Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

NORTH CAROLINA RECEIVED $30 MILLION IN EXCESS FEDERAL FUNDS RELATED TO IMPROPERLY CLAIMED HEALTH HOME EXPENDITURES

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

Amy J. Frontz
Deputy Inspector General
for Audit Services

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Office of Inspector General

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Report in Brief
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Report No. A-04-18-00120

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

North Carolina Received $30 Million in Excess Federal Funds Related to Improperly Claimed Health Home Expenditures

Why OIG Did This Audit

The Medicaid "health home" option allows States to create programs that provide care coordination and care management for beneficiaries with chronic health conditions. Health homes are not physical spaces. Rather, they are a healthcare model in which providers work together to coordinate and manage beneficiaries' care at a reasonable cost.

As of March 2019, North Carolina was among 23 States to receive approval to implement Medicaid health home programs. This audit is one in a series of audits to determine whether States complied with Federal and State requirements when claiming Federal Medicaid reimbursement for payments made to health home providers.

Our objective was to determine whether North Carolina claimed Federal Medicaid reimbursement for health home expenditures in accordance with Federal and State requirements.

How OIG Did This Audit

Our audit covered $124.6 million ($112.2 million Federal share) that North Carolina claimed as health home expenditures from October 1, 2011, through September 30, 2013. We removed $5.4 million in State-estimated amounts and $5 million in unauthorized amounts to derive our sampling frame of $114.2 million ($102.8 million Federal share). From our sampling frame, we selected a stratified random sample of 100 beneficiaries for review, associated with 2,999 payments totaling $23,676 ($21,308 Federal share).

What OIG Found

North Carolina did not claim Federal Medicaid reimbursement for health home expenditures in accordance with Federal and State requirements. Instead, it improperly claimed $124.6 million in Primary Care Case Management (PCCM) expenditures, which should have been reimbursed at the regular Federal medical assistance percentage (FMAP) ($81.5 million Federal share), as health home expenditures, which were reimbursed at the enhanced FMAP ($112.2 million Federal share). North Carolina did not claim any health home expenditures before or after the enhanced FMAP period for Federal fiscal years 2012 and 2013. Of the 2,999 payments associated with 100 beneficiaries in our stratified random sample, none met all of the requirements for payment identified in North Carolina's approved State plan amendment for health home services. North Carolina claimed PCCM expenditures as health home expenditures because it did not take certain steps to ensure implementation of the health home option and did not implement internal controls needed to ensure compliance. As a result, North Carolina received $30.7 million in excess Federal funds.

What OIG Recommends and North Carolina's Comments

We recommend that North Carolina reclassify $124.6 million ($112.2 million Federal share) from health home expenditures to PCCM expenditures and refund $30.7 million in excess Federal funds to the Federal Government.

In written comments on our draft report, North Carolina agreed with our findings and recommendations and described actions that it plans to take to address them. These actions include working with the Centers for Medicare & Medicaid Services to reclassify the PCCM expenditures and to determine the amount, method, and timing of the refund.

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INTRODUCTION

WHY WE DID THIS AUDIT

The Medicaid "health home" option allows States to create programs that provide care coordination and care management for Medicaid beneficiaries with chronic health conditions. Health homes are not physical spaces. Rather, they are a healthcare model based on the idea that several providers can work together to coordinate and manage beneficiaries' care and, in doing so, provide quality care at a reasonable cost. As of March 2019, North Carolina was among 23 States to receive approval to implement Medicaid health home programs.

This audit is one in a series of audits to determine whether selected States complied with Federal and State requirements when claiming Federal Medicaid reimbursement for payments made to health home providers.[1] We reviewed payments made to North Carolina's Medicaid providers on behalf of beneficiaries diagnosed with certain chronic health conditions, including asthma, diabetes, heart disease, and obesity.

