

**Report on Support Improvement in the Accuracy
of Medicaid Eligibility Determinations
Audit of County Medicaid Determinations**

SL 2017-57, Section 11H.22.(e)



**Report to the
Joint Legislative Oversight Committee on Medicaid and NC
Health Choice**

**By
North Carolina Department of Health and Human Services**

March 23, 2018

I. Introduction

On January 12, 2017, the Office of the State Auditor issued report FCA-2015-4440 'North Carolina Medicaid Program Recipient Eligibility Determination' ("OSA Report") of its review of Medicaid eligibility determination in ten (10) selected counties. The report noted that eligibility determinations were not consistently performed across counties and error rates were significant in some counties.

North Carolina Session Law 2017-57 Section 11H.22.(e), Audit Plan for County Eligibility Determinations (see *Appendix A*), requires the Division of Medicaid Assistance (DMA) of the North Carolina Department of Health and Human Services to collaborate with the State Auditor to: 1) develop accuracy and quality assurance standards for county eligibility determinations and 2) develop an audit plan to review and evaluate the counties' performance in relation to the standards.

II. Performance Standards

A. Accuracy Standards

The Centers for Medicare & Medicaid Services (CMS) has set the acceptable error rate for eligibility determinations at 3.2% for the State of North Carolina. Utilizing this existing standard, the Department will implement accuracy standards as follows:

The Department will establish a 3.2% error rate threshold per fiscal year for each county for accuracy errors that cause Medicaid applicants to be approved for Medicaid benefits when the applicants are truly ineligible.

The Department will establish a 3.2% error rate threshold per fiscal year for each county for accuracy errors that cause Medicaid applicants to be denied Medicaid benefits when the applicants are truly eligible.

The Department establishes an initial error rate threshold of 10% per fiscal year for each county for errors made during the eligibility determination process that did not impact the outcome of the eligibility determination decision. A review of the actual initial error rates will be evaluated in the risk assessment process to determine if an adjustment to this threshold is needed to achieve the 3.2% error rate goals that impact eligibility determination.

B. Quality Assurance Standards

On March 30, 2017, the Department issued an administrative letter to the counties outlining enhanced procedures for conducting second party quality assurance reviews, effective April 1, 2017. The directive included implementation of additional staff training, a detailed worksheet for documenting the review, and minimum sample sizes to be reviewed (see *Appendix B*).

The Department also implemented a tracking spreadsheet that identifies: 1) the number of cases reviewed per program, 2) the number of errors cited, 3) the percentage of errors, and 4) specific categories of errors. The county is expected to analyze the results of this review and take appropriate

action to correct issues identified. The tracking spreadsheet is submitted to the Department on a quarterly basis for review.

The Department will evaluate the counties' performance of the quality assurance standards in conjunction with the evaluation of the counties' accuracy standards.

III. Audit Plan Considerations

As directed by the session law, the Department consulted with the Office of the State Auditor (OSA) to determine an appropriate methodology and schedule for auditing the counties' performance of the above referenced standards. The Department 1) analyzed the cost of the legislative audit requirement in consultation with OSA, 2) evaluated the current eligibility review processes, and 3) considered impacts to current Department and county resources and initiatives.

In discussing the eligibility performance audit outlined in the OSA Report, several factors were identified for the Department to consider in determining audit methodology, schedule, and anticipated costs.

Review time

The process for determining eligibility requires many data points to be evaluated against policy. An initial review of a single eligibility determination takes approximately 2-3 hours to complete, not counting time for management review. Some case types take as much as 6-8 hours to review. Using OSA's sampling methodology, the Department would invest approximately 218,750 staff-hours annually to audit the eligibility determination in all 100 counties.

Expertise

To conduct an efficient review of an eligibility determination, the reviewer must possess experience with the eligibility determination process, i.e. Medicaid eligibility policy and NC FAST utilization experience. In the State of North Carolina, personnel with such experience are primarily limited to retired and existing county and state workers. OSA utilized a staffing contractor that was able to draw in expertise from available county workers with Medicaid experience. The State would need to consider a similar approach.

Sample size

Matching the level of effort performed by OSA, the Department would use the same sample methodology. This methodology requires testing a sample of 250 items for each attribute (500 total per county), which would allow enough of a review to attain sufficient evidence to support a calculated accuracy rate.

Estimated Costs

Utilizing the cost information obtained from OSA when conducting the eligibility performance audit, the Department has estimated the projected hard dollar cost of this effort (under the current requirement to audit all 100 counties) to be approximately \$11.2 million annually. The table below shows the work effort and related costs of conducting the review, if an experienced contractor were used.

