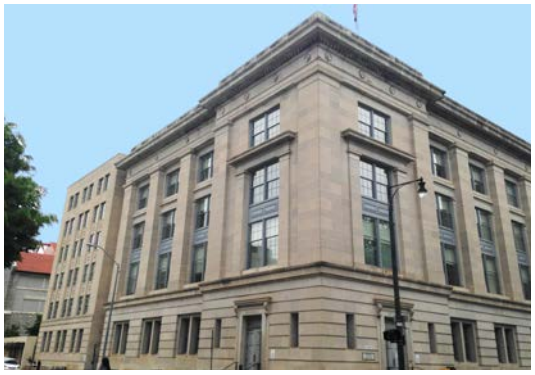
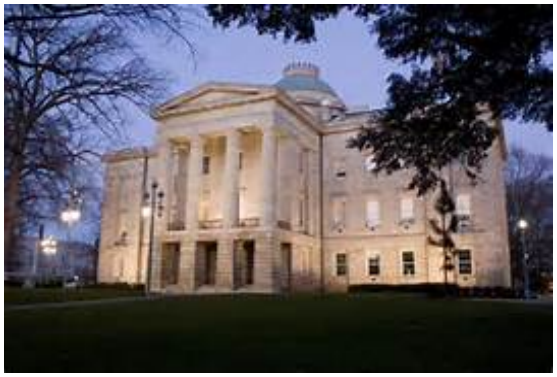
State of North Carolina

Office of the State Auditor

Beth A. Wood, CPA





Department of Health and Human Services

Medicaid Durable Medical Equipment Claims

Performance Audit

August 2016

NC OSA
The Taxpayers' Watchdog

EXECUTIVE SUMMARY

PURPOSE

The Office of the State Auditor initiated this audit to identify improvement opportunities for the prevention and detection of improper payments of Medicaid durable medical equipment claims.

BACKGROUND

The State spent approximately $170 million on Medicaid claims for durable medical equipment during fiscal year 2015. Examples of durable medical equipment include wheelchairs, hospital beds, and oxygen tanks.

The federal Centers for Medicare and Medicaid Services (CMS) and the federal Patient Protection and Affordable Care Act designated durable medical equipment as high risk for waste and abuse. CMS calculated a 39.9% improper payment rate on Medicare claims for durable medical equipment during federal fiscal year 2015.

To reduce payments for fraudulent, abusive, and other types of improper Medicaid claims, the Department engaged contractors to perform pre- and post-payment reviews of Medicaid providers that have abnormal billing patterns. The contractors reviewed claims of multiple provider types including providers of durable medical equipment.

KEY FINDINGS

- The Department omitted accuracy standards and changed payment method from contingency to hourly for post-payment reviews, despite known problems with contractor work
- The Department did not evaluate the accuracy of post-payment reviews that the contractor performed of durable medical equipment claims
- The Department did not have a formal quality assurance process to evaluate the accuracy of the contractor's prepayment reviews
- The Department excluded penalties for nonperformance from its Medicaid claims prepayment review contract

KEY RECOMMENDATIONS

- The Department should evaluate and regularly monitor its practices to ensure contracts include terms necessary to compensate post-payment contractors based on performance with contract requirements
- The Department should evaluate and regularly monitor its methods to ensure the Medicaid post-payment review contractor is complying with contract performance standards
- The Department should direct the Program Integrity Section to select a random sample of claims to evaluate the accuracy of contractor prepayment claim reviews
- The Department should evaluate and regularly monitor its practices to ensure contracts include terms necessary to compensate prepayment contractors based on performance with contract requirements

MATTER FOR FURTHER CONSIDERATION

- The Department's contract processes and state law needs review

The key findings and recommendations in this summary may not be inclusive of all the findings and recommendations in this report.

STATE OF NORTH CAROLINA
Office of the State Auditor

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AUDITOR'S TRANSMITTAL

The Honorable Pat McCrory, Governor
The General Assembly of North Carolina
Mr. Rick Brajer, Secretary, Department of Health and Human Services

Ladies and Gentlemen:

We are pleased to submit this performance audit titled "Department of Health and Human Services – Medicaid Durable Medical Equipment Claims." The audit objective was to determine if the Department of Health and Human Services had adequate internal control to prevent and detect improper payment of claims for durable medical equipment.

Department of Health and Human Services Secretary Rick Brajer reviewed a draft copy of this report. The Secretary agreed with the findings and recommendations. His full response begins on page 16.

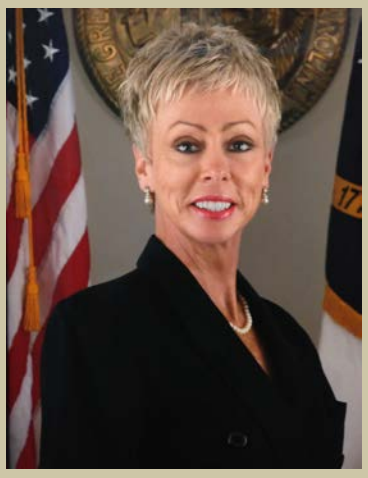
The Office of the State Auditor initiated this audit to identify improvement opportunities in the prevention and detection of improper payments of Medicaid Durable Medical Equipment claims.

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.

