

STATE OF NORTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF GOVERNMENT AFFAIRS

JOSH STEIN
GOVERNOR

DEVDUTTA SANGVAI
SECRETARY

JANSSEN WHITE
ASSISTANT SECRETARY FOR GOVERNMENT AFFAIRS

January 21, 2026

SENT VIA ELECTRONIC MAIL

The Honorable Phil Berger, Co-Chair
Joint Legislative Commission on
Governmental Operations
North Carolina General Assembly
Room 2007, Legislative Building
Raleigh, NC 27601

The Honorable Destin Hall, Co-Chair
Joint Legislative Commission on
Governmental Operations
North Carolina General Assembly
Room 2304, Legislative Building
Raleigh, NC 27601

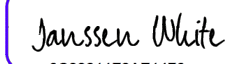
Dear Chairmen:

North Carolina General Statute §143B-216.51(g) requires the Department of Health and Human Services' (Department) Office of Internal Auditor to monitor the implementation of the Department's response to any audit of the Department conducted by the State Auditor and to issue a report to the Secretary on the status of corrective actions implemented no later than six months after the State Auditor publishes any audit report pursuant to law. The law also requires that a copy of this report be filed with the Joint Legislative Commission on Governmental Operations. Pursuant to the provisions of law, the Department is pleased to submit the attached report.

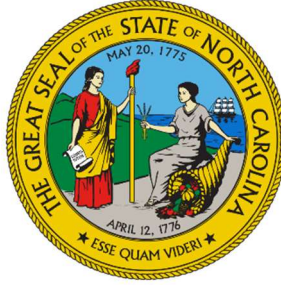
Should you have any questions regarding the report, please contact Jeff Grimes, Director of the Office of the Internal Auditor, at Jeff.Grimes@dhhs.nc.gov.

Sincerely,

Signed by:


6C83811F8AE1476...
Janssen White

Assistant Secretary for Government Affairs



NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Office of the Internal Auditor

Follow-up Assessment of the Department's Response to Findings and
Recommendations from the Medicaid Provider Enrollment Follow-Up
Performance Audit Report, PER-2024-4445

Issued by the Office of the State Auditor
July 10, 2025

January 9, 2026

Executive Summary

The Office of the Internal Auditor (OIA) has conducted a follow-up assessment of the Department of Health and Human Services' (Department) response to the findings and recommendations in the Medicaid Provider Enrollment Follow-Up Performance Audit, PER-2024-4445. The report was issued by the Office of the State Auditor (OSA) on July 10, 2025.

One of four findings is considered resolved. The Department took sufficient corrective action to reduce identified risk for one finding to an acceptable level. An additional three findings are considered partially resolved. The Department took some action to reduce identified risks for those three findings. However, the corrective action taken is not sufficient to reduce risk to an acceptable level, and the Department continues to work to address the findings.

OIA will continue to follow up with the Department to ensure its work activities reduce risk to an acceptable level. A summary of OSA's findings and recommendations and OIA's follow-up results are included in the Results section.

Objective and Scope

The objective of our follow-up assessment was to evaluate whether the Department took appropriate corrective action in response to OSA's findings and recommendations, pursuant to G.S. 143B-216.51(g). The General Statute requires OIA to issue a report to the Secretary on the status of corrective action taken no later than six months after the State Auditor publishes any audit report pursuant to law. The scope of our assessment included a review of activities directed toward the resolution of OSA's findings and recommendations as well as the Department's corrective action taken. A copy of this report will be filed with the Joint Legislative Commission on Governmental Operations, pursuant to the General Statute.

Methodology

We conducted this engagement in conformance with the *Global Internal Audit Standards* issued by The Institute of Internal Auditors. In order to form an opinion on the current status of the four findings, we performed the following procedures:

- We reviewed OSA's audit report to gain a better understanding of the findings.
- We discussed the basis for the findings and the associated corrective action with Department management.
- We conducted tests to evaluate whether corrective action taken by the Department reduced risk to an acceptable level.