	Sample size	Hours*	Hourly Rate	Total Cost**	State Share
Contractor Review	50,000	175,000	\$ 45.00	\$7,875,000	\$2,520,000
DHHS Oversight (25% of audit effort)		43,750	\$ 75.00	\$3,281,250	\$1,050,000
Total		218,750		\$11,156,250	\$3,570,000

* Hour Estimate: 500 cases * 3.5 hours * 100 counties = 175,000 hours

** Contractor billed OSA at rate of 3.5 hours per case to include travel and administrative costs.

The Department would require approximately 26 additional staff to oversee the contractor's work effort. Additional costs would also be realized by the counties, as staffing levels would need to increase to support the audit process.

The effort as depicted above is a large undertaking requiring resources not readily available at the Department.

Current Reviews of Eligibility Determination

Outside of this audit requirement, there are several existing ways the eligibility determination is reviewed. Eligibility determinations at the county-level are reviewed by the County Operations Quality Assurance team in the Office of Compliance and Program Integrity (OCPI). The team conducts Medicaid Eligibility Quality Control (MEQC) reviews on behalf of CMS annually. As a separate state effort, the team conducts Corrective Action Record Reviews (CARR) annually, in which it selects beneficiary cases from each county and reviews the eligibility determination for technical errors which may or may not affect eligibility determination outcomes. Results are discussed with county personnel and corrective actions are identified.

While the work of this team currently addresses some of the intent of this legislation, it was determined that more can be done within the team's established work plan to meet the full spirit of the legislation. As part of current reorganization efforts within OCPI, this team is enhancing the focus of its CARR efforts to include more in-depth eligibility accuracy reviews and follow-up.

Also, during the annual Single Audit, local CPA firms review eligibility determinations as part of their financial audit efforts. The reviews are conducted using eligibility determination guidance developed by the Department in consultation with OSA. The State Auditor has confirmed that while eligibility reviews have long been a part of the Single Audit process, some of the work performed by the local CPA firms has not been adequate to meet the full intent of the review. Over the last two years the State Auditor has scrutinized and evaluated the results of the Single Audit eligibility reviews and is now looking to hold the CPA firms responsible for delivering quality reviews. As a result, beginning with the SFY 2018 Single Audit, OSA will specify the sample items for the Medicaid reviews conducted by the local CPA firms, mandating their use of the eligibility determination checklist developed by the Department. In this effort, OSA will effectively review eligibility determinations for all 100 counties each year.

Beginning in the Spring of 2018, CMS will also include reviews of eligibility determination in its Payment Error Rate Measurement (PERM) audit. CMS will utilize a federal contractor to perform the reviews with coordination assistance from the OCPI County Operations Quality Assurance team noted above.

Resource Considerations

The Department is currently working with the local County Department of Social Services (DSS) leadership to implement the requirements of Session Law 2017-41, which prescribes comparable enhancements and accountability for other programs administered by the DSS. The comparable efforts required by Session Law 2017-41 and Session Law 2017-57 Section 11H.22(e) will be carried out by the same group of individuals in each county. Managing both initiatives at the County level separately, given current staffing levels and turnover, will present a management challenge for the counties.

Additionally, Department resources are heavily engaged in the task of Medicaid transformation to the managed care environment, while maintaining demanding daily operations cycles. Oversight of such a significant audit effort will require additional staffing.

IV. Audit Plan Schedule, Methodology, Anticipated Costs, and Recommendations

Accuracy and Quality Assurance Standards

The Department recommends establishing SFY 2019 as a period for counties to assess internal challenges and implement corrective action to meet the accuracy rate threshold. OSA will provide the Department with county level results from the State Single Audit, so that accuracy performance for SFY 2019 can be determined.

Audit Timing

Given the initiatives currently underway at the Department and in the counties, the Department recommends implementing the annual audit requirement if sufficient funding is provided no sooner than beginning in January 2020 with initial results being reported in January 2021. The General Assembly should also consider whether, given the significant costs of this effort, enhancements already underway in existing audits, including those conducted by OSA as part of the state single audit, could meet the needs more efficiently than implementing a new process.

Audit Schedule and Methodology

Given the work in progress to enhance the OCPI QA team CARR reviews along with OSA's focus on improving eligibility reviews by local CPAs during the annual state single audit and the enormity and cost of the audit review process as currently prescribed, if a new process is implemented the Department recommends an annual audit plan that reviews the counties on a rotating, risk-based cycle, covering each county once every three (3) years. The order of the counties to be reviewed would be determined based on a risk assessment process, which evaluates the annual results from the CMS MEQC reviews, CMS PERM audit, OCPI CARR reviews, and findings of the local CPAs during the State Single Audit performed by OSA.

