**NC Department of Health and Human Services**

# Accuracy Improvement Plan (AIP)

## *Recipient Eligibility Determination Audit (REDA)*

**Round 2, Cycle 1 Counties – CY 2022**

**Office of Compliance and Program Integrity**

**May 23, 2023**

# Today's Talking Points

- **REDA Round 2 – Cycle 1 Standings**
- **Initial Joint AIP Partnership Meeting**
- **AIP Development & Approval**
- **AIP Implementation, Immersion, & Monitoring**
- **Auditing of Cases & Case Correction Process**
- **Successful Closeout or Extension of AIP**
- **AIP Timeline**
- **AIP Round 1 Lessons Learned**
- **Importance of Internal Control Activities to Mitigate Risk**
- **Next Steps**

# REDA Round 2 Cycle 1 Standings
# 29 Counties CY 2022



31%

69%

- Met Accuracy Standards
- Did not meet accuracy standards

**https://medicaid.ncdhhs.gov/reports/transformation-reports/legislative-reports**
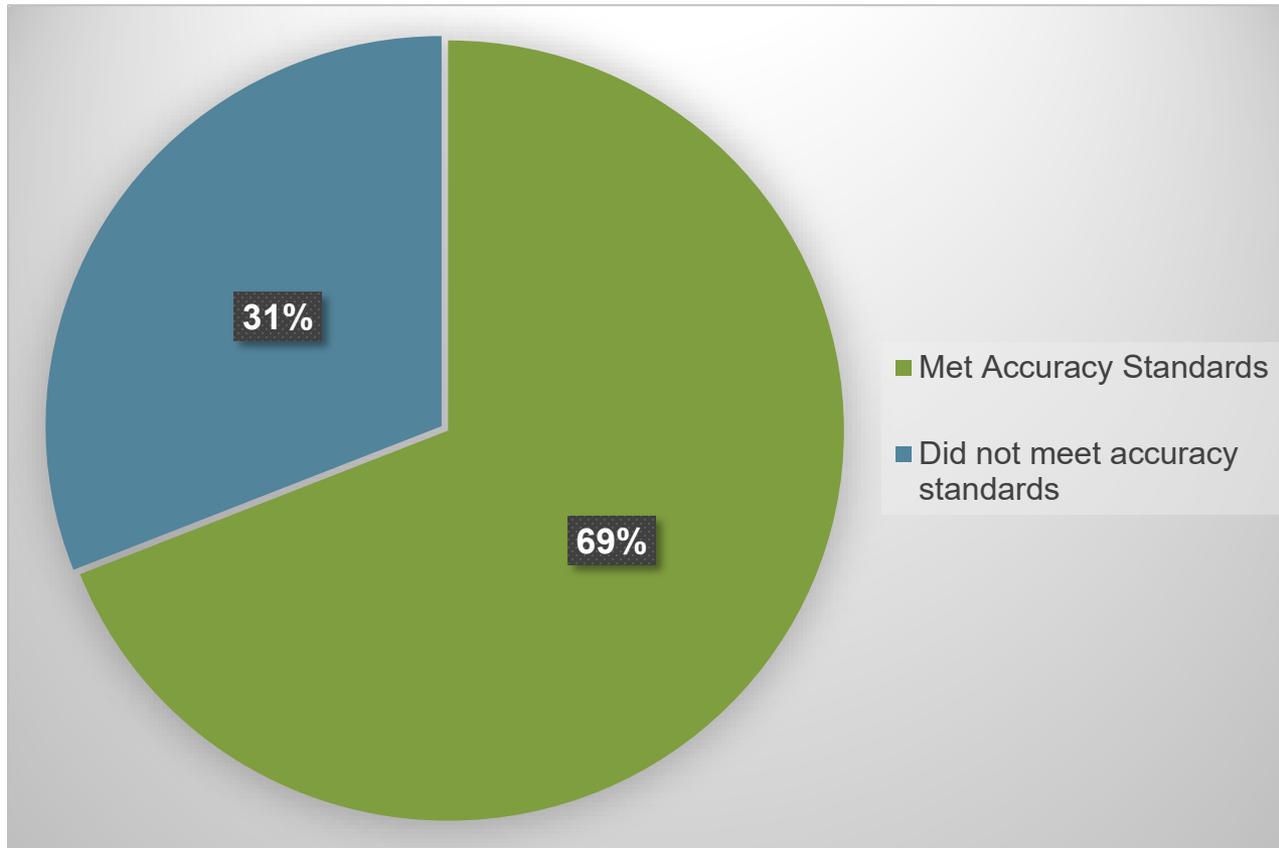
# Initial Joint Partnership Meeting

