# DEPARTMENT OF HEALTH AND HUMAN SERVICES
## OFFICE OF GOVERNMENT AFFAIRS

ROY COOPER
GOVERNOR

MANDY COHEN, MD, MPH
SECRETARY

MATT GROSS
ASSISTANT SECRETARY FOR LEGISLATION

October 17, 2018

**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 Tim Moore, 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' Office of Internal Auditor to monitor the implementation of the Department's response to any audit of the Department conducted by the State Auditor pursuant to law 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 General Statute. In accordance with the requirement found in General Statute §143B-216.51(g), please find the attached report.

Should you have any questions regarding the report, please contact David King, Director of the Office of the Internal Auditor, at 919-527-6840.

Sincerely,

Matt Gross
Assistant Secretary for Legislation

cc: David King, Theresa Matula, Leah Burns, Walker Wilson, Marjorie Donaldson, Joyce Jones, LT McCrimmon, reports@ncleg.net, Rod Davis, Pam Kilpatrick, Matt Gross, Bill Scott, Katherine Restrepo, Deborah Landry, Zack Wortman

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

# Follow-up Assessment of the Department's Response to the Findings and Recommendations Identified in the State of North Carolina Single Audit Report for the Fiscal Year Ended June 30, 2017

Issued by the Office of the State Auditor
April 3, 2018

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September 27, 2018

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September 27, 2018

Secretary Mandy Cohen, MD, MPH
N.C. Department of Health and Human Services
Adams Building, 101 Blair Drive
Raleigh, NC 27603

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 identified in the State of North Carolina Single Audit Report, FSA-2017-4410, and the Department of Health and Human Services Statewide Federal Compliance Audit Procedures, FSA-2017-8730, for the fiscal year ended June 30, 2017. The reports were issued by the Office of the State Auditor (OSA) on April 4, 2018 and April 3, 2018, respectively.

Results
Thirteen of the twenty findings are considered resolved: OIA obtained sufficient evidence to conclude that the Department took appropriate corrective action to reduce risks identified in OSA's audit reports. In our opinion, corrective action taken for those thirteen findings was adequate to reduce risk to an acceptable level. An additional seven findings are considered partially resolved: the Department took some action to reduce risks identified. 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 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 Appendix A. Due to their sensitive nature and pursuant to G.S. 132-6.1(c), a separate letter will be issued to Secretary Cohen that includes detailed follow-up results from the four security-related findings noted in OSA's audit reports.

Objective
The objective of our follow-up assessment was to evaluate whether the Department has taken appropriate corrective action in response to OSA's findings and recommendations. Our follow-up assessment was conducted 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 actions taken by the Department no later than six months after the State Auditor publishes any audit report pursuant to law. A copy of this report shall also be filed with the Joint Legislative Commission on Governmental Operations pursuant to the General Statute.

Scope
The scope of our follow-up assessment included the review of activities directed toward the resolution of OSA's findings and recommendations as well as the corrective action taken by the Department.

Methodology
In order to form an opinion on the current status of the twenty findings, we performed the following procedures:

- We reviewed OSA's audit reports 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 evaluated evidence that actionable items were completed and implemented to reduce risk to an acceptable level.
- Partially Resolved: We evaluated evidence that progress has been made toward the implementation of the actionable items in the Department's response and is ongoing to reduce risk to an acceptable level.
- Unresolved: Evidence was not provided to show progress has been made 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 and the Office of the State Auditor for their cooperation and assistance during this follow-up assessment.

David A. King
Director, Office of the Internal Auditor

## APPENDIX A

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

**1) OSA FINDING AND RECOMMENDATION – *2017-001: ERRORS IN SNAP NOTIFICATIONS AND BENEFIT CALCULATIONS***

*10.551 SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM*
*DIVISION OF SOCIAL SERVICES*

*Finding 2017-001: 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 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.*

*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) and NC FAST staff are trying to determine the root cause of the errors.*

*Federal regulations 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.*

*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.*

*OSA Recommendations: 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.*

*Corrective Action Plan: The Department will create a change request to update the DSS-8562 Effect of Change notice.*

*The Department implemented corrections for three notice errors as identified in the finding. These errors were resolved between August and September 2017.*

*The Department identified the root cause of one notice error and the corrective action will be prioritized for implementation during the current State fiscal year (SFY '18).*

*The Department created tasks for the five remaining notification errors to determine the root cause. Corrective actions will be prioritized for implementation during the current State fiscal year (SFY '18) as necessary.*

*The Department resolved one benefit calculation error in January 2018. The other benefit calculation error will be reviewed to determine if a change request is needed. The Department will ensure that both overpayments are recouped and processed according to policy.*

*The Department created tasks to perform root cause analysis of the household income error and shelter error, which had no impact to the beneficiary. After analysis, corrective actions will be prioritized for implementation during the current State fiscal year (SFY '18) as necessary.*

