

STATE OF NORTH CAROLINA

OFFICE OF THE STATE AUDITOR

BETH A. WOOD, CPA



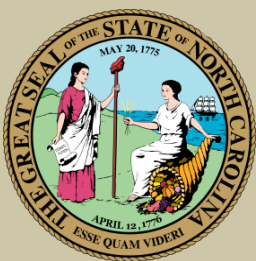
MEDICAID PROVIDER ENROLLMENT

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF HEALTH BENEFITS

PERFORMANCE AUDIT

FEBRUARY 2021



NCOSA
The Taxpayers' Watchdog

EXECUTIVE SUMMARY

PURPOSE

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

The audit scope included the **initial enrollment** of providers, **re-verification** of providers, and **ongoing discipline checks** of professional licenses for state fiscal year 2019.

BACKGROUND

Medicaid is a joint federal and state funded program that provides health insurance coverage to eligible low-income parents, children, seniors, and people with disabilities. Medicaid pays providers (such as doctors and pharmacies) for services provided to eligible beneficiaries.

To combat potential provider fraud, waste, and abuse, the federal Centers for Medicare and Medicaid Services (CMS) issued requirements for states to follow when screening and enrolling providers. Compliance with the requirements is crucial for screening out providers at risk of committing fraud or providing services without professional credentials (e.g. a medical license). For example, the Government Accountability Office (GAO) reported that **"States' non-compliance with provider screening and enrollment requirements contributed to over a third of the \$36.3 billion estimated improper payments in Medicaid in 2018."**¹

The NC Department of Health and Human Services' (Department) Division of Health Benefits (Division) is responsible for screening and enrolling Medicaid providers in accordance with CMS requirements. The Division outsources most of the provider enrollment process to General Dynamics Information Technology – GDIT (Contractor), **although the Division has ultimate responsibility.**

KEY FINDINGS

The Medicaid Provider Enrollment process did not ensure that only qualified providers² were approved to provide services to Medicaid beneficiaries and to receive payments from North Carolina's Medicaid program. Specifically, the Division:

- Did not identify and remove enrolled providers from the Medicaid program who had their professional license suspended or terminated.³
- Allowed all providers who had professional license limitations to remain enrolled in the Medicaid program.

¹ GAO, CMS Oversight Should Ensure State Implementation of Screening and Enrollment Requirements, October 2019.

² Doctors, pharmacies, hospitals, mental health counselors, durable medical equipment suppliers, and personal care services are all examples of providers.

³ Includes providers with Non-Practice Agreements (NPAs). An NPA is an agreement between a state licensing board and a licensee in which the licensee cannot practice or perform any act that requires that license in North Carolina while the agreement is in effect.

EXECUTIVE SUMMARY (CONCLUDED)

- Did not ensure that its contractor verified all professional credentials during the Medicaid provider enrollment re-verification process.⁴
- Did not require its contractor to verify provider ownership information during the Medicaid provider enrollment re-verification process.

As a result, there was an increased risk that providers whose actions posed a threat to patient safety were enrolled in Medicaid and could receive millions of dollars in improper payments⁵ from the State.

KEY RECOMMENDATIONS

- The Division should immediately remove all providers who have suspended or terminated professional licenses from the Medicaid program.
- The Division should immediately remove all providers from the Medicaid program who have professional license limitations and pose threats to the safety of beneficiaries.
- The Division should remove all providers who do not have the appropriate professional credentials required by the State Plan⁶ from the Medicaid program.
- The Division should verify the accuracy of all provider ownership disclosures so that background checks can be performed.⁷ When providers submit inaccurate information but are still allowed to enroll, the Division should document the reasons why termination or denial of enrollment is not in the best interests of the Medicaid program.

MATTERS FOR FURTHER CONSIDERATION

- The Division should improve its documentation supporting the approval of higher-risk providers.⁸ The Division should also consider increasing the oversight of these same providers.
- The Division should consider increasing its oversight of the enrollment of providers who operate under Local Management Entities/Managed Care Organizations (LME-MCOs).⁹

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

⁴ The Medicaid re-verification process is separate from the initial enrollment process. While the Division directly source verifies credentials during the initial enrollment process, it does not in the re-verification process.

⁵ Any payment that should not have been made or that was made in an incorrect amount due to administrative error, fraud, waste, or abuse.

⁶ An agreement between a state and the federal government describing how that state administers its Medicaid program. It gives an assurance that a state will abide by federal rules and may claim federal matching funds for its program activities. The State Plan sets out groups of individuals to be covered, services to be provided, methodologies for providers to be reimbursed, and the administrative activities that are underway in the state.

⁷ Providers are required to disclose all owners, managing employees, or others with controlling interest (collectively referred to as ownership information).

⁸ When adverse actions such as a criminal history or a professional license limitation of a provider are identified in the screening and enrollment process, General Dynamics Information Technology (GDIT) sends these "flagged, higher-risk" provider applications to the Division for further review and to approve or deny the provider to participate in NC Medicaid.

⁹ LME/MCOs are political subdivisions of the State that contract with the Division to provide managed care behavioral health services (mental health, substance abuse, and developmental disability) for Medicaid beneficiaries through a network of licensed practitioners and provider agencies.

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AUDITOR'S TRANSMITTAL

The Honorable Roy Cooper, Governor
Members of the North Carolina General Assembly
Dr. Mandy K. Cohen, Secretary
Dave Richard, Deputy Secretary for Medicaid

Ladies and Gentlemen:

We are pleased to submit this performance audit report titled *Medicaid Provider Enrollment*. The audit objective was to determine whether the Medicaid Provider Enrollment process ensures that only qualified providers are approved to provide services to Medicaid beneficiaries and to receive payments from North Carolina's Medicaid program.

The Department of Health and Human Services Secretary, Dr. Mandy Cohen, reviewed a draft copy of this report. Her written comments are included starting on page 27.

This audit was conducted in accordance with Chapter 147, Article 5A of the *North Carolina General Statutes*.

We appreciate the courtesy and cooperation received from management and the employees of Department of Health and Human Services and the Division of Health Benefits during our audit.

Respectfully submitted,

A handwritten signature in cursive script that reads "Beth A. Wood".

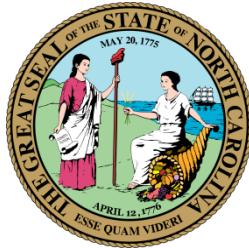
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BACKGROUND

North Carolina Medicaid (Medicaid) is a joint federal and state funded program that provides health insurance coverage to eligible beneficiaries (including low-income parents, children, seniors, and people with disabilities). All individuals or organizations who deliver health services or goods to Medicaid beneficiaries are called providers.¹⁰ There were approximately 90,000 Medicaid providers during state fiscal year 2019.

Per federal regulations, providers must apply, undergo various screenings, and be enrolled in order to receive Medicaid payments for provided services or goods. The screening and enrollment process requires an investigation of each provider's past and verification of all professional credentials.¹¹

The Government Accounting Office (GAO) notes that provider screening and enrollment is critical for helping to prevent fraud and abuse in the Medicaid program. The GAO states:

A crucial component of protecting the integrity of the Medicaid program is ensuring that only eligible providers participate in Medicaid. **States' non-compliance with provider screening and enrollment requirements contributed to over a third of the \$36.3 billion estimated improper payments** in Medicaid in 2018.¹² (*Emphasis Added*)

The federal Centers for Medicare and Medicaid Services (CMS) established regulations¹³ governing the screening and enrollment of Medicaid providers. The regulations instruct states on how to screen out providers at risk of committing fraud or providing services without professional credentials.

The North Carolina Department of Health and Human Services' (Department) Division of Health Benefits (Division) is responsible for screening and enrolling Medicaid providers in accordance with federal regulations.

The Division outsources most of the screening and enrollment process to General Dynamics Information Technology (GDIT), but the Division has **ultimate responsibility** for the screening and enrollment of Medicaid providers in accordance with federal regulations.

Medicaid spent approximately \$14.2 billion in federal and state funds during state fiscal year 2019.

The Provider Enrollment Process

The provider enrollment process begins when a provider submits an application for **initial enrollment**. This process includes a background review and credential verification (licenses, accreditations, and certifications). Depending on the services offered by the provider, a fingerprint-based background check, mandatory training, and a site visit may be required.

¹⁰ Doctors, pharmacies, hospitals, mental health counselors, durable medical equipment suppliers, and personal care services are all examples of providers.

¹¹ Such as a medical license, registered nurse license, facility accreditation, etc.

¹² GAO, CMS Oversight Should Ensure State Implementation of Screening and Enrollment Requirements, October 2019.

¹³ 42 CFR §455 Subpart E.