## Required

- County DSS Director (or Designee)
- County DSS Medicaid Leadership
- Office of Compliance and Program Integrity (OCPI) AIP Lead and Representative
- Operational Support Team (OST) Representative

## Optional

- County Manager
- County Commissioner Chair (or Designee)
- County DSS Board Chair (or Designee)
- Any others determined by DSS Director

# Individual Joint Partnership Meeting
## Roles & Responsibilities

## OCPI

- Schedule and facilitate meeting
- Brief presentation on REDA audit and County's individual results
- Key reminders
- Collaboration on AIP/Plan-Do-Check-Act (PDCA) Template completion

## County

- Present an overview of the County's current corrective action measures implemented and results
- Collaboration on AIP/PDCA Template completion

## OST

- Case correction process
- Serve as Subject Matter Expert (SME) for Medicaid Policy questions

# QUESTIONS?

# Stages of the AIP Process

# AIP Development

## County DSS Liaison & AIP Representative Consultations

- Assess the risk areas identified in the REDA audit
- Review measures implemented or what will be implemented
- Review progress and continued challenges
- Implement/revise measures for <u>SUSTAINABLE</u> results in meeting the federally required accuracy rate of 96.8%

**WHO?**

**WHAT?**

**HOW?**

**WHEN?**

# Approval of AIP

## County's AIP/PDCA Template MUST Clearly Incorporate:

- County's identified errors & control activities to mitigate the <u>root cause</u> of the errors

- Responsible staff & their role in the process

- Dates when new controls were/will be implemented

- Timeframes to reassess the new controls & progress

- Internal monitoring plan (2nd party review) & tools

- PDCA will be used to document the County's actions and progress
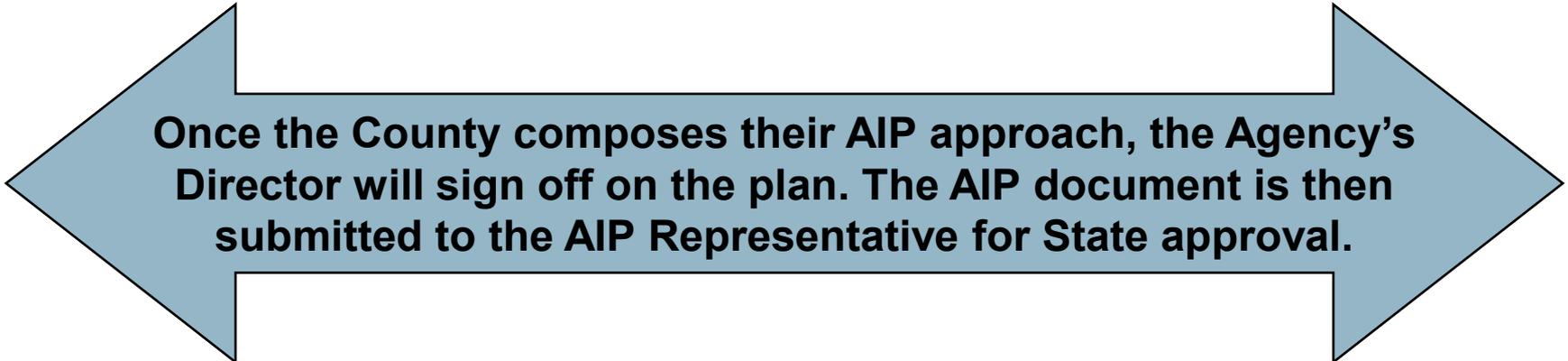
**Once the County composes their AIP approach, the Agency's Director will sign off on the plan. The AIP document is then submitted to the AIP Representative for State approval.**

## Joint State/Local Agency Accuracy Improvement Plan
### Example County Department of Social Services
**Date AIP Developed between County DSS and State's AIP Representative:** 06/05/2023

**REQUIREMENT:** Accurate processing of Medicaid applications/redeterminations to meet the State standards.

### ACCURACY STANDARDS

- Only eligible applicants are approved for Medicaid benefits 96.8% of the time.
- Eligible applicants are not denied/terminated 96.8% of the time.

