Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicaid Integrity Program

North Carolina Comprehensive Program Integrity Review

Final Report

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INTRODUCTION

The Centers for Medicare & Medicaid Services' (CMS) Medicaid Integrity Group (MIG) conducted a comprehensive program integrity review of the North Carolina Medicaid Program. The onsite portion of the review was conducted at the offices of the North Carolina Division of Medical Assistance (DMA). The MIG review team also visited the offices of the Medicaid Integrity Unit (MIU), North Carolina's Medicaid Fraud Control Unit (MFCU).

This review focused on the activities of the Program Integrity Section (PI Section), which is responsible for Medicaid program integrity. This report describes six effective practices, four regulatory compliance issues and five vulnerabilities in the State's program integrity operations.

THE REVIEW

Objectives of the Review

1. Determine compliance with Federal program integrity laws and regulations;
2. Identify program vulnerabilities and effective practices;
3. Help North Carolina improve its overall program integrity efforts; and
4. Consider opportunities for future technical assistance.

Overview of North Carolina's Medicaid Program

The DMA, within North Carolina's Department of Health and Human Services, administers the Medicaid program and NC Health Choice for Children, North Carolina's State Children's Health Insurance Program (SCHIP). As of January 16, 2008, the program served nearly 1,217,000 recipients. Over 64 percent of the recipients are enrolled in Carolina ACCESS, a primary care case management program.

Medicaid expenditures in North Carolina for the State fiscal year (SFY) ending June 30, 2007 totaled $9,428,784,260. In Federal fiscal year 2007, the Federal medical assistance percentage was 64.52 percent. DMA processed an average of 68.75 million claims annually for the past three SFYs. Of those claims, approximately 93 percent were submitted electronically.

As of January 16, 2008, the State had 66,361 enrolled providers in the fee-for-service (FFS) Medicaid program. The providers currently operating outside this framework are transportation providers in the State's Non-Emergency Medical Transportation (NEMT) program, which is administered at the county level, and Piedmont Behavioral Health (PBH) providers credentialed to serve a small population in five counties as a managed care behavioral health program.

The State's contract with Electronic Data Systems, Inc. (EDS) for daily claims processing will terminate on December 31, 2008. North Carolina released a Request for Proposals on July 27, 2007 for a replacement for its 30 year old Medicaid Management Information System (MMIS). The State anticipates that final vendor selection will occur in the third quarter of SFY 2008.

Program Integrity Section

In North Carolina, the organizational component dedicated to the prevention and detection of provider fraud is the PI Section located within the DMA. At the time of the review, the Deputy Director for Budget and Finance was serving as interim manager of the PI Section. The PI Section had 95 staff and eight managers and supervisors, three of whom are registered nurses. The PI Section includes four Investigative Sections: Provider Medical, Provider Administrative, Pharmacy, and Home Care. There are also Third Party Recovery, Quality Assurance/Medicaid Eligibility Quality Control, and Special Projects Sections.

The PI Section utilizes four contractors: Carolinas Center for Medical Excellence, Health Management Systems, Affiliated Computer Systems, and Value Options. The PI Section conducts oversight reviews of these contractors, whose responsibilities include reviews of billing accuracy of diagnosis related group payments and of psychiatric admissions, as well as continuing stay criteria.

The table below presents the total number of administrative actions or sanctions, identified overpayments and amounts recouped in the past three SFYs as a result of program integrity activities.

Table 1

SFY	Number of State Administrative Actions or Sanctions	Amount of Overpayments Identified	Amounts Recouped (includes past settlement collections)
2005	1,880	$ 7,118,617	$ 12,508,218
2006	3,357	$ 10,838,009	$ 10,278,091
2007	2,729	$ 19,712,717	$ 13,070,968

In addition, the State has identified $59 million in overpayments as a result of its behavioral health program reform efforts in 2007.

