

STATE OF NORTH CAROLINA

OFFICE OF THE STATE AUDITOR

BETH A. WOOD, CPA

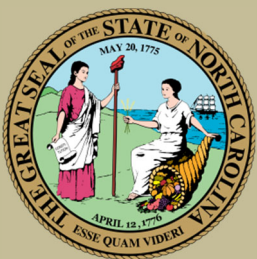


NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

RALEIGH, NORTH CAROLINA

STATEWIDE FEDERAL COMPLIANCE AUDIT PROCEDURES

FOR THE YEAR ENDED JUNE 30, 2021



NC OSA
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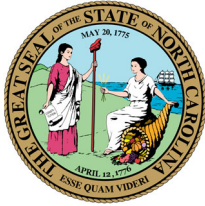


Beth A. Wood, CPA
State Auditor

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STATE OF NORTH CAROLINA
Office of the State Auditor



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AUDITOR'S TRANSMITTAL

The Honorable Roy Cooper, Governor
The General Assembly of North Carolina
Kody Kinsley, Secretary
North Carolina Department of Health and Human Services

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 federal programs, we have completed certain audit procedures at the North Carolina Department of Health and Human Services (Department) for the year ended June 30, 2021.

We conducted our audit of compliance in accordance with the 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). Our audit objective was to express an opinion on the State of North Carolina's compliance for each of its major federal programs. However, 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. The State Auditor expresses an opinion on the State of North Carolina's compliance with requirements applicable to its major federal programs in the State's *Single Audit Report*.

Our federal compliance audit scope at the Department included the following:

- Pandemic EBT Food Benefits (Assistance Listing Number 10.542)
- WIC Special Supplemental Nutrition Program for Women, Infants and Children (Assistance Listing Number 10.557)
- Child and Adult Care Food Program (Assistance Listing Number 10.558)
- Coronavirus Relief Fund (Assistance Listing Number 21.019)
- Epidemiology and Laboratory Capacity for Infectious Diseases (Assistance Listing Number 93.323)
- Child Care and Development Fund (CCDF) Cluster:
 - Child Care Disaster Relief (Assistance Listing Number 93.489)

- Child Care and Development Block Grant (Assistance Listing Number 93.575)
 - Child Care Mandatory and Matching Funds of the Child Care and Development Fund (Assistance Listing Number 93.596)
- Child Support Enforcement (Assistance Listing Number 93.563)
- Low-Income Home Energy Assistance (Assistance Listing Number 93.568)
- Medicaid Cluster:
 - State Medicaid Fraud Control Units (Assistance Listing Number 93.775)
 - State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare (Assistance Listing Number 93.777)
 - Medical Assistance Program (Medicaid; Title XIX) (Assistance Listing Number 93.778)

Our audit was performed by authority of Chapter 147, Article 5A of the *North Carolina General Statutes*.

Compliance

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 and which are described in findings 1, 2, 3, 5, and 6 in the Findings, Recommendations, and Views of Responsible Officials of the Auditee section.

Internal Control Over Compliance

In planning and performing our audit of compliance, we considered the Department's 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 the Department's internal control over compliance. Accordingly, we do not express an opinion on the effectiveness of the Department's 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 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.

Therefore, material weaknesses and significant deficiencies may exist that have not been identified. However, as discussed in the Findings, Recommendations, and Views of Responsible Officials of the Auditee section, we did identify certain deficiencies in internal control over compliance that we consider to be material weaknesses and significant deficiencies. The deficiencies described in findings 1 and 2 are considered to be material weaknesses in internal control over compliance. Furthermore, the deficiencies described in findings 3, 4, 5, 6, and 7 are considered to be significant deficiencies in internal control over compliance.

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 Views of Responsible Officials of the Auditee section of this transmittal. 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 This Transmittal

The purpose of this transmittal is solely to describe the scope of our testing of internal control over compliance and testing of compliance and the results of that testing at the Department based on the requirements of the Uniform Guidance. Accordingly, this transmittal is not suitable for any other purpose.