Applicants must disclose any adverse actions on the Medicaid enrollment application. GDIT staff use the following sources to check for adverse actions against the provider, agents, managing employees, and owners listed on the application:

- The Office of Inspector General (OIG) website (Exclusions Database)¹⁴
- The North Carolina Provider Penalty Tracking Database (PPTD)¹⁵
- The Center for Medicare and Medicaid Services (CMS) Medicaid and Children's Health Insurance Program State Information Sharing System (MCSIS) database¹⁶
- LexisNexis background checks - includes verification of Name, DOB, and SSN. Also checks the Social Security Administration's Death Master File, criminal history, List of Excluded Individuals/Entities (LEIE) and the Excluded Parties List System (EPLS)¹⁷

GDIT will approve or deny the provider application depending on the results of the background review and credential verification process. Certain applications will be sent to the Division for further review (see Initial Enrollment Process Flowchart in Appendix A for more details).

Medicaid providers must have their enrollment **re-verified** every five years.¹⁸ Re-verification ensures that the provider's information is current and accurate, including verification of the provider's credentials.

Further, the Division performs **discipline checks**¹⁹ to search for limitations that a state licensing board may have placed on a provider's professional license. The Division relies on the LexisNexis crawler and monthly background report to perform discipline checks on an ongoing basis.

Federal regulations required the Division to ensure that providers had all required professional licenses and that there were no current limitations in order to participate in Medicaid.

See Appendix B for chart of licensing boards that regulate services covered by Medicaid.

Responsible parties discussed in this report include:

*North Carolina Department of Health and Human Services*²⁰ - The Department's mission is to improve the health, safety, and well-being of all North Carolinians. The Department helps provide specific services to special populations including individuals who are deaf, blind, developmentally disabled, mentally ill, or economically disadvantaged.

¹⁴ Federal government's list of providers who are excluded from any federal health care programs and cannot receive payment from federal healthcare programs for any items or services they furnish, order, or prescribe.

¹⁵ Online database maintained by the Department that lists group home providers who had violations that resulted in penalties or serious administrative actions against their license. The database also includes information concerning Medicaid enrollment restrictions or terminations for licensed and unlicensed providers.

¹⁶ MCSIS, managed by CMS, is designed to prevent terminated health care providers from enrolling and billing another state's Medicaid program. MCSIS is also known as the CMS Adverse Action Report.

¹⁷ EPLS is an electronic directory of individuals and organizations that are not permitted to receive federal contracts or assistance from the federal government. It is managed by the US General Services Administration.

¹⁸ 42 CFR §455.414.

¹⁹ 42 CFR §455.412.

²⁰ <https://www.ncdhhs.gov/mission-vision>, <https://www.ncdhhs.gov/about/overview>.

The Department is divided into multiple divisions and offices that fall under four broad service areas: (1) health, (2) human services, (3) administrative, and (4) support functions. The Department also oversees developmental centers, neuro-medical treatment centers, psychiatric hospitals, alcohol and drug abuse treatment centers, and two residential programs for children.

*Division of Health Benefits (Division)*²¹ - The Division's mission is to provide access to physical and behavioral health care and services to improve the health and well-being of over 2.1 million North Carolinians. Overseen by the Department, the Division manages Medicaid.

General Dynamics Information Technology (GDIT) - The Department contracts with GDIT, a non-governmental organization, to perform most of the provider enrollment functions on behalf of the Division.

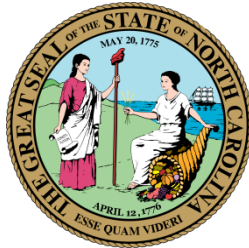
Systems discussed in this report include:

LexisNexis - The Division relies on a LexisNexis crawler and monthly background report to verify credentials for re-verification applications and for ongoing discipline checks. LexisNexis is one of the largest databases in the world of legal and public-records related information.

NCTracks - The Department's Medicaid Management Information System, NCTracks is the IT system by which providers are enrolled in Medicaid, re-verified every five years, and terminated when appropriate.

Crawler - Part of NCTracks, the crawler is a program that was designed to notify providers of upcoming licensure, accreditation, or certification expiration dates and to suspend or terminate providers that do not update their credentials.

²¹ <https://medicaid.ncdhhs.gov/>.



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 beneficiaries and to receive payments from North Carolina's Medicaid (Medicaid) program.

The audit scope included the **initial enrollment** of providers, **re-verification** of providers, and **ongoing discipline checks** of professional licenses for state fiscal year 2019.

To achieve the audit objective, auditors:

- Interviewed Department of Health and Human and Health Services' (Department) personnel as well as personnel at the Department's contractors, General Dynamics Information Technology (GDIT)
- Reviewed Department policies and procedures
- Reviewed provider information from NCTracks
- Reviewed state and federal laws and regulations relevant to enrolling and re-verifying Medicaid providers

From a population of approximately 90,000 Medicaid providers,²² auditors tested three populations: (1) providers who enrolled during 2019, (2) providers subject to re-verification during 2019, and (3) providers with a professional license limitation (discipline checks) during 2019:

1. *Enrollment* - Auditors tested providers whose enrollment applications were approved during the audit period to determine whether they were eligible to receive Medicaid payments.

The population contained 16,044 unique providers with approved enrollment applications. Auditors selected a sample of 172 applications for testing.

2. *Re-verification* - Auditors tested providers whose re-verification applications were approved during the audit period to determine whether they were eligible to receive Medicaid payments.

The population contained 27,334 unique providers with approved re-verification applications. Auditors selected a sample of 191 applications for testing.

Additionally, auditors tested if providers flagged by the LexisNexis crawler and monthly background report were properly reviewed and removed from the Medicaid program in a timely manner. The population contained 40,284 unique providers flagged for manual review (one provider could have multiple flags). Auditors selected a sample of 172 providers for testing.

3. *Ongoing Discipline Checks* - Auditors tested providers with professional licenses in NC who were disciplined by their state licensing board to determine whether they were properly removed from the Medicaid program.

Auditors obtained a list of all disciplined providers from each NC licensing board that regulates a service covered by Medicaid (see Appendix B for chart of licensing boards), then removed providers who were not enrolled in Medicaid. The remaining population contained 66 unique providers who were disciplined by their licensing board and participated in Medicaid. Auditors tested all 66 providers.

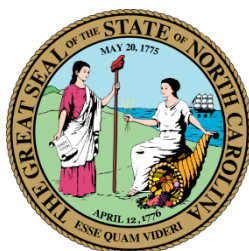
²² Of the approximately 90,000 providers, 16,044 were enrolled during state fiscal year 2019 and 27,334 were subject to re-verification during state fiscal year 2019.

Whenever sampling was used, auditors applied a non-statistical approach. Therefore, results could not be projected to the population. This approach was determined to adequately support audit conclusions.

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. However, our audit does not provide a basis for rendering an opinion on internal control, and consequently, we have not issued such an opinion. See Appendix D for internal control components and underlying principles that were significant to our audit objective.

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.



RESULTS AND CONCLUSIONS

The Medicaid Provider Enrollment process did not ensure that only qualified providers²³ were approved to provide services to Medicaid beneficiaries and to receive payments from North Carolina's Medicaid program. Specifically, the Department of Health and Human Services' Division of Health Benefits:

- Did not identify and remove enrolled providers from the Medicaid program who had their professional license suspended or terminated.²⁴
- Allowed all providers who had professional license limitations to remain enrolled in the Medicaid program.
- Did not ensure that its contractor verified all professional credentials during the Medicaid provider enrollment re-verification process.²⁵
- Did not require its contractor to verify provider ownership information during the Medicaid provider enrollment re-verification process.

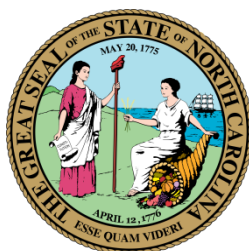
As a result, there was an increased risk that providers whose actions posed a threat to patient safety were enrolled in Medicaid and could receive millions of dollars in improper payments²⁶ from the State.

²³ Doctors, pharmacies, hospitals, mental health counselors, durable medical equipment suppliers, and personal care services are all examples of providers.

²⁴ Includes providers with Non-Practice Agreements (NPAs). An NPA is an agreement between a state licensing board and a licensee in which the licensee cannot practice or perform any act that requires that license in North Carolina while the agreement is in effect.

²⁵ The Medicaid re-verification process is separate from the initial enrollment process. While the Division directly source verifies credentials during the initial enrollment process, it does not in the re-verification process.

²⁶ Any payment that should not have been made or that was made in an incorrect amount due to administrative error, fraud, waste, or abuse.



FINDINGS, RECOMMENDATIONS, AND RESPONSES

1. UNLICENSED PROVIDERS SERVED MEDICAID BENEFICIARIES AND RECEIVED PAYMENTS

The Department of Health and Human Services' (Department) Division of Health Benefits (Division) did not identify and remove enrolled providers²⁷ from the Medicaid program who had their professional license suspended or terminated. Consequently, unlicensed providers were allowed to continue to serve Medicaid beneficiaries and receive payment from the State. The Division failed to remove these providers because it did not monitor disciplinary reports from state licensing boards. Federal regulations required enrolled providers to be licensed in the service provided.

Providers with Suspended or Terminated Professional Licenses Not Removed from Medicaid Program

The Division did not identify and remove providers who had their licenses suspended or terminated by professional state licensing boards.

