Department of Health and Human Services

Centers for Medicare & Medicaid Services

Center for Program Integrity

North Carolina Focused Program Integrity Review

Final Report

May 2016

Submitted By:
Mark Rogers, Review Team Leader
Sandra Christensen
Horace Dozier
Gloria Franco

Table of Contents

Objective of the Review

The Centers for Medicare & Medicaid Services (CMS) conducted a focused review of North Carolina's Medicaid program to determine the extent of program integrity oversight of the managed care and non-emergency medical transportation (NEMT) programs at the state level and assess the program integrity activities performed by selected behavioral health managed care entities, operating in North Carolina as prepaid inpatient health plans (PIHPs) pursuant to 42 CFR Part 438.

This review focused primarily on efforts by the state, PIHPs, and NEMT providers to prevent and detect fraud and abuse on the part of network providers and NEMT vendors. The review also included a follow up on the state's progress in implementing the corrective action plan (CAP) that resulted from CMS's last program integrity review in September 2011.

Background: State Medicaid Program Overview

North Carolina's Medicaid program had approximately 1.8 million beneficiaries in state fiscal year (SFY) 2014 and total computable Medicaid expenditures of approximately $13.65 billion. Since 2005, North Carolina has operated a limited benefit, pre-paid program under its 1915(b)/(c) waiver for Mental Health, Developmental Disability, and Substance Abuse Services. The program began as a five county pilot in the Piedmont region and became statewide in 2013. The 1915(b)/(c) waiver used public local management entities (LMEs) to manage behavioral health and developmental disabilities services for most Medicaid beneficiaries with behavioral health needs on a mandatory basis. The eight PIHPs, formerly called LMEs, represent the only risk-based Medicaid managed care program in North Carolina. The PIHPs contract with the North Carolina Department of Health and Human Services (DHHS) and are paid a per-member per-month capitation payment to manage the delivery of mental health and other services for 1.45 million Medicaid members through a network of licensed practitioners and provider agencies. They are governed by area boards consisting of representatives from the county commissioners in their service areas and their appointees. The state paid $2.43 billion to the eight PIHPs in federal fiscal year (FFY) 2014.

North Carolina does not participate in Medicaid expansion under provisions of the Affordable Care Act.

Title XIX of the Social Security Act does not specifically mandate provision of transportation as a Medicaid service. However, federal regulations and interpretations of Title XIX of the Social Security Act authorize states to cover transportation as either an optional service and/or as an administrative service. North Carolina has federal approval to claim transportation as an administrative service reimbursement for transportation arranged and paid by the North Carolina County Department of Social Services (County DSS) as an agent for the state.

Medicaid is required to assure transportation to medical appointments for all eligible individuals who need and request assistance with transportation. Transportation is available if the

beneficiary receives a Medicaid covered service provided by a qualified Medicaid provider. Medicaid only pays for the least expensive means suitable to the beneficiary's needs.

North Carolina spent $53.9 million dollars providing NEMT services to Medicaid beneficiaries in SFY 2015. The Division of Medical Assistance (DMA), Office of Recipient and Provider Services provides oversight of the NEMT services arranged for and provided by County DSS offices.

Methodology of the Review

In advance of the onsite visit, CMS requested that North Carolina complete a review guide that provided the CMS review team detailed insight to the operational activities of the areas that were subject of the focused review. The PIHPs selected for the focused review also completed review guides and the County DSS offices completed questionnaires. A four-person team from CMS reviewed the responses and materials that the state provided in advance of the onsite visit.

During the week of September 15, 2015, the CMS review team met with staff from the state's program integrity unit (PIU) and the special investigations units (SIUs) of the three PIHPs selected for review. The team conducted interviews with numerous state agency staff involved in program integrity and managed care. In addition, the CMS review team conducted sampling of program integrity cases and other primary data to validate the selected PIHPs' program integrity practices. The review team also interviewed NEMT providers as well as state staff responsible for overseeing these providers and the operation of the NEMT program.

Results of the Review

The CMS review team identified several areas of concern with the state's managed care program integrity activities thereby creating risks to the Medicaid program. These issues and CMS's recommendations for improvement are described in detail in this report. CMS will work closely with the state to ensure that all of the identified issues are satisfactorily resolved as soon as possible, especially those issues that remain from the previous review.