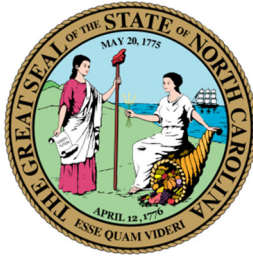
North Carolina General Statutes require the State Auditor to make audit reports available to the public. Copies of audit reports issued by the Office of the State Auditor may be obtained through one of the options listed in the back of this transmittal.



Beth A. Wood, CPA
State Auditor

Raleigh, North Carolina

March 30, 2022



FINDINGS, RECOMMENDATIONS, AND VIEWS OF RESPONSIBLE OFFICIALS OF THE AUDITEE

Matters Related to Federal Compliance Audit Objectives**ALN 93.323 – EPIDEMIOLOGY AND LABORATORY CAPACITY FOR INFECTIOUS DISEASES****1. ERRORS IN FFATA REPORTING**

The Department of Health and Human Services (Department) did not report complete, accurate, and timely subaward information for some subrecipients of the Epidemiology and Laboratory Capacity cooperative agreement (ELC) to the Federal Funding Accountability and Transparency Act (FFATA) Subaward Reporting System (FSRS).

Auditors reviewed all 330 subawards totaling \$128.6 million that were required to be reported to the FSRS and found the following errors:

- 238 subawards totaling \$117 million were not reported at all.
- 74 subawards totaling \$8.6 million were reported between two to six months late.
- 17 subawards totaling \$6.2 million were reported at the incorrect amount.

In addition, auditors found that 91 subawards were reported to the FSRS with the incorrect month and subaward obligation dates.

The FFATA was enacted to empower every American citizen with the ability to hold the government accountable for each spending decision. When subaward information is not reported accurately or timely to the FSRS, citizens do not have reliable information about how federal funds are being used in their communities.

According to Department management, the errors occurred because there were no formal procedures or policies in place to ensure that all subawards reported in the FSRS were complete, accurate, and reported within the required timeframe.

The FFATA¹ requires direct recipients of grants or cooperative agreements to report first-tier subawards of \$30,000 or more to the FSRS no later than the end of the month following the month in which the obligation was made.

Federal Award Information: Federal Awarding Agency: U.S. Department of Health and Human Services; Assistance Listing Number (title): 93.323 (Epidemiology and Laboratory Capacity for Infectious Diseases); Federal Award Identification Number (award period): NU50CK000530 (August 1, 2019 – July 31, 2024).

Recommendation: Department management should develop and implement policies and procedures to ensure complete, accurate, and timely reporting.

Views of Responsible Officials of the Auditee: Management concurs with this finding. As stated in our response to Inadequate Monitoring of Local Health Departments, the enormity of the pandemic created additional challenges for the Department.

The Department has processes in place to address FFATA reporting and to ensure results are submitted timely. The Department believes there was a technical issue regarding 68 of the 238 subawards (found not entered), which prevented these reports from being

¹ 2 CFR 170 Appendix A

saved in FSRS. The Department has opened a help desk ticket with FSRS and is re-entering those subawards at the time of writing this response. We will augment our FFATA reporting process and create a formal policy to include monitoring and standardization of FFATA reporting. Further, the Department will train backup staff in each Section to ensure adequate staffing is in place to manage the reporting. Together, these measures will ensure on-going complete, accurate, and timely reporting.

2. INADEQUATE MONITORING OF LOCAL HEALTH DEPARTMENTS

The Department of Health and Human Services (Department) did not adequately monitor \$46.4 million in federal funds passed to local health departments as part of the Epidemiology and Laboratory Capacity (ELC) cooperative agreement to help detect, prevent, and respond to emerging infectious diseases.

