NC Department of Health and Human Services
Division of Health Benefits

Medicaid Provider Enrollment Follow-Up Audit

Raleigh, NC

Performance Audit Report

July 2025

State Auditor
Dave Boliek

A Constitutional Office of the State of North Carolina

North Carolina Office of the State Auditor
Dave Boliek, State Auditor

Auditor's Transmittal

The Honorable Josh Stein, Governor
The Honorable Phil Berger, President Pro Tempore
The Honorable Destin Hall, Speaker of the House
Honorable Members of the North Carolina General Assembly
Dr. Devdutta Sangvai, Secretary, Department of Health and Human Services
Jay Ludlam, Deputy Secretary for North Carolina Medicaid

To all:

In its audit of the Department of Health and Human Services, Division of Health Benefits, the North Carolina Office of the State Auditor (OSA) has identified cases in which Medicaid providers with professional limitations on their licenses – limitations that pose a threat to the safety of patients – were able to receive Medicaid payments and provide healthcare services to patients enrolled in the Medicaid program.

This report comes four years after similar findings were documented in OSA's initial audit of the state's Medicaid Provider Enrollment. Our findings show that it's clear the Department of Health and Human Services has not fully remedied the issue. The ultimate goal should be to protect North Carolina's Medicaid system and taxpayers vulnerable to fraudulent and potentially dangerous behavior.

We found multiple cases of providers with license limitations remaining active in the Medicaid claims processing system.

In one instance, a physician with a medical license limitation on providing treatment to female patients (along with that physician's nurse practitioner) billed Medicaid for $7,303 and provided services to 21 women. This physician remains enrolled in the state's Medicaid program despite having entered a settlement agreement forcing the return of $75,000 for submitting false or fraudulent claims to the Medicaid program.

A different physician who was prohibited from prescribing controlled medications following a Drug Enforcement Agency (DEA) raid of that physician's practices remained active in the system, as did a dentist whose moderate sedation permit was suspended for administering general anesthesia without a license.

Additionally, our audit shows the Division of Health Benefits did not verify that enrolled Medicaid providers had DEA certification. Healthcare providers are required to have DEA certification to prescribe controlled substances. By not verifying, the Division puts the health and safety of low-income Medicaid patients at greater risk.

OSA offers several recommendations that the Division should implement immediately to protect Medicaid patients and the state's Medicaid system from potential fraud and abuse. We acknowledge that DHHS disagrees with some of our findings, but we stand by our audit and its accuracy.

North Carolina Office of the State Auditor
Dave Boliek, State Auditor

The Department of Health and Human Services has received and reviewed a draft copy of this report, and their written comments are included in the report beginning on page 32.

Respectfully submitted,

Dave Boliek
State Auditor

Executive Summary

The Office of the State Auditor (OSA) has completed a follow-up performance audit in accordance with Chapter 147, Article 5A of the North Carolina General Statutes concerning the Medicaid provider enrollment process overseen by the Department of Health and Human Services, Division of Health Benefits (Division).

OSA's February 2021 audit titled *Medicaid Provider Enrollment* found that the Division did not ensure that only qualified providers[1] were approved to provide services to Medicaid beneficiaries and to receive payments from North Carolina's Medicaid program during the state fiscal year 2019.

Medicaid is a joint federal and state funded program that provides health insurance coverage to eligible 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."[2]

The 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), although the Division has ultimate responsibility.

Objective:

The objective of this audit was to determine whether the Division implemented corrective actions to address the findings and recommendations made in OSA's February 2021 *Medicaid Provider Enrollment* performance audit. Specifically, for the period January 1, 2023, through December 31, 2023, whether the Division:

1. Identified and removed providers from the Medicaid program who had their professional license suspended or terminated.

2. Identified and removed providers from the Medicaid program who had professional license limitations and who posed threats to the safety of beneficiaries.

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

[2] GAO, *CMS Oversight Should Ensure State Implementation of Screening and Enrollment Requirements*, October 2019.

Executive Summary (Continued)

3. Ensured all provider professional accreditations and credentials were verified.
4. Verified provider ownership information.

Key Findings:

The Division **did not fully implement** recommendations made in OSA's *Medicaid Provider Enrollment* performance audit.

The Division did not:

- Identify and remove providers that entered into Non-Practice Agreements[3] with professional licensing boards.
- Evaluate the risk providers with limitations on their licenses may pose to patients nor remove any of the providers from the Medicaid program.
- Verify that enrolled providers possessed a United States Department of Justice's Drug Enforcement Administration (DEA) certification.[4]
- Corroborate ownership information of providers during the Medicaid provider enrollment re-verification process.[5]

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 payments from North Carolina's Medicaid program.

Recommendations:

1. Division management should remove all providers who have had their professional licenses suspended, terminated, or entered into Non-Practice Agreements from the Medicaid program.

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[3] A Non-Practice Agreement 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.

[4] A Drug Enforcement Administration certificate, or license, is required for physicians, nurse practitioners, physician assistants, pharmacists, optometrists and dentists to prescribe controlled substances. The DEA regulates both the prescribing and distribution of controlled substances such as narcotics and sedatives.

[5] The Medicaid re-verification process is separate from the initial enrollment process and is required every five years. As part of the process, provider credentials and qualifications must be evaluated to ensure they meet professional requirements. Re-verification also includes background checks on owners and managing relationships associated with the provider record.

Executive Summary (Concluded)

2. The Division's Medicaid policies and procedures should include the identification and removal of providers that cannot practice or perform any act that requires a license.

3. Division management should remove all providers from the Medicaid program who have professional license limitations that pose threats to the safety of patients.

4. The Division's policies and procedures for the continued enrollment of providers with limitations on their license 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.

5. Division management should verify that providers possess DEA certifications given the potential risk posed to Medicaid patients from providers prescribing controlled substances without required DEA certification.

6. The Division should verify the accuracy of all provider ownership information so that background checks can be performed and identified ineligible providers removed from Medicaid to protect the safety of Medicaid patients and prevent inappropriate payments from the state.

Division management should fully implement prior audit recommendations in a timely manner.

Given this report comes four years after similar findings were documented in OSA's initial audit of the state's Medicaid Provider Enrollment, it's clear the Department of Health and Human Services has failed to fully remedy the issue, leaving North Carolina's Medicaid system and taxpayers vulnerable to fraudulent and potentially dangerous behavior.

Matters for Further Consideration:

Division management should improve monitoring of the $1.5 billion GDIT contract so that the state's interest is protected and to ensure the effective and efficient use of taxpayer funds.

Table of Contents

Chapter 147, Article 5A of the North Carolina General Statutes gives the Auditor broad powers to examine all books, records, files, papers, documents, and financial affairs of every state agency and any organization that receives public funding. The Auditor also has the power to summon people to produce records and to answer questions under oath.

Background

The Office of the State Auditor's (OSA) February 2021 report titled *Medicaid Provider Enrollment* found that the North Carolina Department of Health and Human Services, Division of Health Benefits (Division) did not ensure that only qualified providers were approved to provide services to Medicaid beneficiaries and to receive payments from North Carolina's Medicaid program during the state fiscal year 2019. 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 payments[6] from the state.

The Division did not ensure that only qualified providers were approved to provide Medicaid services and to receive Medicaid payments because:

- The Division did not monitor disciplinary reports from state licensing boards.
- The Division stated it did not have the authority to terminate providers with license limitations.
- The Division had weaknesses in the Division's automated verification process.
- The Division said it was not required to verify ownership information.

Additionally, auditors identified concerns about the effectiveness of the Division's contract monitoring of the fiscal agent General Dynamics Information Technology (GDIT).

The February 2021 audit report recommended that:

- 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 Plan[7] from the Medicaid program.
- The Division should verify the accuracy of all provider ownership disclosures so that background checks can be performed.[8] When providers submit inaccurate information but are still allowed to enroll, the Division of Health Benefits should document the reasons why termination or denial of enrollment is not in the best interest of the Medicaid program.

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

[7] 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 administrative activities that are underway in the state.

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

North Carolina Medicaid Program:

North Carolina 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.[9]

Pursuant to 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.[10]

The federal Centers for Medicare and Medicaid Services (CMS) established regulations[11] 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, 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 GDIT, but the Division has **ultimate responsibility** for the screening and enrollment of Medicaid providers in accordance with federal regulations.

Medicaid spent approximately $19 billion in federal and state funds during the calendar year 2023.

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. Applicants must disclose any adverse actions on the Medicaid enrollment application.

[9] Doctors, pharmacies, hospitals, mental health counselors, durable medical equipment suppliers, and personal care services are all examples of providers.
[10] Such as a medical license, registered nurse license, facility accreditation, etc.
[11] 42 CFR §455 Subpart E.

Medicaid providers must have their enrollment re-verified every five years.[12] 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[13] to search for limitations that a state licensing board may have placed on a provider's professional license.