*Anticipated Completion Date: June 30, 2018*

**OIA Follow-up Results**

**Per OIA follow-up, the Division of Social Services (DSS) and the Office of NC FAST investigated the errors and determined that eleven different system issues caused the issues identified by OSA. DSS and the Office of NC FAST created nine defects (a fix to existing functionality) and one change request (entirely new functionality) in JIRA, the issue tracking and project management system, to investigate the system issues. For one issue, DSS and the Office of NC FAST have not created a defect or change request to date.**

**NC FAST has made progress resolving the various system issues. NC FAST implemented programming changes to resolve four of the seven system issues related to notices not generating under certain conditions. NC FAST implemented programming changes to resolve two of two issues related to incorrectly calculated benefit payments. NC FAST has not resolved two system issues: one error related to shelter deductions and one error related to income.**

**DSS and the Office of NC FAST have partially implemented the corrective action plan and partially mitigated the risk associated with finding 2017-001.**

**This was a repeat finding, which we previously considered partially resolved as of September 13, 2017. We consider this finding partially resolved, with an anticipated completion date of December 31, 2018.**

**2) OSA FINDING AND RECOMMENDATION – *2017-011: ERRORS IN MEDICAL CLAIMS PAYMENT PROCESS***

*84.126 REHABILITATION SERVICES – VOCATIONAL REHABILITATION GRANTS TO STATES*
*DIVISION OF VOCATIONAL REHABILITATION SERVICES*

*Finding 2017-011: 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. 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 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 Report 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.*

*OSA 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.*

*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.*

*Corrective Action Plan: Beginning in November 2015, the new claims processing system (BEAM) directly interfaces with NCTracks to return the Medicaid rate in place on the date of payment for date of service. This interface has helped to reduce the error rate in the sample from 47% in SFY 2014-2015 to 1.5% in SFY 2016-2017.*
*The following corrective actions have been put in place:*

- *Medical claims for which there is no Medicaid rate are manually priced by the Controller's Office. A random sample of at least 10% of all manually priced claims is now audited for accuracy.*
- *Claims processing training for staff was completed in August 2016.*
- *The $438 Medical claim error was invoiced for recoupment on December 18, 2017. If funds are not fully recouped by June 29, 2018, the claim will be reclassified to state funds.*

*Anticipated Completion Date: June 30, 2018*

**OIA Follow-up Results**

**Per OIA follow-up, DVRS worked with the DHHS Office of the Controller to develop claims processing training for situations where there are no Medicaid rates and claims have to be manually priced. All members of the team responsible for claims processing attended the training.**

**Currently, the Office of the Controller reviews all manually priced claims for accuracy. In addition, the $438 of medical claims identified as overpayments were reclassed to State funds.**

**DVRS has fully implemented the corrective action plan and mitigated the risk associated with OSA finding number 2017-011 to an acceptable level to prevent the finding from recurring.**

**We consider this finding resolved as of July 26, 2018.**

**3) OSA FINDING AND RECOMMENDATION – *2017-012: COST ALLOCATION ERRORS***

*84.126 REHABILITATION SERVICES – VOCATIONAL REHABILITATION GRANTS TO STATES*
*DIVISION OF VOCATIONAL REHABILITATION SERVICES*

*Finding 2017-012: The Department did not comply with its cost allocation plan (CAP) 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 was allocated to the grant.*

*Auditors reviewed 46 responsibility cost centers (RCC) of a total 2,355, 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.*

- *Monitoring to ensure the continued appropriateness of the CAP was not adequately performed.*

- *Records that supported the allocations were not properly maintained.*

*Federal regulations 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.*

*Further, federal regulations 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).*

*OSA Recommendations: 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.*

*Corrective Action Plan: The Cost Analysis Branch will provide training to division staff to review and monitor the Cost Allocation Plan and reemphasize the importance of proper execution of the certification statement process including the necessity of an adequate review.*

*The Cost Analysis Branch began to perform monthly allocation variance analyses for divisions in the December 2016 quarter which enhanced the review of the calculations used to allocate costs.*

*Federal funding for the unallowable payroll costs was returned in January 2018.*

*Anticipated Completion Date: December 31, 2018*

*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.*

*Anticipated Completion Date: December 31, 2018*

**OIA Follow-up Results**

**Per OIA follow-up, the Office of the Controller's Cost Analysis Branch provided cost allocation plan training to Budget Officers and other Division staff. In addition, DVRS staff met with the Cost Analysis Branch in March 2018 to review the DSB and DVRS cost allocation plans. The Cost Analysis Branch continues to perform monthly cost allocation variation analysis. In addition, the Office of the Controller reclassed the $98,214 in unallowed payroll costs charged to the Vocational Rehabilitation grant to State funds.**

**DVRS and the Office of the Controller have fully implemented the corrective action plan and mitigated the risk associated with OSA finding number 2017-012 to an acceptable level to prevent the finding from recurring.**

**We consider this finding resolved as of August 14, 2018.**

**4) OSA FINDING AND RECOMMENDATION – *2017-014: WEATHERIZATION FUNDS WERE OVERSPENT***

*93.568 LOW-INCOME HOME ENERGY ASSISTANCE PROGRAM*
*DIVISION OF SOCIAL SERVICES*

*Finding 2017-014: The Department overspent Low-Income Home Energy Assistance Program (LIHEAP) weatherization 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) 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 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 finding was reported in the 2016 Statewide Single Audit Reports 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)*