Respectfully submitted,

Beth A. Wood

Beth A. Wood, CPA
State Auditor



Beth A. Wood, CPA
State Auditor

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BACKGROUND

The North Carolina Medicaid program[1] pays for a variety of health care services and supplies, including durable medical equipment.

The State spent approximately $170 million on nearly 1.4 million Medicaid claims for durable medical equipment during state fiscal year 2015. Examples of durable medical equipment include wheelchairs, hospital beds, and oxygen tanks.

Durable medical equipment has been designated as high risk for waste and abuse by the federal Centers for Medicare and Medicaid Services (CMS) and the federal Patient Protection and Affordable Care Act. CMS calculated a 39.9% improper payment rate on Medicare claims for durable medical equipment during federal fiscal year 2015.

To reduce payments for fraudulent, abusive, and other types of improper Medicaid claims, the Department of Health and Human Services (Department) engaged contractors to perform pre- and post-payment reviews of claims. The contractors reviewed claims of multiple provider types, including providers of durable medical equipment. Contractors were responsible for conducting claims review of "selected Medicaid Providers that have demonstrated significant abusive or aberrant billing problems."

The contractors were the:

- Carolina Center for Medical Excellence (CCME) - Contracted to perform prepayment reviews
- Public Consulting Group (PCG) – Contracted to perform post-payment reviews

The Program Integrity Section of the Department's Division of Medical Assistance administered the contracts with CCME and PCG. Program Integrity's mission is to "ensure compliance, efficiency, and accountability within the N.C. Medicaid Program by detecting and preventing fraud, waste, program abuse, and by ensuring that Medicaid dollars are paid appropriately by implementing tort recoveries, pursuing recoupments, and identifying avenues for cost avoidance."[2]

[1] As defined by the federal Social Security Act, Medicaid provides medical assistance to "families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services."

[2] NC Department of Health and Human Services – NC Division of Medical Assistance, Program Integrity website https://www2.ncdhhs.gov/DMA/pi.htm

OBJECTIVE, SCOPE, AND METHODOLOGY

The Office of the State Auditor initiated this audit to identify improvement opportunities in the prevention and detection of improper payments of Medicaid Durable Medical Equipment claims.

The audit objective was to determine if the Department of Health and Human Services (Department) had adequate internal control to prevent and detect improper payment of claims for durable medical equipment.

The audit scope included claims paid from July 1, 2011, to June 30, 2015. Auditors conducted the fieldwork from July 2015 to March 2016.

To determine if the Department had adequate internal control, auditors interviewed the Department contractors, Department staff, and Medicaid Investigations Unit staff at the NC Department of Justice. Auditors also reviewed Department policies and procedures, contract agreements, and state laws and regulations.

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.

FINDINGS, RECOMMENDATIONS, AND RESPONSES

1. THE DEPARTMENT OMITTED ACCURACY STANDARDS AND CHANGED PAYMENT METHOD FROM CONTINGENCY TO HOURLY FOR *POST-PAYMENT* REVIEWS, DESPITE KNOWN PROBLEMS WITH CONTRACTOR WORK

Note: The Department of Health and Human Services (Department) post-payment vendor, Public Consulting Group (PCG), does not have a separate post-payment review process for durable medical equipment claims even though the Centers for Medicare and Medicaid Services (CMS) designated durable medical equipment as high risk for waste and abuse. Instead, the population of claims on which PCG performs post-payment reviews includes all types of Medicaid claims.

Performance Based Standards Omitted

The Department omitted prior contract terms in a new contract with the PCG that would have continued to protect the State's interest.

Specifically, the Department omitted claim review accuracy targets despite finding errors with PCGs claims review during the prior contract term. The Department also agreed to a change in compensation terms from a contingency basis (pay for results) to an hourly rate.

Compensation Based on Claim Review Accuracy Omitted

Prior to November 2013, the contract required PCG to complete all claim reviews accurately and identified specific payment reduction for noncompliance if PCG did not meet the performance standard target. The prior post-payment review contract with PCG stated:

> "The Contractor shall maintain an accuracy rate and inter-rater reliability confidence level[3] of 95%. In any month, the contractor is allowed a 5% margin of error."
>
> "An error rate greater than 5% shall result in a reduction of the invoice amount by the percentage of the error rate in excess of 5%."

In November 2013, the Department awarded a new contract to PCG that excluded the accuracy standard and the specific compensation reduction for failure to meet the performance target.

The accuracy standard and performance target held PCG accountable to complete claim reviews according to federal and state Medicaid guidelines to identify only fraudulent, abusive, and improper claims as invalid claims.

Payment Method Changed from Contingency Basis to Hourly Rate

The Department changed the payment method from a contingency basis (pay for results) to an hourly rate.

[3] Inter-rater reliability measures the extent to which more than one reviewer (rater) completes a post-payment review of the same claims and comes to the same conclusion.

Prior to November 2013, the Department included a compensation plan in its contract with PCG that tied payments to specific deliverables that had to be accepted by the Department's Program Integrity section. If PCG did not successfully identify improper claims payments that the State could recover from the provider, then PCG did not get paid.[4] In other words, the Department paid PCG for results. Consequently, PCG had an incentive to identify as many recoverable improper claims payments as it could.

In November 2013, the Department awarded a new contract to PCG that did not tie compensation to the contractor's identification of recoverable improper payments. Instead, the new contract paid PCG an hourly rate to conduct investigations and post-payment reviews. Consequently, PCG no longer had the incentive to identify as many improper claims as possible.

