

Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicaid Integrity Program

North Carolina Comprehensive Program Integrity Review

Final Report

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INTRODUCTION

The Centers for Medicare & Medicaid Services' (CMS) Medicaid Integrity Group (MIG) conducted a comprehensive program integrity review of the North Carolina Medicaid Program. The MIG review team conducted the onsite portion of the review at the offices of the Division of Medical Assistance (DMA) and the Medicaid provider enrollment contractor. The review team also visited the office of the State's Medicaid Fraud Control Unit (MFCU), known as the Medicaid Investigation Unit (MIU).

This review focused on the activities of the Program Integrity Unit (PI Unit) within DMA. This report describes one noteworthy practice, two effective practices, seven regulatory compliance issues, and eight vulnerabilities in the State's program integrity operations.

The CMS is concerned that the review identified one partial repeat finding and five partial or complete repeat vulnerabilities from its 2008 review of North Carolina. The CMS plans on working closely with the State to ensure that all issues, particularly those that remain from the previous review, are resolved as soon as possible.

THE REVIEW

Objectives of the Review

1. Determine compliance with Federal program integrity laws and regulations;
2. Identify program vulnerabilities and effective practices;
3. Help North Carolina improve its overall program integrity efforts; and
4. Consider opportunities for future technical assistance.

Overview of North Carolina's Medicaid Program

The DMA is located within the North Carolina Department of Health and Human Services (NCDHHS) which administers the North Carolina Medicaid program. As of January 1, 2011, North Carolina had 1,465,113 beneficiaries participating in the Medicaid program and 72,041 active Medicaid providers. North Carolina has contracted with one managed care entity (MCE) to provide behavioral health services to a five-county region. Per CMS data, total computable Medicaid expenditures during the State fiscal year (SFY) ending on June 30, 2011 were \$11,046,193,100.

Program Integrity Section

The PI Unit within DMA is the organizational component dedicated to anti-fraud and abuse activities. At the time of the review the PI Unit had approximately 50 full-time equivalent staff focusing on Medicaid program integrity. The table below represents the total number of investigations and overpayments identified and collected in the past four SFYs as a result of program integrity activities.

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| SFY | Number of Preliminary Investigations* | Number of Full Investigations * | Amount of Overpayments Identified ** | Amount of Overpayments Collected** |
|------------|--|--|---|---|
| 2008 | 854 | 1,986 | \$ 50,686,821 | \$ 45,090,561 |
| 2009 | 1,125 | 1,830 | \$ 13,300,785 | \$ 18,661,995 |
| 2010 | 600 | 1,638 | \$ 33,994,374 | \$ 2,740,405 |
| 2011 | 1,008 | 2,347 | \$ 70,649,047 | \$ 17,554,885 |

*Preliminary investigations of fraud or abuse complaints determine if there is sufficient basis to warrant a full investigation. Full investigations are conducted when preliminary investigations provide reason to believe fraud or abuse has occurred. They are resolved through a referral to the MFCU or administrative or legal disposition. Typically, States conduct fewer full investigations than preliminary investigations, but North Carolina defines these terms differently. In North Carolina, preliminary investigations are done on all complaints of suspected provider fraud and abuse coming in from various sources, which are reviewed by an investigator and determined to require no further review. These cases are not moved forward for full investigation. Full investigations are those complaints of suspected provider fraud and abuse, which require more than a preliminary review. Accordingly, total investigations are the sum of both preliminary and full and more investigations are treated as full reviews. The number of full investigations also excludes cases that have been referred outside the State’s jurisdiction, such as those cases referred to Medicare or other NCDHHS Divisions.

** The SFY08 figures were unusually high in comparison with SFY09 figures because the former included overpayments identified in a program review which covered the full universe community support services and resulted in the termination of the Community Support Services program. The SFY10 and SFY11 overpayments identified reflect increasing audit and investigation activity, but collections have been delayed due to the length of the administrative appeal and final adjudication process.

Methodology of the Review

In advance of the onsite visit, the review team requested that North Carolina complete a comprehensive review guide and supply documentation in support of its answers. The review guide included such areas as program integrity, provider enrollment/disclosures, managed care and the MFCU. A four-person team reviewed the responses and materials that the State provided in advance of the onsite visit.