Methodology of the Review

In advance of an onsite visit, the review team requested that DMA complete a comprehensive review guide and supply documentation in support of its answers to the review guide. The review guide included such areas as provider enrollment, claims payment and post-payment review, managed care, Surveillance and Utilization Review Subsystem, and the MFCU. A five-person review team reviewed the responses and materials that the State provided in advance of the onsite visit. During the week of February 18, 2008, the MIG review team met with numerous agency and MFCU officials.

Scope and Limitations of the Review

This review focused on the activities of the PI Section, but also considered the work of other components and contractors responsible for a range of complementary functions, including provider enrollment, data mining, and legal support. NC Health Choice for Children is a combination stand-alone and Medicaid expansion health insurance program under SCHIP. The stand-alone portion of the program was not included in this review. The same findings and

vulnerabilities discussed in relation to the Medicaid expansion program also apply to the Medicaid portion of SCHIP.

Unless otherwise noted, DMA provided the program integrity-related staffing and financial information cited in this report. For purposes of this review, the review team did not independently verify any staffing or financial information that DMA provided.

RESULTS OF THE REVIEW

Effective Practices

The State has highlighted several practices that demonstrate its commitment to program integrity. These practices include enhancing provider enrollment packages by adding a Deficit Reduction Act (DRA) attestation, collaboration between the Divisions of Medical Assistance and Mental Health, and utilizing State permissive exclusion authority to remove aberrant providers from the Medicaid program.

DRA letter of attestation

A Letter of Attestation has been added to Medicaid enrollment packages stating that if the entity receives more than $5 million in reimbursement, it will comply with Section 6032 of the DRA regarding the provision of employee education on the Federal False Claims Act. This enhancement places the education requirement on the provider at the time of enrollment.

Collaboration with Division of Mental Health (DMH)

DMA has collaborated with DMH to conduct audits of behavioral health providers. The review process is enhanced by the Divisions' shared policy and integrity experience.

Use of permissive exclusion authority

North Carolina uses its permissive exclusion authority to remove aberrant providers. The State identified and terminated two providers based on their billing practices, not providing records, and providing unauthorized or undocumented services.

Additionally, the CMS review team identified three practices that are particularly noteworthy. CMS recognizes the State's use of at-will provider contracts, enhancements to EOMB information and usage, and including the PI Section in pre-release review of DMA policy statements.

Use of At-Will Provider Contracts

The State provided three examples of how it may terminate provider contracts at will. In one case, the provider failed to comply with DMH rules, clinical policy, regulations and guidance. In the second case, the provider failed to provide documentation of services rendered and billed. A third provider had questionable quality of care and billing practices.

Enhancing Verification of Services Rendered
North Carolina follows up on every returned explanation of medical benefits (EOMB) by documenting each EOMB returned and telephoning the recipient. The State also recently added four questions to EOMBs which the State believes has increased the rate of return from 12 percent in 2005 to 50 percent currently.

Commenting on Policy Issuances
New DMA policy issuances are sent to the PI Section for comment before being released. This practice affords the State a critical review of policies by the PI Section that may ultimately be interpreted and enforced by the PI Section.

Regulatory Compliance Issues

The State does not comply with four Federal regulations related to required disclosure and notification activities. Two of the four findings regarding a failure to require disclosures were identified in a Single State Audit for SFY 2006.

DMA does not meet Federal disclosure requirements concerning the ownership and control of providers and subcontractors.
Under 42 CFR § 455.104(a)(1), a provider, or "disclosing entity," that is not subject to periodic survey under § 455.104(b)(2) must disclose to the Medicaid agency, prior to enrolling, the name and address of each person with an ownership or controlling interest in the disclosing entity or in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of five percent or more. Additionally, under § 455.104(a)(2), a disclosing entity must disclose whether any of the named persons is related to another as spouse, parent, child, or sibling. Moreover, under § 455.104(a)(3), there must be disclosure of the name of any other disclosing entity in which a person with an ownership or controlling interest in the disclosing entity has an ownership or controlling interest. Finally, under § 455.104(c), fiscal agents must disclose ownership and control information at the time of contracting.

