

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**NORTH CAROLINA MADE CAPITATION
PAYMENTS TO MANAGED CARE
ENTITIES AFTER BENEFICIARIES'
DEATHS**

*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

September 2020
A-04-16-00112

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 audits 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 website.

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: September 2020
Report No. A-04-16-00112

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



Why OIG Did This Audit

Previous OIG audits found that States had improperly paid Medicaid managed care entities capitation payments on behalf of deceased beneficiaries. We conducted a similar audit of the North Carolina Department of Health and Human Services, Division of Health Benefits, which administers the Medicaid program.

Our objective was to determine whether North Carolina made capitation payments on behalf of deceased beneficiaries.

How OIG Did This Audit

Our audit covered 37,434 capitation payments, totaling \$3.5 million, made from July 1, 2009, through June 30, 2014 (audit period), on behalf of beneficiaries identified by North Carolina as possibly deceased. After matching the Medicaid Management Information System (MMIS) data for these payments to the Social Security Administration Death Master File, we eliminated 3,912 payments, totaling \$567,252, either paid before the beneficiary's death or recovered.

For each of the remaining 33,522 payments, totaling \$2.9 million, we determined the beneficiary's month and year of death from at least two corroborating sources. We identified each capitation payment for monthly coverage after the beneficiary's determined month and year of death, and we summed these to determine total unallowable payments.

North Carolina Made Capitation Payments to Managed Care Entities After Beneficiaries' Deaths

What OIG Found

North Carolina made unallowable capitation payments to certain managed care entities on behalf of deceased beneficiaries. Of the 37,434 capitation payments reviewed, North Carolina paid 3,912 before the beneficiaries' deaths or recovered the payments. However, the remaining 33,522 were for monthly coverage after the beneficiaries' deaths, were unrecovered, and were therefore unallowable. Although North Carolina identified and recovered some unallowable payments, it did not always identify and process death information in its eligibility system and MMIS. As a result, North Carolina made \$2.9 million (Federal share \$1.9 million) in unallowable payments to certain managed care entities for the audit period.

What OIG Recommends and North Carolina Comments

We recommend that North Carolina refund \$1.9 million to the Federal Government, identify capitation payments made to managed care entities on behalf of deceased beneficiaries before and after our audit period and refund the Federal share of amounts recovered, and improve the accuracy of eligibility system date of death information and apply MMIS edits as necessary to identify all deceased beneficiaries, prevent all capitation payments for monthly coverage after death, and recover such unallowable payments.

In written comments on our draft report, North Carolina agreed with our recommendations and described actions that it has taken or plans to take to address them. North Carolina plans to work with the Centers for Medicare & Medicaid Services regional office to determine the amount, method, and timing of the refund in our first recommendation. North Carolina implemented MMIS edits to prevent and recover capitation payments made on behalf of deceased beneficiaries, and its contractors reviewed such payments that may have occurred outside of the audit period. North Carolina also plans to continue contractor reviews, enhance information sources for identifying deceased beneficiaries, and streamline tracking and followup processes to ensure appropriate action is taken timely.

TABLE OF CONTENTS

INTRODUCTION	1
Why We Did This Audit	1
Objective	1
Background	1
The Medicaid Program.....	1
Social Security Administration: Date of Death Information	2
Federal and State Requirements	2
North Carolina’s Medicaid Managed Care Program.....	2
How We Conducted This Audit	3
FINDINGS.....	4
The State Agency Made Unallowable Payments to Certain Medicaid Managed Care Entities	5
Unallowable Prepaid Inpatient Health Plan Payments.....	5
Unallowable Prepaid Ambulatory Health Plan Payments	5
Unallowable Program for All-Inclusive Care for the Elderly Payments	5
The State Agency Did Not Always Identify and Process Death Information	6
Unallowable Capitation Payments.....	6
RECOMMENDATIONS	7
STATE AGENCY COMMENTS	7
APPENDICES	
A: Audit Scope and Methodology	8
B: Related Office of Inspector General Reports	10
C: Federal and State Requirements.....	12
D: State Agency Comments	14