Contractor Nonperformance Was Known

The Department had identified problems with PCG's claim reviews during the 25 quality assurance evaluations performed by its Program Integrity Section between June 2012 and January 2014 (all evaluations applied to the pre-November 2013 contract). The Program Integrity Section performed evaluations of PCG claim reviews at least monthly.

The Program Integrity Section found:

- 12 of the PCG reviews (48%) received a major non-conformance rating[5]
- 11 PCG reviews (31%) received a minor non-conformance rating
- 2 PCG reviews (8%) received a conformance rating

During the 25 quality assurance reviews, the Program Integrity Section tested a total of 69 cases[6] that PCG had reviewed. Some cases had two or more errors.

The Program Integrity Section found that in:

- 60 cases (87%), PCG did not have correct documentation for how it projected the sample results to the entire population
- 29 cases (52%), PCG reviewed less than 95% of the claim items accurately
- 6 cases (9%), PCG chose an incorrect sample
- 4 cases (6%), PCG incorrectly projected the sample results to the population

[4] Contract # RFP No. 30-DMA-256-10 states that PCG would be paid 7.75% of Post-Payment Recoupment. "Post-Payment Recoupment means the total value of claim payments recouped as a direct result of the Contractor's Post-Payment Review activities under this Contract. For purposes of this Contract, Recoupment occurs when an account receivable is established after a hearing and after Appeals have been exhausted or if the provider does not request a hearing within thirty (30) days of the date of the recoupment letter.

[5] Major non-conformance, minor non-conformance, and conformance ratings are internally defined based on Program Integrity's mathematical calculation of the scorecard results of its internal quality review.

[6] A case is a collection of potentially improper billings and claims payments for a single provider over a specified period of time.

Without Performance Standards the Risk Increased That Millions of Dollars in Fraudulent and Improper Medicaid Claims Were Not Detected and Recovered

PCG reviewed a sample, or portion, of Medicaid claims. The State attempted to recover the cost of those claims PCG determined to be improper.

The risk that PCG did not effectively review Medicaid claims (i.e. identification of recoverable improper claims) increased after the Department switched payment methods from contingency to hourly.

Several authoritative sources have estimated the percent of fraudulent and abusive health care expenditures nationally. Using these estimates, the State incurred hundreds of millions of dollars of improper Medicaid expenditures each year.

FBI Fraud Estimate

The most recent (fiscal year 2010-2011) Financial Crimes Report by the Federal Bureau of Investigations (FBI) estimates fraudulent billings to health care programs, both public and private, are between **3 and 10 percent** of total health care expenditures.

Applying the FBI rate to state fiscal year 2011 – 2015 claims data for **Medicaid durable medical equipment claim types**, the State paid **$4 million to $17 million per year** in fraudulent and abusive claims. If detected by PCG, **some** of the claims could have been recovered by the State:

SFY	No. of Claims	Dollar Value of Claims	Applied 3% - 10% FBI Estimated Fraud Rate
2011	1,296,952	$139,126,932	$4,173,808 - $13,912,693
2012	1,325,696	$143,637,743	$4,309,132 - $14,363,774
2013	1,329,628	$143,066,360	$4,291,991 - $14,306,636
2014	1,263,982	$155,345,651	$4,660,369 - $15,534,565
2015	1,351,580	$170,236,197	$5,107,086 - $17,023,620

IBM Fraud Estimate

The FBI fraud estimate may below.

In 2009, the International Business Machines Corporation (IBM) estimated an **18 percent Medicaid fraud rate** in a "proof of concept" study for the Department.[7] The Department used that estimate as part of its basis for a $6 million contract with IBM for fraud detection software.

Applying the IBM rate to state fiscal year 2011 – 2015 claims data for **Medicaid durable medical equipment claim types**, the State paid **$25 million to $31 million per year** in fraudulent and abusive claims. If detected by PCG, **some** of the claims could have been recovered by the State.

[7] DHHS "Contract Justification Memorandum" dated December 17, 2009, page 6.

CMS Improper Payment Estimates

CMS calculated a **12.0%**[8] **improper payment rate** for Children's Health Insurance Program (CHIP) **durable medical equipment claims** for federal fiscal year 2014. The error rate is almost twice the 6.2%[8] percent improper payment rate for all CHIP claims. An improper payment is a payment that should not have been made or made in an incorrect amount.

Additionally, CMS calculated a **39.9 percent**[9] **improper payment rate** for Medicare **durable medical equipment claims** for the federal fiscal year 2015. The error rate is three times more than the 12.1 percent[9] improper payment rate for **all** Medicare claims.

Department Cannot Explain Contract Omissions

Current Program Integrity Section management was unable to explain why the current contract with PCG omitted terms to base compensation on the State's recovery of improper claims PCG identified and on PCG performance with claim review accuracy targets.

- Current management was not involved in the contract negotiation process
- Management involved in the contract negotiation are no longer employed with the Department

Best Practices Recommend Performance Standards and Contractor Payment Based on Deliverables

The National State Auditors Association's "Best Practices in Contracting for Services" states that that contract terms should "protect the interests of the agency." Its best practices provide that contracts should contain "performance standards" and "Tie payments to the acceptance of deliverables or the final product, if possible."