Responsible parties discussed in this report include:

North Carolina Department of Health and Human Services[14] – The Department of Health and Human Services' mission is to improve the health, safety, and well-being of all North Carolinians. The Department of Health and Human Services helps to provide specific services to special populations including individuals who are deaf, blind, developmentally disabled, mentally ill, or economically disadvantaged.

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

Division of Health Benefits[15] – The Division of Health Benefits mission is to provide access to physical and behavioral health care and services to improve the health and well-being of North Carolinians. Overseen by the Department of Health and Human Services, the Division of Health Benefits manages the state's Medicaid program.

General Dynamics Information Technology – The Department of Health and Human Services contracts with General Dynamics Information Technology, a non-governmental organization, to perform most of the Medicaid provider enrollment functions on behalf of the Division. See related Matter for Further Consideration on page 22.

System discussed in this report:

NCTracks – The Department of Health and Human Services' Medicaid Management Information System. NCTracks is the Information Technology system by which providers are enrolled in Medicaid, re-verified every five years, and terminated when appropriate.

[12] 42 CFR §455.414.
[13] 42 CFR §455.412.
[14] www.ncdhhs.gov.
[15] Ibid.

Findings and Recommendations

1. Did Not Fully Implement Recommendations to Identify and Remove Providers with Suspended or Terminated Licenses

The Division did not fully implement OSA's recommendations[16] to identify and remove enrolled providers from the Medicaid program who had their professional license suspended[17] or terminated. Licensing boards can suspend or terminate provider licenses for reasons that include:

Negligence | Professional Misconduct | Fraud | Sexual Misconduct

In response to OSA's February 2021 *Medicaid Provider Enrollment* performance audit, Division management agreed with OSA's findings and recommendations to remove providers from Medicaid with suspended or terminated licenses (which included providers that entered into Non-Practice Agreements). The Division developed and implemented Provider Screening[18] and License Board Monitoring procedures[19] to terminate providers from Medicaid with suspended or terminated licenses (which included providers that entered into Non-Practice Agreements).

During 2023, the Division removed 18 of 20 (90%) providers with disciplinary actions that included suspensions or termination; however, two of 20 (10%) providers with Non-Practice Agreements were allowed to remain in the Medicaid program.

Additionally, during 2024, Division management revised its Provider Screening procedures to no longer terminate providers from the Medicaid program that were determined to be under Non-Practice Agreements.

Providers With Non-Practice Agreements Were Not Removed from the Medicaid Program, Continued to Serve Medicaid Patients, and Received Payment from the State

As a result, providers who entered into Non-Practice Agreements with professional state licensing boards in which the provider **could not practice or perform any act that**

[16] *Medicaid Provider Enrollment*.
[17] Includes providers with Non-Practice Agreements. A Non-Practice Agreement 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.
[18] Department of Health and Human Services, Division of Health Benefits, Provider Screening Procedure, Document No. PO-11-020, Revision No. 000, Effective September 2, 2022.
[19] Department of Health and Human Services, Division of Health Benefits, License Board Monitoring Procedure, Document No. PO-03-003, Revision No. 001, Effective September 9, 2022.

Providers with Non-Practice Agreements are prohibited from practicing or performing any act that requires a license and therefore should be removed from the Medicaid program.

requires a license were not removed from the Medicaid program. These providers continued to serve Medicaid patients and received payment from the state.

Auditors obtained lists of all Medicaid providers disciplined by four state professional licensing boards[20] during the period January 1, 2023, through December 31, 2023, directly from the licensing boards.

Of the 63 Medicaid providers who were disciplined by their licensing board, 20 (32%) had a suspended[21] or terminated license. Auditors tested all 20 providers and determined that one (5%) provider was not removed from the Medicaid program at all, and one (5%) provider was not timely removed. Specifically,

- **Provider A:** A physician entered into a Non-Practice Agreement with their licensing board that **did not allow the physician to practice or perform any act that required a license** during the period October 2022 through December 2023, for practicing medicine while abusing alcohol. The provider was never removed from the Medicaid program.

  One physician improperly treated 21 Medicaid patients and received $1,311 while under a Non-Practice Agreement.

  This provider treated 21 Medicaid patients from October 1, 2022, through December 31, 2023, and received approximately $1,311 in Medicaid payments during that time.

- **Provider B:** A physician entered into a Non-Practice Agreement with their licensing board that **did not allow the physician to practice or perform any act that required a license** during the period February 2023 through October 2023 for inappropriately prescribing controlled substances and medications to friends and romantic partners. The provider was not removed from the Medicaid program until the licensing board suspended the provider's license in October 2023 (eight months later).

  Another physician improperly treated 14 Medicaid patients and received $5,415 while under a Non-Practice Agreement.

  This provider treated 14 Medicaid patients from February 1, 2023, through October 30, 2023, and received approximately $5,415 in Medicaid payments during that time. When the Division eventually took action to remove Provider B from the Medicaid program, its procedures required the Division to retroactively disallow Provider B's payments back to February 2023 (the date of the NPA). However, the Division did not.

[20] Four licensing boards included for testing: NC Medical Board, NC State Board of Dental Examiners, NC Board of Pharmacy, and NC Board of Nursing. These are the four largest boards in terms of licensees.

[21] Includes providers with Non-Practice Agreements. A Non-Practice Agreement 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.

Without fully implementing the recommendation, the risk remains that providers that **cannot practice or perform any act that requires a license** serve Medicaid patients and receive payment from the state.

Caused by Division's Change in Position That It Was Not Required to Remove Providers

Division management did not remove providers who entered into Non-Practice Agreements with licensing boards because it changed its position and stated it was not required to terminate them.

Division Management agreed with our findings and made changes in response to our last audit.

As previously stated, this is a change in stance by Division management. In response to OSA's February 2021 *Medicaid Provider Enrollment* performance audit, Division management agreed with OSA's findings and recommendations and developed procedures to identify and terminate medical providers with suspended or terminated licenses, including providers that entered into Non-Practice Agreements.

The Division's Provider Screening[22] and License Board Monitoring[23] procedures were implemented in September 2022 and stated that the Division shall terminate a medical provider from participation in Medicaid when it is determined that a licensing board notification of license revocation, license termination, license suspension, or **Non-Practice Agreement** applies to an active, enrolled provider effective with the date of the action as indicated in the notice.

Specifically,

- The Division's License Board Monitoring procedure states that GDIT (as the fiscal agent) shall terminate a provider from participation with NC Medicaid when it is determined that a NC licensing board notification of license revocation, license termination or license suspension applies to an active, enrolled provider with the effective date of termination being the date of action in the notice.

- The Division's Provider Screening procedure establishes criteria for the provider screening meetings and monitoring, including the requirements for Denial/ Terminations of providers with disciplinary actions:

    - Denial or Termination actions are warranted if the impact to the provider's permitted scope of practice cannot be monitored through the current NCTracks enrollment process, and/or poses a potential risk for beneficiary safety. Examples include:

        - If the provider is not permitted to treat specific patient populations such as children or females.

[22] Department of Health and Human Services, Division of Health Benefits, Provider Screening Procedure, Document No. PO-11-020, Revision No. 000, Effective September 2, 2022.
[23] Department of Health and Human Services, Division of Health Benefits, License Board Monitoring Procedure, Document No. PO-03-003, Revision No. 001, Effective September 9, 2022.

- If the provider is not permitted to use specific treatment protocols, such as sedation.

- If an NPA between the provider and license board is in effect.

- The effective date of denial/termination action shall be the date the licensing board imposed the impacts to the provider's permitted scope of practice. In circumstances when the action is imposed months or years prior to the screening, it may be determined that in lieu of termination, a pre-pay or post-pay review may be warranted.

- The effective date of denial/termination due to an NPA that was or is still in effect shall be the effective date of the NPA. There is no statute, code, rule, or regulation that allows a provider with such a limitation to participate in the NC Medicaid program.

But then, Division Management changed their procedures to no longer terminate providers with Non-Practice Agreements.

However, during 2024, Division management revised its Provider Screening procedures to no longer terminate providers from the Medicaid program that were determined to be under Non-Practice Agreements.

As reported in OSA's February 2021 audit,[24] the federal Centers for Medicare and Medicaid Services confirmed that the Division had the responsibility and authority to terminate enrollment taking into consideration the provider poses to the safety of patients.

According to the Centers of Medicare and Medicaid Services,

> 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)*

Regulation Required Medicaid Providers to Have Professional Licenses Without Limitations

Federal regulation 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.

[24] *Medicaid Provider Enrollment.*

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

Best Practices Recommend Timely Implementation of Corrective Action

The United States Government Accountability Office (GAO) recommends as a best practice[25] that management should implement corrective action **timely**:

> **17.06** Management completes and documents corrective actions to remediate internal control deficiencies on a timely basis. These corrective actions include resolution of audit findings.

