State of North Carolina

Office of The State Auditor

Beth A. Wood, CPA

Department of Health and Human Services

Raleigh, North Carolina

Statewide Federal Compliance Audit Procedures

For the Year Ended June 30, 2017

NC OSA

The Taxpayers' Watchdog

STATE OF NORTH CAROLINA
Office of the State Auditor

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AUDITOR'S TRANSMITTAL

The Honorable Roy Cooper, Governor
Members of the North Carolina General Assembly
Dr. Mandy K. Cohen, 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, 2017. We conducted our audit in accordance with the auditing standards generally accepted in the United States of America; the standards applicable to financial audits contained in *Governmental Auditing Standards*, issued by the Comptroller General of the United States; and the audit requirements of Title 2 U.S. *Code of Federal Regulations* Part 200*, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance). 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 major federal programs 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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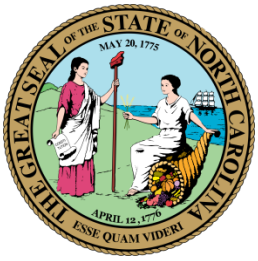
Article V, Chapter 147 of the North Carolina General Statutes, gives the Auditor broad powers to examine all books, records, files, papers, documents, and financial affairs of every state agency and any organization that receives public funding. The Auditor also has the power to summon people to produce 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 REQUIRED BY THE UNIFORM GUIDANCE

Dr. Mandy Cohen, Secretary and the Audit Committee and Management of the North Carolina Department of Health and Human Services

Report on Compliance for Each Major Federal Program

As part of our audit of the State of North Carolina's compliance with the types of requirements described in the *OMB Compliance Supplement* that could have a direct and material effect on each of its major programs for the year ended June 30, 2017, 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 Title 2 U.S. *Code of Federal Regulations* Part 200*, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance) 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 84.126 – Rehabilitation Services – Vocational Rehabilitation Grants to States
- CFDA 93.568 – Low-Income Home Energy Assistance Program (LIHEAP)
- CFDA 93.658 – Foster Care – Title IV-E
- CFDA 93.659 – Adoption Assistance – Title IV-E
- CFDA 93.767 – Children's Health Insurance Program (CHIP)
- 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 93.994 Maternal and Child Health Services Block Grant to the States

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 federal statutes, regulation, and the terms and conditions of its federal awards applicable to its 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 and the Adoption Assistance program. We designated these programs to be audited as major programs at certain local governments by their local government auditors. 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 in conjunction with our audit procedures.

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 the audit requirements of Title 2 U.S*. Code of Federal Regulations* Part 200*, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance). Those standards and the Uniform Guidance 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 the Uniform Guidance. As described in the accompanying schedule of Findings, Recommendations, and Responses section of this report, these include the following findings:

Finding Number	Type of Compliance Requirement	CFDA	Major Federal Program
1	Special Tests and Provisions	10.551	SNAP Cluster
2	Activities Allowed or Unallowed / Allowable Costs / Cost Principles	84.126	Rehabilitation Services - Vocational Rehabilitation Grants to States
3	Allowable Costs / Cost Principles	84.126	Rehabilitation Services - Vocational Rehabilitation Grants to States
4	Matching, Level of Effort, Earmarking	93.568	Low-Income Home Energy Assistance Program
5	Activities Allowed or Unallowed / Allowable Costs / Cost Principles	93.658	Foster Care – Title IV-E
6	Subrecipient Monitoring	93.658	Foster Care – Title IV-E
7	Eligibility	93.659	Adoption Assistance – Title IV-E
8	Subrecipient Monitoring	93.659	Adoption Assistance – Title IV-E
9	Activities Allowed or Unallowed / Allowable Costs / Cost Principles / Eligibility	93.767	Children's Health Insurance Program
10	Allowable Costs / Cost Principles / Eligibility	93.767	Children's Health Insurance Program
14	Activities Allowed or Unallowed / Allowable Costs / Cost Principles / Eligibility	93.778	Medical Assistance Program
15	Allowable Costs / Cost Principles / Eligibility	93.778	Medical Assistance Program
16	Allowable Costs / Cost Principles	93.778	Medical Assistance Program
20	Eligibility	93.778	Medical Assistance Program

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 the Uniform Guidance, 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 for the following findings described in the Findings, Recommendations, and Responses section of this report to be material weaknesses in internal control over compliance.

Finding Number	Type of Compliance Requirement	CFDA	Major Federal Program
4	Matching, Level of Effort, Earmarking	93.568	Low-Income Home Energy Assistance Program
20	Eligibility	93.778	Medical Assistance Program

Furthermore, we consider the deficiencies for the following findings described in the Findings, Recommendations, and Responses section of this report to be significant deficiencies in internal control over compliance.

Finding Number	Type of Compliance Requirement	CFDA	Major Federal Program
1	Special Tests and Provisions	10.551	Supplemental Nutrition Assistance Program
2	Activities Allowed or Unallowed / Allowable Costs / Cost Principles	84.126	Rehabilitation Services - Vocational Rehabilitation Grants to States
3	Allowable Costs / Cost Principles	84.126	Rehabilitation Services - Vocational Rehabilitation Grants to States
5	Activities Allowed or Unallowed / Allowable Costs / Cost Principles	93.658	Foster Care – Title IV-E
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9	Activities Allowed or Unallowed / Allowable Costs / Cost Principles / Eligibility	93.767	Children's Health Insurance Program
10	Allowable Costs / Cost Principles / Eligibility	93.767	Children's Health Insurance Program
11,12,13	Allowable Costs / Cost Principles	93.767	Children's Health Insurance Program
14	Activities Allowed or Unallowed / Allowable Costs / Cost Principles / Eligibility	93.778	Medical Assistance Program
15	Allowable Costs / Cost Principles / Eligibility	93.778	Medical Assistance Program
16	Allowable Costs / Cost Principles	93.778	Medical Assistance Program
17,18	Allowable Costs / Cost Principles/ Special Tests and Provisions	93.778	Medical Assistance Program
19	Special Tests and Provisions	93.778	Medical Assistance Program

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, and accordingly, we express no opinion on the responses.

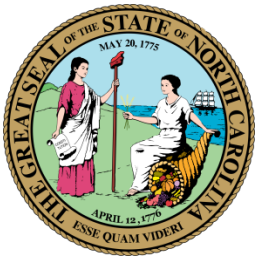
Purpose of Report on Internal Control Over Compliance

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 the Uniform Guidance. Accordingly, this report is not suitable for any other purpose.

Beth A. Wood, CPA
State Auditor

Raleigh, North Carolina

March 19, 2018



FINDINGS, RECOMMENDATIONS, AND RESPONSES

Matters Related to Federal Compliance Audit Objectives

SNAP CLUSTER – SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM

1. ERRORS IN SNAP NOTIFICATIONS AND BENEFIT CALCULATIONS

NC FAST, the Department's automated system for the Supplemental Nutrition Assistance Program (SNAP), did not accurately generate notifications and calculate benefits. During state fiscal year 2017, the Department used NC FAST[1] to process $2.2 billion in benefits for 1.25 million households.

From a sample of 298 SNAP cases totaling $88,451 in benefit payments, auditors identified the following errors:

- In 10 (3.4%) cases, NC FAST either did not generate the required notice or did not generate an accurate notice. Notices communicate changes in eligibility, certification periods, benefit allotments, and adverse actions.
- In 2 (0.6%) cases, NC FAST incorrectly calculated benefits. Errors included using the wrong rates and not properly calculating deductions for housing costs, resulting in overpayments of $155.
- In 2 (0.6%) cases, NC FAST did not accurately or completely process information such as updated rates, deductions for housing costs and income. However, the errors did not affect the benefit amount.

Even though the tests identified only $155 in questioned costs, if extended to the entire population, questioned costs could exceed $25,000[2].

As a result of the errors, SNAP recipients received more benefits than they were entitled to receive. Also, additional program administration costs will be incurred to correct the errors and generate the correct notices.