*OSA Recommendations: 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 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.*

*Corrective Action Plan: The Department received guidance from the U.S. Department of Health and Human Services (HHS) Administration for Children and Families (ACF) for allocating and expending the Weatherization funds. The Department revised the process for allocating and expending the Weatherization funds to comply with the federal guidelines to ensure compliance with federal regulations.*

*The Department applied for and received approval for the Weatherization Waiver for FFY 2017.*

*Corrective action was completed on: September 30, 2017*

**OIA Follow-up Results**

**Per OIA follow-up, DSS conducted a teleconference with the Administration for Children and Families (a division of the US Department of Health and Human Services) to seek guidance regarding the allocation and reporting of Weatherization funds on July 6, 2017. DSS used the Federal guidance to aid in development of the State's FFY 2017 Detailed LIHEAP Model Plan and the FFY 2017 working plan which detail LIHEAP spending, including Weatherization. Finally, DSS received a weatherization waiver from ACF for FFY 2017 and FFY 2018.**

**DSS has fully implemented the corrective action plan and mitigated the risk associated with OSA finding number 2017-014 to an acceptable level to prevent the finding from recurring.**

**We consider this finding resolved as of August 15, 2018.**

**5) OSA FINDING AND RECOMMENDATION – *2017-015: NON-ALLOWED EXPENSES PAID FROM FOSTER CARE FUNDS***

*93.658 FOSTER CARE - TITLE IV-E*

*DIVISION ON SOCIAL SERVICES*

*Finding 2017-015: 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. 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.*

*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).*

*OSA Recommendations: 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.*

*Corrective Action Plan: The Department implemented a standard review and verification process of the monthly vendor invoices performed by the Budget Section staff.*

*The process includes the following:*

- *The Budget Section verifies and allocates the invoice amounts based on the timesheets and percentages provided by the vendor; and*

- *The Senior Project Manager and the Division Director review and approve the invoices.*

*In addition, the template used to populate hours was revised to automatically calculate the percentage based on hours by project code.*

*Corrective action was completed on: October 31, 2017*

**OIA Follow-up Results**

**The Office of NC FAST has implemented a process to verify the allocation of invoices for the comprehensive child welfare information system based on the timesheets and percentages provided by Accenture. The Budget Analyst reviews invoice amounts based on timesheets and percentages provided by Accenture. The process also includes the review and approval of the invoices and/or hours (percentages) by the NC FAST Program Director and the NC FAST Senior Project Manager. In addition, NC FAST has identified and reclassified approximately $488,700 of questioned costs from Foster Care to the appropriate programs.**

**The Office of NC FAST has fully implemented the corrective action plan and mitigated the risk associated with OSA finding number 2017-015 to an acceptable level to prevent the finding from recurring.**

**We consider this finding resolved as of July 30, 2018.**

**6) OSA FINDING AND RECOMMENDATION – *2017-016: INADEQUATE SUBRECIPIENT MONITORING INCREASES RISK OF WASTED FUNDS***

*93.658 FOSTER CARE - TITLE IV-E*
*DIVISION OF SOCIAL SERVICES*

*Finding 2017-016: 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 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).*

*OSA Recommendations: 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.*

*Corrective Action Plan: Monitors were provided with instruction on the requirements for the enhanced process for resolving findings in May 2017.*

*In July 2017, monitors followed up with counties by phone and/or email to fully document that all activities outlined on the corrective action plan were implemented. The timeframe for follow up is based on the projected completion date outlined within the plan to ensure that all activities have been implemented. Monitors will maintain documentation verifying completion of the corrective action plan.*

*Monitors confirmed and documented the adjustment was made with the controller's office.*

*An email confirmation was sent to the county director and other designated staff to document that fiscal adjustments were made and findings were resolved.*

*Corrective action was completed on: January 1, 2018*

**OIA Follow-up Results**

**Per OIA's follow-up work, DSS has provided instructions to its monitoring staff regarding the requirements for the enhanced process for resolving findings and has recouped approximately $34,846 in ineligible funds paid to the counties in FY2017. At the time the CAP was created, no timeframe had been identified as to the timing of the email confirmation. As of August 22, 2018, Child Welfare Monitoring policies and procedures were updated, and timing of the email confirmation was clarified. However, there was no evidence that an email confirmation was sent to the county directors and other designated staff to document that fiscal adjustments were made, and findings were resolved.**

**DSS has partially implemented the corrective action plan and partially mitigated the risk associated with finding 2017-016.**

**We consider this finding partially resolved, with an anticipated completion date of September 1, 2018.**

**7) OSA FINDING AND RECOMMENDATION – *2017-017: DEFICIENCIES IN COUNTY ELIGIBILITY DETERMINATION PROCESS***

*93.659 ADOPTION ASSISTANCE*
*DIVISION OF SOCIAL SERVICES*

*Finding 2017-017: 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. 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.*