Recommendations:

1. Division management should remove all providers who have had their professional licenses suspended, terminated, or entered into Non-Practice Agreements from the Medicaid program.

2. The Division's Medicaid policies and procedures should include the identification and removal of providers that cannot practice or perform any act that requires a license.

Division management should fully implement prior audit recommendations in a timely manner to address the identified issues and to reduce the risk providers may pose to Medicaid patients.

[25] United States Government Accountability Office, Standards for Internal Control in the Federal Government, September 2014.

2. Did Not Fully Implement Recommendations to Remove Providers with Professional License Limitations That Pose Threats to Medicaid Patients

The Division did not fully implement OSA recommendations[26] regarding the continued enrollment or termination of providers with limitations on their license that may pose threats to the safety of patients. License limitations are specific restrictions imposed on a licensee's ability to practice for reasons that include:

Negligence | Professional Misconduct | Fraud | Sexual Misconduct

Specifically, OSA's February 2021 *Medicaid Provider Enrollment* performance audit recommended that:

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

In response to OSA's February 2021 *Medicaid Provider Enrollment* performance audit, Division management:

- Agreed with OSA's findings and recommendations to remove providers with license limitations whose actions were determined to pose a threat to patient safety from Medicaid.
- Developed and implemented Provider Screening procedures[27] to review provider license limitations, evaluate the risk the limitations posed to patient safety, and terminate providers with license limitations whose actions were determined to pose a threat to patient safety.

However, the Division did not follow its procedures and did not remove any providers that may have posed a threat to patient safety. The Division allowed all providers with license limitations, even limitations that were imposed for reasons that could include sexual misconduct, to remain enrolled in Medicaid and able to see Medicaid patients.

[26] *Medicaid Provider Enrollment.*
[27] Department of Health and Human Services, Division of Health Benefits, Provider Screening Procedure, Document No. PO-11-020, Revision No. 000, Effective September 2, 2022.

Additionally, the Division did not document its evaluation of the risk providers with license limitations may pose to patient safety, or the decisions to support the continued enrollment or termination of a provider.

The Division did document notes regarding providers with license limitations in meeting minutes and Provider Screening Monitoring Logs. However, these documents **do not** include documentation of the providers' specific license limitations, the determination of whether these providers pose a risk to patient safety or not, any increased oversight or monitoring activities of these providers, or an actual decision to allow the provider to remain enrolled or terminate the provider.

As such, the Division allowed all providers with license limitations to remain enrolled.

Resulted in Continued Risk to Medicaid Program and Patients

Because the Division allowed all providers who had professional license limitations to remain enrolled in Medicaid, there may have been an increased risk to patient safety.

Auditors obtained lists of all Medicaid providers disciplined by four state professional licensing boards[28] during the period January 1, 2023, through December 31, 2023, directly from the licensing boards.

Of those 63 Medicaid providers who were disciplined by their licensing board, 32 (51%) had current license limitations.

Auditors then reviewed documentation of the license limitations and determined that the Division had allowed all 32 (100%) providers who had current license limitations to continue to participate in the Medicaid program without restrictions.

The Division did not remove any providers with license limitations from the Medicaid Program.

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

- **Provider C**: A physician's medical license had a limitation that prohibited the physician from treating any female patients and from supervising any nurse practitioners or physician assistants who treated female patients. Previous license limitations dating back to 2014 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 is listed as a Provider on the Division's website[29] and is accepting both adult and child female patients. Additionally, Provider C and their nurse practitioner billed Medicaid for services provided to 78 Medicaid patients, including

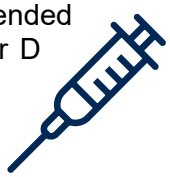
[28] The four licensing boards tested were the NC Medical Board, NC State Board of Dental Examiners, NC Board of Pharmacy, and NC Board of Nursing. These are the four largest boards in terms of licensees.

[29] Search by Provider for a Plan | NC Medicaid Managed Care (ncmedicaidplans.gov).

21 female patients in the amount of $7,303 from January 1, 2023, through December 31, 2023.

It should be noted that Provider C also entered into a Settlement Agreement with the state to pay back $75,000 for submitting false or fraudulent claims to the Medicaid program, yet remains enrolled in the Medicaid program seeing patients, including females.

- **Provider D**: A dentist's Moderate Sedation permit[30] was suspended from July 7, 2022, through February 22, 2024, because Provider D was administering general anesthesia[31] without a permit.



Despite not receiving payments from Medicaid, the provider remained active in the Medicaid claims processing system (NCTracks) and was eligible to receive payments through February 22, 2024.

- **Provider E**: A physician had a license limitation effective June 9, 2023, that prohibited the provider from prescribing controlled medications[32] after the Drug Enforcement Agency (DEA) raided Provider E's medical practices. This license limitation noted that in September 2019, the Medical Board found the provider's care "failed to meet the standards of acceptable and prevailing medical practice in NC and disregarded and failed to address abnormal urine drug screens indicating possible patient misuse or diversion of the narcotics prescribed."

The provider remained active in the Medicaid claims processing system (NCTracks) and was eligible to receive payments until November 2023. Provider E was removed after they did not apply to reverify within the Medicaid program due to having pleaded guilty in Virginia to "conspiring to use, in the course of dispensing and distributing controlled substances, a DEA registration number issued to another person". Provider E was sentenced to 18 months in prison and fined over $200,000.

Caused by Division's Change in Position That It Was Not Required to Remove Providers

Division management did not remove providers with limitations on their licenses because it changed its position and stated that it was not required to terminate them.

[30] Moderate Sedation Permit holder provides conscious sedation characterized by a drug induced depression of consciousness, during which patients respond to verbal commands, either alone or accompanied by light tactile stimulation. A moderate sedation provider shall not use the following: (1) drugs designed by the manufacturer for use in administering general anesthesia or deep sedation; or (2) drugs contraindicated for use in moderate conscious sedation. (21NCAC16Q .0101 (29)).

[31] General anesthesia – the intended controlled state of a depressed level of consciousness that is produced by pharmacologic agents and accompanied by a partial or complete loss of protective reflexes, including the ability to maintain an airway and respond purposefully to physical stimulation or verbal commands. (21NCAC16Q .0101 (22)).

[32] Controlled medications and/or substances are drugs that fall into a category between Schedule I through Schedule V. These medications have a likelihood for physical and mental dependence. Examples include Stimulants, Opioids, Hallucinogens, Anabolic steroids, and Depressants.

As previously stated, this is a change in stance. In response to OSA's February 2021 *Medicaid Provider Enrollment* performance audit, Division management agreed with OSA's findings and recommendations to remove providers with license limitations whose actions posed a threat to patient safety from Medicaid and implemented provider screening procedures[33] to terminate providers with license limitations whose actions were determined to pose a threat to patient safety.

The Division's Provider Screening[34] procedures were implemented in September 2022 and outlined denial or termination actions to providers with license limitations based on the potential risks the provider may pose to beneficiary safety.

Specifically, the Division's Provider Screening procedures stated:

> 6.1 Denial/Termination Actions
>
> Denial or Termination actions are warranted if the impact to the provider's permitted scope of practice cannot be monitored through the current NCTracks[35] enrollment process, and/or poses a potential risk for beneficiary [patients] safety.
>
> Examples of this include:
>
> a. If the provider is not permitted to treat specific patient populations such as children or females.
>
> b. If the provider is not permitted to use specific treatment protocols such as sedation.
>
> c. If a Non-Practice Agreement[36] between provider and license board is in effect.

However, during 2024 Division management revised its stance and its Provider Screening procedures. The Division allowed all providers with license limitations, even limitations that were imposed for reasons that could include sexual misconduct, to remain enrolled in Medicaid and able to see Medicaid patients.

As mentioned, Division management did so because it said it was not required to terminate these providers.

As reported in OSA's 2021 audit, the federal Centers for Medicare and Medicaid Services confirmed that the Division had the responsibility and authority to terminate enrollment taking into consideration the threat the provider poses to the safety of patients. Per the Centers of Medicare and Medicaid Services:

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[33] Department of Health and Human Services, Division of Health Benefits, Provider Screening Procedure, Document No. PO-11-020, Revision No. 000, Effective September 2, 2022.

[34] Department of Health and Human Services, Division of Health Benefits, Provider Screening Procedure, Document No. PO-11-020, Revision No. 000, Effective September 2, 2022.

[35] 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.

[36] Non-Practice Agreement 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.

> 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 Centers for Medicare and Medicaid Services response also said that a state could enroll providers with license limitations if the state was comfortable with enrolling them. **However, with the Division's change in stance and updated procedures, it is stating that it is comfortable with allowing all providers with limitations to remain enrolled.**

Also Caused by Division's Position That Licensing Boards Monitor and Enforce Provider Disciplinary Actions

Division Management also stated that it did not remove providers with license limitations because it believed licensing boards monitored and enforced disciplinary actions imposed on providers. Division management stated that it understood that if licensing boards determined providers were noncompliant with their license limitations, the licensing board would provide additional discipline to the providers.