Section 1: Managed Care Program Integrity

Overview of the State's Managed Care Program

The PIU within DMA is principally responsible for providing program integrity oversight of North Carolina's Medicaid program. The PIU's behavioral health review unit oversees the behavioral health program integrity operations of the managed care program. The state paid approximately $2.43 billion in FFY 2014 to eleven PIHPs providing behavioral health services. Through consolidation, the number of PIHPs dropped to eight at the time of the review.

The state relies on the External Quality Review Organization (EQRO) to conduct annual oversight reviews of the PIHPs for contract compliance. The EQRO's reviews center around

quality and service delivery as mandated in the PIHPs' contracts. However, these reviews currently do not include substantive program integrity monitoring.

The state also has a contractor who, with the assistance of state program integrity staff, performs annual PIHP compliance reviews that include fraud, waste, and abuse procedures. All eight plans are reviewed annually, the most recent review being conducted in May 2015 at Cardinal Innovations Healthcare Solutions.

While it appears the oversight of PIHPs using annual reviews conducted by contractors and state staff provides valuable oversight, it is a concern that despite these follow-up activities, the PIHPs continue to not search the SSADMF and have a low number of fraud referrals to DMA. It was also reported that encounter data does not contain a full set of encounters to be useful for program integrity type analysis.

Summary Information on the Plans Reviewed

During the week of the onsite review, the CMS review team traveled to and met with the program integrity and other staff from Alliance Behavioral Healthcare, Eastpointe Human Services, and Cardinal Innovations Healthcare to discuss their provider enrollment and program integrity activities at length.

Cardinal Innovations Healthcare Solutions is the oldest and largest PIHP serving approximately 370,000 beneficiaries in its sixteen counties. Cardinal was formally known as Piedmont Behavioral Health, an LME, and has been in operation since 2005 when the waiver began. It participated in the state pilot project to provide new services with this type of delivery system. The successful outcome of the waiver led to the consolidation of the LME and PIHP. Cardinal's SIU is an independently functioning entity that is responsible for all lines of business. Cardinal reported that 81 percent of its business is Medicaid related.

Eastpointe Human Services began receiving Medicaid funding when it became a PIHP on January 1, 2013. It is currently more than 87 percent Medicaid serving approximately 180,000 beneficiaries. It is a local managed care contractor with four sites covering 12 counties.

Alliance Behavioral Healthcare is a local managed care contractor covering 220,000 beneficiaries in four counties, with Medicaid being 81 percent of its business. In addition, Alliance manages state and local county funding for behavioral health services. The SIU corporate office is located in Durham and has four field offices.

Below is summary data for the PIHPs reviewed:

Table 1: Summary Data for North Carolina PIHPs

PIHP	Medicaid Enrollees	Medicaid Contracted Providers	Size and Composition of SIU	Average Medicaid Expenditures (SFYs 2012-2014)
Cardinal	368,813	4,375	5.6 SIU FTEs*: 1 Manager (50 percent of time) 3 Special Investigators 1 Clinical Investigator 1.5 Data Analysts (Devotes 75 percent of time)	$271.7 million
Eastpointe	180,194	2,785	5.5 SIU FTEs: 1 Manager 4 Program Integrity Specialists 0.5 Data Analyst	$195.4 million
Alliance	219,632	2,431	4 SIU FTEs: 1 Manager 3 Investigators	$242.9 million

**Full time equivalent*

PIHP Program Integrity Activities

Investigations of Fraud, Waste, and Abuse

The state paid $1 billion to these three PIHPs in FFY 2014 which represents 42 percent paid to all of the PIHPs that year. All three PIHPs have distinct SIUs that handle program integrity issues, verify that services paid for were rendered, conduct fraud and abuse awareness training, and have a compliance plan that meets the requirements under 42 CFR 438.608.