Auditors obtained lists of all providers disciplined by professional state licensing boards during state fiscal year (SFY) 2019 directly from the licensing boards. These boards can suspend or terminate provider licenses for reasons that include:

- Negligence and malpractice
- Professional misconduct
- Medicaid fraud
- Sexual misconduct

Of the 66 Medicaid providers who were disciplined by their licensing board, 26 had a suspended or terminated license during SFY 2019.²⁸ Auditors tested all 26 providers to determine whether the Division identified and removed them from the Medicaid program.

Auditors found that 18 providers (69%) with suspended or terminated licenses were not removed from the Medicaid program at all. Specifically,

- 8 providers had suspended or terminated licenses for substance abuse (prescription drugs and/or alcohol).
- 6 providers had suspended or terminated licenses for unprofessional conduct.
- 2 providers had suspended or terminated licenses for sexual misconduct/inappropriate behavior with women.
- 1 provider had a terminated license for a felony conviction related to health care fraud.
- 1 provider had a suspended license due to concerns over a "mental condition that, if left untreated, may impair his ability to practice clinical medicine."

The Division removed 14 of the providers with suspended or terminated licenses from the Medicaid program **only after** auditors brought the test results to its attention.

²⁷ Enrolled Providers met the licensing requirements during the initial enrollment process and subsequently incurred the suspension or termination imposed by a state licensing board.

²⁸ Includes providers with Non-Practice Agreements (NPAs). An NPA is an agreement between a state licensing board and a licensee in which the licensee cannot practice or perform any act that requires that license in North Carolina while the agreement is in effect.

Further, the Division did not remove three (12%) disciplined providers from the Medicaid program timely. Specifically,

- 1 provider had an indefinitely suspended license for substance abuse (prescription drugs and/or alcohol) but was not removed from the Medicaid program until 4 months after the date of the state licensing board's consent order²⁹ and 9 months after the license was retroactively suspended.
- 1 provider had a suspended license for sexual misconduct/inappropriate behavior with women but was not removed from the Medicaid program until 4 months after the license suspension date.
- 1 provider had a terminated license for patient safety concerns but was not removed from the Medicaid program until 5 weeks after the license termination date.

Resulted in Increased Risk to Medicaid Beneficiaries from Unlicensed Providers

Approximately 2,400 beneficiaries were at an increased risk of receiving substandard care because the Division did not identify and remove providers with suspended and terminated professional licenses from participating in the Medicaid program. For example,

- A physician assistant treated 564 beneficiaries from April 26, 2018, the date of suspension,³⁰ through June 30, 2020. The provider's license was suspended for allegations regarding inappropriate exams of female patients, not complying with a chaperone requirement, and watching pornography while on duty in an emergency department.
- A physician treated 1,775 beneficiaries from January 31, 2018, the date of suspension,³¹ through June 30, 2020. The provider's license was suspended for "access[ing] medical records of at least one patient and read[ing] an electro-cardiogram" while under the influence of alcohol.

Also Resulted in Unlicensed Providers Receiving \$1.64 million in Medicaid Payments

Because the Division did not identify and remove providers with suspended and terminated professional licenses from the Medicaid program, 21 unlicensed providers³² received approximately \$1.64 million in Medicaid payments from the date of their license suspension or termination through June 30, 2020. For example,

- The physician assistant noted above received approximately \$1.6 million.
- The physician noted above received approximately \$38,000.

Additionally, the federal government may consider payments to unlicensed professionals to be improper payments³³ and require the Division to repay those funds.

²⁹ An order of a state licensing board that provides notification regarding the termination, suspension, or other limitation placed on a practitioner's license.

³⁰ The physician assistant was under an NPA. An NPA is an agreement between a state licensing board and a licensee in which the licensee cannot practice or perform any act that requires that license in North Carolina while the agreement is in effect.

³¹ The physician was under an NPA. An NPA is an agreement between a state licensing board and a licensee in which the licensee cannot practice or perform any act that requires that license in North Carolina while the agreement is in effect.

³² Includes 18 providers that were not terminated by the Division and three that were not terminated timely.

³³ Any payment that should not have been made or that was made in an incorrect amount due to administrative error, fraud, waste, or abuse.

Caused by the Department Failing to Monitor Reports from Licensing Boards

The Division did not identify and remove providers with suspended and terminated professional licenses from participating in the Medicaid program because the Division did not monitor all disciplinary reports from the professional state licensing boards as required by its own policy.

In 2015, the Division implemented a policy to receive disciplinary reports via an email listserv from each state licensing board.³⁴ The Division created the policy in response to a 2015 audit³⁵ which also found that Medicaid providers with suspended, surrendered, or revoked licenses were not properly removed from the Medicaid claims processing system (NCTracks).

However, from 2015 through 2019, no emails were received.

Instead of investigating the lack of emails, the individual at the Division responsible for receiving these emails reported to Division management that there were no disciplinary actions from the state licensing boards for every month since 2015. Division management accepted this response without further investigation.

Regulations Required Medicaid Providers to Have Professional Licenses Without Limitations

Federal regulations required the Division to ensure that providers had all required professional licenses and that there were no current limitations:

42 CFR §455.412 Verification of provider licenses.

The State Medicaid agency must -

- (a) Have a method for verifying that any provider purporting to be licensed in accordance with the laws of any State is licensed by such State.
- (b) **Confirm that** the provider's license has not expired and that **there are no current limitations on the provider's license.** (*Emphasis Added*)

RECOMMENDATIONS

The Division should immediately remove all providers who have suspended or terminated professional licenses from the Medicaid program.

The Division should monitor reports from all state licensing boards that regulate services covered by the Medicaid program to identify and remove providers from the Medicaid program with suspended or terminated professional licenses.

The Secretary should have a method to ensure the Division complies with CMS regulations.

AGENCY RESPONSE

See page 28 for the Department's response to this finding.

³⁴ The North Carolina Medical Board was excluded from the email listserv. The Division received reports from the medical board via a direct electronic feed.

³⁵ 2015 statewide single audit.

2. DIVISION INCREASED RISK TO MEDICAID PROGRAM AND BENEFICIARIES BY ALLOWING PROVIDERS WITH LICENSE LIMITATIONS TO REMAIN ENROLLED IN MEDICAID

The Department of Health and Human Services' (Department) Division of Health Benefits (Division) allowed all providers who had professional license limitations during state fiscal year (SFY) 2019 to remain enrolled in the Medicaid program. Consequently, there was an increased risk that providers whose actions posed a threat to patient safety were enrolled in Medicaid. The Division allowed the providers to remain enrolled because it stated it did not have the authority to terminate. However, the Division did have the authority, and federal regulations required the Division to confirm that there were no current limitations on the provider's license.

Division Allowed 100% of Providers with License Limitations to Remain Enrolled

During the audit period, the Division allowed all providers who had professional license limitations to remain enrolled in the Medicaid program. License limitations are specific restrictions imposed on a licensee's ability to practice for reasons that include:

- Negligence
- Malpractice
- Professional misconduct
- Fraud
- Sexual misconduct

Auditors obtained a list of all disciplined providers from each NC licensing board that regulates a service covered by Medicaid (see Appendix B for chart of licensing boards), and then removed providers who were not enrolled in Medicaid. The remaining population contained 66 unique providers³⁶ who were disciplined by their licensing board and participated in Medicaid. Of those 66 providers, 36 had current license limitations.

Auditors then reviewed documentation of the license limitations and determined that the Division had allowed all 36 providers who had current license limitations to continue to participate in the Medicaid program.

Resulted in Increased Risks to Medicaid Program and Beneficiaries

Because the Division allowed all providers who had professional license limitations to remain enrolled, there was an increased risk that providers whose actions posed a threat to patient safety were enrolled in Medicaid.

For example, the Division allowed the following providers with license limitations to continue to participate in the Medicaid program:

- **Provider A:** An oral surgeon's dental license was terminated after the death of a patient following surgery. The dental board found that the dentist violated the standard of care that caused or contributed to a patient's death, engaged in a "deliberate, dishonest plan or scheme to routinely and systematically defraud the Medicaid program and to enrich himself for his own personal gain" and that Medicaid was fraudulently deprived of substantial sums of money as a result of [the oral surgeon's] dishonesty and misconduct.

³⁶ The 66 disciplined providers include 36 with license limitations included in this finding, 26 with suspended or terminated licenses discussed in Finding 1, and four with miscellaneous disciplinary actions.

Despite the loss of his dental license, the oral surgeon retained his medical license and remains an active Medicaid provider. Additionally, the Division allowed him to provide services in two service areas that required a dental license he no longer had.³⁷ Provider A billed Medicaid for services provided to 1,460 Medicaid beneficiaries in the amount of \$1.5 million from July 28, 2016, through June 30, 2020.

- **Provider B:** A dentist's general anesthesia permit was suspended from May 3, 2019, to October 28, 2019, following a patient death. The dentist retained his dental license.

