

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**NORTH CAROLINA DID NOT
COMPLY WITH FEDERAL AND
STATE REQUIREMENTS WHEN
MAKING MEDICAID COST-
SHARING PAYMENTS FOR
PROFESSIONAL MEDICAL
SERVICES**

*Inquiries about this report may be addressed to the Office of Public Affairs at
Public.Affairs@oig.hhs.gov.*



Gloria L. Jarmon
Deputy Inspector General
for Audit Services

October 2017
A-04-16-04054

Office of Inspector General

<https://oig.hhs.gov>

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC
at <https://oig.hhs.gov>

Section 8M of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site.

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

Report in Brief

Date: November 2017

Report No. A-04-16-04054



Why OIG Did This Review

States must make medical assistance available for Medicare deductibles, coinsurance, and copayments (cost-sharing) for certain individuals who are dually eligible to be enrolled in both Medicare and Medicaid.

In North Carolina, Medicaid is required to make cost-sharing payments at the lesser of the cost-sharing amount or the Medicaid allowable payment.

While conducting work on one of North Carolina's Medicaid programs, we identified cost-sharing payments that did not comply with Federal and State requirements. Our work indicated that the issue was likely systemic.

Our objective was to determine whether North Carolina complied with Federal and State requirements when making cost-sharing payments for professional medical services for dual-eligible individuals.

How OIG Did This Review

We calculated the Medicaid cost-sharing payment for a statistical sample of 200 professional medical services provided from July 1, 2011, through June 30, 2013. Our calculation used the required cost-sharing payment methodology.

For each sample item, we compared our calculation result to the payment made by North Carolina to determine any overpayment or underpayment.

North Carolina Did Not Comply With Federal and State Requirements When Making Medicaid Cost-Sharing Payments for Professional Medical Services

What OIG Found

North Carolina did not comply with Federal and State requirements when making Medicaid cost-sharing payments for professional medical services. Of the 200 sample items we reviewed, 184 were paid incorrectly. The other 16 sample items were initially paid incorrectly but were canceled prior to our sample review. For the purposes of our audit, we considered these 16 sample items to be non-errors. On the basis of our sample results, we estimated that North Carolina made at least \$63 million in improper Medicaid cost-sharing payments and claimed Federal reimbursement of at least \$41.2 million for these payments.

These improper payments occurred because North Carolina did not program its Medicaid Management Information System (MMIS) to calculate Medicaid cost-sharing payments for professional medical services in accordance with the State's required cost-sharing payment methodology.

North Carolina replaced its MMIS after our audit period. We reviewed a limited number of cost-sharing payments made after our audit period and verified that North Carolina's replacement MMIS calculated payments in compliance with the State's required cost-sharing payment methodology.

What OIG Recommends and North Carolina Comments

We recommend that North Carolina (1) refund \$41.2 million to the Federal Government for cost-sharing payments for professional medical services that did not comply with Federal and State requirements and (2) ensure that future changes to Medicaid payment methodologies comply with the Medicaid State plan.

North Carolina disagreed with our findings and recommendations. It stated that it verbally informed CMS of its intention to deviate from the cost-sharing payment methodology in the Medicaid State plan. It further stated that CMS did not require a formal submission and that CMS did not officially comment on the change. Additionally, North Carolina stated that CMS consented to the change when it approved a State plan amendment (SPA) related to another matter. After reviewing North Carolina's comments, we maintain that the evidence supports our findings and recommendations. North Carolina must submit SPAs for material changes to its Medicaid program. The SPA it referred to was related to another matter and not relevant to North Carolina's use of predetermined percentages to calculate cost-sharing payments.

TABLE OF CONTENTS

INTRODUCTION.....1

 Why We Did This Review1

 Objective1

 Background1

 Medicaid Program.....1

 Qualified Medicare Beneficiary2

 North Carolina Medicaid Cost-Sharing Payments2

 How We Conducted This Review3

FINDING.....3

 State Agency Incorrectly Made Cost-Sharing Payments for
 Professional Medical Services4

 State Agency Did Not Program Its Medicaid Management Information System To
 Perform Required Calculation5

 Estimate of Improper Payments.....6

RECOMMENDATIONS6

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE6

 State Agency Comments.....6

 Office of Inspector General Response7

APPENDICES

 A: Federal and State Requirements8

 B: Audit Scope and Methodology11

 C: Statistical Sampling Methodology13

 D: Sample Results and Estimates.....15

 E: State Agency Comments.....16

INTRODUCTION

WHY WE DID THIS REVIEW

States must make financial assistance available for Medicare deductibles, coinsurance, and copayments (cost-sharing) for certain individuals who are dually eligible to be enrolled in both Medicare and Medicaid. While conducting work on one of North Carolina's Medicaid programs, we identified cost-sharing payments that did not comply with Federal and State requirements. Our work indicated that the issue was likely systemic.

OBJECTIVE

Our objective was to determine whether the North Carolina Department of Health and Human Services (State agency) complied with Federal and State requirements when making cost-sharing payments for professional medical services¹ for dually eligible individuals.

BACKGROUND

Medicaid Program

The Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. The State plan establishes which services the Medicaid program will cover. Although the State has considerable flexibility in designing and operating its program, it must comply with applicable Federal requirements.

The Federal Government pays its share of the State's Medicaid expenditures based on the Federal medical assistance percentage (FMAP), which varies depending on the State's relative per capita income. The amount of Federal reimbursement is known as the Federal share. During State fiscal years (SFYs) 2012 and 2013² (audit period), the FMAP in North Carolina ranged from 64.71 percent to 65.51 percent.