*Federal regulations 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).*

*OSA Recommendations: 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.*

*Corrective Action Plan: The Department verified the questioned costs for the ineligible cases and submitted the required documentation and request to the NC DHHS Controller's Office to recoup the funds.*

*The Department will conduct an on-site monitoring visit or desk review before the end of the SFY 2018. During the monitoring visit or desk review, the Department will review the client files to ensure the required documentation is maintained.*

*The Department will continue to conduct on-site eligibility determination monitoring in each county on a semi-annual basis as specified in the North Carolina Local Social Service Agencies Monitoring Plan. The Department will utilize on-going technical support and departmental communications to remind counties of policy and training opportunities available to them.*

*Anticipated Completion Date: June 30, 2018*

**OIA Follow-up Results**

**Per OIA follow-up, DSS provided opportunities for training to local county personnel. DSS also provided instructions to the monitoring staff regarding requirements for the enhanced process for resolving findings, which included verification of adjustments. DSS recouped over $284,000 in eligible funds.**

**DSS conducted on-site monitoring visits or desk reviews during SFY 2018. In addition, several counties reviewed 100% of their clients' adoption assistance files in order to determine if all relevant documents were included in the files.**

**DSS has fully implemented the corrective action plan and mitigated the risk associated with OSA finding number 2017-017 to an acceptable level to prevent the finding from recurring.**

**We consider this finding resolved as of August 20, 2018.**

**8) OSA FINDING AND RECOMMENDATION – *2017-018: INADEQUATE SUBRECIPIENT MONITORING INCREASES RISK OF WASTED FUNDS***

*93.659 ADOPTION ASSISTANCE*

*DIVISION OF SOCIAL SERVICES*

*Finding 2017-018: 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.*

*Federal regulations 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).*

*OSA Recommendations: 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.*

*Corrective Action Plan: Monitors were provided with instruction on the requirements for the enhanced process for resolving findings in May 2017.*

*In July 2017, monitors followed up with counties by phone and/or email to fully document that all activities outlined on the corrective action plan were implemented. The timeframe for follow up is based on the projected completion date outlined within the plan to ensure that all activities have been implemented. Monitors will maintain documentation verifying completion of the corrective action plan.*

*Monitors confirmed and documented the adjustment was made with the controller's office.*

*An email confirmation was sent to the county director and other designated staff to document that fiscal adjustments were made and findings were resolved.*

*Corrective action was completed on: January 1, 2018*

**OIA Follow-up Results**

**Per OIA's follow-up work, DSS has provided instructions to its monitoring staff regarding the requirements for the enhanced process for resolving findings and has recouped approximately $34,846 in ineligible funds paid to the counties in FY2017. At the time the CAP was created, no timeframe had been identified as to the timing of the email confirmation. As of August 22, 2018, Child Welfare Monitoring policies and procedures were updated, and timing of the email confirmation was clarified. However, there was no evidence that an email confirmation was sent to the county directors and other designated staff to document that fiscal adjustments were made, and findings were resolved.**

**DSS has partially implemented the corrective action plan and partially mitigated the risk associated with finding 2017-018.**

**We consider this finding partially resolved, with an anticipated completion date of September 1, 2018.**

**9) OSA FINDING AND RECOMMENDATION – *2017-019: ERRORS IN CHILDREN'S HEALTH INSURANCE FEE-FOR-SERVICE CLAIMS PAYMENT PROCESS***

*93.767 CHILDREN'S HEALTH INSURANCE PROGRAM*
*DIVISION OF MEDICAL ASSISTANCE*

*Finding 2017-019: 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).*
- *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 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 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 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 Report 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).*

*OSA Recommendations: 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.*

*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.*

*Corrective Action Plan: Following standard industry practice, the Department does not systematically reprocess claims because of retroactive State Maximum Allowable Cost (SMAC) rates. However, pharmacies may reverse and rebill claims to obtain the retroactive rate. The Department will continue to inform providers of their ability to submit adjustment claims when SMAC rates are updated after a claims date of service. The Centers for Medicare and Medicaid Services (CMS) has provided its concurrence with the State's process.*

*Corrective action was completed on: February 12, 2018*

*The Department will issue a Medicaid Bulletin to reiterate to providers the requirement to maintain proper documentation to support the medical necessity and proper coding of services billed to the Medicaid Program. 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.*

*Anticipated Completion Date: June 30, 2018*

**OIA Follow-up Results**

**Per OIA follow-up, DMA received concurrence from CMS that when pharmacy rate adjustments are received by DMA after the effective date, it does not expect states to reprocess claims that have already been adjudicated. In the July 2017 Pharmacy Newsletter, DMA reminded providers of their ability to submit adjustment claims when State Maximum Allowable Cost rates are adjusted after a claim's date of service. In addition, DMA included articles in monthly Medicaid Bulletins reiterating**

**requirements for providers to maintain documentation for medical necessity and to support coding.**

**DMA sent a Tentative Notice of Overpayment or Notice of Underpayment to each provider that was cited as having an over/underpayment; however, DMA has not returned the Federal share of overpayments.**