Provider B billed Medicaid for services provided to 119 Medicaid beneficiaries in the amount of \$73,000 from May 3, 2019, through October 28, 2019.

- **Provider C:** A physician had a license limitation that prohibited treating any female patients. A previous license limitation had required that a chaperone be present and document their presence any time the physician examined a female patient because of multiple past sexual and professional misconduct allegations.

Despite the license limitation restricting the physician from treating female patients, Provider C billed Medicaid for services provided to 208 female patients in the amount of \$78,000 from October 18, 2018, through June 30, 2020.

- **Provider D:** A physician had a license limitation that prohibited treating any female patients. The medical board was "concerned about the process [the physician] follows for breast examinations" and found the physician's conduct to be "a departure from the standards of acceptable and prevailing medical practice within the meaning of NCGS §90-14(a)(6)."

Despite not receiving payments from Medicaid, the provider remained active in the Medicaid claims processing system (NCTracks) and was eligible to receive payments.

- **Provider E:** A physician was placed on probation for multiple "departure[s] from the standards of acceptable and prevailing medical practice." The physician used a single-use syringe on multiple patients, injected unused pharmaceutical product from a previously used syringe into more than one patient, and failed to properly dispose of human waste - instead, the physician stored it "in a box in a closet near the nurse's station."

Despite not receiving payments from Medicaid, the provider remained active in the Medicaid claims processing system (NCTracks) and was eligible to receive payments.

Caused by Division's Position That It Lacked Authority to Remove Providers

The Division said that it did not have the authority to remove providers with current license limitations from the Medicaid program.

For instance, when the Division allowed a provider to continue to participate in Medicaid despite license limitations, it entered the following note (or similar) into the Medicaid claims processing system (NCTracks):

PROVIDER SERVICES HAS DETERMINED THE PROVIDER IS APPROVED DUE TO THE VIOLATION/OFFENSE DOES NOT MEET THE DENIAL / TERMINATION / EXCLUSION CRITERIA SET FORTH IN NCGS 108C AND/OR 42CFR. IF ALL OTHER CRITERIA ARE MET, APPROVED

³⁷ The two service areas were Oral and Maxillofacial Radiology and Oral and Maxillofacial Pathology.

However, the NC General Statute that the Division cited, *NCGS 108C*, does not directly address license limitations. And the federal regulation that the Division cited, 42 CFR §455.412(b), simply says:

Confirm that the provider's license has not expired and that **there are no current limitations on the provider's license.** (*Emphasis Added*)

During our audit, the Division sought additional guidance from the Centers for Medicare and Medicaid Services (CMS) about the Division's authority to remove providers with license limitations from the Medicaid program. In an email response dated July 29, 2020, CMS confirmed that the Division had the authority to deny or terminate enrollment:

When a provider has limitations on their license **each state has authority to make that determination if your state is comfortable with enrolling them with those limitations or not.** The licensing board should be monitoring the limitations, and if there are any changes the provider should make the state aware. We recommend knowing these limitations, and being aware of them for the safety of patients. (*Emphasis Added*)

As noted above, the CMS response also said that a state could enroll providers with license limitations if the state was comfortable with enrolling them. However, the Division has no policies and procedures to govern such a decision.

Regulations Required the Division to Confirm There Were No License Limitations

Federal regulations required the Division to ensure that providers had all required professional licenses and that there were no current limitations:

42 CFR §455.412 Verification of provider licenses.

The State Medicaid agency must -

- (a) Have a method for verifying that any provider purporting to be licensed in accordance with the laws of any State is licensed by such State.
- (b) **Confirm that** the provider's license has not expired and that **there are no current limitations on the provider's license.** (*Emphasis Added*)

RECOMMENDATIONS

The Division should immediately remove all providers from the Medicaid program who have professional license limitations and pose threats to the safety of beneficiaries.

The Division should create written policies and procedures for the continued enrollment of providers with limitations on their license. The policy should describe the types of license limitations that the Division finds acceptable. The policy should also require adequate documentation to support decisions to either enroll or deny enrollment.

The Secretary should have a method to ensure the Division complies with CMS regulations.

AGENCY RESPONSE

See page 28 for the Department's response to this finding.

3. PROVIDERS WITHOUT REQUIRED CREDENTIALS PAID \$11.2 MILLION

The Department of Health and Human Services’ (Department) Division of Health Benefits (Division) did not ensure that its contractor verified all professional credentials³⁸ during the Medicaid provider enrollment re-verification process.³⁹ As a result, uncredentialed providers were re-verified in the Medicaid program, allowed to serve Medicaid beneficiaries, and received payment from the State. Credentials were not verified because of weaknesses in the Division’s automated verification process. However, federal regulations and the Medicaid State Plan⁴⁰ required the Division to verify Medicaid provider credentials.

Division Did Not Ensure All Provider Professional Credentials Were Verified

The Division did not ensure that its contractor verified all professional credentials during the Medicaid provider enrollment re-verification process. Verifying professional credentials involves confirming with the appropriate licensing authority that the provider has the required licenses, accreditations, and certifications.

The Division used an automated LexisNexis crawler and monthly background report to check provider credentials instead of the process used during initial enrollment.⁴¹ However, the automated process did not ensure that all professional credentials were verified because:

- LexisNexis did not check accreditations, certifications, or organizations. It only included checks of individual’s licenses.
- Items that **were** flagged by the LexisNexis crawler and monthly background report needed to **be reviewed and acted on**. The Division had not completed these reviews timely. According to the Division, there was a backlog of over 30,000 flags raised by LexisNexis during state fiscal year (SFY) 2019 that had not yet been reviewed by the Division or its contractor.

Auditors tested a sample of 191 approved applications and found that the Division did not verify 185 (97%) provider’s professional credentials. During SFY 2019, the Division approved 27,334 provider re-verification applications.

Not only did the Division fail to verify any of the 185 provider credentials, but 153 of the 185 provider credentials had not been verified for more than five-years.⁴²

# of Providers	# of Days Past 5-Year Re-verification Date
19	30-120 days
55	121 - 240 days
57	241 - 360 days
22	> 360 days

³⁸ Professional credentials include any licenses, certifications, and accreditations that Medicaid requires providers to have in order to participate in the Medicaid program.

³⁹ The Medicaid re-verification process is separate from the initial enrollment process. While the Division directly source verifies credentials during the initial enrollment process, it does not in the re-verification process.

⁴⁰ An agreement between a state and the federal government describing how that state administers its Medicaid program. It gives an assurance that a state will abide by federal rules and may claim federal matching funds for its program activities. The State Plan sets out groups of individuals to be covered, services to be provided, methodologies for providers to be reimbursed, and the administrative activities that are underway in the state.

⁴¹ The Division directly source verifies credentials during the initial enrollment process.

⁴² 42 CFR §455.414 states that “The State Medicaid agency must revalidate the enrollment of all providers regardless of provider type at least every 5 years.”

Resulted in Uncredentialed Providers Enrolled in the Medicaid Program

As a result, uncredentialed providers were allowed to continue to be enrolled in the Medicaid program, serve Medicaid beneficiaries, and receive payment from the State.

Of the 185 applications for which the Division failed to verify provider credentials, six providers (3%) lacked the required credentials to provide services in the area of Medicaid in which they were enrolled. For example,

- An adult care facility lacked a family care home license. This provider was paid approximately \$5.9 million by Medicaid for serving 150 beneficiaries since January 1, 2018.⁴³
- An organizational provider that works with disabled individuals was missing a required home care license. The provider was paid approximately \$4.7 million by Medicaid for serving 593 beneficiaries since January 1, 2018.
- An adult day care facility lacked a home care nursing care license. This provider was paid approximately \$529,000 by Medicaid for serving 68 beneficiaries since January 1, 2018.

In total, these six providers served 822 beneficiaries and were paid approximately \$11.2 million in Medicaid funds from their ineligibility date to the end of June 2020.

Additionally, the Division was unable to provide evidence that 21 of the 185 (11%) providers held the required credentials when their re-verification application was approved. Examples of providers for which the Division could not provide documentation include:

- A Home Healthcare Agency that served 378 beneficiaries and was paid approximately \$18.1 million by Medicaid since January 1, 2018.
- A Home Healthcare Agency that served 711 beneficiaries and was paid approximately \$15.5 million by Medicaid since January 1, 2018.
- An organizational provider specializing in Senior Care that served 230 beneficiaries and was paid approximately \$11.6 million by Medicaid since January 1, 2018.

In total, these 21 providers served 4,630 beneficiaries and were paid approximately \$74.6 million in Medicaid funds from their re-verification date to the end of June 2020.

The providers identified above and the associated Medicaid funds they were paid were only those identified in the sample and may not include all that exist in the entire population.⁴⁴

Caused by Process Weaknesses That Limited Credential Verification

Professional credentials were not verified during the Medicaid Provider Enrollment re-verification process because weaknesses in its process prevented the Division from ensuring that all provider credentials were verified.⁴⁵

⁴³ In some instances, providers lacked the required credentials before their re-verification application approval date. When this occurred, auditors calculated payment and beneficiary totals from either the date the provider *first* lacked the required credentials or January 1, 2018, whichever was later.