¹ Professional medical services are outpatient and inpatient medical services provided by noninstitutional entities such as physicians, suppliers, and ambulance service providers. These noninstitutional entities are referred to as professional providers. Institutional providers include entities such as hospitals, skilled nursing facilities, rural health clinics, federally qualified health centers, home health agencies, etc. Institutional providers are reimbursed for facility charges such as equipment, supplies, and laboratory and radiology services used in providing medical care.

² North Carolina's fiscal year is from July 1 through June 30.

In North Carolina, the State agency supervises the administration of the Medicaid program. Within the State agency, the Division of Medical Assistance administers the Medicaid program.

Qualified Medicare Beneficiary

A Qualified Medicare Beneficiary (beneficiary) is a dually eligible individual entitled to both Medicare and Medicaid benefits and who receives Medicaid assistance with Medicare cost-sharing.³ After a beneficiary receives a service, the provider submits a claim to Medicare as the primary insurer.⁴ Medicare pays the provider the Medicare allowable amount, less any applicable cost-sharing amount. Medicare then transfers the claim data to the State agency to determine what portion of the cost-sharing amount, if any, Medicaid will reimburse the provider. The State agency determines the Medicaid payment according to its Medicaid State plan, and the beneficiary is not responsible for any unpaid difference.

North Carolina Medicaid Cost-Sharing Payments

In North Carolina, State law requires that if prior to the State agency's payment for particular services or appliances, the provider, the patient, or a person responsible for the patient receives partial or total payment for the services or appliances from a third-party payer, or receives funds in settlement of a civil claim, the State agency shall pay only the amount, if any, by which the State agency's payment rate exceeds the amount received by the person (10A NCAC 45A.0303(e)).

The Medicaid State plan requires that, in all circumstances involving third-party payment, Medicaid is the payer of last resort. Any amounts paid by non-Medicaid sources are deducted in determining the Medicaid allowable payment.⁵ For patients with Medicare and Medicaid coverage, Medicaid payment is limited to the amount of Medicare-related deductibles or coinsurance for services, supplies, and equipment covered under the Medicare program⁶

³ There are various categories of dual eligibles. This report is concerned with Qualified Medicare Beneficiaries (QMBs). QMBs are persons whose income does not exceed 100 percent of the Federal poverty level and whose resources do not exceed three times the limit for Supplemental Security Income (SSI) program eligibility. In addition to assistance with Medicare deductibles, coinsurance, and copayments, beneficiaries also receive Medicaid assistance with their Medicare Part A and Part B premiums (1902(a)(10)(E)(i); 1905(p)(1) and (p)(3) of the Social Security Act).

⁴ Medicare reimburses professional medical services under Part B (Medical Insurance) of the Medicare program.

⁵ Medicaid allowable payment is the Medicaid fee schedule amount for a service minus any amount paid by a liable third party for the service.

⁶ Generally, Medicaid pays the full Medicaid fee schedule amount when a beneficiary receives a service that is covered by Medicaid but is not covered by Medicare (North Carolina Medicaid Special Bulletin, Number V, August 2004, pages 7-8). The Medicaid State Plan does not limit payment for services that are covered by Medicare but are not covered by Medicaid. Accordingly, Medicaid pays the entire cost-sharing amount when a beneficiary receives a service that is covered by Medicare but is not covered under Medicaid.

(Medicaid State Plan Attachment 4.19-B, section 7, page 4(c)). See Table 1 below for examples of the required Medicaid cost-sharing payment calculation for professional medical services.

Table 1: Required Medicaid Cost-Sharing Calculation

	Service 1	Service 2
Medicare Fee Schedule Amount	\$100	\$80
Medicare Payment	(80)	(65)
Medicare Cost-Sharing Amount	20	15
Medicaid Fee Schedule Amount	85	85
Medicare Payment	(80)	(65)
Medicaid Allowable Payment	5	20
Cost-Sharing Payment (Lesser of Cost-Sharing Amount or Medicaid Allowable Payment)	\$5	\$15

HOW WE CONDUCTED THIS REVIEW

We identified approximately \$204.5 million (\$133.6 million Federal share) in Medicaid cost-sharing payments for professional medical services provided from July 1, 2011, through June 30, 2013. Of this amount, we focused our review on \$175.6 million (\$114.7 million Federal share) in payments with a high risk of being in error because of the State agency’s cost-sharing payment methodology. We selected for review a stratified random sample of 200 Medicaid payments that totaled \$12,255 (\$8,007 Federal share).

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A contains Federal and State requirements, Appendix B contains the details of our scope and methodology, Appendix C contains our statistical sampling methodology, and Appendix D contains a summary of our sample results and estimates.

FINDING

North Carolina did not comply with Federal and State requirements when making Medicaid cost-sharing payments for professional medical services. Of the 200 sample items we reviewed, 184 were paid incorrectly. The other 16 sample items were initially paid incorrectly but were

canceled prior to our sample review.⁷ On the basis of our sample results, we estimate that the State agency made at least \$63,046,569 in improper Medicaid cost-sharing payments and claimed Federal reimbursement of at least \$41,188,318 for these payments.⁸

These improper payments occurred because the State agency did not program its Medicaid Management Information System (MMIS)⁹ to calculate Medicaid cost-sharing payments for professional medical services in accordance with the State's required cost-sharing payment methodology.

