23] were not completed on time for 12 (5.6%) out of 214 participant files.

As a result, there is an increased risk that an individual's rehabilitative needs are not met in time to help them obtain employment or improve their job status.

According to the Department, they had not had time to fully comply with the law since it was enacted in July 2014.

Federal law[24] requires an IPE to be completed as soon as possible, but not later than 90 days after the eligibility determination date, unless the agency and the individual agree to an extension.

[23] A written document developed and implemented in a manner that gives eligible individuals the opportunity to exercise informed choice consistent with selecting an employment outcome including the employment setting, specific Vocational Rehabilitation services needed to achieve the employment outcome, including the setting in which services will be provided, the entity or entities that will provide the services.

[24] Section 103(a) of the Workforce Innovation and Opportunity Act

Federal Award Information: This finding affects the Rehabilitation Services – Vocational Rehabilitation Grants to States federal grant awards H126A130049, H126A130050, H126A140049, H126A140050, H126A150049, H126A150050 for the federal fiscal years ended September 30, 2013 to 2015.

Recommendation: The Department should set aside time in its schedule to fully implement the law to ensure timely completion of an Individualized Plan of Employment for each participant.

Agency Response: The Department agrees with the errors noted. Effective October 1, 2015 the Division implemented a policy regarding the timely development of an Individualized Plan for Employment (IPE). The Division is currently developing procedures and measures to effectively manage and emphasize timely and compliant IPE development.

CFDA 93.268 – IMMUNIZATION COOPERATIVE AGREEMENTS

15. DEPARTMENT DID NOT ENSURE CORRECTIVE ACTIONS

Department monitors for the Vaccine for Children (VFC) program did not require follow-up action when they identified provider noncompliance such as failure to obtain corrective action plans and failure to maintain accurate vaccine inventory. Under the VFC program, 1,212 providers received approximately $120 million worth of vaccines and administered approximately 2.5 million doses.

Department monitors performed site visits on 524 providers. Auditors examined site visit documentation for 120 of the 524 providers and found errors in 36 of the visits. Some visits had multiple errors. Specifically,

- Sixteen (13%) providers did not submit corrective action plans within the 30-day deadline. Department monitors did not formally suspend the providers in the vaccine ordering system.
- Nine (8%) reviews were insufficient because Department monitors did not document their eligibility review of the required minimum number of cases (10 cases).
- Eight (7%) provider vaccine inventory reviews had errors which exceeded the 5% error threshold[25]. Department monitors did not require providers to submit a corrective action.
- Six (5%) providers' corrective action plans did not document that the follow-up actions were completed.

[25] North Carolina Immunization Program "Vaccines for Children Site Visit and Local Health Department Contact and Visits Policy and Procedures Manual"

Inventory errors increase the risk of wasted funds. According to the Centers for Disease Control and Prevention (CDC) price list, VFC program vaccines range in price from $9.45 to $126.25 per dose. Consequently, the federal "Vaccines for Children Operations Guide" states "Vaccine loss is both costly and preventable. There are many reasons for vaccine loss… Vaccine management and storage and handling procedures must include proper ordering and inventory management to prevent vaccine waste."

According to the Department, procedures were changed during the year to allow self-review by the monitors who performed the site visits. Allowing Department monitors to review their own work did not provide reasonable assurance that problems with the monitors' work would be identified and corrected as intended by federal program requirements.

The Department was required to ensure follow-up action for provider noncompliance identified during site visits. Specifically, North Carolina Immunization Program Procedures Manual[26] states "At the end of the site visit, the Regional Nurse checks off the areas on the Provider Follow-Up Plan that need more attention and/or improvement by the provider in order for them to be in compliance… A plan for addressing any issues of noncompliance/opportunities for improvement are agreed upon and documented in writing… The Regional Nurse instructs the provider that the Performance Improvement Plan must be returned within 30 calendar days of the visit." Otherwise, vaccine orders can be withheld until the Performance Improvement Plan is received. The Regional Nurse (reviewer) is required to follow up on all the issues identified during the site visit.

Federal Award Information: This finding affects Immunization Cooperative Agreements federal grant award 5H23IP000759-02 for the year ended December 31, 2014.

Recommendation: The Department should establish supervisory review procedures in accordance with the "Vaccines for Children Operations Guide" and ensure that follow-up and educational plans are made to address staff and/or provider needs as necessary.

Agency Response: The Department agrees with the errors noted. The Division is committed to administering and managing the Vaccines for Children Program with the highest degree of accuracy, integrity and accountability. The Division has implemented new procedures and reemphasized existing processes to ensure follow-up on corrective actions occur in accordance with The Vaccines for Children (VFC) program's policies and guidelines.

TANF CLUSTER – TEMPORARY ASSISTANCE FOR NEEDY FAMILIES STATE PROGRAMS

16. DEFICIENCIES IN SYSTEM ACCESS CONTROLS

The results of our audit disclosed deficiencies considered reportable under generally accepted *Government Auditing Standards*. These deficiencies regard security, which due to their sensitivity, are reported to the Department by separate sensitive letter. Pursuant to *North Carolina General Statute 132-6.1(c)*, the sensitive letter including your responses will not be publicly released.

[26] North Carolina Immunization Program "Vaccines for Children Site Visit and Local Health Department Contact and Visits Policy and Procedures Manual"

Federal Award Information: This finding affects the Temporary Assistance for Needy Families federal grant awards 1402NCTANF, 1502NCTANF, and 1502NCTAN3 for the federal fiscal years ended September 30, 2014, and 2015, respectively.

Agency Response: The Department is committed to maintaining adequate information security and system access controls. The Department has designed and/or implemented corrective actions to address the risks identified in this audit. These corrective actions have been detailed in a response separately submitted to the State Auditor. Security risks are given the highest priority by the Department and corrective actions will be monitored by senior leadership.

17. DEFICIENCIES IN COUNTY ELIGIBILITY DETERMINATION PROCESSES

County departments of social services offices had errors in Temporary Assistance for Needy Families eligibility determinations.

Certified Public Accountants performing the county audits tested 972 case files and found eligibility documentation deficiencies in 23 (2%) cases. The auditors identified questioned costs of $16,872.

The document deficiencies noted by the auditors related to key eligibility requirements for the program. These files were missing items such as applications, county-participant agreements, and state residency verification documentation.

The issues identified result in at least $16,872 of service payments that could have been used to provide services to other eligible participants. Even though sample results identified only $16,872 in questioned costs, if tests were extended to the entire population, questioned costs could be significant to the program.

In accordance with 42 USC 601, recipients are only eligible if they meet the requirements of a financially needy family with children.

Similar aspects of this finding were reported in previous years.

Federal Award Information: This finding affects the Temporary Assistance for Needy Families federal grant awards 1402NCTANF, 1502NCTANF, and 1502NCTAN3 for the federal fiscal years ended September 30, 2014, and 2015, respectively.

Recommendation: The Department should monitor to ensure eligibility determinations are completed accurately and supporting documentation is maintained in case files.

Agency Response: The Department of Health and Human Services is the single State agency designated to administer or supervise the administration of the Temporary Assistance for Needy Families (TANF). North Carolina TANF is State supervised and county administered. The Department will continue to provide training, monitoring and guidance to county departments of social services (DSS) to ensure the adequacy of eligibility determinations. Additional requirements will be established and shared with county DSS agencies. The Department will review questioned costs identified and make the appropriate recoupments/payments.