Three of the notice errors occurred because of system flaws that were identified during the prior year audit. The Department implemented changes to NC FAST in August and September of 2017 that would prevent these types of errors from occurring in the future. However, the changes were not timely enough to prevent the errors from occurring during the audit period.

In the other cases, the Division of Social Services (DSS)[3] and NC FAST staff are trying to determine the root cause of the errors.

Federal regulations[4] require state automated systems to calculate benefits, determine eligibility, and generate notifications. Automation is required for cost effective reductions in errors and improvements in management efficiency, such as decreases in administrative costs.

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1 North Carolina Families Accessing Services through Technology

2 2 CFR 200.516(a)(3) requires auditors to report known questioned costs when likely questioned costs are greater than $25,000.

3 DSS is the division of the Department that is responsible for administering SNAP.

4 7 CFR 272.10(b)

Specifically, federal regulations require the automated system to:

- "Determine eligibility and calculate benefits or validate the eligibility worker's calculations by processing and storing all case file information."

- "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."

This finding was reported in the 2016 Statewide Single Audit Report as finding number 2016-001.

Federal Award Information: Federal Awarding Agency: U.S. Department of Health and Human Services; CFDA Number (title): 10.551 (Supplemental Nutrition Assistance Program); Award Period: October 1, 2015 – September 30, 2016 and October 1, 2016 – September 30, 2017.

Recommendation: Department management should recoup the identified benefit overpayments.

Department management should ensure that priority is given to identifying the root cause of the other errors.

Agency Response: The Department agrees with the results and remains committed to administering the SNAP program in accordance with applicable federal and State requirements. However, the Department notes that the federal regulation cited, 7 CFR 272.10, speaks to "sufficient automation" of a state's system used to calculate benefits, determine eligibility and generate notifications. According to this regulation, "Sufficient automation levels are those which result in effective programs, cost effective reductions in errors and improvements in management efficiency, such as decreases in program administrative costs"; but not 100% accuracy in the performance thereof.

Preliminary investigations have been performed for all the cited errors. For the 10 notification errors, one case will require a change request to update the DSS-8562 Effect of Change notice. Three cases were corrected during the current State fiscal year (SFY '18). For one case, the Department completed root cause analysis and is tracking resolution of the issue. The remaining five notification errors have tasks to analyze the root cause to determine if corrective actions are necessary.

For the two benefit calculation errors, the Department will recoup and process the overpayments according to policy. One error was corrected during the current State fiscal year (SFY '18). The other error will be reviewed to determine if a change request is needed.

The remaining two errors were related to a household income error and a shelter error. These errors had no effect on the benefit amount. Both errors have tasks to analyze the root cause of these scenarios to determine if corrective actions are necessary.

CFDA 84.126 - REHABILITATION SERVICES – VOCATIONAL REHABILITATION GRANTS TO STATES

2. ERRORS IN MEDICAL CLAIMS PAYMENT PROCESS

The Department made payments that did not comply with its policy manual. During the state fiscal year 2017, the Department processed more than 30,000 claims for vocational rehabilitation medical claims services totaling more than $8.7 million.

Auditors tested 79 claims totaling $434,483. One of the 79 (1.3%) claims was paid at the wrong rate, resulting in an overpayment of $438 and federal questioned costs of $345.[5] Even though the test identified only $345 in questioned costs, if tests were extended to the entire population, questioned costs could be greater than $25,000.

As a result of the improper payment, program funds were unavailable to provide rehabilitation services to other eligible clients.

Department personnel stated that the error occurred as a result of human error in manually pricing claims. In addition, there was no supervisory review of the claims pricing.

Federal regulations[6] require the Department to "establish and maintain written policies to govern the rates of payment for all purchased vocational rehabilitation services." The Department's vocational rehabilitation policy manual prescribes that Medicaid or Medicare rates will be used to process medical claims.

For 10 of the past 11 years, the Department has made payments that did not comply with its policy manual. This was most recently reported in the 2016 Statewide Single Audit as finding number 2016-025.

Federal Award Information: This finding affects U.S. Department of Education, CFDA number 84.126 – Rehabilitation Services – Vocational Rehabilitation Grants to States grant awards H126A150049, H126A150050, H126A160049, H126A160050, H126A170049, and H126A170050 for the federal fiscal years ended September 30, 2015 to 2017.

Recommendation: Department management should implement a secondary review process to ensure claims are paid correctly in compliance with its policy manual.

Agency Response: The Department agrees with the finding that only 1 of the 79 (1.3%) claims tested was paid at the wrong rate resulting in an overpayment of $438, federal questioned costs of $345. In SFY 2015-2016, the Division implemented the NCTracks/BEAM interface for the payment of medical, pharmaceutical, and institutional goods and services. Since the implementation of the NCTracks/BEAM interface, there has been a significant decrease from 104 errors (47%) in SFY 2015 to one error (1.3%) noted for SFY 2017. Claims are now only manually priced when the Medicaid rate needs to be modified or added.

[5] 2 CFR 200.516(a)(3) requires auditors to report known questioned costs when likely questioned costs are greater than $25,000.

[6] 34 CFR 361.50

The DHHS Controller's Office provided refresher training during August 2016 to the claims payment staff on manual claims processing. As recommended in the SFY 2016 audit, a secondary review process was implemented in August 2016 to review no less than 10% of all manually priced claims that do not have a Medicaid rate to ensure that claims were calculated and paid correctly. The one error found for SFY 2017 was keyed in July 2016, one month prior to implementing the secondary review process. No additional audit errors were reported after the Division implemented the secondary review process.

3. COST ALLOCATION ERRORS

The Department did not comply with its cost allocation plan (CAP)[7] for the Vocational Rehabilitation (VR) grant. Consequently, the Department improperly charged at least $98,000 in payroll cost to the grant. During the audit period, approximately $45.7 million in Department payroll cost were allocated to the grant.

Auditors reviewed 46 responsibility cost centers (RCC)[8] of a total 2,355[9], representing $4 million of the payroll costs charged to the VR grant. The review found that costs charged to 18 (39%) of the RCCs did not comply with the CAP as follows:

- For 17 (37%) of the RCCs reviewed, inaccurate data was used to allocate costs. Data used included inaccurate full-time equivalent positions, inaccurate square footage allocable to the grant, and an outdated "clients served" report.

- For one (2%) of the RCCs reviewed, salary costs were allocated 100% to the VR Grant for employees that did not exclusively perform VR Grant work. The employees' positions were originally assigned to VR Grant work when the CAP was approved, but the positions were later reassigned to other work. However, the salaries continued to be charged to the grant in error. Further review of all RCCs with salary costs charged 100% to the VR Grant revealed a total of three employees that never worked on the grant and two others that only partially worked on the grant.

As a result, the Department overstated administrative costs of the program by at least $98,000 (federal share $77,737) which may need to be returned and possibly could have been used for other program-specific purposes.

According to Department management, the cost allocation errors occurred because:

- Review of the workbooks used to calculate the basis for and allocate costs was not sufficient.

[7] A cost allocation plan (CAP) provides a narrative description of the procedures that are used to identify, measure, and allocate costs to each administered program.

[8] The Responsibility Cost Center (RCC) is an element in the statewide accounting system which allows the Department to define responsibility areas or reporting needs. A narrative is included in the CAP for each RCC specifically outlining the activities performed by employees with salaries assigned to the RCC, as well as, the type and source of the data used to identify, measure, and allocate activities to the grant.

[9] Auditors sampled each RCC by pay period. Though there were only 196 unique RCCs which contained charges to the VR Grant during the audit period, these RCCs had an opportunity to be selected for each pay period they had charges resulting in the total population noted.

- Monitoring to ensure the continued appropriateness of the CAP was not adequately performed.
- Records that supported the allocations were not properly maintained.

Federal regulations[10] require a state to claim Federal financial participation for costs associated with a program only in accordance with its approved cost allocation plan. All federal costs must be adequately documented.[11]

Further, federal regulations[12] require salary charges to federal awards to be based on "records that accurately reflect the work performed" and must "be supported by a system of internal control which provides reasonable assurance that the charges are accurate [and] allowable…"

Federal Award Information: Federal Awarding Agency: U.S. Department of Education; CFDA Number (title): 84.126 (Rehabilitation Services – Vocational Rehabilitation Grants to States); Federal Award Number (award period): H126A150049, H126A150050, H126A160049, H126A160050, H126A170049, H126A170050 (federal fiscal years ended September 30, 2015 to 2017).