As stated above, the Department would spend the next year strengthening its eligibility review processes (to include enhanced training efforts) while establishing and monitoring baseline results

from the noted reviews for input into the risk assessment process. The risk assessment process would also allow for the implementation of improvements/enhancements in NCFAST and reviews of county submitted quality assurance results. Results from all 100 counties would be reviewed and evaluated to develop the three-year audit schedule.

To further reduce costs, the Department could reduce the number of reviews it conducts in each county. The NC Medicaid Office of Compliance and Program Integrity (OCPI) developed its sampling methodology in consultation with experts, including from CMS. Utilizing the OCPI sampling methodology, a sample size of 100 applications and 100 re-certifications (rather than 250 each) for each county would be reviewed. The review of approval and denials will be proportionately distributed within each sample with a minimum strata size of 30 determinations. The annual audit workplan would be based on 27,000 hours of staff audit time, allowing all 100 counties to be reviewed over the rotating 3-year period.

Estimated Costs

Employing the OCPI sampling approach and using a 3-year schedule lowers the projected cost for the audit effort from \$11.2 million (State share: \$3.6 million) to roughly \$1.6 million (State share: \$513,604), when employing an experienced contractor. The Department would need the ability to sole-source a contract with a vendor that can assemble the available personnel with Medicaid eligibility and NC FAST experience to carry out the annual audit. This approach would allow the modification of this audit requirement with minimal impact to state staff. As an alternative, the Department would require funding to hire and train an additional 12 permanent staff to perform the recommended audit approach. Estimates for hiring permanent staff within the Department are reflected in *Appendix C*.

Monitoring & Training Resources Needed

The OCPI County Operations Quality Assurance team currently consists of 10 staff members assigned to monitor the counties' eligibility determinations. This team will be the Department's primary group tasked with monitoring eligibility accuracy in the counties in addition to their existing tasks for CMS. To adequately perform the needed reviews and sufficiently engage with county staff, the Department is recommending expanding the county-to-QA team staffing ratio from 10:1 to 7:1 by adding 4 additional positions to the team. This will allow the staff to adequately monitor, consult, and track county corrective action plans from all review sources and perform accuracy determinations for denied applications. Estimates for expanding the team to a sufficient level are reflected in *Appendix E*.

To further improve accuracy in eligibility determinations for Medicaid, a state-level, dedicated Medicaid training team should be created. The responsibilities of the training staff would include development and delivery of eligibility policy training, that's based on compliance standards and incorporates various adult-learning principles and methodologies to be housed with NC FAST functionality training in the Learning Gateway and/or delivered in various methods, including virtual or on-site delivery. This training staff would work closely with eligibility policy subject matter experts, policy compliance staff, as well as NC FAST trainers. In addition to regular eligibility training, these positions would develop targeted training based on findings in compliance reviews, audits, and other accuracy monitoring. This training staff would also provide enhanced training and guidance for the Operational Support Team (OST) dedicated to Medicaid eligibility. This OST team would in turn provide targeted training and consultation to the county eligibility workers.

The eligibility training team will consist of three (3) training staff. This will allow the development and revision of Medicaid eligibility training as well as ongoing training in response to issues identified in compliance monitoring.

V. OSA Audit Plan Certification

A certification indicating State Auditor approval of the Department's plan for the annual audits is found in *Appendix D*.

VI. Conclusion

The Department supports the goal of improving eligibility determination outcomes. With the implementation and monitoring of the accuracy and quality assurance standards, the Department believes there will be improvement in the Medicaid eligibility determination process. Additionally, the Department is continuing its work efforts to streamline and complete the automation of the eligibility determination process within the NCFAST system. As this effort matures, the potential for human error in the process will significantly decrease, resulting in more consistently accurate eligibility determinations.

Appendix A

Medicaid Eligibility Monitoring: Session Law 2017-57, Section 11H.22.(e)

SECTION 11H.22.(e) The Department of Health and Human Services, Division of Central Management and Support (Department), shall collaborate with the State Auditor to develop a plan of implementation of the annual audits under this section. The plan must include the following information:

- (1) Accuracy standards and quality assurance standards to be implemented.
- (2) The audit schedule that includes all counties.
- (3) The audit methodology to be utilized, including any information that may vary based upon county size or other factors.
- (4) Details illustrating that the audit methodology is statistically sound, including the statistically significant number of cases to be reviewed in each county.
- (5) Anticipated costs of implementing the plan.
- (6) A certification from the State Auditor that the Department's plan for the annual audits has the approval of the State Auditor.