The State agency replaced its MMIS after our audit period. We reviewed a limited number of cost-sharing payments made after our audit period and verified that the State agency's replacement MMIS calculated payments in compliance with the State's required cost-sharing payment methodology.

STATE AGENCY INCORRECTLY MADE COST-SHARING PAYMENTS FOR PROFESSIONAL MEDICAL SERVICES

State Medicaid agencies are required to reimburse medical providers for any Medicare cost-sharing due for beneficiaries according to the cost-sharing payment methodology in the State's CMS-approved Medicaid State plan.¹⁰ The North Carolina Medicaid State plan required that the State agency make cost-sharing payments for professional medical services at the lesser of the cost-sharing amount or the Medicaid allowable payment.¹¹

Of the 200 payments in our sample, the State agency did not calculate 184 Medicaid cost-sharing payments for professional medical services in accordance with the State's required cost-sharing payment methodology. Of the 184 sample items, 154 were overpayments and 30 were underpayments.

The State agency did not use the required payment methodology, which was the lesser of the cost-sharing amount or the Medicaid allowable payment, to calculate cost-sharing payments for professional medical services (Table 1 on prior page). Instead, the State agency paid a

⁷ For the purposes of our audit, we considered these 16 sample items to be non-errors. Generally, a provider cancels a claim when it needs to change the information on a previously paid claim. If necessary, the provider submits a separate and unique claim with the corrected information.

⁸ To be conservative, we recommend recovery of overpayments at the lower limit of a two-sided 90-percent confidence interval. Lower limits calculated in this manner will be less than the actual overpayment total 95 percent of the time.

⁹ An MMIS is a system of software and hardware used to process Medicaid claims and manage information about Medicaid beneficiaries and services.

¹⁰ Social Security Act §§ 1902(a)(10)(E) and 1902(n)(2), 42 CFR § 433.139(b)(1), CMS Informational Bulletin, June 7, 2013.

¹¹ Medicaid State Plan Attachment 4.19-B, section 7, page 4(c).

predetermined percentage of the cost-sharing amount. The percentage paid was specific to the specialty of the provider that submitted the claim. For example, the State agency paid family medicine providers 73.3 percent of the cost-sharing amount and rheumatology providers 69 percent of the cost-sharing amount. According to State agency officials, the State agency developed these payment percentages using historical claim information. However, the officials could not provide any documentation supporting how the State agency developed these percentages.

See Table 2 below for an example comparison of the correct cost-sharing payment and the State agency’s payment.

Table 2: Comparison of Cost-Sharing Payment Methodologies

	Service 1		Service 2	
	Correct Payment	State Agency Payment	Correct Payment	State Agency Payment
Medicare Fee Schedule Amount	\$100.00	\$100.00	\$80.00	\$80.00
Medicare Payment	(80.00)	(\$80.00)	(65.00)	(\$65.00)
Medicare Cost-Sharing Amount	20.00	\$20.00	15.00	\$15.00
Medicaid Fee Schedule Amount	85.00		85.00	
Medicare Payment	(80.00)		(65.00)	
Medicaid Allowable Payment	5.00		20.00	
Payment Percentage Applied to the Cost-Sharing Amount		73.3%		73.3%
Cost-Sharing Payment	\$5.00	\$14.66	\$15.00	\$10.99

STATE AGENCY DID NOT PROGRAM ITS MEDICAID MANAGEMENT INFORMATION SYSTEM TO PERFORM REQUIRED CALCULATION

The State agency did not program its MMIS to calculate Medicaid cost-sharing payments for professional medical services in accordance with the required cost-sharing payment methodology in the State’s CMS-approved Medicaid State plan.

According to State agency officials, prior to our audit period, the State agency programmed its MMIS to calculate cost-sharing payments at a predetermined percentage of the total cost-sharing amount because its MMIS could not receive all of the Medicare data necessary to correctly calculate the payments. The officials stated that its MMIS later began receiving the necessary data. However, the State agency did not reprogram its MMIS to perform the required calculation because it was developing a replacement MMIS, and it decided not to divert resources to reprogram its obsolete MMIS.

On July 1, 2013, the State agency replaced its MMIS that was in operation during our audit period. Our review of an additional 18 judgmentally selected cost-sharing payments made after our audit period showed that the State agency's replacement MMIS used the required payment methodology.

ESTIMATE OF IMPROPER PAYMENTS

On the basis of our sample results, we estimated that the State agency made at least \$63,046,569 in improper Medicaid cost-sharing payments and claimed Federal reimbursement of at least \$41,188,318 for these payments during our audit period. The details of our sample results and estimates are shown in Appendix D.

RECOMMENDATIONS

We recommend that the State agency:

- refund \$41,188,318 to the Federal Government for cost-sharing payments for professional medical services that did not comply with Federal and State requirements and
- ensure that future changes to Medicaid payment methodologies comply with the Medicaid State plan.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency disagreed with our findings and recommendations. The State agency said that it verbally informed CMS of its intention to deviate from the cost-sharing payment methodology in its Medicaid State plan. It further stated that CMS did not require a formal submission and that CMS did not officially comment on the change to the payment methodology.

The State agency also said that CMS consented to its change to the cost-sharing payment methodology by later approving a State plan amendment (SPA) related to the State agency's Medicaid payment methodology for psychiatric services. To support the amendment, the State agency said that it provided CMS with "calculations as to how the psychiatric payment would be applied to the percentage table for secondary claims." The State agency further said that "CMS approved the SPA, thereby documenting its consent to the percentage payment method."

