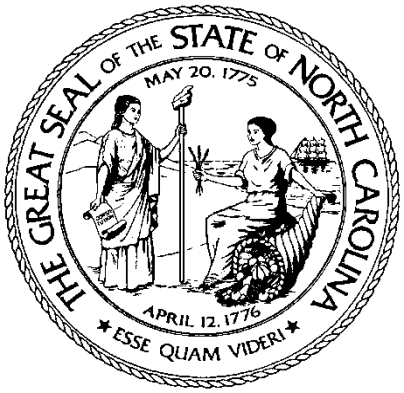

STATE OF NORTH CAROLINA

PERFORMANCE AUDIT

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF MEDICAL ASSISTANCE

MEDICAID PROVIDER ELIGIBILITY

AUGUST 2014

OFFICE OF THE STATE AUDITOR

BETH A. WOOD, CPA

STATE AUDITOR

EXECUTIVE SUMMARY

PURPOSE

This audit evaluated the process to enroll only qualified providers in the North Carolina Medicaid program.

BACKGROUND

The Department of Health and Human Services' Division of Medical Assistance (Division) is responsible for establishing qualification requirements for Medicaid providers and enrolling the providers. All providers (individuals or organizations) must apply through an application process that includes investigating the provider's past and verifying all applicable licenses and credentials.

The Division outsources a major part of the application review process to Computer Sciences Corporation, Inc. (Contractor). The contract for provider enrollment application reviews was $4.6 million in fiscal year 2012 and $5.3 million in fiscal year 2013. The North Carolina Medicaid Program spends around $13.5 billion annually in federal and state funds.

KEY FINDINGS

- Deficiencies in the enrollment process increase the risk of unqualified providers participating in the Medicaid Program.
- Documentation to support higher risk provider applications is often not available or insufficient to support the application approval.
- The Contractor's enrollment review procedures do not provide reasonable assurance that only qualified providers are approved to participate in the NC Medicaid program.
- The Contractor does not always have evidence to support that mandatory verification checks were completed.
- Quality assurance reviews were not conducted or were ineffective.
- Contract lacks adequate performance measures to hold the Contractor accountable for processing applications accurately and reliably.

KEY RECOMMENDATIONS

- Specific evidence requirements for determining and documenting provider eligibility should be added to enrollment process procedures.
- The contract between the State and the Contractor should establish documentation requirements and performance measures for accuracy and reliability.
- Systematic quality assurance reviews of the enrollment processes should be conducted.

*The key findings and recommendations in this summary are not inclusive of all the findings and recommendations in the report.

AUDITOR'S TRANSMITTAL

August 14, 2014

The Honorable Pat McCrory, Governor
The General Assembly of North Carolina
Dr. Aldona Wos, Secretary, Department of Health and Human Services

Ladies and Gentlemen:

We are pleased to submit this performance audit titled "*Division of Medical Assistance – Medicaid Provider Eligibility*." The audit objective was to evaluate the process to enroll only qualified providers in the North Carolina Medicaid program.

Department of Health and Human Services Secretary Dr. Aldona Wos reviewed a draft copy of this report. Her written comments are included after each finding and in Appendix C.

Some of the statements in the response could mislead readers of the report. An Auditor's Comment is included in Appendix B.

The Office of the State Auditor initiated this audit to ensure that tax dollars are paid to, and Medicaid recipients are served by, only qualified providers.

We wish to express our appreciation to the staff of the Department of Health and Human Services for the courtesy, cooperation, and assistance provided us during the audit.

Sincerely,

Beth A. Wood

Beth A. Wood, CPA
State Auditor

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BACKGROUND

All individuals or organizations (providers) who deliver health services or goods to Medicaid recipients must apply through an application process. The application review process investigates the providers' past and verifies all licenses and credentials. Without approval, the providers cannot receive Medicaid payments for provided services.

The screening and enrollment of Medicaid providers is required by federal laws and regulations implemented to help prevent fraud, waste and abuse. Federal laws instruct the states on screening providers based on categories of risk for fraud and abuse. High risk providers receive the highest level of scrutiny.

Federal laws do not set standards or criteria to determine a provider's enrollment qualifications. That decision is left to the state Medicaid agency.

The Department of Health and Human Services' Division of Medical Assistance (Division) is responsible for setting qualification requirements and enrolling providers. Within the Division, the Provider Relations Section is directly responsible for ensuring that approved Medicaid providers meet qualification requirements.

The Division outsources the application review process to Computer Sciences Corporation, Inc. (Contractor). The Office of Medicaid Management Information Systems Services oversees the contract with the Contractor. The portion of the contract that covers provider enrollment accounted for $4.6 million in fiscal year 2012 and $5.3 million in fiscal year 2013.

The provider enrollment process is the first step in program integrity efforts to help prevent fraud and abuse in North Carolina's Medicaid Program. Currently, Medicaid spends about $13.5 billion annually in federal and state funds.

The Provider Enrollment Process

The provider enrollment process begins when a provider submits an application. The Contractor runs several searches to identify potential areas of concern, including various background checks. If the background checks are clean and the provider's licenses or credentials are valid, then the Contractor approves the application. If the searches identify negative background history or past sanctions against licenses or credentials, the Contractor has the authority to deny certain applications based on specific rules developed by the Division. For negative results not covered by these rules, the Contractor sends applications to the Division's Provider Relations Section for a secondary review (see Provider Enrollment Process Flowchart in Appendix A).

There are four areas in the verification and credentialing process that could prompt the Contractor to send the application to the Division for a secondary review:

- Provider Penalty Tracking Database: Online database maintained by the Department of Health and Human Services that maintains a list of penalties and sanctions levied against providers;

- Office of Inspector General Exclusion Database: Federal government's list of providers who are excluded from any federal health care programs

- Intellicorp criminal background report: Background check that identifies criminal convictions, misdemeanors or felonies committed by the providers, owners, and managers disclosed on the application; and

- Licensing or Health Information Protection Database: Online database that returns results for providers that have had penalties, sanctions, suspensions or terminations imposed by a professional licensing board such as a state Medical Board.

When the Provider Relations Section receives an escalated application from the Contractor, the Division enrollment specialists determine whether a provider with negative results noted in any of the four areas should be approved or denied.