**DMA has partially implemented the corrective action plan and partially mitigated the risk associated with finding 2017-019.**

**We consider this finding partially resolved with an anticipated completion date of December 31, 2018.**

**10) OSA FINDING AND RECOMMENDATION – *2017-020: ERRORS IN MANAGEMENT FEE PAYMENT PROCESS***

*93.767 CHILDREN'S HEALTH INSURANCE PROGRAM*

*DIVISION OF MEDICAL ASSISTANCE*

*Finding 2017-020: The Department made approximately $6 million in capitation claim overpayments to Local Management Entities and Managed Care Organizations (LME/MCO) 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 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 require costs to be adequately documented, authorized, necessary and reasonable, and be consistent with program regulations applicable to the federal award.*

*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).*

*OSA Recommendations: 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.*

*Corrective Action Plan: The appropriate logic to prevent duplicate payments was implemented in NCTracks in August 2017. DMA identified and corrected the payments that were impacted and recouped the overpayments on December 5, 2017 and February 6, 2018. DMA continues to monitor the monthly capitation payments by Monthly Monitoring Reports, Monthly Financial Reports, SB 208 Audits, and other External Quality review activities designed to identify any issues related to MCO payments.*

*Corrective action was completed on: February 6, 2018*

**OIA Follow-up Results**

**Per OIA follow-up, DMA worked with the NCTracks vendor (CSRA) to identify the cause of the errors and implement the appropriate system logic within NCTracks to prevent duplicate payments, which were caused by issues with rounding and split payments. In addition, DMA worked with CSRA to recoup the overpayments in December 2017 and February 2018.**

**DMA has fully implemented the corrective action plan and mitigated the risk associated with OSA finding number 2017-020 to an acceptable level to prevent the finding from recurring.**

**We consider this finding resolved as of July 31, 2018.**

**11) OSA FINDING AND RECOMMENDATION – *2017-021: DEFICIENCIES IN SYSTEM ACCESS***

*93.767 CHILDREN'S HEALTH INSURANCE PROGRAM*
*DIVISION OF MEDICAL ASSISTANCE*

*Finding 2017-021: 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 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.*

*Corrective Action Plan: The Department is committed to maintaining information security and system access controls. As a result, we have implemented corrective actions to address the risks identified by the audit team. These corrective actions have been detailed in a response separately submitted to the State Auditor. Any potential security risks or noncompliance are given the highest priority by the Department and corrective actions will be monitored.*

*Anticipated Completion Date: December 31, 2018*

**OIA Follow-up Results**

**Per OIA follow-up, DMA has partially implemented the corrective action plan and partially mitigated the risk associated with finding 2017-021. Due to the sensitivity of the finding, details of OIA's follow-up activities are not included in this report. A separate letter will be issued to the Secretary with detailed follow-up results.**

**We consider this finding partially resolved with an anticipated completion date of June 30, 2019.**

**12) OSA FINDING AND RECOMMENDATION – *2017-022: DELAYED REMEDIATION OF WEAKNESSES***

*93.767 CHILDREN'S HEALTH INSURANCE PROGRAM*
*DIVISION OF MEDICAL ASSISTANCE*

*Finding 2017-022: 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.*

*Corrective Action Plan: The Department is committed to maintaining information security and system access controls. As a result, we have implemented corrective actions to address the risks identified by the audit team. These corrective actions have been detailed in a response separately submitted to the State Auditor. Any potential security risks or noncompliance are given the highest priority by the Department and corrective actions will be monitored.*

*Anticipated Completion Date: March 31, 2018*

**OIA Follow-up Results**

**Per OIA follow-up, ITD has fully implemented the corrective action plan and mitigated the risk associated with OSA finding number 2017-022 to an acceptable level to prevent the finding from recurring. Due to the sensitivity of the finding, details of OIA's follow-up activities are not included in this report. A separate letter will be issued to the Secretary with detailed follow-up results.**

**We consider this finding resolved as of August 24, 2018.**

**13) OSA FINDING AND RECOMMENDATION – *2017-023: LACK OF QUALITY ASSURANCE REVIEWS INCREASED RISK OF UNDETECTED PAYMENT ERRORS***

*93.767 CHILDREN'S HEALTH INSURANCE PROGRAM*
*DIVISION OF MEDICAL ASSISTANCE*

*<u>Finding 2017-023:</u> 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. 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 casefiles.*
- *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.*

*Additionally, monitoring of PCG was important because the Department identified performance problems with PCG before. As previously reported, 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 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 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 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).*

*<u>OSA Recommendations:</u> 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 to ensure future reviews are completed timely. The procedure is documented in the OCPI Operations Manual.*

*Corrective Action Plan: The quality assurance case reviews of the Public Consulting Group's work for the 3rd and 4th quarters of SFY 2017 were completed by mid-October 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 Office of Compliance and Program Integrity Operations Manual.*