The State agency comments are included in their entirety as Appendix E.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing North Carolina's comments, we maintain that the evidence supports our findings and recommendations.

The State agency was required to follow the Medicaid cost-sharing payment methodology in its CMS-approved Medicaid State plan. In guidance to State agencies, CMS reminded the State agencies that "State Medicaid agencies have a legal obligation to reimburse providers for any Medicare cost sharing that is due for QMBs according to the state's CMS-approved Medicare cost sharing payment methodology."¹² Moreover, State agencies are required to promptly submit written State plan amendments whenever there is a material change in State policy or operations of the Medicaid program.¹³

During our audit, we requested that the State agency provide documentation of discussions it had with CMS regarding deviating from the required cost-sharing payment methodology. The State agency did not provide any such documentation during our fieldwork or in its comments on our draft report.

CMS's approval of a SPA unrelated to the cost-sharing payment methodology was not relevant. The SPA that the State agency referenced in its comments incorporated into the Medicaid State plan a change to the payment methodology for psychiatric services. We reviewed the SPA and its supporting correspondence, but we did not identify any information relevant to the State agency's use of predetermined percentages to calculate cost-sharing payments.

¹² CMS Informational Bulletin, June 7, 2013.

¹³ 42 CFR § 430.12.

APPENDIX A: FEDERAL AND STATE REQUIREMENTS

FEDERAL REQUIREMENTS

Social Security Act § 1902(a)

A State plan for medical assistance must . . .

(10) provide—(E)(i) for making medical assistance available for medicare cost-sharing . . . for qualified medicare beneficiaries . . .;

(25) provide—(A) that the State or local agency administering such plan will take all reasonable measures to ascertain the legal liability of third parties (including health insurers, self-insured plans, group health plans . . . , service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service) to pay for care and services available under the plan

Social Security Act § 1902(n)(2)

A State is not required to provide any payment for any expenses incurred relating to payment for deductibles, coinsurance, or copayments for medicare cost-sharing to the extent that payment under title XVIII for the service would exceed the payment amount that otherwise would be made under the State plan under this title for such service if provided to an eligible recipient other than a medicare beneficiary.

Social Security Act § 1905(p)(1)

The term “qualified medicare beneficiary” means an individual—

(A) who is entitled to hospital insurance benefits under Part A of title XVIII . . .

(B) whose income [as determined in accordance with SSI methodologies] . . . does not exceed an income level established by the State [and does not exceed the 100% of the Federal poverty guidelines] . . . , and

(C) whose resources . . . do not exceed twice the maximum amount [established for SSI eligibility], or effective January 1, 2010, whose resources do not exceed [three times the maximum amount of resources that an individual may have and obtain benefits for SSI eligibility].

Social Security Act § 1905(p)(3)

The term “medicare cost-sharing” means (subject to section 1902(n)(2)) the following costs incurred with respect to a qualified medicare beneficiary, without regard to whether the costs incurred were for items and services for which medical assistance is otherwise available under the plan:

(A)(i) premiums under section 1818 or 1818A, and
(ii) premiums under section 1839,

(B) Coinsurance under title XVIII (including coinsurance described in section 1813).

(C) Deductibles established under title XVIII (including those described in section 1813 and section 1833(b)).

(D) The difference between the amount that is paid under section 1833(a) and the amount that would be paid under such section if any reference to “80 percent” therein were deemed a reference to “100 percent”.

Such term also may include, at the option of a State, premiums for enrollment of a qualified medicare beneficiary with an eligible organization under section 1876.

2 CFR Part 225, Appendix A, Section C

To be allowable under Federal awards, costs must meet the following general criteria: . . . c. Be authorized or not prohibited under State or local laws or regulations

42 CFR § 430.12

(c) Plan amendments.

(1) The plan must provide that it will be amended whenever necessary to reflect -

(i) Changes in Federal law, regulations, policy interpretations, or court decisions; or

(ii) Material changes in State law, organization, or policy, or in the State's operation of the Medicaid program. For changes related to advance directive requirements, amendments must be submitted as soon as possible, but no later than 60 days from the effective date of the change to State law concerning advance directives.

42 CFR § 433.138(a)

Basic provisions. The agency must take reasonable measures to determine the legal liability of the third parties who are liable to pay for services furnished under the plan.

42 CFR § 433.139(b)(1)

If the agency has established the probable existence of third party liability at the time the claim is filed, the agency must reject the claim and return it to the provider for a determination of the amount of liability. The establishment of third party liability takes place when the agency receives confirmation from the provider or a third party resource indicating the extent of third party liability. When the amount of liability is determined, the agency must then pay the claim to the extent that payment allowed under the agency's payment schedule exceeds the amount of the third party's payment.

CMS Informational Bulletin, June 7, 2013

State Medicaid agencies have a legal obligation to reimburse providers for any Medicare cost sharing that is due for QMBs according to the state's CMS-approved Medicare cost sharing payment methodology.

STATE REQUIREMENTS

10A NCAC 45A.0303(e)

If prior to the Department's payment for particular services or appliances, the provider, the patient, or a person responsible for the patient receives partial or total payment for the services or appliances from a third party payor, or receives funds in settlement of a civil claim, the Department shall pay only the amount, if any, by which the Department's payment rate exceeds the amount received by the person

North Carolina Medicaid State Plan, Attachment 4.19-B, Section 7, Page 4(c)

In all circumstances involving third party payment, Medicaid is the payor of last resort. Any amounts paid by non-Medicaid sources are deducted in determining Medicaid payment. For patients with both Medicare and Medicaid coverage, Medicaid payment is limited to the amount of Medicare-related deductibles and/or coinsurance for services, supplies and equipment covered under the Medicare program.

