NC Department of Health and Human Services

NC Medicaid

Recipient Eligibility Determination Audit (REDA) – Round 2, Cycle 2

Office of Compliance and Program Integrity

March 2023

Vision

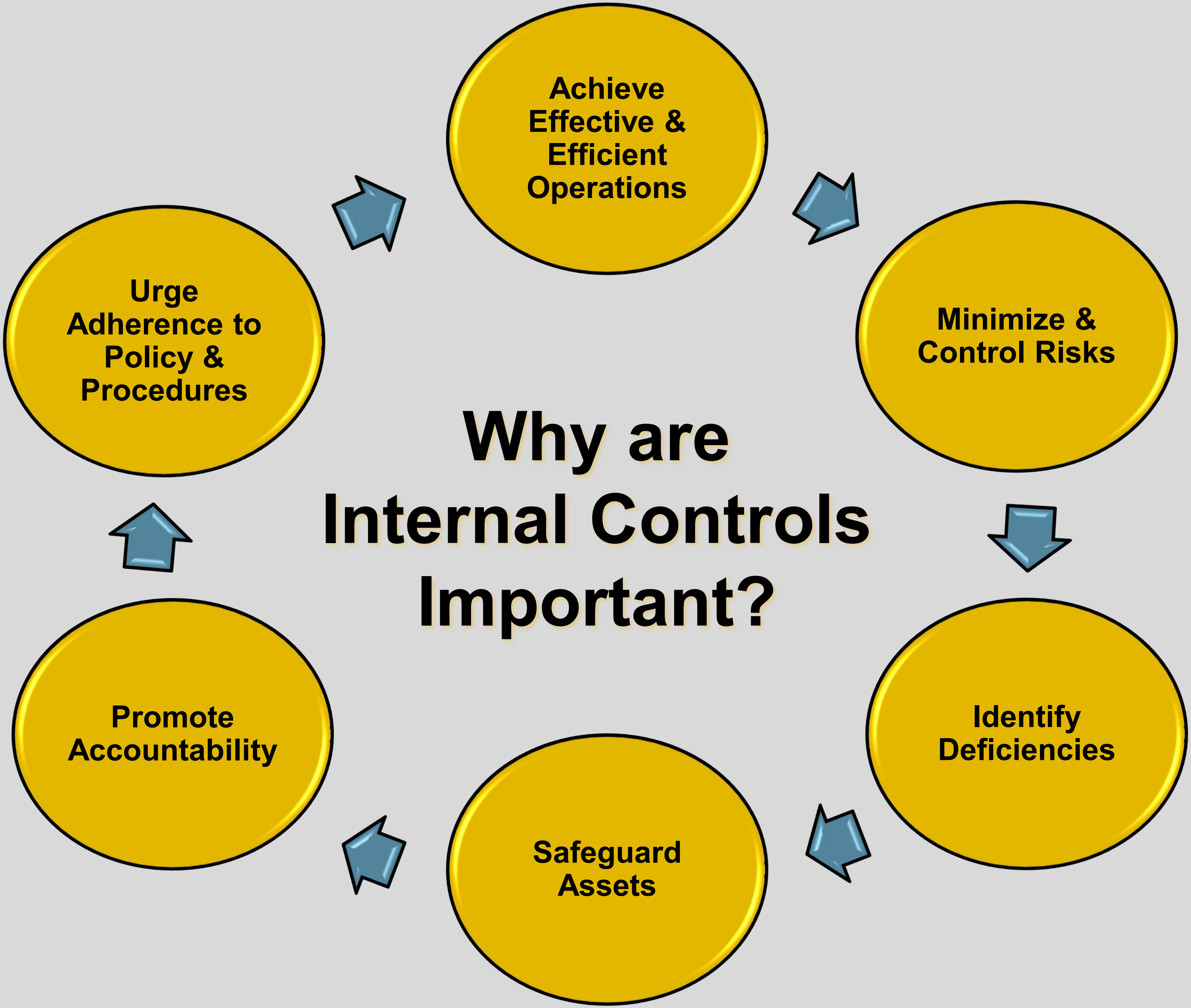
- Ensure benefits are provided only to those individuals eligible for Medicaid and NC Health Choice benefits
- Identify and eliminate ineligible individuals from receiving Medicaid and NC Health Choice benefits