Auditors reviewed the Department's monitoring procedures for all 85 local health departments that received ELC funds during the fiscal year ended June 30, 2021. The Department's monitoring procedures included collecting and reviewing data² from the local health departments. However, auditors found that Department personnel did not:

- Review evidence or other support to determine if funds were spent according to the agreement.
- Ensure all local health departments submitted the data.

Inadequate monitoring increased the risk that federal funds would not be used in accordance with federal regulations, which could have reduced funding available for responding to emerging infectious diseases.

According to Department management, they did not have adequate monitoring procedures in place because they prioritized the obligation and technical assistance of ELC funds over monitoring in order to help the local health departments quickly respond to the COVID-19 pandemic.

Federal regulations³ require the Department to "establish and maintain effective internal control over the federal award that provides reasonable assurance that the Department is managing the program in compliance with federal statutes, regulation, and the terms and conditions of the federal award." Monitoring the local health departments is an effective control over compliance.

Federal Award Information: Federal Awarding Agency: U.S. Department of Health and Human Services; Assistance Listing Number (title): 93.323 (Epidemiology and Laboratory Capacity for Infectious Diseases); Federal Award Identification Number (award period): NU50CK000530 (August 1, 2019 – July 31, 2024).

Recommendation: Department management should prioritize the development and implementation of procedures, even when unforeseen events occur, to ensure that the local health departments are monitored for compliance with federal regulations.

Views of Responsible Officials of the Auditee: Management agrees with this finding. We also acknowledge that the audit period under review occurred during an unprecedented

² Data included performance measures such as demographic information for COVID-19 contact tracers and the total amount of funds received.

³ 2 CFR 200.303 – Internal controls

worldwide pandemic, and when efforts were focused on saving lives, protecting high-risk and vulnerable populations, and preserving hospital capacity. We note the COVID-19 pandemic is by no means over as new variants and vaccine hesitancy suggest further challenges to come.

In March of 2020, the highly transmissible virus known as COVID-19 resulted in a global pandemic which upended nearly every facet of life and laid bare the vulnerabilities of our health systems and communities. Our early response was complicated by an uncoordinated federal response, a collapse of the global supply chain, and lack of adequate staffing resources at the state and local levels of government. The overarching strategy employed by NCDHHS in its COVID-19 response was organized around two primary pillars:

- Mitigation and Prevention strategies to prevent or slow the spread of COVID-19 across the population in total (such as through public education and messaging, policy making and guidance, PPE procurement and distribution, and eventually vaccination); and
- Response Mobilization, including both case-based containment (such as through identification/testing, case investigation and contact tracing, isolation, and quarantine protocols with wrap-around supports) and surge capacity planning and intervention.

The Department quickly partnered with our 85 local health departments and districts to mobilize the response at the local level. During this audit period (July 1, 2020 – June 30, 2021), there were 948,176 cases of COVID-19, 12,064 COVID-19 associated deaths, and 12,889,960 COVID tests administered. At the height of the January 2021 surge, there were over 11,000 cases and over 100 deaths reported in one day, over 500 new COVID-19 hospital admissions, and over 750 active outbreaks and clusters. By contrast, the worst influenza season in the past 10 years had 391 influenza associated deaths during the entire season.

Given the grave state of the COVID-19 outbreak at the time, and that no vaccine or treatment was available for the first nine months of the pandemic, the Department prioritized the rapid allocation and availability of the COVID-19 supplemental funds to ensure that pandemic response measures and programmatic monitoring were initiated as rapidly as possible.

Local Health Departments are entities of local government and, therefore, are subject to annual single county audits. They are also long-standing partners of NCDHHS. These facts led to the Department's determination that these local entities were a low risk for fiscal noncompliance. Even so, the Department engaged in weekly meetings with Local Health Departments, providing technical assistance, fielding questions, and communicating federally allowable and unallowable activities.