APPENDIX B: AUDIT SCOPE AND METHODOLOGY

SCOPE

We identified approximately \$204.5 million (\$133.6 million Federal share) in Medicaid cost-sharing payments for professional medical services from July 1, 2011, through June 30, 2013 (audit period). Of this amount, we focused our review on \$175.6 million (\$114.7 million Federal share) in payments with a high risk of overpayment¹⁴ and selected a stratified random sample of 200 Medicaid payments. The 200 Medicaid payments we selected for review totaled \$12,255 (\$8,007 Federal share).

We limited our review of internal controls to those related to our objective. We conducted fieldwork at the State agency's offices in Raleigh, North Carolina, from October 2016 through March 2017.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State laws and regulations and the Medicaid State plan, policies, and procedures;
- held discussions with State agency officials to gain an understanding of their processes, procedures, and calculation methodology for making cost-sharing payments;
- created a sampling frame consisting of 8,383,853 cost-sharing claim lines (Appendix C);
- selected a random sample of 200 paid claim lines (Appendix C);
- For each sample item, we:
 - identified the Medicare payment, deductible, coinsurance, and copayment amounts from the Medicare National Claims History database;
 - identified the Medicaid payment schedule amount for the sample service;
 - calculated the Medicaid cost-sharing payment amount using the methodology required by Federal and State laws and the Medicaid State plan; and
 - calculated any overpayment or underpayment as the difference between the payment made by the State agency and the OIG-calculated payment amount;

¹⁴ See Appendix C, Sampling Frame, for additional details.

- estimated the Medicaid reimbursement paid to the State agency for incorrect cost-sharing payments it made for professional medical services identified in our sample (Appendix D);
- reviewed 18 judgmentally selected cost-sharing payments that the State agency made after our audit period and verified that the State agency's current MMIS used the required payment methodology; and
- discussed the results of our review with State agency officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX C: STATISTICAL SAMPLING METHODOLOGY

TARGET POPULATION

The target population consisted of Medicaid cost-sharing payments for professional medical services with dates of service from July 1, 2011, through June 30, 2013.

SAMPLING FRAME

The State agency provided quarterly Medicaid claim data extracted from the North Carolina MMIS. The Medicaid claim data files were Microsoft Access databases containing 21,800,298 claim lines for professional and institutional medical services provided to beneficiaries that were paid during SFYs 2012, 2013, and 2014, with total payments of \$264,810,325.

We removed 13,416,445 claim lines that were (1) for institutional medical services;¹⁵ (2) for dates of service outside of our audit period; (3) duplicates; (4) subsequently canceled by the State agency; (5) less than \$3; and, to focus on claim lines with a higher risk of overpayment, (6) durable medical equipment, prosthetics, orthotics, and supplies.

The resulting sampling frame contained 8,383,853 cost-sharing claim lines for professional medical services with dates of service during July 1, 2011, through June 30, 2013, with a total paid amount of \$175,608,172 (\$114,770,342 Federal share).

SAMPLE UNIT

The sample unit was a claim line for a professional service provided to a beneficiary.

SAMPLE DESIGN AND SAMPLE SIZE

We used a stratified random sample design, as follows:

Table 3: Sample Design

Stratum	Payment Range	Sample Item Count	Total Payments	Sample Size
1	\$3 to < \$23	6,383,159	\$70,782,785	64
2	\$23 to < \$63	1,566,930	56,334,670	48
3	\$63 to < \$92,348	433,764	48,490,717	88
Total		8,383,853	\$175,608,172	200

¹⁵ There were approximately \$204.5 million (\$133.6 million Federal share) in Medicaid cost-sharing payments for professional medical services after we removed claim lines for institutional medical services.

SOURCE OF RANDOM NUMBERS

We generated the random numbers using the OIG, Office of Audit Services (OAS), statistical software.

METHOD FOR SELECTING SAMPLE ITEMS

We consecutively numbered the items in the sampling frame from 1 to 6,383,159 for stratum 1, from 1 to 1,566,930 for stratum 2, and from 1 to 433,764 for stratum 3. We generated 64 random numbers for stratum 1, 48 random numbers for stratum 2, and 88 random numbers for stratum 3. We then selected the corresponding frame items from each stratum.

ESTIMATION METHODOLOGY

We used the OIG/OAS RAT-STATS Variable Appraisal Program for stratified samples to estimate the improper Medicaid cost-sharing payments made by the State and the claimed Federal reimbursement associated with these payments. To be conservative, the recommended refund amount was based on the lower limit of a two-sided 90-percent confidence interval. Lower limits calculated in this manner will be less than the actual improper payment amount 95 percent of the time.