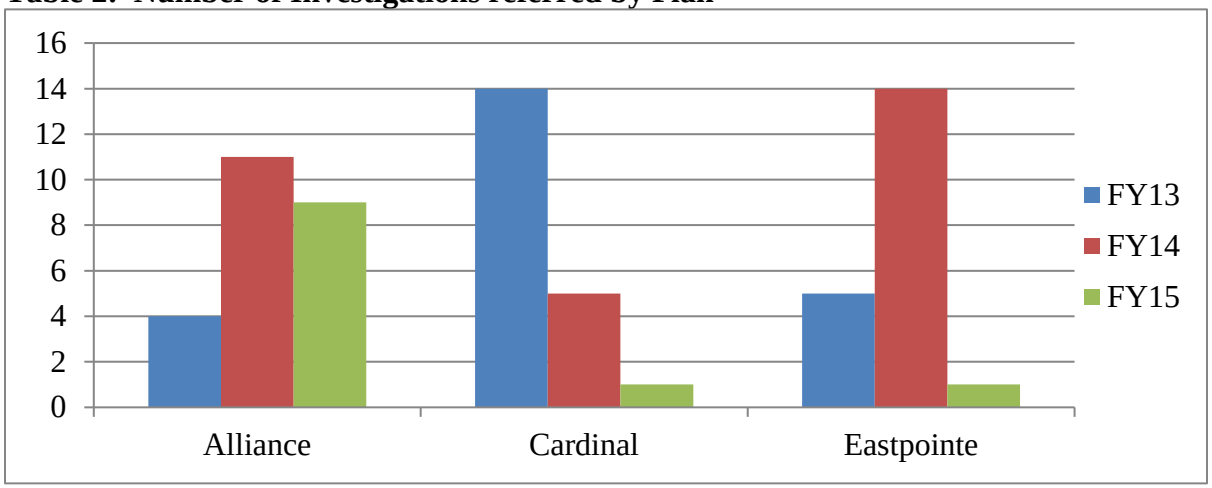
The PIHPs are complying with contract language requiring monthly reporting of provider cases opened, along with overpayments identified and collected, providers terminated and denied enrollment, provider self-audits, and potential fraud and abuse cases that were also reported at the time of discovery. However, when a problem provider's contract is not renewed and the provider is dropped from a PIHP's network, that information is not specifically reported to DMA where it can be disseminated to provider enrollment and other PIHPs.

All PIHPs are required to use a DMA-approved fraud and abuse management system to detect and prevent fraud, waste, and abuse in their networks. PIHPs are allowed by contract to keep any collected overpayments, but cannot take any administrative actions regarding allegations of

suspected fraud without DMA approval. The PIHPs do not utilize pre-payment review as a type of sanction.

The table below shows the number of cases that each plan referred to the state in the past three fiscal years.

Table 2: Number of Investigations referred by Plan



Meetings and Training

For programmatic oversight, the state utilizes the Interdepartmental Monitoring Team consisting of staff from finance, program integrity, and quality management departments. State program integrity staff meets quarterly with state managed care staff and the Medicaid Investigation Division (MID), the Medicaid Fraud Control Unit in North Carolina, to discuss provider trends, relevant cases, and potential fraudulent activities. Program integrity forums are held quarterly with the PIHPs and state managed care staff to discuss referrals, reporting, case files, and work plans. These meetings help increase the standardization across all PIHPs. Program integrity and state managed care staff also have oversight meetings every two weeks to discuss program integrity issues and other major oversight concerns, including encounter data, credentialing, provider monitoring, and records retention. The most recent oversight meeting was held in July 2015. All of these meetings provide the opportunity for program integrity instruction and training.

Additional program integrity training takes place during joint training for PIHP and state managed care staff and is presented by program integrity and the MID. The latest joint training was held in April 2015. The state also holds annual summits to educate the PIHPs about program integrity. The last summit was held in October 2014.

The PIHPs provide a variety of fraud and abuse training to their staff and network providers. Training for employees includes the False Claims Act and Anti-Kickback Statute, identifying and reporting fraud and abuse, the compliance program, and conflicts of interest. Network provider education conducted by the PIHPs includes an overview of the SIU, the False Claims

Act, and defining fraud and abuse. In a joint effort, Alliance Behavioral Healthcare, along with other PIHPs, developed a program integrity program for providers and presented it at the recent annual summit. This training covered the purpose of program integrity; definitions of fraud, waste, and abuse; program integrity responsibilities; and types of investigations and outcomes.