Division management stated that they believed licensing boards monitored and enforced disciplinary actions imposed on providers.

In 2023, OSA found that the NC Medical Board did not monitor or enforce 56% of its public disciplinary actions.

However, relying on the licensing boards to monitor to ensure providers complied with imposed disciplinary actions could be risky. For example, OSA's 2023 audit[37] of the North Carolina Medical Board found that the Medical Board **did not monitor and enforce 54 of 96 (56%)** public disciplinary actions it imposed.[38] Part of the Medical Board's reasoning for not monitoring and enforcing disciplinary actions was that it was not legally required to do so.

Regulation Required the Division to Confirm There Were No License Limitations

Federal regulation 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.

[37] *North Carolina Medical Board Investigations of Medical Providers*.
[38] During the period July 1, 2019, through June 30, 2021.

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

Best Practices Recommend Timely Implementation of Corrective Action

United States Government Accountability Office (GAO) best practices[39] recommend that management should implement corrective action **timely**:

17.06 Management completes and documents corrective actions to remediate internal control deficiencies on a timely basis. These corrective actions include resolution of audit findings.

Recommendations:

3 Division management should remove all providers from the Medicaid program who have professional license limitations that pose threats to the safety of patients.

4 The Division's policies and procedures for the continued enrollment of providers with limitations on their license 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.

Division management should fully implement prior audit recommendations in a timely manner to address the identified issues and to reduce the risk providers with license limitations may pose to Medicaid patients.

[39] United States Government Accountability Office, Standards for Internal Control in the Federal Government, September 2014.

3. Did Not Fully Implement Recommendations to Strengthen Provider Credential Verification

The Division did not fully implement OSA recommendations[40] to strengthen its verification of provider credentials[41] for providers enrolled in the Medicaid program. Verifying professional credentials required confirming with the appropriate credentialing authorities that the provider has the required license, accreditation, and/or certification.

Specifically, the Division updated its provider credential verification procedures during the Medicaid provider enrollment re-verification process.[42] The Division now:

- No longer relies on the LexisNexis[43] crawler and monthly background reports to perform ongoing credential verification. OSA's February 2021 *Medicaid Provider Enrollment* performance audit noted several weaknesses in the Division's reliance on the crawler and monthly background reports to perform credential verifications including that they did not conduct primary verification of credentials.

- Performs direct verification of most provider credentials with the credentialing agency (including accreditations and certifications) during the initial and reverification process.[44]

However, while the Division has strengthened its processes by taking the above actions, the Division did not ensure that enrolled providers possessed DEA certification.[45] The Division uses a weekly file provided by the DEA to update the expiration dates of the DEA certifications for providers within Medicaid.

Auditors obtained and reviewed professional credentialing documentation for all 63 Medicaid providers[46] who had disciplinary actions taken against their professional license[47] during the period January 1, 2023, through December 31, 2023, to determine whether these providers' credentialing requirements had been verified. Of these, 9 (14%) did not possess the required DEA certification or the Division was unable to provide evidence that the providers' DEA certifications were verified. Specifically, for:

- Five (8%) providers, they lacked the required DEA certification.

- Four (6%) providers, the Division was unable to provide evidence that the provider held the required DEA certification.

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[40] *Medicaid Provider Enrollment.*

[41] Professional credentials include any licenses, certifications, and accreditations that Medicaid requires providers to have to participate in the Medicaid program beyond licenses from the North Carolina professional boards.

[42] This procedure was already implemented for the Medicaid provider initial enrollment process at the time of OSA's February 2021 *Medicaid Provider Enrollment* performance audit.

[43] One of the largest databases in the world of legal and public-records related information.

[44] 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.

[45] A DEA certification, or license, is required for physicians, nurse practitioners, physician assistants, pharmacists, optometrists and dentists to prescribe controlled substances. The DEA regulates both the prescribing and distribution of controlled substances such as narcotics and sedatives.

[46] Four licensing boards included for testing: NC Medical Board, NC State Board of Dental Examiners, NC Board of Pharmacy, and NC Board of Nursing. These are the four largest boards in terms of licensees.

[47] Professional licensing includes medical, dental, pharmacy, and nursing. The Division monitors disciplinary actions from 20 boards and five state/federal agencies for the Medicaid program.

Valid DEA certifications are required to prescribe controlled substances.[48]

Resulted in Increased Risk to Medicaid Beneficiaries from Uncredentialed Providers

As a result, there is a risk that providers prescribed controlled substances[49] without a DEA certification that is required to prescribe controlled substances increasing the risk to Medicaid patients. For example,

- **Provider F** performed dental services for Medicaid patients during the first 3.5 months of 2023 and wrote at least three prescriptions that were filled[50] for a Schedule II controlled substance.[51] The Division was unable to provide documentation that Provider F had the required DEA certification.

  Provider F was enrolled as a Medicaid provider from September 2016 to April 2023. The provider treated 126 Medicaid patients and received approximately $53,500 in Medicaid payments during 2023 before their dental license was revoked in April 2023.

- **Provider G** provided medical services in both Emergency and Family Medicine for Medicaid patients in North Carolina from July 2013 to June 2023, with a Tennessee (TN) medical license but without the required DEA certification.

  Provider G's Tennessee medical license was revoked in June 2023 after pleading guilty in March 2023 to "three counts of causing…various quantities of prescription drugs Subutex (Schedule III),[52] Suboxone (Schedule III), clonazepam (Schedule IV controlled substance)[53] and gabapentin to be dispensed without valid prescriptions ..." Provider G was sentenced to federal prison.

  Provider G was enrolled in Medicaid and able to write prescriptions for Medicaid patients until removed in September 2023, effective June 2023.

[48] A controlled substance is a drug that the DEA regulates to ensure safety, facilitate medical use, and prevent misuse within legal guidelines. Controlled substances are drugs that fall into a category between Schedule I through Schedule V. These medications have a likelihood for physical and mental dependence. Examples include Stimulants, Opioids, Hallucinogens, Anabolic steroids, and Depressants.

[49] A controlled substance is a drug that the DEA regulates to ensure safety, facilitate medical use, and prevent misuse within legal guidelines. Controlled substances are drugs that fall into a category between Schedule I through Schedule V. These medications have a likelihood for physical and mental dependence. Examples include Stimulants, Opioids, Hallucinogens, Anabolic steroids, and Depressants.

[50] Four controlled substance prescriptions were rejected by pharmacies.

[51] Schedule II controlled substances are drugs with a high potential for abuse, with use potentially leading to severe psychological or physical dependence and are considered dangerous. Some examples are hydrocodone (Vicodin), cocaine, methamphetamine, methadone, hydromorphone (Dilaudid), meperidine (Demerol), oxycodone (OxyContin), fentanyl, Dexedrine, Adderall, and Ritalin.

[52] Schedule III controlled substances are drugs with a moderate to low potential for physical dependence or psychological dependence. Some examples of Schedule III drugs are products containing less than 90 milligrams of codeine per dosage unit (Tylenol with codeine), ketamine, anabolic steroids, and testosterone.

[53] Schedule IV drugs, substances, or chemicals are defined as drugs with a low potential for abuse and low risk of dependence. Some examples of Schedule IV drugs are Xanax, Soma, Darvon, Darvocet, Valium, Ativan, Talwin, Ambien, Tramadol.

- **Provider D (from Finding 2), in addition to having a license limitation due to carrying out general anesthesia without a permit,** performed services that required a DEA certification with a dental license. However, the Division was unable to provide documentation that provider had the required DEA certification at any time from his initial enrollment in 2016 through 2023.

Did Not Verify DEA Certifications Because It Relied on Providers to Provide Documentation They Were Not Certified

Despite Division requirements that state providers must meet all program requirements and qualifications as provided in the Provider Permission Matrix (PPM),[54] Division management stated that it did not verify whether providers possessed required DEA certifications because it relied on providers that were required to have the DEA certification to opt out and provide documentation that they did not have the DEA certification.

The Division relied on providers to opt out and to provide documentation that they did not have a DEA certification.

Specifically, Division procedures[55] required providers who do not have a DEA certification to complete a designation form to confirm that the provider does not meet the requirements for enrollment and the alternative arrangements for patients that require controlled substances.

However, the Division was unable to provide designation forms for any of the five providers auditors found that did not possess DEA certification.

However, the Division couldn't provide designation forms for any of the providers auditors found lacking a DEA certification.

Also Relied on Pharmacies to Deny Prescriptions of Controlled Substances from Uncredentialed Providers

Additionally, Division management stated that it did not verify provider DEA certifications because pharmacies were required to confirm that providers possessed the required DEA certifications prior to filling prescriptions for controlled substances.

The Division also did not verify DEA certifications because it relied on pharmacies to confirm certifications prior to filling prescriptions.

