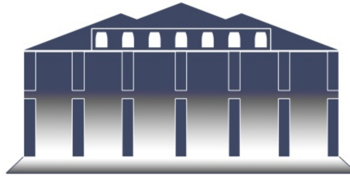
# Medicaid Program Integrity Section is Not Cost-Effectively Identifying and Preventing Fraud, Waste, and Abuse

**Final Report to the Joint Legislative Program Evaluation Oversight Committee**

**Report Number 2016-10**

**November 14, 2016**



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Director

November 14, 2016

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Representative Craig Horn, Co-Chair, Joint Legislative Program Evaluation Oversight Committee

North Carolina General Assembly
Legislative Building
16 West Jones Street
Raleigh, NC 27601

Honorable Co-Chairs:

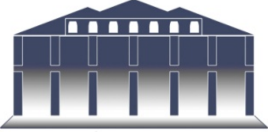
The Joint Legislative Program Evaluation Oversight Committee's 2015–17 Work Plan directed the Program Evaluation Division to examine the effectiveness and efficiency of the Program Integrity Section of the North Carolina Medicaid program.

I am pleased to report that the Department of Health and Human Services cooperated with us fully and was at all times courteous to our evaluators during the evaluation.

Sincerely,

John W. Turcotte
Director

AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER



# Program Evaluation Division
## North Carolina General Assembly

November 2016 Report No. 2016-10

# Medicaid Program Integrity Section is Not Cost-Effectively Identifying and Preventing Fraud, Waste, and Abuse

## Summary


The Joint Legislative Program Evaluation Oversight Committee's 2015–17 Work Plan directed the Program Evaluation Division to examine the effectiveness and efficiency of the state Department of Health and Human Services' Medicaid Program Integrity (PI) Section. The PI Section contributes to the strategic objective of the North Carolina Medicaid program by detecting and preventing fraud, waste, and program abuse, and by ensuring that taxpayer dollars are used appropriately.

**Due in part to a lack of access to valid and reliable claim payment data, the number of fraud referrals made by the Program Integrity Section to the state Department of Justice's Medicaid Investigations Division (MID) declined by 84% from Fiscal Year 2012–13 to Fiscal Year 2014–15.** In addition, MID was limited in its ability to pursue prosecutions of the fraud referrals submitted by the PI Section in Fiscal Year 2014–15.

**The lack of a formal risk assessment process and performance management information has limited the cost-effectiveness of the PI Section.** In Fiscal Year 2014–15, payments to contractors performing pre-claim and post-claim payment reviews exceeded associated savings to state funding requirements by $3.2 million. The PI Section is also not effectively monitoring Medicaid recipient eligibility determinations performed by county departments of social services. Further, the PI Section is not effectively utilizing available information gleaned from reviews of eligibility determinations and medical service claims.

**To address these findings, the General Assembly should amend state law to:**

- adopt a uniform methodology to identify and measure the severity of Medicaid eligibility and medical service claim errors,
- provide incentives for county departments of social services to ensure the accuracy of Medicaid eligibility determinations,
- require the North Carolina Medicaid program, in partnership with the Office of Administrative Hearings and MID, to identify alternatives to increase the amount recouped from identified overpayments and the percentage of fraud referrals accepted by MID for further investigation and prosecution,
- develop and incorporate a Progressive Corrective Action process for providers selected for enhanced oversight, and
- produce an annual performance report and work plan that documents results and provides a roadmap to reduce fraud, waste, and abuse.

## Purpose and Scope

The Joint Legislative Program Evaluation Oversight Committee's 2015–17 Work Plan directed the Program Evaluation Division to examine the effectiveness and efficiency of the Program Integrity Section of the North Carolina Medicaid program.

In response to a specific request by the Medicaid program, the evaluation was limited to activities performed in Fiscal Year 2014-15. The Medicaid program requested that prior year performance information not be included in the evaluation due to concerns regarding the validity and reliability of the information.

Four central research questions guided the study:

- What are the Program Integrity activities that contribute to the achievement of its mission?
- What are the appropriate performance measures to determine the cost-effectiveness of each Program Integrity Section activity?
- What is the contribution of each Program Integrity Section activity towards achievement of its mission?
- How can the effectiveness of the Program Integrity Section be improved?

The Program Evaluation Division collected data from several sources, including

- reviews of laws and policies guiding the North Carolina Medicaid program,
- interviews and queries of Program Integrity Section managers,
- information regarding sources and uses of funding for the Program Integrity Section,
- performance measures (if available) for Program Integrity Section activities, and
- comparable performance measures (if available) of other state Medicaid Program Integrity activities.

## Background

Medicaid is predominately a means-tested entitlement program that provides health care coverage to low-income families, qualified pregnant women and children, and aged, blind, and disabled individuals. States have considerable flexibility in structuring their Medicaid programs within broad federal guidelines governing eligibility, provider payment levels, and benefits.

Medicaid covers a broad range of services to meet the health needs of eligible recipients. Federally mandated services include hospital inpatient and outpatient services, comprehensive health screening, diagnostic and treatment services to children, home health care, laboratory and X-ray services, physician services, and nursing home care. Commonly offered optional products and services include prescription drugs, dental care, eyeglasses, prosthetic devices, hearing aids, home and community-based services, and services in intermediate care facilities for individuals with a mental illness.

The Medicaid program represents a partnership between federal and state governments. At the federal level, the Centers for Medicare & Medicaid Services (CMS) within the Department of Health and Human Services is responsible for overseeing the program. As required by federal law, the North Carolina Department of Health and Human Services has been designated as the state agency that is responsible to the federal government for the Medicaid program in North Carolina.[1]

The strategic objective of North Carolina's Medicaid program is to cost-effectively use available resources and leverage partnerships with other program stakeholders to improve health care for all North Carolinians. The Division of Medical Assistance within DHHS has been delegated most of the responsibility for ensuring the Medicaid program cost-effectively achieves this strategic objective.

In Fiscal Year 2014–15, total expenditures for the Medicaid program were $13.8 billion. Approximately $13.2 billion (96%) of these expenditures were associated with recipient medical services, with the remaining $607 million used for program administration.[2] The Federal government reimburses North Carolina's Medicaid program for approximately two-thirds of eligible medical services and for half of most administrative services.[3] In Fiscal Year 2015-16, North Carolina's Medicaid program consisted of 66,255 enrolled providers delivering medical services to 2,295,654 citizens of North Carolina.

**North Carolina's Medicaid program has established processes to identify and prevent fraud, waste, and abuse.[4]** To help ensure federal and state funding is being cost-effectively used to achieve its strategic objective, North Carolina's Medicaid program reviews all medical service claims and conducts eligibility determinations for all Medicaid providers and recipients.

As shown in Exhibit 1, North Carolina's Medicaid program helps prevent fraud, waste, and abuse by:

- reviewing all submitted claims through an automated process that uses the state Medicaid Management Information System (NC TRACKS),

[1] Title XIX of the Social Security Act.

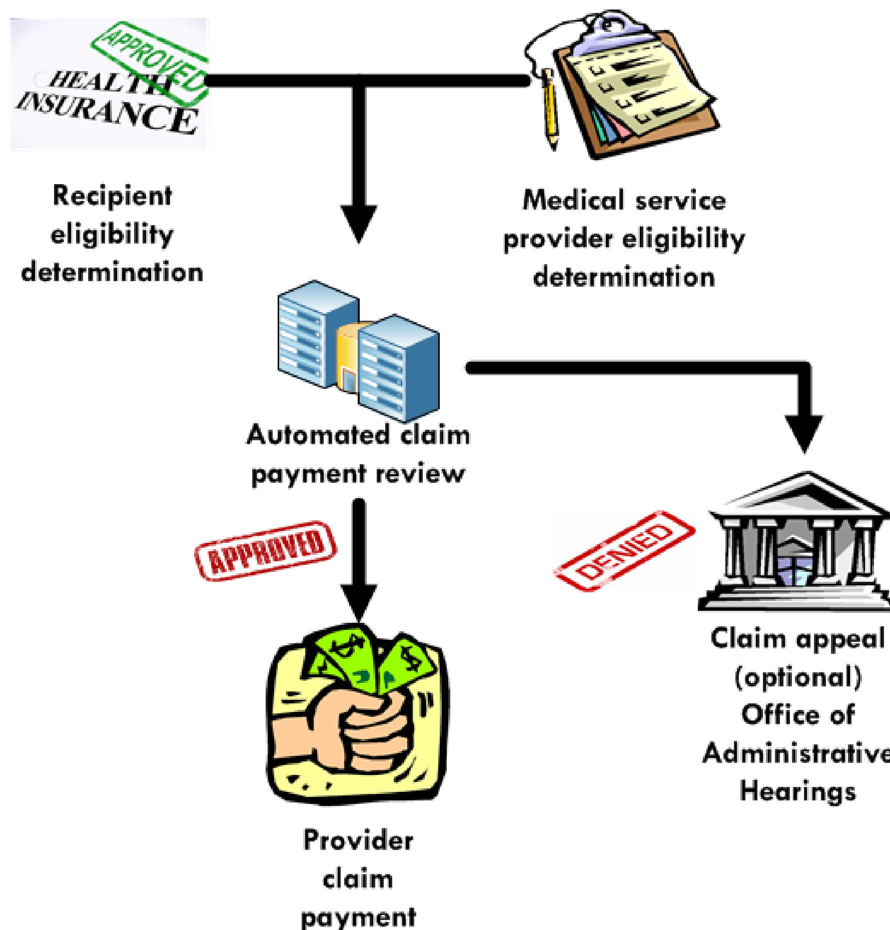
[2] In North Carolina, eligibility for Medicaid and other public assistance programs is determined through a state-supervised and county-administered system. Such programs are administered by county departments of social services under the supervision of state social services agencies. In Fiscal Year 2014–15, counties spent $65.2 million to support Medicaid enrollment activities. See the 2016 Program Evaluation Division report, "Timeliness of Medicaid Eligibility Determinations Declined Due to Challenges Imposed by NC FAST and Affordable Care Act Implementation."

[3] The amount of federal payments to a state for medical services is based on the amount of eligible expenditures and the Federal Medical Assistance Percentage (FMAP). The FMAP is calculated through a formula that takes into account the average per capita income for each state relative to the national average. The federal reimbursement rate for some specified administrative activities is higher than 50%. For example, the federal reimbursement rate for costs associated with the operation of an approved Medicaid Management Information System for claims and information processing is 75%.

[4] Medicaid fraud is defined as an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to that person or some other person and includes any act that constitutes fraud under applicable federal or state law. Waste is not currently defined in federal Medicaid regulations, yet it is generally understood to encompass the over-use or inappropriate use of services and misuse of resources, and typically is not a criminal or intentional act. Abuse includes provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care and health care coding. It also includes non-fraudulent recipient practices that result in unnecessary cost to the Medicaid program.

- identifying and rejecting inaccurate or incomplete claim information submitted by Medicaid providers for reimbursement of rendered services,
- performing Medicaid participant eligibility reviews to ensure claims are paid for eligible medical services by qualified medical service providers,
- performing Medicaid provider eligibility determinations to help ensure potentially fraudulent heath care providers and recipients are prevented from entering the Medicaid program or submitting claims, and
- performing Medicaid recipient eligibility determinations to help prevent the inappropriate use of state and federal funds associated with claim payments for services provided to ineligible recipients.[5]

## Exhibit 1: North Carolina's Medicaid Program Has Established Processes to Identify and Prevent Fraud, Waste, and Abuse




*Source: Program Integrity Section based on reviews of state and federal law and consultations with PI Section managers.*

Installed system edits are used to identify incorrect or incomplete claims before a payment is made to the provider. Identified errors may be associated with incorrect service pricing, non-covered service, or when a

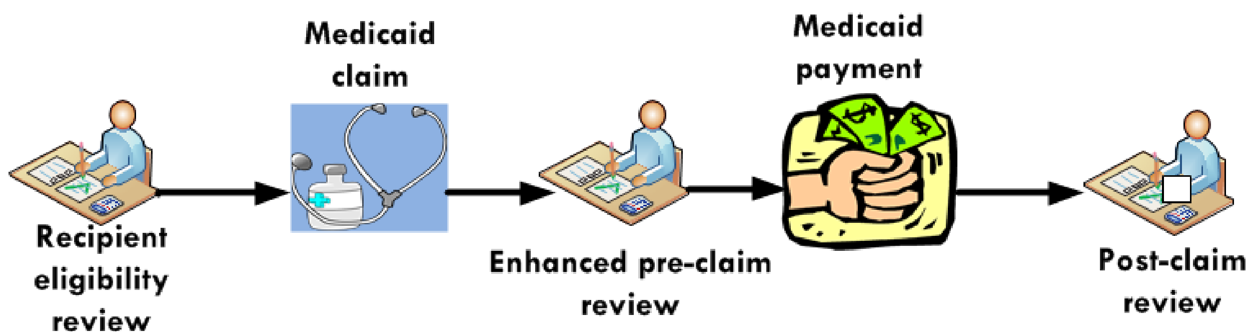
[5] Medicaid participant eligibility determinations include verifying and validating individuals' eligibility at the time of application and periodically thereafter, and promptly disenrolling individuals who are not eligible.

service was not provided. In addition, North Carolina's Medicaid program helps ensure the accuracy and appropriateness of medical service claims through issuance of policies and procedures to guide compliance with claim processing requirements and by providing education and training that can help to effectively reduce inadvertent claim processing errors.

**The Program Integrity Section also helps to identify and prevent Medicaid fraud, waste, and abuse.** North Carolina's Medicaid program also includes a Program Integrity (PI) Section. The PI Section performs activities intended to contribute to achievement of the objectives of the State's Medicaid program by ensuring compliance, efficiency, and accountability within the Medicaid program through the detection and prevention of fraud, waste, and program abuse and by ensuring that taxpayer dollars are spent appropriately by implementing tort recoveries, pursuing recoupment, and identifying opportunities for cost avoidance.

As shown in Exhibit 2, the PI Section contributes to the reduction in fraud, waste, and abuse through reviews of Medicaid recipient eligibility determinations and claim payment processing error detection activities. Reviews of recipient eligibility determinations involve identifying current Medicaid participants who received an inaccurate eligibility determination. These reviews help ensure that all eligible applicants are allowed access to appropriate Medicaid program services.