OBJECTIVE

Our objective was to determine whether the North Carolina Department of Health and Human Services, Division of Health Benefits (State agency),[2] claimed Federal Medicaid reimbursement for health home expenditures in accordance with Federal and State requirements.

BACKGROUND

Medicaid Health Home Services

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. In North Carolina, the State agency administers the Medicaid program.

Effective January 2011, section 1945 of the Social Security Act (the Act) was amended to include an option for States to establish a health home program through a Medicaid State plan amendment (SPA) approved by CMS. Under an SPA, States can establish a health home program through a care management service model in which all parties involved in a

[1] The most recently issued Office of Inspector General (OIG) reports on this topic are *New York Claimed Federal Reimbursement for Some Payments to Health Home Providers That Did Not Meet Medicaid Requirements* (A-02-17-01004) and *Iowa Inadequately Monitored Its Medicaid Health Home Providers, Resulting in Tens of Millions in Improperly Claimed Reimbursement* (A-07-18-04109).

[2] During the audit, the State agency changed its name from Division of Medical Assistance to Division of Health Benefits.

beneficiary's care communicate with one another so that medical, behavioral health, and social needs are addressed in a comprehensive manner. While States have flexibility to define the core health home services, they must provide all core services required in the Act. Specifically, the Act requires that health home services include comprehensive care management, care coordination, health promotion, comprehensive transitional care, patient and family support, and referral to community and social support services.[3] Beneficiaries enrolled in a health home program receive services through provider networks, health plans, and community-based organizations.

In 2010, CMS issued guidance[4] regarding the implementation of section 1945 of the Act, which acknowledged that a goal of implementing health home models would be to expand upon traditional medical home models to build linkages to other community and social supports, and to enhance coordination of medical and behavioral health care. CMS encouraged States with existing or planned medical home initiatives to compare those programs to the definition of health homes in the Act. While considering the intent of section 1945 of the Act and in keeping with the needs of persons with multiple chronic illnesses, States could design the health home option to complement their existing medical home initiatives.

North Carolina Medical Home Program and Health Home Option

On May 24, 2012, CMS approved North Carolina's Health Home SPA with a retroactive effective date of October 1, 2011. According to the Health Home SPA, health home services were to be delivered through the existing statewide Primary Care Case Management (PCCM) medical home program.[5] The State agency identified that approximately 500,000 of its over 1.4 million medical home enrollees were beneficiaries with qualifying chronic conditions.

North Carolina's PCCM SPA required enrollees to select a primary care provider (medical home) responsible for managing their care.[6] Regardless of whether the enrollee received services

[3] Section 1945(h)(4) of the Act.

[4] *State Medicaid Directors Letter* dated November 16, 2010, SMDL #10-024.

[5] Community Care of North Carolina (CCNC) was the larger of two PCCM programs that served North Carolina's Medicaid beneficiaries. The second PCCM program, Carolina Access, started in 1991 under a section 1915(b) managed care waiver. In 1998, CMS approved an amendment to North Carolina's 1915(b) waiver to implement CCNC, a new enhanced Medicaid PCCM program. Enrollment in one of these two PCCM programs was mandatory for most Medicaid beneficiaries. Optional enrollment groups included those dually eligible for Medicare and Medicaid, children receiving Supplemental Security Income or foster care/adoption assistance, members of federally recognized Indian Tribes, individuals with end-stage renal disease, and pregnant women.

[6] CCNC was composed of 14 regional networks operating statewide. Once enrolled in CCNC, each beneficiary was linked to one of more than 1,500 participating primary care provider medical homes. In addition to providing acute, chronic, and preventive care, these medical homes were also responsible for care management. The regional networks supported the medical homes, providing a range of resources depending on provider needs and the existing care infrastructure. Each regional network employed a staff of care managers who worked to augment the care management services provided by the medical home team.

during the period covered by the payment, the providers and their network received PCCM per member per month (capitation) payments based on the number of Medicaid beneficiaries enrolled.[7]