Status Definitions

The status of each finding is categorized as follows:

- Resolved: We observed evidence that actionable items were completed and implemented to reduce risk to an acceptable level.
- Partially Resolved: We observed evidence of progress toward the implementation of the actionable items in the Department's response and activity is ongoing to reduce risk to an acceptable level.
- Unresolved: We did not observe evidence to demonstrate Department progress toward the implementation of the actionable items in the Department's response, to reduce risk to an acceptable level.

We express our appreciation to Department management and staff for their cooperation and assistance during this follow-up assessment.

Office of the Internal Auditor

Jeff Grimes, Director

RESULTS

SUMMARY OF FINDINGS AND RECOMMENDATIONS FROM OSA REPORT (ITALICIZED) AND OIA'S FOLLOW-UP RESULTS (BOLDED)

1. OSA FINDING AND RECOMMENDATION – *Did Not Fully Implement Recommendations to Identify and Remove Providers with Suspended or Terminated Licenses*

The Division (Division of Health Benefits) did not fully implement OSA's recommendations to identify and remove enrolled providers from the Medicaid program who had their professional license suspended or terminated. Licensing boards can suspend or terminate provider licenses for reasons that include:

- *Negligence*
- *Professional Misconduct*
- *Fraud*
- *Sexual Misconduct*

In response to OSA's February 2021 Medicaid Provider Enrollment performance audit, Division management agreed with OSA's findings and recommendations to remove providers from Medicaid with suspended or terminated licenses (which included providers that entered into Non-Practice Agreements). The Division developed and implemented Provider Screening and License Board Monitoring procedures to terminate providers from Medicaid with suspended or terminated licenses (which included providers that entered into Non-Practice Agreements).

During 2023, the Division removed 18 of 20 (90%) providers with disciplinary actions that included suspensions or termination; however, two of 20 (10%) providers with Non-Practice Agreements were allowed to remain in the Medicaid program.

Additionally, during 2024, Division management revised its Provider Screening procedures to no longer terminate providers from the Medicaid program that were determined to be under Non-Practice Agreements.

As a result, providers who entered into Non-Practice Agreements with professional state licensing boards in which the provider could not practice or perform any act that requires a license were not removed from the Medicaid program. These providers continued to serve Medicaid patients and received payment from the state.

Auditors obtained lists of all Medicaid providers disciplined by four state professional licensing boards during the period January 1, 2023, through December 31, 2023, directly from the licensing boards. Of the 63 Medicaid providers who were disciplined by their licensing board, 20 (32%) had a suspended or terminated license. Auditors tested all 20 providers and determined that one (5%) provider was not removed from the Medicaid program at all, and one (5%) provider was not timely removed. Specifically,

- *Provider A: A physician entered into a Non-Practice Agreement with their licensing board that did not allow the physician to practice or perform any act that required a license during the period October 2022 through December 2023, for practicing medicine while abusing alcohol. The provider was never removed from the Medicaid program.*

This provider treated 21 Medicaid patients from October 1, 2022, through December 31, 2023, and received approximately \$1,311 in Medicaid payments during that time.

- *Provider B: A physician entered into a Non-Practice Agreement with their licensing board that did not allow the physician to practice or perform any act that required a license during the period February 2023 through October 2023 for inappropriately prescribing controlled substances and medications to friends and romantic partners. The provider was not removed from the Medicaid program until the licensing board suspended the provider's license in October 2023 (eight months later).*

This provider treated 14 Medicaid patients from February 1, 2023, through October 30, 2023, and received approximately \$5,415 in Medicaid payments during that time. When the Division eventually took action to remove Provider B from the Medicaid program, its procedures required the Division to retroactively disallow Provider B's payments back to February 2023 (the date of the NPA). However, the Division did not.

OSA Recommendations:

1. *Division management should remove all providers who have had their professional licenses suspended, terminated, or entered into Non-Practice Agreements from the Medicaid program.*
2. *The Division's Medicaid policies and procedures should include the identification and removal of providers that cannot practice or perform any act that requires a license.*
3. *Division management should fully implement prior audit recommendations in a timely manner to address the identified issues and to reduce the risk providers may pose to Medicaid patients.*

Agency Response:

The Division disagrees with the finding.