Encounter Data

The PIHP's contract with the state requires the submission of an electronic record for every encounter between a network provider and an enrollee, and the PIHPs are subject to sanctions for late or incomplete submissions. No sanctions have been imposed as there have been systems issues that have added to submission difficulties that the state is currently working on to correct.

Overpayment Recoveries, Audit Activity, and Return on Investment

The PIHP contracts describe how the PIHPs should use data mining and complaints to identify, track, and report overpayments. Various departments in the PIHPs provide leads that may result in an audit or investigation. The PIHP's SIU is responsible for initiating a preliminary investigation upon the receipt of an allegation of fraud and reporting it to DMA within five days of its determination.

The PIHP contract with the state allows for the PIHP to collect and retain an overpayment that is not potentially fraud related. These overpayments must be reported monthly to DMA and are incorporated into the next rate setting. However, the PIHP is not allowed to take administrative action regarding allegations of suspected fraud on any providers referred to DMA program integrity. Any administrative action must be with DMA approval or direction.

The tables below indicate the number of investigations by the North Carolina PIHPs and the overpayments identified and collected by each of the PIHPs for the past four years.

Table 3A: Investigations and Overpayments collected by Cardinal

SFY	Number of Preliminary Investigations	Number of Full Investigations	Amount of Overpayments Identified and Collected
2012	*	37	$40,979
2013	*	101	$38,855
2014	*	82	$ 298,466
2015	75	101	$ 71,408

**Information not tracked by PIHP at this time*

Table 3B: Investigations and Overpayments collected by Eastpointe

SFY	Number of Preliminary Investigations	Number of Full Investigations	Amount of Overpayments Identified and Collected
2012	*	*	N/A
2013	0	39	$215,150
2014	2	82	$113,814
2015	132	57	$234,840

**PIHP began operations in 2013*

Table 3C: Investigations and Overpayments collected by Alliance

SFY	Number of Preliminary Investigations	Number of Full Investigations	Amount of Overpayments Identified and Collected
2012	*	*	N/A
2013	35	4	$264,532
2014	54	11	$152,367
2015	29	9	$12,728

**PIHP began operations in 2013*

Alliance Behavioral Healthcare is the only one of the three PIHPs interviewed that does not calculate return on investment (ROI). The other two calculate ROI by dividing recoupments by the program integrity budget for the year. Cost avoidance is included as part of the ROI calculation.

Payment Suspensions

The PIHP contract with DMA requires that all suspected provider fraud and abuse cases be referred to the state immediately where a preliminary investigation will determine if a full investigation is needed and whether to make an appropriate referral to the Medicaid fraud control unit pursuant to 42 CFR 455.23. All three PIHPs follow this requirement and do not suspend payments to a network provider based on a credible allegation of fraud without DMA approval. Only Cardinal Innovations Healthcare Solutions reported having internal determinations to suspend network provider payments for other reasons.

Terminated Providers and Adverse Action Reporting

The PIHP contract with DMA states that the PIHP must report all provider terminations quarterly, including the reason for the termination and the effective date. The PIHPs do report terminations to program integrity at DMA. However, if a problem provider's contract is not renewed, that information is not reported to the state. Other adverse actions related to a fraud referral or investigation are discussed at quarterly meetings and forums with the state and other PIHPs.

The table below depicts the number of terminated providers reported by each of the PIHPs. Regardless of how many providers a plan has enrolled (refer to Table 1), the number of providers terminated for cause are similarly low across the plans interviewed.