The North Carolina Health Home SPA established health homes[8] for Medicaid beneficiaries with diagnoses of two or more chronic conditions or with a diagnosis of one chronic condition and the risk of developing a second chronic condition. The Health Home SPA also established using the PCCM network's Care Management Information System (CMIS) to document care management activities related to health home services.[9]

Medicaid Expenditures and Federal Reimbursement

The amount the Federal Government reimburses to State Medicaid agencies, known as Federal financial participation (FFP) or Federal share, is determined by the Federal medical assistance percentage (FMAP), which varies depending on a State's relative per capita income.[10] From October 1, 2011, through September 30, 2013 (audit period), the FMAP in North Carolina ranged from 65.28 to 65.51 percent.

The Act provided enhanced FFP (90-percent FMAP) to States implementing health home services for the first 8 quarters beginning on the effective date of the SPA. After the initial 8 quarters, expenditures for health home services were matched at the State's regular FMAP. The 90-percent enhanced FMAP applied to expenditures for the health home services listed in the Act but did not apply to expenditures for underlying Medicaid services also provided to individuals enrolled in a health home.[11]

[7] The PCCM capitation payment was a form of payment identified as a case management fee in the North Carolina PCCM SPA. The CFR defines capitation payments as payments the State agency makes periodically to a contractor on behalf of each beneficiary enrolled under a contract for the provision of medical services under the State plan, regardless of whether the beneficiary receives services during the period covered by the payment (42 CFR § 438.2).

[8] Consistent with the Act, North Carolina's Health Home SPA defined the health home as a team of health care professionals, to include the primary care provider, the regional CCNC network, and the contractor administratively overseeing the CCNC program (North Carolina SPA #11-0050).

[9] The CMIS is a web-based portal accessible to all CCNC networks. The CMIS acts as a centralized care management tool, allowing care managers to access and manually update key patient health and provider information, develop and implement care plans, and identify care gaps through chart audits. According to North Carolina's Health Home SPA, "The CMIS incorporates a record of all care management interventions, including referrals to community and social support services." Regarding comprehensive care management services, the SPA identified a list of activities documented in the CMIS, including but not limited to care plans, interventions, and care management activities.

[10] 42 CFR § 433.10.

[11] Section 1945(c)(1) of the Act.

The State agency claimed[12] Federal Medicaid reimbursement for health home expenditures totaling $124.6 million ($112.2 million Federal share), composed of $119.2 million ($107.3 million Federal share) in actual expenditures and $5.4 million ($4.9 million Federal share) in State-estimated expenditures,[13] during the audit period.

Financial Management Review

On June 17, 2019, CMS issued a final Financial Management Review (FMR)[14] report finding that the State agency did not differentiate between PCCM medical home enrollees and health home enrollees and did not provide evidence that enrollees received the appropriate level of care to receive the enhanced FFP. CMS considered all health home expenditures claimed as unsupported, recommended removal of health home service language from the State plan,[15] and instructed the State agency to either issue a credit adjustment on the next CMS-64 to refund all health home expenditures claimed during the audit period or face disallowance.[16]

HOW WE CONDUCTED THIS AUDIT

Our audit covered $124.6 million ($112.2 million Federal share), composed of $119.2 million ($107.3 million Federal share) in actual expenditures and $5.4 million ($4.9 million Federal share) in State-estimated expenditures, claimed by the State agency as health home expenditures on the CMS-64.[17] We reviewed expenditures for which the State agency claimed reimbursement from October 1, 2011, through September 30, 2013 (FFYs 2012 and 2013). This was the period for which North Carolina was authorized to receive 90-percent FMAP for health home expenditures.

[12] The State agency claimed health home expenditures and the associated Federal share on the Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (CMS-64).

[13] The actual amounts were $124,636,146 ($112,172,531 Federal share), $119,220,100 ($107,298,090 Federal share), and $5,416,046 ($4,874,441 Federal share).