Note: The eligibility determination process is free of technical errors that do not change the outcome of the eligibility determination 90% of the time.

| STATE POINT OF CONTACT | COUNTY POINT OF CONTACT |
|---|---|
| **Name:** | **Name:** |
| Autumn Johnson | Mary Smith, Director |
| **E-mail address:** | **E-mail address:** |
| autumn.m.johnson@dhhs.nc.gov | mary.smith@county.nc.gov |
| **Phone number:** | **Phone number:** |
| 336-467-0515 | 336-222-2222 |

| County Metrics | County Self-Assessment and/or Audit Findings |
|---|---|
| *[List programs and months out of compliance and associated accuracy metrics]* | *[Brief summary of county self-assessment and/or audit findings listing reasons for failure to meet accuracy standards]* |
| **Approval Actions =** 98 % <br><br> **Denial/Termination Actions =** 94 % <br><br> **Technical Errors =** 92 % | REDA audit identified the County failed to meet the accuracy rate in the negative action standard. Errors identified during the REDA audit have also been identified in the County's internal quality control. The County misinterpreted policy. Therefore, caseworkers applied policy incorrectly. The error trend and data analysis report were reviewed and considered when developing corrective action plan. |

### Initiatives Currently Underway Prior to AIP

*[Initiatives/improvements currently underway to address accuracy issues; steps already taken in months prior to implementing AIP]*

○ Lead Workers, since July 2018, conduct 2nd party reviews utilizing the DMA-7078 State 2nd Party Audit Tool. Lead Workers review a combination of Active and Denied/Terminated cases of 10 cases per worker per month.

○ Based on analysis of error trends conducted each month, Lead Workers and Supervisors assess the need for refresher training. Based on the analysis, individual worker retention, coaching conducted and/or group training is performed monthly. Coaching memos are given and signed off by supervisor and caseworker. Training agendas and sign-in sheets are available for monthly training.

○ Based on analysis of job performance and staff input, SOPs are evaluated amongst Medicaid leadership at least quarterly or sooner if risk appears. Leadership meeting minutes are available.

## ACTION PLAN

**KEY GOAL**: Meet or exceed the 96.8% eligibility accuracy standard.

### Strategies & Actions for Improvement

*[Control Activities to be implemented to mitigate risk]*

**Strategy/Action:** In a collaborative effort, the State and County DSS will utilize the Plan-Do-Check-Act (PDCA) Template to document Control Activities, to be implemented by the County, from development through implementation through reassessment. Refer to the County's PDCA Template as Addendum 1 to this AIP Template. Tracking, review, reassessment, and potential revisions will be noted on the County's PDCA Template. The PDCA Template will become the County's working document to address the risks within the DSS agency and steps enacted to mitigate the risks during the AIP process.

**Summary of Strategies/Actions:**

1. Failure to Evaluate All Medicaid Programs – Supervisor/QA Staff to review dispositions for required spin-off applications.

2. Failure to Request Required Information on 2 DHB-5097s prior to Denial Disposition – Supervisor/QA Staff to review denial actions for appropriate requests for information.

**Date of AIP Review/Acceptance:**   06/06/2023

**Reviewed By:**   *Renee Jones*

## Internal Control Implementation
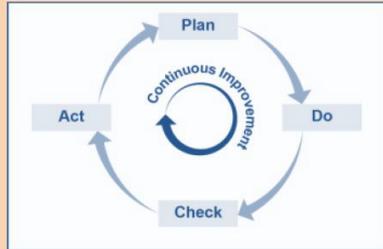


## PLAN

**Create/Develop Control Activities based on
Root Cause Analyses driven from data.**

| Error Trend(s) to Eliminate | Date Error Identified | Internal Control Activities to Implement |
|---|---|---|
| TREND 1: As identified through the REDA audit, failure to evaluate all Medicaid programs in F&C and Adult Medicaid units. | 1: 03/27/2023 | 1: Supervisors/QA staff to evaluate all applications for all Medicaid programs prior to disposition. Adult Medicaid unit will spin off adult applications to F&C for evaluation of all F&C programs when applications come into agency. F&C will spin off applications to adult when the a/b alleges disability or OVS/online data indicates a/b is disabled/aged. |
| TREND 2: As identified through the REDA audit, failure to request information on 2 DHB-5097s prior to denial disposition in F&C and Adult Medicaid units. | 2: 03/27/2023 | 2: Supervisors/QA staff will review denials on Mon, Wed, and Fridays for each unit (F&C and Adult) to verify that 2 DHB-5097s were sent to a/b prior to disposition. The 3 days of denials will encompass all caseworkers. The DHB-7078 form will be utilized for the 2nd party review. |