Recipient
Eligibility
Determination
Audit

- Round 1 to Round 2 & the IC Process
- Round 2 Updated Approach
- Medicaid Accuracy Standards
- Accuracy Rate Approach
- Strategic Plan Development
- County Audit Process
- County Cycle Assignment
- Audit Prep & Findings Process
- Corrections Process
- Reporting Process
- Recoupment Methodology
- Joint Accuracy Improvement Plan
- Responsibilities & Review Process

REDA – Round 1 to Round 2

- Under Round 1, all 100 counties audited for CY 2019 through CY 2021
- Accuracy Improvement Plan (AIP) enacted for Cycle 1 and Cycle 2 counties who did not meet eligibility accuracy standards
- Accuracy Improvement Plan (AIP) underway for Cycle 3 counties who did not meet eligibility accuracy standards
- Round 2 commenced May 2022 to measure the counties' continued performance when determining Medicaid/NCHC eligibility


Why are Internal Controls Important?
Achieve Effective & Efficient Operations
Minimize & Control Risks
Identify Deficiencies
Safeguard Assets
Promote Accountability
Urge Adherence to Policy & Procedures

Internal Control Activity

Checklist:

(Active Action)

Evaluation for All Programs

Active Action: Evaluation/Documentation Checklist Application Approvals ~ Recertifications			
Instructions: Complete **Section A.** prior to each approval disposition (application approval, recertification) to ensure the a/b is evaluated for all programs and authorized for the greatest eligible program/benefit.			
A/B NAME			**CNDS ID**
GENDER	Male	Female	**DATE OF BIRTH**
What is the a/b's citizenship status - U.S. citizen, qualified alien, undocumented? *(potential for full Medicaid or emergency only)*			
A. Evaluation for all Programs			
LEADS TO POTENTIAL ELIGIBILITY:	**Y**	**N**	**EVALUATION NOTES/DETAILS** *If **Y** indicated, a statement regarding the evaluation RESULT must be noted in this column.*
Is the a/b a caretaker of a minor child under age 18? *(potential MAF)*			
Did the a/b receive MAF/C at least 3 of the preceding 6 months but now ineligible due to new/increased income? *(potential Transitional)*			
Is the a/b age 19 or 20? *(potential MAF/N)*			
Is the a/b age 18 or under? *(potential MAF/MIC)*			
Is the a/b pregnant? *(potential MPW)*			
Is the a/b disabled (or does the a/b allege disability)? *(potential MAD/HCWD & Franklin v. Kinsley considerations)*			
Is the a/b age 65 or older (or will turn age 65 during application processing period)? *(potential MAA)*			
Is the a/b former SSI/SA recipient who lost SSI/SA due to RSDI? *(potential Passalong eligible)*			
Is there an indication of need for LTC, SA, or CAP? *(potential for additional services)*			
Does the a/b have Medicare? *(potential MQB)*			
Is there an indication of medical need for evaluation under medically needy coverage groups (old, current, anticipated medical expenses)? *(potential MAF/M, MAABD/M)*			
Does the a/b meet FPP (MAF/D) eligibility requirements (not pregnant, countable income at or below 195% FPL, non-financial criteria)? *(Note: A/B cannot opt out of FPP; FPP is a Medicaid program and if a/b is eligible, they must be authorized.)*			
Does a/b meet eligibility requirements for MCV (U.S. citizen or qualified alien, NC resident, uninsured)? *(Note: If insured status is unknown, additional follow-up is required.)*			
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Internal Control Activity

Checklist:

(Negative Action)

Evaluation for All Programs & Denials for Failure to Provide Information

Negative Action: Evaluation/Documentation Checklist
Denial ~ Termination ~ Reduction in Benefits

Instructions:
A. Complete **Section A.** prior to each negative disposition (denial, termination, reduction) to ensure a/b is evaluated for all programs.
B. Also, complete **Section B.** prior to the negative disposition for Denial for Failure to Provide Information to ensure policy is followed.
(If an application, remember to evaluate for RETRO and/or ONGOING based on the a/b's needs.)