Recommendation: Department management should:

- Enhance the review of all calculations used to allocate costs.
- Implement routine monitoring procedures to ensure employee salary allocations remain appropriate for work being performed and allocation source data is representative.
- Return federal funding for unallowed payroll costs identified as a result of these errors.

Agency Response: The Department agrees with the findings and recommendations. Formula errors and the unavailability of contemporaneous statistics caused the errors in the allocation of certain administrative costs. The Department corrected the formula errors and a new report was developed, which provided contemporaneous statistical data of clients served. The Department has begun to enhance the review of all calculations used to allocate costs by performing monthly allocation variance analyses.

Due to staff oversight, the HR/Payroll system was not updated to reflect position changes and payroll costs were charged to incorrect cost centers. A reconciliation process for organization unit assignments has been implemented to address this issue. The Department will provide training to division budget staff on reviewing and monitoring the Cost Allocation Plan and reemphasize the importance of proper execution of the certification statement process including the necessity of adequate review. In addition, division management and budget staff will periodically review the cost center structure and relevant cost allocation plans to ensure that payroll costs are allocated correctly.

The Department has returned the appropriate amount of federal funding for unallowable payroll costs.

[10] 45 CFR 95.517(a)
[11] 2 CFR 200.403(g)
[12] 2 CFR 200.430(i)(1)(i)

CFDA 93.568 – LOW-INCOME HOME ENERGY ASSISTANCE (LIHEAP)

4. WEATHERIZATION FUNDS WERE OVERSPENT

The Department overspent Low-Income Home Energy Assistance Program (LIHEAP)[13] weatherization[14] funds by $7.3 million.

The Department provided $32.8 million (19%) of the $170 million received from the LIHEAP block grant to the Department of Environmental Quality (DEQ) to provide residential weatherization and other energy-related home repairs to low-income families. However, federal regulations only allowed them to use $25.5 million (15%) on these activities.

As a result, $7.3 million was not available to assist low-income households meet their immediate home energy costs. In addition, subsequent funding could be withheld by the federal government for failure to comply with federal requirements.

According to Division of Social Services Management, they were unaware that LIHEAP funds provided to DEQ for the Heating Air Repair and Replacement Program (HARRP)[15] counted towards the 15% spending limit for weatherization until it was brought to their attention during the prior year audit. However, by that time, the deadline to apply for a waiver that would have allowed them to expend up to 25% on weatherization activities had passed. Therefore the Division provided more than the maximum amount allowed to DEQ for those activities.

Federal regulations[16] require that no more than 15% of the funds allotted or the funds available to the grantee for a federal fiscal year be used for low-cost residential weatherization or other energy-related home repairs unless the federal awarding agency grants a waiver.

This was reported in the 2016 Statewide Single Audit as finding number 2016-045.

Federal Award Information: Federal Awarding Agency: U.S. Department of Health and Human Services; CFDA Number (title): 93.568 (Low-Income Home Energy Assistance Program); Federal Award Number(s) (period) G-15BNCLIEA (October 1, 2014 – September 30, 2016) and G-16B1NCLIEA (October 1, 2015 – September 30, 2017)

Recommendation: Department management should ensure that the staff that oversees grant management have a clear understanding of the weatherization spending requirement and, if necessary, apply for a waiver each year before the submission deadline.

Agency Response: The Department agrees with the finding and has revised its current practice for allocating and expending all Weatherization funds to comply with federal guidance. The Department applied the amount over the 15% federal requirement to the

[13] The primary purpose of LIHEAP is to provide funds to assist eligible households to meet the immediate costs of heating and cooling their residences, including monthly utility bills for gas and electric services.

[14] Weatherization includes the installation of energy conservation materials and the implementation of energy efficiency measures in the home.

[15] The HARRP works in concert with the Weatherization Assistance Program to repair and/or replace inefficient heating systems in homes of low-income families.

[16] 42 USC 8624(k)

Weatherization Assistance Program (WAP) and the Heating Air Repair and Replacement Program (HARRP) to assist low-income households with their energy costs. The Department applied for and received approval for the Weatherization Waiver for FFY 2017.

CFDA 93.658 FOSTER CARE – TITLE IV-E

5. NON-ALLOWED EXPENSES PAID FROM FOSTER CARE FUNDS

The Department improperly charged $522,213 of contract cost for the comprehensive child welfare information system (CCWIS) to the Foster Care Title IV-E federal award (Foster Care). The CCWIS is being implemented to support Foster Care and other federal programs which are sharing the costs of the system. During the fiscal year ended June 30, 2017, the Department allocated $12.6 million of CCWIS contract costs to Foster Care and received $6.3 million in federal reimbursements.

Auditors reviewed the timesheet calculations and supporting data for 13 of 20 contractor invoices charged to Foster Care. For all but one (92%) of the invoices tested, contractor costs were improperly allocated between applicable federal awards.

As a result, $522,213 of CCWIS costs (federal share $261,107) that should have been charged to other programs were charged to Foster Care. The federal share is being questioned.

Improper charging of expenses increases the overall costs necessary for the Foster Care program to achieve its objectives. Foster Care is charged with helping agencies administer Title IV-E programs to provide safe, appropriate, 24-hour, substitute care for children who need temporary placement and care outside their homes.

According to the Department, the allocation errors occurred because:

- Department staff made clerical errors when allocating CCWIS costs to each federal program using the contractor-provided timesheets.
- Department staff did not adequately review the contractor-provided timesheets, some of which contained errors in allocating time worked on the project.
- Department staff lacked a complete understanding of the policies surrounding the distribution of costs between federal programs.

Foster Care funds may be expended for costs related to design, implementation, and operation of a CCWIS which receives any required Administration for Children and Families (ACF) approval on or after August 1, 2016[17]. Costs allocable to a particular federal award generally may not be charged to other federal awards unless specifically indicated in the terms and conditions of the federal awards.[18]

Federal Award Information: Federal Awarding Agency: U.S. Department of Health and Human Services; CFDA Number (title): 93.658 (Foster Care Title IV-E); Federal Award Number (award period): 1701NCFOST (October 1, 2016 to September 30, 2017)

[17] Funds are available for CCWIS qualifying costs for expenditures made on or after August 1, 2016 (45 CFR sections 1355.52, 1355.56, 1355.57, 1356.60(e) and 95.611)

[18] 2 CFR 200.405

Recommendation: Department management should develop and implement review procedures sufficient to detect and correct allocation errors between federal awards. Department management should ensure all staff are aware of and follow policies related to the distribution of costs between federal awards.

Agency Response: The Department agrees with the finding. The error resulted from a procedural issue within the review process whereby expenditures were charged to the wrong cost center. The Department has now implemented a standard review process, which includes additional invoice verification.

6. INADEQUATE SUBRECIPIENT MONITORING INCREASES RISK OF WASTED FUNDS

The Department did not fully follow up on issues identified by its programmatic monitoring of subrecipients (counties) receiving federal pass-through funding for the Title IV-E Foster Care program.

The Department monitors subrecipients on a rotating basis. During fiscal year 2017, the Department monitored 33 subrecipients, accounting for $10 million of the $32 million administered by subrecipients on behalf of Foster Care Title IV-E participants.

In review of supporting documentation of 9 of the 33 counties that were monitored, we determined that in 3 instances (33%) there were findings communicated to the subrecipient. In all 3 of these instances, there was no follow-up performed. For each one of the errors, the findings included payments made on behalf of ineligible children.

Inadequate follow-up of corrective actions increases the risk that payments could be made on behalf of ineligible children, reducing funding available for the intended beneficiaries of the federal programs.

According to Department management, they did not recognize that they should obtain verification from the subrecipients that corrective action was completed for issues identified during the on-site monitoring.