Table 4: Provider Terminations in Managed Care

Selected PIHPs	No. Providers Disenrolled or Terminated in Last 3 Completed FFYs		No. Providers Terminated for Cause in Last 3 Completed FFYs	
Cardinal	2013 2014 2015	* 155 6	2013 2014 2015	* 6 1
Eastpointe	2013 2014 2015	11 29 3	2013 2014 2015	5 14 1
Alliance	2013 2014 2015	100 100 118	2013 2014 2015	2 2 3

**Information not tracked by PIHP at this time*

Federal Database Checks

The regulation at 42 CFR 455.436 requires that the state Medicaid agency must check the exclusion status of the provider, persons with an ownership or control interest in the provider, and agents and managing employees of the provider on the U.S. Department of Health and Human Services-Office of Inspector General's List of Excluded Individuals and Entities, the Excluded Parties List System (EPLS) on the System for Award Management, the Social Security Administration's Death Master File (SSADMF), the National Plan and the Provider Enumeration System upon enrollment and reenrollment; and check the List of Excluded Individuals and Entities and EPLS no less frequently than monthly.

The DMA delegates enrollment and reenrollment processes to the PIHPs. Network providers are not required to be enrolled in Medicaid prior to applying to a PIHP. DMA relies on the PIHPs to perform all of the required federal database checks for managed care providers who are initially enrolling, re-enrolling, reactivating or revalidating, or when there is a requested change of ownership. The contract between DMA and the PIHPs requires the PIHPs to search the SSADMF in accordance with 42 CFR 436. Of the three PIHPs interviewed, only Alliance reported checking providers against the SSADMF upon enrollment and reenrollment. All other database checks were conducted by the three PIHPs upon enrollment and reenrollment and on a monthly basis thereafter.

The state should monitor PIHPs' compliance with contractual requirements for checking the Social Security Administration's SSADMF when credentialing.

Section 2: NEMT Oversight

The DMA uses a contractor to supply most of its NEMT oversight through annual compliance reviews of each of the 100 counties in North Carolina. The compliance reviews were conducted between June 2012 thru February 2013 with a second year of reviews conducted between November 2013 and June 2014, and a third year of reviews starting in October 2015 which targeted the 43 counties that had the most review findings in the first two review years. Draft reports are issued at the end of the onsite review and the County DSS has 30 days to correct deficiencies identified. The final review reports are sent to County DSS and DMA identifying original findings, corrective actions, and outstanding issues. These reviews provide general oversight of NEMT operations and contract compliance including capturing vendor owners and managing employee information and whether the county conducts searches for those individuals for federal exclusions.

The ability of each vendor to monitor and check on the appropriateness and accuracy of ride documentation and billings vary greatly. However, the NEMT providers have not reported potential NEMT network provider fraud to DMA and Durham County does not have a policy to do so and has not had any investigations of providers in the past ten years. While adverse actions taken against a provider must be searched for and reported, driver or vendor fraud cases are not sought out by the counties even though they have program integrity units available.

The DMA has a memorandum of understanding with each County DSS-NEMT provider and has limited oversight of NEMT vendors and drivers, due to not having them directly enrolled in the Medicaid Management Information System. In addition, DMA also uses a voucher system to pay the counties, which hinders their ability to have oversight of trip payments for program integrity purposes. The state has no policy to receive, identify, or specifically work potential NEMT provider fraud cases other than a proactive policy to work any fraud case that may be identified through call-in numbers, web-sites, or other means. The only exception is for ambulance providers and this is because they are enrolled by the state and not by the County DSS vendors.

The DMA does receive reports from the counties of adverse actions taken against vendors and drivers based on searches of the state penalty tracking and federal exclusion databases and criminal background checks, as requested in the prior CMS review. However, state and contractor monitoring of County DSS operations do not evaluate the vendor‘s driver enrollment processes or the ability of County DSS to identify potentially fraudulent drivers or vendors. Two of the areas included in KFH Group (consultants to the transit industry) reviews are record keeping and ensuring compliance with state and federal regulations, including, but not limited to the disclosure regulations at 42 CFR 455.104-106. The team’s review of the KFH reports show that some of the issues initially identified are later determined to be acceptable with corrective actions or post-review determinations made within 30 days of the onsite review. Below are a few examples where initial findings were identified, but were deemed corrected by KFH with no final finding or additional follow-up required.