18. INACCURATE PERFORMANCE REPORTS COULD POTENTIALLY RESULT IN PENALTIES OF UP TO $75 MILLION

The Department did not submit complete, accurate and supported quarterly performance reports for the Temporary Assistance for Needy Families Grant (TANF) to the Administration of Children and Families (ACF). The TANF grant provides time-limited assistance to needy families.

The Department is required to submit the ACF199 federal performance report quarterly. The ACF199 is a federal performance report containing data on the cases of families receiving assistance, families no longer receiving assistance and families applying for assistance from TANF funds.

Auditors sampled the reports from quarters ending December 31, 2014 and June 30, 2015. A test of 120 cases included on these reports identified the following items that did not either agree to or could not be supported by the underlying records:

- The total number of TANF grant cases reported for both quarters tested;
- The type of family structure reported in 60 of the 120 cases (50%);
- The work participation status reported for individuals in 40 of the 120 cases (33%);
- The work hours reported for individuals for all cases tested (100%).

The Department's failure to submit complete and accurate reports that are supported by underlying records could lead to substantial penalties reducing future available funds directly impacting needy families in North Carolina. In addition, the ACF uses the ACF199 report to determine the State Work Participation Rate (WPR)[27]. Possible penalties include:

- Failure to submit complete and accurate reports could result in a penalty of 4%[28] of the State Family Assistance Grant (SFAG), which is the underlying block grant that supports the TANF grant for federal fiscal year 2015. This results in a potential penalty of approximately $12 million (SFAG/TANF grant was $301,435,018).
- The State's failure to meet the required work participation rates could result in a penalty of up to 21%[29], approximately $63 million.

[27] The WPR is a percentage of working families receiving TANF funds that must be met in order to maintain funding and avoid penalties.

[28] In accordance with 45 CFR 262.1, there is a penalty of four percent of the adjusted SFAG for each quarter a State fails to submit an accurate, complete and timely required report.

[29] In accordance with 45 CFR 262.3, ACF uses the TANF Data Report to determine if a State failed to meet participation rates. In addition, 42 USC 609 (a) states that failure to meet the minimum work participation rates could lead to up to 21% in penalties of the SFAG.

According to the Department, in October 2014, North Carolina moved the TANF program into a new data collection system. After the completion of the transition and preparation of the ACF199 performance report, the Client Services Data Warehouse and the Division of Social Services Performance Reporting discovered errors in the data necessary to prepare the reports. Specifically, the TANF cases were incomplete, required fields contained inappropriate values, and certain fields did not contain any data. In an effort to get the reports submitted by the deadline, the Department knowingly included incorrect values in the performance reports.

Federal regulations[30] require the Department to submit quarterly performance reports that are accurate, complete and supported by underlying documentation.

Federal Award Information: This finding affects the Temporary Assistance for Needy Families federal grant awards 1502NCTANF and 1502NCTAN3 for the federal fiscal year ended September 30, 2015.

Recommendation: The Department should ensure that performance reports are complete, accurate and are supported by reliable underlying records.

Agency Response: The Department submitted the best available information to the ACF on the initial due date of the report and notified the ACF of its challenges with compiling the information. The Department has been and continues to work with the ACF to submit a final report prior to March 31, 2016. The ACF has provided immeasurable support to the Department in working toward the final report submission.

CFDA 93.659 – ADOPTION ASSISTANCE – TITLE IV-E

19. DEFICIENCIES IN COUNTY ELIGIBILITY DETERMINATION PROCESSES

County departments of social services offices had errors in eligibility determinations for the Adoption Assistance Title IV-E program.

Certified Public Accountants performing the county audits tested 506 case files and found eligibility documentation deficiencies in 28 (6%) cases. The auditors identified questioned costs of $9,614[31].

The document deficiencies noted by the auditors were related to key eligibility requirements for the program. Specifically:

- 18 (3.6%) client files were missing documentation of child abuse and neglect registry checks.
- 4 (0.8%) client files were missing some element of eligibility determination documentation.

[30] 45 CFR 262.1

[31] OMB A-133 Section .510(a)(3) requires auditors to report known questioned costs when likely questioned costs are greater than $10,000. Even though sample results identified only $9,614 in questioned costs, if tests were extended to the entire population, questioned costs would likely exceed $10,000 and could be significant to the program.

- 3 (0.6%) client files did not contain citizenship documentation.
- 2 (0.4%) clients were ineligible to receive funds under the Adoption Assistance Title IV-E program.
- 1 (0.2%) client received $318 more than the amount for which they were eligible.

As a result of not doing the required background checks, children could be placed in an unsafe environment. Further, the issues identified result in at least $9,614 of service payments that could have been used to provide services to other eligible participants.

In accordance with 42 USC 671, the state shall check any child abuse and neglect registry maintained by the state for information before the prospective parent or any other adult living in the home may be finally approved for placement of a child.

In accordance with 42 USC 675, a signed and dated adoption agreement must be completed to document the type of services and amount of the subsidy prior to the receipt of adoption assistance funding.

Similar aspects of this finding were reported in previous years, including no documentation of child abuse and neglect registry checks being performed reported in the prior year.

Federal Award Information: This finding affects the Adoption Assistance Title IV-E federal grant awards 1401NC1407 and 1501NC1407 for the federal fiscal years ended September 30, 2014, and 2015, respectively.

Recommendation: The Department should monitor to ensure eligibility determinations are completed accurately and supporting documentation is maintained in case files.

Agency Response: The Department of Health and Human Services is the single State agency designated to administer or supervise the administration of the Adoption Assistance Title IV-E program. The North Carolina Adoption Assistance program is State supervised and county administered. The Department will continue to provide training, monitoring and guidance to county departments of social services (DSS) to ensure the adequacy of eligibility determinations. Additional requirements will be established and shared with county DSS agencies. The Department will review questioned costs identified and make the appropriate recoupments/payments.

MEDICAID CLUSTER

20. ERRORS IN MEDICAID PROVIDER BILLING AND PAYMENT PROCESS

The Department processed more than 127 million payments for services totaling $11 billion during state fiscal year 2015. Fifty of a sample of 396 (13%) payments contained errors. The total errors identified resulted in overpayments of $4,288 and federal questioned costs of $2,824.

The 50 items contained one or more errors. This resulted in 55 errors as follows:

- 19 claims totaling $2,250 had insufficient or improper documentation to support the services rendered. For 3 of the 19 claims, the auditor's specialist in health care compliance questioned whether documentation supported the service paid. The Department stated that the documentation provided does not lend itself to a clear and defendable denial of the service paid; and 2 of the 3 were billing differences of less than $150 which the Department does not consider cost effective to pursue recoupment[32].
- 15 claims totaling $1,388 were payments to providers ineligible to render the services.
- 11 claims totaling $38 impacted by retroactive rate changes were not voided and replaced with claim payments at the new rate prior to the end of the fiscal year. Per the Department, they have corrected, or are currently implementing corrective action, on the claim errors resulting from retroactive rate changes.
- Seven claims totaling $336 had the incorrect payment methodology applied to the calculation of the claim payment. Per the Department, they have corrected, or are currently implementing corrective action, on the claim errors resulting from incorrect payment methodology.
- Two claims totaling $424 did not have the required prior approval attained prior to the rendering of the service.
- One claim totaling $269 was a payment to a provider for services that did not comply with Medicaid policy.