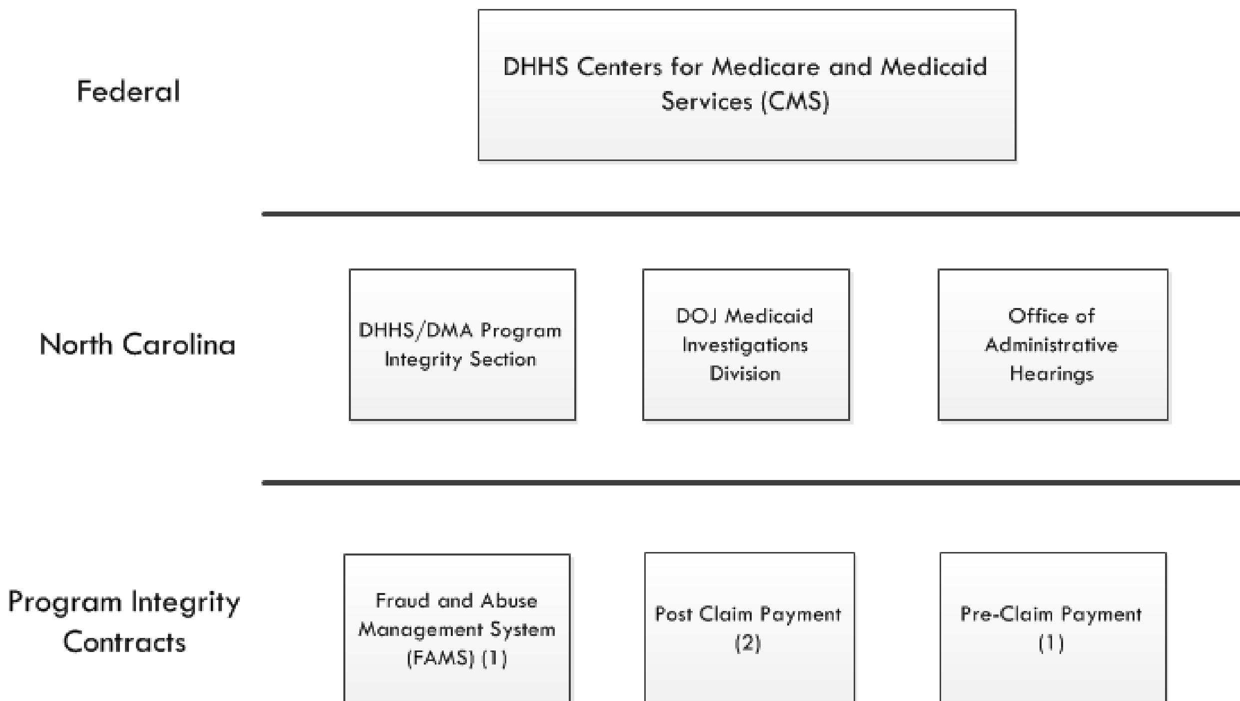
## Exhibit 2: Program Integrity Section Contributes to Reductions in Medicaid Fraud, Waste, and Abuse by Reviewing Eligibility Determinations and Service Claims




*Source: Program Evaluation Division based on review of GAO studies, state and federal law, and consultations with PI Section managers.*

Reviews of Medicaid claim processing activities help ensure the accuracy and appropriateness of payments for medical services. They may be performed through enhanced reviews of Medicaid claims prior to payment or through reviews performed after claims are paid to providers. Enhanced pre-claim payment reviews are designed to ensure claims are filed properly by ensuring the claim data submitted by providers is accurate. Post-claim payment reviews are designed to identify payment errors and recoup claim overpayments. These reviews also help reduce Medicaid funding requirements by withholding claim payments until identified errors are corrected. Exhibit 3 presents a broad outline of the major agencies and contracts contributing to the performance of Medicaid Program Integrity.

## Exhibit 3: The North Carolina Medicaid Program is a Partnership with Federal, State, and Private Entities




*Source: Program Evaluation Division.*

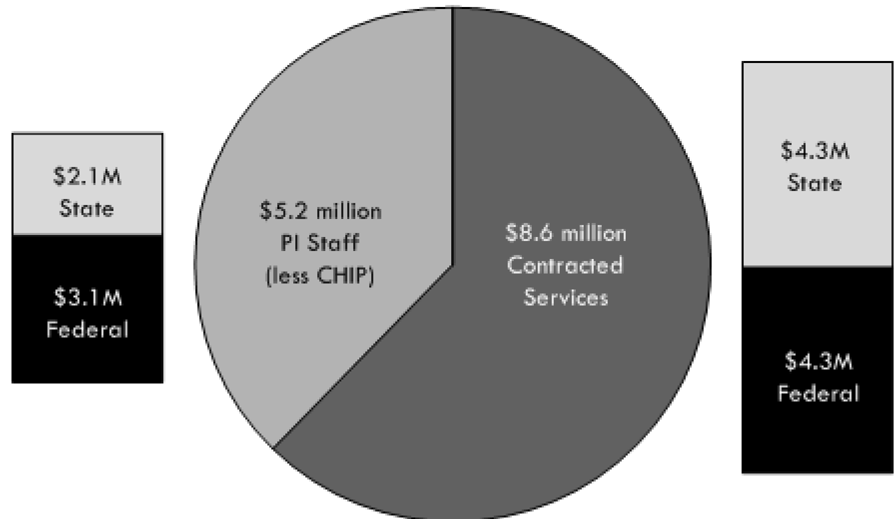
To ensure achievement of the Medicaid program's strategic objective to cost-effectively contribute to improved health care for all North Carolinians, PI Section activities designed to improve overall efficiency through reductions in payment errors should also include consideration of the impact on quality and availability of services. For example, while increased oversight can serve to reduce payment errors, it also increases administrative expenses for providers and discourages honest and qualified providers from accepting Medicaid-insured patients.

As shown in Exhibit 4, the PI Section expended approximately $13.8 million in Fiscal Year 2014–15. The PI Section contracted with four private providers to help perform several of its key activities including enhanced pre-claim reviews, post-claim reviews, and data analytics. As the exhibit shows, private contractors were paid $8.6 million to support the PI Section in providing these services, with the remaining $5.2 million used to fund and support authorized PI staff.[6]

[6] PI staff expenditures do not include expenditures associated with the Medicaid Children's Health Insurance Program, which in Fiscal Year 2014–15 were estimated by PED to total approximately $426,000.

## Exhibit 4

The Program Integrity Section Expended $13.8 Million in State and Federal Funds During Fiscal Year 2014–15




*Source: Program Evaluation Division based on analysis of North Carolina Accounting System, contract expenditure data, and FY 2014–15 DHHS Federal Cost Allocation Plan.*

**Recent reviews of North Carolina's Medicaid program provided estimated payment error rates along with projections of associated value.** As required by federal law, the U.S. Centers for Medicare and Medicaid Services (CMS) is also responsible for producing an estimate of the amount of improper payments and establishing corrective action plans to meet planned improper payment reduction targets.[7] As a result, CMS conducts periodic reviews of each state Medicaid program through its Payment Error Rate Measurement (PERM) program.[8]

A payment error is a payment that should not have been made or was made in an incorrect amount. Identified payment errors can be classified as either medical review errors or data processing errors. A medical review error is an error resulting in an overpayment or underpayment that is determined from a comparison of the provider's medical record and other applicable documentation with the information presented on the claim. A data processing error is an error resulting in an overpayment or underpayment that is determined from a review of the claim and other information available in the State's Medicaid Management Information System (NC TRACKS).

The most recently available federal review of North Carolina's Medicaid program, conducted in 2013, reported an estimated payment error rate of 6.7% and projected the associated value of these errors to be $664.5 million. These results reflect an improvement on North Carolina's 2010 federal review, which reported an estimated payment error rate of 11.9% with projected value of $798.6 million.

As part of the annual Statewide Federal Compliance Audit, the North Carolina Office of the State Auditor also reviews North Carolina's Medicaid program. The state audit for Fiscal Year 2014–15 reported an

[7] As specified in Pub. L. No. 111-204 (July 22, 2010).

[8] The PERM program conducts reviews of state Medicaid programs on a rotating cycle with one-third of states being reviewed each year.

estimate of Medicaid claim payment error rate with a projected value of $835 million.

In summary, North Carolina's Medicaid program requires a major outlay of state and federal funds to provide medical services to North Carolina residents. Because of the size of North Carolina's Medicaid program and the reported levels of claim payment errors, it is important that the State continues to find ways to prevent and reduce fraud, waste, and abuse. The Program Integrity Section has a key role in ensuring that North Carolina's Medicaid program cost-effectively achieves its strategic objective by helping to prevent fraud and ensuring the accuracy and appropriateness of payments for medical services.

## Findings

**Finding 1. Due in part to a lack of access to valid and reliable claim payment data, the number of referrals of potential fraudulent activity by the Program Integrity Section to the state Department of Justice's Medicaid Investigations Division declined by 84% from Fiscal Year 2012–13 to Fiscal Year 2014–15.**

The state Department of Justice's Medicaid Investigations Division (MID) contributes to the effectiveness of the North Carolina Medicaid program by investigating and prosecuting credible allegations of fraud.[9] To resolve cases, MID may coordinate its efforts with other law enforcement entities, such as the Internal Revenue Service, the North Carolina State Bureau of Investigation, the U.S. Attorney, the U.S. Department of Health and Human Services' Office of Inspector General, and Medicaid Fraud Control Units in other states.

The North Carolina Medicaid program has an integral role in the successful prosecution of nearly all of the Medicaid fraud referrals received by MID by ensuring the availability of pertinent claim payment information. To support investigations and prosecutions of cases, analysts and investigators access information about key actions taken to process claims as they are filed and the specific details about claims already paid, including check numbers on payments of claims and other specific information that could help establish provider intent. Ready access to valid and reliable information regarding Medicaid expenditures helps ensure MID can effectively prosecute fraudulent activity and recoup state funds associated with associated claim payments.

**The Program Integrity (PI) Section is responsible for referring potentially fraudulent activity to MID for further investigation.** As federally mandated, North Carolina's Medicaid program is required to conduct a preliminary investigation when it receives a complaint of Medicaid fraud or abuse from any source or identifies questionable practices. In addition, if the findings of a preliminary investigation identify a reason to believe

[9] As specified in C.F.R. § 455.2, fraud refers to an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

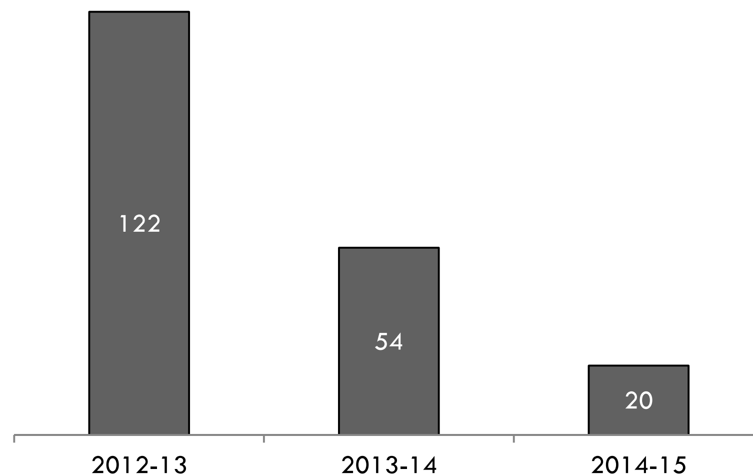
fraudulent activity has occurred, the case must be referred to MID for a full investigation.[10]

**The number of referrals of potential fraudulent activity by the PI Section to MID has declined by 84% in recent years, from 122 in Fiscal Year 2012–13 to 20 in Fiscal Year 2014–15.** The PI Section is a primary source of fraud referrals submitted to MID. Other common referral sources include private citizens, Managed Care Organizations, DHHS' Division of Health Service Regulation, the United States Attorney's Offices, and other law enforcement agencies such as the Internal Revenue Service and the Drug Enforcement Agency.[11]

As shown in Exhibit 5, in a period of three years the number of Medicaid fraud referrals from the PI Section declined by 84%, from 122 referrals in Fiscal Year 2012–13 to 20 fraud referrals in Fiscal Year 2014–15. These totals, as reported by MID, do not include referrals generated by Medicaid Managed Care Organizations and submitted to MID via the PI Section.

## Exhibit 5

Medicaid Fraud Referrals from the Program Integrity Section Declined by 84% from Fiscal Year 2012–13 to 2014–15




*Source: Program Integrity Section based on the 2014–15 annual report to the General Assembly by the Medicaid Investigations Division.*

The PI Section reported that unreliable Medicaid claim payment information limited its ability to establish credible allegations of fraud. The reduction in the number of fraud referrals has coincided with the North Carolina Medicaid program's transition to its current medical claim processing system (NC TRACKS) in July 2013.

MID expressed concern in its annual report for Fiscal Year 2014–15 that access to reliable and accurate Medicaid data from NC TRACKS has

[10] As specified in C.F.R. §455.15.

[11] The Medicaid Investigations Division may also be involved in global cases, which are civil false claims cases that are brought by the U.S. Department of Justice and involve a group of state Medicaid investigative entities. The National Association of Medicaid Fraud Control Units facilitates the settlement of global cases on behalf of the states. North Carolina's MID also investigates patient abuse cases. North Carolina's Division of Health Service Regulation is the primary agency designated to receive patient physical abuse complaints from or involving long-term care providers in North Carolina.

contributed to this reduction in referrals.[12] MID also reported that it lost access to current data that was sufficiently reliable to be admissible in court.

In response, MID reported that it implemented a work-around plan to obtain reliable data on a case-by-case basis. In addition, Medicaid program and MID staff conducted regular meetings during 2014 culminating in the submission of a corrective action plan to CMS in February 2015. The scope of the corrective action plan addressed system and operational deficiencies cited by CMS, including MID's ability to access valid claims data. The state Department of Health and Human Services reported that the corrective action plan was verified as satisfactorily completed and approved by CMS on December 14, 2015.