⁴⁴ The sample was originally pulled statistically with the plan to extrapolate to the population. But the high error rate would have required expanding the sample significantly to allow meaningful extrapolation.

⁴⁵ Verification of credentials was performed by the Division's contractor GDIT. However, the method used by GDIT was prescribed by the Division and the responsibility of verifying credentials is ultimately the Division's.

In July 2017, the Division began relying on an automated process that included a:

- Licensure/accreditation/certification provider notification crawler program within the Medicaid claims processing system (NCTracks) to notify providers of upcoming licensure, accreditation, or certification expiration dates and to suspend or terminate providers that do not update their credentials.
- Straight file feed from the NC Medical Board (NCMB) to ensure direct licensure updates.
- LexisNexis⁴⁶ crawler and monthly background report to perform ongoing credential verifications.

During a 2019 audit, the Office of the State Auditor (OSA) notified the Division of weaknesses in its re-verification process.

The Division asked the Centers for Medicare and Medicaid Services (CMS) if the Division's process met federal requirements. In an email to CMS dated March 28, 2019, the Division wrote:

We have a question about the CFR 455.450 requirement to conduct license verification during revalidation. If we use a crawler which runs all the time to perform ongoing license verifications, would that meet this requirement? We also run monthly sanctions/license/database checks with Lexis Nexis.

In an April 25, 2019, email, CMS said that the Division's process as described would meet federal requirements:

What you have suggested below would meet the requirement. You would just use the prior month's license verification checks to satisfy the check required upon the revalidation date.

However, the Division neglected to inform CMS about weaknesses in the Division's process that prevented compliance with federal requirements. For example, the Division did not inform CMS that:

- The licensure/accreditation/certification provider notification crawler program does not conduct primary source verification. It only notifies providers of upcoming licensure, accreditation, or certification expirations and tells them to update their NCTracks record.
- The portion of the licensure/accreditation/certification provider notification crawler program that is supposed to suspend or terminate providers if they do not update their credentials has not worked since 2013.
- The NCMB straight file feed only provides direct licensure updates for its Board; providers with expired or revoked licenses must still be reviewed and removed manually. The feed does not provide licensure updates for any of the other 20 relevant boards. Additionally, the NCMB straight file feed does not provide licensure updates for organizations or provide updates on accreditations/certifications.
- The LexisNexis crawler and monthly background report do not allow the Division to verify accreditations or certifications (only licenses).

⁴⁶ One of the largest databases in the world of legal and public-records related information.

- The LexisNexis crawler and monthly background report do not allow the Division to verify licenses that belong to businesses or organizations (only individuals).
- The LexisNexis crawler and monthly background report do not include up-to-date licensure information from all state licensing boards (some boards are only updated twice-a-year).
- The LexisNexis crawler and monthly background report only check whether the provider's credentials are valid, not whether providers have the credentials required by the State Plan.
- The LexisNexis crawler and monthly background report findings were not reviewed in a timely manner. According to the Division, there was a backlog of over 30,000 flags raised by LexisNexis but not yet reviewed by the Division or its contractor.

The weaknesses listed above continue to prevent the Division from ensuring that all provider credentials are properly verified during the re-verification process.

Federal Regulations and the State Plan Require Verification of Professional Credentials

CMS regulations require the Division to verify that providers have all required professional licenses to participate in Medicaid and to revalidate enrollment every five years:

42 CFR §455.412 Verification of provider licenses.

The State Medicaid agency must -

- (a) Have a method for verifying that any provider purporting to be licensed in accordance with the laws of any State is licensed by such State.

42 CFR §455.414 Revalidation of enrollment.

The State Medicaid agency must revalidate the enrollment of all providers regardless of provider type at least every 5 years.

The Medicaid State Plan (the Division's agreement with CMS) requires the Division to ensure that providers have all required accreditations and certifications in order to participate in Medicaid. The service areas that require accreditation or certification are spread throughout the State Plan and are summarized in the Provider Permission Matrix (see Appendix C for an example).

RECOMMENDATIONS

The Division should remove all providers who do not have the appropriate professional credentials required by the State Plan from the Medicaid program.

The Division should source verify the credentials of the 21 providers for whom it was unable to provide credentialing documentation.

The Division should source verify credentials directly with the credentialing agency during re-verification without relying on the crawler program or LexisNexis crawler and monthly background report. Alternatively, the Division could correct issues with the crawler program so that it functions properly or perform additional procedures to compensate for the LexisNexis crawler and monthly background report's limitations.

The Division should source verify professional credentials of enrolled Medicaid providers during the re-verification process at least once every five years to ensure that only qualified providers serve Medicaid beneficiaries and receive payments from the State.

The Secretary should have a method to ensure the Division complies with CMS regulations.

AGENCY RESPONSE

See page 29 for the Department's response to this finding.

4. DIVISION DID NOT VERIFY PROVIDER OWNERSHIP INFORMATION; MILLIONS PAID TO PROVIDERS WHO POTENTIALLY SHOULD HAVE BEEN REMOVED FROM MEDICAID, AND FRAUD RISK WAS INCREASED

The Department of Health and Human Services' (Department) Division of Health Benefits (Division) did not require its contractor to verify provider ownership information during the Medicaid provider enrollment re-verification process.⁴⁷ As a result, the Division paid millions of dollars to providers who potentially should have been removed from the Medicaid program. Additionally, the Division's ability to detect and prevent potential Medicaid fraud was reduced. Ownership information was not verified because the Division said it was not required to do so. However, it is a Centers for Medicare and Medicaid (CMS) best practice to verify the ownership information of providers enrolled in the Medicaid program.

The Division Did Not Verify Provider Ownership

The Division did not verify owners, managing employees, or others with controlling interest (collectively referred to as ownership information) of providers during the Medicaid provider enrollment re-verification process.

CMS has stated that verifying ownership is critical. Specifically, CMS stated:

Provider enrollment is the first line of defense in program integrity. When applying for enrollment, providers are required to furnish **information that State Medicaid agencies can use to prevent fraudulent providers from enrolling.**⁴⁸ (*Emphasis Added*)

Additionally, CMS notes that disclosure of ownership information has been, and continues to be, the most widely cited finding in their program integrity reviews in both fee-for-service and managed care settings.⁴⁹

Auditors tested a sample of 191 approved applications. For all 191 applications (100%), the Division failed to verify the ownership information.⁵⁰ During the state fiscal year (SFY) 2019, the Division approved 27,334 provider re-verification applications.

⁴⁷ The Medicaid re-verification process is separate from the initial enrollment process. Auditors did not find reportable errors in the initial enrollment process.

⁴⁸ <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/ebulletins-providerenrollment-disclosureownership.pdf>

⁴⁹ <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/fftoolkit-ownership-control.pdf>

⁵⁰ Verification of provider ownership should be performed by the Division's contractor, GDIT. However, GDIT did not verify ownership because the Division did not direct them to do so. Further, the responsibility of verifying ownership information is ultimately the Division's.

Resulted in \$41.7 Million to Providers That Potentially Should Have Been Removed from Medicaid Program

Because the Division did not verify ownership information, it did not identify providers who submitted inaccurate information. Therefore, those providers remained enrolled in the Medicaid program, served Medicaid beneficiaries, and received payment from the State. Federal regulations required the Division to remove providers who submitted inaccurate ownership information from the Medicaid program.⁵¹

Of the 191 approved provider re-verification applications tested, 21 of the 191 (11%) providers did not disclose complete and accurate information.⁵² For example,

- **The President of an assisted living facility** did not disclose a controlling interest on the organization's re-verification application. At the time of the Division's approval of the application on September 25, 2018, this individual **was a defendant in a \$60 million lawsuit for alleged Medicaid fraud**. From January 1, 2018, to June 30, 2020, this facility served 74 beneficiaries and was paid approximately \$1.8 million by Medicaid.
- A medical device manufacturing and service company that only serves infant children failed to disclose three of its company officers on its re-verification application. From the Division's approval of the application on August 28, 2018, through June 30, 2020, this organization provided services and equipment to 524 children and was paid approximately \$1.5 million by Medicaid.
- The owner of a pharmacy failed to disclose that one of its managing employees was actually a company owner. From the Division's approval of the application on December 19, 2018, through June 30, 2020, the pharmacy was paid approximately \$113,000 by Medicaid.

Because the Division did not verify ownership information, the Division could not and did not perform background checks, verify credentials, and complete other steps necessary to determine whether the undisclosed owners were eligible to be enrolled in Medicaid.

In total, these 21 providers served over 37,600 beneficiaries and were paid approximately \$41.7 million in Medicaid funds for services provided from the date they submitted inaccurate information or from when the Division missed the provider's re-verification deadline to the end of June 2020.