In accordance with OMB Circular A-133 Section .510(a)(3), auditors must report known questioned costs when likely questioned costs are greater than $10,000. When the known errors ($4,288) found in the sample are projected to the entire population, the likely total errors are $835 million. When evaluated at a 90% confidence interval, the results[33] are unlikely to be less than $492 million, or more than $1.2 billion. Therefore, the overpayments of $4,288 (federal share $2,824) are being questioned.

The known errors resulting from retroactive rate changes and improper payment methodology totaled $374. When projected to the entire population, the likely total errors resulting from these two conditions are $72 million of the $835 million above.

As a result, the Department made improper payments of program funds that could have been used to provide additional services to other eligible beneficiaries, or reduce overall program cost.

[32] *North Carolina General Statute* 108C-8 – Threshold recovery amount – states "The Department shall not pursue recovery of Medicaid or Health Choice overpayments … less than on hundred fifty dollars ($150) … unless such recovery would be cost-effective…"

[33] The statistical sampling method used was stratified statistical variable sampling.

Several of the errors noted were due to providers submitting documentation to the auditors that was inadequate to support the services rendered. Per the State's Plan, the Department pays provider claims, as submitted, and documentation supporting the claim is not required. However, as part of the provider agreement with the State, the provider is required to submit the supporting documentation for the claim paid, upon request. As noted above, not all documentation provided for the claims tested by the auditors clearly supported the services for which they were paid. Also, errors resulted from providers improperly billing services or failure to comply with policy or the state plan.

According to the Department, other errors were the result of the Department not implementing payment rate and methodology changes timely or system edits to verify provider eligibility and prior approval not functioning as originally planned with the implementation of NCTracks.

Federal regulations[34] require costs to be adequately documented; authorized; necessary and reasonable; and be consistent with program regulations that apply to the federal award.

In accordance with the 42 CFR 431.107, providers sign an agreement to participate in the program that requires them to maintain records disclosing the extent of services furnished to recipients and, on request, furnish the records to the Department.

Federal regulations[35] dictates "the State Medicaid agency must require all ordering or referring physicians or other professionals providing services under the State plan or under a waiver of the plan to be enrolled as participating providers."

Similar aspects of this finding were reported in previous years.

Federal Award Information: This finding affects the Medical Assistance Program federal grant awards 05-1405NC5MAP and 05-1505NC5MAP for the federal fiscal years ended September 30, 2014, and 2015, respectively.

Recommendations: The Department should continue to enhance its control procedures to improve the accuracy of the claims payment process:

- Management should ensure the proper and timely implementation of system changes, including effective payment edits.
- Emphasis should be placed on educating providers as to proper coding and documentation standards necessary to support the medical services being provided.
- Identified over and underpaid claims should be followed up for timely and appropriate collection or payment.
- Enhance procedures to evaluate potential up-coding (billing at higher rates) by providers and take necessary action to ensure proper billing and claim payment.

[34] OMB Circular A-87, 2 CFR 225
[35] 42 CFR 455.410

Agency Response: The Department agrees with 31 of the 50 payments with errors noted from the sample of 396 payments, resulting in an error rate of 7.8%. This error rate closely aligns with the Department's SFY2013 PERM rate of 6.7% which at the time was lower than the 8.2% overall PERM rate for the 17 states that North Carolina is compared with. While the auditor's error rate is based on the number of payment errors, the PERM error rate is based on the dollar value of payment errors.

As indicated in the auditor's comments, DMA clinical staff conducted an independent review for each of the individual claims that were cited as errors by OSA. As a result of this review, a determination was made that 3 of the 19 claims cited for errors related to documentation of services rendered were appropriately paid under Medicaid policy. These claims represent $743 of the total questioned costs cited (federal share $369).

With respect to each of the billing differences, the Department adheres to *NCGS §108C-8* to determine if collecting recoupment amounts under $150.00 is warranted. Due to the extensive appeal rights afforded providers when the Department seeks to recoup overpayments, collection efforts for an error less than $150.00 has the potential to cost the Department in excess of $500.00. It is both cost effective and in the best interest of Medicaid and the State of North Carolina to refrain from pursuing recoupments of less than $150.00.

Rate changes in the Medicaid program are legislated by the General Assembly with an effective date for implementation. However, per CFRs 447 and 430, CMS approval is required prior to the implementation of any rate changes. In order to receive this approval, a State Plan Amendment (SPA) is prepared and submitted to CMS for review. The SPA approval process typically requires an extensive review period, which creates a delay in enacting rate adjustments. This requires DMA to retroactively adjust rates back to the legislative effective date once CMS approval is received.

Each of these claims were also impacted by the 3% Physician rate reduction enacted with Session Law 2013-360 requiring an effective date of January 1, 2014. CMS approved the SPA on June 27, 2014. Since ACA providers were excluded from the physician rate reductions, extensive analysis involving programming in the claims payment system was required to correctly identify the subset of providers impacted by the rate changes. Upon completion of the analysis, implementation of the rate adjustments occurred in two (2) separate phases. Phase 1, which occurred on March 2, 2015, involved loading the rates into the claims payment system. Phase 2 involved the reprocessing of claims with dates of service from January 1, 2014 to March 2, 2015. The reprocessing began in April 2015 and is expected to be completed by December 31, 2016. As there currently is no state or federal regulation that requires claims reprocessing to occur within specific timeframes, the Department took the time needed to ensure the reprocessing plan was well designed and executed.

The seven claims cited for the use of incorrect payment methodology resulted from the misinterpretation of a CMS Information Bulletin informing states of the obligation of Medicaid to reimburse providers for cost sharing that is due for a Qualified Medicare Beneficiary (QMB). The correct methodology was identified and implemented in November 2015. A systematic reprocessing of claims has been initiated and will occur between March 29, 2016 and June 21, 2016.

The Department chose to recalculate the estimated errors in the population adjusting the baseline to exclude the retroactive rate changes and the claims determined to be sufficiently documented. The Department recalculated this projection utilizing our standardized extrapolation process[36]. Using this revised baseline results in a projected error total of $690 million across the total population, not too distant from the auditor's calculation of $763 million ($835 million less $72 million).

21. DEFICIENCIES WITH THE RATE CHANGE PROCESS

The Department did not always ensure that the amounts reimbursed to providers for rendering services to Medicaid recipients were consistent with Medicaid plan and rates.

Sixteen rate changes from a sample of 97 (17%) lacked adequate documentation to support the Department's timely review of changes to the claims processing system (NCTracks).

Additional testing procedures identified the following errors:

- One rate change was made using an incorrect calculation. The rate change was made to rates used to reimburse numerous providers for multiple procedures rendered to patients. The rate change was made to 16,556 claims totaling $792,768 for the Medicaid program. Auditors were unable to determine the overall cost impact; however the incorrect calculation could cause errors ranging from 1% to 15% of the actual amounts paid.
- The Department entered the wrong rate for one provider's reimbursement rate change. The error was made to 112 claims totaling $106,277 and resulted in an underpayment of $214.

As a result, the Department will incur additional costs. The process of determining the overpayments and underpayments, the recoupment of the overpayments plus possible appeals, and the reprocessing of underpayments could result in significant use of agency resources and administrative costs.

According to the Department, they verbally discussed implementing new policies and procedures to review rates in the new claims processing system (NCTracks) in the last quarter of state fiscal year 2015, but the new policy was not formalized until July 2015.

The Department performed 133 rate changes after the verbal policy implementation. Auditors reviewed 34 of the 133 rate changes processed after the verbal policy implementation and no errors were found.