INTRODUCTION

WHY WE DID THIS AUDIT

The North Carolina Department of Health and Human Services, Division of Health Benefits (State agency) pays Medicaid managed care entities to make services available to enrolled Medicaid beneficiaries in return for a monthly fixed payment for each enrolled beneficiary (capitation payment). Previous Office of Inspector General (OIG) audits¹ found that State Medicaid agencies had improperly paid capitation payments on behalf of deceased beneficiaries. We conducted a similar audit of the State agency, which administers the Medicaid program.

OBJECTIVE

Our objective was to determine whether the State agency made capitation payments on behalf of deceased Medicaid beneficiaries.

BACKGROUND

The Medicaid Program

The Medicaid program provides medical assistance to low-income individuals and individuals with disabilities (Title XIX of the Social Security Act (the Act)). 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. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

The Medicaid managed care programs are intended to increase access to and improve quality of health care for Medicaid beneficiaries. States contract with managed care entities to make services available to enrolled Medicaid beneficiaries, usually in return for capitation payments. States report capitation payments claimed by Medicaid managed care entities on the States' Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (Form CMS-64). The Federal Government pays its share of a State's medical assistance expenditures (Federal share) under Medicaid based on the Federal medical assistance percentage (FMAP), which varies depending on the State's relative per capita income as calculated by a defined

¹ See Appendix B for related OIG reports.

formula (42 CFR § 433.10). From July 1, 2009, through June 30, 2014 (audit period), the FMAP in North Carolina ranged from 64.60 percent to 74.98 percent.²

Social Security Administration: Date of Death Information

The Social Security Administration (SSA) maintains death record information, including date of death, by obtaining death information from relatives of deceased beneficiaries, funeral directors, financial institutions, and postal authorities. SSA processes death notifications through its Death Alert, Control, and Update System, which matches the information received from external sources against the Master Beneficiary Record and the Supplemental Security Income Record.³ SSA records the resulting death information in its Numerical Identification System (the Numident).⁴ SSA then uses information from the Numident to create a national record of death information called the Death Master File (DMF).^{5, 6}

Federal and State Requirements

A capitation payment is “a payment 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. The State agency makes the payment regardless of whether the particular beneficiary receives services during the period covered by the payment” (42 CFR § 438.2).

The State agency “will seek full restitution of any and all improper payments made to providers by the Medicaid Program” (10 A North Carolina Administrative Code 22F.0601).

North Carolina’s Medicaid Managed Care Program

In 1991 the State agency began operating parts of its Medicaid program using managed care through a primary care case management program, called Carolina ACCESS, to provide

² Because of the Patient Protection and Affordable Care Act’s Medicaid expansion, payments for “newly eligible” adults were reimbursed at a 100-percent FMAP during calendar years 2014 through 2016.

³ SSA, *Programs Operations Manual System*, GN 02602.060 (May 13, 2011). The Master Beneficiary Record is an electronic record of all Title II (of the Act) beneficiaries. The Supplemental Security Income Record is an electronic record of all Title XVI (of the Act) beneficiaries.

⁴ The Numident contains personally identifiable information for each individual issued a Social Security number (SSN).

⁵ SSA, *Programs Operations Manual System*, GN 02602.060.B.1 (May 13, 2011).

⁶ SSA maintains death data—including names, SSNs, dates of birth (DOBs), and States of death—in the DMF for approximately 98 million deceased individuals.

beneficiaries with a designated medical home and primary care provider to coordinate care. Certain Medicaid beneficiaries were enrolled on a mandatory basis, while certain other Medicaid beneficiaries had the option to enroll.⁷ By 1997 the program expanded statewide as Community Care of North Carolina, which paid 14 community health networks a monthly fee to provide case management, data analysis, and quality improvement and training activities for participating primary care practices.