Federal regulations[19] require the pass-through entity to:

> "Monitor the activities of the subrecipient as necessary to ensure that the subaward is used for authorized purposes in compliance with Federal statutes, regulations, and the terms and conditions of the subaward; and that subaward performance goals are achieved."

Furthermore, the pass-through entity is responsible for:

> "Following-up and ensuring that the subrecipient takes timely and appropriate action on all deficiencies pertaining to the Federal award…detected through audits, on-site reviews, and other means."

Federal Award Information: Federal Awarding Agency: U.S. Department of Health and Human Services; CFDA Number (title): CFDA 93.658 (Foster Care Title IV-E); Federal Award Numbers (award period): 1601NCFOST (October 1, 2015 to September 30, 2016) and 1701NCFOST (October 1, 2016 to September 30, 2017)

[19] 2 CFR Part 200.331(d)

Recommendation: Department management should ensure that each monitor has adequate training and understands the required monitoring procedures.

Department management should determine if the amounts paid on behalf of ineligible children should be recouped.

Agency Response: The Department complied with 2 CFR 200.331(d) in monitoring the activities of subrecipients and following up to ensure timely and appropriate action on all deficiencies, including ensuring that all Title IV-E payments were recouped on behalf of ineligible children and verifying that corrective actions were implemented to prevent the use of funds for ineligible children. The Department agrees that the supporting documentation was incomplete in some instances and has since implemented procedures to improve its documentation of follow-up activities.

CFDA 93.659 ADOPTION ASSISTANCE – TITLE IV-E

7. DEFICIENCIES IN COUNTY ELIGIBILITY DETERMINATION PROCESS

The Department made Adoption Assistance Title IV-E payments based on inaccurate and inadequately documented eligibility determinations. During the audit period, approximately 11,400 children received $74.1 million in Adoption Assistance Title IV-E benefits.

The task of determining eligibility for the Adoption Assistance Title IV-E program has been delegated to the county departments of social services[20]. Therefore, Certified Public Accountant (CPA) firms audited county offices and tested 795 case files. CPAs found one or more errors in 28 (3.5%) client files. Specifically:

- 24 (3%) client files were missing some of the required eligibility documentation. Examples of missing information included child abuse and neglect registry checks, background checks, the adoption agreement, and accurate income calculations. However, when auditors determined eligibility using updated information, the children were eligible.
- 4 (0.5%) client files contain ineligible children during the coverage period. For these cases, the adoption agreements were not signed and dated prior to the final adoption decree. Payments of $232,541 were paid to, or on behalf of, these beneficiaries.

As a result, the Department paid at least $232,541 in error that could have been used to provide services for other eligible children.

According to the Department, eligibility is determined only once and continues throughout the life of the case. There is no process to verify ongoing eligibility. Therefore initial eligibility could have been determined several years ago. These initial determinations would have been completed when there was insufficient training to provide clarity on determining eligibility.

[20] *North Carolina General Statute* §108A-25(a)(4)

Federal regulations[21] require the State to maintain documentation of the eligibility determination. Specifically, the State should maintain documentation of:

- Checks of 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.
- An adoption agreement listing the type of services and the amount of the subsidy that was completed, signed, and dated prior to the receipt of benefits.

Federal Award Information: Federal Awarding Agency: U.S. Department of Health and Human Services; CFDA Number (title): 93.659 (Adoption Assistance – Title IV-E); Federal Award Number (award period): 1601NCADPT (October 1, 2015 to September 30, 2016) and 1701NCADPT (October 1, 2016 to September 30, 2017).

Recommendation: Department management should evaluate the identified errors and determine whether the additional work to identify errors from previous years is warranted. Further, Department management should evaluate whether further training is needed.

Agency Response: The Department agrees with the finding and will continue to provide training, monitoring, and guidance to county departments of social services to ensure the adequacy of the eligibility determination process. The Department will evaluate identified errors and determine whether additional work to identify errors from previous years is warranted.

8. INADEQUATE SUBRECIPIENT MONITORING INCREASES RISK OF WASTED FUNDS

The Department did not fully follow up on issues identified by its programmatic monitoring of subrecipients (counties) receiving federal pass-through funding for the Title IV-E Adoption Assistance program.

The Department monitors subrecipients on a rotating basis. During fiscal year 2017, the Department monitored 33 subrecipients, accounting for $21 million of the $50 million administered by subrecipients on behalf of Adoption Assistance Title IV-E participants.

In review of supporting documentation of 9 of the 33 counties that were monitored, we determined that in 3 instances (33%) there were findings communicated to the subrecipient. In all 3 of these instances, there was no follow-up performed. In each one of the errors identified, the findings included payments made on behalf of ineligible children.

Inadequate follow-up of corrective actions increases the risk that payments could be made on behalf of ineligible children, reducing funding available for the intended beneficiaries of the federal programs.

According to Department management, they did not recognize that they should obtain verification from the subrecipients that corrective action was completed for issues identified during the on-site monitoring.

[21] 42 USC 671 and 42 USC 675

Federal regulations[22] require the pass-through entity to:

> "Monitor the activities of the subrecipient as necessary to ensure that the subaward is used for authorized purposes in compliance with Federal statutes, regulations, and the terms and conditions of the subaward; and that subaward performance goals are achieved."

Furthermore, the pass-through entity is responsible for:

> "Following-up and ensuring that the subrecipient takes timely and appropriate action on all deficiencies pertaining to the Federal award…detected through audits, on-site reviews, and other means."

Federal Award Information: Federal Awarding Agency: U.S. Department of Health and Human Services; CFDA Number (title): CFDA 93.659 (Adoption Assistance Title IV-E); Federal Award Number(s) (period): 1601NCADPT (October 1, 2015 to September 30, 2016) and 1701NCADPT (October 1, 2016 to September 30, 2017).

Recommendation: Department management should ensure that each monitor has adequate training and understands the required monitoring procedures.

Department management should determine if the amounts paid on behalf of ineligible children should be recouped.

Agency Response: The Department complied with 2 CFR 200.331(d) in monitoring the activities of subrecipients and following up to ensure timely and appropriate action on all deficiencies, including ensuring that all Title IV-E payments were recouped on behalf of ineligible children and verifying that corrective actions were implemented to prevent the use of funds for ineligible children. The Department agrees that the supporting documentation was incomplete in some instances and has since implemented procedures to improve its documentation of follow-up activities.

CFDA 93.767 CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

9. ERRORS IN CHILDREN'S HEALTH INSURANCE FEE-FOR-SERVICE CLAIMS PAYMENT PROCESS

The Department made an estimated $1.1 million net overpayment to Children's Health Insurance Program (CHIP) providers during state fiscal year 2017. During that period, the Department processed more than 4.1 million payments for fee-for-service claims totaling $394.5 million.

Auditors reviewed a statistical sample of 299 fee-for-service payments totaling approximately $3.4 million and identified 12 (4.0%) payments that contained errors. Specifically:

- 6 (2.0%) claims contained medical coding errors. The result was a net underpayment of $38,045 (federal share $38,019).

[22] 2 CFR Part 200.331(d)

- 5 (1.7%) claims were reimbursed using payment rates that were expired or superseded at the claim date(s) of service. The result was a net underpayment of $102 (federal share $102).
- 1 (0.3%) claim lacked documentation to support performance of services rendered by the provider. The result was an overpayment of $3,804 (federal share $3,780).

As a result, the Department overpaid an estimated $1.1[23] million that could have been used to provide additional services to other eligible beneficiaries or reduce overall program costs.

According to the Department, there were various reasons for the errors identified. Documentation and medical coding errors were due to record retention and clerical errors on behalf of health care providers.

Additionally, per the Department, the rate errors were related to the implementation of pharmacy rates. Pharmacy rates are provided to the Department via First Databank weekly with effective dates that may be earlier than the date received. The Department then enters the pharmacy rates into the system. Therefore, a delay in implementing the new rates typically exists resulting in incorrect payments for this time period.

Federal regulations[24] require costs to be adequately documented; authorized; necessary and reasonable; and be consistent with program regulations that apply to the federal award.