[36] DMA utilizes a standardized process and statistical software to perform all Medicaid related extrapolations. This includes extrapolations that relate to Medicaid overpayments as well as those associated with federal audits and reviews (e.g. PERM). The software utilized is RAT-STATS and is sanctioned by the Office of Inspector General (OIG). It is publicly available at: http://www.oig.hhs.gov/compliance/rat-stats/index.

The Medicaid state plan dictates the methodology to calculate the reimbursement rates to providers that result in the costs to the program. OMB Circular A-87 states that to be allowable under a grant program, the costs must be consistent with policies, regulations, procedures, and state Medicaid plan and rates. It also states that costs must be adequately documented.

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

Federal Award Information: This finding affects the Medical Assistance Program federal grant awards 05-1405NC5MAP and 05-1505NC5MAP for the federal fiscal years ended September 30, 2014, and 2015, respectively.

Recommendations: The Department should continue to ensure procedures over the independent verification of rate modifications in NCTracks are operating.

The Department should follow-up on claims impacted by inaccurate rate modifications and make the appropriate collection or payment.

Agency Response: The Department agrees with the errors noted. The Department implemented procedures to ensure that appropriate documentation is reviewed timely and retained to support rate modifications in NCTracks. All errors noted resulted in underpayments so there is no questioned cost impact.

22. DEFICIENCIES IN SYSTEM ACCESS CONTROLS

The results of our audit disclosed deficiencies considered reportable under generally accepted *Government Auditing Standards*. These deficiencies regard security, which due to their sensitivity, are reported to the Department by separate sensitive letter. Pursuant to *North Carolina General Statute 132-6.1(c)*, the sensitive letter including your responses will not be publicly released.

Federal Award Information: This finding affects the Medical Assistance Program federal grant awards 05-1405NC5MAP and 05-1505NC5MAP for the federal fiscal years ended September 30, 2014, and 2015, respectively.

Agency Response: The Department is committed to maintaining adequate information security and system access controls. The Department has designed and/or implemented corrective actions to address the risks identified in this audit. These corrective actions have been detailed in a response separately submitted to the State Auditor. Security risks are given the highest priority by the Department and corrective actions will be monitored by senior leadership.

23. DEFICIENCIES IN COUNTY ELIGIBILITY DETERMINATION PROCESSES

County departments of social services offices had errors in Medicaid eligibility determinations.

Certified Public Accountants auditing the counties tested 5,771 case files and found eligibility documentation deficiencies in 239 (4.1%) cases. The auditors identified questioned costs of $74,072.

The document deficiencies noted by the auditors were related to key eligibility requirements for the program. The deficiencies found are described below:

- One hundred thirty-three (2.3%) client files did not contain all the required eligibility documentation. These case files were missing signed applications, proof of residency, and online verification documentation.
- Fifty-two (0.9%) client files were missing or contained inaccurate calculations related to the budget. These inaccurate calculations included errors in the computation of income and documentation of wages.
- Forty-three (0.7%) client files did not contain all the required eligibility and budget documentation. These case files were missing budget verification forms and verification of medical expenses.
- Eleven (0.2%) client files contained ineligible recipients for a part or the entire Medicaid coverage period. The errors included a case file that was not terminated at the end of the approved certification period and a case that did not indicate the correct certification period.

The issues identified resulted in at least $74,072 of service payments that could have been used to provide services to other eligible participants.

In accordance with 42 CFR 435, documentation must be obtained as needed to determine if a recipient meets specific income standards and documentation must be maintained to support eligibility determinations.

Similar aspects of this finding were reported in previous years.

Federal Award Information: This finding affects the Medical Assistance Program federal grant awards 05-1405NC5MAP and 05-1505NC5MAP for the federal fiscal years ended September 30, 2014, and 2015, respectively.

Recommendation: The Department should monitor to ensure eligibility determinations are completed accurately and supporting documentation is maintained in case files.

Agency Response: The Department of Health and Human Services is the single State agency designated to administer or supervise the administration of the Medicaid program under title XIX and XXI of the Social Security Act. North Carolina Medicaid and North Carolina Children's Health Insurance Program are State supervised and county administered. The deficiencies cited from the county visits are recognized as repeat findings. The Department will continue to provide training, monitoring and guidance to county departments of social services (DSS) to ensure the adequacy of eligibility determinations. Additional requirements will be established and shared with county DSS agencies. The Department will review questioned costs identified and make the appropriate recoupments/payments.

24. DEFICIENCIES IN PROVIDER ENROLLMENT AND TERMINATION PROCESSES

The Department's contracted agent (contractor) is responsible for determining eligibility of providers participating in the Medicaid program. The contractor processed and approved enrollment and update activites for 28,342 providers (out of 58,352 total providers) during state fiscal year 2015.

Sixty-seven of 117 (57%) sampled provider records had multiple types of errors including:

- In 27 of 117 (23%) provider records, there was no evidence the contractor conducted accreditation checks, background checks, and Office of Inspector General and/or North Carolina penalty searches for owners, office administrators, managing employees, and/or providers.
- In two of 117 (2%) provider records, there was no evidence of risk-based screening for high risk providers. Risk-based screening includes performing site visits prior to being determined eligible.
- In 12 of 117 (10%) provider records, the contractor's searches were performed using incorrect social security numbers and misspelled names.
- In 47 of the 117 (40%) sampled provider records, the licenses, certifications, or accreditations in the system were expired, but the provider remained active.

In addition, 23 of 194 (12%) providers with licenses suspended, surrendered, or revoked were not properly terminated in the claims processing system (NCTracks).

There is an increased risk that ineligible providers are treating Medicaid patients. There is also an increased risk of payments to ineligible providers that could result in federal funding being returned.

According to the Department, the errors were not detected because they did not have adequate monitoring procedures in place to ensure the contractor achieved expected results. In addition, the realignment of the responsible staff and management presented challenges to timely implement improved monitoring procedures.

In addition, the Department deactivated the program used to detect the expired dates for certifications, licenses, or accreditations.

In accordance with 42 CFR 455, the state agency must confirm the identity and determine the exclusion status of providers and any person with an ownership or control interest or who is an agent or managing employee of the provider through routine checks of federal databases. The state agency must also have a method for verifying providers' licenses and confirm that they have not expired or have no current limitations.

Significant aspects of this finding were reported in previous years.

Federal Award Information: This finding affects the Medical Assistance Program federal grant awards 05-1405NC5MAP and 05-1505NC5MAP for the federal fiscal years ended September 30, 2014, and 2015, respectively.

Recommendations: The Department should monitor to ensure eligibility determinations are completed accurately and supporting documentation is maintained in the provider files.

The Department should also ensure that all sanctioned providers are properly removed from the claims payment system (NCTracks).

Agency Response: As a result of previous single audits, the Department implemented monitoring activities with the fiscal agent on December 21, 2015. Monitoring enrollment activities are performed to ensure the accuracy of the eligibility determinations performed by the contractor, compliance to federal and state requirements and that supporting documentation is maintained in provider files.

Additionally, as enhancements to the monitoring activities stated above, system improvements and modifications are ongoing to detect errors related to providers with licenses suspended, surrendered, or revoked. April 2016 is the target date to implement an automated process to ensure that all sanctioned providers are terminated and properly removed from the claims payment system (NCTracks) as required. Additional system enhancements are also being developed to automate license, background, and penalty/sanction checks. Implementation is pending for August 2016.