In 2005 North Carolina began operating a limited benefit, pre-paid program under its 1915(b)/(c) waiver⁸ for mental health, developmental disability, and substance abuse services. Under this waiver, North Carolina used Prepaid Inpatient Health Plans (PIHPs) to manage behavioral health and developmental disability services on a mandatory basis for most Medicaid beneficiaries with behavioral health needs.

In 2008 North Carolina expanded managed care to include Medicare-Medicaid dual enrollees and Medicaid-only individuals with long-term care needs. North Carolina contracted with Prepaid Ambulatory Health Plan (PAHP) providers for high tech imaging and ultrasound services to eligible Medicaid beneficiaries, and it offered a Program for All-Inclusive Care for the Elderly (PACE) to provide all Medicare and Medicaid services to individuals over age 55 who required a nursing home level of care.

State Medicaid agencies use the Medicaid Management Information System (MMIS), which interfaces with the State agency's eligibility system, to process payments and maintain beneficiary eligibility and enrollment information.⁹

HOW WE CONDUCTED THIS AUDIT

Our audit covered 37,434 PIHP, PAHP, and PACE capitation payments from July 1, 2009, through June 30, 2014,¹⁰ totaling \$3,478,847 (Federal share \$2,321,552), made on behalf of

⁷ Children, non-elderly individuals with disabilities and low-income caretaker adults are enrolled on a mandatory basis, while older adults, American Indian/Alaska Natives, Foster Care Children, dual eligibles, pregnant women, and special needs children have the option to enroll.

⁸ The 1915(b)/(c) waiver program became statewide in 2013.

⁹ The State agency implemented a new MMIS on July 1, 2013. It also implemented a new eligibility system called North Carolina Families Accessing Services through Technology (NC FAST) on October 1, 2013.

¹⁰ The audit period encompassed the most current data available at the time we initiated our audit.

beneficiaries who the State agency identified as possibly deceased prior to the month of the capitation payment.¹¹

For these 37,434 capitation payments, we matched the claim data on the State agency file to the SSA DMF and used the beneficiary's SSN, name, and date of birth to identify the beneficiary's date of death¹² and capitation payments with beginning dates of service after the beneficiary's date of death. For each of these payments, we used a variety of sources, including the MMIS, the SSA DMF, the CWF, vital records data, and online obituaries, to determine the beneficiary's month and year of death from at least two corroborating sources. We then analyzed these payments to identify individual unallowable capitation payments for monthly coverage after each beneficiary's determined month and year of death and to determine total unallowable payments.

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 scope and methodology, and Appendix C contains the Federal and State requirements.

FINDINGS

The State agency made unallowable capitation payments to certain managed care entities on behalf of deceased beneficiaries. Of the 37,434 capitation payments reviewed, the State agency paid 3,912 before the beneficiaries' deaths or recovered the payments.¹³ However, the remaining 33,522 were for monthly coverage after the beneficiaries' deaths, were unrecovered, and were therefore unallowable. Although the State agency identified and recovered some unallowable payments, it did not always identify and process death information in its eligibility system and MMIS. As a result, the State agency made \$2,911,595 (Federal share \$1,948,657) in unallowable payments to certain managed care entities for the audit period.

¹¹ Using claim data extracted from its MMIS, the State agency provided an Excel file (the State agency file) identifying 37,434 capitation payments totaling \$3,478,847 (Federal share \$2,321,552) on behalf of PIHP, PAHP, and PACE enrollees who were possibly deceased and, therefore, ineligible for Medicaid.

¹² Of the 37,434 Medicaid beneficiaries associated with these claims, we identified 37,428 in the SSA DMF. For the six beneficiaries not identified in the SSA DMF, we obtained four beneficiaries' dates of death from the Common Working File (CWF) and one beneficiary's date of death from an online obituary. Because we could not verify the remaining beneficiary's date of death, we treated it as a non-error.