RECOMMENDATIONS

The Department should evaluate and regularly monitor its practices to ensure contracts include terms necessary to compensate post-payment contractors based on performance with contract requirements.

The Department should ensure that contracts included performance measures and targets for claim review accuracy.

The Department should ensure that contractor compensation is tied to acceptance of deliverables or the final product when possible.

The Department should ensure that contract negotiations are documented and that the documentation is maintained for reference and audit.

[8] US Department of Health and Human Services, "Medicaid and CHIP 2014 Improper Payments Report," page 32.

[9] US Department of Health and Human Services, "The Supplementary Appendices for the Medicare Fee-for-Service 2015 Improper Payments Report," page 4.

AGENCY RESPONSE

The Department agreed with the finding and recommendations. The Department's full response to this finding begins on page 16.

2. THE DEPARTMENT DID NOT EVALUATE THE ACCURACY OF POST-PAYMENT REVIEWS THAT THE CONTRACTOR PERFORMED OF DURABLE MEDICAL EQUIPMENT CLAIMS

The Department of Health and Human Services (Department) did not evaluate the accuracy of reviews made by the Public Consulting Group (PCG) of durable medical equipment claims. Federal agencies designated Medicaid claims for durable medical equipment as **high risk**. In fact, CMS found durable medical equipment claims had 12.0% and 39.9% improper payment rates in the Children's Health Insurance Program (CHIP) and Medicare programs, respectively.

The State paid about $170 million in state fiscal year 2015 for Medicaid claims.

PCG Reviews of Durable Medical Equipment Claims Were Not Selected for Evaluation

The Department did not select for evaluation any post-payment reviews made by PCG of durable medical equipment claims. PCG reviewed **all types** of Medicaid claims including durable medical equipment claims.

The Department's Program Integrity Section conducted monthly quality assurance evaluations on a sample of PCG reviews to evaluate their accuracy. Between June 2012 and January 2014, 25 quality assurance evaluations were performed. These evaluations included 69 PCG reviews, none of which were durable medical equipment claims.

Department Did Not Know if Durable Medical Equipment Claims Were Accurate

Because the Department did not examine any of the durable medical claims that PCG reviewed, the Department did not know if PCG is adequately performing post-payment reviews of those claims.

As a result, the risk increased that poor contractor performance would **not** be identified and corrected to ensure that inaccurate claims were detected and associated claim costs were recovered by the State.

CMS and Affordable Care Act Designation and Estimates

The federal Centers for Medicare and Medicaid Services (CMS) and the federal Patient Protection and Affordable Care Act designated durable medical equipment as high risk for waste and abuse.[10]

[10] GAO report "Medicare and Medicaid Fraud, Waste, and Abuse," pg 6. Patient Protection and Affordable Care Action, Section 6406.

CMS calculated a **12.0%**[11] **improper payment rate** for CHIP **durable medical equipment claims** for federal fiscal year 2014. The error rate is almost twice the 6.2%[11] percent improper payment rate for all CHIP claims. An improper payment is a payment that should not have been made or made in an incorrect amount.

Additionally, CMS calculated a **39.9 percent**[12] **improper payment rate** for Medicare **durable medical equipment claims** for the federal fiscal year 2015. The error rate is three times more than the 12.1 percent[12] improper payment rate for **all** Medicare claims.

Sample Methodology Reduced Chance for Department Evaluation of PCG Reviews of Durable Medical Equipment Claims

Durable medical equipment claims were never selected for evaluation using the Department's sampling methodology. The number of durable medical equipment claims is small compared to the total of all other Medicaid provider type claims.

The sampling methodology used by the Department's Program Integrity Section provided for an evaluation of 12 PCG reviews monthly. The reviews were selected randomly with a limit of three PCG case reviews per Program Integrity review section. There are four review sections: provider medical review, pharmacy review, behavioral health review, and home care review.

Durable medical equipment provider types are one of ten provider types included in the home care review section of Program Integrity. Provider types in this section include: home health and hospice, dentists, durable medical equipment, private duty nursing, personal care services, independent practitioners, community alternatives programs for disabled adults and for children, HIV case management, home infusion therapy, and adult care homes.

The Department's Program sampling methodology did not consider critical characteristics of the Medicaid case population such as:

- Case types at higher risk of receiving an inaccurate review
- Error rate expected to be found in the sample population
- Desired confidence level needed to rely on the conclusions obtained from the sample
- Population size of all cases reviewed by PCG

Current Program Integrity Section management stated that limited available staff was a significant determinant in its sampling methodology.

Best Practices Recommend a Sound Contract Monitoring Process

The National State Auditors "Best Practices in Contracting for Services" states:

[11] US Department of Health and Human Services, "Medicaid and CHIP 2014 Improper Payments Report," page 32.

[12] US Department of Health and Human Services, "The Supplementary Appendices for the Medicare Fee-for-Service 2015 Improper Payments Report," page 4.

> "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."

CMS uses a statistical sample methodology to select Medicaid cases for review to determine and monitor each state's "Payment Error Rate Measurement."[13] Using a statistical sampling methodology, all sample items have an equal chance of being selected, and sample results can be evaluated objectively by projections to the entire sample population based on mathematical probability properties.

The AICPA and The Journal of Applied Business Research state the following regarding statistical sample sizes:

> "To determine the size of a statistical sample, the auditor explicitly considers several factors. Those include materiality, the expected error rate or amount, the risk of over-reliance or the risk of incorrect acceptance, audit risk, **inherent risk**, control risk, standard deviation, and population size. These factors are needed to obtain the required sample size from statistical tables."