The contractor's 11/10/2014 report for Durham County shows:

- In the area of NEMT vendor monitoring, it was determined there is a standard contract clause missing that the vendor shall disclose all information required by 42 CFR 455.104, 105, and 106. This requirement along with the requirement to report adverse actions taken against NEMT vendors and providers to DMA (added as a result of CMS's Medicaid Integrity Group comprehensive review in September, 2011) were communicated to all County Directors of Social Services on 05/31/2012. As a result, adverse actions identified by the County DSS are being reported to DMA. As a corrective action, the disclosure clause was being added to the SFY 2014/SFY 2015 contracts with the two County DSS vendors and the contractor determined no final finding. It is unclear if the PIU conducts follow-up reviews for compliance.
- For 16 randomly selected trip files missing trip information, County DSS could confirm that the beneficiary had attended the appointment or that the trip had not been billed to Medicaid. A corrective action reply was submitted to DMA. However, the contractor did not treat the fact that the trip files lacked proper documentation as a final finding.

The contractor's 11/19/2014 report for Wake County shows:

- There was no indication that the contract clause requiring the vendor to disclose all information required by 42 CFR 455.104, 105, and 106 as was done for Durham County. One requirement to review the vendor's contract with County DSS showed the FY 2013 contract to be incomplete. This may be the vendor monitoring requirement mentioned above that was conducted in Durham County, but was not evaluated because the 2014 contract was in the process of being finalized during their onsite review and no finding was reported. No final finding was issued. This requirement was communicated to all County Directors of Social Services on 05/31/2012.
- For 23 of the 44 trips selected for review, the trip verification form had correct names and dates of service. However, it was reported that dialysis center reporting requirements had not been implemented by County DSS at the time of KFH's review, but were reporting attendance and dates at the time the report was issued and KFH reported no finding on this issue. It is not clear if all of the 21 trips with insufficient name and date reporting were all attributable to dialysis centers or if there were other provider types as well. No final finding was issued.

Section 3: Status of Corrective Action Plan

North Carolina's last CMS program integrity report was issued in 2012 and contained seven findings and eight vulnerabilities. On December 3, 2012, staff from CMS held a conference call with the state on its CAP developed in response to the issues identified. On December 14, 2012, CMS responded to the state highlighting two issues considered still outstanding from the CAP. Only one CAP issue from North Carolina's previous review is still outstanding:

Regulatory Compliance Issue #5 noted that the State does not conduct complete exclusion searches. CMS's response to the state's CAP noted that EPLS checks at enrollment and no less

frequently than monthly were not being completed for the fee-for-service program. The EPLS is still not being searched as required by the regulation at 42 CFR 455.436.

Recommendations for Improvement in Managed Care and NEMT

1. The state should monitor PIHPs' compliance with contractual requirements for checking the SSADMF when credentialing and re-credentialing providers in accordance with 42 CFR 455.436 and correct the regulatory citation in the PIHP contract.
2. The state should supplement contractor oversight of PIHPs with program integrity specific monitoring, reviews, and follow-up activities to include determining why fraud referrals have decreased and assist PIHPs in their fraud and abuse detection.
3. The state should modify PIHP contracts to include the reporting to DMA of provider contracts not being renewed and not just those terminated or denied enrollment.
4. The state should continue its efforts to correct system issues affecting the submission of encounter data and assist PIHPs in submitting complete and accurate encounter data.
5. The state should develop policies and procedures to monitor and review the NEMT program integrity operations in the County DSS offices to include assisting in the identification and referral of program integrity issues to DMA; tracking and verifying services rendered to beneficiaries; and enrolling providers in the NEMT program.
6. In order to satisfy the outstanding issue from the CAP review, search the EPLS when enrolling and re-enrolling Medicaid providers as identified in the last CMS comprehensive report.
7. Based on the size of the managed care program, the state should address low referral numbers and the lack of reporting of all suspected fraud cases to the state Medicaid agency and/or MFCU by strengthening its contract language and/or the policies which promote PIHP participation in the identification of fraud and abuse.
8. The state should develop policies and implement procedures to monitor and review NEMT services to ensure necessary services are delivered and reimbursed appropriately by qualified vendors and drivers.