No later than March 1, 2018, the Department shall submit a copy of the plan to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice with any proposed recommendations, suggested legislation, or funding requests.



DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE

ROY
COOPER
GOVERNOR

MANDY COHEN, MD, MPH
SECRETARY

DAVE RICHARD
DEPUTY SECRETARY FOR MEDICAL ASSISTANCE

March 30, 2017

Re: Medicaid Eligibility Second Party Review Corrective Action Plan

Dear County Director of Social Services:

The Division of Medical Assistance (DMA) has analyzed the Second Party Review findings from the Corrective Action Plan (CAP) submitted by local departments of social services during the last two SFY 2017 Quarters. Those findings identified five top errors where additional Medicaid policy training will need to be provided to ensure Medicaid/North Carolina Health Choice policy is applied accurately.

1. Incorrect calculation of earned income
2. Incorrect calculation of self-employment income
3. Documenting and providing evidence that supports eligibility or ineligibility of Medicaid/NCHC (on-line verification and documentation)
4. Failure to verify resources
5. Inappropriate notices (timely vs adequate) or no notice provided

The analysis also concurs with the findings noted in the Office of State Auditor Performance Audit, dated January 2017, and the Single Audit Compliance findings for SFY 2015 - 2016. Based on these findings, additional resources and measurement tools are being provided to evaluate and improve accuracy. The tools will provide formal Medicaid/NCHC training, a detailed Second Party Review sheet, required number of cases to review per quarter and a spreadsheet for tracking findings.

The four tools to be implemented effective April 1, 2017 are as follows:

- o Formal Medicaid/NCHC Medicaid training material has been posted in NCFAST Learning Gateway. More webinars are being added to the NCFAST Learning Gateway and should be used to enhance county training knowledge. This training should be added to the local agencies' existing training plans for all new and existing staff implementing Medicaid/NCHC.
- o A new Second Party Review worksheet, along with recommended program documents, has been designed for use effective April 1, 2017, in completing second party reviews. This review sheet will ensure all Medicaid eligibility areas are identified for consistency among local agencies. Findings from these reviews can be used for policy training each month to reduce/eliminate errors discovered.

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AN EQUAL OPPORTUNITY / AFFIRMATIVE ACTION EMPLOYER

- o A chart titled "2nd Party Review Minimum Quarterly Sample Size" is attached. This chart includes the minimum number of cases each agency should review during a quarter. Local agencies may choose to increase that number based on the number of findings/errors cited. The review sample should include the following types of cases:
 - o Applications (approvals, withdraws or denials) for Medicaid/NCHC to include:
 - MAGI, Non-MAGI Family and Children and/or Adult
 - Other actions to include:
 - Recertifications
 - Terminations
- o DMA Tracking Spreadsheet is provided for quarterly submission of findings, including:
 - o Number of cases reviewed per program
 - o Number of errors cited
 - o Percentage of errors
 - o Specific category of errors


The Division of Medical Assistance has defined what is considered an error based on Federal regulations for the Medicaid/NCHC program. An error should be reported when:

- o Medicaid/NCHC individual authorized for benefits/programs who is ineligible, or determined eligible for benefits in incorrect program.
- o Appropriate notices not given/sent to an applicant/beneficiary regarding approval, denial or termination, including rights to appeal.
- o No documentation obtained to verify eligibility, when required.

Counties must take appropriate corrective action after analyzing results of the monitoring, which may include policy and functionality training. Documentation of these actions, such as attendance logs and summary of the training should be submitted with the quarterly report. Please begin using these tools upon receipt of this letter. The next formal reporting quarter will be April - June, 2017.

These tools will aid in providing consistency in reporting and measuring the accuracy of Medicaid eligibility determinations by local agencies. The goal of the CAP mandate is to ensure accurate Medicaid/NCHC benefits are provided to the residents of North Carolina.

If you have any questions regarding this information, please contact your Operational Support Team representative.