In 2012, 33 providers were convicted of Medicaid fraud and abuse and the State recovered $10.2 million in fraudulent and abusive Medicaid claims. In 2013, 32 providers were convicted of Medicaid fraud and abuse and the State recovered $5.5 million.

OBJECTIVE, SCOPE, AND METHODOLOGY

The audit objective was to determine whether the Medicaid Provider Enrollment process ensures that only qualified providers are approved to provide services to Medicaid recipients and to receive payments from North Carolina's Medicaid program.

The Office of the State Auditor initiated this audit to ensure the State is approving only qualified and properly vetted Medicaid providers.

The audit scope included provider applications approved for the Medicaid program during calendar year 2012. Denied providers were not included as they do not pose a risk of fraud, waste, and abuse.

To achieve the audit objective, auditors interviewed personnel with the Division of Medical Assistance (Division), the Office of Medicaid Management Information Systems Services, and the vendor, Computer Sciences Corporation, Inc. (Contractor). Auditors reviewed provider enrollment business rules and procedure manuals and tested a sample of provider approved applications and supporting documentation.

Auditors identified two distinct groups of applications for testing: 1) Provider applications approved by the Contractor and 2) provider applications approved by the Division.

The size of the two samples and random selection method ensure that conclusions from the audit sample hold true for the audit population within a 95 % confidence interval.

The audit testing processes were designed to assess appropriateness of approval but cannot detect a provider that intends to deceive the application process by falsifying ownership or failing to disclose one or more business owners or managers.

Auditors conducted fieldwork from October 2013 to February 2014.

Because of the test nature and other inherent limitations of an audit, together with limitations of any system of internal and management controls, this audit would not necessarily disclose all performance weaknesses or lack of compliance.

As a basis for evaluating internal control, auditors applied the internal control guidance contained in professional auditing standards. As discussed in the standards, internal control consists of five interrelated components, which are (1) control environment, (2) risk assessment, (3) control activities, (4) information and communication, and (5) monitoring.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

1. DIVISION PROCEDURAL WEAKNESSES COULD HAVE ALLOWED UNQUALIFIED PROVIDERS TO ENROLL

The Division of Medical Assistance (Division) procedures did not provide reasonable assurance that only qualified providers were approved to enroll in the North Carolina Medicaid program.

Consequently, there is an increased risk that unqualified providers could have been enrolled in the Medicaid program and allowed to serve Medicaid recipients and receive payment from the State.

Specifically, the Division lacked (1) documentation needed to review higher-risk[1] provider approvals, (2) reviews of higher-risk provider approval process, and (3) sufficient written procedures for documenting the approval of higher-risk provider applications.

Based on the audit procedures, auditors did not identify any approved providers that should have clearly been denied. However, as noted below, the Division's documentation to support the approvals was lacking and not always available for review.

Division Lacked Documentation Needed to Review Higher-Risk Approvals

The Division did not maintain the documentation that management and auditors needed to effectively evaluate the approval and enrollment of higher-risk providers in the North Carolina Medicaid program. Specifically, approved higher-risk provider application files often did not contain information about the criteria used to evaluate providers, how the criteria was considered, and how the final approval decision was reached.

Consequently, management and auditors cannot have reasonable assurance that the enrollment process prevented unqualified providers from enrolling in Medicaid, providing services to Medicaid clients, and receiving payments from the State. Furthermore, the lack of documentation could prevent unqualified providers from being identified by a review process.

The Office of Inspector General (OIG) within the federal Department of Health and Human Services notes the importance of an effective enrollment process. In its publication titled "Medicaid Proactive Safeguards," the OIG states:

> "Provider enrollment is the first line of defense in the fight against fraud and abuse. Keeping unqualified and unscrupulous providers from gaining access to Medicaid systems not only **protects patients** but also **lowers administrative costs** and **protects program assets**." *(Emphasis added)*

[1]When the contracted enrollment vendor identifies providers with a history of criminal convictions or sanctions through background checks, licensing checks, etc., the Division business rules require that the vendor escalate these applications to the Division for further review. For the purposes of this report, these providers are identified as higher-risk compared to providers without adverse actions found during background and other verification checks.

Auditors concluded that about 548 of 843 (65%)[2] higher-risk provider applications approved in 2012 did not contain sufficient documentation to allow an effective review of the Division's approval decision.

This conclusion is based on a statistical sample of 100 out of 843 higher-risk enrollment application files that the Division approved during the year ended December 31, 2012.

The sample showed that 65 out of 100 (65%) higher-risk application files did not contain sufficient explanations or documentation to clearly support the Division's approval decisions. Specifically, the sample showed that:

- Only 35 out of 100 (35%) higher-risk provider application files had a sufficient explanation and documentation to clearly support the approval.
- 29 out of 100 (29%) higher-risk provider application files included a sufficient explanation for the approval but lacked any supporting documentation.
- 36 out of 100 (36%) higher-risk provider application files had no explanation or documentation to support the approval except for a standard statement that read, "Violations cited do not exclude the provider from participation."

Higher-risk provider application files listed various adverse actions ranging from recoupment actions[3] and license suspensions to felony drug convictions. All of these actions are potential reasons to deny a provider application. However, despite the severity or age of adverse actions, the Division approved these provider applications without sufficient, documented evidence to support the approval.

For example, the Division approved applications from the following higher-risk providers without adequately documenting its reasons or providing evidence to support its decision.

- A provider whose criminal background check showed two convictions for felony possession of controlled substances.
- A provider whose license had been revoked by the NC Board of Occupational Therapy due to fraudulent billing. (The license had been restored at the time of the application.)
- A provider who was suspended from the federal Medicare program until December 20, 2012. (The Division approved the provider's Medicaid provider application on October 4, 2012.)
- A provider who did not disclose a misdemeanor shoplifting conviction and submitted an affirmation statement to the Division that the provider had never been charged with a misdemeanor or a felony. (The provider later updated the application and disclosed the conviction.)

[2] Error rate of 65% plus or minus 9.3%. 95% confident that the number of applications with errors is between 469 and 627.
[3] Recoupment actions include funds owed to the State for overpayments, disallowed payments, etc.