Management understands the importance of programmatic and fiscal monitoring and the need to collect, verify and report data on a timely basis. A pandemic such as COVID-19 comes with no playbook, so we prioritized programmatic monitoring, followed by reporting and fiscal monitoring. Doing so allowed North Carolina to implement our mitigation and prevention strategies and largely avoid the worst effects of COVID-19 - ranking us 31st among all states for cases per capita and 36th for deaths per capita attributed to COVID-19.

The Department has implemented additional processes and procedures to ensure that local health departments are adequately monitored for fiscal compliance with federal regulations. The Department has also established a uniform reporting platform that captures fiscal and programmatic reporting and document submission by Local Health Departments, reviews that data for completeness and accuracy, and conducts randomized desk audits.

Even though monitoring was delayed during the audit review period, we have subsequently addressed this finding and we are up-to-date on all past and current monitoring activities.

ALN 93.568 – LOW-INCOME HOME ENERGY ASSISTANCE

3. WEATHERIZATION FUNDS WERE OVERSPENT

The Department of Health and Human Services (Department) overspent Low-Income Home Energy Assistance Program (LIHEAP)⁴ weatherization funds by \$308,000.

During the federal award period, the Department provided \$15,502,000 (16.03%) of the \$96.7 million received for LIHEAP to the Department of Environmental Quality (DEQ) to provide residential weatherization⁵ and other home repairs to low-income families. However, the federal awarding agency only approved them to use \$15,194,000 (15.71%) for these activities.

As a result of the weatherization overspending, \$308,000 is considered questioned costs⁶ and the Department may be required to pay the funds back to the federal government. In addition, the overspent funds could have been used to assist low-income households pay their monthly energy expenses.

The Department's Division of Social Services (Division) obtained a waiver from the U.S. Department of Health and Human Services, Administration for Children and Families that approved them to use \$15,194,000 (15.71%) of the LIHEAP federal award on weatherization activities. According to the Division, they were unaware another waiver was needed to use funds in excess of what was previously approved.

Federal regulations⁷ require that no more than 15% of the funds allotted or 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 that allows up to 25% to be used.

Federal Award Information: Federal Awarding Agency: U.S. Department of Health and Human Services; Assistance Listing Number (title): 93.568 (Low-Income Home Energy Assistance Program) Federal Award Identification Number (award period): 1901NCLIEA (October 1, 2018 - September 30, 2020).

⁴ The primary purpose of the LIHEAP award is to provide funds to assist eligible households meet the immediate costs of heating and cooling their residences, including monthly utility bills for gas and electric services.

⁵ Up to 25% of the award (with approval) can be used to provide weatherization activities to make homes more energy efficient, such as weather stripping, and repairing or replacing home heating and cooling systems.

⁶ 2 CFR 200.516(a)(3) requires the auditor to report known questioned costs greater than \$25,000 for a type of compliance requirement for a major program.

⁷ 42 USC 8624(k)

Recommendation: Department management should ensure that staff overseeing the federal award have a clear understanding of waiver requirements.

Views of Responsible Officials of the Auditee: The Department agrees with this finding. To gain clarification on this finding, the Division met with the Administration of Children and Families and was advised that multiple waivers can be submitted when it is determined that Weatherization activities will exceed the approved percentage requested on the initial waiver. It was our understanding that the request for a waiver to spend more than the 15% was a one-time request that must be made prior to April. Due to that timeframe, our waiver request is based upon budget as actual year-end expenditures are not available at that time. Weatherization activities that exceeded the approved waiver request were due to that factor as well as the fact that the Crisis Intervention Program was under expensing, causing the percentage of weatherization to go up.

4. ERRORS IN FFATA REPORTING

The Department of Health and Human Services (Department) did not report complete and accurate subaward information for some subrecipients of the Low-Income Home Energy Assistance Program (LIHEAP) to the Federal Funding Accountability and Transparency Act (FFATA) Subaward Reporting System (FSRS).