During the week of September 19, 2011, the MIG review team visited the DMA, enrollment contractor and MIU offices. The team conducted interviews with numerous DMA officials, the State’s provider enrollment contractor, MCE, and MIU staff. To determine whether non-emergency medical transportation (NEMT) providers were complying with contract provisions and other Federal regulations relating to program integrity, the MIG team also interviewed DMA staff who oversee the NEMT program. In addition, the team conducted sampling of provider enrollment applications, selected case files, and other primary data to validate the State’s program integrity practices.

Scope and Limitations of the Review

This review focused on the activities of DMA as they relate to program integrity but also considered the work of other components and contractors responsible for a range of program integrity functions, including provider enrollment, and managed care and NEMT oversight.

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North Carolina operates its Children's Health Insurance Program (CHIP) both as a stand-alone Title XXI program and a Title XIX Medicaid expansion program. The expansion program operates under the same billing and provider enrollment policies as North Carolina's Title XIX program. The same noteworthy and effective practices, findings and vulnerabilities discussed in relation to the Medicaid program also apply to the expansion CHIP. The stand-alone program operates under the authority of Title XXI and is beyond the scope of this review.

Unless otherwise noted, North Carolina provided the program integrity-related staffing and financial information cited in this report. For purposes of this review, the review team did not independently verify any staffing or financial information that DMA provided.

RESULTS OF THE REVIEW

Noteworthy Practices

As part of its comprehensive review process, the CMS review team has identified one practice that merits consideration as a noteworthy or "best" practice. The CMS recommends that other States consider emulating this activity.

Controlling payment and service authorizations in personal care services (PCS)

The DMA contracts with an outside entity to conduct independent assessments (IA) and reassessments in North Carolina's PCS program. The Independent Assessment Entity (IAE) processes all incoming physician office referrals and conducts beneficiary assessments to make a determination of whether or not a potential PCS beneficiary meets DMA program coverage criteria to ensure the most appropriate use of services. As a result, the IAE issues service authorizations to qualified enrolled home care providers selected by the beneficiary and processes PCS agency change requests. The IAE also authorizes fiscal agent payments to the agency selected by the beneficiary, which are limited to the maximum daily allowable units and monthly authorized services. These limits are entered into the DMA fiscal system. The IAE work processes and directives are issued, approved and monitored for quality by the DMA Clinical Policy section. Consequently, North Carolina has seen a reduction in the number of beneficiaries using PCS and in average monthly expenditures since the inception of the program. For example, from a monthly total of 37,500 beneficiaries served in March 2010 and generating \$29.5 million per month in outlays before IA, the State reports that 28,500 beneficiaries per month have been served on average in the first full fiscal year of the IA program, generating \$20.6 million in average monthly payments, a 30 percent reduction in expenditures.

Effective Practices

As part of its comprehensive review process, CMS also invites each State to self-report practices that it believes are effective and demonstrate its commitment to program integrity. The CMS does not conduct a detailed assessment of each State-reported effective practice. North Carolina

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reported the implementation of a prepayment review program and a policy of conducting background checks as part of the State's provider enrollment process.

Provider pre-payment review program

The PI Unit has been working with contractors over a series of years to build a prepayment review program. This program places providers on notice that 100 percent of their claims will be reviewed manually before they are paid because of problems noted in either the volume or billing of claims. The prepayment review program has produced high dollar returns from 2008-2009 to the time of the onsite review. In 2008-2009, North Carolina estimated savings of \$9.5 million from placing four providers on prepayment review who provided services in the consumer directed program formerly known as Community Support Services. The DMA calculated that it saved (cost avoided) \$1.65 million by rejecting non-compliant claims, another \$2.5 million in cost avoidance due to a decrease in claims while the four providers were under review, and \$5.4 million when the providers discontinued submitting claims. The State now focuses almost exclusively on reviewing behavioral health and PCS claims, which comprise 52 and 48 percent of the claims reviewed under the prepayment review program, respectively. The DMA estimates that it has saved \$41.2 million for SFY 2010-2011 alone from three sources: a reduction in historical claims from those providers who choose not to participate in prepayment review (\$11.7 million); a reduction in claims from providers who participate in the program (\$27.8 million); and a reduction in the absolute value of claims paid (\$1.7 million).

Criminal background checks as part of provider enrollment

North Carolina's provider enrollment contractor utilizes a computer program that performs background checks on all names disclosed as part of the provider enrollment process. The enrollment contractor pulls data from State and national criminal files, the Health Integrity and Protection Database and other sources that are national in scope during the enrollment process. Background checks are performed on all persons with ownership and control interests, agents and managing employees listed on the application. The contractor also routinely checks provider names against two databases that have been developed by the State. The first database, the Provider Penalty Tracking Database, acts as a general State debarment list. A second list, called the Program Integrity (PI) Database, is also checked. The PI Database is an offshoot of DMA's program integrity case tracking system and is updated weekly or monthly. Every provider is placed on this list if, within a rolling five year period, they:

- had any accounts receivable set up related to an overpayment,
- had a recoupment action taken,
- had evidence of an action taken against their participation in Medicaid, or
- were involved in an active investigation.