Internal control[4] best practices state that adequate documentation is necessary for the proper review of an entity's processes and to ensure that the processes are being performed properly. Specifically, the "Internal Control – Integrated Framework" issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO)[5] states:

> "Documentation also provides evidence of the performance of activities that are part of the system of internal control, enables proper monitoring, and supports reporting on internal control effectiveness, particularly when evaluated by other parties interacting with the entity, such as regulators, auditors, or customers."

Furthermore, internal control best practices state that management should expect auditors to ask for documentation that shows the entity's processes are being performed properly. Specifically, COSO states:

> "In cases where an external auditor attests to the effectiveness of the overall system of internal control, **management will likely be expected to provide the auditor with support for its assertion on the effectiveness of internal control**. That support includes evidence that the system of internal control is properly designed and operating effectively to provide reasonable assurance of achieving the entity's objective. In considering the nature and extent of documentation needed, management should remember that the documentation to support the assertion will likely be used by the external auditor as part of his or her audit evidence. **Management would also need to document significant judgments, how such decisions were considered, and how the final decisions were reached.**" *(Emphasis added)*

Finally, the Government Accountability Office (GAO)[6] requires auditors to consider whether a lack of adequate documentation could be the basis for an audit finding. Specifically, the GAO states:

> "Auditors should also evaluate whether the lack of sufficient, appropriate evidence is due to internal control deficiencies or other program weaknesses, and whether the lack of sufficient, appropriate evidence could be the basis for audit findings."

[4] "Internal control, sometimes referred to as management control, in the broadest sense includes the plan, policies, methods, and procedures adopted by management to meet its missions, goals, and objectives." Government Auditing Standards, 2011

[5] The Committee of Sponsoring Organizations of the Treadway Commission (COSO) is a joint initiative of five private sector organizations and is dedicated to providing thought leadership through the development of frameworks and guidance on enterprise risk management, internal control, and fraud deterrence. The five private sector organizations include the Institute of Management Accountants, American Accounting Association, American Institute of Certified Public Accountants, Institute of Internal Auditors, and Financial Executives International.

[6] Government Auditing Standards, 2011

Division Lacked Reviews for Higher-Risk Provider Approval Process

The Division did not perform reviews of its higher-risk provider approval process or use similar supervisory controls to ensure that employees only approve higher-risk provider applications in accordance with Division policies and procedures.

Approving applications without following Division policies and procedures increases the risk that unqualified providers could enroll in, treat clients of, and receive payments from the Medicaid program.

COSO states the purpose of supervisory controls such as reviews is to:

> "…**assess whether** other transaction control activities (i.e., particular verifications, reconciliations, authorizations and **approvals**, controls over standing data, and physical control activities) **are being performed completely, accurately, and according to policy and procedures**." *(Emphasis added)*

The lack of reviews could prevent the Division from timely identifying employees who approve higher-risk provider applications without performing the research, using the criteria, or following the documentation standards established in Division policy and procedures.

In fact, the Division learned that an employee had been approving higher-risk provider applications for approximately eight months without any research or review to support the approval. The employee was subsequently terminated.

However, the situation only came to the Division's attention because a provider complained to the Division about the time it took to approve an application. The Division did not discover the problem on its own.

Internal control best practices require management to perform reviews or use other control activities to provide reasonable assurance that employees are complying with agency policy. For example, the GAO recommends that management perform functional or activity level reviews. Additionally, the GAO states:

> "Internal control activities **help ensure that management's directives are carried out**. The control activities should be effective and efficient in accomplishing the agency's control objectives."[7] *(Emphasis added)*

[7] GAO, Standards for Internal Control in the Federal Government

Division Lacked Sufficient Written Procedures for Documenting Approvals

The Division did not have sufficient written policies and procedures for documenting the approval of higher-risk providers.

The lack of sufficient written policies and procedures increases the risk that personnel will not consistently apply approval criteria and consistently document evidence to support the approval decisions.

In turn, inconsistent application of criteria and approval documentation could allow unqualified providers to be enrolled and not be identified by a review process.

In fact, the sample of 100 higher-risk application files mentioned earlier in the report showed that Division personnel inconsistently documented higher-risk provider application approvals. For example, the sample of higher-risk provider application files showed that:

- Some files had a sufficient explanation and documentation to clearly support the approval (35%);
- Some files had a sufficient explanation for the approval but lacked any supporting documentation (29%);
- And other files had no explanation or documentation to support the approval except for a standard statement that read, "Violations cited do not exclude the provider from participation" (36%).

Internal control best practices recommend written policies and procedures to help ensure that employees consistently follow established procedures. For example, the COSO "Internal Control - Integrated Framework" notes the importance of documentation:

> "Entities develop and maintain documentation for their internal control system for a number of reasons. One is to provide clarity around roles and responsibilities, which **promotes consistency in adhering to desired practices in managing the business**. Effective documentation assists in communicating the who, what, when, where, and why of internal control execution, and creates standards and expectation of performance and conduct." *(Emphasis added)*

During the course of the audit, the Division implemented written procedures requiring evidence to support approvals.[8] The Division also established the following policy as a result of the auditor's findings:

> "When returning the approved [application] for processing, the staff is required to follow Provider Services Business Rule Administrative #27 (PSBRA27) attaching ALL supporting documentation and paperwork to become permanent portion of the provider record. This includes, but is not limited to, any and all of the following that is applicable: Provider statements, email correspondence, official

[8] DMA Provider Relations Policy 5.2.3

> correspondence from state and federal entities, screenshots, and results from any web based applications that were reviewed, etc."

However, the new procedures still do not specify what evidence is necessary for approving each type of higher-risk provider. Also, the new procedures do not require the staff to provide detailed support.

For example, the new written procedures about approval support allow Division staff to simply state that "The violations cited do not exclude the provider from violation." The procedures state:

> "After a determination to approve the [application], the staff members are responsible for documenting the reason for the approval using the minimum standard phase 'The violations cited do not exclude the provider from participation. If all other criteria are met, enrollment is approved.' **It is permissible and preferred (but not required)** that the Enrollment Specialist include additional notes to support the approval decision."[9] *(Emphasis added)*

If notes or justification is not included, management and auditors cannot have reasonable assurance that the enrollment process prevented unqualified providers from enrolling in Medicaid, providing services to Medicaid clients, and receiving payments from the State.

