Recommendations

Recommendation 1. The General Assembly should require the North Carolina Medicaid program to develop and implement policies and procedures ensuring available resources are being cost-effectively used to identify and prevent fraud, waste, and abuse.

As reported, the Program Integrity Section has not established a uniform methodology to identify and measure the contribution of reviews of medical service claims and eligibility determinations.

To help ensure that the Program Integrity Section cost-effectively uses state funds to reduce Medicaid fraud, waste and abuse, the General Assembly should require the PI Section to develop and implement policies and procedures to accomplish the following objectives:

- Ensure use of a uniform methodology to identify and measure the severity of Medicaid eligibility determinations and medical service claim errors. At a minimum, this methodology should include criteria to
    - ensure payment errors can be categorized by provider type, medical procedure, associated oversight activity, and can be compared and if necessary combined with the results of federal PERM reviews and other applicable oversight activities,
    - identify monetary impact to Medicaid funding requirements and determine whether errors are inadvertent or due to fraudulent activity, and
    - ensure that review requirements are limited to those necessary to determine the accuracy of each participant eligibility determination and medical service claim.
- Provide incentives for county DSS offices to ensure the accuracy of Medicaid eligibility determinations.
- Ensure effective consideration of the results of periodic root-cause analysis of claim payment errors, and measure the impact of associated operational improvements on the level of Medicaid fraud, waste, and abuse.

To ensure cost-effective use of all available claim and eligibility review information, the General Assembly should also direct that the methodology used to identify and measure the severity of Medicaid eligibility determinations and medical service claim errors be made available and used by other state entities performing Medicaid oversight activities, when feasible.

Recommendation 2. The General Assembly should direct the North Carolina Medicaid program, in partnership with the Office of Administrative Hearings and the Medicaid Investigations Division, to identify alternatives to improve the effectiveness of efforts to recoup identified claim overpayments and to prosecute fraudulent activity.

As identified in Findings 1 and 2, the effectiveness of the Program Integrity Section in reducing fraud and recouping claim overpayments may be unnecessarily limited due to inadequate coordination with other state entities participating in the North Carolina Medicaid program.

To help ensure state funds are cost-effectively used to recoup identified medical service claim overpayments and prosecute fraudulent activity, the General Assembly should require the North Carolina Medicaid program, in partnership with the Office of Administrative Hearings and the state Department of Justice's Medicaid Investigations Division, to identify alternatives, to include proposed legislation, to increase the amounts recouped from identified overpayments and the percentage of fraud referrals accepted for further investigation and prosecution.

The results of this analysis should be provided to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice and to the Fiscal Research Division by March 31, 2017.

Recommendation 3. The General Assembly should require the North Carolina Medicaid program to develop policies and procedures to ensure any additional oversight cost-effectively addresses identified noncompliance.

As reported in Finding 3, enhanced pre-claim and post-claim payment reviews may unnecessarily increase the administrative burden and associated costs to Medicaid service providers. Excessive administrative requirements create unnecessary additional costs to the provider that do not contribute to reducing fraud, waste, and abuse. These additional costs can adversely affect the financial viability of private service providers and their ability to participate in the Medicaid program and provide access to quality health care for recipients.

To help ensure actions imposed upon Medicaid service providers with identified aberrant behavior are appropriate given the level of non-compliance, the General Assembly should amend N.C. Gen. Stat. § 108C-7(a) to require the Medicaid program to develop and incorporate a Progressive Corrective Action process for providers selected for enhanced pre-claim and post-claim payment review. At a minimum the process should ensure

- aberrant behavior as identified through data analytics or from external sources is validated by enhanced pre-claim or post-claim payment review that includes clinical reviews, and/or a provider eligibility determination, as appropriate,
- workloads are targeted, specific, and prioritized to ensure an adequate return on investment of available resources,
- documentation requirements for claims subject to the enhanced pre-claim and post-claim payment reviews are limited to those necessary to determine the accuracy and appropriateness of the information used in the automated claim payment process,
- recoupments of overpayments are made when errors are validated,
- referrals to the Medicaid Investigations Division are made when credible allegations of fraud are established, and
- provider feedback and education are used when aberrant behavior is due to abuse and absent an established credible allegation of fraud.

Recommendation 4. The General Assembly should require the North Carolina Medicaid program to produce an annual performance report documenting results and an annual work plan that provides a roadmap to reduce fraud, waste, and abuse.

As identified in each of the findings, the North Carolina Medicaid program is not effectively utilizing available information from reviews of eligibility determinations and medical service claims to improve existing Medicaid processes to prevent fraud, waste, and abuse.

To help ensure that the Program Integrity Section is cost-effectively identifying and preventing fraud, waste, and abuse, the General Assembly should amend state law to require the North Carolina Medicaid program to produce an annual report documenting its impact and achievement of associated performance targets, to include:

- cost to perform each activity;
- number and value of identified valid claim payment errors associated with waste and abuse, to include
  - recoupments of claim overpayments and
  - cost-avoidance through detection of errors prior to claim payment;
- number of reviews of Medicaid service providers and of recipient eligibility determinations performed, to include
  - number of Medicaid service providers and recipient eligibility determinations identified as inaccurate,
  - number and estimated value of claim payment errors associated with approvals of ineligible Medicaid service providers and recipients, and
  - number of disapprovals of eligible providers and recipients;
- reductions in Medicaid state funding requirements associated with business process improvements of systemic deficiencies identified through root-cause analysis of inaccurate provider claims and eligibility determinations by the Program Integrity Section, to include:
  - description of each system deficiency,
  - cost to implement associated business process improvement, if applicable, and
  - estimated reduction in state funding requirements realized from business process improvement, if applicable; and
- number of Medicaid fraud referrals accepted by the Medicaid Investigations Division for prosecution, to include
  - number and value of claim payment errors associated with fraudulent Medicaid participant activity.

The General Assembly should also require the North Carolina Medicaid program to produce an annual work plan identifying the most cost-effective allocation of available resources to reduce Medicaid fraud, waste, and abuse during the upcoming fiscal year.

The composition of planned oversight activities should be established from the results of an annual assessment of potential Medicaid fraud, waste,

and abuse. At a minimum, the risk assessment should identify specific Medicaid participant and medical service categories, and for each category include consideration of the following factors and information from the most recently available state fiscal year:

- annual number and average value of Medicaid eligibility determination/claim payments,
- estimated percentage of valid Medicaid eligibility determination/claim payment errors from all sources,
- cost to identify payment errors and realize savings to state funding requirements, and
- number of fraud referrals accepted by MID.

The annual performance report for the most recent fiscal year and work plan for the upcoming fiscal year should be provided to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice and to the Fiscal Research Division by December 1.

The General Assembly should also direct the Joint Legislative Oversight Committee on Medicaid and NC Health Choice to review the implementation by the North Carolina Medicaid program of each of the recommendations contained in this report. As authorized in N.C. Gen. Stat. § 102-19, this review may include invitations to affected stakeholders and other interested parties to appear and testify before the Committee. The Committee co-chairs may establish subcommittees to assist with various parts of the review, including determining whether contracted services are effectively contributing to Medicaid program objectives, and whether appropriate performance measures and targets have been established.

Agency Response

A draft of this report was submitted to the Department of Health and Human Services for review. Its response is provided following the appendices.

Program Evaluation Division Contact and Acknowledgments

For more information on this report, please contact the lead evaluator, Chuck Hefren, at chuck.hefren@ncleg.net.

Staff members who made key contributions to this report include Jim Horne, CPA. John W. Turcotte is the director of the Program Evaluation Division.