[14] CMS conducts FMRs to examine specific areas of claiming of Federal funds for the Medicaid programs to determine whether the States are following their approved Medicaid State plans and Federal laws, regulations, and policies in providing services and claiming expenditures for those services. In September 2016, CMS completed its on-site review of North Carolina's health home data and expenditures for Federal fiscal years (FFYs) 2012 and 2013. We did not rely on CMS's FMR. Instead, we independently obtained and reviewed documentation related to the health home expenditures claimed in developing our findings and recommendations.

[15] On June 21, 2019, North Carolina submitted an SPA to remove health home service language from its State plan, and CMS approved it on June 25, 2019, with an effective date of June 21, 2019 (North Carolina SPA #19-0004).

[16] The State agency disagreed with CMS's instructions to issue a credit adjustment. To date, no funds have been recouped by CMS. CMS awaits our report to resolve this issue through the CMS-64 process.

[17] The State agency said that it estimated certain health home expenditures because it was transitioning to a new Medicaid Management Information System (MMIS) effective July 1, 2013.

The State agency did not claim any health home expenditures before or after the enhanced FMAP period (FFYs 2012 and 2013). Therefore, our audit did not include a review of expenditures after September 30, 2013.

From the $119.2 million ($107.3 million Federal share) in actual expenditures, we removed $5 million ($4.5 million Federal share) for expenditures not authorized in the Health Home SPA and identified a sampling frame of $114.2 million ($102.8 million Federal share).[18] We then selected a stratified random sample of 100 beneficiaries for review, associated with 2,999 payments totaling $23,676 ($21,308 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 the details of our audit scope and methodology, Appendix B contains our statistical sampling methodology, and Appendix C contains the details of Medicaid expenditures and Federal share claimed.

FINDINGS

The State agency did not claim FFP for health home expenditures in accordance with Federal and State requirements. Instead, it improperly claimed $124.6 million in PCCM expenditures, which should have been reimbursed at the regular FMAP ($81.5 million Federal share),[19] as health home expenditures, which were reimbursed at the enhanced FMAP ($112.2 million Federal share).[20] The State agency did not claim any health home expenditures before or after the enhanced FMAP period (FFYs 2012 and 2013).

Of the 2,999 payments associated with 100 beneficiaries in our stratified random sample, none met all of the requirements for payment identified in the CMS-approved Health Home SPA. The State agency claimed PCCM expenditures as health home expenditures because it did not take certain steps necessary to implement the health home option. Furthermore, the State agency did not implement internal controls needed to ensure compliance with Federal and State requirements for documenting health home services and for claiming expenditures for Federal reimbursement. As a result, North Carolina received $30.7 million in excess FFP attributable to

[18] The actual amounts were $119,220,100 ($107,298,090 Federal share), $5,017,880 ($4,516,092 Federal share), and $114,202,220 ($102,781,998 Federal share). Payments removed included add-on payments not approved in the SPA and payments with dates of service prior to the effective date of the SPA.

[19] If claimed as PCCM, the amounts would have been $124,636,146 (Federal share $81,523,418).

[20] The actual amount claimed at the enhanced FMAP was $124,636,146 (Federal share $112,172,531).

the difference between the enhanced FMAP for health home expenditures and the regular FMAP for PCCM expenditures.[21]

FEDERAL AND STATE REQUIREMENTS

Congress amended section 1945 of the Act to include an option for States to establish a health home program through a Medicaid SPA approved by CMS. This amendment also provided enhanced FFP for expenditures for health home services defined as "comprehensive and timely high-quality services."[22]

FFP is generally available in expenditures under the State plan.[23] The State plan contains all information necessary for CMS to determine whether the plan can be approved to serve as a basis for FFP in the State program.[24] FFP is available only for allowable actual Medicaid expenditures for which there is adequate supporting documentation.[25]