All prospective providers are checked against the PI Database. If a provider appears on it, the enrollment contractor sends the enrollment to DMA for further review and a determination of whether to enroll the provider.

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The use of these databases creates a tighter screening of providers prior to enrollment and makes it more difficult for problem providers to enroll in the Medicaid program. Notwithstanding the State's criminal background checking policies, the review team found some problems with the collection of required disclosures and performance of licensure verifications during the provider enrollment process. These are discussed in the Regulatory Compliance and Vulnerability sections below.

Regulatory Compliance Issues

North Carolina is not in compliance with Federal regulations related to beneficiary fraud referrals, ownership and control, business transaction, and health care-related criminal conviction disclosures, and exclusion searches. Issues also include the notice requirement for excluded providers and compliance monitoring regarding False Claims Act education.

The State does not refer beneficiary fraud to an appropriate law enforcement agency.

Under 42 CFR § 455.15(b) and (c), if the State Medicaid agency's preliminary investigation leads to a suspicion that a beneficiary has defrauded the Medicaid program, the case must be referred to an appropriate law enforcement agency; if the agency believes that a beneficiary has abused the program, the State Medicaid agency must conduct a full investigation.

The DMA does not refer suspected beneficiary fraud directly to law enforcement agencies. The DMA conducts a preliminary investigation and refers cases of suspect beneficiary fraud to county departments of social services, which are then responsible for the referral to law enforcement.

Recommendation: Develop and implement policies and procedures to refer suspected beneficiary fraud cases directly to an appropriate law enforcement agency.

The State does not capture all required ownership and control disclosures from disclosing entities. (Uncorrected Partial Repeat Finding)

Under 42 CFR § 455.104(b)(1), a provider (or "disclosing entity"), fiscal agent, or MCE, must disclose to the State Medicaid agency the name, address, date of birth (DOB), and Social Security Number (SSN) of each person or entity with an ownership or controlling interest in the disclosing entity or in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5 percent or more. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address. Additionally, under § 455.104(b)(2), a disclosing entity, fiscal agent, or MCE must disclose whether any of the named persons is related to another disclosing entity, fiscal agent, or MCE as spouse, parent, child, or sibling. Moreover, under § 455.104(b)(3), there must be disclosure of the name of any other disclosing entity, fiscal agent, or MCE in which a person with an ownership or controlling interest in the disclosing entity, fiscal agent, or MCE has an ownership or controlling interest. In addition, under § 455.104(b)(4), the disclosing entity must provide the name, address, DOB, and SSN of any managing employee of the disclosing entity, fiscal agent, or MCE. As set forth under § 455.104(c), the State agency must collect the disclosures from

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disclosing entities, fiscal agents, and MCEs prior to entering into the provider agreement or contract with such disclosing entity, fiscal agent, or managed care entity.

In response to the 2008 CMS review, North Carolina redesigned its provider enrollment applications. The 2011 CMS review team noted that in the redesign DMA corrected several problems and addressed some of the new disclosure requirements that went into effect on March 25, 2011. However, the forms in use at the time of the current review still did not meet all of the § 455.104 requirements. Specifically:

- While the provider applications were corrected to collect DOBs and SSNs from persons with ownership or control interest and managing employees, they do not solicit address information from these parties [42 CFR § 455.104(b)(1)].
- Applications inquire whether any named owners have a business or familial relationship to the enrolling provider citing to an OIG regulation 42 CFR §1002.3. However, they do not request the precise information required by an element of the CMS Medicaid regulations, specifically whether persons with an ownership or control interest in the disclosing entity or in any subcontractor are related to another person with ownership or control [42 CFR § 455.104(b)(2)]. The applications also do not request disclosures of those persons with any ownership or control interest in any subcontractor in which the disclosing entity has a 5 percent or more interest.
- The applications do not request disclosure of the name of any other disclosing entity in which a person with an ownership or control interest in the disclosing entity has an ownership interest [42 CFR § 455.104 (b)(3)].