The Department conducted an analysis of the 47 providers noted as errors due to license, certification and accreditation concerns. The Department completed an in-depth review of websites and contacted North Carolina Licensing Boards and the Division of Health Service Regulations. The review disclosed that only one provider had an expired license during SFY2015. The Department also reviewed paid claims data for this provider. While the automation was partially in place during this audit period, the Department verified that the provider had zero claims submitted and paid by Medicaid during SFY2015.

CFDA 93.767 CHILDREN'S HEALTH INSURANCE PROGRAM

25. ERRORS IN CHILDREN'S HEALTH INSURANCE PROVIDER BILLING AND PAYMENT PROCESS

The Department processed more than 11 million payments for services totaling $437 million during state fiscal year 2015. Twenty-eight of a sample of 240 (12%) payments contained errors. The total errors identified resulted in net overpayments of $4,825 and federal questioned costs of $3,670.

The 28 items contained one or more errors. This resulted in 32 errors as follows:

- 13 claims totaling $664 had insufficient or improper documentation to support the services rendered. For two of the 13 claims, the auditor's specialist in health care compliance questioned whether documentation supported the service paid. The Department stated that the documentation provided does not lend itself to a clear and defendable denial of the service paid; and both were billing differences of less than $150 which the Department does not consider cost effective to pursue recoupment[37].

[37] See note 32 for *NCGS 108C-8*

- 10 claims totaling $132 impacted by retroactive rate changes were not voided and replaced with claim payments at the new rate prior to the end of the fiscal year. Per the Department, they have corrected, or are currently implementing corrective action, on the claim errors resulting from retroactive rate changes.
- Eight claims totaling $4,045 were payments to providers ineligible to render the services.
- One claim totaling $96 did not have the required prior approval attained prior to rendering the service.

In accordance with OMB Circular A-133 Section .510(a)(3), auditors must report known questioned costs when likely questioned costs are greater than $10,000. When the known errors ($4,825) found in the sample are projected to the entire population, the likely total errors are $81 million[38]. Therefore, the overpayments of $4,825 (federal share $3,670) are being questioned.

As a result, the Department made improper payments with program funds that could have been used to provide additional services to other eligible beneficiaries, or reduce overall program cost.

Several of the errors noted were due to providers submitting documentation to the auditors that was inadequate to support the services rendered. Per the State's Plan, the Department pays provider claims, as submitted, and documentation supporting the claim is not required. However, as a part of the provider agreement with the State, the provider is required to submit the supporting documentation for the claim paid, upon request. As noted above, not all documentation provided for the claims tested by the auditors clearly supported the services for which they were paid. Also, errors resulted from providers improperly billing services or failure to comply with policy or the state plan.

According to the Department, other errors were the result of the Department not implementing payment rate and methodology changes timely or system edits to verify provider eligibility and prior approval not functioning as originally planned with the implementation of NCTracks.

Federal regulations[39] require costs to be adequately documented; authorized; necessary and reasonable; and be consistent with program regulations that apply to the federal award.

In accordance with the 42 CFR 431.107, providers sign an agreement to participate in the program that requires them to maintain records disclosing the extent of services furnished to recipients and, on request, furnish the records to the Department.

[38] The statistical sampling method used was stratified statistical variable sampling. When evaluated at the 90% confidence interval, the results are unlikely to be less than $0, or more than $210 million.
[39] OMB Circular A-87, 2 CFR 225

Federal regulations[40] dictates "the State Medicaid agency must require all ordering or referring physicians or other professionals providing services under the State plan or under a waiver of the plan to be enrolled as participating providers."

Similar aspects of this finding were reported in previous years.

Federal Award Information: This finding affects the Children's Health Insurance Program federal grant awards 05-1405NC5021 and 05-1505NC5021 for the federal fiscal years ended September 30, 2014, and 2015, respectively.

Recommendations: The Department should enhance its control procedures to improve the accuracy of the claims payment process:

- Management should ensure the proper and timely implementation of system changes, including effective payment edits.
- Emphasis should be placed on educating providers as to proper coding and documentation standards necessary to support the medical services being provided.
- Identified over and underpaid claims should be followed up for timely and appropriate collection or payment.
- Enhance procedures to evaluate potential up-coding (billing at higher rates) by providers and take necessary action to ensure proper billing and claim payment.

Agency Response: As implied in the auditor's comments, DMA clinical staff conducted an independent review for each of these individual claims that were cited as errors by OSA. As a result of this review, a determination was made that the 2 of the 13 claims cited for errors were appropriately paid under Medicaid policy. These claims represent $131 in total questioned costs cited (Federal share $100).

With respect to each of the billing differences, the Department adheres to *NCGS §108C-8* to determine if collecting recoupment amounts under $150.00 is warranted. Due to the extensive appeal rights afforded providers when the Department seeks to recoup overpayments collection for an error less than $150.00 has the potential to cost the Department in excess of $500.00. It is both cost effective and in the best interest of Medicaid and the State of North Carolina to refrain from pursuing recoupments of less than $150.00.

Rate changes in the Medicaid program are legislated by the General Assembly with an effective date for implementation. However, per CFRs 447 and 430, CMS approval is required prior to the implementation of any rate changes. In order to receive this approval, a State Plan Amendment (SPA) is prepared and submitted to CMS for review. The SPA approval process typically requires an extensive review period, which creates a delay in enacting rate adjustments. This requires DMA to retroactively adjust rates following CMS approval back to the legislative effective date.

[40] 42 CFR 455.410

Each of these claims were also impacted by the 3% Physician rate reduction enacted with Session Law 2013-360 requiring an effective date of January 1, 2014. CMS approved the SPA on June 27, 2014. Since ACA providers were excluded from the physician rate reductions, extensive analysis involving programming in the claims payment system was required to correctly identify the subset of providers impacted by the rate change. Upon completion of the analysis, implementation of the rate adjustments occurred in two (2) separate phases. Phase 1, which occurred on March 2, 2015, involved loading the rates into the claims payment system. Phase 2 involved the reprocessing of claims with dates of service from January 1, 2014 to March 2, 2015. The reprocessing began in April 2015 and is expected to be completed by December 31, 2016. As there currently is no state or federal regulation that requires claims reprocessing to occur within specific timeframes, the Department took the time needed to ensure the reprocessing plan was well designed and executed.

The Department chose to recalculate the estimated errors in the population adjusting the baseline to exclude the retroactive rate changes and the claims determined to be sufficiently documented. The Department recalculated this projection utilizing our standardized extrapolation process[41]. Using this revised baseline results in a projected error total of $78M across the total population, which closely aligns with the auditor's calculation.

26. DEFICIENCIES WITH THE RATE CHANGE PROCESS

The Department did not always ensure that the amounts reimbursed to providers for rendering services to Children's Health Insurance Program recipients were consistent with Medicaid plan and rates.

Sixteen rate changes from a sample of 97 (17%) lacked adequate documentation to support the Department's timely review of changes to the claims processing system (NCTracks).

Additional testing procedures identified one rate change was made using an incorrect calculation. The rate change was made to rates used to reimburse numerous providers for multiple procedures rendered to patients. The rate change was made to 913 claims totaling $17,332 for the Children's Health Insurance Program. Auditors were unable to determine the overall cost impact; however the incorrect calculation could cause errors ranging from 1% to 15% of the actual amounts paid.

As a result, the Department will incur additional costs. The process of determining the overpayments and underpayments, the recoupment of the overpayments plus possible appeals, and the reprocessing of underpayments could result in significant use of agency resources and administrative costs.