RECOMMENDATIONS

The Department should evaluate and regularly monitor its methods to ensure the Medicaid post-payment review contractor is complying with contract performance standards.

The Department should use statistical sampling to evaluate contractor post-payment reviews.

The Department should use sample selection methods that factor high risk provider types.

AGENCY RESPONSE

The Department agreed with the finding and recommendations. The Department's full response to this finding begins on page 17.

3. THE DEPARTMENT DID NOT HAVE A FORMAL QUALITY ASSURANCE PROCESS TO EVALUATE THE ACCURACY OF CONTRACTOR'S PREPAYMENT REVIEWS

Note: The Department of Health and Human Services (Department) prepayment vendor, Carolina Center for Medical Excellence (CCME), does not have a separate prepayment review process for durable medical equipment claims even though the Centers for Medicare and Medicaid Services (CMS) designated durable medical equipment as high risk for waste and abuse. Instead, the population of claims on which CCME performs prepayment reviews includes all types of Medicaid claims.

[13] CMS States the objectives of the PERM Program as "…a joint effort between CMS and the states to calculate Medicaid and CHIP improper payment rates."

Self-Assessments by the Contractor

The Carolina's Center for Medical Excellence (CCME) provided monthly performance reports of its own internal quality assurance reviews of all Medicaid claims to demonstrate to the Department that the contract performance standard were being met.

The contract states:

> "The Contractor shall maintain an accuracy rate and inter-rater reliability confidence level[14] of 95%. In any month, the contractor is allowed a 5% margin of error."

The Department of Health and Human Services (Department) did not mitigate the risk of self-assessments (positive rater bias) by:

- Testing the validity of the information provided in the self-assessments
- Performing evaluations themselves or by an independent party

Increased Risk that Poor Contractor Performance Was Not Identified

Because the Department did not perform independent evaluations, there is an increased risk that poor contractor performance was not identified and corrected to ensure that improper Medicaid claims were prevented and associated claim costs were not incurred by the State.

As noted above, this condition applies to all Medicaid claims reviewed by the contractor, including durable medical equipment.

FBI Fraud Estimate

The most recent (fiscal year 2010-2011) Financial Crimes Report by the Federal Bureau of Investigations (FBI) estimates fraudulent billings to health care programs, both public and private, are between **three and 10 percent** of total health care expenditures.

Applying the FBI rate to state fiscal year 2011 – 2015 claims data for **Medicaid durable medical equipment claim types,** the State paid **$4 million to $17 million per year** in fraudulent and abusive claims. If detected by CCME, **some** of the claims could have been prevented:

SFY	No. of Claims	Dollar Value of Claims	Applied 3% - 10% FBI Estimated Fraud Rate
2011	1,296,952	$139,126,932	$4,173,808 - $13,912,693
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2014	1,263,982	$155,345,651	$4,660,369 - $15,534,565
2015	1,351,580	$170,236,197	$5,107,086 - $17,023,620

[14] Inter-rater reliability measures the extent to which more than one reviewer (rater) completes a post-payment review of the same claims and comes to the same conclusion.

IBM Fraud Estimate

The FBI fraud estimate may be low.

In 2009, the International Business Machines Corporation (IBM) estimated an **18 percent Medicaid fraud rate** in a "proof of concept" study for the Department.[15] The Department used that estimate as part of its basis for a $6 million contract with IBM for fraud detection software.

Applying the IBM rate to state fiscal year 2011 – 2015 claims data for **Medicaid durable medical equipment claim types**, the State paid **$25 million to $31 million per year** in fraudulent and abusive claims. If detected by CCME, **some** of the claims could have been prevented.

CMS Improper Payment Estimates

CMS calculated a **12.0%**[16] **improper payment rate** for Children's Health Insurance Program (CHIP) **durable medical equipment claims** for federal fiscal year 2014. The error rate is almost twice the 6.2%[16] percent improper payment rate for all CHIP claims. An improper payment is a payment that should not have been made or made in an incorrect amount.

Additionally, CMS calculated a **39.9 percent**[17] **improper payment rate** for Medicare **durable medical equipment claims** for the federal fiscal year 2015. The error rate is three times more than the 12.1 percent[17] improper payment rate for **all** Medicaid claims.

Department Cannot Explain Why Evaluation of CCME Claims Did Not Occur

Current Program Integrity Section management was unable to explain why the Department did not conduct quality assurance evaluations of pre-payment claims reviewed by CCME.

- Current management was not involved in the quality assurance evaluation process during the audit period
- Management involved in the quality assurance evaluation process during the audit period are no longer employed with the Department

Contract and Best Practice Require Evaluation by Department of CCME Reviews

Contract

Section 4.4(b) of the contract states that the Department's Program Integrity Section will select a random sample of claims:

> "… to assess the accuracy of CCME's clinical decisions and IRR."

[15] DHHS "Contract Justification Memorandum" dated December 17, 2009, page 6.
[16] US Department of Health and Human Services, "Medicaid and CHIP 2014 Improper Payments Report," page 32.
[17] US Department of Health and Human Services, "The Supplementary Appendices for the Medicare Fee-for-Service 2015 Improper Payments Report," page 4.