States receive Federal reimbursement for actual expenditures reported on the CMS-64.[26] Reporting instructions for the CMS-64 identify category of service line definitions for expenditures claimed for Federal reimbursement, including line 25 for PCCM and line 43 for "Health Home for Enrollees w Chronic Conditions." Instructions for line 43 are consistent with requirements of the Act and define health home services as including comprehensive care management, care coordination, health promotion, comprehensive transitional care, patient and family support, and referral to community and social support services.[27]

Requirements for North Carolina's health home program are detailed in its Health Home SPA, which defines each of the qualifying health home services consistent with requirements of the Act and identifies the following requirements for payment:

- the beneficiary meets health home eligibility criteria in the State's MMIS and the PCCM network's CMIS,

- the beneficiary was enrolled as a health home member,

[21] The actual amount of excess FFP was $30,649,113.

[22] Sections 1945(c)(1) and 1945(h)(4)(A) of the Act.

[23] 42 CFR § 440.2(b).

[24] 42 CFR § 430.10.

[25] Section 1902(a)(27) of the Act, CMS *State Medicaid Manual* § 2497, 45 CFR § 75.403 (g), and 42 CFR 431.17.

[26] 42 CFR § 430.30(c)(2).

[27] CMS *State Medicaid Manual,* section 2500.2, and *CMS-64.9 Base Category of Service Definitions*.

- care management monitoring or another health home service was provided to the beneficiary that month, and

- the health home tracked and recorded the delivery of a qualifying service to the beneficiary on a monthly health home activity report.[28]

MILLIONS IN HEALTH HOME EXPENDITURES IMPROPERLY CLAIMED

The State agency did not claim FFP for health home expenditures in accordance with Federal and State requirements. Instead, it improperly claimed $124.6 million in PCCM expenditures, which should have been reimbursed at the regular FMAP ($81.5 million Federal share), as health home expenditures, which were reimbursed at the enhanced FMAP ($112.2 million Federal share). In accordance with the PCCM SPA, the State agency made $287.3 million in PCCM capitation payments for all Medicaid beneficiaries, including those with chronic conditions, who were enrolled in the existing statewide PCCM program. Using the $287.3 million and the number of chronically ill beneficiaries enrolled in the PCCM program, the State agency "carved out" $124.6 million in PCCM expenditures related to beneficiaries with chronic conditions and claimed such amounts on its CMS-64s as health home expenditures. The State agency did not claim any health home expenditures on line 43 of its CMS-64s before or after the enhanced FMAP period composed of FFYs 2012 and 2013 (see Appendix C).

Contrary to requirements in North Carolina's Health Home SPA, the State agency did not require monthly health home activity reports for these health home expenditures and, therefore, did not adequately document health home services. Claiming $124.6 million in expenditures (as health home on line 43 of its CMS-64s) for PCCM capitation payments that did not meet the requirements under North Carolina's Health Home SPA was contrary to 42 CFR § 430.10 and the reporting instructions for the CMS-64 and, therefore, this amount did not qualify for the enhanced FMAP.

In addition, our review of a stratified random sample corroborated that these expenditures were not health home expenditures.[29] All 2,999 PCCM capitation payments associated with 100 beneficiaries in our stratified random sample complied with the CMS-approved PCCM SPA and, therefore, qualified for reimbursement at the regular FMAP. However, none of these payments fully complied with the payment requirements under North Carolina's Health Home

[28] According to the Health Home SPA, the health home would track and record qualifying health home services using a monthly health home activity report identifying the provider number, beneficiary number, and date of service (North Carolina SPA #11-0050, Attachment 4.19-B).

[29] We did not estimate unallowable payments based on our sample results. However, our sample results disclosed that the associated payments were for PCCM (not health home) services and, therefore, supported our finding that the State agency did not claim FFP for health home expenditures in accordance with Federal and State requirements.

SPA. Specifically, none of these payments complied with the first, second, and fourth requirements for payment identified in the CMS-approved Health Home SPA.