Technical Assistance Resources

To assist the state in strengthening its program integrity operations, CMS offers the following technical assistance resources for North Carolina to consider utilizing:

- Use the program integrity review guides posted in the Regional Information Sharing Systems as a self-assessment tool to help strengthen the state's program integrity efforts. Access the managed care folders in Regional Information Sharing Systems for information provided by other states including best practices and managed care contracts.
- Continue to take advantage of courses and trainings at the Medicaid Integrity Institute which can help address the risk areas identified in this report. Courses that may be helpful to North Carolina based on its identified risks include those related to managed care. More information can be found at http://www.justice.gov/usao/training/mii/.

- Regularly attend the Fraud and Abuse Technical Advisory Group and the Regional Program Integrity Directors calls to hear other states' ideas for successfully managing program integrity activities.
- Access the annual program integrity review summary reports on the CMS's website at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/StateProgramIntegrityReviews.html. These reports contain information on noteworthy and effective program integrity practices in states. We recommend that North Carolina review the effective and noteworthy practices in program integrity and consider emulating these practices as appropriate.
- Access the Toolkits to Address Frequent Findings: 42 CFR 455.436 Federal Database Checks website at http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/fftoolkit-federal-database-checks.pdf.

Conclusion

CMS supports North Carolina's efforts and encourages it to look for additional opportunities to improve overall program integrity. The CMS focused review identified areas of concern which should be addressed immediately.

We require the state to provide a CAP for each of the recommendations within 30 calendar days from the date of the final report letter. The CAP should address all specific risk areas identified in this report and explain how the state will ensure that the deficiencies will not recur. The CAP should include the timeframes for each correction along with the specific steps the state expects will take place, and identify which area of the state Medicaid agency is responsible for correcting the issue. We are also requesting that the state provide any supporting documentation associated with the CAP such as new or revised policies and procedures, updated contracts, or revised provider applications and agreements. The state should provide an explanation if corrective action in any of the risk areas will take more than 90 calendar days from the date of the letter. If the state has already taken action to correct compliance deficiencies or vulnerabilities, the plan should identify those corrections as well.

CMS looks forward to working with North Carolina to build an effective and strengthened program integrity function.

Official Response from North Carolina
June 2016

North Carolina Department of Health and Human Services

Pat McCrory
Governor

Richard O. Brajer
Secretary

June 20, 2016

Laurie Battaglia, Acting Director
Center for Medicare & Medicaid Services
Investigations and Audits Group
7500 Security Boulevard
Mail Stop AR-21-55
Baltimore, Maryland 21244-1850

Dear Ms. Battaglia:

We have reviewed your final report entitled *North Carolina Focused Program Integrity Review*. The areas of concerns identified in the report have been reviewed in detail and are duly noted. The following represents our response and corrective action plan to the Recommendations for Improvements identified in this report and the outstanding Corrective Action Plan item identified in the 2011 CMS review.

Recommendations for Improvement in Managed Care and NEMT

1. The state should monitor PIHPs' compliance with contractual requirements for checking the SSADMF when credentialing and re-credentialing providers in accordance with 42 CFR 455.436 and correct the regulatory citation in the PIHP contract.

DHHS Response: Effective July 1, 2016, the state will update Section 7.8, Network Provider Qualification, of the prepaid inpatient health plans (PIHP) contract to correct the regulatory citation and add the requirement to check the Social Security Administration's Death Master File (SSADMF) during credentialing and re-credentialing. *See Attachment A: Amendment 2 Division Contract #3*.

The state will monitor PHIPs compliance with the SSADMF requirement during the annual onsite External Quality Review (EQR) process which will include a review of the credentialing and re-credentialing files. The mandatory protocol for EQR is documented in *Attachment B: EQR Protocol 1 Assessment of Compliance with Medicaid Managed Care Regulations*. The state has already begun work with the PIHPs to ensure that the SSADMF database search will occur during their credentialing and re-credentialing procedures. PIHPs cited for non-compliance with the SSADMF requirement during the EQR will be required to submit a corrective action plan to remediate the issue.

The compliance review process to verify that the SSADMF has been checked by the PIHPs at credentialing and re-credentialing began on June 2, 2016.

www.ncdhhs.gov
Telephone 919-855-4800 • Fax 919-715-4645
Location: 101 Blair Drive • Adams Building• Raleigh, NC 27603
Mailing Address: 2001 Mail Service Center • Raleigh, NC 27699-2001