The LIHEAP is administered at the state level by the Division of Social Services⁸ (DSS) and the Department of Environmental Quality⁹ (DEQ). The DSS Business Operations Section is responsible for completing the FFATA reporting for the entire program.

Auditors reviewed all 226 subawards totaling \$113.9 million that were required to be reported to the FSRS during the audit period and found that 126 subawards totaling \$38 million were not reported.

In addition, auditors reviewed the 100 subawards that were reported to FSRS and found errors in one or more key data elements.¹⁰

The FFATA was enacted to empower every American citizen with the ability to hold the government accountable for each spending decision. When subaward information is not reported accurately to the FSRS, citizens do not have complete and accurate information about how federal funds are being used in their communities.

According to the DSS management, the incomplete and inaccurate reporting occurred because the DSS Business Operations Section was understaffed and focused priorities on COVID operational tasks. Significant turnover during the audit period reduced the number of staff available to carry out the FFATA reporting requirements. For the subawards reported to the FSRS, the DSS did not review the submission to ensure agreement with source documentation.

⁸ The Division of Social Services is the division within the Department that is responsible for overseeing the portion of the LIHEAP program that provides vendor payments to help eligible households pay their heating and cooling bills.

⁹ The Department of Environmental Quality is responsible for overseeing the portion of the LIHEAP program that provides weatherization activities to eligible households.

¹⁰ Those key data elements were: Subaward Project Description and Subawardee Names and Compensation of Highly Compensated Officers.

The FFATA¹¹ requires direct recipients of grants or cooperative agreements to report first-tier subawards of \$30,000 or more to the FSRS.

Federal Award Information: Federal Awarding Agency: U.S. Department of Health and Human Services; Assistance Listing Number (title): 93.568 (Low-Income Home Energy Assistance Program) Federal Award Identification Numbers (award periods): 2101NCLIEA (October 1, 2020 - September 30, 2022); 2001NCE5C3 (COVID-19) (March 27, 2020 – September 30, 2021).

Recommendation: Department management should establish a contingency plan to ensure FFATA reporting is completed when employee turnover occurs.

Additionally, Department management should develop review procedures over the submitted reports to ensure accuracy.

Views of Responsible Officials of the Auditee: The Department agrees with this finding. Various Business Operations positions were vacant during this timeframe with staff focused on supporting critical core and COVID operations. The Department will establish a contingency plan to ensure FFATA reporting is completed when employee turnover occurs. In addition, Department management will review and develop additional procedures as needed to confirm submitted reports are accurate.

ALN 93.778 – MEDICAL ASSISTANCE PROGRAM

5. ERRORS IN MEDICAID PROVIDER BILLING AND PAYMENT PROCESS

The Department of Health and Human Services (Department) made overpayments to Medicaid providers during the fiscal year ended June 30, 2021. During that period, the Department processed more than 46 million original fee-for-service claims totaling \$10.8 billion in payments.

Auditors reviewed the medical documentation for a sample of 151¹² original fee-for-service claims totaling approximately \$20.1 million in payments and identified eight (5.3%) claims that contained errors. Specifically:

- Three (2.0%) claims lacked documentation to support the services rendered by the provider.
- Three (2.0%) laboratory claims lacked a provider signature.
- Two (1.3%) claims contained medical coding errors which impacted the payment calculation.

Even though the tests identified only \$396 in overpayments (federal share \$292), if tests were extended to the entire population, questioned costs could be greater than \$25,000.¹³

As a result, there is an increased cost to the Medicaid Program for both the state and federal government. The program is jointly financed by these two governments and is

¹¹ 2 CFR 170 Appendix A

¹² The 151 items that were reviewed included 27 items that were deemed individually important. These items were tested 100% and removed from the population. The other 124 items were selected from the remaining population.

¹³ 2 CFR 200.516(a)(3) requires auditors to report known questioned costs when likely questioned costs are greater than \$25,000 for a type of compliance requirement for a major program.

administered by the state. Additionally, the overpaid funds could have been used to provide other services.