In addition to reiterating the adverse impact of unreliable Medicaid data on its ability to develop credible allegations of fraud supporting case investigations and court hearings, the PI Section also reported that the 2013 transition of mental health providers to a managed care delivery system, to include responsibility for investigations of potential fraud, also contributed to a reduction in the number of fraud referrals by the Section.

**MID is responsible for prosecuting Medicaid fraud referrals.** The process of obtaining a criminal conviction and/or civil settlement associated with Medicaid fraud is complex and labor-intensive. Medicaid fraud investigations and prosecutions often require specialized skills because investigations must establish that a Medicaid provider intended to falsify a claim to achieve some gain. As a result, fraud is more difficult to prove than an inadvertent claim payment error.

To help ensure that available resources are cost-effectively used to investigate and prosecute allegations of Medicaid fraud, MID reviews each referral to determine whether the fraud allegation is credible and can be effectively prosecuted.[13] For Medicaid fraud referrals that do not include sufficient information to establish a credible allegation or cost-effectively obtain a criminal conviction or civil settlement, MID may close the case or request that the referring entity provide additional information.[14]

In Fiscal Year 2014–15, the PI Section reported that about half of Medicaid fraud allegations it referred were accepted by MID. Specifically, the PI Section reported that 32 cases of suspected Medicaid fraud were referred to MID for further investigation. MID accepted only 17 (53%) of these 32 referrals. While the PI Section was unable to provide a reconciliation, differences in the reported number of fraud referrals in FY 2014–15 by the PI Section (32) and by MID (20) were attributed in part to MID not including referrals originating with Managed Care Organizations and submitted through the Program Integrity Section,

[12] As required in N.C. Gen. Stat. § 114-2.5A, this annual report is required to be submitted by September 1 to the Chairs of the Appropriations Subcommittees on Justice and Public Safety and Health and Human Services of the Senate and House of Representatives and to the Fiscal Research Division of the Legislative Services Office.

[13] As specified in C.F.R. 455.2, allegations are considered to be credible when a careful review of all allegations, facts, and evidence determines that a criminal act probably occurred.

[14] As reported by MID in its 2014–15 annual report to the General Assembly, some of the allegations did not pertain to Medicaid provider fraud but rather pertained to Medicaid recipient fraud. MID's federal grant does not allow it to use funding to investigate Medicaid recipient fraud. Therefore, MID refers recipient fraud allegations to the Division of Medical Assistance and the relevant county department of social services.

and to MID combining some of the Program Integrity fraud referrals with previously submitted fraud referrals.

MID and the PI Section both reported challenges with Medicaid fraud referrals. MID reported that fraud referrals sometimes lack sufficient information to enable the division to cost-effectively investigate and obtain a criminal conviction or civil settlement. Conversely, the PI Section reported that MID did not always have sufficient staffing and resources to effectively investigate and prosecute referrals determined to be credible allegations of fraud.

In response to concerns regarding the number of valid fraud referrals made by Medicaid programs to the associated Medicaid Investigations Division, both CMS and the Federal Department of Health and Human Services' Office of Inspector General have issued recommendations to improve overall performance. These recommendations include development of a close working relationship between the Medicaid program and MID to include:

- involving MID in selecting fraud cases,
- providing MID with education and consultative services on Medicaid program operations and regulations,
- developing guidelines for referring possible fraud cases, and
- establishing performance measures and standards.

While ensuring MID maintains effective oversight of the Medicaid program, increased coordination with the PI Section can improve the effectiveness of North Carolina's Medicaid program by ensuring the roles and responsibilities of each entity are clearly defined and designed to cost-effectively identify and prosecute Medicaid fraud. In addition, establishing specific criteria for credible allegations of fraud can help to reduce the number of referrals MID does not accept for further investigation and prosecution.

In summary, the number of fraud referrals submitted by the Program Integrity Section declined by 84% during the three-year period from Fiscal Year 2012–13 to Fiscal Year 2014–15. Increased coordination between North Carolina's Medicaid program and the Medicaid Investigations Division can help to increase the number of fraud referrals that are generated and accepted for further investigation and prosecution.

**Finding 2. Due to an inadequate risk assessment process, contract expenditures used to perform reviews of medical service claims exceeded associated savings to state funding requirements by $3.2 million in Fiscal Year 2014–15.**

The strategic objective of the Program Integrity Section is to cost-effectively use available resources to ensure Medicaid expenditures are accurate and made in accordance with applicable laws and regulations. To achieve this objective, the PI Section seeks to identify and prevent fraud, waste, and abuse by conducting reviews of claims for medical services.

**To help achieve its strategic objective, the PI Section performs enhanced pre-claim payment and post-claim payment reviews of selected providers.** The PI Section conducts enhanced pre-claim payment reviews to ensure claims are filed properly and accurately. These reviews are performed as a condition of a claim payment and include a requirement for providers to submit documentation supporting the appropriateness and accuracy of a medical service claim. Payments to providers are withheld for claims with identified errors until the errors are corrected.[15] In Fiscal Year 2014–15, enhanced pre-claim reviews were performed via a contract with a private entity.

The PI Section additionally conducts post-claim payment reviews, which also include a review of claim payment documentation but are performed after claim payment. Post-claim reviews may also include a review of medical records and an on-site review to determine whether the service identified in the claim was medically necessary. Post-claim reviews are more complex and generally require specific expertise in the associated medical service. In Fiscal Year 2014–15, the State's contract to perform post-claim payment reviews also included requirements to assist with the recoupment of identified claim overpayments from providers.

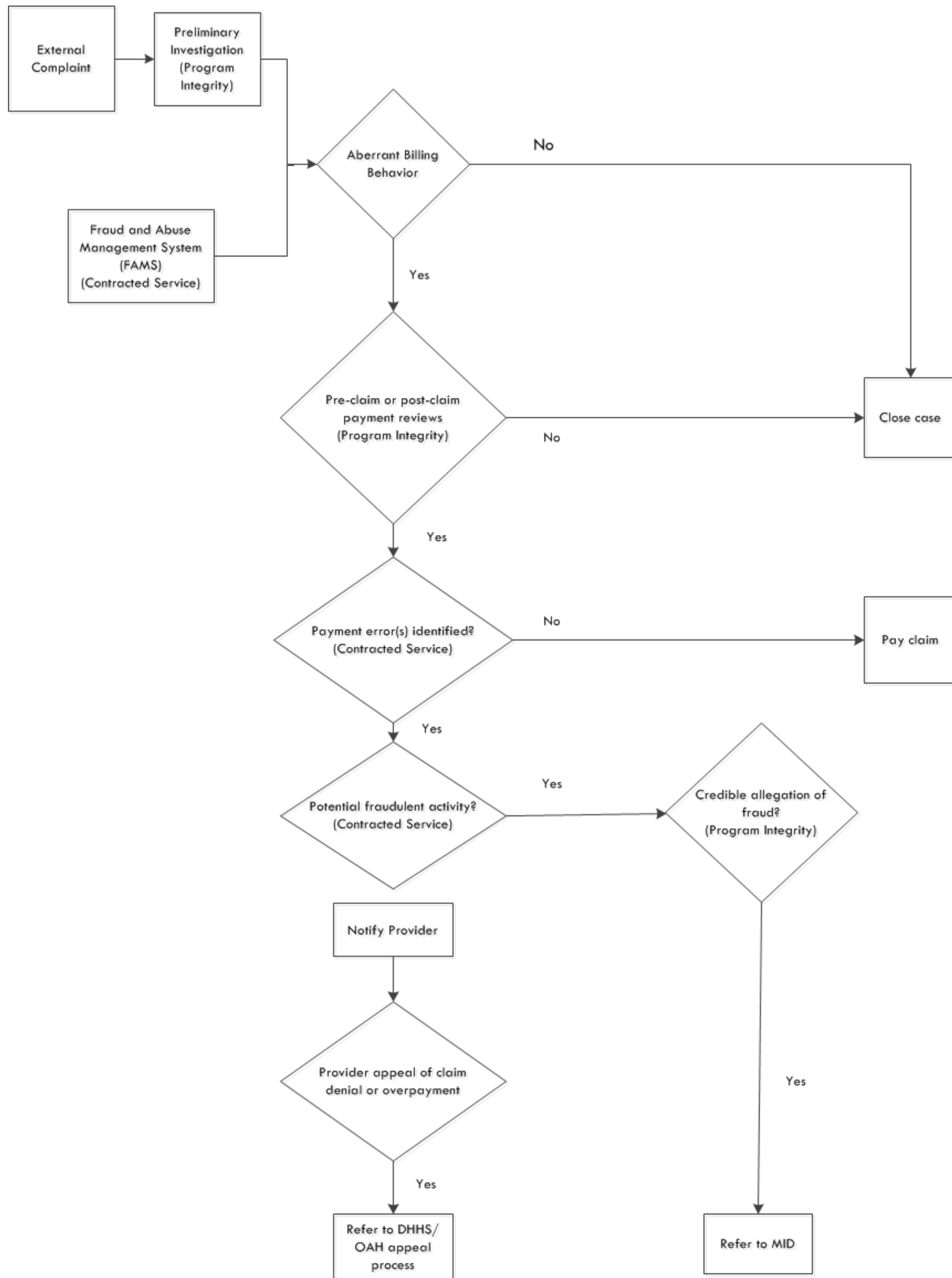
**Providers selected for enhanced pre-claim payment and post-claim payment reviews are identified from complaints received from external sources and through analysis of Medicaid claim payment data.** The North Carolina Medicaid program is federally required to maintain a customer service phone number and fraud hotline to provide external stakeholders with the opportunity to report potential instances of fraud, waste, and abuse.[16] In Fiscal Year 2014–15, the PI Section completed 2,680 preliminary investigations of potential fraud, waste, and abuse as identified by external sources.

The PI Section contracts with a private service provider to operate the North Carolina Medicaid program's Fraud and Abuse Management System (FAMS). The contracted service provider is responsible for analyzing Medicaid claim and provider data in FAMS to identify aberrant and/or noncompliant billing behavior. The PI Section is then responsible for determining whether identified providers should be subjected to enhanced pre-claim and post-claim payment reviews.

Providers selected for review by the PI Section are referred to another contracted service provider. Claims identified as potentially ineligible or inaccurate are referred back to the Section for final determination. The PI Section is then responsible for referring these cases to MID when a credible allegation of fraud can be established. Upon notification of a denied claim or inaccurate claim payment, providers are statutorily authorized to appeal the determination at the North Carolina Office of Administrative Hearings. Exhibit 6 encapsulates the process by which providers are selected for additional oversight.

[15] Enhanced pre-claim payment reviews of pre-payment activity may also include reviews of claims data from prior incidents of known fraudulent behavior in the effort to identify providers for further investigation.
[16] As specified in C.F.R. § 455.14.

## Exhibit 6: Providers are Selected for Enhanced Oversight Through External Complaints and Analysis of Claim Payment Data



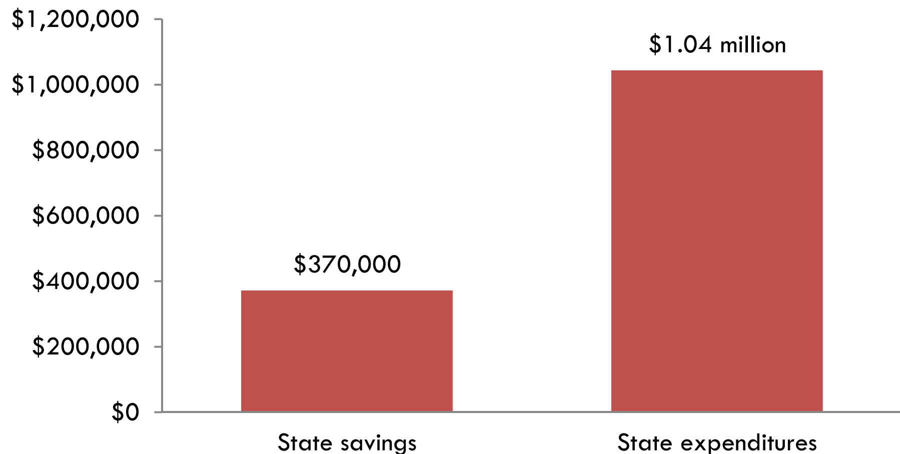

*Source: Program Evaluation Division based on reviews of state and federal law and consultations with Program Integrity Section managers.*

**Enhanced pre-claim reviews are not cost-effectively identifying claim payment errors.** Reductions in Medicaid funding requirements are shared between the federal Centers for Medicare and Medicaid Services (CMS) and the State's Medicaid program. The costs to perform review activities are also shared between the federal CMS and the State.

As shown in Exhibit 7, in Fiscal Year 2014–15 the State's share of contracted costs to perform enhanced pre-claim reviews exceeded the realized savings to state funding requirements by approximately $670,000. The PI Section paid the assigned contractor $1.04 million in state funds to perform enhanced pre-claim reviews of selected providers. In comparison, these reviews yielded only $370,000 in reductions to Medicaid state funding requirements.

## Exhibit 7

The State Paid a Contractor Over $1 Million to Perform Pre-Claim Payment Reviews in Fiscal Year 2014–15 But Realized Less Than $400,000 in State Savings




*Source: Program Evaluation Division based on information provided by the North Carolina Medicaid program.*

The reduction in state funding requirements attributed to enhanced pre-claim reviews includes the value of claim denials issued in Fiscal Year 2014–15. The PI Section has asserted that reductions in the value of claim submissions as a result of enhanced pre-claim reviews should also be considered as associated savings to the State. However, the Program Evaluation Division did not include the associated decrease in the value of provider claim submissions because the PI Section was unable to assert that these reductions were attributable to unwarranted medical services rather than associated with eligible recipients transferring to another service provider. Consequently, it is unclear how much of this reduction in claim volume was attributable to fraud, waste, and abuse, and how much was associated with recipient transfers or with a recipient's inability to access another provider in those instances in which their current provider ceased participation in the Medicaid program as a result of being subjected to the enhanced pre-claim review process.