APPENDIX D: SAMPLE RESULTS AND ESTIMATES

Table 4: Sample Results

Stratum	Frame Size	Value of Frame	Sample Size	Value of Sample	Value of Sample (Federal Share)	Number of Improper Payments	Value of Improper Payments	Value of Improper Payments (Federal Share)
1	6,383,159	\$70,782,785	64	\$701	\$458	61	\$270	\$176
2	1,566,930	56,334,670	48	1,760	1,151	45	924	604
3	433,764	48,490,717	88	9,795	6,398	78	3,399	2,220
Total	8,383,853	\$175,608,172	200	\$12,255¹⁶	\$8,007	184	\$4,593	\$3,000

ESTIMATES

**Table 5: Estimated Value of Improper Payments
(Limits Calculated for a 90-Percent Confidence Interval)**

Point Estimate	\$73,870,767
Lower Limit	63,046,569
Upper Limit	84,694,965

**Table 6: Estimated Value of Improper Payments (Federal Share)
(Limits Calculated for a 90-Percent Confidence Interval)**

Point Estimate	\$48,264,636
Lower Limit	41,188,318
Upper Limit	55,340,953

¹⁶ The sample totals for the individual strata do not sum to the overall sample total because of rounding.

APPENDIX E: STATE AGENCY COMMENTS



STATE OF NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

ROY COOPER
GOVERNOR

August 24, 2017

MANDY COHEN, MD, MPH
SECRETARY

Lori S. Pilcher, Regional Inspector
General for Audit Services
Office of Audit Services, Region IV
61 Forsyth Street, SW, Suite 3t41
Atlanta, GA 30303

Re: Report Number: A-04-16-04054

Dear Ms. Pilcher:

We have reviewed your draft report entitled *North Carolina Did Not Comply with Federal and State Requirements When Making Medicaid Cost Sharing Payments for Professional Medical Services* covering the audit period July 1, 2011 through June 30, 2013. North Carolina Medicaid makes payments to providers in accordance with an approved State Plan. Payment methodologies are routinely vetted in consultation with CMS to ensure compliance with Federal requirements. The Department disagrees with the conclusions as presented in the audit report. The following represents our response to the findings and recommendations.

The State Plan for cross-over claims was approved by CMS in 2002, and required the State to pay a total reimbursement up to the Medicaid fee schedule rate when Medicaid was secondary payer. The initial implementation of the SPA required providers to submit to a "secondary" claim which contained all the required Medicare data fields necessary to calculate the payment. The required Medicare data fields were the Medicare allowable amount, the Medicare cash payment amount, and all components of the Medicare cost share (deductible, co-payment, and co-insurance). The State required the provider to submit these data elements on a secondary claim because the cross-over file received from the Medicare Carrier did not include all of them.

In 2004, the affected providers petitioned the Department to find a method by which the Medicare Carrier's electronic file could be used to calculate the Medicaid payment, eliminating the need for the provider to submit a secondary claim. The Department agreed after reviewing several options and in verbal consultation with CMS, found that a percentage table would be the most feasible method to implement and maintain. Since the percentage payment method was implemented subsequent to the 2002 approval of the SPA, CMS did not require any formal submission and did not officially comment on its implementation. In 2008 the Department filed SPA 08-003 to adjust our methodology to accommodate the changes in the psychiatric payment

WWW.NCDHHS.GOV

TEL 919-855-4800 • FAX 919-715-4645

LOCATION: 101 BLAIR DRIVE • ADAMS BUILDING • RALEIGH, NC 27603
MAILING ADDRESS: 2001 MAIL SERVICE CENTER • RALEIGH, NC 27699-2001
AN EQUAL OPPORTUNITY / AFFIRMATIVE ACTION EMPLOYER

being applied by Medicare. In response to the CMS RAI, the Department supplied the calculations as to how the psychiatric payment would be applied to the percentage table for secondary claims. CMS approved the SPA, thereby documenting its consent to the percentage payment method. (See Exhibit A). The Department continued to pay cost-sharing claims under the percentage payment method until the new MMIS went live on July 1, 2013.

Thank you for this opportunity to respond. If you need any additional information, please contact Susan Bryan at (919) 814-0154.

Sincerely,



Mandy Cohen, MD, MPH
Secretary

MC/jet

cc: Dave Richard, Deputy Secretary of Medical Assistance
Roger Barnes, Chief Financial Officer, Division of Medical Assistance
John E. Thompson, Director of Compliance and Program Integrity
Sandy Terrell, Director of Clinical Policy
Lisa Corbett, General Counsel
Rod Davis, Chief Financial Officer
Laketha M. Miller, Controller
Mark Payne, Interim Director, Office of the Internal Auditor
Lisa Allnutt, Manager, Risk Mitigation & Audit Monitoring

EXHIBIT A

Department of Health & Human Services
Centers for Medicare & Medicaid Services
61 Forsyth St., Suite 4T20
Atlanta, Georgia 30303-8909



August 19, 2008



William W. Lawrence Jr., M.D., Acting Director
Division of Medical Assistance
North Carolina Department of Health and Human Services
2501 Mail Service Center
Raleigh, North Carolina 27699-2501

Attention: Teresa Smith

RE: North Carolina Title XIX State Plan Amendment, Transmittal #08-003

Dear Dr. Lawrence:

We have reviewed the proposed amendment to the North Carolina Medicaid State Plan that was submitted under transmittal number 08-003 and received in the Regional Office on June 03, 2008. Due to a legislative decision, this amendment allows the State of North Carolina to reimburse providers for psychiatric services for dual eligibles.

Based on the information provided, we are pleased to inform you that Medicaid State Plan Amendment 08-003 was approved on August 15, 2008. The effective date of this amendment is April 1, 2008. We are enclosing the approved Form HCFA-179 and plan pages.