As noted in this report, the Division implemented Provider Screening and License Board Monitoring procedures in response to the February 2021 audit. The screening procedures do not call for an automatic termination of providers that enter into Non-Practice Agreements (NPA), as the details in such agreements may vary and should be treated on a case-by-case basis. Most NPAs are private agreements between the Medical Board and the provider and are not known to the public or the Medicaid agency. When publicly available, NPAs are referred by the monitors to the Provider Screening Process for review and action.

The Division agrees that Provider A was not removed from the Medicaid program due to human oversight in monitoring and represents the single error in the screening process of the 20 providers disciplined by their licensing board during the audit period. Provider A has been retroactively terminated from the Medicaid program effective May 2023.

The Division does not agree that the timing of Provider B's removal was problematic. The Division removed Provider B from the Medicaid program within four (4) days of the publication of the Consent Order which indefinitely suspended Provider B's license. The Consent Order did not confirm that a prior NPA existed; therefore, the Division could not have removed Provider B for the time period prior to the Consent Order. NC Medicaid can only act on provider information that is available for review and properly documented. The Division will reach out to the Medical Board to request documentation of an NPA for Provider B prior to the Consent Order. If it is found that an NPA did exist, the Division will take appropriate retroactive action.

The Division will review and enhance the internal controls surrounding the monitoring workflow to ensure the risk of disciplined providers remaining in the program is sufficiently mitigated. The Division will engage with the licensing boards to evaluate the opportunity to obtain provider sanction information that is not readily available to the public.

OIA Follow-up Results

OIA conducted a follow-up review and determined that the Division of Health Benefits has not implemented sufficient procedures to address the OSA finding. The Division has engaged with the North Carolina Medical Board to assess the availability of provider sanction information that is not readily accessible to the public. The Division was referred to the Medical Board's Chief Legal Officer and discussions will continue. On July 8, 2025, the Division retroactively terminated Provider A from participation in the Medicaid program, effective May 2023. In addition, the Division confirmed with the North Carolina Medical Board that no Notice of Professional Action (NPA) was in place for Provider B.

The Division is currently working on re-training the License Board monitors and clarifying procedural content of provider NPAs. In addition, the Division is exploring the use of Artificial Intelligence to reduce the risk of human error in interpreting consent orders and assisting in the monitoring effort.

OIA considers this finding partially resolved with an anticipated completion date of March 31, 2026.

2. OSA FINDING AND RECOMMENDATION – *Did Not Fully Implement Recommendations to Remove Providers with Professional License Limitations That Pose Threats to Medicaid Patients*

The Division (Division of Health Benefits) did not fully implement OSA recommendations regarding the continued enrollment or termination of providers with limitations on their license that may pose threats to the safety of patients. License limitations are specific restrictions imposed on a licensee's ability to practice for reasons that include:

- *Negligence*
- *Professional Misconduct*
- *Fraud*
- *Sexual Misconduct*

Specifically, OSA's February 2021 Medicaid Provider Enrollment performance audit recommended that:

- *The Division should immediately remove all providers from the Medicaid program who have professional license limitations and pose threats to the safety of patients.*
- *The Division should create written policies and procedures for the continued enrollment of providers with limitations on their license. The policy should describe the types of license limitations that the Division finds acceptable. The policy should also require adequate documentation to support decisions to either enroll or deny enrollment.*

In response to OSA's February 2021 Medicaid Provider Enrollment performance audit, Division management:

- *Agreed with OSA's findings and recommendations to remove providers with license limitations whose actions were determined to pose a threat to patient safety from Medicaid.*
- *Developed and implemented Provider Screening procedures to review provider license limitations, evaluate the risk the limitations posed to patient safety, and terminate providers with license limitations whose actions were determined to pose a threat to patient safety.*

However, the Division did not follow its procedures and did not remove any providers that may have posed a threat to patient safety. The Division allowed all providers with license limitations, even limitations that were imposed for reasons that could include sexual misconduct, to remain enrolled in Medicaid and able to see Medicaid patients.

Additionally, the Division did not document its evaluation of the risk providers with license limitations may pose to patient safety, or the decisions to support the continued enrollment or termination of a provider.