**State savings realized through post-claim payment reviews represented only 6% of the total amount of overpayments identified.** In Fiscal Year 2014–15, the PI Section used two contractors to perform post-claim payment reviews.[17] Together, the two contractors were paid $5.4 million for these services, of which $2.7 million was derived from state funds. As

[17] The two contractors were Public Consulting Group, Inc. (PCG) and Health Management Systems, Inc. (HMS).

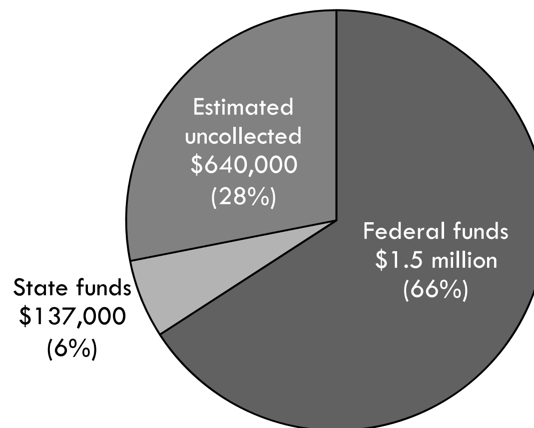
shown in Exhibit 8, post-claim payment reviews performed by the two contractors identified $2.3 million in claim overpayments in Fiscal Year 2014–15. However, only $137,000 in state funds (representing 6% of the identified amount) was recouped from claim overpayments identified during these reviews. Consequently, the PI Section paid these contractors approximately $2.6 million more in state funds than was recouped through associated post-claim payment reviews. Combining this amount with the $670,000 by which contracted costs for enhanced pre-claim reviews exceeded savings means that, in total, contract expenditures used to perform reviews of medical service claims exceeded associated savings to state funding requirements by approximately $3.2 million in Fiscal Year 2014–15.

Federal law limits the ability of the Program Integrity Section to recoup state funds from providers with identified claim overpayments. As federally mandated, state Medicaid programs are generally required to remit the entire federal share of claim overpayments as initially reported to the provider regardless of whether the identified overpayment was actually recouped.[18] As a result, the state share of recoupments from identified claim overpayments is reduced by the difference between the overpayment amount initially reported to providers and the associated recoupments.

As also shown in Exhibit 8, the Program Evaluation Division determined that approximately $640,000 (28%) in claim overpayments identified during post-claim reviews conducted in Fiscal Year 2014–15 was not recouped from providers.[19] Identified claim overpayments may not be recouped because of reductions in the identified amount resulting from appeals by providers and because of the inability or failure of providers to remit the entire amount owed.[20]

## Exhibit 8

State Savings Realized Through Post-Claim Payment Reviews Represented Only 6% of Total Amount of Overpayments Identified in Fiscal Year 2014–15




Total = $2.3 million

*Source: Program Evaluation Division based on review of NCAS and contract data.*

[18] As specified in C.F.R §§ 433.316 and 433.318.
[19] Based on collections received through April 2016.
[20] The Program Integrity Section was unable to provide sufficient information to distinguish the amount of unrecouped overpayments that were associated with provider appeals from those that could not be collected from providers.

**The Program Integrity Section has not performed a risk assessment to identify the categories of Medicaid services that will realize the most cost-effective allocation of resources to reduce Medicaid fraud, waste, and abuse.** All organizations face a variety of risks from external and internal sources. Risk is defined as the possibility that an event will occur and adversely affect the achievement of objectives. The purpose of a risk assessment is to identify the most cost-effective use of available resources to mitigate identified risks and achieve intended objectives.

A risk assessment for the PI Section should include consideration of various risk factors and a determination of their contribution toward reductions in Medicaid fraud, waste, and abuse.[21] In addition, the risk assessment should identify specific Medicaid participant and medical service categories and allocate the impact of each risk factor among the identified classifications.

Based on reviews of literature regarding business risk assessment and available quantifiable information received from the Program Integrity Section, the Program Evaluation Division determined that the risk factors associated with cost-effectively reducing Medicaid fraud, waste, and abuse should include:

- **Annual number and average value of Medicaid eligibility determination/claim payments.** This factor identifies the number of outputs and their associated impact on state funding requirements. A high number of eligibility determinations/claim payments increases the risk of payment error. A high average value increases the financial impact of associated payment errors.
- **Estimated percentage of valid Medicaid eligibility determination/claim payment errors.** This factor identifies the probability of a payment error occurring. Information from prior reviews of recipient eligibility determinations and medical service claims can be used to identify types of eligibility and Medicaid service categories that are most likely to have a high number of claim payment errors.
- **Cost to identify payment errors and realize savings to state funding requirements.** This factor identifies the expected contribution to reductions in state funding requirements associated with associated resource requirements. A high cost to identify payment errors and realize reductions in state funding requirements provides an indication of the expected contribution of the associated oversight activity.
- **Number of fraud referrals accepted by MID.** This factor identifies the contribution of the Program Integrity Section in reducing Medicaid fraud. A high number of accepted fraud referrals by North Carolina's Medicaid Investigations Division provide an indication of increased levels of criminal activity.

In summary, the Program Integrity Section is not cost-effectively utilizing state funds to identify claim payment errors or recoup associated overpayments from providers. As a result, in Fiscal Year 2014–15, the

[21] Risk factors are observable and/or measurable characteristics of risks that can combine the analysis of risks, consequences, and controls all at once into conceptual attributes to allow risk to be more easily measured.

contracted costs to perform enhanced pre-claim and post-claim reviews exceeded identified savings to state Medicaid funding requirements by approximately $3.2 million. Development and use of a risk assessment can help ensure the cost-effective use of available resources in reducing Medicaid fraud, waste, and abuse.

**Finding 3. Lack of policies and procedures has limited the effectiveness of the Program Integrity Section in deterring fraud and ensuring that access to services is not unnecessarily impacted.**

The strategic objective of the PI Section is to cost-effectively use available resources to ensure Medicaid expenditures are accurate and made in accordance with applicable laws and regulations. Prevention is a more efficient and effective means of minimizing fraud, waste, and abuse than trying to establish criminal intent or recoup funds after a claim has been paid. Thus, deterring Medicaid participants from committing fraud by placing them at risk of detection through increased oversight is an important element in an effective fraud-prevention program.

**Medicaid services with high payment error rates are not being subjected to increased oversight by the Program Integrity Section.** As shown in Exhibit 9, based on the most recently published federal Payment Error Rate Measurement (PERM) review of North Carolina Medicaid program payment errors, associated prescription drug services had the highest impact on state and federal funding and accounted for 40% of the estimated $212 million in claim payment errors under the State Fee-For-Service (FFS) delivery system.

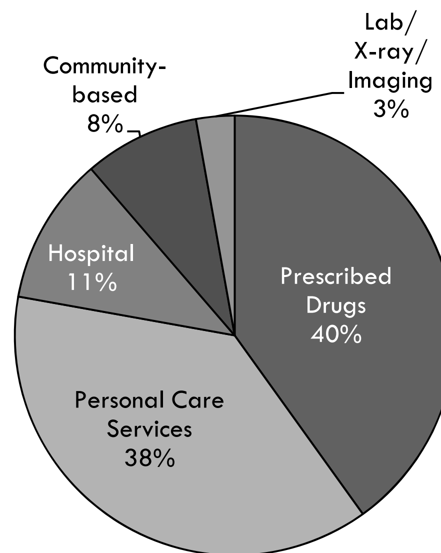
As of May 2016, no providers of prescription drug services were being subjected to enhanced pre-claim payment reviews by the contracted service provider. In addition, a review of the payment errors identified by the two contractors performing post-claim payment reviews found that only 1 of the 235 (0.4%) overpayment notifications issued in Fiscal Year 2014–15 was associated with providers of these services.

The 2013 PERM review also reported that Personal Care Services (PCS) accounted for 38% of the estimated value of claim payment errors.[22] Since this review was conducted, the North Carolina General Assembly enacted legislation to reduce the risk of claim payment errors associated with these services.[23] Specifically, in 2013, the General Assembly enacted legislation to require an independent assessment to include the number of PCS hours needed by the recipient individual. Due to the lack of more recent payment error data, the Program Evaluation was unable to determine whether this legislation was effective in reducing the value of PCS-related claim payment errors.

[22] Home/Personal Care Services (PCS) are Medicaid programs that provide services to individuals that live outside of nursing homes; they instead reside at home or in their community.
[23] As specified in Session Law 2013-306.

## Exhibit 9

The Most Recently Published Federal Government Review Estimated Prescribed Drug Services Accounted for 40% of Claim Errors in North Carolina




*Source: Program Evaluation Division based on results of 2010 and 2013 federal PERM reviews.*

**The Program Integrity Section is also not performing enhanced pre-claim and post-claim payment reviews for some Medicaid services with high claim volume.** The PI Section reported that nearly all of the medical service claims reviewed under the enhanced pre-claim review process are associated with services performed by Home/Personal Services (PCS) providers. Specifically, in May 2016, 19 of the 23 providers being subjected to enhanced pre-claim reviews were PCS providers. However, claims submitted by providers performing PCS services accounted for only 7.3% of total medical service claim payments in Fiscal Year 2014–15.

Conversely, although in Fiscal Year 2014–15 physician services accounted for over 24% of the total value of Medicaid claim payments, there were no associated claim overpayments identified through post-claim payment reviews. Consequently, oversight of medical service claims performed by the Program Integrity Section may not be providing uniform and effective deterrence against Medicaid fraud, waste, and abuse because many medical service providers are not subject to detection through these reviews.

**Contracted Medicaid claim data analytics is not providing a cost-effective deterrence against Medicaid fraud, waste and abuse for many services with high claim volume.** Data analytics can be a useful tool in the identification and prevention of Medicaid fraud, waste, and abuse. Performance of data analytics allows for detection and identification of patterns of fraudulent behavior not otherwise readily apparent. The results of claim data analysis also help ensure the cost-effective use of resources to perform pre-claim and post-claim payment reviews by identifying providers at greatest risk for fraud, waste, or abuse. In addition, information obtained through the analysis of Medicaid claim data can be used to identify areas where Medicaid claim processing can be cost-effectively improved to prevent payment errors.

In November 2011, the North Carolina Medicaid program entered into a contract with International Business Machines (IBM) to perform data analysis

of claim payments to identify fraud, waste, and abuse. The contract includes requirements to use the vendor's Fraud and Abuse Management System (FAMS) and InfoSphere Identity Insight to analyze Medicaid claim data to identify providers with aberrant billing behavior. These identified aberrant billing practices may be the result of fraudulent activity or inadvertent errors.

The contract also requires the vendor to produce an allegation package when medical service providers are identified as having exhibited aberrant billing behavior. Aberrant billing behavior may be identified through analysis of Medicaid claim data, investigations of complaints received from external sources, or as a result of enhanced Medicaid claim reviews. Each allegation package is required to include information regarding provider claim activity and evidence supporting the aberrant billing allegation. The allegation package also includes a recommended investigative approach that is used by the PI Section to determine whether the provider should be subjected to an enhanced pre-claim or post-claim review.

These allegation packages may be based on analysis of a specific medical service or of an individual provider. Allegation packages based on analysis of a specified medical service are designed to identify all of the providers with aberrant billing practices for an associated claim. In Fiscal Year 2014–15, the PI Section reported that six allegation packages were submitted based on analysis of a specific medical service. For example, data analysis was performed for payments made to dental providers for services for pregnant women whose eligibility for dental services ended upon the child's birth. The resulting allegation package identified 102 dental providers with aberrant billing practices for claims submitted for this medical service delivery scenario.

Allegation packages for individual providers submitted in Fiscal Year 2014–15 identified a limited number of providers of services with high claim volume for increased oversight. Specifically, in Fiscal Year 2014–15, the contractor performing Medicaid claim data analysis services submitted 102 allegation packages for individual providers to the PI Section, which included a recommendation to subject an identified provider to enhanced pre-claim or post-claim payment reviews. As shown in Exhibit 10, 95 of these 102 allegation packages for individual providers (93%) were associated with providers of only three Medicaid service types – PCS, Behavioral Health, and Ambulance.[24] Together, these three Medicaid services only represented 8.5% of the total value of Medicaid claim payments in Fiscal Year 2014–15.

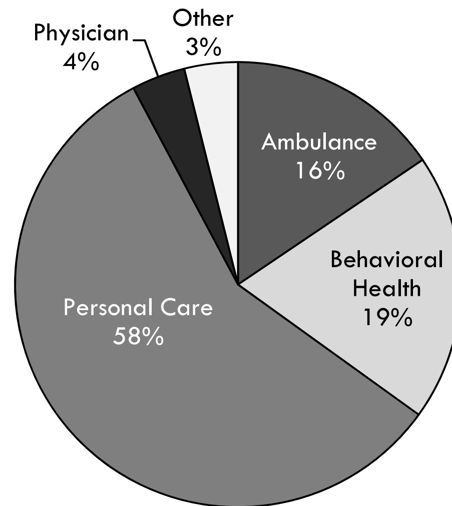
On the other hand, there were no allegation packages for individual providers submitted for providers of many services with high claim volume such as Skilled Nursing Facilities, Prescription Drugs, and Inpatient/Outpatient Hospital, which combined in Fiscal Year 2014–15 to account for more than 52% of the value of Medicaid claims paid. Consequently, the PI Section-contracted data analytic services performed

[24] The other Medicaid service types with a provider-specific allegation package submitted in FY 2014–15 were Adult Care Home (1), Durable Medical Equipment (1), and General Specialty (1).

in Fiscal Year 2014–15 did not provide an effective deterrent against fraud, waste, and abuse.

**Exhibit 10**

Over 90% of the Provider-Specific Allegation Packages Submitted in FY 2014–15 Were Associated with Three Types of Medicaid Services – Personal Care Services, Behavioral Health, and Ambulance




*Source: Program Evaluation Division based on information provided by the North Carolina Medicaid program.*

The PI Section reported that the allegation packages for individual providers submitted in Fiscal Year 2014–15 were concentrated on three low claim volume services based upon a mutual determination by the Section and the contractor to focus available data analytic resources on these services. In addition, the PI Section reported that data analysis was also conducted by one of the post-claim payment review contractors. The contractor used data analytics to identify providers of inpatient and outpatient hospital services for post-claim payment review. In Fiscal Year 2014–15 this contractor identified 295 claim overpayments of inpatient and outpatient hospital services totaling $1 million. As of April 2016, only $580,000 of these identified overpayments had been recouped despite having to remit the full federal share, $664,000, of the identified overpayments.