AIP/PDCA Template

# DO

## Implement/Introduce Control Activities by documenting a Standard Operating Procedure (SOP).

| Effective Date of Internal Control Activities | Internal Control Procedure (describe in detail – step by step) | Immersion Period (effective date through reassessment date) |
|---|---|---|
| 07/01/2023 | Trend 1 from PLAN section: Failure to evaluate all Medicaid programs prior to disposition. <br><br> 1. Review every application for spin off to other agency program. (Family to Adult and Adult to Family). Agency to keep an excel spreadsheet which will house spin off IAA/ISA for caseworkers to reference. <br> 2. Supervisors to Ensure that spin off application has been keyed into NCFAST and document the IAA/ISA on excel spreadsheet. <br> 3. Caseworker to reference excel spreadsheet and obtain spin off IAA/ISA to incorporate in narrative documentation at disposition. <br> 4. Caseworker to utilize agency checklist to ensure that all programs have been evaluated for prior to disposition and scan checklist into NCFAST at disposition. | 07/01/2023 - 07/31/2023 |
| 07/01/2023 | Trend 2 from PLAN section: Failure to request information on 2 DHB-5097s prior to denial disposition. <br><br> 1. Caseworker to utilize application checklist at each application. Caseworker to complete checklist and upload to NCFAST at disposition. <br> 2. QA/Supervisor to Review denied applications on Mon, Wed and Friday for F&C and Adult Medicaid to ensure 2 DHB-5097s are in the file and information was requested from caseworker prior to disposition. <br> 3. Utilize the DHB-7078 to review each record. | 07/01/2023 - 07/31/2023 |

## CHECK
### Monitor Control Activities to determine effectiveness.

| Key Staff Monitoring Internal Control Activities | Date Monitoring Begins | Monitoring Methodology (describe in detail – step by step) |
|---|---|---|
| QA Staff<br><br>Supervisors | 08/01/2023 | 1. QA to check denial cases on Mondays, Wednesdays, and Fridays weekly to ensure all denials are appropriate for each application specifically looking to ensure all programs are evaluated for and 2 DHB-5097s have been issued to a/b prior to disposition.<br><br>2. QA to check Excel spreadsheet which is to be kept by Supervisor to ensure that spin off applications have been keyed as needed in other units.<br><br>3. QA to check that Caseworkers have checked excel spreadsheets and obtained the IAA/ISA which will be incorporated into narrative at disposition.<br><br>4. QA to check that Caseworkers have utilized the application checklist and it is uploaded in NCFAST.<br><br>5. QA to check time standard application worksheet issued by DHB to ensure days are calculated correctly for each denial application.<br><br>6. QA to notify Supervisor and caseworker by email with the results of the 2nd party review. If errors identified, caseworker has 2 business days to initiate corrections. Once caseworker has completed the case corrections, they are to notify Supervisor and QA by email those corrections are complete. QA to re-review to ensure completed correctly.<br><br>7. QA to utilize excel spreadsheet to ensure case corrections are completed timely.<br><br>8. If changes are made to this monitoring plan, track date and actions of new implementations. |

**AIP/PDCA Template**

## ACT

### Reassess to determine if the Control Activities are meeting the objective.

County Instructions: Reassessment to be conducted by the County DSS at the end of the 30-day immersion period. Modifications to be determined and discussed during joint OCPI and County DSS meetings at each Audit Month Reassessment. Future modifications to be documented on the PDCA Review chart.)