A/B NAME			CNDS ID
GENDER	Male	Female	DATE OF BIRTH
What is the a/b's citizenship status - U.S. citizen, qualified alien, undocumented? *(potential for full Medicaid or emergency only)*			

A. Evaluation for all Programs

LEADS TO POTENTIAL ELIGIBILITY PRIOR TO DENIAL, TERMINATION, OR REDUCTION IN BENEFITS:	Y	N	EVALUATION NOTES/DETAILS *If **Y** indicated, a statement regarding the evaluation RESULT must be noted in this column.*
Is the a/b a caretaker of a minor child under age 18? *(potential MAF)*			
Did the a/b receive MAF/C at least 3 of the preceding 6 months but now ineligible due to new/increased income? *(potential Transitional)*			
Is the a/b age 19 or 20? *(potential MAF/N)*			
Is the a/b age 18 or under? *(potential MAF/MIC)*			
Is the a/b pregnant? *(potential MPW)*			
Is the a/b disabled (or does the a/b allege disability)? *(potential MAD/HCWD & Franklin v. Kinsley considerations)*			
Is the a/b age 65 or older (or will turn age 65 during application processing period)? *(potential MAA)*			
Is the a/b former SSI/SA recipient who lost SSI/SA due to RSDI? *(potential Passalong eligible)*			
Is there an indication of need for LTC, SA, or CAP? *(potential for additional services)*			
Does the a/b have Medicare? *(potential MQB)*			
Is there an indication of medical need for evaluation under medically needy coverage groups (old, current, anticipated medical expenses)? *(potential MAF/M, MAABD/M)*			
Does the a/b meet FPP (MAF/D) eligibility requirements (not pregnant, countable income at or below 195% FPL, non-financial criteria)? *(Note: A/B cannot opt out of FPP; FPP is a Medicaid program and if a/b is eligible, they must be authorized.)*			
Does a/b meet eligibility requirements for MCV (U.S. citizen or qualified alien, NC resident, uninsured)? *(Note: If insured status is unknown, additional follow-up is required.)*			

B. Processing Checklist - Denial for Failure to Provide Information

LEADS FOR APPROPRIATE EVALUATION PRIOR TO DENIAL FOR FAILURE TO PROVIDE INFORMATION:	Y	N	EVALUATION NOTES/DETAILS
Was NCFAST checked to see if there are other agency records for the missing/required information? *(Answer "Y" for no other agency records and/or info that would not be in other agency records.)*			
Did the DHB-5097's request the same, required information twice (2x) and was the information necessary to determine eligibility?			
Were the two (2) DHB-5097's sent to the a/b (and their Authorized Representative, if applicable)?			
Were the DHB-5097's at least 12 days apart?			
Has the application pended the full 45 processing days (or 90 days if MAD)?			

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Internal Control Activity

Checklist:

Application Withdrawals

WITHDRAWAL TEMPLATE

Date/Time withdrawal requested: ______
Method of contact: ______
Person requesting withdrawal: ______

YES	NO	Withdrawal Procedures
Discussion of alternatives to withdrawal:		
		Open-shut for period of time eligibility can be established
		Reopening the app to protect original date of application
		Reapply for retro coverage to reduce deductible
Withdrawals via mail, ePass, or voice mail message:		
		One attempt made to contact individual by phone to discuss alternatives
		Contact successful
		Contact unsuccessful
		Attempt to contact has been documented in NCFAST
		Withdrawal discussion and results have been documented in NCFAST, if contact successful
Discussion with individual, prior to proceeding with withdrawal, included:		
		Individual who is aged (65 or older), blind, or disabled
		Individual who has Medicare
		Individual who has need for Long Term Care services, CAP, SA
		Individual who has minor children in the home (caretaker/relative)
		Individual who has unpaid medical bills
		Individual who is pregnant
		Individual who has need for 1-, 2-, or 3-months retro
		Family planning program discussed and coverages reviewed (FPP)
		COVID-19 testing coverage discussed (MCV)
		If individual needs assistance obtaining verifications, County can assist
		If excess reserve, individual has options to reduce/rebut reserve
		If excess income, individual can explore deductible
		All other programs and services discussed and offered including HIPP, Food and Nutrition Services, Work First, WIC, Transportation Services, Lifeline/Link-up, Estate Recovery, Medicaid Managed Care, and Voter Registration
		Also discussed Federally Facilitated Marketplace (FFM) and individual understands that by withdrawing application they would not be eligible for certain tax credits and subsidies provided by the FFM
Individual requests to proceed with Withdrawal Request:		
Detailed Reason for Withdrawal (documented in NCFAST):		
Additional explanations and responses (documented in NCFAST):		
		Individual understands that by withdrawing their application they still have the ability to reapply at anytime for any reason
		Application has been withdrawn per individual's request and the DHB-8109 generated and mailed along with NVRA cover letter and voter registration