**The disproportionate use of enhanced pre-claim payment reviews of PCS providers may create unintended consequence of limiting access to Medicaid services.** While enhanced pre-claim and post-claim payment reviews help reduce Medicaid fraud, waste, and abuse by identifying and preventing inaccurate payments, they also can reduce a provider's ability to participate in the Medicaid program. Subjecting providers to an unnecessarily rigorous claim review process decreases net revenue by delaying claim payments and increasing administrative costs. As a result, access to medical services by Medicaid recipients may be adversely affected if these increased costs force providers to terminate participation in North Carolina's Medicaid program.

For example, the financial burden for PCS providers under the enhanced pre-claim payment review process can exceed the revenue that can be realized from the associated claim payment. Generally, as a condition of payment authorization under the enhanced pre-claim payment review process, providers have specified document submission requirements for

each service provided to a Medicaid recipient. For claims submitted by PCS providers under the enhanced pre-claim review process, the provider is currently required to submit recipient-specific, employee-specific, and provider-specific documentation.[25] These documentation requirements can exceed 100 pages for claims of less than $50.[26]

The enhanced pre-claim review process extends the period between claim submission and payment. North Carolina's Medicaid program is statutorily required to process all clean claims submitted for pre-payment review within 20 days. If a review identifies missing documentation or records, the provider is required to submit the missing documentation within five business days upon receipt of the notification. Once received, the state Medicaid program then has an additional 20 days to review the claim.[27] For PCS providers who primarily serve Medicaid recipients and may not have large cash reserves, the additional time needed to perform these reviews and approve payment may prevent them from being able to make payroll and continue to be able to service Medicaid recipients.

Many providers subjected to enhanced pre-claim reviews have ceased participation in the Medicaid program. In May 2016, there were 23 providers on enhanced pre-claim review, 19 of which were PCS providers. Twelve of these 23 providers (52%) had stopped participating in the Medicaid program, as evidenced by having no claim submissions in May 2016.[28] For the remaining 11 providers who did submit Medicaid service claims in May 2016, the claim volume for these providers decreased by 76% from an average of $160,000 in the six months prior to being placed on enhanced pre-claim reviews to $39,000 in May 2016.

While some of the providers subjected to enhanced pre-claim reviews were indeed also referred to MID for criminal investigation, others ceased participation without having been notified of any allegations of fraud or of having been referred to MID for further investigation. Consequently, providers having been given no indications of criminal intent may have ceased participating in North Carolina's Medicaid program because of the adverse impact of the enhanced pre-claim review process. As a result, access to medically necessary Medicaid services by eligible recipients may have been unnecessarily limited.

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[25] Recipient specific document requirements include: 15-page Independent Assessment, Service Notes, 18 months of Quarterly Supervisory Visit Notes, Recipient Plan of Care, Recipient Referral Form, Authorization Documents, Narrative Notes, Client's Rights Notification Form, Recipient Appeal Form, and Any Recipient Appeal Documents. Employee specific documentation requirements include: Job Application, High School Diploma, Transcript, or GED Certification, License or Credential, Employee Training Material in Seven Specific Training Areas, Criminal Background Check Authorization Form, Proof of Criminal Background Check, Proof of Employee Orientation, Health Care Personnel Registry Check, and Skills Checklist. Agency-Specific documentation requirements include: License, Complaint/Concern Log, and Quality Assurance Documentation for Past 12 Months.

[26] As specified in N.C. Gen. Stat. § 108-C-7(e)., providers remain subject to the enhanced prepayment claims review process until the provider achieves three consecutive months with a minimum 70% clean claims rate. If the provider does not meet this standard within six months of being placed on prepayment claims review, the Department may implement sanctions, including termination from Medicaid program participation or an extension of the requirement to participate in the process for up to a maximum of 12 months.

[27] As specified in N.C. Gen. Stat. §108C-7.

[28] In addition to the 19 PCS providers, there were 3 providers of Behavior Health services and 1 provider of Ambulance services being subjected to the enhanced pre-claim review process in May 2016.

**The Program Integrity Section has not developed policies and procedures to ensure the cost-effectiveness of reviews of claims for Medicaid services in identifying and preventing fraud, waste, and abuse.** Policies and procedures help ensure the PI Section is consistently using established criteria and a uniform process to achieve its strategic objective. To help ensure enhanced pre-claim and post-claim payment reviews are cost-effectively preventing and identifying fraud, waste and abuse, associated policies and procedures should address the following areas:

**Provider Selection.** Effectiveness of provider selection for review should be based on impact on identification and prevention of fraud, waste and abuse, as well as on cost to identify payment errors and recoup identified overpayments.

**Claim Error Determination.** Identification of errors should include categorization by provider type, medical procedure, and associated oversight activity. Determination of the severity of errors should include consideration of the monetary impact to Medicaid funding requirements and whether the errors are inadvertent or due to fraudulent activity. To ensure identified overpayments effectively contribute to recoupments of state funds, the calculation methodology should include consideration of the results of provider appeals of identified overpayments from prior reviews.

**Level of Oversight.** The level of oversight associated with enhanced pre-claim and post-claim payment reviews should ensure that the associated costs to North Carolina's Medicaid program and to the affected provider are appropriate given the potential risk of fraud, waste, and abuse. For example, the federal Medicare program uses a Progressive Corrective Action process to ensure costs of additional oversight are appropriate given the identified level of aberrant billing behavior/noncompliance. In addition to enhanced pre-claim and post-claim payment reviews, this process incorporates provider education and training when it is determined that identified aberrant billing is not associated with fraudulent activities. In addition, under the Medicare Progressive Corrective Action process, the number of claims reviewed is based on the estimated severity of the provider's payment errors and is periodically re-evaluated until there is evidence that the provider's billing behavior has been rehabilitated.

In summary, enhanced pre-claim payment and post-claim payment reviews can help reduce Medicaid fraud, waste and abuse by providing deterrence against criminal activity. However, the Program Integrity Section does not have established policies and procedures in place to select providers for enhanced oversight. To ensure achievement of the Medicaid program's strategic objective to cost-effectively contribute to improved health care for all North Carolinians, the PI Section should also ensure that increased oversight of Medicaid claims does not unnecessarily limit recipient access to medical services. The Progressive Corrective Action process is used in the federal Medicare program to help ensure the costs of additional oversight are appropriate given the identified level of aberrant billing behavior/noncompliance.

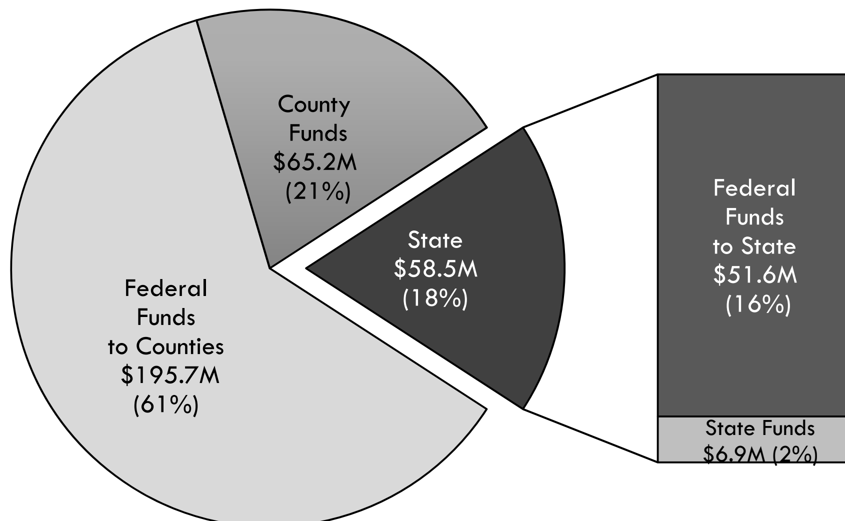
**Finding 4. Federal requirements and inadequate performance incentives have limited the effectiveness of Program Integrity Section oversight of Medicaid recipient eligibility determinations performed by counties.**

The Program Integrity Section is also responsible for conducting reviews of recipient eligibility determinations for the Medicaid program. Medicaid recipient eligibility determinations are currently performed by county departments of social services (county DSS offices). During Fiscal Year 2014–15, county DSS offices enrolled 2,289,777 individuals.

As shown in Exhibit 11, in Fiscal Year 2014–15, expenditures for Medicaid recipient eligibility determinations totaled $319.4 million, of which $65.2 million (21%) came from local funding sources.[29] State funding accounted for $6.9 million (2%) of total expenditures and was utilized to operate the recipient eligibility determination system, NC FAST, and to provide state oversight of the Medicaid enrollment process. The remaining $247.3 million came from Medicaid federal funding, with $195.7 million allocated to county DSS offices and $51.6 million to the North Carolina Medicaid program.

Exhibit 11

Counties Spent $261 Million of the $319 Million Used to Perform Medicaid Eligibility Determinations in Fiscal Year 2014–15




*Source: Program Evaluation Division based on information provided by the North Carolina Medicaid program.*

Oversight of the Medicaid eligibility determinations made by county DSS offices helps to ensure sound program administration and the timely identification of fraudulent and abusive behavior. As federally required, the Program Integrity Section is responsible for conducting reviews of recipient eligibility determinations. These reviews are required to be conducted in accordance with the CMS-administered Medicaid Eligibility Quality Control (MEQC) and Payment Error Rate Measurement (PERM) initiatives.[30]

[29] The Centers for Medicare/Medicaid Services authorized a 75% Federal Financial Participation rate for activities directly related to processing Medicaid eligibility effective January 1, 2014.
[30] As specified for PERM in 42 C.F.R. §§ 431.950 - 431.1002 and for MEQC in 42 C.F.R. §§ 431.800 - 431.865.

**MEQC reviews have not been used to establish statewide and county-level error rates for recipient eligibility determinations since 1995.** The MEQC initiative was originally designed to enable states, through statistical sampling, to estimate their percentage of ineligible recipients and provide information to help them reduce the percentage. However, in 1995, the Centers for Medicare and Medicaid Services (CMS) approved North Carolina to complete pilot reviews instead of conducting reviews that could produce estimates of the eligibility determination error rate for the State's Medicaid population.

These pilot reviews have generally focused on specific Medicaid populations or specific areas of the eligibility determination process, such as income determinations that are error-prone. For example, in Fiscal Year 2014–15, the Program Integrity Section conducted a review of recipient eligibility redeterminations with specific income determination characteristics. The purpose of this review was to see if counties were determining eligibility based on income and resources correctly and in a timely manner. However, this review only included a maximum of ten cases from each county. Consequently, the results from this pilot review could not be used to provide a valid estimate of the associated error rate for state or county Medicaid populations.

**The Program Integrity Section contributes to the federal Payment Error Rate Measurement (PERM) by conducting Medicaid eligibility determination reviews.** In 2002, in response to a federal statutory requirement, the Centers for Medicare and Medicaid Services (CMS) developed the PERM program.[31] The PERM program includes reviews of each state's Medicaid program, which take place on a rotating cycle with one-third of states being reviewed each year.[32] The results of each state-level review are combined to yield national Medicaid program error rates. In addition, CMS publishes a PERM report for each state that includes state error rates for each Medicaid component but does not include calculated county error rates.

PERM calculates error rates within three components of the Medicaid program:

- **Fee-for-service (FFS)**. A traditional method of paying for medical services under which providers are paid for each service rendered.
- **Managed care**. A system in which a state contracts with health plans, on a prospective full-risk or partial-risk basis, to deliver health services through a specified network of doctors and hospitals. The health plan is then responsible for reimbursing providers for specific services delivered.
- **Medicaid eligibility**. Recipient eligibility consists of two universes, active and negative. Active cases include recipients who were enrolled in the Medicaid program during the review period. Negative cases include applicants for Medicaid benefits who were

[31] As specified in the Improper Payments Information Act of 2002, the PERM program is designed to help reduce improper payments across the federal government.
[32] The 17 states in North Carolina's PERM cycle are: Alabama, California, Colorado, Georgia, Kentucky, Maryland, Massachusetts, Nebraska, New Hampshire, New Jersey, North Carolina, Rhode Island, South Carolina, Tennessee, Utah, Vermont, and West Virginia.

denied or whose benefits were terminated during the review period.[33]

Reviews of eligibility case records for active cases include reviews of applications by recipients to participate in the Medicaid program and redeterminations of a recipient's eligibility for continued participation in the Medicaid program.[34] Reviews of eligibility case records for negative case actions (denials or terminations) are performed to determine whether an applicant's eligibility for Medicaid services was improperly denied or terminated.

**North Carolina's claim payment error rate associated with inaccurate Medicaid eligibility determinations was more than twice the overall rate of the states in its review cycle.** As shown in Exhibit 12, CMS reported that PERM reviews of active recipient Medicaid determinations conducted in 2010 and 2013 both showed an error rate for North Carolina's Medicaid program that was at least two times greater than the combined average rate of the states in its review cycle. Specifically, North Carolina's payment error rate associated with active recipient eligibility determinations conducted in 2010 was 8.9%, compared to the combined average error rate of 4% for all 17 states in the review cycle.[35] Correspondingly, the State's payment error rate for recipient eligibility determinations of in 2013, 4.6%, was exactly double the combined average payment error rate of 2.3% reported by all states.[36]

[33] As specified in 42 C.F.R. §431.804, an active case refers to an individual or family determined to be currently authorized as eligible for Medicaid by the agency. A negative case action refers to an action that was taken to deny or otherwise dispose of a Medicaid application without a determination of eligibility (for instance, because the application was withdrawn or abandoned) or an action to deny, suspend, or terminate an individual or family.