The providers identified above and the associated Medicaid funds they were paid were only those identified in the sample and may not include all that exist in the entire population.⁵³

Also Resulted in Reduced Ability to Detect and Prevent Potential Medicaid Fraud

Failure to verify ownership information also reduced the Division's ability to identify and prevent potentially fraudulent providers from enrolling in Medicaid.

⁵¹ 42 CFR §455.416 requires states to terminate the providers' enrollment or deny enrollment of the provider if the provider or a person with an ownership control or controlling interest or who is an agent or managing employee of the provider fails to submit timely or accurate information, unless the state determines that termination or denial of enrollment is not in the best interests of the Medicaid program and the State Medicaid agency documents that determination in writing.

⁵² Determined by comparing the provider's application to information from the North Carolina Secretary of State. <https://www.sosnc.gov/search/index/corp>.

⁵³ The sample was originally pulled statistically with the plan to extrapolate to the population. But the high error rate would have required expanding the sample significantly to allow meaningful extrapolation.

The New York Times reported that the operators of Agape Healthcare Systems and Assured Healthcare Systems were indicted for an alleged \$13 million fraud from Medicaid over 10 years.⁵⁴ The operators disclosed inaccurate ownership information in their enrollment and re-verification applications. One of the undisclosed owners had a prior felony conviction for identity theft.

If the Division had verified the ownership information during the re-verification process, it would have performed the necessary background check, discovered the felony conviction, and had the opportunity to remove the provider from the Medicaid program. However, the Division did not verify any of the disclosures for accuracy.

As of January 2021, Assured Healthcare Systems remained an active provider in the Medicaid claims processing system (NCTracks).

Caused by Division's Position That It Was Not Required to Verify Ownership Information

The Division said it did not verify provider ownership information during the Medicaid provider enrollment re-verification process because it was not required to do so.⁵⁵

CMS Best Practice is to Verify Accuracy of Ownership Information

Verification of ownership interest is identified as a best practice by CMS. In an E-Bulletin titled "Provider Enrollment: Disclosure of Ownership and Control Snapshot," CMS states:⁵⁶

It is a best practice for SMAs [State Medicaid Agencies] to screen identity and ownership information by comparing it to data available from State business licensure boards.⁵⁷

RECOMMENDATION

The Division should verify the accuracy of all provider ownership disclosures so that background checks can be performed.

When providers submit inaccurate information but are still allowed to enroll, the Division should document the reasons why termination or denial of enrollment is not in the best interests of the Medicaid program. Additionally, the Division should consider increasing its monitoring of these providers.

The Secretary should have a method to ensure the Division complies with CMS regulations.

AGENCY RESPONSE

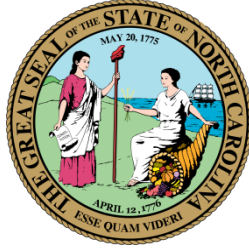
See page 29 for the Department's response to this finding.

⁵⁴ <https://www.nytimes.com/2020/05/28/us/medicare-fraud-las-vegas.html>.

⁵⁵ Verification of provider ownership should be performed by the Division's contractor, GDIT. However, GDIT did not verify ownership because the Division did not direct them to do so. Further, the responsibility of verifying ownership information is ultimately the Division's.

⁵⁶ <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/ebulletins-providerenrollment-disclosureownership.pdf>.

⁵⁷ In North Carolina, the State's business licensure board function is performed by the North Carolina Secretary of State.



MATTERS FOR FURTHER CONSIDERATION

1. IMPROVED DOCUMENTATION AND OVERSIGHT NEEDED FOR PROVIDERS FLAGGED AS HIGHER-RISK

The Division of Health Benefits (Division) should improve its documentation supporting the approval of higher-risk providers.⁵⁸ The Division should also consider increasing the oversight of these same providers.

Federal regulations⁵⁹ allow the Division to enroll higher-risk providers if:

the State Medicaid agency determines that denial or termination of enrollment is not in the best interests of the Medicaid program and the State Medicaid agency documents that determination in writing.

For example, the Division may approve such a provider because there was no other provider providing the same service in that region of the State.

However, the Division's documentation does not consistently contain:

- The criteria used to evaluate these providers.
- How the criteria were considered.
- What evidence was reviewed and gathered.
- How the final approval decision was reached.

Consequently, management cannot determine whether the approval of these providers is truly in the best interest of the Medicaid program.

Department management was made aware of the documentation deficiencies six years ago in a 2014 Office of the State Auditor audit of the Division's Provider Enrollment process.⁶⁰ The audit found that documentation to support higher-risk provider applications was often not available or insufficient to support the application approval.

Additionally, the Division should consider implementing procedures to more closely track and monitor flagged, higher-risk providers.

It's prudent to increase oversight for providers deemed to be at higher-risk of committing fraud, waste, and abuse. And providers who are allowed to participate in Medicaid after being flagged as higher-risk are by definition at greater risk of committing fraud, waste, and abuse.

However, the Division does not currently perform any additional monitoring or oversight (such as additional review of claims for payment) once it approves a higher-risk provider for participation in the Medicaid program.

⁵⁸ When adverse actions such as a criminal history or a professional license limitation of a provider are identified in the screening and enrollment process, General Dynamics Information Technology (GDIT) sends these "flagged, higher-risk" provider applications to the Division for further review and to approve or deny the provider to participate in NC Medicaid.

⁵⁹ 42 CFR §455.416.

⁶⁰ <https://www.auditor.nc.gov/EPSSWeb/reports/performance/PER-2014-4445.pdf>.

2. IMPROVED OVERSIGHT NEEDED FOR LOCAL MANAGEMENT ENTITY/MANAGED CARE ORGANIZATION PROVIDER ENROLLMENT

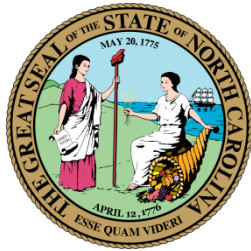
The Division of Health Benefits (Division) should consider increasing its oversight of Local Management Entities/Managed Care Organizations (LME-MCOs)⁶¹ provider enrollment.

LME-MCOs maintain their own provider networks, but each provider is still required to apply through the Division's Medicaid enrollment process.

However, the Division does not have procedures to ensure that all LME-MCO providers are properly enrolled in Medicaid.

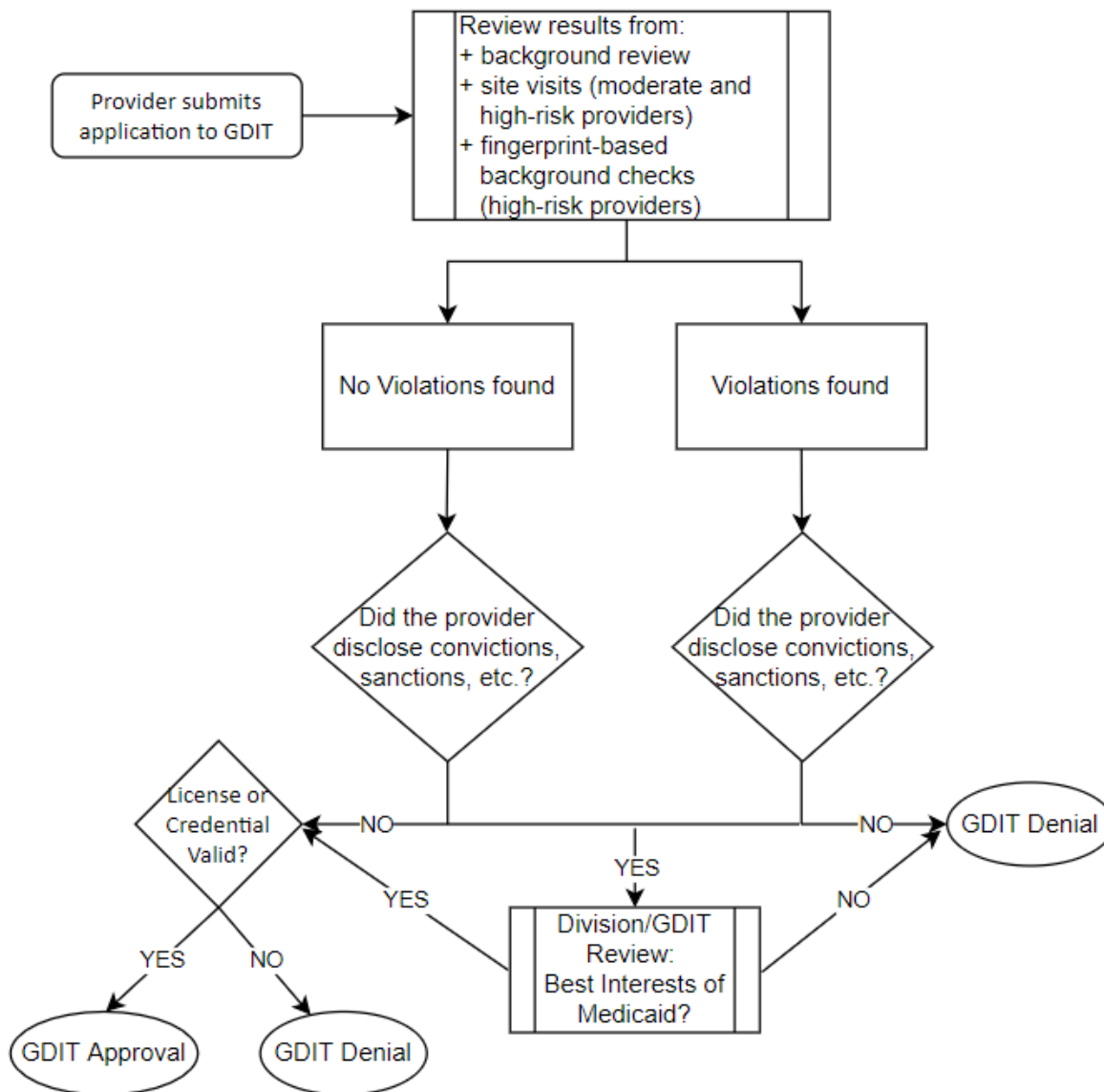
As a result, the Division cannot determine if LME-MCOs are paying ineligible providers.