According to Department management, the documentation and coding errors were due to clerical errors and inadequate documentation maintained by the health care providers.

Federal regulations¹⁴ 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 agreement¹⁵ 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 2020 Statewide Single Audit as finding number 2020-037.

Federal Award Information: Federal Awarding Agency: U.S. Department of Health and Human Services; Assistance Listing Number (title): 93.778 (Medical Assistance Program (Medicaid; Title XIX)); Federal Award Identification Number (award period): 2105NC5MAP (October 1, 2020 – September 30, 2021).

Recommendation: Department management should analyze each error to specifically identify corrective action such as further education of providers.

In addition, the Department should follow-up on the overpaid claims for immediate collection.

Views of Responsible Officials of the Auditee: The Department agrees with this finding. The Department is dedicated to claims payment accuracy and continues to work with providers to minimize errors in the claims payment process. The Centers for Medicare & Medicaid Services (CMS) has established an acceptable payment error rate for North Carolina of 3.2% based on the total dollars paid in error compared to the total dollars in the sample population. The Department acknowledges the payment error rate reflected in this audit sample is less than the CMS standard. The Department will analyze each error and take immediate and appropriate corrective action, including recouping any identified overpayments and emphasizing provider education where necessary.

6. DEFICIENCIES IN THE MEDICAID ELIGIBILITY DETERMINATION PROCESS

The Department of Health and Human Services (Department) made Medical Assistance Program (Medicaid) payments to providers based on inaccurate and inadequately documented eligibility determinations. During the audit period, approximately 2.1 million beneficiaries received \$14.1 billion in Medicaid benefits.

The task of determining eligibility for the Medicaid program has been delegated to the county departments of social services (DSS).¹⁶ However, the Department was responsible for ensuring compliance with the eligibility requirements.

¹⁴ 2 CFR 200.403.

¹⁵ In accordance with 42 CFR 431.107.

¹⁶ North Carolina General Statute §108A-25(b).

Auditors redetermined eligibility for a sample of 152 beneficiaries¹⁷ that had benefits totaling \$47.1 million paid on their behalf during the audit period and found three (1.97%) eligibility errors. Specifically:

- Two (1.31%) beneficiaries were determined eligible for the incorrect Medicaid group,¹⁸ and received services during the coverage period they were not entitled to receive. Payments for those services totaling \$2,762 (federal share \$2,029) were paid on behalf of those beneficiaries.
- One (0.66%) beneficiary was found to be ineligible for a portion of the coverage period due to inaccurate eligibility calculations. Payments totaling \$109 (federal share \$80) were paid on behalf of this beneficiary during the ineligible portion of the coverage period.

In addition to the eligibility errors noted above, auditors also identified 20 beneficiaries whose case files were either missing required eligibility documentation, such as child support verifications, or inaccurate calculations and household composition were used. However, when auditors redetermined eligibility using the correct information the beneficiaries were found to be eligible.

As a result, there is an increased cost for the Medicaid Program for both the state and federal government. The program is jointly financed by these two governments, and is administered by the state. Even though the tests identified only \$2,871 in overpayments (federal share \$2,109), if tests were extended to the entire population, questioned costs could be greater than \$25,000.¹⁹

Although \$2,871 resulted from the errors identified, the amount of Medicaid funds paid on behalf of ineligible beneficiaries is likely greater. Self-attestation by applicants is accepted for certain elements of the Modified Adjusted Gross Income methodology of determining eligibility.²⁰ Further verification or documentation is not required. Auditors tested participant eligibility using the documentation contained in the case files, which includes self-attested data that could not be verified by the auditors.

According to the Department, the eligibility errors occurred because of inaccurate application of established eligibility policies by the county DSS staff. The county DSS staff utilize NC FAST²¹ to input data and make eligibility determinations; however, the Department is responsible for establishing the eligibility determination policies, maintaining NC FAST, and facilitating training.