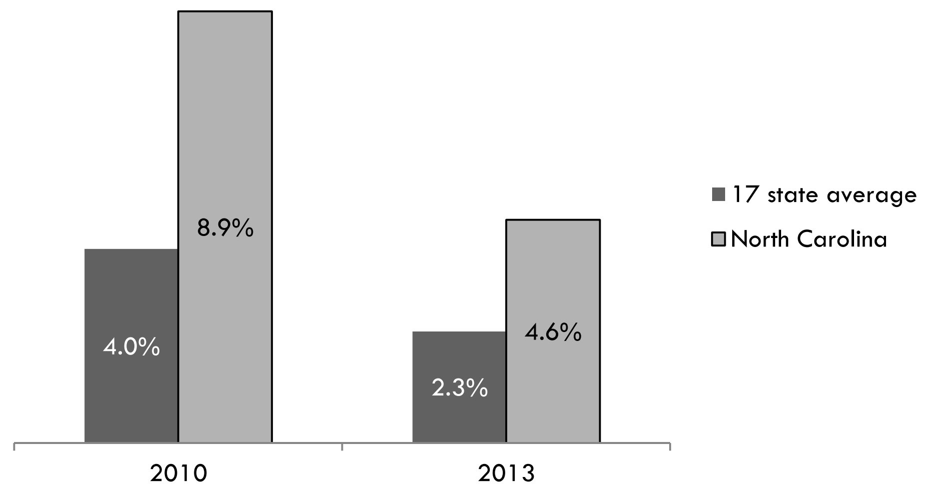
[34] An application is defined as a case that is being reviewed for the first time to determine eligibility. A redetermination is defined as a case that is currently eligible and is either due for a predetermined re-review or experienced a change in circumstances requiring the State to review the eligibility of the case.

[35] Based on a sample size of 216 active cases, the lower confidence interval was -6.7% and the upper confidence interval was 24.6%. A confidence interval is a range around a measurement that conveys the precision of that measurement. If repeatedly sampled, the results would fall within these ranges 95% of the time.

[36] Based on a sample size of 972 active cases, the lower confidence interval was .63% and the upper confidence interval was 8.48%.

## Exhibit 12

North Carolina's Claim Payment Error Rate For Inaccurate Medicaid Eligibility Determinations Was More Than Twice the Average Rate of the 17 States in its Review Cycle




*Source: Program Evaluation Division based on 2010 and 2013 PERM reviews of North Carolina's Medicaid program.*

**Both PERM reviews projected that inaccurate Medicaid eligibility determination errors have resulted in annual overpayment of at least $150 million in state funds.**[37] The 2013 PERM review estimated that improper payments associated with medical services to ineligible recipients totaled $442 million in Federal Fiscal Year 2013, of which approximately $152.4 million was paid with state funds with the remaining $289.6 million paid with federal funds.[38] Correspondingly, the 2010 PERM review projected that inaccurate Medicaid eligibility determinations resulted in $493.1 million paid to ineligible recipients, with state funds accounting for approximately $172 million of that total.[39]

**Federal PERM reviews also reported high levels of inaccurate denials of eligibility to participants in the Medicaid program.** Specifically, the 2013 PERM review of the North Carolina Medicaid program reviewed 384 negative cases and reported that 91 (23.7%) of these determinations to either deny or terminate eligibility for Medicaid services were inaccurate. The 2010 PERM review reported that 20 of 204 negative case reviews (9.8%) represented an inaccurate determination. As a result, these individuals may have been inappropriately denied access to Medicaid services.

**The Program Integrity Section did not conduct comprehensive reviews of recipient eligibility determinations in Fiscal Year 2014–15.** Beginning in June 2014, the CMS mandated that states participate in a five-round

[37] As specified in 42 C.F.R. 431.804, eligibility error means that Medicaid coverage has been authorized or payment has been made for a beneficiary or family under review who (1)was ineligible when authorized or when he received services; or (2)was eligible for Medicaid but was ineligible for certain services he received; or (3)had not met beneficiary liability requirements when authorized eligible for Medicaid; that is, he had not incurred medical expenses equal to the amount of his excess income over the State's financial eligibility level or he had incurred medical expenses that exceeded the amount of excess income over the State's financial eligibility level, or was making an incorrect amount of payment toward the cost of services.

[38] The projected impact of the erroneous recipient eligibility determinations was based on the size of the associated population of Medicaid recipients for each of the identified errors.

[39] The impact on Medicaid funding for each identified error was based on the payment amounts for the ineligible services received during the first five months of participation in the Medicaid program.

recipient eligibility determination pilot review process. Instead of conducting PERM and MEQC eligibility reviews, all states are required to participate in the Medicaid recipient eligibility review pilots to provide information on the accuracy of eligibility determinations for cases with specific income determination characteristics.[40] In addition, CMS stipulated that no error rate will be calculated for the state or for its counties for these reviews.

In Fiscal Year 2014–15, the PI Section implemented a Corrective Action Record Review (CARR) project to conduct reviews of redeterminations for selected recipient eligibility determinations.[41] This CARR project focused on assessing whether counties correctly determined eligibility in a timely manner. In Fiscal Year 2014–15, the PI Section completed 939 eligibility determination reviews under the CARR project. Deficiencies were identified in 477, or more than half, of the reviewed eligibility determinations.

However, these reviews did not determine the impact on medical service claim payment errors associated with the eligibility determination deficiencies identified during the review. Therefore, the North Carolina Medicaid program may not have a clear understanding of the impact that errors in the recipient eligibility determination process have on Medicaid fraud or on the number and value of associated Medicaid payment errors.

The PI Section reported that it does not plan on conducting any comprehensive recipient eligibility reviews until completion of the CMS-mandated pilot in September 2017. In addition, the scheduled 2016 PERM review for North Carolina will not include an error rate for the recipient eligibility component of the review.

Until these comprehensive reviews are conducted, the PI Section will be limited in its ability to effectively contribute to the reduction in the number and associated value of claims paid for medical services provided to ineligible Medicaid recipients. In addition, the PI Section will be unable to help effectively reduce the number of individuals who are inappropriately denied participation in the Medicaid program.

**The use of performance incentives can help to improve the accuracy of Medicaid eligibility determinations by county DSS offices.** The North Carolina Medicaid program has established agreements with county DSS offices to perform Medicaid eligibility determinations. As with contracts for services with private entities, the objective of each of these agreements is to ensure Medicaid funding is being used to achieve best value.[42] Best value represents the optimal trade-off between price and performance, where quality is considered an integral performance factor.

To help ensure the risks and rewards associated with achievement of best value are shared, state law encourages the inclusion of performance

[40] The first and second rounds have been completed. The first round consisted of reviews of the accuracy of Modified Adjusted Gross Income (MAGI) applications (approved and denied) and measured the accuracy of MAGI eligibility determinations. The second round consisted of reviews of the accuracy of MAGI applications and redeterminations (approved, denied, and terminated). The third and fourth rounds deal with the accuracy and timeliness of MAGI and non-MAGI applications and redeterminations (approved, denied, and terminated). CMS has not yet issued guidance on the fifth round.

[41] The selected cases include eligibility determinations for recipients with reported incomes, but the determination did not utilize the Modified Adjusted Gross Income application.

[42] As specified in N.C. Gen. Stat. § 143-135.9(a)(1).

metrics and incentives in the development of contracts for high-value services. These incentives may be positive, negative, or a combination of both. The purpose of performance incentives is to motivate the service provider to meet or exceed established performance standards and to promote more efficient operations.

Performance incentives should be based on achievement of intended outcomes as defined by the associated performance measures and targets. For example, incorporating achievement of associated performance objectives as a basis for determining payment amounts in the payment authorization process may serve as a financial incentive for providers to deliver the most cost-effective service. Conversely, the loss of value associated with not achieving intended outcomes can be reflected in a reduction in payments for the services performed.

The Program Evaluation Division determined that the agreements between the Medicaid program and county DSS offices did not include all of the requirements necessary to ensure the cost-effective achievement of performance objectives. Specifically, these agreements do not include necessary financial incentives to promote accurate and timely Medicaid eligibility determinations. Consequently, the financial impact associated with making claim payments to ineligible Medicaid recipients due to inaccurate Medicaid eligibility determinations is not being shared with counties.

An example of a potential financial incentive to promote achievement of the performance objectives of the Medicaid eligibility determination process would be if the State were to fund a portion of a county's cost to perform these services when Medicaid eligibility determination accuracy and timeliness performance targets are achieved. In this way, county DSS offices would be incentivized to reduce Medicaid eligibility determination errors, thereby reducing state funding requirements associated with claim payments to ineligible recipients.

To be effective, performance targets should be based on an established performance baseline for each county DSS office. The performance baseline should be based on a comprehensive review of a sample of Medicaid eligibility determinations that would allow for the results to be projected to the population of eligibility determinations that are performed by the county DSS office during the associated state fiscal year. These results should include an estimate of the impact of eligibility determination errors on Medicaid state funding requirements associated with claim payments to ineligible Medicaid recipients. Development of a performance baseline will enable the PI Section to establish attainable performance targets that account for the current level of performance of each county DSS office.

In summary, improving the accuracy of recipient eligibility determinations is one of the most effective ways to reduce claim payment errors and to ensure the cost-effective use of state and federal funds. However, the Program Integrity Section has not been conducting comprehensive reviews of recipient eligibility determinations that would enable the North Carolina Medicaid program and county DSS offices to effectively use available resources to reduce fraud, waste, and abuse.

**Finding 5. The Program Integrity Section is not effectively utilizing available information from various internal and external reviews of eligibility determinations and medical service claims to improve the systemic effectiveness of the Medicaid program in reducing fraud, waste, and abuse.**

Though the Medicaid program represents a partnership between the federal and state governments, each state is responsible for the day-to-day operation of its program. This responsibility includes setting policy and managing the program to achieve its strategic objective. This charge also includes having systems in place to prevent fraud, waste, and abuse from occurring, and to identify and implement alternatives to improve the efficiency and effectiveness of its policy and operating systems.

The Program Integrity Section contributes to the overall efficiency and effectiveness of the North Carolina Medicaid program by conducting reviews of Medicaid eligibility determinations and claims for medical services. In addition to identifying fraud, waste, and abuse and recouping state funds, the activities performed by the PI Section can contribute to reductions in state funding requirements by identifying systemic deficiencies in Medicaid program operations. Through an effective process to address these identified system deficiencies, the North Carolina Medicaid program can better ensure appropriate medical services are being delivered by qualified providers at the appropriate price to eligible recipients.

**The Program Integrity Section is not effectively utilizing available information from reviews of eligibility determinations and medical service claims to improve the effectiveness of Medicaid business processes.** Despite having access to the data analytics capabilities of the Fraud and Abuse Management System and information from reviews of Medicaid eligibility determinations, the PI Section is not effectively identifying systemic deficiencies in the operations of North Carolina's Medicaid program.

The PI Section does not have a documented process to notify the Medicaid program of identified systemic deficiencies. The Section reported that there are currently multiple mechanisms by which root cause analysis of identified deficiencies is disseminated to internal and external stakeholders. These mechanisms include the use of written communications such as Monthly Medical Bulletins and e-mail to identify trends or patterns from reviews of medical service claims. The Program Integrity Section also reported using meetings and training sessions with internal and external stakeholders to share lessons learned from its activities.

Further, the North Carolina Medicaid program does not have formal policies and procedures to monitor the corrective action taken by the applicable Medicaid business unit or to measure the associated reductions in fraud, waste and abuse. Consequently, potential reductions in state funding requirements associated with inadvertent payment errors and fraudulent activity are not being fully realized or documented.

For example, the PI Section reported that in Fiscal Year 2014–15, the Fraud and Abuse Management System was used to identify claims paid for services after the recipient's date of death. The lack of formal policies and procedures to notify the Medicaid program of this potential system

deficiency in the automated claims review process and to monitor the effectiveness of the associated corrective action limits the ability to realize and document improvements in the claim review process.

**The federal PERM review process requires states to develop a plan to address identified system deficiencies.** CMS requires that each state Medicaid program complete and submit a corrective action plan based on the errors found during the PERM process. Specifically, state Medicaid programs are required to analyze findings from PERM, identifying root causes of errors and developing corrective actions designed to reduce major error causes, trends in errors, or other vulnerabilities for purposes of reducing improper payments.

The 2013 PERM report for North Carolina's Medicaid program identified claim payment errors with a projected annual value of $188 million. Nearly all of the identified claim payment errors were associated with claims for medical service submitted by an ineligible provider.[43] Specifically, the 2013 PERM report identified four root causes for these errors:

1. **Referring/ordering provider not enrolled.** Seven overpayment errors occurred because the referring or ordering providers were not enrolled in Medicaid on the dates of service.
2. **Attending or rendering provider required but not listed on institutional claim**. Seven overpayment errors were cited because the name of an attending provider was not submitted on the electronically filed claim.
3. **New provider not enrolled using the applicable risk-based criteria**. Three overpayment errors were cited because the State did not complete risk-based screening for newly enrolled providers.
4. **Provider not enrolled in Medicaid**. One overpayment error was cited because the provider was not enrolled in Medicaid on the date of service.

The corrective action plan prepared by the North Carolina Medicaid program in conjunction with the 2013 PERM review included a course of action to address each of the root causes of identified payment errors. Steps to address the errors included:

- development of system edits to the automated claim processing system,
- provider education, and/or
- revisions to Medicaid policies and procedures.

However, the plan did not include a requirement to determine whether the corrective action associated with each identified claim processing error effectively addressed the associated system deficiency. Consequently, the Medicaid program did not determine whether the applicable systemic changes effectively addressed each of the associated system deficiencies.

**The Program Integrity Section is not effectively utilizing the results of reviews by other federal and state entities.** Reviews of Medicaid recipient eligibility determinations and claims for medical services are also

[43] The only other identified payment error was a system input error caused by incorrect pricing in which the State paid an outdated dispensing fee that was greater than the dispensing fee in effect on the date of service.

performed by other federal and state organizations. At the federal level, activities designed to identify fraud, waste, and abuse are performed by various entities including the Centers for Medicare and Medicaid Services (CMS), the Office of Inspector General within the Department of Health and Human Services, and the Federal Bureau of Investigation and Drug Enforcement Agency within the U.S. Department of Justice. For example, CMS operates a Payment Error Rate Measurement (PERM) program, which identifies and measures the severity of recipient eligibility determinations and claim payment errors.