RECOMMENDATIONS:

The Division should ensure that adequate documentation is maintained so that management and auditors can effectively evaluate the higher-risk provider application approval process.

The Division should perform reviews of its higher-risk provider application approval process to ensure that Division policies and procedures are being followed.

The Division should improve its existing written policies and procedures for higher-risk provider application approvals by adding specific supporting evidence requirements.

AGENCY RESPONSE:[10]

In September 2013, DMA established and implemented Management Monitoring Quality Controls (Monitoring Plan) for reviewing approval and denial decisions related to provider applications referred to it by the Contractor due to a potential concern. The Monitoring Plan established standardized policies and procedures and ensures that staff adheres to them in making enrollment determinations.

[9] DMA Provider Relations Policy 5.2.1-5.2.2

[10] The responses below are a portion of the Department's full response. See Appendix C. The Department's full response has statements that could mislead the reader. The Auditor's response clarifies these issues. See Appendix B.

DMA will benchmark its policies and procedures and adopt "best practices" utilized by other state Medicaid agencies.

Owner: DMA Provider Relations

Targeted Completion Date: March 31, 2015

2. CONTRACTOR PROCEDURAL WEAKNESSES COULD HAVE ALLOWED UNQUALIFIED PROVIDERS TO ENROLL

Computer Sciences Corporation's, Inc. (Contractor) provider enrollment review procedures and the Division of Medical Assistance's (Division) oversight of the Contractor did not provide reasonable assurance that only qualified providers were approved to enroll in the North Carolina Medicaid program.

Consequently, there is an increased risk that unqualified providers could have been enrolled in the Medicaid program and allowed to serve Medicaid recipients and receive payment from the State.

Procedural weaknesses included: (1) missing documentation indicating a risk that some verification checks were not performed; (2) verification checks that were performed using incorrect provider data; (3) Contractor and Division monitoring procedures were inadequate; and (4) no performance measures to hold the Contractor accountable.

Based on the audit procedures, auditors did not identify any approved providers that should have clearly been denied. However, as noted below, documentation to make that determination was not always retained by the Contractor.

Risk That Some Verification Checks Were Not Performed

In 40 out of 200 (20%) provider enrollment applications tested for the 2012 calendar year, documentation was missing for at least one of the four mandatory verification checks that the Contractor is required to perform.

Consequently, there is a risk that the Contractor may not have performed some of the verification checks that the Division determined was necessary to prevent unqualified providers from enrolling in the State's Medicaid program. Each incorrectly processed application is an opportunity for an unqualified provider to enroll in the Medicaid program, provide services to Medicaid clients, and receive Medicaid reimbursement.

Division policy requires the Contractor to perform all four of the following verification checks to prevent unqualified providers from enrolling in the State's Medicaid program:

1. *Office of the Inspector General (OIG) Database*: Searchable database of providers excluded from participating in federally-funded health-care programs like

Medicare and Medicaid. The OIG can exclude providers convicted of patient abuse or neglect, health care fraud, and other adverse sanctions and penalties.

2. *Provider Penalty Tracking Database*: Searchable database created to track providers, owners, principals or affiliates who have had violations that resulted in penalties or serious administrative actions against their license.

3. *IntelliCorp Criminal Background Database*: Searchable database that provides criminal background and sanction reports on the applicants based on Social Security Number or employer identification number and address history matches. The reports contain criminal history from court proceedings and actions logged in the Health Integrity and Protection Data Bank (HIPDB). The HIPDB is a repository for any penalty, sanction, suspension, or termination actions taken against a professional license, such as medical doctor, nurse and other licensed, health care providers.

4. *License/Certification verification*: Searchable database of professional licenses and certifications. The provider type as indicated in the application will determine the licensing and certification requirements. Dependent on the provider type and the type of service, multiple licenses and certification may be required, for example, a Board certified Medical License, DEA license to prescribe drugs, Facility License, etc.

Some Verification Checks Used Incorrect Provider Data

In 43 out of 200 (21.5%) provider enrollment applications tested for the 2012 calendar year, the Contractor performed at least one of the mandatory verification checks using an incorrect provider name, a misspelled provider name, or an incorrect Social Security Number.

Using incorrect search criteria to perform provider enrollment verifications increases the risk that unqualified providers could be allowed to enroll in the State's Medicaid program. When the Contactor does not search an applicant's name correctly, for example, the search results may not identify an applicant with a significant criminal history or may not identify an applicant that has been sanctioned for actions that would impact a provider's approval to participate in the NC Medicaid Program.

As noted above, Division policy requires the Contractor to perform four verifications to prevent unqualified providers from enrolling in the State's Medicaid program. The verifications must be performed with accurate search criteria to be effective.

Contractor and Division Monitoring Procedures Were Inadequate

Contractor and Division monitoring did not provide reasonable assurance that the Contractor accurately and reliably performed the provider enrollment review services. Additionally, the monitoring procedures were not adequate to ensure the timely

identification and correction of errors that could have allowed an unqualified provider to enroll in the Medicaid program.

First, the Contractor's quality control review process was incomplete in that it did not determine whether the provider was correctly approved or denied. Instead, the Contractor's quality control group only reviewed individual steps in the process. For example, the Contractor's quality control review would only check whether the background check was completed for an application and would not review the other verification steps for that application.

Second, the Division's quality reviews were incomplete and sporadic. For example, a Division quality control review included reviewing data entry accuracy and the accuracy of the letters sent to providers. The reviews did not assess whether the provider was correctly approved or denied. Additionally, the Division did not ensure that the reviews were performed systematically. The Division assigned the reviews to one staff member who performed the reviews "as time permits."

Inadequate monitoring procedures increase the risk that the Contractor and Division would not identify a significant number of errors that could allow an unqualified provider to enroll in the Medicaid program. For example, the Contractor's quality control review determined that its provider approval process had a 20% error rate. However, auditors determined that the Contractor's provider application review process had a 30% error rate for the 2012 calendar year. From a sample of 200 applications, auditors identified 60 applications (30%)[11] with one or more processing errors.[12]

Projected to the population, 4,153 of the 13,843 approved applications had at least one processing error.[13]

Best practices require that state agencies monitor contractor performance to ensure that services are accurately and reliably performed. Specifically, the National State Auditors Association's "Best Practices in Contracting for Services" states:

> "Monitoring should ensure that contactors comply with contract terms, performance expectations are achieved, and any problems are identified and resolved. Without a sound monitoring process, the contracting agency does not have adequate assurance it receives what it contracts for."