The CMS review team also determined that the State did not collect any required disclosures from the current fiscal agent. Further, although the State-MCE contract requires ownership and control disclosures, North Carolina could not produce any evidence of ever having requested or collected disclosures.

Recommendations: Develop policies and procedures for the appropriate collection of disclosures from disclosing entities, fiscal agents, or MCEs regarding persons with an ownership or control interest, or who are managing employees of the disclosing entities, fiscal agents, or MCEs. Modify disclosure forms as necessary to capture all disclosures required under the 42 CFR § 455.104 regulation. The MIG made a similar recommendation in its 2008 report. While some corrective action on fee-for-service (FFS) Medicaid provider disclosures was taken, pre-contracting disclosures from the MCE and fiscal agent remain outstanding.

The State does not adequately address business transaction disclosure requirements in its managed care contract.

The regulation at 42 CFR § 455.105(b)(2) requires that, upon request, providers furnish to the State or U.S. Department of Health and Human Services (HHS) information about certain business transactions with wholly owned suppliers or any subcontractors.

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North Carolina's contract with its MCE requires disclosure of business transactions upon request. However, the disclosure requirements cite Section 1903(m) of the Social Security Act¹ and not the Medicaid program integrity regulations; accordingly, the requirements do not match those of 42 CFR § 455.105(b)(2).

Recommendation: Revise the MCE contract language to require disclosures, upon request, of business transaction information identified in 42 CFR § 455.105(b).

The State does not capture criminal conviction disclosures from its MCE.

The regulation at 42 CFR § 455.106 stipulates that providers must disclose to Medicaid agencies any criminal convictions related to Medicare, Medicaid, or Title XX programs at the time they apply or renew their applications for Medicaid participation or at any time on request. The regulation further requires that the Medicaid agency notify the U.S. Department of Health and Human Services, Office of Inspector General (HHS-OIG) whenever such disclosures are made. In addition, pursuant to 42 CFR § 455.106(b)(1), States must report criminal conviction information to HHS-OIG within 20 working days.

North Carolina's contract with its MCE requires the disclosure of criminal conviction information. However, the information solicited is based on Sections 1128 and 1128A of the Social Security Act and does not specifically refer to the requirements of 42 CFR § 455.106.² In particular, the contract requirements do not specify the disclosure of health care-related criminal convictions from all required parties such as persons with ownership and control interests, agents and managing employees, since the inception of Medicare, Medicaid or Title XX programs.

Recommendations: Develop policies and procedures for the appropriate collection of disclosures from MCEs regarding persons with an ownership or control interest, or persons who are agents or managing employees of the MCE, who have been convicted of a criminal offense related to Medicare, Medicaid or Title XX since the inception of the programs. Modify disclosure forms as necessary to capture all disclosures required under 42 CFR § 455.106.

The State does not conduct complete searches for individuals and entities excluded from participating in Medicaid.

The Federal regulation at 42 CFR § 455.436 requires that the State Medicaid agency must check the exclusion status of the provider, persons with an ownership or control interest in the provider, and agents and managing employees of the provider on HHS-OIG's List of Excluded Individuals/Entities (LEIE) and the General Services Administration's Excluded Parties List System (EPLS) no less frequently than monthly.

¹ Section 1903(m) requires disclosure of ownership and control information and disclosures of transactions between managed care entities and parties of interest.

² Section 1128 of the Social Security Act lists reasons to exclude individuals and entities from participation in Federal and State health care programs as a result of certain types of criminal convictions, other disqualifying activities, and fraud and abuse determinations. Section 1128A lists reasons for the imposition of Civil Monetary Penalties administered as a result of prohibited fraud-related actions.

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Prior to implementation of this new regulation, CMS issued a State Medicaid Director Letter (SMDL) #08-003 dated June 16, 2008 providing guidance to States on checking providers and contractors for excluded individuals. That SMDL recommended that States check either the LEIE or the Medicare Exclusion Database (MED) upon enrollment of providers and monthly thereafter. States should check for providers' exclusions and those of persons with ownership or control interests in the providers. A follow-up SMDL (#09-001) dated January 16, 2009 provided further guidance to States on how to instruct providers and contractors to screen their own employees and subcontractors for excluded parties.

Based on document review as well as interviews with DMA's provider enrollment contractor and oversight staff, it was noted that while North Carolina checks the LEIE prior to enrollment and the MED monthly, current procedures do not require the EPLS to be checked prior to enrollment or monthly. A review of the State's MCE contract also revealed no requirements for the MCE to perform monthly exclusion checking. The State confirmed in interviews that the contract does not specify how often the MCE is required to check exclusion databases. While the MCE reported that it conducts monthly exclusion checking of both the LEIE and EPLS for its providers, it only checks its own employees, contractors, officers and board members at the time of hire, contracting, or appointment or as part of annual random sample checks.