At the state level, the Office of the State Auditor also conducts reviews of participant eligibility determinations and medical service claims. For example, in conjunction with the audit of the State of North Carolina's compliance with federal program requirements for Fiscal Year 2014–15, the Auditor reviewed 396 claim payments, 5,771 recipient eligibility determinations, and 117 provider eligibility determinations.[44] The North Carolina Department of Justice also contributes to reductions in fraudulent activity through enforcement of applicable laws and prosecution of criminal activity.

Incorporating the results of reviews by external entities with the results of the reviews performed by the Program Integrity Section of Medicaid eligibility and claim payment processes should help enable the PI Section to identify specific system deficiencies and provide the North Carolina Medicaid program with better information to determine the most effective business process improvements among available alternatives. For example, by compiling the results of all oversight activities into a single data set, the PI Section may be able to effectively analyze specific medical services and participant types. This targeted analysis would allow for identification of system deficiencies that may otherwise go undetected.

Use of all available Medicaid oversight information would allow the PI Section to provide a better estimate of the overall impact of identified deficiencies. Currently, each federal and state entity does not perform a sufficient number of reviews of participant eligibility determinations and medical service claims on its own to produce an estimate of the impact of identified deficiencies that can reliably be used to evaluate Medicaid program effectiveness.

For example, as shown in Exhibit 13, the most recently published federal reviews of North Carolina's Medicaid program reported an estimated claim payment error rate of 2.7% for claims paid in 2013 and 3.4% for claims paid in 2010. However, due to limited sample size, these reported error rates are not definitive and may not reflect the actual payment error rates. Based on the selected sample size, it would be more accurate to conclude that the payment error rate for claims paid in 2013 is likely between 0.9% and 4.6%, and between 0.8% and 5.9% for claims paid in 2010.[45]

[44] Office of the State Auditor, North Carolina Department of Health and Human Services, Statewide Federal Compliance Audit Procedures for the Year Ended June 30, 2015.

[45] The reported range is a measurement that conveys the precision of the reported payment error rate. If repeatedly sampled, the results would fall within the ranges shown 95% of the time.

## Exhibit 13: Due to Limited Sample Size, Payment Error Rates as Reported in the Most Recent Federal Reviews are Not Definitive

| Source | Sample Size | Error Rate Estimate | Lower Confidence Interval (95%) | Upper Confidence Interval (95%) | Confidence Interval Range (95%) |
|---|---|---|---|---|---|
| 2010 PERM | 540 | 3.4% | 0.8% | 5.9% | 5.1% |
| 2013 PERM | 397 | 2.7% | 0.9% | 4.6% | 3.7% |

*Source: Program Evaluation Division based on results of 2010 and 2013 federal PERM reviews.*

A recent audit by the Office of the State Auditor estimated the value of claim payment errors at $835 million for Fiscal Year 2014–15.[46] However, as with the reported results of recent federal reviews, due to limited sample size these results are not definitive and likely do not reflect the actual payment error rate of claims paid. As a result, the Office of the State Auditor also reported that the actual value of payment errors likely ranged from $492 million to $1.2 billion.[47]

While the results of these reviews provide valuable information that can be used by the Medicaid program to identify deficiencies and improve performance, the range in the estimated error rates when extrapolated to the larger population limits their usefulness when evaluating overall performance. By combining the results of all available reviews of eligibility determinations and claim payment errors, the PI Section will be able to provide a more precise estimate of projected error rates and better determine the impact of its efforts to reduce Medicaid fraud, waste, and abuse.

**However, the ability of the Program Integrity Section to compile the results of the oversight activities performed by each federal and state entity is currently limited because a uniform methodology to perform these reviews has not been established.** The results reported by each entity cannot be meaningfully compared at present because the criteria used to identify errors and determine the associated severity may vary between reviewing entities. For example, the PERM program administered by CMS uses five months of medical service claims when determining the monetary impact of a Medicaid recipient eligibility determination error. Conversely, the Program Integrity Section reported that it uses two months of claim activity when calculating the monetary impact of these errors. The PI Section also reported that due to differences in the methodology used by the Office of the State Auditor in the medical service claim reviews it conducted in conjunction with the recent federal program compliance audit, the Medicaid program did not agree with 19 of its 50 payment error determinations and did not initiate efforts to recoup those identified overpayments from the provider.

**The California Medicaid program conducts periodic payment error studies as part of its program integrity efforts.** The California Medicaid program uses the results of these studies to determine where the program is

[46] Office of the State Auditor, North Carolina Department of Health and Human Services, Statewide Federal Compliance Audit Procedures for the Year-ended June 30, 2015.
[47] The statistical sampling method used was a stratified statistical variable sample, with reported confidence interval of 90%.

at greatest risk for payment errors.[48] On that basis, it then determines how to allocate and direct resources and activities to cost-effectively reduce fraud, waste, and abuse. The study report produced by California also includes a description of the provider and billing error types as well as a description of the medical claim review process, allowing the program to categorize results and identify specific areas where Medicaid fraud, waste and abuse can be reduced. In addition, documentation of the methodology to conduct the study helps ensure that the results from each study can be compared to evaluate the effectiveness of the California Medicaid program's efforts.

In summary, the Program Integrity Section can increase its contribution to reductions in Medicaid fraud, waste, and abuse by using information available from reviews of claims for medical services and participant eligibility determinations. However, the Program Integrity Section has not developed policies and procedures to ensure these oversight activities can be effectively used by the North Carolina Medicaid program to improve associated business processes. In addition, the Program Integrity Section has not established a methodology to identify or to determine the severity of claim payment and eligibility determination errors, which would allow for the results of all associated oversight activities to be compiled and compared to produce better information.

## Recommendations

**Recommendation 1. The General Assembly should require the North Carolina Medicaid program to develop and implement policies and procedures ensuring available resources are being cost-effectively used to identify and prevent fraud, waste, and abuse.**

As reported, the Program Integrity Section has not established a uniform methodology to identify and measure the contribution of reviews of medical service claims and eligibility determinations.

To help ensure that the Program Integrity Section cost-effectively uses state funds to reduce Medicaid fraud, waste and abuse, the General Assembly should require the PI Section to develop and implement policies and procedures to accomplish the following objectives:

- Ensure use of a uniform methodology to identify and measure the severity of Medicaid eligibility determinations and medical service claim errors. At a minimum, this methodology should include criteria to
  - ensure payment errors can be categorized by provider type, medical procedure, associated oversight activity, and can be compared and if necessary combined with the results of federal PERM reviews and other applicable oversight activities,
  - identify monetary impact to Medicaid funding requirements and determine whether errors are inadvertent or due to fraudulent activity, and

[48] The sample size ensured a 95% confidence level with ± 3% precision relative to the overall payment error rate.

   - o ensure that review requirements are limited to those necessary to determine the accuracy of each participant eligibility determination and medical service claim.
- Provide incentives for county DSS offices to ensure the accuracy of Medicaid eligibility determinations.
- Ensure effective consideration of the results of periodic root-cause analysis of claim payment errors, and measure the impact of associated operational improvements on the level of Medicaid fraud, waste, and abuse.

To ensure cost-effective use of all available claim and eligibility review information, the General Assembly should also direct that the methodology used to identify and measure the severity of Medicaid eligibility determinations and medical service claim errors be made available and used by other state entities performing Medicaid oversight activities, when feasible.

**Recommendation 2. The General Assembly should direct the North Carolina Medicaid program, in partnership with the Office of Administrative Hearings and the Medicaid Investigations Division, to identify alternatives to improve the effectiveness of efforts to recoup identified claim overpayments and to prosecute fraudulent activity.**

As identified in Findings 1 and 2, the effectiveness of the Program Integrity Section in reducing fraud and recouping claim overpayments may be unnecessarily limited due to inadequate coordination with other state entities participating in the North Carolina Medicaid program.

To help ensure state funds are cost-effectively used to recoup identified medical service claim overpayments and prosecute fraudulent activity, the General Assembly should require the North Carolina Medicaid program, in partnership with the Office of Administrative Hearings and the state Department of Justice's Medicaid Investigations Division, to identify alternatives, to include proposed legislation, to increase the amounts recouped from identified overpayments and the percentage of fraud referrals accepted for further investigation and prosecution.

The results of this analysis should be provided to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice and to the Fiscal Research Division by March 31, 2017.

**Recommendation 3. The General Assembly should require the North Carolina Medicaid program to develop policies and procedures to ensure any additional oversight cost-effectively addresses identified noncompliance.**

As reported in Finding 3, enhanced pre-claim and post-claim payment reviews may unnecessarily increase the administrative burden and associated costs to Medicaid service providers. Excessive administrative requirements create unnecessary additional costs to the provider that do not contribute to reducing fraud, waste, and abuse. These additional costs can adversely affect the financial viability of private service providers and

their ability to participate in the Medicaid program and provide access to quality health care for recipients.

To help ensure actions imposed upon Medicaid service providers with identified aberrant behavior are appropriate given the level of non-compliance, the General Assembly should amend N.C. Gen. Stat. § 108C-7(a) to require the Medicaid program to develop and incorporate a Progressive Corrective Action process for providers selected for enhanced pre-claim and post-claim payment review. At a minimum the process should ensure

- aberrant behavior as identified through data analytics or from external sources is validated by enhanced pre-claim or post-claim payment review that includes clinical reviews, and/or a provider eligibility determination, as appropriate,
- workloads are targeted, specific, and prioritized to ensure an adequate return on investment of available resources,
- documentation requirements for claims subject to the enhanced pre-claim and post-claim payment reviews are limited to those necessary to determine the accuracy and appropriateness of the information used in the automated claim payment process,
- recoupments of overpayments are made when errors are validated,
- referrals to the Medicaid Investigations Division are made when credible allegations of fraud are established, and
- provider feedback and education are used when aberrant behavior is due to abuse and absent an established credible allegation of fraud.

**Recommendation 4. The General Assembly should require the North Carolina Medicaid program to produce an annual performance report documenting results and an annual work plan that provides a roadmap to reduce fraud, waste, and abuse.**

As identified in each of the findings, the North Carolina Medicaid program is not effectively utilizing available information from reviews of eligibility determinations and medical service claims to improve existing Medicaid processes to prevent fraud, waste, and abuse.

To help ensure that the Program Integrity Section is cost-effectively identifying and preventing fraud, waste, and abuse, the General Assembly should amend state law to require the North Carolina Medicaid program to produce an annual report documenting its impact and achievement of associated performance targets, to include:

- cost to perform each activity;
- number and value of identified valid claim payment errors associated with waste and abuse, to include
  - recoupments of claim overpayments and
  - cost-avoidance through detection of errors prior to claim payment;
- number of reviews of Medicaid service providers and of recipient eligibility determinations performed, to include

  - o number of Medicaid service providers and recipient eligibility determinations identified as inaccurate,
  - o number and estimated value of claim payment errors associated with approvals of ineligible Medicaid service providers and recipients, and
  - o number of disapprovals of eligible providers and recipients;
- reductions in Medicaid state funding requirements associated with business process improvements of systemic deficiencies identified through root-cause analysis of inaccurate provider claims and eligibility determinations by the Program Integrity Section, to include:
  - o description of each system deficiency,
  - o cost to implement associated business process improvement, if applicable, and
  - o estimated reduction in state funding requirements realized from business process improvement, if applicable; and
- number of Medicaid fraud referrals accepted by the Medicaid Investigations Division for prosecution, to include
  - o number and value of claim payment errors associated with fraudulent Medicaid participant activity.

The General Assembly should also require the North Carolina Medicaid program to produce an annual work plan identifying the most cost-effective allocation of available resources to reduce Medicaid fraud, waste, and abuse during the upcoming fiscal year.

The composition of planned oversight activities should be established from the results of an annual assessment of potential Medicaid fraud, waste, and abuse. At a minimum, the risk assessment should identify specific Medicaid participant and medical service categories, and for each category include consideration of the following factors and information from the most recently available state fiscal year:

  - o annual number and average value of Medicaid eligibility determination/claim payments,
  - o estimated percentage of valid Medicaid eligibility determination/claim payment errors from all sources,
  - o cost to identify payment errors and realize savings to state funding requirements, and
  - o number of fraud referrals accepted by MID.

The annual performance report for the most recent fiscal year and work plan for the upcoming fiscal year should be provided to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice and to the Fiscal Research Division by December 1.

The General Assembly should also direct the Joint Legislative Oversight Committee on Medicaid and NC Health Choice to review the implementation by the North Carolina Medicaid program of each of the recommendations contained in this report. As authorized in N.C. Gen. Stat. § 102-19, this review may include invitations to affected stakeholders and other interested parties to appear and testify before the Committee. The Committee co-chairs may establish subcommittees to assist with various parts of the review, including determining whether contracted services are

effectively contributing to Medicaid program objectives, and whether appropriate performance measures and targets have been established.

## Agency Response

A draft of this report was submitted to the Department of Health and Human Services for review. Its response is provided following the appendices.

## Program Evaluation Division Contact and Acknowledgments

For more information on this report, please contact the lead evaluator, Chuck Hefren, at chuck.hefren@ncleg.net.

Staff members who made key contributions to this report include Jim Horne, CPA. John W. Turcotte is the director of the Program Evaluation Division.

Health and Human Services

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*Secretary*

September 29, 2016

John W. Turcotte, Director
Program Evaluation Division
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Raleigh, NC 27603-5925

Dear Mr. Turcotte,

The Department of Health and Human Services has received your report on its examination of the effectiveness and efficiency of Medicaid Program Integrity Section (PED Report No. 2016-10). The Department has significant concerns with the methodology utilized in conducting the review and disagrees with the majority of the findings as presented in the report.

The review of the Office of Compliance and Program Integrity commenced on March 8, 2016 with an entrance conference in which PED presented a number of assumptions about the work of OCPI. In the ensuing six months PED made multiple requests for data but never actively engaged in discussions with OCPI staff to understand the daily processes and encumbrances faced by OCPI. Additionally, there was no consideration given to the changes which have been made within OCPI since 2014-2015 to strengthen efforts for preventing and detecting fraud waste and abuse in the Medicaid program. Because the review process of OCPI was performed with limited engagement of OCPI personnel, the resulting report includes errant assumptions and statements which cannot be fully understood unless placed in proper context. Within this response letter OCPI has provided examples of only a portion of the concerns that the Department has identified with respect to the PED report findings.