[11] Some applications had more than one error, so the reader cannot simply add the error rate for the mandatory verification checks (20%) to the incorrect data error rate (21.5%) to get the overall application error rates. The error types were not exclusive. For example, 23 applications had two or more errors with two applications having more than five errors each.
[12] Errors include (1) no evidence that a verification check was complete, (2) verification checks were completed using incorrect information, and (3) the Contractor approved an application that should have been sent to the Division for review.
[13] Error rate of 30% plus or minus 6.4%. 95% confident that the number of applications with errors is between 3,274 and 5,032.

No Accuracy or Reliability Performance Measures to Hold Contractor Accountable

The Medicaid contract in place during the audit period did not contain sufficient performance measures to hold the Contractor accountable for accuracy and reliability of Medicaid provider application processing.

Without sufficient performance measures, the State did not have a method to hold the Contractor accountable for accurately and reliably performing the services for which it was paid. The Division paid the Contractor $4.6 million in 2012 and $5.3 million in 2013 to process Medicaid provider applications.

The new contract terms implemented in 2013 include financial penalties for some performance measures, such as not meeting deadlines for processing applications.[14] However, the existing performance measures are still deficient, as the contract does not include any requirements or standards for accuracy and reliability.

Best practices require that state contracts hold contractors accountable by including performance measures for evaluating contractor performance. Specifically, the National State Auditors Association's "Best Practices in Contracting for Services" states:

> "Once the decision to contract has been made, the agency should develop performance requirements that will hold vendors accountable for the delivery of quality services. Performance requirements should:
>
> 1. Clearly state the services expected.
> 2. Clearly define performance standards and measurable outcomes.
> 3. Identify how vendor performance will be evaluated."

RECOMMENDATIONS:

The Division should ensure that the Contractor performs and retains adequate documentation for all required provider application verification checks. Documentation should be readily available for management, internal auditor, and external auditor reviews.

The Division should ensure that the Contractor has the policies and procedures in place necessary to provide reasonable assurance that all required provider application verification checks are performed using accurate search criteria.

The Division should ensure that it performs effective and systematic quality control reviews as a part of contract monitoring process. The reviews should include evaluating whether providers are appropriately approved and supported by sufficient evidence rather than reviewing individual steps in the process.

[14] Contract Requirement # 40.5.3.1 - 40.5.3.8.

The Division should establish accuracy and reliability performance measures for the provider enrollment review process. The Division should include the performance measures in the contract, monitor the Contractor's compliance with the new performance measures, and hold the Contractor accountable if the measures are not met.

AGENCY RESPONSE:[15]

The Contractor began using an industry leading workflow application on July 1, 2013 that requires its enrollment and credentialing staff to utilize standardized procedures in reviewing each provider enrollment application. Pertinent images are captured during the review process and indexed to the provider's National Provider Identification number.

DMA will formalize its process to monitor the Contractor's adherence to its policies and procedures to ensure the accuracy of all required provider application verification checks.

Owner: DMA Provider Relations

Targeted Completion Date: March 31, 2015

DMA and the Office of NCTracks will establish a process to monitor the Contractor's adherence to its policies and procedures to ensure providers are appropriately approved and documentation of verification and approval process is sufficient.

Owner: DMA and Office of NCTracks

Targeted Completion Date: June 30, 2015

DHHS will seek the Contractor's agreement to performance measures specific to the accuracy of the provider enrollment review process to supplement its contractual obligation to perform in accordance with industry standard. This performance measure will be in addition to the existing standards applicable to the timeliness of its review of provider enrollment applications.