Recommendations: Develop policies and procedures for appropriate collection and maintenance of disclosure information about the MCE, any person with an ownership or control interest, or who is an agent or managing employee of the MCE. Search the LEIE (or the MED) and the EPLS upon contracting and at least monthly thereafter, by the names of the above persons and entities, to ensure that the State does not pay Federal funds to excluded persons or entities.

Modify the managed care contract to require MCEs to search the LEIE and EPLS upon contract execution and monthly thereafter by the names of any person with an ownership or control interest in the MCE, or who is an agent or managing employee of the MCE.

The State does not provide notice of exclusion consistent with the regulation.

Under the regulation at 42 CFR § 1002.212, if a State agency initiates exclusion pursuant to the regulation at 42 CFR § 1002.210, it must provide notice to the individual or entity subject to the exclusion, as well as other State agencies; the State medical licensing board, as applicable; the public; beneficiaries; and others as provided in §§ 1001.2005 and 1001.2006.

Based on interviews and documentation, DMA does not routinely provide notice to the public or beneficiaries as well as to others as provided in the above regulations. While the State has a protocol to notify stakeholders when a nursing facility is terminated, DMA does not provide the full range of notifications when other providers are terminated.

Recommendation: Develop and implement policies and procedures to ensure that all parties identified by 42 CFR § 1002.212 are notified of a State-initiated exclusion.

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The State does not comply with its State Plan regarding False Claims education monitoring. Section 1902(a)(68) of the Social Security Act [42 U.S.C. 1396a(a)(68)] requires a State to ensure that providers and contractors receiving or making payments of at least \$5 million annually under a State's Medicaid program have: (a) established written policies for all employees (including management) about the Federal False Claims Act, whistleblower protections, administrative remedies, and any pertinent State laws and rules; (b) included as part of these policies detailed provisions regarding detecting and preventing fraud, waste, and abuse; and (c) included in any employee handbook a discussion of the False Claims Act, whistleblower protections, administrative remedies, and pertinent State laws and rules.

North Carolina's State Plan amendment and supporting attachment on False Claims Act education includes plans for the State to review the policies and procedures of providers subject to the rule through routine and random audits on an ongoing basis to assure compliance. North Carolina requires providers who are covered entities to sign and return an annual attestation for False Claims Act education and it has begun the process of withholding claims payments if the attestation is not received on a timely basis. However, DMA has not yet implemented audits to verify compliance with the attestations consistent with its State Plan.

Recommendation: Implement the State Plan requirement to review provider and contractor policies for educating employees about the False Claims Act, whistleblower protections and other compliance requirements, including review of employee handbooks, if applicable.

Vulnerabilities

The review team identified eight areas of vulnerability in North Carolina's program integrity practices. These related to the verification of out-of-state provider licenses, lack of oversight in the NEMT program, not verifying whether MCE enrollees are receiving services as billed, and not capturing disclosures from managed care and NEMT network providers. The State also does not conduct complete exclusion searches in the managed care and NEMT provider networks, and does not report to HHS-OIG all adverse actions taken against managed care and NEMT network providers.

Not verifying out-of-state provider licenses during the application process. (Uncorrected Repeat Vulnerability)

Both the 2008 and 2011 CMS review teams noted that DMA does not contact the issuing state's licensing agency to verify out-of-state provider licenses or to determine if a license has limitations imposed that were never reported. The DMA reviews out-of-state licenses for effective date and name but does not contact the issuing State's licensing agency to determine if out-of-state provider licenses have restrictions. The DMA may discover irregularities related to out-of-state providers from other databases checked at enrollment. However, the failure to check licenses directly with the issuing state leaves North Carolina vulnerable to enrolling out-of-state providers who may have serious violations, penalties or enrollment actions on their license.

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Recommendation: Develop and implement a procedure to routinely verify provider licenses during the enrollment and re-enrollment processes. The same recommendation was made in the 2008 review report.