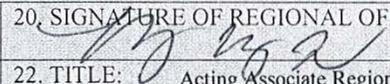
If you have any questions or need any further assistance, please contact Cheryl Brimage at (404) 562-7116.

Sincerely,

A handwritten signature in black ink, appearing to read "Mary Kaye Justis".

Mary Kaye Justis, RN, MBA
Acting Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosures

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: 08-003	2. STATE NC
FOR: HEALTH CARE FINANCING ADMINISTRATION		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE March 1, 2008	
5. TYPE OF PLAN MATERIAL (Check One): <input checked="" type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input type="checkbox"/> AMENDMENT COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION: Section 1902(A)(n)(1)		7. FEDERAL BUDGET IMPACT: a. FFY 2008 - 2009 \$1,341,630.18 b. FFY 2009 - 2010 \$2,298,860.71	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-B, Section 24, Page 1a		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): NA	
10. SUBJECT OF AMENDMENT: Reimbursement of the allowable portion of the psychiatric reduction.			
11. GOVERNOR'S REVIEW (Check One): <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input checked="" type="checkbox"/> OTHER, AS SPECIFIED: <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO: Office of the Secretary Department of Health and Human Services 2001 Mail Service Center Raleigh, North Carolina 27699-2001	
13. TYPED NAME: Dempsey Benton		14. TITLE: Secretary	
15. DATE SUBMITTED: 3/31/08			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: 07/03/08		18. DATE APPROVED: 08/15/08	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: 04/01/08		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: Mary Kaye Justis, RN, MBA		22. TITLE: Acting Associate Regional Administrator Division of Medicaid & Children's Health Opns	
23. REMARKS: Approved with the following changes to item 4 as authorized by State Agency on email dated April 3, 2008: Block number 4 March 1, 2008 should read block 4 April 1, 2008.			

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT MEDICAL ASSISTANCE PROGRAM

STATE NORTH CAROLINA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Item.. VIII Payment of Title XVIII Part B Outpatient Psychiatric Reduction

Except for a nominal recipient co-payment, if applicable, the Medicaid agency uses the following method:

	Medicare-Medicaid Individual	Medicare-Medicaid/QMB Individual	Medicare QMB Individual
Part B	<input checked="" type="checkbox"/> Limited to State Plan rates*	<input checked="" type="checkbox"/> Limited to State Plan rates*	<input checked="" type="checkbox"/> Limited to State Outpatient Plan rates*
Psychiatric Reduction	Full amount	Full amount	Full amount

*For these title XVIII services not otherwise covered by the title XIX State plan, the Medicaid agency has established reimbursement methodologies that are described in 4.19-B, Item(s) _____

TN No. 08-003
Supersedes
TN No. New

Approval Date: 08/15/08

Effective Date 04/01/2008



North Carolina Department of Health and Human Services
Division of Medical Assistance

2501 Mail Service Center • Raleigh, N. C. 27699-2501
Tel 919-855-4100 • Fax 919-733-6608

Michael F. Easley, Governor
Dempsey Benton, Secretary

William W. Lawrence, Jr., M.D., Acting Director

May 30, 2008

Teresa Decaro, RN, M.S.
Acting Associate Regional Administrator
Division of Medicaid & Children's Health Operations
Centers for Medicare and Medicaid Services
Region IV
Atlanta Federal Center
61 Forsyth Street, SW Suite 4T20
Atlanta, GA 30303-8909

Subject: Response to RAI Transmittal #2008-003

Dear Ms. Decaro:

This letter is the Department of Health and Human Services, Division of Medical Assistance's response to the Request for Additional Information (RAI) for State Plan Amendment (SPA) 08-003, dated May 29, 2008. Please find the responses in question and answer format.

1. It appears that North Carolina is not currently paying any portion of the psychiatric reduction. Please explain why the State has chosen to start paying for these services. For example, is this change in response to a new law, a court decision or provider pressure, etc.?

Response: The Agency is proposing the reimbursement change due to legislation. The change will allow modification of payment to support a fairly significant problem with access to high level mental health professionals for the dually eligible population in need of certain mental health services: particularly PhD level psychologists, psychiatrists and other licensed clinicians. Many regions of the State do not have psychiatrist or licensed psychologists and payment has been highlighted as a deterring factor.

2. Please provide an example of how a claim will be paid?

Response: Current Medicaid policy did not allow for payment of the psychiatric reduction of 37.5% of the Medicare allowed rate. This created a disparity in the gross Medicaid allowed amount for recipients who were not dually eligible and the Medicaid gross allowed amount for recipients who are dually eligible.

- The Medicaid allowed amount is a graduated amount based on the provider's certification. This change as denoted below is reflected on Attachment 4.19-B, Section 6, page 1.
 - a. The maximum allowable rate for Psychiatrists is the physician rate which is 95% of the Medicare allowed amount.