[54] The PPM is a Division document that summarizes required accreditations and certifications for provider service areas.

[55] General Dynamics Information Technology North Carolina Medicaid Management Information System (NCMMIS, also known as NCTracks) DEA Certification Verification and Manual DEA Certification Verification.

While OSA acknowledges this and obtained evidence that pharmacies did reject prescriptions of controlled substances from some of these uncredentialed providers in the examples cited above, our tests and examples cited above also identified filled prescriptions of controlled substances.

We identified instances where uncertified providers wrote prescriptions for controlled substances that pharmacies filled.

Federal Regulation and the State Plan Require Verification of Professional Credentials

Federal regulation requires the Division to verify that providers have all required professional licenses to participate in Medicaid.

> **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.

The Medicaid State Plan[56] (the Division's agreement with the Centers for Medicare and Medicaid Services) requires the Division to ensure providers have all required accreditations and certifications to participate in Medicaid. The service areas that require accreditation or certification are spread throughout the State Plan and are summarized in the Division's PPM.

Best Practices Recommend Timely Implementation of Corrective Action

United States' GAO best practices[57] recommend that management should, implement corrective action **timely**:

> **17.06** Management completes and documents corrective actions to remediate internal control deficiencies on a timely basis. These corrective actions include resolution of audit findings.

Recommendations:

5 Division management should verify that providers possess DEA certifications given the potential risk posed to Medicaid patients from providers prescribing controlled substances without required DEA certification.

Division management should fully implement prior audit recommendations in a timely manner.

[56] The NC State Plan states 'The State Medicaid agency will assure enrolled providers will be screened in accordance with 42CFR 455.400 et. seq.' and 'The State Medicaid agency will comply with section 1902(a)(39) of the Social Security Act and with the requirements outlined in 42 CFR 455.416 for all terminations or denials of provider enrollment.'

[57] United States Government Accountability Office, Standards for Internal Control in the Federal Government, September 2014.

4. Did Not Fully Implement Recommendation to Corroborate Provider Ownership Information

The Division did not fully implement OSA's recommendations[58] to corroborate the accuracy of ownership information of Medicaid providers during the Medicaid provider enrollment process. Specifically, the Division did not corroborate owners, managing employees, or others with controlling interest (collectively referred to as ownership information) of providers during the Medicaid provider initial enrollment or re-verification processes.[59]

As part of the Medicaid provider enrollment process, the Division performs criminal background checks on all disclosed owners and managing relationships associated with the provider record. Without corroborating ownership information, there is a risk that providers submitted inaccurate information, and undisclosed owners go without their credentials evaluated and a background check performed.

The Division is responsible for corroborating provider ownership information which includes performing background checks.

The Centers for Medicare and Medicaid Services have stated that corroborating ownership is critical. Specifically, the Centers for Medicare and Medicaid Services 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**.[60] (*Emphasis Added)*

Additionally, the Centers for Medicare and Medicaid Services note 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.[61]

CMS has noted that disclosure of ownership information is the most widely cited finding in their program integrity reviews.

Initial Enrollment

In response to OSA's February 2021 *Medicaid Provider Enrollment* performance audit, Division management did implement a procedure[62] performed during the Medicaid provider initial enrollment process to compare provider-disclosed ownership information to CMS's Provider Enrollment, Chain, and Ownership System (PECOS).[63]

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58 *Medicaid Provider Enrollment.*

59 The Medicaid re-verification process is separate from the initial enrollment process and is required every five years. As part of the process, provider credentials and qualifications should be evaluated to ensure they meet professional requirements. Reverification should also include a criminal background check on all owners and managing relationships associated with the provider record.

60 Provider Enrollment: Disclosure of Ownership and Control Snapshot E-Bulletin (cms.gov).

61 TOOLKITS FOR FREQUENT FINDINGS: 42 CFR 455.104.

62 Effective for audit period (January 1, 2023, through December 31, 2023).

63 PECOS supports the Medicare Provider and Supplier enrollment process by allowing registered users to securely and electronically submit and manage Medicare enrollment information.

In 2023,[64] the Division reported that it compared the 1,674 provider initial enrollment applications approved to PECOS. However, comparing provider-disclosed ownership information to PECOS provides limited verification of ownership. Specifically,

1. The provider-disclosed ownership information that is compared to PECOS is self-reported.

2. PECOS is used to collect information on providers participating in Medicare; therefore, the data is limited to Medicare taxonomies[65] and does not cover all Medicaid services.

3. According to the U.S. Government Accountability Office, CMS data (from PECOS) does not provide a means to readily identify ownership information and was not designed to do so [with respect to nursing homes].[66]

As such, auditors found that the Division's comparison to PECOS does not always result in ownership corroboration. Auditors tested a sample of 60 approved applications[67] during initial enrollment from January 1, 2023, through December 31, 2023, to verify the Division confirmed and compared disclosed ownership information to PECOS. Auditors determined that 52 of the 60 (87%) tested providers did not have ownership information in PECOS or documentation to support that ownership information was compared to PECOS. Specifically, for:

> Auditors tested a sample of 60 approved applications and found that ownership information for 52 (87%) applications was not corroborated.

- 42 of 60 (70%) providers, the Division was unable to compare the provider-disclosed ownership information to PECOS because there was no match. The Division's documentation for each of the 42 providers stated:

  "Unable to locate in PECOS" and either:

  - "The Provider is not found in PECOS therefore ownership cannot be compared," or

  - "The Provider is not found in PECOS therefore ownership and managing employees cannot be compared."

- 10 of 60 (17%) providers, there was no documentation that the provider had been searched in PECOS to compare ownership.

[64] January 1, 2023, through December 31, 2023.
[65] Healthcare Provider Taxonomy Codes are designed to categorize the type, classification, and/or specialization of health care providers. Medicare Provider and Supplier Taxonomy Crosswalk Methodology | CMS Data.
[66] GAO-23-106163, NURSING HOMES: Limitations of Using CMS Data to Identify Private Equity and Other Ownership.
[67] During January 1, 2023, through December 31, 2023, the Division approved 1,674 initial enrollment applications.

Re-Verification

The Division did not corroborate the ownership information for any of the 4,860 reverification applications that were approved from January 1, 2023, through December 31, 2023, during the Medicaid provider enrollment re-verification process.

Auditors found that the Division did not corroborate ownership information for **any** of the 4,860 reverification applications that were approved in 2023.

Instead, Division management stated it accepted the provider's electronic signature on the NC DHHS Provider Administrative Participation Agreement[68] as the provider's attestation that all required ownership disclosures were provided.

Resulted in Increased Risk Providers that Potentially Should Have Been Removed from Medicaid Program Remained Enrolled, Served Medicaid Beneficiaries, and Received Payment from the State.

Because the Division did not corroborate ownership information, it did not identify providers who may have submitted inaccurate information.

Therefore, there was an increased risk that those providers remained enrolled in Medicaid, served Medicaid beneficiaries, and received payment from the state. Federal regulation required the Division to remove providers who submitted inaccurate ownership information from the Medicaid program.[69] For example, in OSA's February 2021 *Medicaid Provider Enrollment* performance audit, auditors found that of the 191 approved provider re-verification applications tested, 21 of the 191 (11%) providers did not disclose complete and accurate information.

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.

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

While Division management acknowledged that ownership should be disclosed on Medicaid provider enrollment applications, Division management stated it did not always corroborate provider ownership information during the initial application or reverification because there was no federal or state law that required the Division to do so.

[68] NC DHHS Provider Administrative Participation Agreement.

[69] 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.

CMS Best Practice is to Verify Accuracy of Ownership Information

Verification of ownership interest is identified as a best practice by the Centers for Medicare and Medicaid Services. In an E-Bulletin titled "Provider Enrollment: Disclosure of Ownership and Control Snapshot," the Centers for Medicare and Medicaid Services states:[70]

> 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.

Best Practices Recommend Timely Implementation of Corrective Action

The United States GAO recommends as a best practice[71] that management should implement corrective action **timely**:

> **17.06** Management completes and documents corrective actions to remediate internal control deficiencies on a timely basis. These corrective actions include resolution of audit findings.

Recommendations

6 The Division should corroborate the accuracy of all provider ownership information to data available from state licensure boards or the Secretary of State. This should be completed so background checks can be performed and identified ineligible providers removed from Medicaid to protect the safety of Medicaid patients and prevent inappropriate payments from the state.

Division management should fully implement prior audit recommendations timely.

[70] Provider Enrollment: Disclosure of Ownership and Control Snapshot E-Bulletin (cms.gov).
[71] United States Government Accountability Office, Standards for Internal Control in the Federal Government, September 2014.

Matters for Further Consideration

During an audit, the Office of the State Auditor staff may identify potential items of interest that are outside of the audit objectives. Below is one such item.