*Corrective action was completed on: November 3, 2017*

**OIA Follow-up Results**

**Per OIA's follow-up work, DMA completed the SFY17 3rd and 4th quarter quality assurance reviews of PCG's claim reviews and continued to perform quality assurance reviews of PCG's work during the first three quarters of SFY18. The Division also hired a Data Analytics Manager, documented the random sampling process in the OCPI Operations Manual, and trained three additional staff on random sample selection.**

**DMA has fully implemented the corrective action plan and mitigated the risk associated with OSA finding number 2017-023 to an acceptable level to prevent the finding from recurring.**

**We consider this finding resolved as of July 31, 2018.**

**14) OSA FINDING AND RECOMMENDATION – *2017-024: ERRORS IN MEDICAID FEE-FOR-SERVICE CLAIMS PAYMENT PROCESS***

*93.778 MEDICAL ASSISTANCE PROGRAM*
*DIVISION OF MEDICAL ASSISTANCE*

*Finding 2017-024: 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 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 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.*
- *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 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 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 Report 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).*

*OSA Recommendations: 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 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.*

*Corrective Action Plan: To mitigate any future risk, the vendor has been instructed to cross reference all policies added to NCTracks to the vendor commercial insurance recovery file. This is to ensure that we identify liable third parties who are responsible for paying Medicaid recipient's medical bills. This issue will continue to be communicated during the monthly client meetings.*

*The audit findings will be addressed by HMS along with DMA's assistance that all Medicare eligibility data captured from MMA (Medicare Modernization Act) and EDB (Enrollment Database) files are transmitted to HMS in the GEF (Global Eligibility Files). HMS is redesigning their data intake and Medicare Disallowance process for matching against claims that should be coordinated with Medicare. The Medicare invoice back up report lists the Medicare Multiple Adjustment forms that are invoiced. The listed forms are crossed referenced with the corresponding processed forms from CSRA in a filing system. This will verify that the recouped amount on the invoice equals the amount processed and completed by CSRA. Any discrepancies found are reported to HMS for correction. If there is data missing from the file, HMS will notify the Division of Medical Assistance (DMA) to obtain the data needed on the file. This process will be monitored monthly by DMA's Third-Party Liability Quality Assurance staff.*

*Anticipated Completion Date: June 30, 2018*

*Following standard industry practice, the Department does not systematically reprocess claims because of retroactive State Maximum Allowable Cost (SMAC) rates. However, pharmacies may reverse and rebill claims to obtain the retroactive date. The Department will continue to inform providers of their ability to submit adjustment claims when SMAC rates are updated after a claims date of service. The Centers for Medicare and Medicaid Services (CMS) has provided its concurrence with the State's process. The Division of Medical Assistance (DMA) Provider Reimbursement generated File Maintenance Request (FMR) 5249 to address the reprocessing of the private duty nursing claims. CMS approved the rate increase for private duty nursing under the Community Alternatives Program for Children (CAP/C) Waiver program in May 2017 with an effective date of July 1, 2016. The revised date was implemented in the NCTracks system in May 2017, which was after the claim was originally paid in March 2017. The claims were systematically reprocessed on August 15, 2017 and paid at the correct rate.*

*Corrective action was completed on: February 12, 2018*

*The Department will issue a Medicaid Bulletin to reiterate to providers the requirement to maintain proper documentation to support the medical necessity and proper coding of services billed to the Medicaid Program. 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.*

*Anticipated Completion Date: June 30, 2018*

**OIA Follow-up Results**

**Per OIA follow-up, DMA received concurrence from CMS that when pharmacy rate adjustments are received by DMA after the effective date, it does not expect states to reprocess claims that have already been adjudicated. In the July 2017 Pharmacy Newsletter, DMA reminded providers of their ability to submit adjustment claims when State Maximum Allowable Cost rates are adjusted after a claim's date of service. In addition, DMA included articles in monthly Medicaid Bulletins reiterating requirements for providers to maintain documentation for medical necessity and to support coding.**

**DMA provided the Third-Party Recovery vendor with instructions regarding third-party insurance issues. DMA also continued monitoring the Third-Party Recovery vendor's monthly invoices and ensured that the Third-Party Recovery vendor began using the Global Eligibility Files to improve identification of data needed to pursue recovery.**

**DMA implemented the revised private-duty nursing rate in NCTracks in May 2017 and retroactively reprocessed claims after receiving approval from CMS.**

**DMA sent a Tentative Notice of Overpayment or Notice of Underpayment to each provider that was cited as having an over/underpayment; however, DMA has not returned the Federal share of overpayments.**

**DMA has partially implemented the corrective action plan and partially mitigated the risk associated with finding 2017-024.**

**We consider this finding partially resolved with an anticipated completion date of December 31, 2018.**

**15) OSA FINDING AND RECOMMENDATION – *2017-025: ERRORS IN MANAGEMENT FEE PAYMENT PROCESS***

*93.778 MEDICAL ASSISTANCE PROGRAM*

*DIVISION OF MEDICAL ASSISTANCE*

*Finding 2017-025: The Department made approximately $6 million in capitation claim overpayments to Local Management Entities and Managed Care Organizations (LME/MCO) 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 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 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).*