| County's Results of Initial Monitoring | Initial Modifications Needed? |
|---|---|
| TREND 1: QA is utilizing the DHB-7078 to perform 2nd party reviews. Training has been created for the Adult Medicaid and the Family & Children's Medicaid units for evaluation of all Medicaid programs utilizing the application checklist. QA checks to see that IAA/ISA of spin off application has been documented on excel spread sheet via supervisor and that caseworker has incorporated in narrative at disposition. | As of 08/30/2023, modifications are required to ensure New Hire Training includes utilization of checklists at application disposition and to ensure spin off applications are keyed/evaluated. New Hire Training Plan/SOP updated as of 08/21/2023. County will continue to monitor results through 09/30/2023. |
| TREND 2: Training conducted on 06/12/2023 for F&C and Adult Medicaid staff that 2 DHB-5097s must be sent to a/b prior to disposition requesting information. QA to check denial records on Mondays, Wednesdays, and Fridays of all caseworkers to ensure that each record has 2 DHB-5097s requests for information in file prior to disposition. Caseworker is to utilize application checklist and verify that 2 DHB-5097s have been sent. QA to utilize DHB-7078 to perform 2nd party reviews and verify that 2 DHB-5097s were in file prior to disposition and that application checklist was utilized and uploaded into NCFAST. | As of 08/30/2023, no modifications are needed currently. QA is finding that caseworkers are utilizing the application checklist and uploading into NCFAST to ensure 2 DHB-5097s have been sent to a/b prior to disposition. County will continue to monitor results through 09/30/2023. |

# AIP/PDCA Template

# PDCA Review

## Review and Progression of the County's PDCA Plan and Performance.

Instructions: PDCA to be reviewed and signed at initial development and at each monthly AIP/PDCA reassessment for measurement of the County's progress and effectiveness of Control Activities. PDCA modifications will be noted at each applicable Monthly Assessment, when required. Modifications should include implementation effective date of the stated modifications.

| Signature/Comments |
|---|

### INITIAL DEVELOPMENT/ACCEPTANCE OF PDCA APPROACH

County Signature: *Mary Smith, Director*

County Comments:

PDCA activities to be implemented by the stipulated immersion start date of 07/01/2023.

County Signature Date: 06/05/2023

OCPI Signature: *Autumn Johnson*

OCPI Comments:

County has developed and implemented control activities post-REDA to include training and checklist utilization. County is committed to continued improvement and will implement all documented activities by 07/01/2023. County will conduct internal monitoring effective 08/01/2023. OCPI/QA will commence AIP auditing effective 08/2023 for the 07/2023 Sample Month.

OCPI Signature Date: 06/05/2023

**AIP/PDCA Template**

## MONTH 1 REASSESSMENT
### *(County Monitoring Results & AIP Audit Findings)*

County Signature: *Mary Smith, Director*

County Comments:

During internal targeted reviews in 08/2023, County finds new hires were not utilizing the mandatory checklist to mitigate Error Trend 1. PDCA being amended to include updates to New Hire Training effective 08/21/2023 to ensure new hires utilize existing checklists to ensure spin-off applications keyed and evaluated, when appropriate. Training SOP updated. County monitoring finds no issues for Error Trend 2.

County Signature Date: 08/30/2023

OCPI Signature: *Autumn Johnson*

OCPI Comments:

In 08/2023, QA finds no Eligibility Errors in the first AIP audit Sample Month of 07/2023. QA notes PDCA/AIP plan amended to incorporate new hire training and mandatory requirement to utilize agency checklists. See ACT section of the PDCA Template for the County's initial monitoring assessment and plan modifications.

OCPI Signature Date: 08/30/2023

# AIP/PDCA Template

# Implementation, Immersion, & Monitoring

## Implementation

- County incorporates measures outlined in the AIP defined by the root cause analysis

## Immersion

- County immerses in the AIP's improvement measures to correct and prevent future errors

## Monitoring

- County reassesses the improvement measures, within the stated timeframes, to ensure the objectives are or will be met

**When the AIP appears to not be on track to meet the objectives, revisions to the plan should be <u>immediate</u> AND the AIP/PDCA template updated with appropriate modifications to the County's control activities.**

# QUESTIONS?

# AIP Case Auditing

# Case Auditing
## *Begins After AIP Immersion Period*

- ### *Similar* Procedures as REDA Audit

  - **DHB-7002AIP, DHB-7001AIP, DHB-7005AIP forms**

  - **Auditing of prior month's actions**

  - **Five Cases per month (Negative actions)**

  - **Three workdays to upload supporting documentation to NC FAST**

  - **Three workdays to concur or rebut error findings**

  - **Ten calendar days for case corrections**

  - **Medicaid Overpayments are applicable during the AIP but will not impact Cycle 1 AIP Counties since auditing for negative actions only**