INADEQUATE PROGRAM IMPLEMENTATION AND UNIMPLEMENTED INTERNAL CONTROLS

The State agency claimed PCCM expenditures as health home expenditures because it did not adequately implement the health home option and did not implement internal controls needed to ensure compliance with Federal and State requirements for documenting health home services and for claiming these expenditures for Federal reimbursement.

The State agency did not take certain steps to ensure the proper implementation of the health home option as required under the CMS-approved Health Home SPA. For example, it did not:

- modify its existing PCCM program to add qualifying health home services and distinguish them from PCCM services,
- amend existing PCCM contracts and billing practices or establish new health home contracts and billing practices,
- ensure providers and beneficiaries were informed of their participation in health home activities specified in section 1945(h)(4) of the Act,
- establish a separate or additional payment for health home services, or
- require providers to document health home services in compliance with the requirements under the CMS-approved Health Home SPA.

Furthermore, the State agency did not implement internal controls, such as health home activity reports, needed to ensure compliance with Federal and State requirements for documenting Medicaid services and for claiming expenditures for Federal reimbursement.

MILLIONS IN EXCESS FEDERAL FUNDS RECEIVED

The State agency improperly claimed $124.6 million in PCCM expenditures as health home expenditures reimbursed at the enhanced FMAP. Only expenditures for health home services, as specified in the Act, qualified for the enhanced FMAP. As a result, North Carolina received $30,649,113 in excess FFP attributable to the difference between the enhanced FMAP for health home expenditures and the regular FMAP for PCCM expenditures.

RECOMMENDATIONS

We recommend that the North Carolina Department of Health and Human Services, Division of Health Benefits:

- reclassify $124,636,146 ($112,172,531 Federal share) from health home expenditures to PCCM expenditures and

- refund $30,649,113 in excess Federal funds to the Federal Government.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency agreed with our findings and recommendations and described actions that it plans to take to address them. These actions include working with CMS to reclassify the PCCM expenditures on the CMS-64 and to determine the amount, method, and timing of the refund.

The State agency's comments are included in their entirety as Appendix D.

OFFICE OF INSPECTOR GENERAL RESPONSE

We continue to recommend that the State agency refund $30.7 million to the Federal Government, and we agree that it should work with CMS to resolve our findings and recommendations.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered $124,636,146 ($112,172,531 Federal share), composed of $119,220,100 ($107,298,090 Federal share) in actual expenditures and $5,416,046 ($4,874,441 Federal share) in State-estimated expenditures, that the State agency claimed as health home expenditures from October 1, 2011, through September 30, 2013 (audit period).

From the $119,220,100 ($107,298,090 Federal share) in actual expenditures, we removed $5,017,880 ($4,516,092 Federal share) for expenditures not authorized in the Health Home SPA and identified a sampling frame of $114,202,220 ($102,781,998 Federal share). We then selected a stratified random sample of 100 beneficiaries for review, associated with 2,999 payments totaling $23,676 ($21,308 Federal share).

We did not assess the State agency's overall internal control structure. Rather, we limited our review of internal controls to those applicable to our audit objective.

We performed our fieldwork at offices of the State agency and its contractor in Raleigh, North Carolina, and at a provider office in Smithfield, North Carolina.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State requirements;
- met with CMS financial and program management officials to gain an understanding of their involvement with the North Carolina health home program;
- met with State agency officials to gain an understanding of the State agency's administration of the PCCM program and implementation of the health home option;
- met with a provider to gain an understanding of how care management activities should be documented in the CMIS;
- obtained data files and supporting documentation for capitation payments and Federal reporting;
- reconciled $287,288,026 in PCCM expenditures claimed on CMS-64s as PCCM (line 25) and health home (line 43) for FFYs 2012 through 2013 to the State agency's underlying accounting records;

- selected a stratified random sample of 100 beneficiaries for review, associated with 2,999 payments totaling $23,676 ($21,308 Federal share) (Appendix B);