⁶¹ LME/MCOs are political subdivisions of the State that contract with the Division to provide managed care behavioral health services (mental health, substance abuse, and developmental disability) for Medicaid beneficiaries through a network of licensed practitioners and provider agencies.



APPENDICES

APPENDIX A

INITIAL ENROLLMENT PROCESS FLOWCHART

Division of Health Benefits (Division) - The Division's mission is to provide access to physical and behavioral health care and services to improve the health and well-being of over 2.1 million North Carolinians. Overseen by the Department, the Division manages Medicaid.

General Dynamics Information Technology (GDIT) - The Department contracts with GDIT, a non-governmental organization, to perform most of the provider enrollment functions on behalf of the Division.

APPENDIX B

The NC licensing boards that regulate services covered by Medicaid are in the chart below:

North Carolina State Licensing Boards

NC Medical Board	NC Board of Licensed Clinical Mental Health Counselors	NC Board of Optometry	NC Social Work Certification and Licensure Board
NC Board of Dental Examiners	NC Board of Nursing	NC Board of Physical Therapy Examiners	NC Board of Chiropractic Examiners
NC Board of Pharmacy	NC Board of Occupational Therapy	NC Marriage & Family Licensure Therapy Board	NC Acupuncture Licensing Board
NC State Hearing Aid Dealers and Fitters Board	NC Board of Podiatry Examiners	NC Psychology Board	NC Board of Dietetics/Nutrition
NC Board of Examiners for Speech-Language Pathologists and Audiologists	NC State Board of Opticians	NC Respiratory Care Board	NC Addictions Specialists Professional Practice Board

APPENDIX C – EXAMPLE OF PROVIDER PERMISSION MATRIX

ENROLLMENT TYPE	TAXONOMY LEVEL 2	TAXONOMY LEVEL 3	CERTIFICATION / LICENSE / ACCREDITATION RQRD?	CERTIFICATION / LICENSE / ACCREDITATION TYPE	CERTIFICATION / LICENSE / ACCREDITATION AGENCY
Individual	Pathology	Neuropathology	YES	DOCTOR OF MEDICINE (MD) OR DOCTOR OF OSTEOPATHIC MEDICINE (DO)	STATE MEDICAL BOARD
Individual	Psychiatry & Neurology	Neurology	YES	DOCTOR OF MEDICINE (MD) OR DOCTOR OF OSTEOPATHIC MEDICINE (DO)	STATE MEDICAL BOARD
Individual	Psychiatry & Neurology	Psychiatry	YES	DOCTOR OF MEDICINE (MD) OR DOCTOR OF OSTEOPATHIC MEDICINE (DO)	STATE MEDICAL BOARD
Individual	Radiology	Diagnostic Radiology	YES	DOCTOR OF MEDICINE (MD) OR DOCTOR OF OSTEOPATHIC MEDICINE (DO)	STATE MEDICAL BOARD
Individual	Radiology	Diagnostic Ultrasound	YES	DOCTOR OF MEDICINE (MD) OR DOCTOR OF OSTEOPATHIC MEDICINE (DO)	STATE MEDICAL BOARD
Individual	Dermatology		YES	DOCTOR OF MEDICINE (MD) OR DOCTOR OF OSTEOPATHIC MEDICINE (DO)	STATE MEDICAL BOARD
Individual	Nuclear Medicine	Nuclear Cardiology	YES	DOCTOR OF MEDICINE (MD) OR DOCTOR OF OSTEOPATHIC MEDICINE (DO)	STATE MEDICAL BOARD
Individual	Pediatrics	Neurodevelopmental Disabilities	YES	DOCTOR OF MEDICINE (MD) OR DOCTOR OF OSTEOPATHIC MEDICINE (DO)	STATE MEDICAL BOARD
Individual	Pediatrics	Pediatric Cardiology	YES	DOCTOR OF MEDICINE (MD) OR DOCTOR OF OSTEOPATHIC MEDICINE (DO)	STATE MEDICAL BOARD
Individual	Pediatrics	Pediatric Rheumatology	YES	DOCTOR OF MEDICINE (MD) OR DOCTOR OF OSTEOPATHIC MEDICINE (DO)	STATE MEDICAL BOARD
Individual	Dentist	Pediatric Dentistry	YES	LICENSED DENTIST	STATE BOARD OF DENTAL EXAMINERS
Organization	Technician / Technologist	Optician	YES	LICENSED OPTICIAN/OPTICAL SUPPLIER	STATE BOARD OF OPTICIANS
Individual	Physician Assistant		YES	LICENSED PHYSICIAN ASSISTANT	STATE MEDICAL BOARD
Individual	Nurse Practitioner	Primary Care	YES	NURSE PRACTITIONER	STATE BOARD OF NURSING
Individual	Podiatrist	Foot & Ankle Surgery	YES	LICENSED PODIATRIST	STATE BOARD OF PODIATRY EXAMINERS
Individual	Orthotist		NO		
Individual	Occupational Therapist		YES	LICENSED OCCUPATIONAL THERAPIST	STATE BOARD OF OCCUPATIONAL THERAPY
Individual	Audiologist		YES	LICENSED AUDIOLOGIST	STATE BOARD OF EXAMINERS FOR SPEECH & LANGUAGE PATHOLOGISTS & AUDIOLOGISTS
Organization	Audiologist-Hearing Aid Fitter		YES	LICENSED AUDIOLOGIST	STATE BOARD OF EXAMINERS FOR SPEECH & LANGUAGE PATHOLOGISTS & AUDIOLOGISTS
Organization	Pharmacy	Community/Retail Pharmacy	YES	PHARMACY PERMIT	STATE BOARD OF PHARMACY

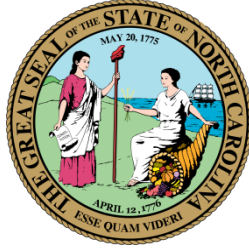
APPENDIX D

INTERNAL CONTROL COMPONENTS AND PRINCIPLES SIGNIFICANT TO THE AUDIT OBJECTIVE

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

Internal control components and underlying principles that were significant to our audit objective are identified in the table below.

COMPONENTS AND PRINCIPLES	SIGNIFICANT
CONTROL ENVIRONMENT	
1. The oversight body and management should demonstrate a commitment to integrity and ethical values.	
2. The oversight body should oversee the entity's internal control system.	
3. Management should establish an organizational structure, assign responsibility, and delegate authority to achieve the entity's objectives.	
4. Management should demonstrate a commitment to recruit, develop, and retain competent individuals.	
5. Management should evaluate performance and hold individuals accountable for their internal control responsibilities.	
RISK ASSESSMENT	
6. Management should define objectives clearly to enable the identification of risks and define risk tolerances.	
7. Management should identify, analyze, and respond to risks related to achieving the defined objectives.	X
8. Management should consider the potential for fraud when identifying, analyzing, and responding to risks.	
9. Management should identify, analyze, and respond to significant changes that could impact the internal control system.	
CONTROL ACTIVITIES	
10. Management should design control activities to achieve objectives and respond to risks.	X
11. Management should design the entity's information system and related control activities to achieve objectives and respond to risks.	
12. Management should implement control activities through policies.	X
INFORMATION AND COMMUNICATION	
13. Management should use quality information to achieve the entity's objectives.	X
14. Management should internally communicate the necessary quality information to achieve the entity's objectives.	
15. Management should externally communicate the necessary quality information to achieve the entity's objectives.	
MONITORING ACTIVITIES	
16. Management should establish and operate monitoring activities to monitor the internal control system and evaluate the results.	X
17. Management should remediate identified internal control deficiencies on a timely basis.	



STATE AUDITOR'S RESPONSE

The Office of the State Auditor (OSA) is required to provide additional explanation when an agency's response could potentially cloud an issue, mislead the reader, or inappropriately minimize the importance of the auditor findings.