¹³ The vast majority of these were payments on the first of the month for monthly coverage interrupted by the beneficiary's death. Additionally, the State agency recovered 478 of these payments.

THE STATE AGENCY MADE UNALLOWABLE PAYMENTS TO CERTAIN MEDICAID MANAGED CARE ENTITIES

The State agency's PIHP, PAHP, and PACE contracts established Medicaid eligibility as a requirement for enrollment and generally provided for recoupment of payments made in error. However, despite recovery efforts, the State agency did not recover all capitation payments made on behalf of deceased beneficiaries. Of the 37,434 capitation payments that we reviewed, totaling \$3,478,847 (Federal share \$2,321,552), the State agency paid 3,912, totaling \$567,252 (Federal share \$372,895), to certain managed care entities before the beneficiaries' deaths or recovered the payments. However, the remaining 33,522 payments, totaling \$2,911,595 (Federal share \$1,948,657), were on behalf of deceased beneficiaries and were unrecovered.¹⁴

Unallowable Prepaid Inpatient Health Plan Payments

The State agency made 19,285 PIHP capitation payments totaling \$2,515,173 (Federal share \$1,679,137) on behalf of deceased beneficiaries. The PIHP contracts provided for automatic disenrollment upon enrollee death and recoupment of overpayments (PIHP Contract, sections 4 and 10). However, these unallowable payments (representing 86.38 percent of total unallowable payments) were unrecovered.

Unallowable Prepaid Ambulatory Health Plan Payments

The State agency made 14,196 PAHP capitation payments totaling \$267,188 (Federal share \$183,821) on behalf of deceased beneficiaries. The PAHP contracts provided for audit, reconciliation of payments, reporting of errors to the State agency, and recoupment of payments made in error, including after an individual is retroactively terminated (PAHP Contract, Attachment B, sections C and E). However, these unallowable payments (representing 9.18 percent of total unallowable payments) were unrecovered.

Unallowable Program for All-Inclusive Care for the Elderly Payments

The State agency made 41 PACE capitation payments totaling \$129,234 (Federal share \$85,699) on behalf of deceased beneficiaries. The PACE contracts provided for termination upon a beneficiary's death (PACE Contract, Appendix G). However, these unallowable payments (representing 4.44 percent of total unallowable payments) were unrecovered.

¹⁴ Despite the State agency's efforts to identify and recover unallowable payments, 22 percent of these unallowable payments occurred more than 3 months after the beneficiaries' deaths.

THE STATE AGENCY DID NOT ALWAYS IDENTIFY AND PROCESS DEATH INFORMATION

The State agency did not always identify and process death information in its eligibility system and MMIS.

On October 1, 2013, the State agency implemented a new eligibility system, NC FAST, which determined whether an individual was eligible for Medicaid. Because the date of death indicator field in NC FAST did not automatically populate, it was added manually using data obtained from the SSA DMF or the county Department of Social Services (DSS). This manual input was subject to human error and inaccuracies in the SSA DMF and DSS data. Although case workers at the county level researched and retroactively corrected some discrepancies, NC FAST date of death information was not always accurate.

Beneficiary information in NC FAST interfaced with the MMIS as part of the claim payment process, and the State agency implemented MMIS edits to prevent payment of claims on behalf of deceased beneficiaries. For example, the new MMIS that was implemented on July 1, 2013, included edit checks to identify and prevent such payments.¹⁵ However, because the State agency did not apply these edit checks to capitation payments, it made 33,522 unallowable capitation payments to PIHP, PAHP, and PACE providers.

In 2015 the State agency's recovery audit contractor and primary post-payment vendor completed reviews of selected Medicaid payments made after the beneficiary's date of death and submitted recovery letters to providers for recovery of all overpayments identified. Additionally, the State agency began performing quarterly reviews of selected Medicaid payments made after a beneficiary's date of death.