Sincerely,

Dave Richard

Attachments (4)

**2ND PARTY REVIEW
WORKSHEET**
(Effective 4/1/2017)

Caseworker Name	Supervisor	Date of Review (mm/dd/yy)	Type
			MAGI TRADITIONAL HEALTH CHOICE
ADD or IA/IS #	Program/Class	Disposition Date	CH/Primary Person
Certification Period: (mm/ dd/ yy)		Authorization Period: (mm/ dd/yy)	
Application	DOA:	Denial/Withdrawals	Renewals Terminations

A. AGENCY RECORD:			
1. Case set up with correct IA/IS# (Income application/Income Support)	Y	N	N/A
B. DOCUMENTATION:			
1. Appropriate case narrative/notes/documentation in NCFast	Y	N	N/A
C. TIMELINESS:			
1. Case processed within required timeframe)	Y	N	N/A
D. NOTICES:			
1. Notice sent upon approval	Y	N	N/A
2. Notice sent upon denial/termination/withdrawal	Y	N	N/A
3. Notice sent but was not timely	Y	N	N/A
4. Notice sent but did not contain correct information	Y	N	N/A
E. NON-INCOME ELIGIBILITY:			
1. Correct Date of Birth entered NCFast	Y	N	N/A
2. Correct Gender entered into NCFast	Y	N	N/A
3. Correct SSN entered into NCFast	Y	N	N/A
4. Citizenship/alien status verification provided and verification meets policy requirements	Y	N	N/A
5. Failed to assist applicant with obtaining verification of citizenship if needed	Y	N	N/A
6. Reasonable opportunity policy applied appropriately (citizenship/alien)	Y	N	N/A
7. Identity verified appropriately	Y	N	N/A
8. Residency verified appropriately	Y	N	N/A
9. Correct household composition	Y	N	N/A
10. Managed Care or Exempt Code entered into NCFast appropriately	Y	N	N/A
F. INCOME/BUDGETING:			
1. Earned income verified appropriately	Y	N	N/A
a. Available electronic verification of income used (if appropriate)	Y	N	N/A
b. Wages verified appropriately with employer/source	Y	N	N/A
c. Self-employment verified appropriately	Y	N	N/A
2. Earned income entered in NCF correctly	Y	N	N/A
3. Unearned income verified appropriately	Y	N	N/A
a. Available electronic verification of income used (if appropriate)	Y	N	N/A
4. Unearned income entered into NCF correctly	Y	N	N/A
5. Reasonable compatibility policy appropriately applied	Y	N	N/A
6. Income deductions applied appropriately	Y	N	N/A
7. Determinations shows correct Income counted	Y	N	N/A
8. NCHC fee notice sent prior to authorization (12 calendar)	Y	N	N/A
a. Fee paid prior to authorization	Y	N	N/A
b. Ineligible for NCHC due to comprehensive health insurance	Y	N	N/A
9. HCWD premiums calculated correctly	Y	N	N/A
G. DISABILITY:			
1. Disability established	Y	N	N/A
a. Applied for Social Security (post eligibility)	Y	N	N/A
b. Verified by DDS	Y	N	N/A
c. Assessment completed in NCFast	Y	N	N/A

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE
2nd Party Review Eligibility Notices and Forms

Application/Recert:

DMA 4037/5028's/5009 (if applicable) - Disability packet to DDS
DMA 2046/2043/5055/5202A-Third party insurance verification (if applicable)
DMA 5001-Use of Social Security Number
DMA-5094- Rights & Responsibility

DMA 5002/5003 - Medicaid/NCHC approval notices
DMA 5020A- Notice of case status -sent to hospital (if applicable)

DMA 5036 - Track medical bills if forced eligibility is used
DMA 5043 - Self-employment form
DMA 5046/5047/5119/5024 (if applicable)- medical transportation form/assessment/notices

DMA 5097 - Request for information
DMA 5099 -Stop clock notice for deductible case
DMA 5098 -Stop clock notice for pending information

DMA 5152/5153 - Residency declaration
DMA 5200/5201/5008 - Mail-in Application - Verify signature/Name/DOB/Sex/Mailing Address

DMA 5202C- Designation of authorized representative
DMA 8109/8110 - denial/termination w/proper dates
DMA 9006- Managed Care Enrollment
DSS 3431- Bank verification if AVS does not send back known response
DSS 5155 - Life Insurance verifications

LTC:

Copy of FL2 or verification for Level Of Care
DMA 5008C - Community Spousal Resource Protection Worksheet
DMA 5051/5052 - Estate Recovery/all recovery forms
DMA 5057 - Transfer of asset/sanction
Spouse reviewed for eligibility@ app/review
Evaluate for MA PLA prior to placement
DMA-5016 - if applicable
PML budget in NCFAST

CAP:

FL2/Updated Plan of Care (annual)
CAP-MR2 w/prior approval on
CAP indicators identified

Miscellaneous:

NC Voter Registration
NCHC Fee Letter
Budget calculation shown correctly
Resources tallied correctly
Documentation of application/recertification in NC FAST
Child Support Referral in system
Date of Application Received/Keyed
Date Appeal Reversal Received/ Keyed
Certification of Need for Institutional Care for Individual Under Age 21
Date(s) of Emergency Services Requested for an Alien