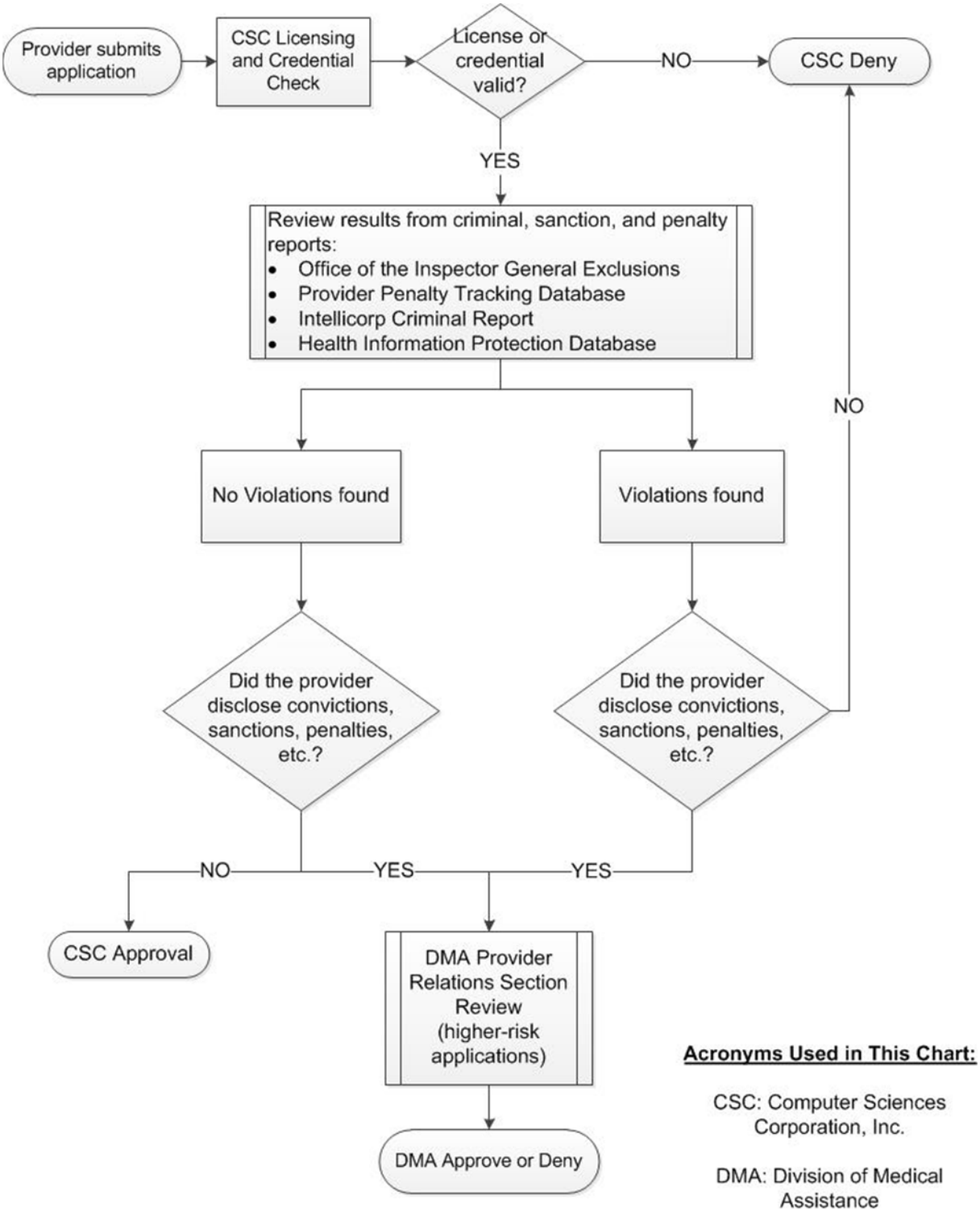
Owner: DMA and Office of NCTracks

Targeted Completion Date: June 30, 2015

[15] The responses below are a portion of the Department's full response. See Appendix C. The Department's full response has statements that could mislead the reader. The Auditor's response clarifies these issues. See Appendix B

APPENDIX A

PROVIDER ENROLLMENT PROCESS FLOWCHART



Auditor's Response

The Department of Health and Human Services (Department) generally agreed with the recommendations made in our report and states that it implemented or will implement new procedures to address noted weaknesses.

However, we are required to provide additional explanation when an agency's response could potentially cloud an issue, mislead the reader, or inappropriately minimize the importance of our findings.

Generally Accepted Government Auditing Standards state:

> "When the audited entity's comments are inconsistent or in conflict with the findings, conclusions, or recommendations in the draft report, or when planned corrective actions do not adequately address the auditor's recommendations, the auditors should evaluate the validity of the audited entity's comments. If the auditors disagree with the comments, they should explain in the report their reasons for disagreement."

To ensure the availability of complete and accurate information and in accordance with Generally Accepted Government Auditing Standards, we offer the following clarifications.

Division and Contractor Procedural Weaknesses

The Department response minimizes the significance of the procedural weaknesses identified in this audit by stating (page 2):

> *"...I am pleased that OSA did not find any approved providers that were inappropriately enrolled in the North Carolina Medicaid Program."*
>
> *"Also, in September of 2013, DMA implemented standard protocols and monitoring to ensure that eligibility determinations related to provider applications referred by the Contractor due to a potential concern are made objectively."*

The overall conclusion of the report is that Division of Medical Assistance (Division) procedures, and those of its Contractor (Computer Sciences Corporation, Inc.), did not provide reasonable assurance that only qualified providers were approved to enroll in the North Carolina Medicaid Program.

As noted in the report, documentation and justification necessary to determine provider eligibility did not always exist. As a result, neither OSA nor the Division could re-verify the approval for 65% of the higher-risk applications approved by the Division and 30% of the non-higher-risk applications

approved by the Contractor based on the available documentation. Therefore, OSA and the Division do not know if approximately 4,701 providers approved in 2012 were qualified.[1]

The Division developed new procedures in September 2013 after auditors shared preliminary concerns with the Division. As noted in the report, auditors reviewed the revised procedures and found them deficient. The Division revised the procedures in May 2014 and did not share them with auditors until after discussing the draft report on July 16, 2014. The effectiveness of the new procedures cannot be determined until a follow-up audit is performed.

Division Lacked Documentation Needed to Review Higher-Risk Approval

The Department response misleads the reader to believe that adequate procedures have been implemented to address the lack of documentation identified in this audit, that adequate documentation exists for most all of the applications tested during the audit, and that compliance with its Business Rule is sufficient by stating (page 2):

> *"In response, DMA implemented standard protocols and monitoring in September of 2013 to ensure that eligibility determinations related to provider applications referred by the Contractor due to a potential concern are made objectively and appropriately documented."* (emphasis added)
>
> *"DMA has confirmed documentation of its approval decisions in the Enrollment, Verification, and Credentialing information system maintained by the Contractor in 95% of the statistical sample of 100 out of 843 enrollment applications approved by DMA during calendar year 2012 that were reviewed by OSA."* (emphasis added)
>
> *"DMA notes that its policy and procedures (Business Rule PSBRA27) only required it to provide the Contractor with instruction to enroll the provider; and, thus, DMA's providing the Contractor with the standard statement that "[v]iolations cited do not exclude the provider from participation" was sufficient as further explanation or documentation to support the decision was not required."* (emphasis added)

As noted above, the Division developed new procedures in September 2013 after auditors shared preliminary concerns with the Division. Auditors reviewed the initial procedures and found them deficient. The Division revised the procedures in May 2014 and did not share them with auditors until after discussing the draft report on July 16, 2014. The effectiveness of the new procedures cannot be determined until a follow-up audit is performed.

The Department says that it reviewed the Contractor's provider enrollment files and confirmed that 95% of the auditor sampled items had an approval decision recorded in the Contractor's system.

[1] As noted in the report, the sample in finding #1 projected about 548 higher-risk provider applications lacked sufficient documentation and finding #2 projected about 4,153 Contractor approved applications. Combined, 4,701 applications lacked sufficient documentation. (548 + 4,153 = 4,701)

We agree that the approval was recorded, but more than half were not properly supported. As noted in the report, auditors found that the documentation and justification the Division needed to make that determination was missing for 65% of the higher-risk provider applications.

The Department says that its business rules did not require documentation and justification to support the approval of a higher-risk provider. As noted in the report, auditors concluded that the internal business rule was deficient and inconsistent with standard internal controls for adequate documentation.