The Division of Medical Assistance, Office of Compliance and Program Integrity (OCPI) is passionately committed to establishing Medicaid excellence by demonstrating and achieving the goal of providing access to quality care for eligible Medicaid recipients. An important component of this effort is having an active and robust integrity program to assure that payments to Medicaid providers are

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reasonable, appropriate and properly documented. OCPI conducts audits, enforces reasonable standards for the endorsement of providers and uses enhanced technology to identify aberrant provider practices as a responsibility to the fiduciary duty to North Carolina tax payers OCPI strives to establish effective working relationships with the provider community and with state and federal stakeholders.

There are inherent limitations in judging the efforts of OCPI when reviewing work completed within a single State Fiscal Year as was done by the PED. In depth case investigations often span multiple State Fiscal Years. Inclusive of the extensive state hearing process and collection efforts the total time to case closure may be 2 to 4 years. A value judgement based on expenditures and the associated collections within the same year has the effect of yielding a skewed perspective of the work which must be thoughtfully and carefully completed to assure the provision of quality care and the appropriate use of limited Medicaid funds.

Notwithstanding, our concerns with the PED findings, the Department agrees that there are additional opportunities to improve both our processes and related outcomes associated with Medicaid program integrity efforts. In fact since SFY 14-15, the Department has already taken steps that are consistent with many of the recommendations outlined in this report.

**Findings.**

**Finding 1. Significant decrease in the number of referrals from OCPI to the MID SFY 2012-SFY 2015**

The Department strongly disagrees with this finding. The Medicaid Investigation Division (MID) has confirmed that the referral count totals referenced in the PED report for SFY 12-13 included referrals associated with supplemental requests. Supplemental requests represent instances where OCPI provides additional information to an existing case and should not be considered a new case. Supplemental requests are typically created when additional information has become available to strengthen a case. It is the Department's understanding that the PED intended only to report new cases.

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The following figures represent the count of OCPI referrals for unique cases submitted to MID. The Department verified each referral by submission date, case number and provider. Case files detailing these individual referrals and dates submitted were offered as available for review.

| SFY | New Program Integrity Referrals* | New LME\MCO Referrals* | Totals* |
|---|---|---|---|
| 12-13 | 58 | 7 | 65 |
| 13-14 | 23 | 49 | 72 |
| 14-15 | 35 | 20 | 55 |

* Does not include supplemental referrals.

As mentioned in the PED report the referral numbers reported for SFY 2014-2015 do not include the referrals that were generated by Medicaid Managed Care Organizations and submitted to the MID via the PI Section. Without including the MCO referral numbers there can be no true evaluation of the total Program Integrity referral body of work completed throughout 2012-2015. The shift to MCO management of behavioral health which was initiated in SFY 2012 did not repudiate PI's responsibility to identify and submit suspected cases of fraud to the MID. PI's responsibility to submit suspected cases of fraud to the MID was carried out by building relationships with the MCOs' staff and providing guidance as to the information needed to build quality MID referrals. Taken as a whole, MID referral activity over the past three SFYs has remained fairly consistent.

Because the collaborative efforts shared with the MID represent critically important work, OCPI and the MID work closely through the following activities:

- Formal meetings between OCPI and the MID occur on a monthly basis to review active cases and discuss emerging trends related to fraud schemes that inform our collective efforts.
- Direct collaboration between OCPI and MID staff to gathering evidence for active criminal and civil cases.

- Annual joint training sessions are conducted by OCPI and the MID for staff to discuss cases and share information related to improving the quality of referrals.
- Quarterly information sharing meetings are held with OCPI, MID and other law enforcement agencies including the FBI and DEA.

**Finding 2. Contract expenditures used to perform reviews exceeded state savings**

The Department disagrees with this finding. The Department believes that the methodology employed by PED in this report contains multiple flaws described below as it makes assumptions about both post payment and prepayment audit methodologies and recoveries. The report methodology for evaluating post payment recoveries attempts to calculate savings and benefits associated with costs and activities performed in SFY 14-15 using results limited within the SFY. The very nature of the activities point to the fact that benefits do not accrue until future years. The report is further flawed by assuming that benefits to the state accrue only when a provider who is placed on prepayment review submits claims that are ultimately denied.

**The PED analysis does not account for federally mandated complaint investigations that do not yield financial recoveries.** During SFY 2014-2015 OCPI closed 1,732 investigations following preliminary investigations for which there are no recoveries associated with the costs of efforts.

**The PED analysis does not include recoveries to accrue from post pay cases in progress in SFY 14-15.** A total of 720 full investigations were opened by the DMA post payment vendor in SFY 14-15. At the close of SFY 14-15, 365 (more than 50%) of these cases remained active investigations. Costs associated with these investigations were included in the PED analysis and no consideration was given to the future benefits which would accrue from these cases once they were completed.

**The PED analysis does not include any recoveries associated with MID referral activities.**

OCPI post payment investigations led to 35 referrals to the Medicaid Investigation Division during SFY 14-15. Costs associated with OCPI and contractor efforts to

complete these referrals are included in the PED analysis; any recoveries associated with this work is assumed to be zero in this report.

**The PED analysis assumes $0 in benefits to the state associated with reduced claiming from providers who have been placed on prepayment review**

To prevent fraud waste and abuse the Department has proactively made efforts through prepayment reviews to identify unnecessary or excess payments, inappropriate use of services and fraudulent claiming. Prepayment reviews assure that claims presented for payment meet both benefit and medical necessity guidelines in advance of payment. Since it's initiation in SFY 09-10, DMA has experienced consistent outcomes both with respect to denied claiming and reductions in billing from providers who have been placed on prepayment review. Providers are selected for prepayment review only when they have been identified at elevated risk for fraud waste or abuse either through investigations or through identification of aberrant billing practices identified through analytics. Through SFY 14-15, a total of 150 providers have been placed on prepayment review. This represents less than .02% of the 80,000 providers in the Medicaid network.

While it is important to note that not all providers placed on prepayment review are suspected of or have committed fraud, specific examples of prepayment cases initiated in SFY 14-15 included:

- A provider who was suspected of selling their Medicaid provider identification information to another provider who was under investigation and later convicted of manufacturing Medicaid claims.
- A known offender under Medicaid review who had concealed their identity to re-enter the network and promptly file for significant dollars in claims.
- A provider billing in excess of 24 hours of care delivered by a single practitioner within the same 24 hour day

Annualized average claiming for providers placed on prepayment review during SFY 14-15 equated to $30.7M. Reductions in claiming for providers placed on prepayment review equated to $16.1M. Of this amount, $11.6M in claim reductions were associated with providers who were ultimately terminated from the Medicaid

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program and $7.2M in claim reductions were associated with providers who were referred and accepted for investigation by the MID.

The PED report assumes that savings from prepayment reviews only accrue when a claim is submitted and denied. This assumption discounts the inherent disincentive there is for providers who are billing inappropriately to submit claims, particularly in cases that rise to the level of fraudulent billing.

There are additional benefits that also accrue from prepayment reviews including:

- Assurance that claims meet federal and state requirements for payment. Any payments that do not meet documentation standards are also at risk for payback to the Centers for Medicare and Medicaid (CMS)
- Promotion of Patient Safety; prepayment reviews also help to ensure client safety by verifying that appropriately qualified staff are providing services in adherence with Medicaid policy. Prepayment reviews have often revealed providers who have been found to be lacking in appropriate certifications, licensure or training.

**Finding 3. The effectiveness of the Program Integrity has been limited by a lack of policies and procedures**

The PED has inferred that high claim volume should act as a primary driver of analytic allegation packages. High claim volume is one of a myriad of factors driving the request for data analytic packages and there are inherent limitations in looking at this one factor over a single year period. A case in point is the data analytics packages cited in this report for dental services for pregnant women. As a project completed expressly for the Office of Inspector General (OIG) PI was required to not only verify OIG findings and seek recoupments for overpayments but also to perform audits of services subsequent to the audit period. This activity while not focused on high volume claims was nevertheless a necessary and unusually high portion of the work required to be addressed in SFY 14-15.

The PED report offers no evidence to support the finding that the disproportionate use of enhanced pre-claim payment reviews of PCS providers may create unintended consequence of limiting access to Medicaid services. In SFY 14-15, a

total of 17 PCS providers were placed on prepayment review. This represented less than ½ of 1% of PCS providers statewide. Additionally, prior to taking any action with a provider including prepayment review, suspension, or termination DMA evaluates a provider's utilization, beneficiary population, geography and local capacity data to assure that the action will not impact beneficiary access to care.

The PED report also asserts that the pre-claim review process is unduly burdensome and cites as an example that a provider is currently required to submit documentation exceeding 50 pages for claims of less than $50. The example provided is atypical. Many of the requests are for documentation that is required once, quarterly, annually or for every two years. The average number of pages of documentation per beneficiary for providers who have passed prepayment review over the life of the program is 29 pages per beneficiary.

**Finding 4. The effectiveness of PI oversight of county recipient eligibility has been limited by Federal requirements**

All MEQC activities are directed by the Centers for Medicare and Medicaid (CMS). Since 1995 CMS has not included a requirement for comprehensive reviews of recipient eligibility determinations with the exception of the Payment Error Rate Measurement Program (PERM). CMS has instead allowed the states to focus on specific programs such as the Community Alternatives Program for Disabled Adults (CAP) which are at high risk for errant eligibility determinations. Although the CMS has the ability to monetarily penalize states with high eligibility error rates they have been reluctant to do so due to their focus on assuring applicants appropriate access to Medicaid benefits. Currently, MEQC resources remain focused on fulfilling directives as required and approved by CMS.

**Finding 5. Program Integrity Section is not effectively utilizing available information to improve the systemic effectiveness of the Medicaid program in reducing fraud, waste, and abuse.**

OCPI has processes in place to utilize available information when identified to improve the systemic effectiveness of the Medicaid program. Over the past year work has taken place to enhance the formalization of these processes to direct systemic improvements. DMA has recently initiated a universal review of Medicaid claims as paid under current policies. This information will be utilized in part to

detect and mitigate any identified system weaknesses and to identify opportunities to strengthen program policies.

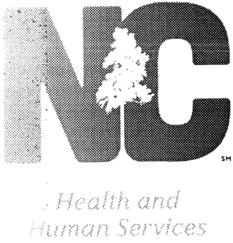
The 2013 PERM program required a Comprehensive Corrective Action Plan (CAP) from the state detailing each error type, activities to correct errors, dates for corrective activities to be implemented and methods to measure the results of the corrective actions. In addition to requiring CMS approval for the written plan the state was obligated to provide a formal visual and oral presentation to CMS utilizing DMA subject matter experts to discuss the Corrective Action Plan. The state is further required to send an update on the CAP activities on a bi annual basis. DMA currently remains in the process of completing the CAP activities and is committed to making the changes needed to address systematic deficiencies. The Department agrees that limitations exist on the ability to compile the results of oversight activities performed by the various federal and state entities. Uniform methodologies with common terminology, time limitations and uniform policy interpretation when utilized by all auditing entities has the potential to vastly improve the ability of Program Integrity to prevent and detect fraud waste and abuse.

**Recommendations**

**Recommendation 1. The General Assembly should require the North Carolina Medicaid program to develop and implement policies and procedures ensuring available resources are being cost-effectively used to identify and prevent fraud, waste, and abuse.**

While the Department fully agrees that a uniform methodology for identifying and measuring the severity of Medicaid eligibility determinations and medical service claim errors is highly desirable and would lead to more consistent reporting, the ability to enact such methodologies is limited by the dissimilarity of audit methods and reporting measures utilized by the CMS, OIG, OSA and other external auditing agencies.

While not endorsing a specific methodology the Department is in agreement that further work can be done to establish and promote efficiency standards for Medicaid eligibility. Innovative strategies are needed in the NC Medicaid program





Pat McCrory
Governor

Richard O. Brajer
Secretary

to lower administrative costs, increase the accuracy of eligibility determination and decrease the dollars spent on improperly enrolled Medicaid recipients. Program Integrity looks forward to working with the General Assembly, MEQC, internal and county stakeholders to design and develop a robust program for accurate eligibility and enrolment determinations.

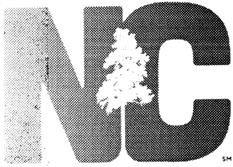
**Recommendation 2. The General Assembly should direct the North Carolina Medicaid program, in partnership with the Office of Administrative Hearings and the Medicaid Investigations Division, to improve the effectiveness of efforts to recoup identified claim overpayments and to prosecute fraudulent activity.**

The Department is fully supportive of working directly with the General Assembly, the Office of Administrative Hearings and the Medicaid Investigation Division to examine opportunities to improve outcomes related to post payment recoveries. We believe that a review of the existing processes would help to identify hindrances to recoveries and improve the efficacy of our collective post payment work.

**Recommendation 3. The General Assembly should require the North Carolina Medicaid program to develop policies and procedures to ensure any additional oversight cost-effectively addresses identified noncompliance.**

**Recommendation 4. The General Assembly should require the Program Integrity Section to produce an annual performance report and work plan that documents results and provides a roadmap to reduce fraud, waste, and abuse.**

With respect to recommendations 3 and 4, the Department welcomes the opportunity to review existing policies and procedures related to current program integrity efforts with the General Assembly. The Department is also fully supportive of reporting on both the planning efforts and program outcomes related to program integrity activities. We believe that a common understanding of the goals, opportunities and barriers related to program integrity efforts will support and enhance our collective opportunities for success.



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The Department is committed to ensuring state and federal dollars are appropriately expended for Medicaid services through reviews of Medicaid claiming, conducting investigations, implementing recoveries, pursuing recoupments and identifying other opportunities for cost avoidance. DMA, OCPI leadership will continue to evaluate the recommendations put forth in this review and make needed improvements.

Sincerely,

Richard O. Brajer
Secretary

cc: Dave Richard, Deputy Secretary for Medical Assistance
Rod Davis, Chief Financial Officer
Rob Kindsvatter, Director, Office of Budget & Analysis
Mark Payne, Assistant Secretary of Audit and Health Service Regulation
Trey Sutten, Chief Financial Officer, Division of Medical Assistance
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