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Internal Control Activity

Checklist:

Conducting Inquiries

INQUIRY TEMPLATE

Date and Time of Inquiry: ______________________

Individual's Name: ______________________

Authorized Rep's (AR) Name, if applicable: ______________________

YES	NO	Inquiry Procedures
Discussion at Inquiry:		
		Individual's right to apply explained
		Individual/AR advised they may apply again at any time
		Individual/AR understands they cannot receive benefits without submitting an application
DMA-5094 – Notice of Right to Apply for Benefits:		
		Individual/AR understands right to appeal if they believe they were discouraged from applying
		Individual/AR signed the DMA-5094
		Original DMA-5094 given to Individual/AR
		DMA-5094 uploaded to NCFAST
DMA-5095 - Inquiry Form:		
		DMA-5095 dated
		DMA-5095 captures individual/AR's name, address, and telephone number
		All relevant facts captured on the DHB-5095 *(No old, unpaid, or anticipated medical bills, nor anticipated medical expenses w/in $300 of potential deductible; Individual/AR declines opportunity to reduce resources, if applicable; Accurate calculation of reported income, resources, and deductible amount)*
		DMA-5095 indicates all programs discussed, the individual evaluated for, or the individual was referred, to include reference to the following *(Individual does not meet eligibility requirements for all Medicaid programs and has been referred to the FFM; Individual understands they must be eligible for Medicaid/NCHC to get tax credits and cost sharing; Medicare Low Income Subsidy (LIS) program information provided; If individual opts to return and apply for retro benefits only, all other eligibility factors must be met in the retro period; Retro benefit and application time frame were explained)*
		DMA-5095 contains documentation on why the individual decided not to apply
		Individual/AR signed the DMA-5095
		If individual refuses to give a reason for not applying and/or refuses to sign the DMA-5095, the refusal has been documented on the DMA-5095 and appeal rights explained
		Original DMA-5095 given to Individual/AR
		DMA-5095 uploaded to NCFAST

Reason Individual/AR decided not to apply:

County's documentation of Individual/AR's refusal to give reason not applying and/or refusal to sign DMA-5095:

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Round 2 Updated Approach

- Audit Actions may include any combination of the below:
  - Application Approvals
  - Recertification Approvals
  - Application Denials
  - Application Withdrawals
  - Case Terminations
  - Inquiries

Change from Round 1

Round 2 Updated Approach (Cont’d)

- **Sample Month for Audit Actions will be two-months prior to the Review Month**
  - **Allows the County adequate time to provide the agency Reception Log for inquiries completed in the sample month**
  - **Allows QA to initiate audit activities on the first workday of the review month and provide audit findings to the County in an expedited timeframe**
  - **Expedited notification of audit findings allows the County additional time to correct eligibility issues to address erroneous eligibility and/or overpayment potential, if identified**
  - **Allows for internal QA checks-and-balances to ensure audit accuracy and consistency across all counties**

Medicaid Accuracy Standards

- Eligible applicants are approved 96.8% of the time
- Eligible applicants are not denied, withdrawn or terminated 96.8% of the time
- The eligibility determination process is free of technical errors, that do not change the outcome of the eligibility determination, 90% of the time

Accuracy Rate Approach

- Number of cases cited in error divided by the number of cases reviewed (per accuracy standard)
- Monthly stats provided to allow county to conduct policy training for improvement over the annual audit reporting cycle
- Annual accuracy rate provided at the completion of the REDA audit

Strategic Plan Development

- **Enhanced audit workbook and reporting process**
- **OCPI/QA collaboration with all 100 Counties during REDA Round 1 for an improved, streamlined audit process**
- **OCPI/QA presentation at the Social Services Institute**
  - ➢ **August 2019: ‘Medicaid Eligibility Monitoring’**
  - ➢ **August 2022: ‘Working Beyond Limits to Mitigate Risks for Continuous Improvement’**
- **Continued Collaborations:**
  - ➢ **County DSS Director’s Association**
  - ➢ **Economics Program Committee**
  - ➢ **NC FAST (access, training and document management)**
  - ➢ **Operational Support Team**
  - ➢ **Eligibility Services**

QUESTIONS

County Audit Process

Sample Methodology under Round 2:

1. **Continue to pull an NC FAST monthly sample for accuracy rate computation**
2. **Conduct an audit of randomly selected actions taken 2-months prior to the review month**
3. **Include County-determined actions for application approvals, recertification approvals, application denials and withdrawals, case terminations, and inquiries**