Division Should Increase Monitoring of $1.5 Billion General Dynamics Information Technology Contract

The Department of Health and Human Services (Department), Division of Health Benefits (Division) management should **increase the monitoring** of the **$1.5 billion contract** with 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.

GDIT also provides the multi-payer Medicaid Management Information System for the Department, known as NCTracks.[72] NCTracks is the system by which providers are enrolled in Medicaid, re-verified every five years, and terminated when appropriate. Ultimately, the Department's contract with GDIT requires GDIT to provide technology and mission support services, including maintaining 100,000 providers and managing claims for all of the state's approximately 3 million Medicaid beneficiaries.

However, during this audit's procedures, OSA determined the Department performed **limited monitoring** of the GDIT contract.

According to the National State Auditors Association's Best Practices for Contracting Services:

> Contract monitoring is an essential part of the contracting process. 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**. *(Emphasis Added)*

Limited GDIT Contract Monitoring

During the audit, it became clear that the Division performed limited monitoring over the GDIT contract. In fact, the Division had difficulty even identifying specific provider enrollment contract monitoring requirements and providing them to the audit team.

The Division's provider enrollment contract monitoring requirements are included in Service Level Agreements (SLAs) between GDIT and the Division's Provider Enrollment team. When asked, the Division could not readily provide the SLAs, indicating that monitoring of GDIT was limited or even performed.

[72] NCTracks is used by the Division of Health Benefits (DHB); the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS); and the Division of Public Health (DPH). Providers enrolled in DHB, DMH/DD/SAS and DPH health plans submit claims for payment of covered health care services through the NCTracks Provider Portal. NCTracks coordinates processing among the payers to ensure the proper assignment of the payer, benefit plan and pricing methodology for each service on a claim. NCTracks processes health care claims for about 100,000 enrolled DHHS providers who serve over 1 million North Carolina citizens.

There are five active SLAs that require GDIT to complete enrollment activities[73] within specified timeframes. There is also one additional SLA that was implemented during the audit that requires GDIT to primary source verify all license, certification, and accreditation requirements outlined in the Provider Permission Matrix (PPM)[74] when completing enrollment activities.

Contract Costs

Additionally, the Division could not provide the cost of the GDIT contract specific to the provider enrollment process. Division management had to request the information from GDIT, and the costs the Division eventually provided were not inclusive of all provider enrollment costs.

> The cost of GDIT's NCTracks contract supporting 100,000 Medicaid providers exceeds $100,000,000 annually.

However, the Division did provide that the initial cost of the entire GDIT contract was approximately $465 million. Though, through contract amendments that included cost increases, the total contract value now exceeds $1.5 billion.[75] As of 2025, annual contract costs exceed $100 million. See Table 1 below and Chart 1 on the following page.

Table 1: Annual and Total GDIT Contract Costs

End Date	Annual Costs	Total
Base Contract	$ 465,123,067	$ 465,123,067
6/30/2019	$ 75,471,725	$ 540,594,792
6/30/2020	$ 65,789,615	$ 606,384,407
6/30/2021	$ 82,892,765	$ 689,277,172
6/30/2022	$ 98,934,263	$ 788,211,435
6/30/2023	$ 115,238,405	$ 903,449,840
6/30/2024	$ 97,996,823	$ 1,001,446,663
6/30/2025	$ 103,846,248	$ 1,105,292,911
6/30/2026	$ 104,072,510	$ 1,209,365,421
6/30/2027	$ 106,298,238	$ 1,315,663,659
6/30/2028	$ 108,581,976	$ 1,424,245,635
6/30/2029	$ 110,925,312	**$ 1,535,170,947**
Total Cost	**$ 1,535,170,947**	

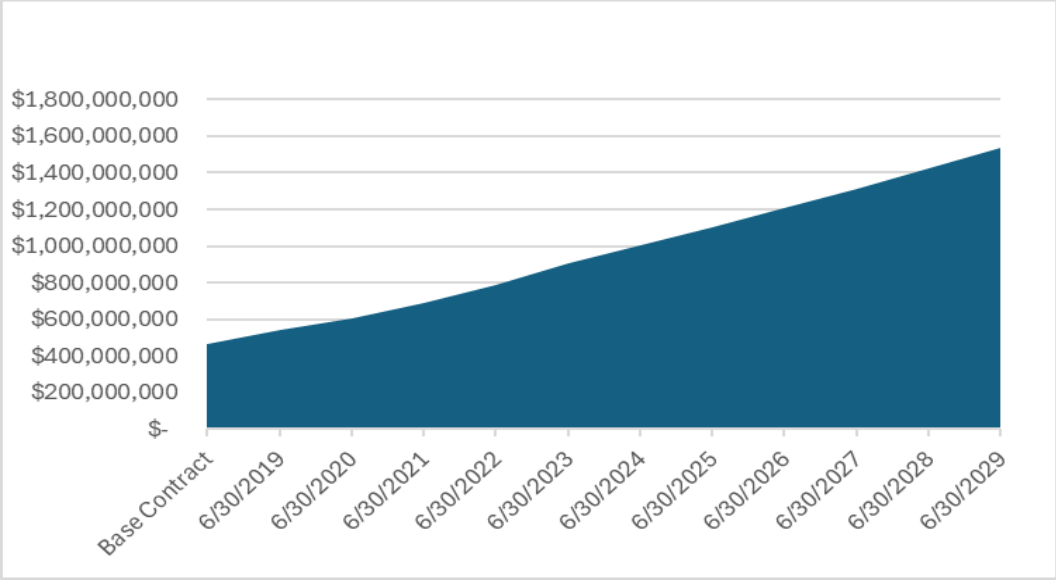
Source: DHHS/GDIT contract and auditor analysis.

[73] Includes processing provider enrollments, re-enrollments, reverifications, and management of provider change request applications.

[74] The PPM is a Division document that summarizes required accreditations and certifications for provider service areas.

[75] Includes the latest contract extension announce by GDIT in June 2024 for $524 million for a two-year base period with three option years through June 30, 2029.

Chart 1: Total GDIT Contract Costs Over Time



Source: DHHS/GDIT contract and auditor analysis.

Without effective contract monitoring, there is an increased risk that:

- Processes are not working properly.
- Quality services are not provided.
- Costs are unreasonable.
- Performance standards are not met
- Performance issues are not detected early on or at all, and are not be corrected in a timely manner.

Consideration:

Division management should improve monitoring of the $1.5 billion GDIT contract so that the state's interest is protected and to ensure the effective and efficient use of taxpayer funds.

Objectives, Scope, and Methodology

The objective of this audit was to determine whether the Department of Health and Human Services (Department), Division of Health Benefits (Division) implemented corrective actions to address the findings and recommendations made in OSA's February 2021 *Medicaid Provider Enrollment* performance audit. Specifically, for the period January 1, 2023, through December 31, 2023, whether the Division:

1. Identified and removed providers from the Medicaid program who had their professional license suspended or terminated.
2. Identified and removed providers from the Medicaid program who had professional license limitations and who posed threats to the safety of beneficiaries.
3. Ensured all provider professional accreditations and credentials were verified.
4. Verified provider ownership information.

The audit scope included the initial enrollment of providers, re-verification of providers, and ongoing discipline checks of professional licenses for calendar year 2023.

To achieve audit objectives, auditors:

- Interviewed Department personnel.
- Reviewed Department policies and procedures regarding the Medicaid provider enrollment process.
- Reviewed provider information from NCTracks.
- Reviewed state and federal laws and regulations relevant to enrolling and reverifying Medicaid providers.
- Enrollment: Auditors tested providers[76] whose enrollment applications were approved during the audit period to determine whether they were eligible to receive Medicaid payments. Auditors tested a sample of 60 of 1,674 total initial enrollment applications approved to determine whether the Division corroborated provider ownership information.
- Re-Verification: Auditors included all 4,860 reverification applications that were approved to determine whether the Division corroborated provider ownership information.
- Auditors obtained a list of all disciplined providers from four NC licensing boards[77] that regulate a service covered by Medicaid then removed providers who were not enrolled in Medicaid. The remaining population contained 63 unique providers who were

[76] From four licensing boards. The four licensing boards tested were the NC Medical Board, NC State Board of Dental Examiners, NC Board of Pharmacy, and NC Board of Nursing. These are the four largest boards in terms of licensees.

[77] The four licensing boards tested were the NC Medical Board, NC State Board of Dental Examiners, NC Board of Pharmacy, and NC Board of Nursing. These are the four largest boards in terms of licensees.

disciplined by their licensing board and participated in Medicaid. Auditors tested all 63 providers.

Whenever sampling was used, auditors applied a nonstatistical 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.

This audit was designed to identify, for those programs, activities, or functions included within the scope of the audit, deficiencies in internal controls significant to our audit objectives. 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.

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 objective.

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 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.

The Department of Health and Human Services, Division of Health Benefits (Division) response included statements that could **mislead the reader** or **minimize the importance** of the auditor findings. To ensure the availability of complete and accurate information, OSA offers the following clarifications.