The State agency's eligibility system, MMIS, and recovery efforts led to identification and recovery of some unallowable capitation payments on behalf of deceased beneficiaries. However, because it did not always identify and process death information in NC FAST and the MMIS, the State agency did not identify and recover 33,522 PIHP, PAHP, and PACE capitation payments after beneficiaries' deaths.

UNALLOWABLE CAPITATION PAYMENTS

As a result, the State agency made \$2,911,595 (Federal share \$1,948,657) in unallowable payments to certain managed care entities for the audit period.

¹⁵ The MMIS included claim edit checks 253 and 261 designed to deny payment for services after beneficiaries' deaths. If the service end date was after the beneficiary's death date, the MMIS automatically denied the claim.

RECOMMENDATIONS

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

- refund \$1,948,657 (Federal share) to the Federal Government;
- identify capitation payments made to managed care entities on behalf of deceased beneficiaries before and after our audit period and refund the Federal share of amounts recovered; and
- improve the accuracy of NC FAST date of death information and apply MMIS edits as necessary to identify all deceased beneficiaries, prevent all capitation payments for monthly coverage after death, and recover such unallowable payments.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency agreed with our recommendations and described actions that it has taken or plans to take to address them. The State agency plans to work with the CMS regional office to determine the amount, method, and timing of the refund in our first recommendation. The State agency implemented MMIS edits to prevent and recover capitation payments made on behalf of deceased beneficiaries, and its contractors reviewed such payments that may have occurred outside of the audit period. The State agency also plans to continue contractor reviews, enhance information sources for identifying deceased beneficiaries, and streamline tracking and followup processes to ensure that it takes appropriate action promptly.

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

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered 37,434 capitation payments to certain Medicaid managed care entities, totaling \$3,478,847 (Federal share \$2,321,552), made on behalf of beneficiaries that the State agency identified as possibly deceased prior to the month of the capitation payment.¹⁶ We reviewed such capitation payments that the State agency made during our audit period of July 1, 2009, through June 30, 2014.

We did not review the overall internal control structure of the State agency or its Medicaid program. Rather, we reviewed only those internal controls related to our objective. We limited our review to determining whether Medicaid managed care entities in North Carolina received capitation payments on behalf of beneficiaries whose dates of death preceded the capitation payment month.

We conducted this audit from June 2016 through May 2020.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- gained an understanding of the State agency's internal controls over identifying deceased beneficiaries, preventing capitation payments for monthly coverage after beneficiaries' deaths, and recovering such unallowable payments;
- obtained the State agency file identifying 37,434 PIHP, PAHP, and PACE, capitation payments, totaling \$3,478,847 (Federal share \$2,321,552), made on behalf of beneficiaries whom the State agency identified as possibly deceased prior to the month of the capitation payment;
- calculated the Federal share of these payments by applying the applicable FMAP;
- matched the claim data on the State agency file to the SSA DMF and used the beneficiary SSN, name, and date of birth to identify the beneficiary's date of death and

¹⁶ We requested that the State agency's Information Technology Department identify capitation payments to certain Medicaid managed care entities on behalf of beneficiaries that were possibly deceased prior to the month of the capitation payment.

capitation payments with beginning dates of service after the beneficiary's date of death;