[41] DMA utilizes a standardized process and statistical software to perform all Medicaid related extrapolations. This includes extrapolations that relate to Medicaid overpayments as well as those associated with federal audits and reviews (e.g. PERM). The software utilized is RAT-STATS and is sanctioned by the Office of Inspector General (OIG). It is publicly available at: http://www.oig.hhs.gov/compliance/rat-stats/index.

According to the Department, they verbally discussed implementing new policies and procedures to review rates in the new claims processing system (NCTracks) in the last quarter of state fiscal year 2015 but the new policy was not formalized until July 2015.

The Department performed 133 rate changes after the verbal policy implementation. Auditors reviewed 34 of the 133 rate changes processed after the verbal policy implementation and no errors were found.

The Children's Health Insurance Program state plan dictates the methodology to calculate the reimbursement rates to providers that result in the costs to the programs. OMB Circular A-87 states that to be allowable under a grant program, the costs must be consistent with policies, regulations, procedures, and state plan and rates. It also states that costs must be adequately documented.

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

Federal Award Information: This finding affects the Children's Health Insurance Program federal grant awards 05-1405NC5021 and 05-1505NC5021 for federal fiscal years ended September 30, 2014, and 2015, respectively.

Recommendations: The Department should continue to ensure procedures over the independent verification of rate modifications in NCTracks are operating.

The Department should follow-up on claims impacted by inaccurate rate modifications and make the appropriate collection or payment.

Agency Response: The Department agrees with the errors noted. The Department implemented procedures to ensure that appropriate documentation is reviewed timely and retained to support rate modifications in NCTracks. All errors noted resulted in underpayments so there is no questioned cost impact.

27. DEFICIENCIES IN PROVIDER ENROLLMENT AND TERMINATION PROCESSES

The Department's contracted agent (contractor) is responsible for determining eligibility of providers participating in the Children's Health Insurance Program. The contractor processed and approved enrollment and update activites for 28,342 providers (out of 58,352 total providers) during state fiscal year 2015.

Sixty-seven of 117 (57%) sampled provider records had multiple types of errors including:

- In 27 of 117 (23%) provider records, there was no evidence the contractor conducted accreditation checks, background checks, and Office of Inspector General and/or North Carolina penalty searches for owners, office administrators, managing employees, and/or providers.
- In two of 117 (2%) provider records, there was no evidence of risk-based screening for high risk providers. Risk-based screening includes performing site visits prior to being determined eligible.

- In 12 of 117 (10%) provider records, the contractor's searches were performed using incorrect social security numbers and misspelled names.
- In 47 of the 117 (40%) sampled provider records, the licenses, certifications, or accreditations in the system were expired, but the provider remained active.

In addition, 23 of 194 (12%) providers with licenses suspended, surrendered, or revoked were not properly terminated in the claims processing system (NCTracks).

There is an increased risk that ineligible providers are treating Children's Health Insurance Program patients. There is also an increased risk of payments to ineligible providers that could result in federal funding being returned.

According to the Department, the errors were not detected because they did not have adequate monitoring procedures in place to ensure the contractor achieved expected results. In addition, the realignment of the responsible staff and management presented challenges to timely implement improved monitoring procedures.

In addition, the Department deactivated the program used to detect the expired dates for certifications, licenses, or accreditations.

In accordance with 42 CFR 455, the state agency must confirm the identity and determine the exclusion status of providers and any person with an ownership or control interest or who is an agent or managing employee of the provider through routine checks of federal databases. The state agency must also have a method for verifying providers' licenses and confirm that they have not expired or have no current limitations.

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

Federal Award Information: This finding affects the Children's Health Insurance Program federal grant awards 05-1405NC5021 and 05-1505NC5021 for federal fiscal years ended September 30, 2014, and 2015, respectively.

Recommendations: The Department should monitor to ensure eligibility determinations are completed accurately and supporting documentation is maintained in the provider files.

The Department should also ensure that all sanctioned providers are properly removed from the claims payment system (NCTracks).

Agency Response: As a result of previous single audits, the Department implemented monitoring activities with the fiscal agent on December 21, 2015. Monitoring enrollment activities are performed to ensure the accuracy in the eligibility determinations performed by the contractor, compliance to federal and state requirements, and that supporting documentation is maintained in provider files.

Additionally, as enhancements to the monitoring activities stated above, system improvements and modifications are ongoing to detect errors related to providers with licenses suspended, surrendered, or revoked. April 2016 is the target date to implement an automated process to ensure that all sanctioned providers are terminated and

properly removed from the claims payment system (NCTracks) as required. Additional system enhancements are also being developed to automate license, background, and penalty/sanction checks. Implementation is pending for August 2016.

The Department conducted an analysis of the 47 providers noted as errors due to license, certification and accreditation concerns. The Department completed an in-depth review of websites and contacted North Carolina Licensing Boards and the Division of Health Service Regulations. The review disclosed that only one provider had an expired license during SFY2015. The Department also reviewed paid claims data for this provider. While the automation was partially in place during this audit period, the Department verified that the provider had zero claims submitted and paid by the Children's Health Insurance Program during SFY2015.

28. DEFICIENCIES IN SYSTEM ACCESS CONTROLS

The results of our audit disclosed deficiencies considered reportable under generally accepted *Government Auditing Standards*. These deficiencies regard security, which due to their sensitivity, are reported to the Department by separate sensitive letter. Pursuant to *North Carolina General Statute 132-6.1(c)*, the sensitive letter including your responses will not be publicly released.

Federal Award Information: This finding affects the Children's Health Insurance Program federal grant awards 05-1405NC5021 and 05-1505NC5021 for the federal fiscal years ended September 30, 2014, and 2015, respectively.

Agency Response: The Department is committed to maintaining adequate information security and system access controls. The Department has designed and/or implemented corrective actions to address the risks identified in this audit. These corrective actions have been detailed in a response separately submitted to the State Auditor. Security risks are given the highest priority by the Department and corrective actions will be monitored by senior leadership.

29. DEFICIENCIES IN COUNTY ELIGIBILITY DETERMINATION PROCESSES

County departments of social services offices had errors in Children's Health Insurance Program eligibility determinations.

Certified Public Accountants performing the county audits tested 1,362 case files and found eligibility documentation deficiencies in 97 (7%) cases. The auditors identified questioned costs of $21,156.

The document deficiencies noted by the auditors were related to key eligibility requirements for the program. The deficiencies found are described below:

- Forty-six (3.4%) client files were missing or contained inaccurate budget calculations.
- Thirty-one (2.3%) client files were missing eligibility documentation.

- Eighteen (1.3%) client files did not contain all the required eligibility and budget documentation. These files were missing items to support the budget, verification of required data matches, and budget verification forms.
- Two (0.1%) client files did not meet the program income limitations; therefore, the recipient would be ineligible for the duration of the period for which the limitations were not met.

The issues identified resulted in at least $21,156 of service payments that could have been used to provide services to other eligible participants. Even though sample results identified only $21,156 in questioned costs, if tests were extended to the entire population, questioned costs could be significant to the program.

In accordance with 42 CFR 435, documentation must be obtained as needed to determine if a recipient meets specific income standards and documentation must be maintained to support eligibility determinations.

Similar aspects of this finding were reported in previous years.

Federal Award Information: This finding affects the Children's Health Insurance Program federal grant awards 05-1405NC5021 and 05-1505NC5021 for the federal fiscal years ended September 30, 2014, and 2015, respectively.

Recommendation: The Department should monitor to ensure eligibility determinations are completed accurately and supporting documentation is maintained in case files.