Finding 1: Did Not Fully Implement Recommendations to Identify and Remove Providers with Suspended or Terminated Licenses

FIRST, in its response to Finding 1, the Division stated:

> The screening procedures do not call for an automatic termination of providers that enter into Non-Practice Agreements (NPA), as the details in such agreements may vary and should be treated on a case-by-case basis.

This is not true. As stated in this report, the Division's screening procedures in place during the audit scope required providers with suspended or terminated licenses **(which included providers that entered into Non-Practice Agreements (NPAs))** to be terminated from the Medicaid program. In 2024, the Division revised its screening procedures to no longer automatically terminate providers that entered into NPAs.

Nevertheless, OSA acknowledges that details in NPAs vary, and the decision whether to terminate a provider or not should be based upon those details and the risk that allowing those providers to remain enrolled may pose to the safety of patients.

However, the Division's response **misleads the reader** to believe that the Division treats providers with NPAs on a case-by-case basis taking into account the details of the agreement and the potential risks to Medicaid patients and the Medicaid program. The Division allowed these providers to remain enrolled with no documentation of its evaluation of the risk providers may have posed to patient safety, or the decisions to support the continued enrollment or termination of a provider. These providers continued to serve Medicaid patients and received payment from the state.

SECOND, in its response to Finding 1, the Division did not agree "that the timing of Provider B's removal was problematic." The Division stated that the consent order "did not confirm that a prior NPA existed." However, the consent order (dated November 2, 2023) stated:

> Provider placed his license on inactive status effective February 23, 2023.

Inactive status precludes the provider from practicing or performing any act that requires a license. Therefore, the Division should have retroactively disallowed payments to Provider B back to the date the license was inactive. As the report states, Provider B treated 14 Medicaid patients from February 1, 2023, through October 30, 2023, and received approximately $5,415 in Medicaid payments during that time.

THIRD, in its response to Finding 1, the Division stated:

> Most NPAs are private agreements between the Medical Board and the provider and are not known to the public or the Medicaid agency.

While accurate, this statement is **concerning**. As stated in this report, 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. The Medical Board is the sole licensing board in North Carolina that utilizes NPAs, and issues them for reasons that include **negligence**, **professional misconduct**, **fraud**, and **sexual misconduct**. This report specifically included examples of providers that entered into NPAs for practicing medicine while **abusing alcohol**, and for **inappropriately prescribing controlled substances** and medications to friends and romantic partners.

Given the potential risk that providers with NPAs may pose to Medicaid patients, it would seem imperative for the Division to be made aware of public and **private agreements** as soon as possible so that action can be taken to protect Medicaid patients as timely as possible (if deemed necessary). The Division should explore entering into an agreement with the Medical Board that allows it to be notified of providers that have entered into private NPAs. It seems reasonable that the Division that is responsible for ensuring that qualified providers are enrolled in Medicaid and serving Medicaid patients is made aware of this information prior to when the general public is. As stated in this report, providers that enter into NPAs have the potential to continue to serve Medicaid patients and receive **public funds** from the state.

Finding 2: Did Not Fully Implement Recommendations to Remove Providers with Professional License Limitations That Pose Threats to Medicaid Patients

In its response to Finding 2, the Division disagreed with the finding and stated:

> The Division disagrees that providers with license limitations automatically pose a safety risk to beneficiaries and should be removed from the program. The Division acknowledges that some provider limitations should be excluded due to the challenge in monitoring for or preventing a violation of the limitation.

This statement **misleads the reader** that OSA asserted that providers with license limitations automatically pose a safety risk to beneficiaries and should be terminated from the Medicaid program. This statement also leads the reader to believe that the Division removed some providers with license limitations from the Medicaid program that may pose risks to patient safety.

This is **not true** and **minimizes the importance** of auditor findings.

OSA's February 2021 *Medicaid Provider Enrollment* performance audit and this report clearly stated, "providers with limitations on their license may pose threats to the safety of patients." The audits recommended:

> 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.

However, despite having written policies and procedures to evaluate and remove providers with license limitations that may pose a threat to patient safety during this audit's scope, the Division **did not remove** any providers with license limitations. Instead, it **allowed all providers** who had current license limitations to continue to participate in the Medicaid program without restrictions.

The Division did not document its evaluation of the risk providers with license limitations may pose to patient safety, or the decisions to support the continued enrollment or termination of a provider. It allowed all to remain enrolled, continue to serve Medicaid patients, and receive money from the state. This included providers,

- Prohibited from treating any female patients and from supervising any nurse practitioners or physician assistants that treated female patients due to multiple past sexual and professional misconduct allegations.

- With a suspended sedation permit due to administering general anesthesia without a permit.

- Prohibited from prescribing controlled medications after a Drug Enforcement Agency raid and after the Medical Board found that the provider "failed to meet the standards of acceptable and prevailing medical practice in NC and disregarded and failed to address abnormal urine drug screens indicating possible patient misuse or diversion of the narcotics prescribed."

Finding 4: Did Not Fully Implement Recommendations to Verify Provider Ownership Information

The Division agreed with Finding 4. However, the Division's response contained statements that **minimized the importance** of the auditor findings and may **mislead the reader**.

In its response, the Division stated:

> In response to the February 2021 report, the Division implemented the following measure for ownership verification beginning April 2022:
>
> *For NC Medicaid participation, providers must disclose 5% or more ownership of the entity enrolling and must self-attest that "Owners with 5% or more ownership in the enrolling provider entered on this application match what was reported to the provider's state business registration entity, licensure board, and Medicare." Disclosure and self-attestation are required with each Initial, Re-enrollment, Manage Change Request, and Re-verification application submitted by the provider. Upon submission of the initial application, ownership is compared to the matching Medicare record in the Provider Enrollment, Chain, and Ownership System (PECOS) when available. A match will allow the*

application to continue processing whereas a mismatch in ownership causes a denial of the application.

This statement **minimizes the importance** of the auditor findings and **misleads the reader** to believe that this implemented measure of ownership verification is sufficient. **It is not.**

As stated in this report, auditors determined that **52 of the 60 (87%)** tested providers **did not have ownership information in PECOS** or documentation to support that ownership information was compared to PECOS. Comparing provider ownership to PECOS provides limited verification of ownership. Specifically,

- The provider-disclosed ownership information that is compared to PECOS is self-reported.
- PECOS is used to collect information on providers participating in Medicare; therefore, the data is limited to Medicare taxonomies and does not cover all Medicaid services.
- According to the U.S. Government Accountability Office, CMS data (from PECOS) does not provide a means to readily identify ownership information and was not designed to do so [with respect to nursing homes].

Additionally, this audit found that the Division **did not corroborate the ownership information** for **any of the 4,860 reverification applications** that were approved from January 1, 2023, through December 31, 2023.

As such, because the Division did not corroborate ownership information, it did not identify providers who may have submitted inaccurate information.

Therefore, there was an increased risk that those providers remained enrolled in Medicaid, served Medicaid beneficiaries, and received payment from the state. For example, OSA's February 2021 *Medicaid Provider Enrollment* performance audit found that of the 191 approved provider re-verification applications tested, 21 of the 191 (11%) providers did not disclose complete and accurate information.

In total, these 21 providers served over 37,600 beneficiaries and were paid approximately $41.7 million in Medicaid funds for services.

The Governor, legislators, and the citizens of North Carolina should consider these clarifications when evaluating the Division's response to this audit's findings and recommendations.

Response from the Department of Health and Human Services

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

JOSH STEIN • Governor
DEVDUTTA SANGVAI • Secretary
JAY LUDLAM • Deputy Secretary, Division of Health Benefits

July 3, 2025

The Honorable Dave Boliek, State Auditor
Office of the State Auditor
2 South Salisbury Street
2061 Mail Service Center
Raleigh, North Carolina 27699-0600

Dear Auditor Boliek:

We have reviewed the draft performance audit report titled, Medicaid Provider Enrollment Follow-Up Audit, covering the period January 1, 2023, through December 31, 2023. The Department fully acknowledges its responsibility to ensure that only qualified providers are enrolled in the Medicaid program to provide care for NC Medicaid beneficiaries and eagerly pursues opportunities to improve our validation efforts of the credentials of all 101,474 providers participating with NC Medicaid (as of December 31, 2023). The Division completed 6,546 monitoring and quality control reviews of provider enrollment data during the 2023 audit period, including monitoring of the fiscal agent and other enrollment vendors, and licensing board consent orders. The following represents our response to the Audit Findings and Recommendations, including any corrective actions taken or planned.

AUDIT FINDINGS, RECOMMENDATIONS, AND RESPONSES

1. Did Not Fully Implement Recommendations to Identify and Remove Providers with Suspended or Terminated Licenses

Recommendations:

Division management should remove all providers who have had their professional licenses suspended or terminated or entered into Non-Practice Agreements from the Medicaid program.