Lack of oversight in the county-based NEMT program. (Uncorrected Repeat Vulnerability)

The State does not provide adequate program integrity oversight of the NEMT program. Each of North Carolina's 100 counties administers the NEMT program, however the State has not provided any demonstrable guidance on obtaining provider ownership and control disclosures, obtaining criminal conviction disclosures (even though background checks are done), conducting exclusion checks on private transportation vendors or drivers, or verifying the provision of services with beneficiaries. The same issues were found during MIG's 2008 program integrity review. Following that review, CMS recommended that North Carolina conduct an audit and make modifications in the NEMT program. Despite identifying numerous steps in its corrective action plan of March 2009, the State does not appear to have corrected the basic problems noted in its oversight of NEMT.

Recommendations: Provide consistent oversight of the NEMT program. Steps to achieve this would include, but not be limited to, issuing guidance to the counties on obtaining the required disclosures, checking for excluded parties at regular intervals, reporting adverse actions taken at enrollment or against participating providers to the State agency and HHS-OIG verifying the delivery of services billed, and conducting periodic audits to check for inappropriate billings. The 2008 review report made similar recommendations and requested that North Carolina follow up on billing issues identified during a 2007 NEMT audit by recouping the identified overpayments. The State treated the 2007 audit as a provider education tool and sought no recoupment, though it issued administrative guidance in the same year. However, no follow-up guidance has been issued since MIG's 2008 review.

Not verifying with managed care enrollees whether services billed were received.

Although the FFS program verifies receipt of services directly with beneficiaries, North Carolina's MCE does not. The State's managed care contract does not require that the MCE conduct verification of services with beneficiaries, nor does the State perform this function. The MCE confirmed that it did not perform verification of services directly with beneficiaries unless it was following up on a complaint or investigation.

Recommendation: Develop and implement procedures to verify with MCE enrollees whether services billed by providers were received.

Not capturing full ownership and control disclosures from managed care and NEMT network providers. (Uncorrected Partial Repeat Vulnerability)

Under 42 CFR § 455.104(b)(1), a provider (or "disclosing entity"), fiscal agent, or MCE, must disclose to the State Medicaid agency the name, address, DOB, and SSN of each person or entity with an ownership or controlling interest in the disclosing entity or in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5 percent or more. The address

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for corporate entities must include as applicable primary business address, every business location, and P.O. Box address. Additionally, under § 455.104(b)(2), a disclosing entity, fiscal agent, or MCE must disclose whether any of the named persons is related to another disclosing entity, fiscal agent, or MCE as spouse, parent, child, or sibling. Moreover, under § 455.104(b)(3), there must be disclosure of the name of any other disclosing entity, fiscal agent, or MCE in which a person with an ownership or controlling interest in the disclosing entity, fiscal agent, or MCE has an ownership or controlling interest. In addition, under § 455.104(b)(4), the disclosing entity must provide the name, address, DOB, and SSN of any managing employee of the disclosing entity, fiscal agent, or MCE. As set forth under § 455.104(c), the State agency must collect the disclosures from disclosing entities, fiscal agents, and MCEs prior to entering into the provider agreement or contract with such disclosing entity, fiscal agent, or MCE.

The 2008 MIG review found little or no ownership and control information being solicited on the behavioral health contractor's network providers. Following that review, the MCE provider application was revised to correct this omission, but it still does not solicit the full range of disclosure information that would be required in the FFS Medicaid program under 42 CFR § 455.104. The MCE provider application does not request the names of persons with ownership and control interests in subcontractors directly or indirectly owned by the provider. It also does not solicit the name of other disclosing entities in which persons with ownership and control interests of a provider also have an ownership or control interest.

With respect to the NEMT program, the State provided no documentation that North Carolina counties were collecting the same ownership and control disclosure information from service providers that would be required of disclosing entities in the FFS program. There are no contract provisions binding counties to collect disclosures in the NEMT program and counties do not appear to be collecting them. Accordingly, transportation providers on contract with each county are not registered with the State Medicaid program. The State reported that only ambulance providers are enrolled directly by the State. The lack of documentation on ownership and control in the NEMT program makes it difficult for the State to determine if excluded parties are participating and receiving Medicaid payments. The same situation was found in the 2008 review.

Recommendations: Modify the managed care contract to require, or ensure that managed care provider enrollment forms require, the disclosure of complete ownership, control, and relationship information from all MCE network providers. Include contract language requiring MCEs to notify the State of such disclosures on a timely basis. Develop and implement policies and procedures for collecting the required disclosures in the NEMT program. Similar recommendations were made in the 2008 review report.

Not adequately addressing business transaction disclosures in MCE and NEMT network provider contracts. (Uncorrected Repeat Vulnerability)

The regulation at 42 CFR § 455.105(b)(2) requires that, upon request, providers furnish to the State or HHS information about certain business transactions with wholly owned suppliers or any subcontractors.