The Division did document notes regarding providers with license limitations in meeting minutes and Provider Screening Monitoring Logs. However, these documents do not include documentation of the providers' specific license limitations, the determination of whether these providers pose a risk to patient safety or not, any increased oversight or monitoring activities of these providers, or an actual decision to allow the provider to remain enrolled or terminate the provider.

For example, the Division allowed the following providers with license limitations to continue to participate in the Medicaid program:

- *Provider C: A physician's medical license had a limitation that prohibited the physician from treating any female patients and from supervising any nurse practitioners or physician assistants who treated female patients. Previous license limitations dating back to 2014 had required that a chaperone be present and document their presence any time the physician examined a female patient because of multiple past sexual and professional misconduct allegations.*

Despite the license limitation restricting the physician from treating female patients, Provider C is listed as a Provider on the Division's website and is accepting both adult and child female patients. Additionally, Provider C and their nurse practitioner billed Medicaid for services provided to 78 Medicaid patients, including 21 female patients in the amount of \$7,303 from January 1, 2023, through December 31, 2023.

It should be noted that Provider C also entered into a Settlement Agreement with the state to pay back \$75,000 for submitting false or fraudulent claims to the Medicaid program, yet remains enrolled in the Medicaid program seeing patients, including females.

OSA Recommendations:

1. *Division management should remove all providers from the Medicaid program who have professional license limitations that pose threats to the safety of patients.*
2. *The Division's policies and procedures for the continued enrollment of providers with limitations on their license should describe the types of license limitations that the Division finds acceptable. The policy should also require adequate documentation to support decisions to either enroll or deny enrollment.*
3. *Division management should fully implement prior audit recommendations in a timely manner to address the identified issues and to reduce the risk providers with license limitations may pose to Medicaid patients.*

Agency Response:

The Division disagrees that providers with license limitations automatically pose a safety risk to beneficiaries and should be removed from the program. The Division acknowledges that some provider limitations should be excluded due to the challenge in monitoring for or preventing a violation of the limitation.

As stated in the report, "According to the Centers for Medicare and Medicaid Services, when a provider has limitations on their license, each state has authority to make that determination if your state is comfortable with enrolling them with those limitations or not." As a result of the February 2021 audit, the Division created the Provider Screening policy to review providers with license limitations and allow them to remain in the program when deemed appropriate. The policy provides for the review of licensing board actions, including Public NPAs, to assess a provider's risk to patient safety as opposed to an immediate termination because of the limitation.

In response to the February 2021 report, the Division issued a termination notice to Provider C and the provider appealed the termination. In accordance with the North Carolina provider appeals process in § 108C-5(d), the provider remains active pending the outcome of the appeal hearings. The Division is monitoring the provider's current compliance via our prepayment review program to ensure further violations do not occur.

The Division acknowledges that opportunities exist to strengthen the license limitation monitoring processes and documentation through enhanced staff training efforts to further mitigate the risk of providers remaining in the program that pose a safety risk to patients. The Division will conduct an analysis of monitoring outcomes and conduct training around identified gaps. The Division will also evaluate the need for additional controls in the review process and implement enhancements where necessary.

OIA Follow-up Results

OIA conducted a follow-up review and determined that the Division of Health Benefits has not implemented sufficient procedures to address the OSA finding. The Division strengthened and updated its operational procedures requiring termination of providers who have been issued disciplinary action, license limitations or entered into a Notice of Professional Action (NPA), effective October 1, 2025. The Division implemented policy updates to ensure closer alignment with federal regulatory requirements. Updates to the policy were posted on the Department's website as well as published in a Provider Communication on October 20, 2025.

The Division is conducting an analysis of the license limitation process to identify potential gaps in internal controls. Based on the results of this analysis, the Division plans to implement additional controls, if necessary, and provide guidance through staff training.

In addition, the Division is pursuing legislation to reinforce the denial of providers with limitations to participate in NCDHHS programs. Proposed updates are expected to be presented during the next legislative session in Spring of 2026.

OIA considers this finding partially resolved with an anticipated completion date of March 31, 2026.