*OSA Recommendations: 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.*

*Corrective Action Plan: The appropriate logic to prevent duplicate payments was implemented in NCTracks in August 2017. DMA identified and corrected the payments that were impacted and recouped the overpayments on December 5, 2017 and*
*February 6, 2018. DMA continues to monitor the monthly capitation payments by Monthly Monitoring Reports, Monthly Financial Reports, SB 208 Audits, and other External Quality review activities designed to identify any issues related to MCO payments.*

*Corrective action was completed on: February 6, 2018*

**OIA Follow-up Results**

**Per OIA follow-up, DMA worked with the NCTracks vendor (CSRA) to identify the cause of the errors and implement the appropriate system logic within NCTracks to prevent duplicate payments, which were being caused by issues with rounding and split payments. In addition, DMA worked with CSRA to recoup the overpayments in December 2017 and February 2018.**

**DMA has fully implemented the corrective action plan and mitigated the risk associated with OSA finding number 2017-025 to an acceptable level to prevent the finding from recurring.**

**We consider this finding resolved as of July 31, 2018.**

**16) OSA FINDING AND RECOMMENDATION – *2017-026: INADEQUATE REVIEWS RESULTED IN OVERPAYMENTS TO HOSPITALS***

*93.778 MEDICAL ASSISTANCE PROGRAM*

*DIVISION OF MEDICAL ASSISTANCE*

*Finding 2017-026: 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. 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 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 require auditors to report known 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 the methodologies in the CMS approved Medicaid State Plan. 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).*

*OSA 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.*

*Corrective Action Plan: The Division of Medical Assistance has taken the following actions to address the finding:*

*1. Expanded the knowledge, review and oversight of the DSH/MRI/GAP Payment Plan model to include staff from the DMA Provider Audit team. This team will furnish an additional level of review and verification of data input into the model for calculation. Additionally, this team will furnish an additional level of review and signoff on memoranda for required transactions.*

*2. In the October 2017 - December 2017 quarter, completed the transactions necessary to correct the over-certification of Uncompensated Care CPE's for Vidant Medical Center and return the net federal share.*

*3. In the October 2017 - December 2017 quarter, completed the transactions necessary to recover $249,381 DSH overpayment from UNC Hospitals and return the net federal share.*

*Anticipated Completion Date: December 31, 2017*

**OIA Follow-up Results**

**Per OIA follow-up, DMA implemented a new process to include additional review by the DMA Provider Audit team for DSH payment calculations and transactions for CPEs. DMA corrected the over-certification of Uncompensated Care CPEs for Vidant Medical Center and returned the Federal share. DMA also completed transactions to recover DSH overpayment to UNC Hospitals to return the Federal share.**

**DMA has fully implemented the corrective action plan and mitigated the risk associated with OSA finding number 2017-026 to an acceptable level to prevent the finding from recurring.**

**We consider this finding resolved as of July 31, 2018.**

**17) OSA FINDING AND RECOMMENDATION – *2017-027: DEFICIENCIES IN SYSTEM ACCESS***

*93.778 MEDICAL ASSISTANCE PROGRAM*

*DIVISION OF MEDICAL ASSISTANCE*

*Finding 2017-027: 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 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.*

*Corrective Action Plan: The Department is committed to maintaining information security and system access controls. As a result, we have implemented corrective actions to address the risks identified by the audit team. These corrective actions have been detailed in a response separately submitted to the State Auditor. Any potential security risks or noncompliance are given the highest priority by the Department and corrective actions will be monitored.*

*Anticipated Completion Date: December 31, 2018*

**OIA Follow-up Results**

**Per OIA follow-up, DMA has partially implemented the corrective action plan and partially mitigated the risk associated with finding 2017-027. Due to the sensitivity of the finding, details of OIA's follow-up activities are not included in this report. A separate letter will be issued to the Secretary with detailed follow-up results.**

**We consider this finding partially resolved with an anticipated completion date of June 30, 2019.**

**18) OSA FINDING AND RECOMMENDATION – *2017-028: DELAYED REMEDIATION OF WEAKNESSES***

*93.778 MEDICAL ASSISTANCE PROGRAM*
*DIVISION OF MEDICAL ASSISTANCE*

*Finding 2017-028: 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 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.*

*Corrective Action Plan: The Department is committed to maintaining information security and system access controls. As a result, we have implemented corrective actions to address the risks identified by the audit team. These corrective actions have been detailed in a response separately submitted to the State Auditor. Any potential security risks or noncompliance are given the highest priority by the Department and corrective actions will be monitored.*

*Anticipated Completion Date: March 31, 2018*

**OIA Follow-up Results**

**Per OIA follow-up, ITD has fully implemented the corrective action plan and mitigated the risk associated with OSA finding number 2017-028 to an acceptable level to prevent the finding from recurring. Due to the sensitivity of the finding, details of OIA's follow-up activities are not included in this report. A separate letter will be issued to the Secretary with detailed follow-up results.**

**We consider this finding resolved as of August 24, 2018.**

**19) OSA FINDING AND RECOMMENDATION – *2017-029: LACK OF QUALITY ASSURANCE REVIEWS INCREASED RISK OF UNDETECTED PAYMENT ERRORS***