Some Verification Checks Used Incorrect Provider Data

The Department response misleads the reader to believe that failure of the Contractor to perform mandatory verification checks is the provider's fault by stating (page 3):

> *"OSA further noted that some verification checks used incorrect provider data. It should be noted that the Contractor is not permitted to alter the information submitted by an applicant. Thus, for example, if the social security number (SSN) indicated on the application was incorrect (e.g., a transposed digit), it may have resulted in a failed criminal background search due to the inability to locate the individual's history. These failed reports were saved in the Contractor's records."* (emphasis added)

This is not the case. Auditors identified errors made by the Contractor, such as searching for a different name or Social Security number than the one provided on the application.

Contractor and Division Monitoring Procedures Were Inadequate

The Department response misleads the reader to believe that the Contractor and Division had adequate monitoring procedures to ensure timely identification and correction of Contractor errors by stating (page 3):

> *"In 2012, the Contractor used checklists to guide the credentialing team in performing reviews according to DMA's policies."* (emphasis added)
>
> *"The Contractor began using an industry leading workflow application on July 1, 2013 that requires its enrollment and credentialing staff to utilize standardized procedures in reviewing each provider enrollment application."* (emphasis added)

As noted in the report, the review and quality control procedures were inadequate. Auditors noted a 30% error rate in applications after the use of the Contractor's checklist and all quality control efforts.

Furthermore, the Contractor's new "industry leading" workflow is embedded within the new Medicaid Management Information system known as NCTracks. This new workflow has not been audited for accuracy.

No Accuracy or Reliability Performance Measures to Hold Contractor Accountable

The Department response misleads the reader to believe that the Medicaid contract is sufficient to hold the Contractor accountable for accuracy and reliability of Medicaid provider application processing by stating (page 5):

> *"DHHS acknowledges that its contract with the Contractor does not include specific performance measures applicable to the Contractor's accurate processing of provider enrollment applications. However, the absence of such specific performance measures does not make it so DHHS may not hold the Contractor accountable for processing applications accurately in accordance with generally accepted industry standards."*

While the Department states it can hold the Contractor accountable for processing applications accurately, as stated in the report, the contract has no penalties or remedies for inaccurate and unreliable results. As of the date of this report, the Department has not come up with a specific plan to hold the Contractor accountable for these errors.

North Carolina Department of Health and Human Services
Division of Medical Assistance

Pat McCrory
Governor

Aldona Z. Wos, M.D.
Ambassador (Ret.)
Secretary DHHS

August 5, 2014

The Honorable Beth A. Wood, CPA
State Auditor
Office of the State Auditor
State of North Carolina
20601 Mail Service Center
Raleigh, North Carolina 27699-0601

Dear Auditor Wood:

Thank you for the opportunity to review the Office of the State Auditor's (OSA) draft performance audit report for the Department of Health and Human Services' (DHHS) Division of Medical Assistance (DMA or Division) – Medicaid Provider Eligibility. Although your audit focused on Medicaid provider applications approved during calendar year 2012 and highlighted several opportunities for improvement that have been or are being addressed, I am pleased that OSA did not find any approved providers that were inappropriately enrolled in the North Carolina Medicaid Program.

Nevertheless, OSA's draft report identifies procedural weakness that could have allowed unqualified providers to enroll. Procedure weaknesses in DMA are described in the first section of the report and procedural weaknesses with its contractor, Computer Sciences Corporation, Inc., (Contractor) in the second section. Per your request, DHHS has prepared the following written responses to be incorporated into the final report issued by OSA.

1. Division Procedural Weaknesses Could Have Allowed Unqualified Providers To Enroll

KEY FINDINGS (EXECUTIVE SUMMARY):

1. Deficiencies in the enrollment process increase the risk of unqualified providers participating in the Medicaid Program.

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DHHS Response: Although OSA did not find any approved providers that were inappropriately enrolled in the North Carolina Medicaid Program, DHHS agrees that deficiencies in the manual enrollment referral process to DMA increased the risk of unqualified providers participating in the Medicaid Program. In response, the Contractor began using an industry leading workflow application on July 1, 2013 that requires its enrollment and credentialing staff to utilize standardized procedures in reviewing each provider enrollment application. Also, in September of 2013, DMA implemented standard protocols and monitoring to ensure that eligibility determinations related to provider applications referred by the Contractor due to a potential concern are made objectively.

2. Documentation to support higher risk provider applications is often not available or insufficient to support the application approval.

DHHS Response: DHHS agrees that documentation of the criteria used to evaluate provider applications referred by the Contractor due to a potential concern may have had some deficiencies during the calendar year ending December 31, 2012. In response, DMA implemented standard protocols and monitoring in September of 2013 to ensure that eligibility determinations related to provider applications referred by the Contractor due to a potential concern are made objectively and appropriately documented. (See Attachment A)

DMA has confirmed documentation of its approval decisions in the Enrollment, Verification, and Credentialing information system maintained by the Contractor in 95% of the statistical sample of 100 out of 843 enrollment applications approved by DMA during calendar year 2012 that were reviewed by OSA. DMA notes that its policy and procedures (Business Rule PSBRA27) only required it to provide the Contractor with instruction to enroll the provider; and, thus, DMA's providing the Contractor with the standard statement that "[v]iolations cited do not exclude the provider from participation" was sufficient as further explanation or documentation to support the decision was not required.

KEY RECOMMENDATIONS (FINDINGS, RECOMMENDATIONS, AND RESPONSES):

1. The Division should ensure that adequate documentation is maintained so that management and auditors can effectively evaluate the higher-risk provider application approval process.

DHHS Response: In September 2013, DMA established and implemented Management Monitoring Quality Controls (Monitoring Plan) for reviewing approval and denial decisions related to provider applications referred to it by the Contractor due to a potential concern. The Monitoring Plan established standardized policies and procedures and ensures that staff adheres to them in making enrollment determinations.

DMA will benchmark its policies and procedures and adopt "best practices" utilized by other state Medicaid agencies.

Owner: DMA Provider Relations *Targeted Completion Date: March 31, 2015*

2. The Division should perform reviews of its higher-risk provider application approval process to ensure that Division policies and procedures are being followed.

DHHS Response: Reviewing approvals of provider applications referred to DMA by the Contractor due to a potential concern is part of the above described Monitoring Plan implemented in September of 2013.