Additionally, providers sign an agreement[25] that requires them to maintain records disclosing the extent of services furnished to recipients and, on request, furnish the records to the Department.

This finding was previously reported in the 2016 Statewide Single Audit as finding number 2016-052.

Federal Award Information: Federal Awarding Agency: U.S. Department of Health and Human Services; CFDA Number (title): 93.767 (Children's Health Insurance Program (CHIP; Title XXI)); Federal Award Number (award period): 05-1605NC5021 (October 1, 2015 to September 30, 2016) and 1705NC0301 (October 1, 2016 to September 30, 2017).

Recommendation: Department management should analyze each error and take immediate and appropriate corrective action including but not limited to education of providers, on-site or focused reviews, and limit the amount of time for submitting the requested documentation.

[23] Auditors used stratified sampling to calculate the most likely error of $1.1 million in overpayments. The majority of the underpayment errors were found in a stratum that represented only 8.9% of the population. The majority of the overpayment errors were found in a stratum that represented 43.1% of the population. Consequently, when the errors were projected into the total claims population, a net overpayment resulted. When the errors are evaluated at a 90% confidence interval, the results are unlikely to be less than an underpayment of $22.2 million or more than an overpayment of $24.5 million

[24] 2 CFR 200.403

[25] In accordance with 42 CFR 431.107

Department management should ensure the proper and timely implementation of rate changes. In cases where rates are implemented after their effective date, any overpayments and underpayments should be corrected.

Identified over and underpaid claims should be followed up for timely and appropriate collection or payment.

Agency Response: The Department partially agrees with this finding. The Department agrees with the claims documentation and coding errors as identified. The responsibility for creating and maintaining appropriate medical record documentation and coding claims for payment lies with the provider. The Department routinely provides education to providers which details documentation and coding requirements per applicable federal, state and local laws, regulatory rules and/or practice. The Department will reiterate to providers the requirement to create and maintain proper medical record documentation to support the medical necessity and coding of services billed to the Medicaid Program via the monthly Medicaid Bulletin, NCTracks Provider Portal and other communication venues. The Department will review the claims errors cited in the report to determine which errors may be resolved by requiring additional documentation from the providers. Appropriate recoupment efforts will be made as necessary.

Regarding the errors relating to the use of expired or superseded rates, the Department processed the claims in accordance with standard industry practice and internal procedures. These errors consisted of five (5) pharmacy rate claims. Pharmacy rate claims are reimbursed using the rate that is active in NCTracks on the date of claim adjudication. Following standard industry practice, the Department does not systematically reprocess pharmacy claims impacted by subsequent drug rate adjustments (which typically increase the price of the drug). However, pharmacy providers may void and resubmit their claims to receive the adjusted drug rate. The Department has received concurrence from CMS that this practice meets its expectations.

10. ERRORS IN MANAGEMENT FEE PAYMENT PROCESS

The Department made approximately $6 million in capitation claim[26] overpayments to Local Management Entities and Managed Care Organizations (LME/MCO)[27] during the state fiscal year 2017. During that period, the Department processed more than 22 million capitation payments to LME/MCOs totaling more than $2.7 billion.

Auditors recalculated the capitation claim payments made to LMEs and MCOs during the audit period. The tests revealed that the Department made approximately:

- $5.9 million in Medicaid overpayments.
- $72,000 in Children's Health Insurance Program (CHIP) overpayments.

[26] Capitation payments are fixed monthly claim payments to contracted providers in lieu of fee-for-service payments for Medicaid participants.

[27] Local Management Entity/Managed Care Organizations (LME/MCOs) are quasi-governmental entities that contract with the NC Department of Health and Human Services (Department) to provide management and oversight of the public system of mental health, developmental disabilities, and substance abuse services at the community level.

As a result, the Department made approximately $6 million in overpayments to the LME/MCOs, money that could have been used to provide additional services or reduce overall program cost. In addition, the Department may be required to repay the federal share of approximately $4 million, which is being questioned ($3.9 million for Medicaid; $72,000 for CHIP).

According to the Department, NCTracks[28] was not properly designed to void original payments when reissuing corrected payments. A corrected payment would be necessary when there is a change to the recipient, such as eligibility. The Department is aware of the overpayments caused by the system limitations and is actively working to correct the payments made in error.

Federal regulations[29] require costs to be adequately documented, authorized, necessary and reasonable, and be consistent with program regulations applicable to the federal award.

Federal Award Information: Federal Awarding Agency: U.S. Department of Health and Human Services; CFDA Number (title): 93.767 (Children's Health Insurance Program (CHIP; Title XXI)); Federal Award Number (award period): 05-1605NC5021 (October 1, 2015 to September 30, 2016) and 1705NC0301 (October 1, 2016 to September 30, 2017).

Recommendation: Department management should ensure that NCTracks is properly designed to correctly make payments. Additionally, Department management should continue their efforts to recoup the payments made in error.

Agency Response: The Department agrees with this finding. Prior to the NCTracks vendor (CSRA) installing a software upgrade in May 2016, NCTracks correctly adjusted the original capitation payment when recipient eligibility changed and a corrected payment was issued. After installation of this software upgrade, the Department determined that certain split eligibility spans were causing incorrect capitation payments and began working with CSRA to identify the root cause and correct the payments. CSRA implemented a software upgrade to correct this problem in August 2017. The Department recouped the overpayments on December 5, 2017 and February 6, 2018.

11. DEFICIENCIES IN SYSTEM ACCESS

The results of our audit disclosed security deficiencies considered reportable under generally accepted *Government Auditing Standards*. These deficiencies are reported to the Department by separate letter in accordance with these standards. These items should be kept confidential as provided by *North Carolina General Statute* 132-6.1(c).

Federal Award Information: Federal Awarding Agency: U.S. Department of Health and Human Services; CFDA Number (title): 93.767 (Children's Health Insurance Program (CHIP; Title XXI)); Federal Award Number (award period): 05-1605NC5021 (October 1, 2015 to September 30, 2016) and 1705NC0301 (October 1, 2016 to September 30, 2017).

Agency Response: The Department is committed to maintaining adequate information security and system access controls. The Department has designed and/or implemented

[28] NCTracks is the information system that processes Medicaid and CHIP claim payments.
[29] 2 CFR 200.403

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.

12. DELAYED REMEDIATION OF WEAKNESSES

The results of our audit disclosed a security deficiency considered reportable under generally accepted *Government Auditing Standards*. These deficiencies are reported to the Department by separate letter in accordance with these standards. These items should be kept confidential as provided by *North Carolina General Statute* 132-6.1(c).

Federal Award Information: Federal Awarding Agency: U.S. Department of Health and Human Services; CFDA Number (title): 93.767 (Children's Health Insurance Program (CHIP; Title XXI)); Federal Award Number (award period): 05-1605NC5021 (October 1, 2015 to September 30, 2016) and 1705NC0301 (October 1, 2016 to September 30, 2017).

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.

13. LACK OF QUALITY ASSURANCE REVIEWS INCREASED RISK OF UNDETECTED PAYMENT ERRORS

The Department did not adequately review the work of a Medicaid contractor. Specifically, the Department did not perform quality assurance reviews of the Public Consulting Group's (PCG) work for half of the 2017 fiscal year. PCG was contracted to review payments made to Medicaid providers. These required reviews evaluate the need for and the quality and timeliness of Medicaid services, which also helps to prevent, reduce, identify, and address suspected fraud[30]. The Department paid a total of approximately $11.4 billion to 19,786 enrolled providers during the fiscal year ended June 30, 2017.

Each quarter, the Department was required to select samples of the PCG case files for a quality assurance review. However, the Department failed to select a sample from 441 of the 589 (75%) PCG-reviewed case files during 2017. Specifically, the Department's monitoring consisted of:

- Qtr. 1 – reviewed 63 sample items from a population of 87 PCG case files.
- Qtr. 2 – reviewed 34 sample items from a population of 61 PCG case files.
- Qtr. 3 – reviewed 0 sample items from a population of 201 PCG case files.
- Qtr. 4 – reviewed 0 sample items from a population of 240 PCG case files.