*93.778 MEDICAL ASSISTANCE PROGRAM*
*DIVISION OF MEDICAL ASSISTANCE*

*Finding 2017-029: 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. 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.*

*Additionally, monitoring of PCG was important because the Department identified performance problems with PCG before. As previously reported, 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 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 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): 93.778 (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)*

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

*Corrective Action Plan: The quality assurance case reviews of the Public Consulting Group's work for the 3rd and 4th quarters of SFY 2017 were completed by mid-October 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 Office of Compliance and Program Integrity Operations Manual.*

*Corrective action was completed on: November 3, 2017*

**OIA Follow-up Results**

**Per OIA's follow-up work, DMA completed the SFY17 3rd and 4th quarter quality assurance reviews of PCG's claim reviews and continued to perform quality assurance reviews of PCG's work during the first three quarters of SFY18. The Division also hired a Data Analytics Manager, documented**

**the random sampling process in the OCPI Operations Manual, and trained three additional staff on random sample selection.**

**DMA has fully implemented the corrective action plan and mitigated the risk associated with OSA finding number 2017-029 to an acceptable level to prevent the finding from recurring.**

**We consider this finding resolved as of July 31, 2018.**

**20) OSA FINDING AND RECOMMENDATION – *2017-030: DEFICIENCIES IN COUNTY ELIGIBILITY DETERMINATION PROCESS***

*93.778 MEDICAL ASSISTANCE PROGRAM*
*DIVISION OF MEDICAL ASSISTANCE*

*Finding 2017-030: 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. 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, 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 maintained program documentation in the case file for the traditional cases.*

*Federal regulations 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 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 Report as finding number 2016-056.*

*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).*

*OSA Recommendations: 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 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.*

*Corrective Action Plan: The Medicaid Eligibility Operational Support Team (OST) provided Medicaid eligibility training through their quarterly cluster meetings held August 11 – 31, 2017 throughout the state of North Carolina. OST worked with NC FAST to develop and implement Medicaid core policy training modules (with testing features) in the Learning Gateway and will continue to develop and implement required training modules. OST will provide training on eligibility determination documentation requirements via the Learning Gateway by May 30, 2018. The Department will issue a Policy Governance Board letter notifying counties of the requirement to begin documenting eligibility determinations in NC FAST as prescribed.*

*The Department is also implementing system enhancements/tools to improve eligibility determinations. These tools will ensure applicable documentation is obtained to determine if a beneficiary meets specific income standards and maintained to support eligibility determinations.*

- *To combat continuous errors identified in both income computations and notices, NC FAST released two system enhancement functions. These two automation functions removed the manual steps county staff must complete in determining Medicaid eligibility. Implementation date effective December 2017.*

- *The Department collaborated with the State Register of Deeds (ROD) Office to verify that all 100 counties in North Carolina have an electronic ROD portal. This new portal access eliminates county staff travel to ROD office; thereby improving efficiency and accuracy. The electronic ROD portal allows county workers to verify real property listed in any county for an applicant or beneficiary when determining Medicaid eligibility. Implementation date effective June 2017.*

- *An additional resource for obtaining asset information is the Asset Verification System (AVS). The AVS is a tool to identify undisclosed financial institutions associated with Medicaid applicants/beneficiaries. AVS determines how many financial institutions to pull into the search based on residence location and has been enhanced to search for additional financial institutions. Implementation date effective January 2018.*

*The Department implemented a new second party review tool to monitor eligibility determinations performed by the county department of social services. Counties are required to conduct second party reviews monthly based on their Medicaid enrollment population size. The Division of Medical Assistance, Division of Social Services, and NC FAST have collaborated to provide additional support to county staff as a result of analyzing second party review findings.*

*Anticipated completion date: July 30, 2018*

**OIA Follow-up Results**

**Per OIA follow-up, DMA provided Medicaid eligibility training throughout the State through quarterly cluster meetings held during August 2017. DMA also added new core policy training courses to the NC FAST Learning Gateway, each of which included a testing component. DMA issued a Policy Governance Board letter to notify counties of the requirement to clearly document all relevant information used to determine eligibility in NC FAST.**

**DMA collaborated with DSS and NC FAST to automate notices and income calculations, which were identified as processes that were causing errors. DMA ensured all 100 counties have an electronic Register of Deeds portal to improve efficiency and accuracy in verifying real property listings for Medicaid eligibility determinations. DMA also increased the number of financial institutions included in searches within the Asset Verification System.**

**DMA revised the second party review tool to ensure all eligibility issues are identified consistently among counties and has continued to analyze the results of the counties' second party reviews.**

**DMA assessed each error cited in finding 2017-030 and determined whether it could be resolved by obtaining additional information or documentation. Where deemed appropriate, DMA issued notices of recoupment and invoices to counties with questioned costs.**

**DMA has fully implemented the corrective action plan and mitigated the risk associated with OSA finding number 2017-030 to an acceptable level to prevent the finding from recurring.**

**We consider this finding resolved as of July 31, 2018.**