The Single State Audit for SFY 2006 identified 40 of 72 provider types for which the State failed to collect required ownership and control disclosures. The CMS review team also observed that although current DMA provider enrollment forms capture the names of individuals who own or have controlling interests in disclosing entities or providers and their familial relationships, they do not gather that information for related subcontractors. The out-of-state provider, hospital, and pharmacy enrollment applications do not require submission of the identity of other disclosing entities in which these individuals have an ownership or controlling interest. In addition, the PBH hospital credentialing application does not capture ownership information, and the PBH credentialing applications for other provider types solicit no ownership or control information. The State's contract with EDS, dating to 1989, does not require disclosure of ownership and control information. The State did not indicate whether EDS provided required ownership and control information.

***Recommendations*:** Modify FFS provider enrollment and managed care credentialing packages to request the full range of disclosure information required under § 455.104(a). Modify the

contract with EDS to require disclosure of ownership and control information and obtain those disclosures from EDS.

DMA does not meet Federal disclosure requirements concerning business transactions.
The regulation at 42 CFR § 455.105(b) requires that upon request, providers furnish to the State or HHS information about certain business transactions with wholly owned suppliers or any subcontractors. While the FFS Hospital Provider Agreement requires such disclosures, no other provider enrollment agreements require these disclosures. PBH does not require such disclosures in its managed care provider credentialing agreements.

***Recommendation*:** Modify FFS provider enrollment and managed care credentialing packages to incorporate the appropriate business transaction language.

DMA does not meet Federal regulations requiring the disclosure of criminal conviction information.
The regulation at 42 CFR § 455.106 stipulates that providers must disclose to Medicaid agencies any criminal convictions related to Medicare, Medicaid, or Title XX programs at the time they apply or renew their applications for Medicaid participation or at any time on request. The regulation further requires that the Medicaid agency notify HHS-OIG whenever such disclosures are made.

The Single State Audit for SFY 2006 identified 40 of 72 provider types for which the State failed to collect required criminal conviction information. The CMS review team also observed that although the hospital, pharmacy and out-of-state provider enrollment applications capture criminal conviction information for providers, owners, and managing employees, the individual and group physician applications do not request the required criminal conviction information. This omission in turn prevents DMA from forwarding information on providers, owners, and managing employees to HHS-OIG within 20 working days, as required by the regulation. PBH collects felony and misdemeanor conviction information in general for individual practitioners but does not ask for other criminal conviction information in its other credentialing applications.

***Recommendations*:** Modify FFS provider enrollment and managed care credentialing packages for all provider types to request provider, owner, agent and managing employee criminal conviction information. Refer that information to the HHS-OIG as required.

DMA does not report to the HHS-OIG adverse actions it takes on provider applications.
The regulation at 42 CFR § 1002.3(b)(2) and (b)(3) requires reporting to HHS-OIG any adverse actions a State takes on provider applications for participation in the program. DMA's provider enrollment staff indicated that DMA does not report to HHS-OIG any adverse actions it takes on provider applications or actions taken to limit provider participation in the program.

***Recommendation*:** Submit appropriate reports to HHS-OIG regarding adverse actions that DMA takes on any provider's application for participation.

Areas of Vulnerability

The review team identified five areas of vulnerability in DMA's practices related to provider enrollment disclosure, verification of licensure, case tracking, and oversight of some services paid outside of the MMIS.

Not capturing managing employee information on its provider enrollment forms

Under 42 CFR § 455.101, a managing employee is defined as "a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operations of an institution, organization or agency." DMA and PBH do not solicit managing employee information in all provider enrollment packages. Thus, DMA and PBH would have no way of knowing if excluded individuals are working for providers or health care entities in such positions as billing managers and department heads.

***Recommendation*:** Modify FFS provider enrollment and managed care credentialing packages to require disclosure of managing employee information.

Not verifying out-of-state provider licenses during the application process

A provider applying to participate in North Carolina Medicaid must submit a copy of its license with the provider enrollment package. An out-of-state provider may not be enrolled unless it has provided services to a North Carolina Medicaid recipient and submitted a claim for services. DMA reviews the out-of-state license for effective date and name, but does not contact the issuing state's licensing agency to verify the license or to determine if out-of-state provider licenses have limitations imposed that were never reported.