¹⁷ The 152 items that were reviewed included 28 items that were deemed individually important. These items were tested 100% and removed from the population. The other 124 items were selected from the remaining population.

¹⁸ Once eligibility has been determined, beneficiaries are placed into groups; the two errors identified in our sample were placed in to the Medicaid to Families with Dependent Children (MAF-C) group instead of the Family Planning (MAF-D) group and beneficiaries in the MAF-C group are entitled to receive services that are beyond those in the MAF-D group.

¹⁹ 2 CFR 200.516(a)(3) requires auditors to report known questioned costs when likely questioned costs are greater than \$25,000 for a type of compliance requirement for a major program.

²⁰ Approximately \$4.7 billion, or 33%, of total Medicaid payments were for beneficiaries whose eligibility was determined using the MAGI methodology.

²¹ The North Carolina Families Accessing Services Through Technology (NC FAST) is the eligibility system used in the Medicaid Program.

Federal regulations²² require that the Department, or its designee, determine eligibility for all individuals applying for or receiving benefits in accordance with eligibility requirements defined in the approved state plan.

Further, federal regulations²³ require that documentation be obtained as needed to determine if a beneficiary meets specific income standards and documentation must be maintained to support eligibility determinations.

Federal Award Information: Federal Awarding Agency: U.S. Department of Health and Human Services; Assistance Listing Number (title): 93.778 (Medical Assistance Program (Medicaid; Title XIX)); Federal Award Identification Numbers (award periods): 2005NC5MAP (October 1, 2019 – September 30, 2020) and 2105NC5MAP (October 1, 2020 – September 30, 2021).

Recommendation: Department management should analyze each error to specifically identify why the errors occurred and develop additional training or establish other procedures as necessary to prevent future errors from occurring.

Views of Responsible Officials of the Auditee: The Department agrees with this finding. As required by the North Carolina Legislature, the Department has delegated the administration of Medicaid eligibility determinations to the 100 local county offices of the Division of Social Services (DSS). The Department provides the NC FAST system, issues eligibility policies, facilitates training and provides technical support to the county DSS' to enable their administration of eligibility determinations. Using CMS's PERM standards as a model, the Department set an acceptable error rate of 3.2% for the accuracy of county eligibility determinations. The Department monitors the accuracy of each county's eligibility determinations and implements accuracy improvement plans as necessary. As part of the monitoring process, the Department engages with the counties to determine if adjustments are needed to policy, training facilitation or the NC FAST system. The Department has reviewed the specific errors identified in the audit and will take appropriate steps to correct the improper eligibility determinations.

7. DEFICIENCIES IN THE MEDICAID PROVIDER ENROLLMENT AND TERMINATION PROCESS

The Department of Health and Human Services' (Department) contracted agent did not properly screen and enroll Medicaid providers. The Department paid approximately \$14.1 billion in Medicaid funds to 18,048 providers during the fiscal year ended June 30, 2021.

The Division of Health Benefits²⁴ (DHB) contracts with General Dynamics Information Technology (GDIT) to screen and enroll providers. However, the Department is responsible for establishing the enrollment screening policies and procedures and monitoring GDIT's work. GDIT performed screening and enrollment activities²⁵ on 4,187 providers that were paid \$3.7 billion during the audit period.

²² 42 CFR 431.10(b)(3).

²³ 42 CFR 435.

²⁴ The Division of Health Benefits is the division within the Department that is responsible for administering the Medicaid program.

²⁵ Screening and enrollment activities included initial enrollments, re-enrollments, or other provider change requests.