Best Practice

The National State Auditors Association "Best Practices in Contracting for Services" states:

> "Contract monitoring is an essential part of the contracting process. Monitoring should ensure that contractors 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." (Emphasis added)

RECOMMENDATIONS

The Department should direct the Program Integrity Section to select a random sample of claims to evaluate the accuracy of CCME prepayment claim reviews.

The Department should evaluate and regularly monitor its methods to ensure the Medicaid prepayment review contractor is complying with contract performance standards.

AGENCY RESPONSE

The Department agreed with the finding and recommendations. The Department's full response to this finding begins on page 18.

4. THE DEPARTMENT EXCLUDED PENALTIES FOR NONPERFORMANCE CIRCUMSTANCES FROM ITS MEDICAID CLAIMS PREPAYMENT REVIEW CONTRACT

Terms to Effectively and Efficiently Address Nonperformance Excluded

No Specific Corrective Action to Reduce Compensation

The Department of Health and Human Resources (Department) did not specify in the contract how much the compensation to the Carolina's Center for Medical Excellence (CCME) would be reduced for not meeting performance standards for prepayment reviews.

The contract stated that in any month,

> "An error rate greater than 5% shall result in a reduction in the Contractor's compensation."

In contrast, the Department's prior contract with Public Consulting Group (PCG) for post-payment reviews cited specific corrective action for not meeting performance standards.

That contract stated,

> "An error rate greater than 5% shall result in a reduction **of the invoice amount by the percentage of the error rate in excess of 5**%**."** (*Emphasis added*)

No Dispute Resolution Process

Additionally, the Department did not include a **dispute resolution** clause in the contract with CCME to resolve challenges to any proposed reduction of the contractor's compensation.

The American Arbitration Association provides the following standard language for a dispute resolution clause:

> "In the event of any dispute, claim, question, or disagreement arising from or relating to this agreement or the breach thereof, the parties hereto shall use their best efforts to settle the dispute, claim, questions, or disagreement. To this effect, they shall consult and negotiate with each other in good faith and, recognizing their mutual interests, attempt to reach a just and equitable solution satisfactory to both parties. If they do not reach such solution within a period of 60 days, then, upon notice by either party to the other, all disputes, claims, questions, or differences shall be finally settled by arbitration administered by the American Arbitration Association in accordance with the provisions of its Arbitration Rules."

Contractor Nonperformance Costs State

Contractor Errors

The State incurs additional cost for errors made by CCME in its prepayment reviews:

- Cost to reprocess claims that should not have been denied
- Cost to recover claims that should have been denied
- Cost of fraudulent and improper claims that will never be recovered
- Opportunity cost of financing claims that should have been denied

Contractor Overpaid When *Negotiated Contract Value Is Not Received*

Without using specific terms to reduce CCME compensation for not achieving accuracy standards, the State may not receive the contract value it negotiated. The Department negotiated with CCME a specific service to be achieved within a certain standard in exchange for equal compensation.

The contract terms indicate that the State will receive the negotiated value at the current payment rate to CCME as long as the contractor's error rate does not exceed 5%. The contract terms indicate that if CCME's error rate exceeds 5% a reduction in compensation to CCME is necessary to compensate for the loss in value received, Otherwise, CCME would be overpaid.

Compensation Disputes Costly

Because the contract lacks a dispute resolution process, the State could incur costly efforts to negotiate solutions and if unsuccessful to terminate the contract and rebid a new contract.

Because the CCME contract does not include an agreement on how much the contractor's compensation will be reduced if review accuracy standards are not achieved, there is a risk that CCME could dispute any proposed compensation reduction.

Department Cannot Explain Contract Exclusions

Current Program Integrity Section management was unable to explain why the contract with CCME excluded specific corrective action to reduce compensation for poor performance and excluded a dispute resolution process.

Current management was not involved in the contract negotiation process.

Management involved in the contract negotiation are no longer employed with the Department.

Best Practices Recommend Corrective Action and Dispute Resolution Process

The National State Auditors Association's "Best Practices in Contracting for Services" states that the contract should contain "corrective actions for nonperformance, with a dispute resolution process."

RECOMMENDATIONS

The Department should evaluate and regularly monitor its practices to ensure contracts include terms necessary to compensate prepayment contractors based on performance with contract requirements.

The Department should ensure that contracts include specific corrective actions to reduce contractor compensaton for noncompliance with claim review accuracy standards and targets.

The Department should ensure that contracts include a dispute resolution process.

The Department should ensure that contract negotiations are documented and that the documentation is maintained for reference and audit.

AGENCY RESPONSE

The Department agreed with the finding and recommendations. The Department's full response to this finding begins on page 19.

MATTER FOR FURTHER CONSIDERATION

During the course of an audit, Office of the State Auditor staff may uncover potential issues that are outside of the audit objective. Although the issues may not have been part of the planned objective, the issues need to be presented to those charged with governance of the organization under audit. Below is such an issue.