- reviewed supporting documentation for each of the 100 beneficiaries in our stratified random sample and associated payments to determine whether:

  - the beneficiary was Medicaid eligible;

  - the beneficiary was eligible for health home services, diagnosed with qualifying chronic conditions, and properly enrolled with a health home;

  - the beneficiary was assigned a care manager;

  - the beneficiary received a qualifying health home service as defined by section 1945 of the Act;

  - the documentation maintained in the CMIS clearly demonstrated that the health home service requirements were met for the enrolled beneficiary; and

  - the beneficiary was enrolled in the PCCM program, assigned to a medical home, and eligible for PCCM capitation payments;

- documented any sample deficiencies; and

- summarized the results of the audit and discussed these results 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 B: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

Using payment data that the State agency provided to us, we identified 20,406,288 capitation payments, valued at $119,220,100 ($107,298,090 Federal share) for FFYs 2012 and 2013, made on behalf of PCCM program enrollees having chronic conditions.[30] We then removed 1,043,333 payments totaling $5,017,880 ($4,516,092 Federal share) that were not authorized in the Health Home SPA.[31] Our final sampling frame contained 868,586 beneficiaries with 19,362,955 payments valued at $114,202,220 ($102,781,998 Federal share).

SAMPLE UNIT

The sample unit was a unique beneficiary.

SAMPLE DESIGN AND SAMPLE SIZE

We used a stratified random sample as follows:

Table 1: Stratified Random Sample

Stratum	Dollar Range	Frame Size	Frame Amount	Sample Size
1	$1.00 to $106.01	515,516	$25,337,417	30
2	$106.04 to $278.67	231,382	39,620,323	30
3	$278.94 to $490.17	121,688	49,244,480	40
Total		**868,586**	**$114,202,220**	**100**

SOURCE OF RANDOM NUMBERS

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

METHOD OF SELECTING SAMPLE ITEMS

We consecutively numbered the unique beneficiaries in each stratum. After generating the random numbers for each stratum, we selected the corresponding frame items for review.

[30] Qualifying chronic conditions were identified in section 1945(h)(2) of the Act and the North Carolina Health Home SPA.

[31] Payments removed included add-on payments not approved in the SPA and payments with dates of service prior to the effective date of the SPA.

ESTIMATION METHODOLOGY

On the basis of evidence outside our sample, we determined that all expenditures covered under our audit were improperly claimed as health home expenditures. As a result, we did not calculate a statistical estimate of the improper payment amount.

APPENDIX C: MEDICAID EXPENDITURES AND FEDERAL SHARE CLAIMED

North Carolina's CMS-64s included lines for reporting Medicaid expenditures for PCCM (line 25) and Health Home for Enrollees with Chronic Conditions (line 43) services. For FFYs 2012 and 2013, the State agency improperly claimed $124,636,146 in PCCM expenditures as health home expenditures, reimbursed at the enhanced FMAP ($112,172,531 Federal share), that should have been claimed as PCCM expenditures and reimbursed at the regular FMAP.[32] The State agency claimed the following amounts on its CMS-64s for FFYs 2010 through 2015:

Table 2: Expenditures and Federal Share Claimed for PCCM and Health Home Services

CMS-64 Reports	Line 25 PCCM Total	Line 43 Health Home Total	Grand Total	Line 25 PCCM Federal Share	Line 43 Health Home Federal Share	Grand Total Federal Share
FFY 2010	$55,989,563	$0	**$55,989,563**	$41,980,974	$0	**$41,980,974**
FFY 2011	91,724,716	0	**91,724,716**	64,141,733	0	**64,141,733**
Total 2010 - 2011	**$147,714,279**	**$0**	**$147,714,279**	**$106,122,707**	**$0**	**$106,122,707**
FFY 2012	$66,696,229	$54,661,419*	**$121,357,648**	$43,540,037	$49,195,277	**$92,735,314**
FFY 2013	95,955,651	69,974,727	**165,930,378**	62,861,137	62,977,254	**125,838,391**
Total 2012 - 2013	**$162,651,880**	**$124,636,146**	**$287,288,026**	**$106,401,174**	**$112,172,531**	**$218,573,705**
FFY 2014	$141,587,805	$0	**$141,587,805**	$93,136,471	$0	**$93,136,471**
FFY 2015	143,665,750	0	**143,665,750**	94,647,337	0	**94,647,337**
Total 2014 - 2015	**$285,253,555**	**$0**	**$285,253,555**	**$187,783,808**	**$0**	**$187,783,808**