Because adequate quality assurance reviews were not performed, there was an increased risk that payment errors could have occurred and remained undetected. Without adequate monitoring, the Department did not have reasonable assurance that PCG effectively reviewed claims and identified payment errors.

[30] 42 CFR parts 455, 456, and 1002

Additionally, monitoring of PCG was important because the Department identified performance problems with PCG before. As previously reported,[31] the Department identified problems with PCG reviews in 23 of 25 (92%) quality assurance evaluations that the Department performed between June 2012 and January 2014.

According to Department management, no quality assurance reviews were performed during the last half of the 2017 fiscal year because the Department lost its statistician. The statistician was responsible for selecting case files for quality assurance reviews. With the statistician gone, the Department did not have anyone who understood the sampling methodology used to select case files for review.

The Department's manual[32] requires quality assurance reviews. The manual states the Department is to perform oversight and monitoring of all vendor contract terms and conditions including, but not limited to conducting quality assurance reviews of contract work. The quality assurance reviews help ensure that the contractor conducts its reviews in accordance with Department approved review guidelines and operational processes.

Furthermore, Federal regulations[33] require the Department to "establish and maintain effective internal control over the federal award that provides reasonable assurance that the non-federal entity is managing the federal award in compliance with federal statutes, regulation, and the terms and conditions of the federal award." The ongoing quality assurance reviews would be an effective control over compliance.

Federal Award Information: Federal Awarding Agency: U.S. Department of Health and Human Services; CFDA Number (title): 93.767 (Children's Health Insurance Program (CHIP; Title XXI)); Federal Award Number (award period): 05-1605NC5021 (October 1, 2015 to September 30, 2016) and 1705NC0301 (October 1, 2016 to September 30, 2017).

Recommendation: Department management should document the sampling methodology so that it is available to other employees in the future. The Department should also train more than one individual to perform the sampling plan or develop other contingency plans to ensure that ongoing quality assurance reviews can be performed.

Agency Response: The Department agrees with the finding. We have now completed these case reviews, and have hired new staff to ensure future reviews are completed timely. The vacancy of the statistician role within the Office of Compliance and Program Integrity ("OCPI") resulted in a knowledge gap which impeded the timely completion of the quality assurance case reviews. The Data Analytics Manager role was filled during August 2017 and immediately focused on the backlog of work items previously handled by the statistician. The quality assurance case reviews of PCG for the 3rd and 4th quarters were completed by mid-October 2017 and resulted in review ratings of 98.9% for 3rd quarter and 100% for 4th quarter without any findings that would warrant a Plan of Correction for the vendor. On November 3, 2017, the Data Analytics Manager trained three additional staff on random sample selection for the quality assurance case reviews

[31] OSA report, DHHS-Medicaid Durable Medical Equipment Claims, pg. 4, August 2016
[32] North Carolina Department of Health and Human Services Division of Medical Assistance Program Integrity Unit Operations Manual
[33] 2 CFR 200.303.

to ensure future reviews are completed timely. The procedure is documented in the OCPI Operations Manual.

MEDICAID CLUSTER

14. ERRORS IN MEDICAID FEE-FOR-SERVICE CLAIMS PAYMENT PROCESS

The Department made an estimated $34.2 million net overpayment to Medicaid providers during state fiscal year 2017. During that period, the Department processed more than 61.5 million payments of fee-for-service claims totaling $8.0 billion.

Auditors reviewed a statistical sample of 565 fee-for-service claim payments totaling approximately $13.7 million and identified 18 (3.2%) payments that contained errors. Specifically:

- 7 (1.2%) claims were reimbursed using payment rates that were expired or superseded at the claim date(s) of service. The result was a net underpayment of $313 (federal share $209).
- 6 (1.1%) claims contained medical coding errors which impacted payment calculation. The result was a net overpayment of $98,787 (federal share $65,590).
- 3 (0.5%) claims lacked documentation to support the amount of time charged for services rendered by the provider. The result was a net overpayment of $526 (federal share $348).
- 2 (0.4%) claims did not properly consider the patient's third party insurance. In one instance, the claim was not reprocessed after the third party liability amount was updated retroactively. In the other instance, the claim was paid prior to third party insurance being applied. The vendor used by the Department did not pursue recovery from the third party insurance provider. The result was an overpayment of $197 (federal share $132).

As a result, the Department overpaid an estimated $34.2[34] million that could have been used to provide additional services to other eligible beneficiaries or reduce overall program costs. Additionally, the overpayments of $99,197 (federal share $65,861) found in the sample are being questioned.

According to the Department, there were various reasons for the errors identified. The documentation and coding errors were due to clerical errors and inadequate documentation being kept by health care providers.

Additionally, per the Department, other errors were the result of the following:

- Some of the rate errors were related to the implementation of pharmacy rates. Pharmacy rates are provided to the Department via First Databank weekly with effective dates that may be earlier than the date received. The Department then enters the pharmacy rates into the system. Therefore, a delay in implementing the new rates typically exists resulting in incorrect payments for this time period.

[34] When the known error is projected to the entire population, the likely total error is $34.2 million. When the errors are evaluated at a 90% confidence interval, the results are unlikely to be less than an underpayment of $203.8 million or more than an overpayment of $272.1 million.

- For the other rate errors, the Department did not implement payment rates timely.
- The third party insurance vendor did not pursue recovery because they were missing information.

Federal regulations[35] require costs to be adequately documented; authorized; necessary and reasonable; and be consistent with program regulations that apply to the federal award. Additionally, providers sign an agreement[36] that requires them to maintain records disclosing the extent of services furnished to recipients and, on request, furnish the records to the Department.

This finding was previously reported in the 2016 Statewide Single Audit as finding number 2016-055.

Federal Award Information: Federal Awarding Agency: U.S. Department of Health and Human Services; CFDA Number (title): 93.778 (Medical Assistance Program (Medicaid; Title XIX)); Federal Award Number (award period): 05-1605NC5MAP (October 1, 2015 to September 30, 2016) and 1705NC5MAP (October 1, 2016 to September 30, 2017).

Recommendation: Department management should analyze each error and take immediate and appropriate corrective action including, but not limited to, education of providers, on-site or focused reviews, and limit the amount of time for submitting the requested documentation.

Department management should ensure the proper and timely implementation of rate changes. In cases where rates are implemented after their effective date, any overpayments and underpayments should be corrected.

Department management should also implement a system to ensure claims submitted to the third party liability recovery vendor include all required documents.

Identified over and underpaid claims should be followed up for timely and appropriate collection or payment.

Agency Response: The Department partially agrees with this finding. The Department agrees with the claims documentation and coding errors as identified. The responsibility for creating and maintaining appropriate medical record documentation and coding claims for payment lies with the provider. The Department routinely provides education to providers which details documentation and coding requirements per applicable federal, state and local laws, regulatory rules and/or practice. The Department will reiterate to providers the requirement to create and maintain proper medical record documentation to support the medical necessity and coding of services billed to the Medicaid Program via the monthly Medicaid Bulletin, NCTracks Provider Portal and other communication venues. The Department will review the claim errors cited in the report to determine which errors may be resolved by requiring additional documentation from the providers. Appropriate recoupment efforts will be made as necessary.

Regarding the errors relating to the use of expired or superseded rates, the Department processed the claims in accordance with standard industry practice and internal

[35] 2 CFR 200.403
[36] In accordance with 42 CFR 431.107

procedures. The seven (7) claims consisted of five (5) pharmacy rate claims and two (2) private duty nursing claims. Pharmacy rate claims are reimbursed using the rate that is active in NCTracks on the date of claim adjudication. Following standard industry practice, the Department does not systematically reprocess pharmacy claims impacted by subsequent drug rate adjustments (which typically increase the price of the drug). However, pharmacy providers may void and resubmit their claims to receive the adjusted drug rate. The Department has received concurrence from CMS that this practice meets its expectations. Non-pharmacy rate changes, including claims for private duty nursing, are not implemented until approved by CMS. There is always a lag between a rate adjustment being approved by the legislature and the corresponding approval from CMS. The private duty nursing claims cited in error were processed prior to the Department's receipt of CMS' approval for the retroactive rate change. Following our normal internal procedures, these claims were subsequently reprocessed and paid at the new rate.