***Recommendation*:** Verify licenses prior to enrolling out-of-state providers in the Medicaid program.

Not capturing information on owners, officers and managing employees in MMIS

While some provider applications capture owner, officer and managing employee information, only individual provider and entity names are captured in the MMIS. Therefore, DMA can not check them for exclusions either at enrollment or any time after. Additionally, management changes at PBH and with subcontracted providers are not captured in the MMIS, so DMA cannot check them for exclusions.

***Recommendation*:** Modify MMIS to capture owner, officer and managing employees in the MMIS provider database.

Not maintaining an effective fraud and abuse case tracking system
DMA's current fraud and abuse case tracking system uses a Microsoft Access database that has limitations affecting the effectiveness of the database, including lack of secured access, inability to track which user entered which data, and constraints from inadequate data fields. Although a new case tracking database was proposed in 2005, no resources have been earmarked for this project.

***Recommendation*:** Modify the tracking system to increase security and enhance utility of the stored data.

Not adequately conducting oversight of the NEMT program
In North Carolina, each of the 100 counties is responsible for its own Medicaid NEMT and each has unique requirements for this service which complicate DMA's oversight efforts. DMA has advised that they have not consistently checked on whether the counties verify delivery of services, check for exclusions, and request disclosures regarding owners and managing employees.

Total State NEMT payments during SFY 2007 were in excess of $33 million, which was offset against each county's share of Medicaid reimbursement. A DMA program integrity review conducted between calendar years 2002 and 2007 in 60 counties scrutinized one month of transportation services in each county and revealed $38,380 in billing inconsistencies and numerous procedural issues. DMA considered the review for educational purposes only and did not seek recovery of the overpayments, but issued administrative guidance on July 12, 2007.

***Recommendations*:** Provide consistent oversight of the NEMT program, such as issuing guidance to the counties on obtaining provider disclosures, checking for excluded providers, and verifying the delivery of services billed. Recover the overpayments identified in the State's program integrity review and return the Federal share. Conduct a new comprehensive, Statewide audit of county reimbursements for Medicaid transportation costs and return the Federal share of any identified overpayments. Review services before and after implementation of the Corrective Action Plans put in place as a result of the transportation audit described in the July 12, 2007, DMA Administrative Letter No. 04-07 to demonstrate the effectiveness of DMA's education and the counties' corrective actions.

CONCLUSION

The State of North Carolina applies some effective practices that demonstrate program strengths and the State's commitment to program integrity. These effective practices include:

- the use of permissive exclusion authority to remove aberrant providers
- adding a Letter of Attestation to Medicaid enrollment packages for DRA compliance
- collaboration between DMA and DMH to conduct audits of behavioral health providers

- effective use of at-will provider contracts
- pre-release review of new DMA policy statements by the PI Section
- the addition of four questions to EOMBs

CMS supports the State's efforts and encourages the State to look for additional opportunities to improve overall program integrity.

However, the identification of four areas of non-compliance with Federal regulations is of concern and should be addressed immediately. That two of those issues were also identified in the Single State Audit for SFY 2006 is particularly troubling. In addition, five areas of vulnerability were identified. CMS encourages DMA to closely examine each of the five areas of vulnerability that were identified in the review.

It is important that these issues be rectified as soon as possible. To that end, we will require DMA to provide a corrective action plan for each area of non-compliance within 30 calendar days from the date of the final report letter. Further, we will request the State include in that plan a description of how it will address the vulnerabilities identified in this report.

The corrective action plan should address how the State of North Carolina will ensure that the deficiencies will not recur. It should include timeframes for each correction along with the specific steps the State expects will occur. Please provide an explanation if correcting any of the areas of non-compliance or vulnerability will take more than 90 calendar days from the date of the letter. If DMA has already taken action to correct compliance deficiencies or vulnerabilities, the plan should identify those corrections as well.

The Medicaid Integrity Group looks forward to working with the State of North Carolina on correcting its areas of non-compliance, eliminating its areas of vulnerability, and building on noteworthy practices.