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As mentioned earlier, the State's MCE contract does not obligate the MCE to provide business transaction disclosures upon request that are consistent with 42 CFR §455.105. The contract also does not require the MCE to obtain such disclosures from network providers upon request by the State agency or HHS Secretary, and the MCE's provider agreement lacks a provision for reporting business transactions as well, such as would be required of FFS providers. The review team found this provision missing from most FFS provider agreements as well as MCE subcontracts in 2008. However, while the omission was subsequently addressed through corrective action on the FFS side, it remains an issue for MCE network providers.

North Carolina counties vary in how they provide and contract for NEMT services. Nonetheless, from a review of sample county documents and interviews with DMA, the review team determined that the State does not provide standard guidance or specify requirements for NEMT contracts that would obligate NEMT providers to provide business transaction information to the State or to the HHS Secretary upon request. Likewise, there was no evidence that the counties independently place these obligations on NEMT providers.

Recommendations: Modify the managed care contract and provider agreements to require disclosure upon request of the information identified in 42 CFR § 455.105(b). The same recommendation was made in the 2008 review report. Develop and implement policies and procedures to ensure that counties require NEMT contractors and subcontractors to disclose the same business transaction information upon request. While the 2008 review team stressed the need for greater State oversight of the NEMT program in North Carolina, this specific recommendation was not made concerning NEMT in the 2008 report.

Not capturing criminal conviction disclosures from MCE and NEMT network providers. (Uncorrected Partial Repeat Vulnerability)

The regulation at 42 CFR § 455.106 stipulates that providers must disclose to Medicaid agencies any criminal convictions related to Medicare, Medicaid, or Title XX programs at the time they apply or renew their applications for Medicaid participation or at any time on request. The regulation further requires that the Medicaid agency notify HHS-OIG whenever such disclosures are made. In addition, pursuant to 42 CFR § 455.106(b)(1), States must report criminal conviction information to HHS-OIG within 20 working days.

In the 2008 review, the CMS team found that North Carolina's MCE collected general criminal conviction information from individual practitioners but not from other network provider types. This was subsequently addressed through corrective action. However, the MCE's provider enrollment application and credentialing materials in use at the time of the 2011 review only request the disclosure of criminal conviction information from the provider applicant. The MCE does not request disclosure of criminal history information from any person who has an ownership or control interest, or is an agent or managing employee of the provider, as is required of FFS providers. The counties which administer the NEMT program conduct criminal background, registry, and license checks as relevant, but also do not require the disclosure of health care-related criminal convictions from the full range of parties described above.

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Recommendations: Modify the managed care contract to require, or ensure that managed care provider enrollment forms require, the disclosure of health care-related criminal convictions on the part of persons with an ownership or control interest, or persons who are agents or managing employees of network providers. Include contract language requiring MCEs to notify the State on a timely basis when such disclosures are made. The same recommendation was made in the 2008 review report. Develop and implement policies and procedures to ensure the collection of health care-related criminal convictions from NEMT providers and the timely reporting of such disclosures to the State and/or HHS-OIG. While the 2008 review team stressed the need for greater State oversight of the NEMT program in North Carolina, this specific recommendation was not made concerning NEMT in the 2008 report.

Not conducting complete searches for individuals and entities excluded from participating in Medicaid.

The regulations at 42 CFR §§ 455.104 through 455.106 require States to solicit disclosure information from disclosing entities, including providers, and require that provider agreements contain language by which the provider agrees to supply disclosures upon request. If the State neither collects nor maintains complete information on owners, officers, and managing employees in the MMIS, then the State cannot conduct adequate searches of the LEIE or the MED.

The CMS issued SMDL #08-003 dated June 16, 2008 providing guidance to States on checking providers and contractors for excluded individuals. That SMDL recommended that States check either the LEIE or the MED upon enrollment of providers and monthly thereafter. States should check for providers' exclusions and those of persons with ownership or control interests in the providers. A follow-up SMDL (#09-001) dated January 16, 2009 provided further guidance to States on how to instruct providers and contractors to screen their own employees and subcontractors for excluded parties, including owners, agents, and managing employees. A new regulation at 42 CFR § 455.436, effective March 25, 2011, now requires States to check enrolled providers, persons with ownership and control interests, and managing employees for exclusions in both the LEIE and the EPLS on a monthly basis.