The Department will continue to work with its third-party liability vendor to ensure third party insurance data is captured and applied timely to claim processing.

15. ERRORS IN MANAGEMENT FEE PAYMENT PROCESS

The Department made approximately $6 million in capitation claim[37] overpayments to Local Management Entities and Managed Care Organizations (LME/MCO)[38] during the state fiscal year 2017. During that period, the Department processed more than 22 million capitation payments to LME/MCOs totaling more than $2.7 billion.

Auditors recalculated the capitation claim payments made to LMEs and MCOs during the audit period. The tests revealed that the Department made approximately:

- $5.9 million in Medicaid overpayments.
- $72,000 in Children's Health Insurance Program (CHIP) overpayments.

As a result, the Department made approximately $6 million in overpayments to the LME/MCOs, money that could have been used to provide additional services or reduce overall program cost. In addition, the Department may be required to repay the federal share of approximately $4 million, which is being questioned ($3.9 million for Medicaid; $72,000 for CHIP).

According to the Department, NCTracks[39] was not properly designed to void original payments when reissuing corrected payments. A corrected payment would be necessary when there is a change to the recipient, such as eligibility. The Department is aware of the overpayments caused by the system limitations and is actively working to correct the payments made in error.

[37] Capitation payments are fixed monthly claim payments to contracted providers in lieu of fee-for-service payments for Medicaid participants.

[38] Local Management Entity/Managed Care Organizations (LME/MCOs) are quasi-governmental entities that contract with the NC Department of Health and Human Services (Department) to provide management and oversight of the public system of mental health, developmental disabilities, and substance abuse services at the community level.

[39] NCTracks is the information system that processes Medicaid and CHIP claim payments.

Federal regulations[40] require costs to be adequately documented, authorized, necessary and reasonable, and be consistent with program regulations applicable to the federal award.

Federal Award Information: Federal Awarding Agency: U.S. Department of Health and Human Services; CFDA Number (title): 93.778 (Medical Assistance Program (Medicaid; Title XIX)); Federal Award Number (award period): 05-1605NC5MAP (October 1, 2015 to September 30, 2016) and 1705NC5MAP (October 1, 2016 to September 30, 2017).

Recommendation: Department management should ensure that NCTracks is properly designed to correctly make payments. Additionally, Department management should continue their efforts to recoup the payments made in error.

Agency Response: The Department agrees with this finding. Prior to the NCTracks vendor (CSRA) installing a software upgrade in May 2016, NCTracks correctly adjusted the original capitation payment when recipient eligibility changed and a corrected payment was issued. After installation of this software upgrade, the Department determined that certain split eligibility spans were causing incorrect capitation payments and began working with CSRA to identify the root cause and correct the payments. CSRA implemented a software upgrade to correct this problem in August 2017. The Department recouped the overpayments on December 5, 2017 and February 6, 2018.

16. INADEQUATE REVIEWS RESULTED IN OVERPAYMENTS TO HOSPITALS

The Department overpaid hospitals $244,751 and erroneously received an additional $31,701 in federal funds related to disproportionate share hospital (DSH), enhanced, and supplemental payments.[41] The Department made more than $2.4 billion in DSH, enhanced, and supplemental payments during the fiscal year ended June 30, 2017.

Auditors reviewed 100% of the DSH, enhanced, and supplemental payments to hospitals and identified the following errors:

- The Department failed to update payment calculations after receiving new information for three hospitals. The Department incorrectly certified public expenditures[42] which resulted in the Department inappropriately receiving $31,701 in federal funds. The Department also underpaid $4,630 to various hospitals as a result of this error.
- The Department's calculation for one hospital was inconsistent with the guidelines described in the Medicaid State Plan. As a result, the Department incorrectly overpaid the hospital $249,381.

The total errors identified resulted in a net overpayment of $244,751 and overdrawing federal funds of $31,701. Federal regulations[43] require auditors to report known

[40] 2 CFR 200.403

[41] Medicaid disproportionate share hospital payments and other Medicaid enhanced and supplemental hospital payments provide financial assistance to hospitals that serve low-income patients.

[42] Certified public expenditures are certifications by local hospitals that they have spent funds on items or services that are eligible for reimbursement from the federal Medicaid program. These expenditures are recognized by the federal government as eligible reimbursable expenditures. The federal funds are provided to the Department for the federal share of these eligible expenditures.

[43] 2 CFR 200.516(a)(3)

questioned costs greater than $25,000. As a result, the Department will be required to repay the net federal share of $193,824.

The errors occurred and were not detected because of a lack of adequate review. During the fiscal year, the Division of Medical Assistance Chief Financial Officer (DMA CFO) position was vacant. The employee responsible for the above-referenced calculations was also given the role of acting DMA CFO. The staff performing the calculations did not have adequate knowledge/experience, and the acting DMA CFO did not have time to complete a thorough review.

Office of Management and Budget Uniform Guidance requires that grant program costs must be in accordance with federal guidelines and[44] the methodologies in the CMS approved Medicaid State Plan.[45] Payments which are not within the federal regulation and the Medicaid State Plan are not allowable.

Federal Award Information: Federal Awarding Agency: U.S. Department of Health and Human Services; CFDA Number (title): 93.778 (Medical Assistance Program (Medicaid; Title XIX)); Federal Award Number (award period): 05-1605NC5MAP (October 1, 2015 to September 30, 2016).

Recommendation: Department management should train additional staff to assist in the performance and review of the payment calculations of Medicaid DSH, enhanced, and supplemental payments to hospitals.

Agency Response: The Department agrees with the finding. The DSH/MRI/GAP model is a complex payment plan model which has historically involved two staff for operation and oversight. As noted in the audit finding, staff capacity was reduced during this period. The Department has trained additional staff from the DMA Provider Audit team to ensure adequate review and oversight of the DSH/MRI/GAP model. This team furnishes additional levels of data verification for the model as well as additional levels of review and signoff on memoranda for required transactions.

The Department has taken actions in the October 2017-December 2017 quarter to correct the over certification of public expenditures, to recover the $249,381 in overpayment of DSH from the noted hospital provider, and to return the appropriate net federal funds.

17. DEFICIENCIES IN SYSTEM ACCESS

The results of our audit disclosed security deficiencies considered reportable under generally accepted *Government Auditing Standards*. These deficiencies are reported to the Department by separate letter in accordance with these standards. These items should be kept confidential as provided by *North Carolina General Statute* 132-6.1(c).

Federal Award Information: Federal Awarding Agency: U.S. Department of Health and Human Services; CFDA Number (title): 93.778 (Medical Assistance Program (Medicaid; Title XIX)); Federal Award Number (award period): 05-1605NC5MAP (October 1, 2015 to September 30, 2016) and 1705NC5MAP (October 1, 2016 to September 30, 2017).

[44] 2 CFR 200 Subpart E
[45] 42 CFR §447.201(b) and 42 CFR §447.252(b)

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.

18. DELAYED REMEDIATION OF WEAKNESSES

The results of our audit disclosed a security deficiency considered reportable under generally accepted *Government Auditing Standards*. These deficiencies are reported to the Department by separate letter in accordance with these standards. These items should be kept confidential as provided by *North Carolina General Statute* 132-6.1(c).

Federal Award Information: Federal Awarding Agency: U.S. Department of Health and Human Services; CFDA Number (title): 93.778 (Medical Assistance Program (Medicaid; Title XIX)); Federal Award Number (award period): 05-1605NC5MAP (October 1, 2015 to September 30, 2016) and 1705NC5MAP (October 1, 2016 to September 30, 2017).

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.

19. LACK OF QUALITY ASSURANCE REVIEWS INCREASED RISK OF UNDETECTED PAYMENT ERRORS

The Department did not adequately review the work of a Medicaid contractor. Specifically, the Department did not perform quality assurance reviews of the Public Consulting Group's (PCG) work for half of the 2017 fiscal year. PCG was contracted to review payments made to Medicaid providers. These required reviews evaluate the need for and the quality and timeliness of Medicaid services, which also helps to prevent, reduce, identify, and address suspected fraud[46]. The Department paid a total of approximately $11.4 billion to 19,786 enrolled providers during the fiscal year ended June 30, 2017.