Location: 1985 Umstead Drive • Dorothea Dix Hospital Campus • Raleigh, N.C. 27603
An Equal Opportunity / Affirmative Action Employer
www.ncdhhs.gov/dma



- b. The maximum allowable rate for Certified Nurse Practitioners and Certified Nurse Specialists is 85% of the Psychiatrists' maximum allowable rate or 85% of 95% of the Medicare rate or 80.75% of the Medicare rate.
 - c. The maximum allowable rate for Licensed Clinical Social Workers, Licensed Professional Counselors, Licensed Marriage & Family Therapists, Certified Psychological Associates, Certified Clinical Addictions Specialists, and Certified Clinical Supervisors is 75% of the Psychiatrists' maximum allowable rate or 75% of 95% of the Medicare rate or 71.25% of the Medicare rate.
- Medicare is paying 50% of the allowable rate computed as 62.5% of the Medicare allowable rate or 80% of 62.5% = 50%. For details on how Medicare pays this please see examples in 42 CFR 410.155. The psychiatric reduction is 37.5% of the allowable rate. Therefore, we would be overpaying the provider (using Medicaid policies and procedures as stated in the proposed state plan amendment, for Attachment 4.19-B, Section 24, page 1a which is consistent with Attachment 4.19-B, Section 24, page 1) for providers in b & c above if we pay the full 37.5 % (50% + 37.5% = 87.5%).
 - a. $50\% + 37.5\% < 95\%$
 - b. $50\% + 37.5\% > 80.75\%$
 - c. $50\% + 37.5\% > 71.25\%$
 - In order to pay the provider the Medicaid maximum allowable rate, we must reduce the Psychiatric Reduction and in one instance the coinsurance. Those percentages for the above provider types are as follows:
 - a. 95%
 - b. 80.75%
 - c. 56.67%
 - For example, on a Medicare submitted claim with a billing amount of \$510 and a Medicare allowed amount of \$500, the following applies:

Medicare allowed amount times 62.5% = Medicare base for payment

$$\$500.00 * 0.625 = \$312.50$$

Medicare allowed amount times 37.5% = Psychiatric Reduction

$$\$500.00 * 0.375 = \$187.50$$

Medicare base for payment times 80% = Medicare paid amount

$$\$312.50 * 0.80 = \$250.00$$

Medicare base for payment times 20% = Medicare Coinsurance

$$\$312.50 * 0.20 = \$62.50$$

Medicare paid amount plus Medicaid payment of full Psychiatric
Reduction plus coinsurance = Total potential payment

$$\boxed{\$250.00 + \$187.50 + \$62.50 = \$500.00}$$

Total amount paid with Medicaid reducing the Psychiatric Reduction
and before reduction of coinsurance

a. Category A above – Psychiatrists

$$\begin{aligned} &\$250.00 + (\$187.50 * 0.95) + \$62.50 = \$490.63 \\ &\$250.00 + \$178.13 + \$62.50 = \$490.63 \\ &\$490.63 / \$500.00 = 98.13\% \text{ of Medicare Allowable} \end{aligned}$$

$$\begin{aligned} &\$250.00 + (\$187.50 * 0.8075) + \$62.50 = \$463.91 \\ &\$250.00 + \$151.41 + \$62.50 = \$463.91 \\ &\$463.91 / \$500.00 = 92.78\% \text{ of Medicare Allowable} \end{aligned}$$

c. Category C above – LCSW's, LPC's, LMFT's, CPA's,
CCAS's, CCS's

$$\begin{aligned} &\$250.00 + (\$187.50 * 0.5667) + \$62.50 = \$418.76 \\ &\$250.00 + \$106.26 + \$62.50 = \$418.76 \\ &\$418.76 / \$500.00 = 83.75\% \text{ of Medicare Allowable} \end{aligned}$$

Total amount paid with Medicaid reducing the Psychiatric Reduction
and after reduction of coinsurance

a. Category A above – Psychiatrists

$$\begin{aligned} &\$250.00 + (\$187.50 * 0.95) + \$46.88 = \$475.01 \\ &\$250.00 + \$178.13 + \$46.88 = \$475.01 \\ &\$475.01 / \$500.00 = 95.00\% \text{ of Medicare Allowable} \end{aligned}$$

b. Category B above – CNP's & CNS's

$$\begin{aligned} &\$250.00 + (\$187.50 * 0.8075) + \$2.34 = \$403.75 \\ &\$250.00 + \$151.41 + \$2.34 = \$403.75 \\ &\$403.75 / \$500.00 = 80.75\% \text{ of Medicare Allowable} \end{aligned}$$

c. Category C above – LCSW's, LPC's, LMFT's, CPA's,
CCAS's, CCS's

$$\begin{aligned} &\$250.00 + (\$187.50 * 0.5667) + \$0.00 = \$356.26 \\ &\$250.00 + \$106.26 + \$0.00 = \$356.26 \\ &\$356.26 / \$500.00 = 71.25\% \text{ of Medicare Allowable} \end{aligned}$$

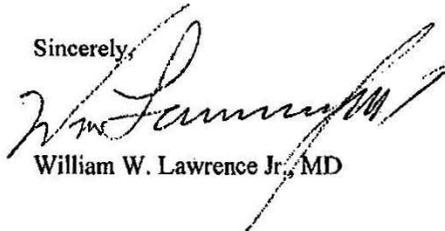
Teresa Decaro, RN, M.S.
May 30, 2008

Page 4

As required by the Centers for Medicare and Medicaid Services, SPA 08-003 has been revised to address all concerns noted in the May 30, 2008 Request for Additional Information letter.

We appreciate the opportunity to respond to these concerns. Should you have questions or additional concerns please contact me or Teresa Smith at Teresa.Smith@ncmail.net or (919) 855-4116.

Sincerely,



William W. Lawrence Jr., MD

c: Cheryl L. Brimage, CMS-RO,
Joyce Wilkerson, CMS-RO
Sheri Gaskins, CMS-CO
Aydlett Hunike
Roger Barnes
Christal Kelly
Deidra Oates
Teresa Smith

Enclosures