4/1/2017

**2nd Party Review Minimum Quarterly Sample Size
Effective 4/1/2017**

County	Sample Size	County	Sample Size	County	Sample Size	County	Sample Size
Alamance	166	Cumberland	401	Johnston	207	Randolph	163
Alexander	73	Currituck	30	Jones	30	Richmond	155
Alleghany	30	Dare	49	Lee	150	Robeson	249
Anson	73	Davidson	168	Lenoir	87	Rockingham	109
Ashe	57	Davie	71	Lincoln	147	Rowan	162
Avery	32	Duplin	76	Macon	73	Rutherford	81
Beaufort	60	Durham	268	Madison	46	Sampson	94
Bertie	58	Edgecombe	97	Martin	64	Scotland	60
Bladen	96	Forsyth	382	McDowell	110	Stanly	125
Brunswick	112	Franklin	136	Mecklenburg	999	Stokes	84
Buncombe	232	Gaston	247	Mitchell	35	Swain	86
Burke	104	Gates	30	Montgomery	74	Surry	43
Cabarrus	180	Graham	30	Moore	74	Transylvania	61
Caldwell	102	Granville	100	Nash	122	Tyrrell	30
Camden	30	Greene	52	New Hanover	173	Union	158
Carteret	60	Guilford	560	Northampton	62	Vance	84
Caswell	56	Halifax	85	Onslow	165	Wake	661
Catawba	161	Harnett	128	Orange	80	Warren	53
Chatham	97	Haywood	68	Pamlico	30	Washington	39
Cherokee	70	Henderson	88	Pasquotank	95	Watauga	45
Chowan	35	Hertford	69	Pender	124	Wayne	166
Clay	30	Hoke	132	Perquimans	30	Wilkes	77
Cleveland	138	Hyde	30	Person	88	Wilson	112
Columbus	88	Iredell	141	Pitt	188	Yadkin	76
Craven	98	Jackson	76	Polk	33	Yancey	40

DMA TRACKING SPREADSHEET

(Effective 4/1/2017)

QUARTER	COUNTY	REF NO.	NO. OF CASES READ		DESCRIPTION OF ERRORS		NO. OF CASES WITH ERRORS		PERCENTAGE OF ERRORS		TRAINING/INSTRUCTIONS PROVIDED	DMA RECOMMENDATIONS
			MEDICAID	CHIP	MEDICAID	CHIP	MEDICAID	CHIP	MEDICAID	CHIP		
		N/A										N/A

DMA 10/10/17

Appendix C Cost Projections for Internal Staffing of Eligibility Audit Requirements

Alternate Approach: Audit of Counties on a 3 YR Cycle

Detail of budget is to be provided at the NCAS Agency Management Report detail level.

Budget for Request (G.S. 143C-3-3) Requirements

Fund Code	Cost Center	Account Number	Account Title	Actual		Authorized		2019-20	2020-21	2021-22	2022-23
				2016-17	2017-18	2018-19	2019-20				
1120	051899	531213	SPA-Reg Salaries	\$ -	\$ -	\$ 1,710,000.00	\$ 1,710,000.00	\$ 1,710,000.00	\$ 1,710,000.00	\$ 1,710,000.00	\$ 1,710,000.00
1120	051899	531513	Social Security Contribution	-	-	130,815	130,815	130,815	130,815	130,815	130,815
1120	051899	531523	Reg Retirement Contribution	-	-	275,652	275,652	275,652	275,652	275,652	275,652
1120	051899	531563	Medical Insurance Contribution	-	-	103,949	103,949	103,949	103,949	103,949	103,949
1120	051899	532199	Misc Contractual Services (Consultant services subject matter experts)	-	-	48,000	48,000	48,000	48,000	48,000	48,000
1120	051899	532724	Substance Lodging etc. (In-State)	-	-	30,090	30,090	30,090	30,090	30,090	30,090
1120	051899	532840	Postage	-	-	1,000	1,000	1,000	1,000	1,000	1,000
1120	051899	532930	Training and Registration Fees	-	-	20,000	20,000	20,000	20,000	20,000	20,000
1120	051899	533110	General Office Supplies	-	-	9,500	9,500	9,500	9,500	9,500	9,500
1120	051899	534534	PC/Printer Equipment (one time purchase)	-	-	15,000	-	-	-	-	-
Requirements				-	-	2,344,006	2,329,006	2,329,006	2,329,006	2,329,006	2,329,006
Number of FTE*				-	-	19.00	19.00	19.00	19.00	19.00	19.00

Receipts

Fund Code	Cost Center	Account Number	Account Title	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2021-22
1120	051899	53886C	DMA Admin & Training	-	-	1,172,003.00	1,164,503.00	1,164,503.00	1,164,503.00	1,164,503.00	1,164,503.00
Total Receipts				-	-	1,172,003.00	1,164,503.00	1,164,503.00	1,164,503.00	1,164,503.00	1,164,503.00
APPROPRIATION				-	-	1,172,003.00	1,164,503.00	1,164,503.00	1,164,503.00	1,164,503.00	1,164,503.00

Positions Requested

Detail of the positions included in this expansion request.