Auditors examined the enrollment screening documentation maintained in NCTracks²⁶ for a sample of 93 paid providers that had screening and enrollment activities during the audit period. Auditors found one or more errors in nine (9.7%) provider records. Specifically:

- In seven (7.5%) provider records, GDIT searches of the Centers for Medicare and Medicaid Services (CMS) Adverse Action Report and the North Carolina Provider Penalty database were performed using incorrect Social Security Numbers (SSN), Employer Identification Numbers (EIN), or National Provider Information (NPI)²⁷ and some searches excluded relevant information such as name, SSN and EIN.
- In one (1.1%) provider record, there was no evidence that GDIT performed a background check or searched the CMS Adverse Action Report or the North Carolina Provider Penalty database for a new owner.
- In one (1.1%) provider record, there was no evidence that GDIT verified whether an out-of-state provider was eligible to participate in their state's Medicaid program.

Provider enrollment screening is an important tool in preventing fraud. When providers are not screened and enrolled properly, it increases the risk that ineligible providers will be paid for services provided to Medicaid program recipients. Keeping ineligible providers from enrolling in the state's Medicaid program also reduces the likelihood that resources will be needed to identify and recover overpayments from such providers.

According to Department management, the errors occurred during the provider enrollment screening process because of GDIT's failure to follow established procedures even though the information was available in NCTracks that would have allowed them to perform the enrollment screening procedures correctly.

Federal regulations require that providers be screened and enrolled in accordance with 42 CFR part 455, subpart E. Specifically, the state Medicaid agency:

- Is to 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.²⁸
- Is to require providers to consent to criminal background checks, including fingerprinting checks when required to do so under state law or by the level screening based on fraud, waste, or abuse, as determined for that category of provider.²⁹
- May rely on the results of the provider screening performed by the Medicaid agencies of other states.³⁰

The North Carolina State Plan³¹ (Plan) also requires the Medicaid state agency to check any other databases as the Secretary may prescribe such as the online North Carolina Provider Penalty Tracking database that is maintained by the Department.

²⁶ NCTracks is the Department's multi-payer Medicaid management information system. Providers use NCTracks to complete the enrollment application to become a licensed provider in North Carolina.

²⁷ NPI is a unique 10-digit number used to identify health care providers.

²⁸ 42 CFR 455.436(a).

²⁹ 42 CFR 455.434(a).

³⁰ 42 CFR 455.410(c)(2).

³¹ The State Plan is an agreement between a state and the federal government describing how that state administers its Medicaid program.

This finding was previously reported in the 2020 Statewide Single Audit as finding number 2020-039.

Federal Award Information: Federal Awarding Agency: U.S. Department of Health and Human Services; Assistance Listing Number (title): 93.778 (Medical Assistance Program (Medicaid; Title XIX)); Federal Award Identification Numbers (award periods): 2005NC5MAP (October 1, 2019 – September 30, 2020) and 2105NC5MAP (October 1, 2020 – September 30, 2021).

Recommendation: Department management should analyze the errors and re-evaluate their monitoring procedures as necessary to prevent future errors from occurring.

In addition, Department management should determine if GDIT's failure to follow established enrollment screening policies and procedures is an indicator that they are not meeting the terms and conditions of their contract with the Department.

Views of Responsible Officials of the Auditee: The Department agrees with this finding. In response to the State Fiscal Year 2020 (SFY2020) finding, the Department analyzed the errors noted and implemented additional monitoring procedures to ensure GDIT was properly conducting the manual screening processes. Additionally, the Department initiated development of a system enhancement to automate the searches of the NC Provider Penalty Tracking Database and the CMS Adverse Action Report. The Department made great progress, as evidenced by the reduction in the error rate since the prior audit and continues in our effort to reduce errors.

The system enhancement was implemented on January 30, 2022. This enhancement will further reduce the potential for human keying errors as well as provide the Department with an additional reporting tool to improve monitoring efforts over provider screening. The Department has reviewed the specific errors identified in the audit and has taken appropriate steps to correct the provider records.

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This audit required 12,188 hours of auditor effort at an approximate cost of \$1,291,928. The cost of the specialist's efforts was \$84,899. As a result, the total cost of this audit was \$1,376,827.