THE DEPARTMENT'S CONTRACT PROCESSES AND STATE LAW NEED REVIEW

This audit found that contracting processes at the Department of Health and Human Services should be evaluated and periodically monitored to ensure:

- Contracts include terms necessary to compensate contractors based on performance with contract requirements
- Contractors are complying with contract performance standards

The Office of the State Auditor has issued several other audit reports with similar findings:

- **July 2012** – "Selected Contracts with Vendors to Identify Improper Payments" - Department's Program Integrity Section had not reviewed any of the contractor's (PCG) post-payment reviews to ensure contractor was meeting the required accuracy rate performance standard.
- **January 2012** – "Replacement MMIS Implementation" - Department did not include a specific corrective action for poor performance in its contract with CSC to build a replacement Medicaid Management Information System (MMIS).
- **November 2010** – "Service Contract Monitoring Practices" - Department was one of nine state agencies that did not provide evidence that it used performance measures in its contracts.
- **July 2008** – "Oversight of the Mental Health Services Utilization Review Contract" - Department did not provide evidence that it had performed any audits to ensure that the contractor had complied with the contract's performance standards.

As detailed in these reports, these circumstances can increase costs to the State, overpay contractors, and jeopardize health and human services to citizens of this State.

The Department of Health and Human Services (Department) should review and monitor its contracting practices.

The General Assembly may want to review laws requiring proposed contracts of more than $1 million to be reviewed by the Attorney General or its designee and consider penalizing agencies that do not get a review or perform inadequate reviews.

RESPONSE FROM THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

North Carolina Department of Health and Human Services

Pat McCrory
Governor

Richard O. Braj
Secretar

July 14, 2016

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

Dear Auditor Wood:

We have reviewed the draft performance report titled Medicaid Durable Medical Equipment Claims, covering the period July 2011 to June 2015. The following represents our response and corrective action plan to the Audit Findings and Recommendations.

AUDIT FINDINGS, RECOMMENDATIONS, AND RESPONSES

1. THE DEPARTMENT OMITTED ACCURACY STANDARDS AND CHANGED PAYMENT METHOD FROM CONTINGENCY TO HOURLY FOR *POST-PAYMENT* REVIEWS, DESPITE KNOWN PROBLEMS WITH CONTRACTOR WORK

   Recommendations:

   The Department should evaluate and regularly monitor its practices to ensure contracts include terms necessary to compensate post-payment contractors based on performance with contract requirements.

   The Department should ensure that contracts included performance measures and targets for claim review accuracy.

   The Department should ensure that contractor compensation is tied to acceptance of deliverables or the final product when possible.

   The Department should ensure that contract negotiations are documented and that the documentation is maintained for reference and audit.

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Agency Response:

As noted above in the Auditor's report, claims for durable medical equipment during State Fiscal Year (SFY) 2015 totaled $170 million, constituting less than 2% of total Medicaid expenditures of $11.5 billion.

The Department agrees that contract terms used to compensate post-payment contractors should be based on their performance adherent to specific contract requirements.

While the existing PCG contract includes certain performance requirements, the Department agrees that the contract referenced in this finding could be strengthened. In particular, the inclusion of performance standards specific to claim review accuracy should be set out in the contract and be one of the required conditions associated with the acceptance of contract deliverables.

The Department has been in review of the PCG contract since December of 2015. As a result of the review process, DMA identified opportunities to strengthen the performance measures associated with the work performed under the contract including the area of claim review accuracy. It is anticipated that these performance requirements and remedies for non-performance will be established in contract within the second quarter of SFY 2017.

The Department agrees that contract negotiations should be documented on material points and the documents should be maintained for management, audit and reference purposes. Documentation related to these activities is currently being maintained accordingly.

The Director of the DMA Office of Compliance and Program Integrity and the Director of the DHHS Office of Procurement will jointly hold responsibility for ensuring the implementation of the appropriate corrective action.

2. THE DEPARTMENT DID NOT EVALUATE THE ACCURACY OF POST-PAYMENT REVIEWS THAT THE CONTRACTOR PERFORMED OF DURABLE MEDICAL EQUIPMENT CLAIMS

Recommendations:

The Department should evaluate and regularly monitor its methods to ensure the Medicaid post-payment review contractor is complying with contract performance standards.

The Department should use statistical sampling to evaluate contractor post-payment reviews.

The Department should use sample selection methods that factor high risk provider types.

Agency Response:

The Department agrees with the State Auditor's finding that the Department did not evaluate contractor accuracy of post-payment reviews specific to durable medical equipment covering the

period of this audit. Although not targeted specifically to durable medical equipment, DMA's review of PCG's post payment reviews was based on a sample of all claims. The Department further agrees that DMA should regularly monitor its methods to ensure that Medicaid post-payment reviews comply with contract performance standards.

Since the initial execution of the PCG contract, the DMA Office of Compliance and Program Integrity (PI) has held biweekly and ad-hoc meetings as necessary with the vendor to provide oversight, guidance and review of the work done under the contract in addition to evaluating vendor performance. Additionally, DMA has historically performed quality assurance testing on post payment cases in order to evaluate the effectiveness of the contractor's performance. Notwithstanding, the Department agrees that there are opportunities to improve the methodology and precision associated with the sample selection processes for post-payment quality assurance reviews. The Department has implemented changes to the sampling process to assure that a larger number of cases will be selected for review on a quarterly basis. This change was implemented in the fourth quarter of SFY 15-16, covering vendor work that was performed during the months of October through December of 2015.

The Department will also adopt a process to formalize prioritization of post-payment casework based upon the risk inherent to each service type within the Medicaid program. This will assure that post-payment casework and accordingly, quality assurance reviews are driven by and directly correlated to service based risk factors. This change will be implemented during second quarter of SFY 2017.