Fund Code	Cost Center	Account Number	Grade	Classification	Effective Date	Retirement Program	Other Information	2017-18 FTE	2018-19 FTE	Annual Salary*	2017-18 Budgeted Salary	2018-19 Budgeted Salary
1120	051899	531213	Audit Manager	SPA Employees	7/1/17	nt System (TSERS)	SPA Employees	1.00	1.00	120,000	120,000	120,000
1120	051899	531213	Staff Auditor III	SPA Employees	7/1/17	nt System (TSERS)	SPA Employees	6.00	6.00	95,000	570,000	570,000
1120	051899	531213	Staff Auditor II	SPA Employees	7/1/17	nt System (TSERS)	SPA Employees	12.00	12.00	85,000	1,020,000	1,020,000
Total#								19.00	19.00	-	1,710,000	1,710,000

** Minimum level salary for the classification requested unless otherwise justified in the Narrative section above.

#Total FTEs equal the number of total FTEs shown on Line 14 of this request.



Beth A. Wood, CPA
State Auditor

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March 5, 2018

Joint Legislative Oversight Committee on Medicaid and NC Health Choice
North Carolina General Assembly
Raleigh, North Carolina

Dear Members:

The North Carolina Office of the State Auditor (NC OSA) has reviewed the North Carolina Department of Health and Human Services' (NC DHHS) Report to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice (Report). This report is in response to Session Law 2017-57, Section 11H.22(e).

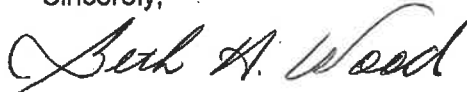
The NC OSA certifies approval of the plan as outlined in the Report, with the following exceptions:

- Section III of the report, under the heading "Current Reviews of Eligibility Determinations", states that, as part of the State's Single Audit, the NC OSA arranges with local CPA firms to review eligibility determinations. There are some inherent differences in the objectives between the work performed by NC OSA under the Single Audit engagement and the objectives of this Report:
 - The NC OSA is required, under Title 2 *U.S. Code of Federal Regulations (CFR) Part 200, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance), to obtain sufficient appropriate audit evidence in the audit of Medicaid as it relates to eligibility. Currently, the Uniform Guidance does not require evidence to be obtained for eligibility determinations made using MAGI (Modified Adjusted Gross Income) methodology, which makes up the majority of the Medicaid population. It is currently unclear when, or if, the Uniform Guidance will require the NC OSA to include the MAGI beneficiaries in the population. However, if the requirements change, beneficiaries whose eligibility is determined under both MAGI and non-MAGI methodologies will be included in the scope of our audit.
 - The NC OSA population does not include NC Health Choice beneficiaries.
 - The NC OSA population only includes the eligibility determinations for those beneficiaries for which a payment was made during the audit period (only those found eligible by the case worker) and does not include applicant's whose benefits were denied when they should have been approved.
 - The NC OSA is required by auditing standards to remain independent to the NC DHHS. As such, any work performed by the NC OSA cannot be viewed as a part of the internal controls or any form of management oversight by the NC DHHS. While our annual State Single Audit provides additional information regarding eligibility determinations, it does not relieve NC DHHS management of their oversight responsibilities.

- Section IV of the report, under the heading "Audit Schedule and Methodology", specifies a sample size of 100 applications and 100 re-certifications for each county reviewed. The NC OSA has not had ample time to review the criteria used to arrive at this sample size as provided by NC DHHS. Therefore, at this time NC OSA cannot certify this to be sufficient evidence to confirm that eligibility determinations are being performed accurately.
- Section IV of the report, under the heading "Monitoring and Training Resources Needed", outlines training that will be implemented to improve accuracy in the eligibility determinations for Medicaid and NC Health Choice. In order for the NC OSA to fully approve the plan, this section must include the immediate development and delivery of comprehensive training related to the current eligibility determination system, NC FAST. A hands-on training component should be considered.

The NC OSA appreciates the opportunity to provide input on matters important to the citizens of North Carolina.