3. OSA FINDING AND RECOMMENDATION – *Did Not Fully Implement Recommendations to Strengthen Provider Credential Verification*

The Division (Division of Health Benefits) did not fully implement OSA recommendations to strengthen its verification of provider credentials for providers enrolled in the Medicaid program. Verifying professional credentials required confirming with the appropriate credentialing authorities that the provider has the required license, accreditation, and/or certification.

Specifically, the Division updated its provider credential verification procedures during the Medicaid provider enrollment re-verification process. The Division now:

- *No longer relies on the LexisNexis crawler and monthly background reports to perform ongoing credential verification. OSA's February 2021 Medicaid Provider Enrollment performance audit noted several weaknesses in the Division's reliance on the crawler and monthly background reports to perform credential verifications including that they did not conduct primary verification of credentials.*
- *Performs direct verification of most provider credentials with the credentialing agency (including accreditations and certifications) during the initial and reverification process.*

However, while the Division has strengthened its processes by taking the above actions, the Division did not ensure that enrolled providers possessed DEA certification. The Division uses a weekly file provided by the DEA to update the expiration dates of the DEA certifications for providers within Medicaid.

Auditors obtained and reviewed professional credentialing documentation for all 63 Medicaid providers who had disciplinary actions taken against their professional license during the period January 1, 2023, through December 31, 2023, to determine whether these providers' credentialing requirements had been verified. Of these, 9 (14%) did not possess the required DEA certification or the Division was unable to provide evidence that the providers' DEA certifications were verified. Specifically, for:

- *Five (8%) providers, they lacked the required DEA certification.*
- *Four (6%) providers, the Division was unable to provide evidence that the provider held the required DEA certification.*

Valid DEA certifications are required to prescribe controlled substances.

OSA Recommendations:

- 1. Division management should verify that providers possess DEA certifications given the potential risk posed to Medicaid patients from providers prescribing controlled substances without required DEA certification.*
- 2. Division management should fully implement prior audit recommendations in a timely manner.*

Agency Response:

The Division agrees with this finding.

As noted in the report, the Division did strengthen its processes by conducting direct primary source verification of provider credentials in response to the February 2021 report. DEA certification became a requirement for participation in the Medicaid program on October 1, 2020, during the Public Health Emergency (PHE). The Division notified providers that beginning on October 1, 2020, they will be required to provide their DEA certification number on any initial enrollment, reverification or Managed Change Request (MCR) application they complete. While verification was conducted for initial enrollments and managed change requests, reverifications were paused from March 13, 2020 through May 11, 2023 due to the PHE.

The Division reviewed the nine (9) providers cited in the report and noted the following:

- *One (1) provider utilized the DEA Designation Form, granting the provider an exception to the DEA certification requirement. The Form was documented in the Notes section of the NCTracks provider enrollment record and made available in documents attached to the record. This met the validation criteria. This provider, the only one currently active, has not reached their reverification date nor submitted a MCR requiring a credentialing review.*

- *Eight (8) providers, including Providers F, G, and D cited in the audit, had not reached their extended reverification date nor submitted an MCR requiring a credentialing review between the effective date of the DEA certification requirement and their termination date, which occurred prior to the end of the audit period.*

The Division acknowledges that the risk existed for prescribing providers to be uncertified by DEA for some portion of the period between October 1, 2020, and the time of their subsequent recertification review. The Division will explore solutions to more timely verify provider DEA licensing compliance.

OIA Follow-up Results

OIA conducted a follow-up review and determined that the Division of Health Benefits has not implemented sufficient procedures to address the OSA finding. The Division completed an initial review of providers to identify those providers who did not have a DEA number or DEA designation form on file, for which none were identified.

The Division generated a listing of providers identified with a DEA designation indicator and is currently conducting a review to assess DEA licensing compliance. Based on results, the Division plans to notify applicable providers of missing or incomplete documentation and take appropriate actions, as necessary.

While significant work has been performed, the Division continues to work with GDIT to develop a more efficient process of identifying providers with DEA designation dummy numbers for verification of DEA licensing compliance.