The Department agrees that durable medical equipment is considered a high risk service area. It is also important to note that one of the factors to be considered in the evaluation of risk by service type is the overall level of expenditure by service type. As mentioned in the Auditor's report, "the number of durable medical equipment claims is small compared to the total of all other Medicaid provider type claims." In SFY 15, durable medical equipment expenditures represented less than 2% of Medicaid service expenditures. While durable medical equipment services will remain a high priority for post payment reviews based on a number of risk factors, the share of quality assurance reviews dedicated to durable medical equipment services will also be correlated directly to the relative size and risk factors associated with all other Medicaid services, the same priority which will be used to prioritize post-payment work.

The Director of the DMA Office of Compliance and Program Integrity will hold responsibility for ensuring the implementation of the appropriate corrective action.

3. THE DEPARTMENT DID NOT HAVE A FORMAL QUALITY ASSURANCE PROCESS TO EVALUATE THE ACCURACY OF CONTRACTOR'S PREPAYMENT REVIEWS

Recommendations:

The Department should direct the Program Integrity Section to select a random sample of claims to evaluate the accuracy of CCME prepayment claim reviews.

The Department should evaluate and regularly monitor its methods to ensure the Medicaid prepayment review contractor is complying with contract performance standards.

Agency Response:

The Department agrees that a formal quality assurance process should be adopted to evaluate the accuracy of contractors' prepayment reviews.

The Department would note that since the initial execution of the CCME contract, the Office of Compliance and Program Integrity (OCPI) has held biweekly and ad-hoc meetings as necessary with the vendor to provide oversight and guidance of the work done under the contract in addition to evaluating vendor performance.

In addition, over the life of this program the Office of Compliance and Program Integrity (OCPI) has historically met as needed with the vendor to review individual provider cases in order to examine approvals and denials of claims, to address provider concerns and to educate providers. Additionally, in preparation for reconsideration reviews and contested case hearings, OCPI has reviewed claim denials and approvals, notes of concerns, communication logs, provider reports, and provider documentation submitted during prepayment reviews in order to determine and affirm the accuracy of work by the vendor.

Notwithstanding, DMA agrees that the inclusion of a standardized and routine process to review the pre-payment activities performed under the contract will enhance the Department's ability to monitor and manage the oversight of the contract and validate performance standards.

The Department has developed and implemented a process to ensure quality assurance by testing of a statistically valid sample of pre-payment cases. The process has been formalized and documented for inclusion in the DMA, Office of Compliance and Program Integrity Operations Manual.

During the fourth quarter of SFY 15-16, the Office of Program Integrity completed a review of a statistically valid sample of cases from work performed by the vendor for the months of October through December of 2015. The review resulted in a vendor accuracy rating of over 95% for this period. Quality assurance reviews will continue to be completed on a quarterly basis using the newly implemented standardized process.

The Director of the DMA Office of Compliance and Program Integrity will hold responsibility for ensuring the implementation of the appropriate corrective action.

4. THE DEPARTMENT EXCLUDED PENALTIES FOR NONPERFORMANCE CIRCUMSTANCES FROM ITS MEDICAID CLAIMS PREPAYMENT REVIEW CONTRACT

Recommendations:

The Department should evaluate and regularly monitor its practices to ensure contracts include terms necessary to compensate prepayment contractors based on performance with contract requirements.

The Department should ensure that contracts include specific corrective actions to reduce contractor compensaton for noncompliance with claim review accuracy standards and targets.

The Department should ensure that contracts include a dispute resolution process.

The Department should ensure that contract negotiations are documented and that the documentation is maintained for reference and audit.

Agency Response:

The Department agrees with the State Auditor's finding that penalties for non-performance of the Medicaid claims prepayment review were excluded from the contract.

The current prepayment contract requires the vendor to maintain an accuracy rate of 95%. The Department agrees that including language to specify corrective action and the impact to compensation for non-performance is one of several approaches that could strengthen the contract terms and reduce the risk for disputes associated with non-performance. Under normal circumstances the State does not enter into binding arbitration. The Department favors language allowing the State to recover its actual damages as a means to strengthen contract terms and encourage vendor performance.

The Department is currently in the process of reviewing the CCME contract. As a result of the review, DMA identified opportunities to provide additional specificity to the contract with regard to penalties for non-compliance associated with the work performed. It is anticipated that these requirements will be incorporated by amendment into the contract within the second quarter of SFY 2017.

The Department agrees that contract negotiations should be documented on material points and the documents should be maintained for management, audit and reference purposes. Documentation related to these activities are currently being maintained accordingly.

The Director of the DMA Office of Compliance and Program Integrity and the Director of the DMA Office of Procurement will jointly hold responsibility for ensuring the implementation of the appropriate corrective action.

We appreciate the assistance and professionalism provided by your staff in the performance of this audit. If you need any additional information, please contact John Thompson at (919) 527-6854.

Sincerely,

Richard O. Brajer
Secretary

RB:jet

cc: Joseph Cooper, Jr., Chief Information Officer
Rod Davis, Chief Financial Officer
Mark Payne, Assistant Secretary of Audit and Health Service Regulation
Dave Richard, Deputy Secretary for Medical Assistance
Trey Sutten, Chief Financial Officer, Division of Medical Assistance
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This audit required 2,685 hours at an approximate cost of $265,815.