Sincerely,

A handwritten signature in cursive script that reads "Beth A. Wood".

Beth A. Wood, CPA
State Auditor

Appendix E Cost Projections for Internal Staffing of Eligibility Audit Requirements

County Operations Quality Assurance Team Expansion

Budget for Request (G.S. 143C-3-3)

Detail of budget is to be provided at the NCAS Agency Management Report detail level.

Requirements

Fund Code	Cost Center	Account Number	Account Title	Actual		Authorized		2019-20	2020-21	2021-22	2022-23	
				2016-17	2017-18	2018-19	2019-20					
1101		531113	EPA-Reg Salaries	\$	\$	258,252	\$	258,252	\$	258,252	\$	258,252
1101		531513	Social Security Contribution	-	-	19,756	-	19,756	-	19,756	-	19,756
1101		531523	Reg Retirement Contribution	-	-	47,622	-	47,622	-	47,622	-	47,622
1101		531563	Medical Insurance Contribution	-	-	24,416	-	24,416	-	24,416	-	24,416
1101		532714	Subsistence, lodging etc. (In-State)	-	-	30,090	-	30,090	-	30,090	-	30,090
1101		532840	Postage	-	-	1,000	-	1,000	-	1,000	-	1,000
1101		532930	Training and Registration Fees	-	-	20,000	-	20,000	-	20,000	-	20,000
1101		533110	General Office Supplies	-	-	6,500	-	6,500	-	6,500	-	6,500
1101		534534	PC/Printer Equipment (one time purchase)	-	-	7,500	-	7,500	-	7,500	-	7,500
			Requirements	-	-	415,136	-	407,636	-	407,636	-	407,636
			Number of FTE*	-	-	4.00	-	4.00	-	4.00	-	4.00

Receipts

Fund Code	Cost Center	Account Number	Account Title	2015-16		2016-17		2017-18		2018-19		2019-20		2020-21		2021-22		2022-23	
1101		53886C	DMA Admin & Training	-	-	-	-	207,568	-	203,818	-	203,818	-	203,818	-	203,818	-	203,818	-
			Total Receipts	-	-	-	-	207,568	-	203,818	-	203,818	-	203,818	-	203,818	-	203,818	-
			APPROPRIATION	-	-	-	-	207,568	-	203,818	-	203,818	-	203,818	-	203,818	-	203,818	-

Positions Requested

Detail of the positions included in this expansion request.

Fund Code	Cost Center	Account Number	Grade	Classification	Effective Date	Retirement Program	Other Information	2018-19		2019-20		2018-19		2019-20				
								FTE	Salary**	FTE	Salary**	Budgeted FTE	Budgeted Salary	Budgeted FTE	Budgeted Salary			
1101		531113		Income Quality Assurance Analyst	7/1/18	System (TSERS)	EPA Employees	4.00	-	4.00	-	51,000	204,000	51,000	204,000			
1101		531113		Salary adj. for existing staff	7/1/18	nt System (TSERS)	EPA Employees	-	-	-	-	3,243	3,243	3,243	3,243			
1101		531113		Salary adj. for existing staff	7/1/18	nt System (TSERS)	EPA Employees	-	-	-	-	5,079	5,079	5,079	5,079			
1101		531113		Salary adj. for existing staff	7/1/18	nt System (TSERS)	EPA Employees	-	-	-	-	5,330	5,330	5,330	5,330			
1101		531113		Salary adj. for existing staff	7/1/18	nt System (TSERS)	EPA Employees	-	-	-	-	9,799	9,799	9,799	9,799			
1101		531113		Salary adj. for existing staff	7/1/18	nt System (TSERS)	EPA Employees	-	-	-	-	4,960	4,960	4,960	4,960			
1101		531113		Salary adj. for existing staff	7/1/18	nt System (TSERS)	EPA Employees	-	-	-	-	3,852	3,852	3,852	3,852			
1101		531113		Salary adj. for existing staff	7/1/18	nt System (TSERS)	EPA Employees	-	-	-	-	7,282	7,282	7,282	7,282			
1101		531113		Salary adj. for existing staff	7/1/18	nt System (TSERS)	EPA Employees	-	-	-	-	7,845	7,845	7,845	7,845			
1101		531113		Salary adj. for existing staff	7/1/18	nt System (TSERS)	EPA Employees	-	-	-	-	6,862	6,862	6,862	6,862			
				Total#				4.00	-	4.00	-	-	258,252	-	258,252	-	258,252	-

** Minimum level salary for the classification requested unless otherwise justified in the Narrative section above.

#Total FTEs equal the number of total FTEs shown on Line 14 of this request.