  - **Complete Eligibility Review of the County's negative action**

# Successful Completion or Extension of AIP

## Completion of AIP

- County meets the 96.8% accuracy rate(s) for THREE consecutive months

- County able to sustain the accuracy rates without a State monitored AIP (not including 100% QA check)

## Extension of AIP

- County does not meet the 96.8% accuracy rate(s) for THREE consecutive months

- AIP will continue until the 96.8% accuracy rate is achieved for THREE consecutive months

**Let's look at some examples**

# Completion Example

## Completion of AIP

- **County meets the 96.8% negative accuracy rate for the Sample Months of July 2023, August 2023, and September 2023.**

- **It appears the County will sustain the accuracy rates with the measures implemented and with frequent reassessment of their control activities and continued internal monitoring.**

- **The County's AIP is considered successfully completed and an official letter of completion is issued to the County DSS Director closing out the County's Accuracy Improvement Plan.**

# Extension Example

## Extension of AIP

- **County meets the 96.8% negative accuracy rate in the July 2023 Sample Month.**

- **County fails to meet the 96.8% negative accuracy rate in the August 2023 Sample Month.**

- **The County's AIP will continue with the September 2023 Sample Month being the first month of the next possible three consecutive months.**

# AIP Timeline

## REDA Round 2

## Cycle 1 Counties

# AIP Timeline

| Counties |
|:---:|
| Granville |
| Guilford |
| Henderson |
| Hertford |
| Jackson |
| Madison |
| Martin |
| Randolph |
| Warren |

| TIMELINE | |
|:---:|:---|
| May 2023 | Joint AIP Presentation |
| June 2023 (1st week) | Individual County DSS Meetings with your AIP Representative |
| June 2023 | Complete AIP/PDCA Template for Error Trends & initiate control activities |
| July 2023 | 30-day Immersion Period for PDCA control activities |
| August 2023 | Initiate AIP auditing for 07/23 actions |

# REDA AIP Round 1 Lessons Learned

# REDA AIP Round 1
# Lessons Learned

- **Revised AIP Template to incorporate the PDCA Template for more effective risk mitigation**

- **Input from all levels of Medicaid staff**

- **Rely on the data – it's available**

- **Drill down to the root cause (isolate it!)**

- **Monitor best practices & internal controls**

- **Keep county administration in the "KNOW"**

- **Supervisors to manage staff, not be absorbed in casework**

- **100% quality check will NOT sustain results**

- **Be SMART! (Specific, Measurable, Actionable, Realistic, and Timebound)**

- **Need help?  ASK!**

# QUESTIONS?

# The Importance of INTERNAL CONTROL ACTIVITIES to Mitigate Risk

# Detection of Risk

| Internal 2nd Party Review |
|---|
| Performed Monthly |
| Conducted by Lead Workers |
| Results Provided to Supervisor and Caseworker |



2ND PARTY REVIEW WORKSHEET
(Revised 05/17/2021)

| SFY 2022 Q4 | Medicaid and CHIP | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| COUNTY REPORT | Total Cases | | Error Rate | Eligibility Cases in Error | | | | | | Negative Cases in Error | | | |
| April, May & June 2022 | # of Cases Read | # Cases in Error | | Not Eligible | Undetermined Eligible | Liab Overstated (PML) | Liab Understated (PML) | Incorrect Deductible | TPL | Improper Denial | Improper Term | Incorrect W/D | |
| County | 175 | 5 | 2.9% | 3 | 0 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | |
| | Done | Done | | Done | Done | Done | Done | Done | Done | Done | Done | Done | |

## Eligibility Errors 4th Qtr 2022

| IMC | Supervisor | Program | Action | Trend |
|---|---|---|---|---|
| Tia J. | Vivian H. | PLA | Denial | Wages not verified/captured |
| Maria L. | Vivian H. | PLA | Approval | Pension not verified/captured |
| Jose H. | Vivian H. | PLA | Approval | VA benefits not entered |
| Lisa M. | Vivian H. | PLA | Approval | Pension not entered |
| Lisa M. | Vivian H. | PLA | Approval | Insurance premium not verified/captured |

MEQC

REDA AUDIT

PERM

COUNTY SINGLE AUDIT

STATEWIDE SINGLE AUDIT

An audit finding is a road map to a fix!

Risk Identified via Root Cause Analysis (RCA)

Control Activity Developed & Implemented

Control Activity Monitored & Reassessed, if required

FIX: Success!