County Audit Process – Cont'd

- **Inquiry Sample**
  - **For Counties using the NC FAST Reception Log, NC FAST will generate the monthly sample → No additional action needed**
  - **For Counties using an internal database for inquiry tracking, the County must provide an exported file of the Reception Log to include all inquiries taken each month**
    - **QA Staff will reach out to the County to obtain the exported log prior to initiation of audit activities for each Sample Month***
    - **OCPI/QA will generate a monthly sample of inquiries using the County's exported log**
  - **For Counties that use a manual Reception Log, the County must provide the manual log to include inquiries taken each month**
    - **QA Staff will reach out to the County to obtain the manual log prior to initiation of audit activities for each Sample Month***
    - **OCPI/QA will generate a monthly sample of inquiries using the County's manual log**

***NOTE: To prepare for QA requests for Reception Logs, please have your monthly Reception Logs available by the 10th Calendar Day of the next month**

County Audit Process – Cont'd

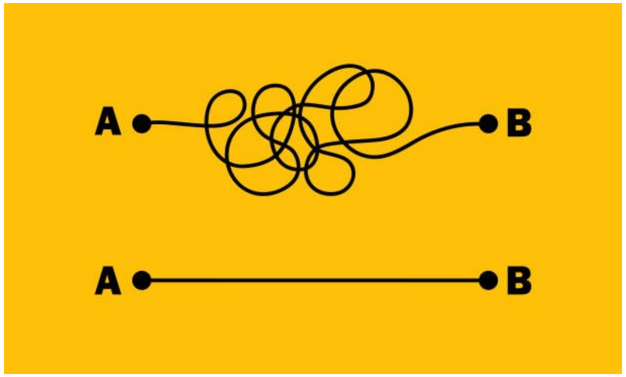
- **A list of cases will be provided to the County Liaisons, DSS Director and other identified staff, as directed by the County DSS**
- **Upon receiving the list of cases, Counties have 5 workdays to upload to NC FAST all verification and/or documentation used in the eligibility determination process**

IMPORTANT:

Counties must ensure ALL verification and/or documentation is uploaded to NC FAST within the initial 5-workday time period

County Audit Process – Cont’d

- Please help us help you by ensuring all documentation or verification that supports the County’s actions is available for review in NC FAST



- Counties should utilize the 5-workday upload period to ensure that ALL supporting documentation and verification has been uploaded
- Failure to upload ALL relevant documentation or verification could result in repeated interruptions or unnecessary errors
- Counties who properly utilize the 5-workday upload period will find the audit process less taxing with less interruptions