3. The Division should improve their existing written policies and procedures for higher-risk provider application approvals by adding specific supporting evidence requirements.

   DHHS Response: DMA established and implemented standardized operating policies and procedures for approving provider applications referred by the Contractor due to a potential concern as part of the above described Monitoring Plan implemented in September of 2013.

   DMA will benchmark its policies and procedures and adopt "best practices" utilized by other state Medicaid agencies.

   Owner: DMA Provider Relations *Targeted Completion Date: March 31, 2015*

2. Contractor Procedural Weaknesses Could Have Allowed Unqualified Providers To Enroll

KEY FINDINGS (EXECUTIVE SUMMARY):

3. The Contractor's enrollment review procedures do not provide reasonable assurance that only qualified providers are approved to participate in the NC Medicaid Program.

   DHHS Response: In 2012, the Contractor used checklists to guide the credentialing team in performing reviews according to DMA's policies. Credentialing Coordinators reviewed the steps completed by their team members before forwarding the file for further review and, ultimately, a final enrollment determination. The Contractor had Quality Control Analysts who conducted reviews of work to document adherence to DMA's business rules and to ensure the correctness of decisions made by the enrollment team. The Contractor's Quality Assurance Team, a unit under different management control from the enrollment staff, also conducted reviews. The Office of Medicaid Management Information Systems Services and DMA conducted frequent reviews of the Contractor's work and met weekly with the Contractor to review any opportunities for improvement.

   The Contractor began using an industry leading workflow application on July 1, 2013 that requires its enrollment and credentialing staff to utilize standardized procedures in reviewing each provider enrollment application.

4. The Contractor does not always have evidence to support that mandatory verification checks were completed.

   DHHS Response: DHHS agrees that the Contractor did not always have evidence to support mandatory verification checks were completed. DMA's policies and procedures (Business Rule PSBRA7) generally requires four verification checks; however, there are exceptions that supersede the policies and procedures. For example, if an individual had a criminal background check performed within the past six months, the background check requirement in the immediate file under review was waived. In this example the historical criminal background check report was not stored a second time.

   OSA further noted that some verification checks used incorrect provider data. It should be noted that the Contractor is not permitted to alter the information submitted by an applicant. Thus, for example, if the social security number (SSN) indicated on the application was incorrect (e.g., a transposed digit), it may have resulted in a failed criminal background search due to the inability to locate the individual's history. These failed reports were saved in the Contractor's records.

5. Quality assurance reviews were not conducted or were ineffective.

   DHHS Response: As noted above, the Contractor had Quality Control Analysts who conducted reviews of work to identify adherence to DMA's business rules and to ensure the correctness of decisions made by the enrollment team. The Contractor's Quality Assurance Team, a unit under different management control from the enrollment staff, also conducted reviews. The Office of Medicaid Management Information Systems Services and DMA conducted frequent reviews of the Contractor's work and met weekly with the Contractor to review any opportunities for improvement.

6. Contract lacks adequate performance measures to hold the Contractor accountable for processing applications accurately and reliably.

   DHHS Response: DHHS acknowledges that its contract with the Contractor does not include specific performance measures applicable to the Contractor's accurate processing of provider enrollment applications.[1] However, the absence of such specific performance measures does not make it so DHHS may not hold the Contractor accountable for processing applications accurately in accordance with generally accepted industry standards.

KEY RECOMMENDATIONS (FINDINGS, RECOMMENDATIONS, AND RESPONSES):

4. The Division should ensure that the Contractor performs and retains adequate documentation for all required provider application verification checks. Documentation should be readily available for management, internal auditor, and external auditor reviews.

   DHHS Response: The Contractor began using an industry leading workflow application on July 1, 2013 that requires its enrollment and credentialing staff to utilize standardized procedures in reviewing each provider enrollment application. Pertinent images are captured during the review process and indexed to the provider's National Provider Identification number.

5. The Division should ensure that the Contractor has the policies and procedures in place necessary to provide reasonable assurance that all required provider application verification checks are performed using accurate search criteria.

   DHHS Response: DMA will formalize its process to monitor the Contractor's adherence to its policies and procedures to ensure the accuracy of all required provider application verification checks.

   Owner: DMA Provider Relations *Targeted Completion Date: March 31, 2015*

6. The Division should ensure that it performs effective and systematic quality control reviews as a part of contract monitoring process. The reviews should include evaluating whether providers are appropriately approved and supported by sufficient evidence rather than reviewing individual steps in the process.

[1] The Replacement MMIS RFP included requirements 40.5.3.1 – 40.5.3.8, thus the contract has always included these requirements. All of these requirements became mutually agreed-upon performance "service level agreements" (SLAs) through Change Service Request (CSR) 885, which was approved by the State on October 7, 2013. Thus, there was no new contract implemented in 2013 as referenced in the report.

DHHS Response: DMA and the Office of NCTracks will establish a process to monitor the Contractor's adherence to its policies and procedures to ensure providers are appropriately approved and documentation of verification and approval process is sufficient.

Owner: DMA and Office of NCTracks *Targeted Completion Date: June 30, 2015*

7. The Division should establish accuracy and reliability performance measures for the provider enrollment review process. The Division should include the performance measures in the contract, monitor the Contractor's compliance with the new performance measures, and hold the Contractor accountable if the measures are not met.

DHHS Response: DHHS will seek the Contractor's agreement to performance measures specific to the accuracy of the provider enrollment review process to supplement its contractual obligation to perform in accordance with industry standard. This performance measure will be in addition to the existing standards applicable to the timeliness of its review of provider enrollment applications.

Owner: DMA and Office of NCTracks *Targeted Completion Date: June 30, 2015*

Thank you for the opportunity to review and respond to the draft report.

Sincerely,

Aldona Z. Wos, M.D.
Secretary DHHS

Attachment

Cc: Robin Cummings, M.D.
Joe Cooper, CIO
Sheila Platts

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ORDERING INFORMATION

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For additional information contact:

Bill Holmes
Director of External Affairs
919-807-7513

This audit required 4,220 audit hours at an approximate cost of $329,160. This cost represents less than 0.0024% of the total Medicaid budget (over $14 billion) for the fiscal year ended June 30, 2014.

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