OIA considers this finding partially resolved with an anticipated completion date of January 31, 2026.

4. OSA FINDING AND RECOMMENDATION – *Did Not Fully Implement Recommendation to Corroborate Provider Ownership Information*

The Division (Division of Health Benefits) did not fully implement OSA’s recommendations to corroborate the accuracy of ownership information of Medicaid providers during the Medicaid provider enrollment process. Specifically, the Division did not corroborate owners, managing employees, or others with controlling interest (collectively referred to as ownership information) of providers during the Medicaid provider initial enrollment or re-verification processes.

As part of the Medicaid provider enrollment process, the Division performs criminal background checks on all disclosed owners and managing relationships associated with the provider record. Without corroborating ownership information, there is a risk that providers submitted inaccurate information, and undisclosed owners go without their credentials evaluated and a background check performed.

OSA Recommendations:

1. *The Division should corroborate the accuracy of all provider ownership information to data available from state licensure boards or the Secretary of State. This should be completed so background checks can be performed and identified ineligible providers removed from Medicaid to protect the safety of Medicaid patients and prevent inappropriate payments from the state.*
2. *Division management should fully implement prior audit recommendations timely.*

Views of Responsible Officials of the Auditee:

The Division appreciates the Auditor's recognition that the February 2021 audit report recommendation to verify provider ownership was not feasible. The Division agrees with the updated recommendation to implement additional procedures to corroborate the provider's ownership disclosure.

For context, there is no federal or state regulation or CMS guidance that requires State Medicaid Agencies to corroborate ownership of providers as stated in the finding. The GAO-23-106163 report on Nursing Homes, noted that determining "whether an unlisted nursing homeowner should have been reported...can be a time-and resource-intensive effort because there is no single, authoritative data source with comprehensive information." However, the Division agrees that prudence requires conducting cost-effective quality assurance efforts to identify whether the provider is consistently identifying all relevant parties so that appropriate screening checks can be performed.

In response to the February 2021 report, the Division implemented the following measure for ownership verification beginning April 2022:

For NC Medicaid participation, providers must disclose 5% or more ownership of the entity enrolling and must self-attest that "Owners with 5% or more ownership in the enrolling provider entered on this application match what was reported to the provider's state business registration entity licensure board, and Medicare." Disclosure and self-attestation are required with each Initial, Re-enrollment, Manage Change Request, and Re-verification application submitted by the provider. Upon submission of the initial application, ownership is compared to the matching Medicare record in the Provider Enrollment, Chain, and Ownership System (PECOS) when available. A match will allow the application to continue processing whereas a mismatch in ownership causes a denial of the application.

During the current audit period, the Division compared 2,398 separate owners reported on 1,764 initial enrollment applications, with mismatches resulting in 30 application denials. The application denials confirm the Division's incorporation of adverse consequences recommended when providers "submit inaccurate information" regarding ownership, thereby protecting the safety of Medicaid patients and preventing inappropriate payments to providers.

The Division acknowledges that the opportunity exists to conduct additional quality assurance checks of other publicly available provider information to increase the likelihood of identifying potentially unreported ownership disclosures. The Division is evaluating the viability of expanding the initial enrollment ownership verification procedures to the reverification and managed change request credentialing processes as well as pursuing the identification of additional sources of provider ownership information that can be reasonably queried for comparison as suggested in CMS' "Toolkit to Address Frequent Findings: 42 CFR 455. 104."

OIA Follow-up Results

OIA conducted a follow-up review and determined that the Division of Health Benefits has implemented sufficient procedures to address the OSA finding. The Division has evaluated the viability of expanding the initial enrollment ownership verification procedures to the reverification and managed change request credentialing processes. The Division expanded the enrollment process to include screening and verification of ownership during initial enrollment, re-enrollment, reverification, and MCR submissions. In addition, the Division has identified and evaluated additional resources, such as the North Carolina Medical License Board, NCDHHS' Division of Health Service Regulation, and the North Carolina Board of Nursing that can be utilized for provider ownership verification.

OIA has determined that the Department's actions taken were sufficient to resolve the risk associated with the finding. OIA considers this finding resolved.