- eliminated 3,912 of these payments, totaling \$567,252 (Federal share \$372,895), that the State agency paid before the beneficiary's death or recovered the payments;
- identified 33,522 remaining capitation payments, totaling \$2,911,595 (Federal share \$1,948,657), for beneficiaries who were likely deceased prior to the month of the capitation payment;
- determined each beneficiary's month and year of death by using a variety of sources including the MMIS, the SSA DMF, the CWF, vital records data, and online obituaries and identifying at least two sources corroborating the beneficiary's month and year of death;
- compared the month and year of each capitation payment to the related beneficiary's determined month and year of death and identified payments for monthly coverage after death as unallowable;
- summed individual unallowable capitation payments to determine total unallowable payments;
- reviewed State agency contracts with PIHP, PAHP, and PACE managed care entities that received unallowable capitation payments for the audit period; and
- discussed the results of our audit 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: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
<i>The New York State Medicaid Agency Made Capitation Payments to Managed Care Organizations After Beneficiaries' Deaths</i>	<u>A-04-19-06223</u>	7/27/20
<i>Michigan Made Capitation Payments to Managed Care Entities After Beneficiaries' Deaths</i>	<u>A-05-17-00048</u>	2/14/20
<i>The Indiana State Medicaid Agency Made Capitation Payments to Managed Care Organizations After Beneficiaries' Deaths</i>	<u>A-05-19-00007</u>	1/29/20
<i>The Minnesota State Medicaid Agency Made Capitation Payments to Managed Care Organizations After Beneficiaries' Deaths</i>	<u>A-05-17-00049</u>	10/01/19
<i>Illinois Medicaid Managed Care Organizations Received Capitation Payments After Beneficiaries' Deaths</i>	<u>A-05-18-00026</u>	8/20/19
<i>Georgia Medicaid Managed Care Organizations Received Capitation Payments After Beneficiaries' Deaths</i>	<u>A-04-15-06183</u>	8/09/19
<i>California Medicaid Managed Care Organizations Received Capitation Payments After Beneficiaries' Deaths</i>	<u>A-04-18-06220</u>	5/07/19
<i>Ohio Medicaid Managed Care Organizations Received Capitation Payments After Beneficiaries' Deaths</i>	<u>A-05-17-00008</u>	10/04/18
<i>Wisconsin Medicaid Managed Care Organizations Received Capitation Payments After Beneficiaries' Deaths</i>	<u>A-05-17-00006</u>	9/27/18

Report Title	Report Number	Date Issued
<i>Tennessee Managed Care Organizations Received Medicaid Capitation Payments After Beneficiary's Death</i>	<u>A-04-15-06190</u>	12/22/17
<i>Texas Managed Care Organizations Received Medicaid Capitation Payments After Beneficiary's Death</i>	<u>A-06-16-05004</u>	11/14/17
<i>Florida Managed Care Organizations Received Medicaid Capitation Payments After Beneficiary's Death</i>	<u>A-04-15-06182</u>	11/30/16

APPENDIX C: FEDERAL AND STATE REQUIREMENTS

FEDERAL REQUIREMENTS

The Federal Government pays its share of a State's medical assistance expenditures under Medicaid based on the FMAP, which varies depending on the State's relative per capita income as calculated by a defined formula (42 CFR § 433.10).

In connection with the Medicaid managed care program, providers are defined as "any individual or entity that is engaged in the delivery of health care services and is legally authorized to do so by the State in which it delivers the services" (42 CFR § 400.203).

A capitation payment is "a payment 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. The State agency makes the payment regardless of whether the particular beneficiary receives services during the period covered by the payment" (42 CFR § 438.2).

An overpayment is the amount paid by a Medicaid agency to a provider that is in excess of the amount that is allowable for services furnished (42 CFR § 433.304).

STATE REQUIREMENTS

The State agency "will seek full restitution of any and all improper payments made to providers by the Medicaid Program" (10 A North Carolina Administrative Code 22F.0601).

North Carolina State Plan

North Carolina's State plan establishes medical assistance eligibility conditions and requirements for individuals covered under the plan, and it identifies eligible groups under its option to use managed care.

North Carolina's State plan (TN No. 03-04) also assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR § 438.56 (c) and that all applicable managed care requirements of 42 CFR part 438 for managed care organizations will be met. Accordingly, all managed care organization contracts must specify the reasons for which the entity may request disenrollment of an enrollee (42 CFR § 438.56), and disenrollment can occur for cause (42 CFR § 438.56 (d)(2)).