Each quarter, the Department was required to select samples of the PCG case files for a quality assurance review. However, the Department failed to select a sample from 441 of the 589 (75%) PCG-reviewed case files during 2017. Specifically, the Department's monitoring consisted of:

- Qtr. 1 – reviewed 63 sample items from a population of 87 PCG case files.
- Qtr. 2 – reviewed 34 sample items from a population of 61 PCG case files.
- Qtr. 3 – reviewed 0 sample items from a population of 201 PCG case files.
- Qtr. 4 – reviewed 0 sample items from a population of 240 PCG case files.

[46] 42 CFR parts 455, 456, and 1002

Because adequate quality assurance reviews were not performed, there was an increased risk that payment errors could have occurred and remained undetected. Without adequate monitoring, the Department did not have reasonable assurance that PCG effectively reviewed claims and identified payment errors.

Additionally, monitoring of PCG was important because the Department identified performance problems with PCG before. As previously reported,[47] the Department identified problems with PCG reviews in 23 of 25 (92%) quality assurance evaluations that the Department performed between June 2012 and January 2014.

According to Department management, no quality assurance reviews were performed during the last half of the 2017 fiscal year because the Department lost its statistician. The statistician was responsible for selecting case files for quality assurance reviews. With the statistician gone, the Department did not have anyone who understood the sampling methodology used to select case files for review.

The Department's manual[48] requires quality assurance reviews. The manual states the Department is to perform oversight and monitoring of all vendor contract terms and conditions including, but not limited to conducting quality assurance reviews of contract work. The quality assurance reviews help ensure that the contractor conducts its reviews in accordance with Department approved review guidelines and operational processes.

Furthermore, Federal regulations[49] require the Department to "establish and maintain effective internal control over the federal award that provides reasonable assurance that the non-federal entity is managing the federal award in compliance with federal statutes, regulation, and the terms and conditions of the federal award." The ongoing quality assurance reviews would be an effective control over compliance.

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Recommendation: Department management should document the sampling methodology so that it is available to other employees in the future. The Department should also train more than one individual to perform the sampling plan or develop other contingency plans to ensure that ongoing quality assurance reviews can be performed.

Agency Response: The Department agrees with the finding. We have now completed these case reviews, and have hired new staff to ensure future reviews are completed timely. The vacancy of the statistician role within the Office of Compliance and Program Integrity ("OCPI") resulted in a knowledge gap which impeded the timely completion of the quality assurance case reviews. The Data Analytics Manager role was filled during August 2017 and immediately focused on the backlog of work items previously handled

[47] OSA report, DHHS-Medicaid Durable Medical Equipment Claims, pg. 4, August 2016
[48] North Carolina Department of Health and Human Services Division of Medical Assistance Program Integrity Unit Operations Manual
[49] 2 CFR 200.303.

by the statistician. The quality assurance case reviews of PCG for the 3rd and 4th quarters were completed by mid-October 2017 and resulted in review ratings of 98.9% for 3rd quarter and 100% for 4th quarter without any findings that would warrant a Plan of Correction for the vendor. On November 3, 2017, the Data Analytics Manager trained three additional staff on random sample selection for the quality assurance case reviews to ensure future reviews are completed timely. The procedure is documented in the OCPI Operations Manual.

20. DEFICIENCIES IN COUNTY ELIGIBILITY DETERMINATION PROCESS

The Department made Medical Assistance Program (Medicaid) payments to beneficiaries based on inaccurate and inadequately documented eligibility determinations. During the audit period, approximately 1.9 million beneficiaries received $10.9 billion in Medicaid benefits.

The task of determining eligibility for the Medicaid program has been delegated to the county departments of social services.[50] Therefore, Certified Public Accountant (CPA) firms audited county offices and tested 8,861 case files. CPAs found one or more errors in 624 (7.02%) client files. Specifically:

- 540 (6.1%) client files were missing some of the required eligibility documentation. Examples of missing information included proof of residency, online verification documentation, and accurate income calculations. However when auditors determined eligibility using updated information, the beneficiary was eligible.
- 82 (0.9%) client files contained ineligible beneficiaries during the coverage period. In these cases, errors included incorrect certification periods,[51] inaccurate eligibility determination calculations, inaccurate program certifications, and untimely termination of cases. Payments totaling $407,701 were paid to, or on behalf of, these ineligible beneficiaries.
- 2 (0.02%) client files were missing, and the eligibility determinations could not be substantiated. Payments totaling $266 were paid to, or on behalf of, the beneficiaries.

As a result, the Department paid at least $407,967 in error that could have been used to provide services to other eligible beneficiaries.

According to the Department, two factors contributed to these errors.

First, the Department did not provide adequate training to ensure all county departments of social services were determining eligibility correctly and consistently.

Second, the Department did not effectively monitor eligibility determinations performed by the county departments of social services. As a result, the Department could not ensure that the counties made accurate eligibility determinations and

[50] *North Carolina General Statute* §108A-25(b)

[51] The certification period is the continuous eligibility period for which the participant is considered eligible for services.

maintained program documentation in the case file for the traditional cases[52].

Federal regulations[53] require that the Department or its designee determine client eligibility for all individuals applying for or receiving benefits in accordance with eligibility requirements defined in the approved State plan.

Further, federal regulations[54] require applicable documentation be obtained to determine if a beneficiary meets specific income standards and documentation must be maintained to support eligibility determinations.

This finding was previously reported in the 2016 Statewide Single Audit as finding number 2016-056.

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Recommendation: Department management should ensure eligibility determinations are performed accurately and are adequately documented. Specifically:

- Department management should develop and provide additional training to the county departments of social services on the requirements for eligibility determinations, including proper documentation.
- Department management should also monitor eligibility determinations of the county departments of social services to ensure traditional eligibility determinations are completed accurately and supporting documentation is maintained in case files.

Agency Response: The Department agrees with the finding. The NC Medicaid Policy Manual specifies the documentation required to be maintained in the beneficiary's eligibility file. The DHHS Policy Governance Board will issue NC FAST documentation guidelines which identify where documentation for the determination of eligibility is to be stored within NC FAST. Counties will be required to conform to these guidelines beginning June 1, 2018. Additionally, the Department has implemented enhancements to NC FAST to improve the county workers' accuracy in computing beneficiary income and has granted county workers access to additional State systems for verifying beneficiary assets. Also, the Department has deployed additional policy training modules in the NC FAST Learning Gateway. The Department will continue to ensure collaboration between the state Division of Social Services (DSS), NC FAST, Division of Medical Assistance Medicaid Eligibility Operational Support Team and the Office of Compliance and Program Integrity to provide and enhance program support, policy

[52] Auditors only tested eligibility determinations using the traditional method. The Affordable Care Act provides a new method for calculating income eligibility for Medicaid. This new method calculates eligibility for all programs based on what is called modified adjusted gross income (MAGI). MAGI will replace the traditional process for calculating Medicaid eligibility that is in place today, which uses income deductions that often differ by eligibility group.

[53] 42 CFR 431.10

[54] 42 CFR 435

guidance, training, onsite consultations and technical assistance regarding eligibility determination to county DSS staff.

The Department continues to strengthen its monitoring efforts of eligibility determinations performed by the county DSS offices. The Department enhanced the county DSS self-assessment tool to provide more focus on eligibility elements required by Federal regulations. An analysis performed on county DSS monthly self-reviews completed April through June 2017, suggests a 5-percentage point improvement in the number of errors in Medicaid eligibility determinations compared to the first and second quarters of SFY 2017. The Department will continue to monitor the county DSS to ensure the accuracy of eligibility determinations and the maintenance of the required program documentation.

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This audit required 17,464 hours of auditor effort at an approximate cost of $1,798,792. The cost of the specialist's effort was $256,936. As a result, the total cost of this audit was $2,055,728.