Agency Response: The Department of Health and Human Services is the single State agency designated to administer or supervise the administration of the Medicaid program under title XIX and XXI of the Social Security Act. North Carolina Medicaid and North Carolina Children's Health Insurance Program are State supervised and county administered. The deficiencies cited from the county visits are recognized as repeat findings. The Department will continue to provide training, monitoring and guidance to county departments of social services (DSS) to ensure the adequacy of eligibility determinations. Additional requirements will be established and shared with county DSS agencies. The Department will review the questioned costs identified and make the appropriate recoupments/payments.

CFDA 93.917 – HIV CARE FORMULA GRANTS

30. BENEFITS PAID TO INELIGIBLE PARTICIPANTS

The Department paid benefits from the Ryan White HIV Formula Grant on behalf of individuals that were not eligible to participate in the program. During the audit period the Department disbursed over $27 million for 9,246 participants for the AIDS Drug Assistance Program (ADAP).

Auditors tested the eligibility determinations for 112 participants and found $55,727 in payments made for 10 (9%) ineligible participants. The entire amount is questioned costs. Specifically,

- 4 (3.6%) were ineligible because their income was higher than that allowed by the program. Payments for these recipients were $28,704.
- 3 (2.7%) were ineligible because the documentation from the local detention center did not explicitly state that there was an inability to pay for medications. Payments for these recipients were $15,458.
- 1 (0.9%) was ineligible because they had private insurance. Payments made for this recipient were $5,769.
- 1 (0.9%) was ineligible because they did not have updated lab results in their case file. Payments for this recipient were $4,848.
- 1 (0.9%) was ineligible because they were in the custody of the state. Payments for this recipient were $948.

As a result, ineligible participants received $55,727 of benefits that could have been used to provide services to other eligible participants.

According to the Department, ineligible participants received benefits because of vague policy and a lack of access to information. They did not have a clearly documented policy which defines when a participant is in the custody of the state. Additionally, those responsible for eligibility determinations did not have access to the Department's Online Verification (OLV) system[42] to verify participants' income.

Per Federal Regulations[43], to be eligible to receive assistance, an individual must have a medical diagnosis of HIV/AIDS, be a low-income individual, be a resident of the state and also be uninsured or underinsured, as defined by the State.

Further, North Carolina policy[44] states that individuals in a local detention center (county jail) may be eligible for the AIDS Drug Assistance Program (ADAP), but those in State or Federal prisons, or in State or Federal custody, are not eligible for ADAP.

Federal Award Information: This finding affects the HIV Care Formula Grants federal grant award X07HA0051 for the fiscal year ended March 31, 2015.

Recommendations: The Department should clearly document policies and procedures to ensure verification of information is performed.

The Department should provide Online Verification access to staff making program eligibility determinations.

[42] OLV provides a single resource for verifying data gathered during the eligibility determination process and allows a caseworker to search for required information from various state and federal systems.
[43] 42 USC 300ff-26(b)
[44] AIDS Drug Assistance Program Application Manual

Agency Response: The Department agrees with these eligibility findings. The Division remains committed to maintaining controls and processes to ensure appropriate compliance with federal and state requirements for this vitally important program. The Division believes in this program because of the value to many individuals. However, we also realize that accountability and the adherence to rules and regulations is an extremely important part of operating any program. Therefore, the Division will implement appropriate actions to help mitigate the identified risks.

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

31. DEFICIENCIES AND ERRORS IN PROVIDER BILLING AND PAYMENT PROCESS

The Department used NCTracks to process more than 111,000 payments for substance abuse services totaling $6.5 million during state fiscal year 2015. Twelve of 194 (6.7%) claims tested had errors that resulted in net overpayments of $271.

Specifically, the following errors were identified:

- Private third-party insurance was not considered for four (2.1%) of 194 claims tested, resulting in overpayments and questioned costs of $406.
- Claims were paid at the incorrect rate for four (2.1%) of 194 claims tested, resulting in an underpayment of $202.
- Medicaid and Medicare coverage was not considered for two (1%) of 194 claims tested, resulting in overpayments and questioned costs of $67.
- There were six active payment rates for two (1%) of 194 claims tested, when there should have been only one active rate for the specific service in the claim processing system. Therefore, the accuracy of the rate and amount paid on the claim could not be determined.

In accordance with OMB Circular A-133 Section .510(a)(3), auditors must report known questioned costs when likely questioned costs are greater than $10,000. Therefore, the actual overpayments of $473 are being questioned.

The Department's failure to consider other insurance coverages could result in payments for services with substance abuse funds that should have been covered by other insurance. Paying at incorrect rates results in improper payments that reduce funds available for additional claim payments and increases program costs.

According to the Department, NCTracks was designed to ensure proper payments. However, the Department did not have a quality control review of claim payments to ensure NCTracks was accurately processing claims.

Additionally, the claims processing system (NCTracks) did not have the proper payment program logic in place as follows:

- The system was programmed to bypass sending claims for certain residential treatment services to third party insurance companies for payment consideration.

- The system was not programmed to prevent multiple active payment rates during the same period for a specific substance abuse service.
- The system was not programmed to reprocess claims when additional insurance coverage or rate changes are added retroactively to the system.

Per 2 CFR 225, in order for a cost to be allowable under a federal program it must be authorized by and consistent with policies, regulations and procedures that apply uniformly to both federal awards and other activities of the governmental unit. The *State-Funded Enhanced Mental Health and Substance Abuse Services* manual requires that "other third-party payors, including Medicaid…and Medicare" be billed before claims are reimbursed by the state's substance abuse program.

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

Federal Award Information: This finding affects the Block Grants for Prevention and Treatment of Substance Abuse federal grant awards TI010032-13, TI010032-14, and TI010032-15 for the federal fiscal years ended September 30, 2013 to 2015.

Recommendations: The Department should enhance its procedures to improve the accuracy of the claims payment process.

Specifically, the Department should:

- Ensure the necessary programming changes are implemented promptly and accurately to properly process claims, and
- Develop a quality control process to select claims for review to ensure claims are paid correctly, subsequent to program changes.

Agency Response: The Department agrees with the finding and will enhance procedures to review claims to ensure that they are being paid correctly. The Department is following up on the 12 claims which were identified as not processing correctly.

32. DEFICIENCIES IN RATE CHANGE PROCESS

The Department did not have adequate documentation to justify substance abuse payment rate changes and to show rates were properly approved prior to changes. Additionally, the Department did not have documentation to show that rate changes in the claims processing system (NCTracks) were verified for accuracy. The Department submitted changes to the system rate tables 29 times during state fiscal year 2015, affecting 292 substance abuse service rates.

Auditors tested six of the 29 rate change submissions, affecting 28 substance abuse service rates. The following errors were noted:

- 22 out of 28 rate changes did not have documentation to support that proper approvals were obtained prior to changing the rates.

- 22 out of 28 rate changes did not have adequate supporting documentation to justify the rate change request.
- 28 of the 28 rate changes did not have documentation verifying the accuracy of the changes made in the system.

Inadequate documentation and review could result in improper rates being implemented in the claims processing system causing substance abuse claims to be paid in error, similar to the errors noted in the finding above.

Per the Department's management, they are reviewing Local Management Entities/Managed Care Organizations (LME/MCO) rate change requests for reasonableness prior to implementing the changes to the system, but had become complacent and failed to maintain adequate documentation to support the rate reviews and approvals. Additionally, it relied on documentation from the claims processing contractor and did not evidence independent end user verification of the rate changes in NCTracks.