State Agency Contracts With Managed Care Entities

The State agency's PIHP, PAHP, and PACE contracts established Medicaid eligibility as a requirement for enrollment and generally provided for recoupment of payments made in error. Specifically:

- The PIHP contracts provided for automatic disenrollment upon enrollee death and recoupment of overpayments (PIHP Contract, sections 4 and 10). If the PIHP erroneously reported (intentionally or unintentionally), fraudulently reported, or knowingly failed to report any information affecting payments to the PIHP, these contracts allowed the State agency to either request a refund of the overpayment or recoup the overpayment by withholding payments due in any one or more subsequent months.
- The PAHP contracts provided for audit, reconciliation of payments, reporting of errors to the State agency, and recoupment of payments made in error, including after an individual is retroactively terminated (PAHP Contract, Attachment B, sections C and E). If the State agency agreed with a reported error, these contracts allowed the State's fiscal agent to recoup the payment within 45 days of the reporting of the error. If beyond 45 days, these contracts allowed the PAHP to adjust the dollars out of the next check write cycle payment.
- The PACE contracts provided for termination upon a beneficiary's death (PACE Contract, Appendix G). The PACE contracts also provided for involuntary disenrollment for various reasons, including but not limited to the enrollee's moving out of the service area for more than 30 consecutive days or no longer meeting nursing home level of care eligibility.

APPENDIX D: STATE AGENCY COMMENTS



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

August 7, 2020

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-04-16-00112

Dear Ms. Pilcher:

We have reviewed your draft report entitled *North Carolina Made Capitation Payments to Managed Care Entities After Beneficiaries' Deaths* (Report) covering the audit period July 1, 2009 through June 30, 2014. The Department agrees with the findings noted in the report. The following represents our response and corrective action plan to the Recommendations.

RECOMMENDATIONS

REFUND \$1,948,657 (FEDERAL SHARE) TO THE FEDERAL GOVERNMENT.

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

IDENTIFY CAPITATION PAYMENTS MADE TO MANAGED CARE ENTITIES ON BEHALF OF DECEASED BENEFICIARIES BEFORE AND AFTER OUR AUDIT PERIOD AND REFUND THE FEDERAL SHARE OF AMOUNTS RECOVERED.

The Department agrees with the recommendation. The Report notes that the Department implemented reviews of payments made on behalf of deceased beneficiaries outside of the audit period. Reviews have been conducted by our recovery audit contractor and a contracted post-payment vendor. The Department will continue to conduct such reviews and refund the federal share of amounts recovered.

IMPROVE THE ACCURACY OF NC FAST DATE OF DEATH INFORMATION AND APPLY MMIS EDITS AS NECESSARY TO IDENTIFY ALL DECEASED BENEFICIARIES, PREVENT ALL CAPITATION PAYMENTS FOR MONTHLY COVERAGE AFTER DEATH, AND RECOVER SUCH UNALLOWABLE PAYMENTS.

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


AN EQUAL OPPORTUNITY / AFFIRMATIVE ACTION EMPLOYER

The Department agrees with the recommendation and has implemented MMIS edits to prevent and recover capitation payments made on behalf of deceased beneficiaries. Additionally, the Department is enhancing its information sources for identifying deceased beneficiaries and streamlining its tracking and follow-up processes to ensure appropriate action is taken timely.

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) 306-0379 or john.e.thompson@dhhs.nc.gov.

Sincerely,

DocuSigned by:

11395D232A054A2...
Dave Richard

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 & Program Integrity, NC Medicaid
Sandy Terrell, Director, Clinical Policy, NC Medicaid
Lisa Corbett, General Counsel, NC DHHS
Rob Kindsvatter, Chief Financial Officer
Laketha M. Miller, Controller, NC DHHS
David King, Director, Office of the Internal Auditor, NC DHHS
Lisa Allnutt, Manager, Risk Mitigation & Audit Monitoring, NC DHHS