The Division's Medicaid policies and procedures should include the identification and removal of providers that cannot practice or perform any act that requires a license.

Division management should fully implement prior audit recommendations in a timely manner to address the identified issues and to reduce the risk providers may pose to Medicaid patients.

Agency Response:

The Division disagrees with the finding.

As noted in this report, the Division implemented Provider Screening and License Board Monitoring procedures in response to the February 2021 audit. The screening procedures do not call for an automatic termination of providers that enter into Non-Practice Agreements (NPA), as the details in such agreements may vary and should be treated on a case-by-case basis. Most NPAs are private

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agreements between the Medical Board and the provider and are not known to the public or the Medicaid agency. When publicly available, NPAs are referred by the monitors to the Provider Screening Process for review and action.

The Division agrees that Provider A was not removed from the Medicaid program due to human oversight in monitoring and represents the single error in the screening process of the 20 providers disciplined by their licensing board during the audit period. Provider A has been retroactively terminated from the Medicaid program effective May 2023.

The Division does not agree that the timing of Provider B's removal was problematic. The Division removed Provider B from the Medicaid program within four (4) days of the publication of the Consent Order which indefinitely suspended Provider B's license. The Consent Order did not confirm that a prior NPA existed; therefore, the Division could not have removed Provider B for the time period prior to the Consent Order. NC Medicaid can only act on provider information that is available for review and properly documented. The Division will reach out to the Medical Board to request documentation of an NPA for Provider B prior to the Consent Order. If it is found that an NPA did exist, the Division will take appropriate retroactive action.

The Division will review and enhance the internal controls surrounding the monitoring workflow to ensure the risk of disciplined providers remaining in the program is sufficiently mitigated. The Division will engage with the licensing boards to evaluate the opportunity to obtain provider sanction information that is not readily available to the public.

2. Did Not Fully Implement Recommendations to Remove Providers with Professional License Limitations That Pose Threats to Medicaid Patients

Recommendations:

Division management should remove all providers from the Medicaid program who have professional license limitations that pose threats to the safety of patients.

The Division's policies and procedures for the continued enrollment of providers with limitations on their license 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.

Division management should fully implement prior audit recommendations in a timely manner to address the identified issues and to reduce the risk providers may pose to Medicaid patients.

Agency Response:

The Division disagrees that providers with license limitations automatically pose a safety risk to beneficiaries and should be removed from the program. The Division acknowledges that some provider limitations should be excluded due to the challenge in monitoring for or preventing a violation of the limitation.

As stated in the report, "According to the Centers for Medicare and Medicaid Services, 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**." As a result of the February 2021 audit, the Division created the Provider Screening policy to review providers with license limitations and allow them to remain in the program when deemed appropriate. The policy provides for the review of licensing board actions, including Public NPAs, to assess a provider's risk to patient safety as opposed to an immediate termination because of the limitation.

In response to the February 2021 report, the Division issued a termination notice to Provider C and the provider appealed the termination. In accordance with the North Carolina provider appeals process in §108C-5(d), the provider remains active pending the outcome of the appeal hearings. The Division is monitoring the provider's current compliance via our prepayment review program to ensure further violations do not occur.

The Division acknowledges that opportunities exist to strengthen the license limitation monitoring processes and documentation through enhanced staff training efforts to further mitigate the risk of providers remaining in the program that pose a safety risk to patients. The Division will conduct an analysis of monitoring outcomes and conduct training around identified gaps. The Division will also evaluate the need for additional controls in the review process and implement enhancements where necessary.

3. Did Not Fully Implement Recommendations to Strengthen Provider Credential Verification

Recommendations:

Division management should verify that providers possess Drug Enforcement Administration (DEA) certifications given the potential risk posed to Medicaid patients from providers prescribing controlled substances without required DEA certification.

Division management should fully implement prior audit recommendations in a timely manner.

Agency Response:

The Division agrees with this finding.

As noted in the report, the Division did strengthen its processes by conducting direct primary source verification of provider credentials in response to the February 2021 report. DEA certification became a requirement for participation in the Medicaid program on October 1, 2020, during the Public Health Emergency (PHE). The Division notified providers that beginning on October 1, 2020, they will be required to provide their DEA certification number on any initial enrollment, reverification or Managed Change Request (MCR) application they complete. While verification was conducted for initial enrollments and managed change requests, reverifications were paused from March 13, 2020 through May 11, 2023 due to the PHE.

The Division reviewed the nine (9) providers cited in the report and noted the following:

- One (1) provider utilized the DEA Designation Form, granting the provider an exception to the DEA certification requirement. The Form was documented in the Notes section of the NCTracks provider enrollment record and made available in documents attached to the record. This met the validation criteria. This provider, the only one currently active, has not reached their reverification date nor submitted a MCR requiring a credentialing review.

- Eight (8) providers, including Providers F, G, and D cited in the audit, had not reached their extended reverification date nor submitted an MCR requiring a credentialing review between the effective date of the DEA certification requirement and their termination date, which occurred prior to the end of the audit period.

The Division acknowledges that the risk existed for prescribing providers to be uncertified by DEA for some portion of the period between October 1, 2020, and the time of their subsequent recredentialing review. The Division will explore solutions to more timely verify provider DEA licensing compliance.

4. Did Not Fully Implement Recommendation to Corroborate Provider Ownership Information

Recommendations:

The Division should verify the accuracy of all provider ownership information to data available from state licensure boards or the Secretary of State. This should be completed so background checks can be performed and identified ineligible providers removed from Medicaid to protect the safety of Medicaid patients and prevent inappropriate payments from the state.

Division management should fully implement prior audit recommendations timely.

Agency Response:

The Division appreciates the Auditor's recognition that the February 2021 audit report recommendation to verify provider ownership was not feasible. The Division agrees with the updated recommendation to implement additional procedures to corroborate the provider's ownership disclosure.

For context, there is no federal or state regulation or CMS guidance that requires State Medicaid Agencies to corroborate ownership of providers as stated in the finding. The GAO-23-106163 report on Nursing Homes, noted that determining "whether an unlisted nursing homeowner **should have been reported**…can be a **time-and resource-intensive effort** because **there is no single, authoritative data source with comprehensive information**." However, the Division agrees that prudence requires conducting cost-effective quality assurance efforts to identify whether the provider is consistently identifying all relevant parties so that appropriate screening checks can be performed.

In response to the February 2021 report, the Division implemented the following measure for ownership verification beginning April 2022:
For NC Medicaid participation, providers must disclose 5% or more ownership of the entity enrolling and must self-attest that "Owners with 5% or more ownership in the enrolling provider entered on this application match what was reported to the provider's state business registration entity, licensure board, and Medicare." Disclosure and self-attestation are required with each Initial, Re-enrollment, Manage Change Request, and Re-verification application submitted by the provider. Upon submission of the initial application, ownership is compared to the matching Medicare record in the Provider Enrollment, Chain, and Ownership System (PECOS) when available. A match will allow the application to continue processing whereas a mismatch in ownership causes a denial of the application.

During the current audit period, the Division compared 2,398 separate owners reported on 1,764 initial enrollment applications, with mismatches resulting in 30 application denials. The application denials confirm the Division's incorporation of adverse consequences recommended when providers "submit inaccurate information" regarding ownership, thereby protecting the safety of Medicaid patients and preventing inappropriate payments to providers.

The Division acknowledges that the opportunity exists to conduct additional quality assurance checks of other publicly available provider information to increase the likelihood of identifying potentially unreported ownership disclosures. The Division is evaluating the viability of expanding the initial enrollment ownership verification procedures to the reverification and managed change request credentialing processes as well as pursuing the identification of additional sources of provider ownership information that can be reasonably queried for comparison as suggested in CMS' "*Toolkit to Address Frequent Findings: 42 CFR 455.104*".

Matter for Further Consideration:

Division management should improve monitoring of the $1.5 billion GDIT contract so that the state's interest is protected and to ensure the effective and efficient use of taxpayer funds.

Agency Response:

The Division appreciates this suggestion and will take it under advisement for future monitoring efforts.

Thank you for the opportunity to respond, and 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,

DocuSigned by:
Jay Ludlam
Jay Ludlam
Deputy Secretary, NC Medicaid

cc: Devdutta Sangvai, Secretary
Dr. ClarLynda Williams-DeVane, Chief Deputy Secretary
Melanie Bush, Assistant Secretary, NC Medicaid
Sarah Gregosky, Chief Operating Officer
Adam Levinson, Chief Financial Officer
Lotta Crabtree, Chief Legal Officer
John Thompson, Chief Compliance Officer
Jeff Grimes, Director, Office of the Internal Auditor
Lisa Allnutt, Senior Audit Manager, Office of the Internal Auditor

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This audit required 2,449.5 hours of auditor effort at an approximate cost of $360,853.