Audit Finding

# Contributing Factors and Root Cause

| Contributing Factors |
| --- |
| > One Year of Experience |
| New Supervisor |
| SOP Not Present |

| Root Cause |
| --- |
| New Hire Training |

**To determine if the team has truly found the root cause, ask these questions**:

- Would the event have occurred if this cause had not been present?
- Will the problem recur if this cause is corrected or eliminated?

If "**No**" is the answer to both questions, then the team has identified the root cause. If the answer is "**Yes**" to either question, the team needs to do some further analysis.

# What Is Root Cause Analysis (RCA)?

Root Cause Analysis (RCA) is a useful popular tool that helps determine the basic, underlying cause of a problem through a series of specific steps. A factor is considered a root cause if its removal from the problem-fault-sequence prevents the final undesirable event from recurring.

When Should Root Cause Analysis be Performed?
• When human errors occur during a workflow process
• When performance is below standard
• When equipment failures or adverse events occur during certain work processes

*The successful application of the determination of the root cause should ultimately result in the elimination of the problem.*

## Steps of RCA

**Step 1:** Identify the Problem

**Step 2:** Select Team

**Step 3:** Collect Data

**Step 4:** Identify Possible Factors

**Step 5:** Identify Root Cause(s)

**Step 6:** Define and Implement an Action Plan

**Step 7:** Monitor and Assess Results

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# Root Cause Analysis

## 5 Whys → Example

*We start by indicating the problem:*

- **MAGI Income Error**

  o Ask "why" until we drill down to the root of the error

  o As you can see in the example, taking a shortcut outside of NC FAST led to our MAGI Income Error

  o Now that we know the Root Cause & Contributing Causes, Internal Controls can be developed & implemented to eliminate the risk from recurring

**MAGI Income Error**

**WHY?**

Incorrect Earned Income computation in NCFAST

**WHY?**

Caseworker manually converted income outside of NCFAST

Caseworker did not include all applicable pay periods in manual computation

Caseworker did not use Income Wizard when inputting Earned Income

**WHY?**

Income Section of Policy not referenced

Staff Training is needed for Income Policy & Income Wizard Job Aid

**WHY?**

**ROOT CAUSE**

Caseworker took a shortcut when inputting income evidence & did not allow NCFAST to compute income

Contributing Root Cause:
- Policy
- Staff Training
- Monitoring

# Correction to Risk

| Provide Retention/Training |
|---|
| NCF Learning Gateway – ABD Income Computation |
| Lead Workers Prepare and Provide Refresher Training |
| Trainers Begin to Revise Income Section of New Hire Training |

**Prioritize the Risk for Correction:**
- Provide an immediate resource for correction
- Reinforce the resource provided
- Include all compliance professionals for long term results

Remember the goal is to mitigate the risk on the front end.  In this case, provide more effective new hire training with income and budgeting in the ABD programs.

# Prevention of Recurring Risk

| Implement Internal Control Activities |
|:---:|
| Budget Worksheet Required of PLA Staff |
| Lead Worker Provides Operational Support |
| SOP is present, clear, and concise |

**Properly Introduce and Implement Internal Control Activity** :
- Create written SOP
- Explain Internal Control Activity to staff (encourage questions/suggestions)
- Emphasize the REQUIREMENT
- Reinforce the REQUIREMENT with internal monitoring
- Reassess to ensure the control is effective

# Next Steps

## Joint AIP Partnership Meeting

- **Counties to receive REDA AIP County Contact/Info form**
- **Counties to return County Contact/Info form by end May 2023**

## Monthly Meetings with County DSS & AIP Representative

- **At conclusion of Initial Joint Partnership Meeting**
- **Implementation, Immersion, & Monitoring of AIP**
- **Auditing Commences August 2023**
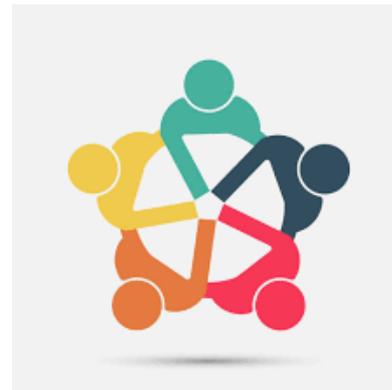
# QUESTIONS?

# Contacts

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