The Department's internal policy requires:

- One level of review and approval for all rate modification requests.
- Rate modifications requesting changes that exceed the state rate must be accompanied by additional justification documentation and a second level of review prior to implementation.
- Verification that the new approved rate has been uploaded correctly into the claims processing system.

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

Federal Award Information: This finding affects the Block Grants for Prevention and Treatment of Substance Abuse federal grant awards TI010032-13, TI010032-14, and TI010032-15 for the federal fiscal years ended September 30, 2013 to 2015.

Recommendations: The Department should maintain documentation to ensure rate changes are justified and approved before being put into the claims processing system.

The Department staff should document verification of rate changes once entered into the claims processing system for accuracy.

Agency Response: The Department agrees with the finding and has implemented procedures to ensure documentation of rate change approvals and verifications are maintained.

33. DEFICIENCIES IN FILE MAINTENANCE REQUEST CHANGE CONTROLS

The Department did not maintain documentation to support that File Maintenance Requests (FMRs) changes by the substance abuse claims processor were operating as expected after implementation. FMRs include provider service changes, medical policy changes and payment processing changes that affect how substance abuse claims are paid.

During the year, there were 23 FMRs submitted and 19 (83%) of the changes did not have documentation of review by Department staff after implementation.

Without review of file maintenance changes, the claims processor could make inaccurate or unauthorized changes or fail to make requested changes that result in improper claim payments.

Per the Department, the claims processor provides before and after evidence of the file maintenance changes to Department staff via email; however, it does not maintain the change evidence or document approval of all changes once implemented in the claims processing system (NCTracks).

The Statewide Information Security Manual, Section 040405 – Managing Change Control Procedures, states that adequate change control processes require proper authorization and approvals as well as testing of implemented changes to ensure operating as expected.

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

Federal Award Information: This finding affects the Block Grants for Prevention and Treatment of Substance Abuse federal grant awards TI010032-13, TI010032-14, and TI010032-15 for the federal fiscal years ended September 30, 2013 to 2015.

Recommendation: The Department should establish procedures to test and maintain documentation that file maintenance changes are operating as expected.

Agency Response: The Department agrees with the finding. The Division's NCTracks Team reviewed File Maintenance Requests (FMR) as they were completed by the Fiscal Agent; however, these reviews were not consistently documented. The Department has enhanced its review process to ensure adequate documentation is maintained.

34. MAINTENANCE OF EFFORT SPENDING NOT SUPPORTED

The Department did not have adequate documentation to support the expenditures reported for state fiscal year 2014 to meet the substance abuse program maintenance of effort[45] requirement. The Department reported $124.6 million of expenditures; however, $9 million were estimates and were not supported by actual expenditures.

The Department met the preceding two-year average state expenditures calculation for maintenance of effort including the expenditure estimates; however, if the estimates were excluded the Department would not have met the requirement. Auditors were unable to determine the reasonableness of the estimate or obtain actual expenditures prior to completion of the audit.

[45] Maintenance of Effort is the requirement for a non-federal entity (the State) to maintain (a) a specified level of service from period to period, (b) a specified level of expenditures from non-Federal or Federal sources for specified activities from period to period, and (c) Federal funds to supplement (add to) and not supplant (replace) non-Federal funding of services.

If maintenance of effort spending requirements were not met, it could result in the reduction of future federal allotments and lead to increased state spending to maintain substance abuse services and/or possible reductions in substance abuse services.

Per the Department, the claims processing system was not able to provide reliable Medicaid matching substance abuse expenditure data to support the maintenance of effort calculation. Additionally, the Department did not request the data from two managed care organizations due to time constraints and chose to estimate those expenditures using existing data from other managed care organizations.

In accordance with 42 USC 300x–30 for the maintenance of effort regarding state expenditures, the State "agency will for such year maintain aggregate State expenditures for authorized activities at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant."

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

Federal Award Information: This finding affects the Block Grants for Prevention and Treatment of Substance Abuse federal grant awards TI010032-13, TI010032-14, and TI010032-15 for the federal fiscal years ended September 30, 2013 to 2015.

Recommendations: The Department should ensure that amounts reported to meet the required maintenance of effort are actual expenditures and are supported by accounting records.

The Department should implement procedures to ensure all the necessary substance abuse expenditure data can be captured for use in computing expenditures for compliance with the maintenance of effort requirement.

Agency Response: The Division requested the actual expenditure data from the two managed care organizations for state fiscal year (SFY) 2014. The requested data was subsequently obtained and supported the numbers that had been previously provided in the estimate, confirming that the Department did meet the required maintenance of effort expenditure. The Division will revise its previously estimated reports with actual expenditure data to the Federal Government for SFY2014. All managed care organizations have submitted data for SFY2015 and are now submitting data on a monthly basis.

35. MONITORING PROCEDURES NEED IMPROVEMENT

The Department did not require corrective action plans to address deficiencies noted during the Local Management Entities/Managed Care Organizations (LME/MCO)[46] fiscal monitoring reviews. LME/MCOs received and administered $24.3 million of substance abuse federal funding during the audit period.

[46] Local Management Entities (LMEs) are responsible for managing, coordinating, facilitating and monitoring the provision of mental health, developmental disabilities, and substance abuse services in the area they serve. Managed Care Organizations (MCOs) are organizations that combine the functions of health insurance, delivery of care, and administration.

We reviewed 4 out of 17 fiscal monitoring reviews performed by the Department. In all 4 cases (100%), multiple deficiencies were noted per review, but corrective action plans were not required by the Department from the LME/MCOs. Deficiencies identified that required corrective action included:

- 4 LME/MCOs had unallowable costs due to invoices without supporting documentation or expenditures paid outside grant period.
- 2 LME/MCOs had advance payments to providers before contracts with providers were signed.
- 2 LME/MCOs paid sales tax to non-profit entity.
- 2 LME/MCOs were missing required certification statement that expenditures were for allowable activities/costs.
- 1 LME/MCO had disallowed expenses to a for-profit entity.

The Department's failure to require corrective action plans could result in noncompliance at the LME/MCOs not being corrected in a timely manner.

According to the Department, monitors focused on recouping the funds that were found to be disallowed. They did not focus attention on obtaining the required corrective action plans.

The Department's *Plans of Correction* policy[47] states when noncompliance is identified during a fiscal monitoring review, "a corrective action plan (or Plan of Correction) is due no more than 15 calendar days from the date of receipt by or attempted delivery of the identified out of compliance finding document." The Department must review the Plan of Correction and notify the LME/MCO if the plan is appropriate or not.

Significant aspects of this finding were reported in previous years.

Federal Award Information: This finding affects the Block Grants for Prevention and Treatment of Substance Abuse federal grant awards TI010032-13, TI010032-14, and TI010032-15 for the federal fiscal years ended September 30, 2013 to 2015.

Recommendation: The Department should follow its monitoring policy and ensure required subrecipient corrective action plans are obtained, approved, and implemented to correct federal block grant noncompliance.

Agency Response: While Plans of Correction were not completed during the audit period, disallowed costs found during the settlement reviews were refunded back to the Department. The Division's Plan of Correction Policy was revised and approved on March 13, 2015 and will be updated periodically as needed. The Financial Audit Team has been moved under new leadership and management for increased guidance, supervision, direction and oversight of the settlement review process.

[47] Division of Mental Health, Developmental Disabilities and Substance Abuse Services Policy and Procedure number ACC002

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This audit was conducted in 24,521 hours at an approximate cost of $2,511,084.