Generally Accepted Government Auditing Standards state,

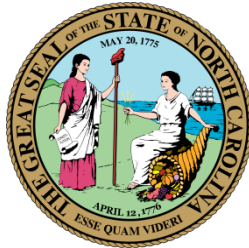
When the audited entity's comments are inconsistent or in conflict with the findings, conclusions, or recommendations in the draft report, the auditors should evaluate the validity of the audited entity's comments. If the auditors disagree with the comments, they should explain in the report their reasons for disagreement.

In its response, the Department of Health and Human Services (Department) agreed with results of this audit and it discussed several corrective actions that are either planned or currently in process. This is reflective of the type of accountability and responsibility taxpayers want to see from their government agencies.

However, the Department's response included language that could mislead the reader and minimize the importance of the auditor findings. Specifically, the Department stated:

The Division has determined that, except for the payment risk associated with not validating provider ownership, the potential overpayments subject to recoupment from the providers reviewed in this audit was \$13.4M.

To clarify, the \$13.4 million noted by the Department includes potential overpayments identified from only the providers included in the sample selected in this audit. It **does not** include all overpayments that may exist in the entire population of payments made to Medicaid providers.



RESPONSE FROM DEPARTMENT OF HEALTH AND HUMAN SERVICES



STATE OF NORTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

ROY COOPER
GOVERNOR

MANDY COHEN, MD, MPH
SECRETARY

February 12, 2021

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:

I have reviewed the performance report titled Medicaid Provider Enrollment, which evaluated the Division's provider enrollment processes in place during State Fiscal Year (SFY) 2019. Ensuring that we enroll and maintain only qualified providers to care for the beneficiaries is a fundamental responsibility of the Medicaid program. I have directed our Medicaid program leadership to make the issues identified in the report a top priority. As you will see in our responses below, we have already implemented many of the recommended changes. For those that require additional actions Medicaid will provide me with monthly updates on their progress and I will provide to you an update within 3 months.

Medicaid is currently instituting an annual compliance monitoring plan that will identify monitoring and oversight risks throughout the program and ensure management implements adequate mitigation efforts in a timely manner. The plan will include enhancements to the Medicaid program to assure follow up of outstanding corrective actions. In addition, the North Carolina Department of Health and Human Services (the Department) is developing a Provider Data Management function which will include a Department-wide credentialing verification component to ensure a uniform and thorough vetting of providers delivering services to the millions of beneficiaries we serve. We anticipate rolling out this strategic enhancement in July 2023.

We take every instance of an unqualified provider very seriously and any overpayment is unacceptable. The Division has determined that, except for the payment risk associated with not validating provider ownership, the potential overpayments subject to recoupment from the providers reviewed in the audit was \$13.4M. The team is pursuing recoupment of all confirmed overpayments.

The following represents our response and corrective actions taken and planned regarding the Audit Findings and Recommendations.

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AUDIT FINDINGS, RECOMMENDATIONS, AND RESPONSES

1. Unlicensed providers served Medicaid beneficiaries and received payments.

Recommendations:

The Division should immediately remove all providers who have suspended or terminated professional licenses from the Medicaid program.

The Division should monitor reports from all state licensing boards that regulate services covered by the Medicaid program to identify and remove providers from the Medicaid program with suspended or terminated professional licenses.

The Secretary should have a method to ensure the Division complies with CMS regulations.

Agency Response:

The Department agrees with the finding and the Division has already taken appropriate steps to address the providers identified in the report, including the initiation of recoupment efforts where necessary. As noted, the Division had implemented an email listserv process with the licensing boards to receive suspension and termination information. Once it was identified that the process was not sufficient, the Division implemented a manual, weekly review of all licensing board updates. Beginning in June 2020, Division staff access the websites of all the licensing boards that publish license actions each week to obtain a listing of impacted providers and takes immediate action as necessary. As some board actions are not always or immediately made public, the Division has engaged in conversation with those licensing boards to determine if an option exists for the Division to be made aware of provider performance risks that impact Medicaid service delivery.

2. Division increased risk to Medicaid program and beneficiaries by allowing providers with license limitations to remain enrolled in Medicaid.

Recommendations:

The Division should immediately remove all providers from the Medicaid program who have professional license limitations and pose threats to the safety of beneficiaries.

The Division should create written policies and procedures for the continued enrollment of providers with limitations on their license. The policy should describe the types of license limitations that the Division finds acceptable. The policy should also require adequate documentation to support decisions to either enroll or deny enrollment.

The Secretary should have a method to ensure the Division complies with CMS regulations.

Agency Response:

The Department agrees with the finding and the Division has implemented the corrective actions listed below to mitigate the risk identified. As noted, the Division did not believe it had the authority to terminate providers with limitations. Immediately upon clarification from CMS, the Division developed a policy for addressing providers with license limitations. The policy, effective August 2020, created a Provider Operations License Limitations Review Committee and established criteria to consider in reviewing a provider's license limitations and what action to take regarding the provider's enrollment in the Medicaid program. The policy identifies when termination is appropriate and allows for monitoring in certain circumstances or termination where monitoring efforts cannot be implemented. The committee meets on a bi-weekly basis. Since the committee's implementation, 52 providers have been reviewed for license limitations resulting in 6 providers being terminated and 12 subjected to monitoring efforts, while 34 providers were deemed low risk to the program and no corrective action was necessary.

3. Providers without required credentials paid \$11.2 million

Recommendations:

The Division should remove all providers who do not have the appropriate professional credentials required by the State Plan from the Medicaid program.

The Division should source verify the credentials of the 21 providers for whom it was unable to provide credentialing documentation.

The Division should source verify credentials directly with the credentialing agency during re-verification without relying on the crawler program or LexisNexis crawler and monthly background report. Alternatively, the Division could correct issues with the crawler program so that it functions properly or perform additional procedures to compensate for the LexisNexis crawler and monthly background report's limitations.

The Division should source verify professional credentials of enrolled Medicaid providers during the re-verification process at least once every five years to ensure that only qualified providers serve Medicaid beneficiaries and receive payments from the State.

The Secretary should have a method to ensure the Division complies with CMS regulations.

Agency Response:

The Department agrees that the opportunity exists to further strengthen our ongoing provider credential monitoring. During FY2019, the Division received updated license credential begin/end dates for 59,126 providers from 18 licensing boards. In accordance with CMS' consent, the Division utilizes a monthly automated credentials review process which eliminates the need to perform credential verification at the time of re-verification, provided that the monthly process covers all provider types. The Division acknowledges that a gap exists in the monthly automated process whereby organization provider types are not evaluated. This gap contributed to the improper payment of \$11.2M to providers as noted in the report. The Division is working to enhance the automation to ensure all provider types are covered each month.

Additionally, the report identified that the sample of the 191 provider credentials tested during the audit revealed that only 21 credentials had not been evaluated by the monthly automated review process. The 21 provider credentials were omitted due to the gap previously noted. While the total payments to these 21 providers approximated \$76.4 million as noted in the audit report, the Division subsequently reviewed the providers' credentials and noted that only one provider was insufficiently licensed during the audit period, resulting in an actual overpayment of \$184,642.18.

Due to the current public health emergency, licensing boards have issued extensive grace periods for licensure renewals so terminations for license expiration has been suspended. Once the public health emergency ends, the Division will manually source verify credentials of organization provider types during re-verification until an effective automated solution is implemented to cover them. Additionally, the Division has implemented a system enhancement to ensure all provider re-verifications are taking place within the current 5-year period as required by CMS.

4. Division did not verify provider ownership information; millions paid to providers who potentially should have been removed from Medicaid, and fraud risk was increased.

Recommendations:

The Division should verify the accuracy of all provider ownership disclosures so that background checks can be performed.

RESPONSE FROM DEPARTMENT OF HEALTH AND HUMAN SERVICES

When providers submit inaccurate information but are still allowed to enroll, the Division should document the reasons why termination or denial of enrollment is not in the best interests of the Medicaid program. Additionally, the Division should consider increasing its monitoring of these providers.

The Secretary should have a method to ensure the Division complies with CMS regulations.

Agency Response:

The Department agrees with the finding. While verification of ownership is not required by CMS and all omitted ownership disclosures do not indicate fraudulent intent, the Department acknowledges that verification of ownership is a best practice and viable method of ensuring the integrity of the Medicaid program. The Division will evaluate the methods available to verify the accuracy of ownership information and implement appropriate policies and procedures.

We appreciate the assistance and professionalism provided by your staff in the performance of this audit. If you need additional information, please contact John Thompson at (919) 527-7701.

Sincerely,



Mandy K. Cohen, MD, MPH
Secretary

MC:jet

cc: Susan Perry-Manning, Principal Deputy Secretary
Rob Kindsvatter, Chief Financial Officer
Dave Richard, Deputy Secretary, NC Medicaid, Division of Health Benefits
Jay Ludlam, Assistant Secretary, NC Medicaid, Division of Health Benefits
Adam Levinson, Chief Financial Officer, NC Medicaid, Division of Health Benefits
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