As discussed in the Findings section, the CMS review team found that North Carolina was not collecting full disclosure information on all persons with ownership and control interests and managing employees associated with the State's MCE contractor and did not require the MCE to conduct monthly exclusion checking pursuant to the guidance above. With regard to the MCE's provider network, the review team noted that although the MCE is required to check the LEIE and EPLS upon provider credentialing and recredentialing — and in practice it does check the LEIE and EPLS monthly for providers — the MCE does not perform monthly checks on persons with an ownership or control interest in its network providers. Nor is the MCE required to notify its providers and contractors to screen their own employees for excluded parties, including owners, agents and managing employees. This leaves the State vulnerable to the participation of an excluded party in its Medicaid program. In addition, the review team determined that no exclusion checks are being performed by either the State or counties on contracted NEMT providers.

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Recommendations: Amend the contract to require the appropriate collection and maintenance of disclosure information about disclosing entities, and about any person with a direct or indirect ownership interest of 5 percent or more, or who is an agent or managing employee of the disclosing entity, or who exercises operational or managerial control over the disclosing entity. Require the MCE contractor and components overseeing the NEMT program to search the LEIE and the EPLS upon enrollment, reenrollment, credentialing or recredentialing of network providers, and at least monthly thereafter, by the names of the above persons and entities, to ensure that the State does not pay Federal funds to excluded persons or entities.

Not reporting all MCE and NEMT adverse actions taken against providers to the HHS-OIG. The regulation at 42 CFR § 1002.3(b)(3) requires reporting to HHS-OIG any adverse actions a State takes on provider applications for participation in the program. The State does not have clear policies and procedures or contract requirements directing MCEs or North Carolina counties to report to it any program integrity-related adverse actions they take on a provider's participation in the network, e.g., denials of credentials, enrollment, or contracts, or terminations of credentials, enrollment, or contracts. Program integrity reasons include fraud, integrity, or quality.

Failure to report adverse actions appropriately was identified as a compliance issue in the FFS program during the 2008 review. While North Carolina subsequently addressed this issue through corrective action, the 2011 review team identified similar reporting problems in the managed care and NEMT programs. The MCE indicated that while it reports cases of suspected fraud and terminations made for reasons of fraud to the State, it does not report providers whose enrollment it denies on the basis of program integrity considerations. Further, DMA's contract with the MCE does not require the plan to notify the State of adverse actions it takes against a provider's participation in the program. If the MCE does not report this information to the State, the State is not able to notify HHS-OIG of the adverse action.

Likewise, in the NEMT program, the State does not require counties or vendors on contract with local government to report adverse actions taken against NEMT providers. The counties perform background checks on all providers seeking to be contracted NEMT providers. Nevertheless, applicants found to have criminal convictions or who are otherwise prohibited from contracting with the NEMT program are not reported to the State or to HHS-OIG by the counties.

Recommendations: Require contracted MCEs and the counties which administer the NEMT benefit to notify the State when they take adverse action against a network provider for program integrity-related reasons. Develop and implement procedures for reporting these actions to HHS-OIG.

CONCLUSION

The State of North Carolina applies some noteworthy and effective practices that demonstrate program strengths and the State's commitment to program integrity. These practices include:

- tight controls over PCS payments and service authorizations,
- effective prepayment review program, and
- national and local background checking for all enrolling providers.

The CMS supports the State's efforts and encourages it to look for additional opportunities to improve overall program integrity.

However, the identification of seven areas of non-compliance with Federal regulations is of concern and should be addressed immediately. In addition, eight areas of vulnerability were identified. The CMS is particularly concerned over the six repeat findings and vulnerabilities. The CMS expects North Carolina to closely examine the vulnerabilities that were identified in this review and correct them as soon as possible.

To that end, we will require North Carolina to provide a corrective action plan for each area of non-compliance within 30 calendar days from the date of the final report letter. Further, we will request the State include in that plan a description of how it will address the vulnerabilities identified in this report.

The corrective action plan should address how the State of North Carolina will ensure that the deficiencies will not recur. It should include the timeframes for each correction along with the specific steps the State expects will occur. Please provide an explanation if correcting any of the regulatory compliance issues or vulnerabilities will take more than 90 calendar days from the date of the letter accompanying this report. If North Carolina has already taken action to correct compliance deficiencies or vulnerabilities, the plan should identify those corrections as well.

The Medicaid Integrity Group looks forward to working with the State of North Carolina on correcting its areas of non-compliance, eliminating its areas of vulnerability, and building on its effective practices.