* For FFY 2012, the State agency initially claimed expenditures as PCCM (line 25) but later reclassified them to health home (line 43) by increasing (line 8) and decreasing (line 10b) adjustments on subsequent CMS-64s.

[32] The State agency's MMIS categorized PCCM capitation payments as PCCM expenditures before, during, and after the audit period. Except for the enhanced FMAP period for FFYs 2012 and 2013, the State agency claimed all expenditures as PCCM (line 25) on its CMS-64s, and it did not claim any health home expenditures before or after the enhanced FMAP period. For FFY 2012, the State agency initially claimed these expenditures as PCCM (line 25) but later reclassified them to health home (line 43) by increasing (line 8) and decreasing (line 10b) adjustments on subsequent CMS-64s.

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Health Benefits

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
DAVE RICHARD • Deputy Secretary, NC Medicaid

April 6, 2019

Department of Health and Human Services
Office of Inspector General
Attn: Lori S. Pilcher
Office of Audit Services, Region IV
62 Forsyth Street, SW, Suite 3T41
Atlanta, GA 30303

Re: Report Number A-04-18-00120

Dear Ms. Pilcher:

We have reviewed your draft report entitled *North Carolina Received $30 Million in Excess Federal Funds Related to Improperly Claimed Home Health Expenditures* (Report) covering the audit period October 1, 2011 through September 30, 2013. The Department agrees with the findings noted in the report. The following represents our response and corrective action plan to the Recommendations.

RECOMMENDATIONS

RECLASSIFY $124,636,146 ($112,172,531 FEDERAL SHARE) FROM HOME HEALTH EXPENDITURES TO PCCM EXPENDITURES.

The Department agrees with the recommendation. The Department will work with the CMS Regional Office to reclassify the PCCM expenditures on the CMS-64.

REFUND $30,649,113 IN EXCESS FEDERAL FUNDS TO THE FEDERAL GOVERNMENT.

The Department agrees with the recommendation to refund excess funds to the Federal Government. The Department will work with the CMS Regional Office to determine the amount, method and timing of the refund.

We greatly appreciate the professionalism of your review staff and the opportunity to respond.

If you need any additional information, please contact John Thompson at (919) 527-7701.

Sincerely,

DocuSigned by:
Dave Richard
11395D232A054A2...

Dave Richard

NC MEDICAID
NC DEPARTMENT OF HEALTH AND HUMAN SERVICES • DIVISION OF HEALTH BENEFITS
LOCATION: 1985 Umstead Drive, Kirby Building, Raleigh NC 27603
MAILING ADDRESS: 2501 Mail Service Center, Raleigh NC 27699-2501
www.ncdhhs.gov • TEL: 919-855-4100

cc: Mandy Cohen, Secretary
Jay Ludlam, Assistant Secretary, NC Medicaid
Adam Levinson, Chief Financial Officer, NC Medicaid
Lotta Crabtree, Chief Legal Officer, NC Medicaid
John E. Thompson, Director, Office of Compliance and Program Integrity
Sandy Terrell, Director of Clinical Policy, NC Medicaid
Lisa Corbett, General Counsel
Rob Kindsvatter, Chief Financial Officer
Laketha M. Miller, Controller
David King, Director, Office of the Internal Auditor
Lisa Allnutt, Manager, Risk Mitigation & Audit Monitoring