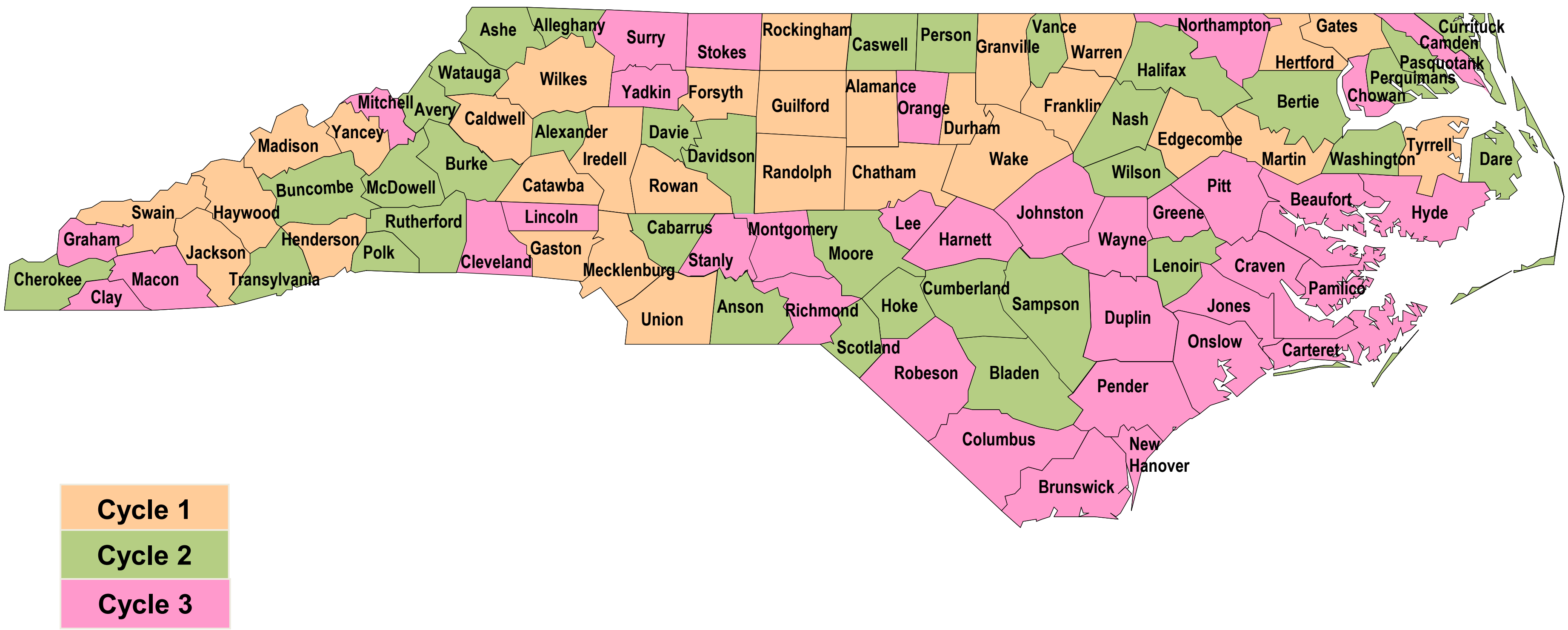
County Audit Process – Cont'd

- The County DSS should not take any <u>corrective action</u>, on cases selected for the audit, until the DHB-7002 is provided with audit findings

> **Per directive from Centers for Medicare & Medicaid Services (CMS), no corrective actions should be taken on cases selected for testing prior to case review**

- Reporting Process for Errors Cited
  - Counties will be given 5 workdays to refute error findings
  - State will make final decision on error findings cited
  - Counties will have 20 calendar days to provide verification of case correction

County Cycle Assignment



County Cycle Assignment
CY 2023

CYCLE 2				
Alexander	Alleghany	Anson	Ashe	Avery
Bertie	Bladen	Buncombe	Burke	Cabarrus
Caswell	Cherokee	Cumberland	Currituck	Dare
Davidson	Davie	Halifax	Hoke	Lenoir
McDowell	Moore	Nash	Pasquotank	Perquimans
Person	Polk	Rutherford	Sampson	Scotland
Transylvania	Vance	Washington	Watauga	Wilson

QUESTIONS

Auditors and Audit Preparation

- **Auditors**
  - **OCPI's Quality Assurance Analysts (QAA)**
  - **Auditors consisting of temporary staff who are retired and former employees of the State of NC and County DSS**
- **Audit activities will be conducted via review of documentation and verification within NC FAST**
- **Actions will be audited to ensure compliance with Medicaid/NCHC policy in effect at the action date under review including PHE, Continuous Coverage Unwinding (CCU), or other special provisions**

Auditors and Audit Preparation – Cont'd

Audit Tools

- Reporting documents provided to the County
  - DHB-7002 (Case Findings Report)
  - DHB-7001 (County Error Response)
  - DHB-7005 (Case Correction Verification)

Case Findings
Correct Case

- DHB-7002 Case Findings Report
  - Auditor sends DHB-7002 to County DSS, OCPI/QA Staff, and OST
  - No further action required on the case

Case Findings
Error Case

- **DHB-7002 Case Findings Report, DHB-7001 County Error Response, & DHB-7005 Case Correction Verification**
  - **Auditor sends DHB-7002, DHB-7001 & DHB-7005 to County DSS, OCPI/QA Staff, and OST**
  - **County DSS has 5 workdays to respond to the auditor with a concurrence or rebuttal using the DHB-7001**
- **<u>Note</u>: A statement has been added to the reporting documents advising Counties to reach out to your OST Representative should you need guidance or direction on how to properly correct errors cited**

Case Findings
Reporting Documents Reminders

- Reporting documents will be provided, through secure/ encrypted email, to County Staff as designated by the County DSS
  - The County should ensure all reporting documents are maintained for future reference
  - Once the DHB-7002 Case Findings Report has been provided by the auditor, the County should <u>immediately</u> initiate corrections for cases cited in error
  - The County should ensure case corrections are complete, adequate, and timely

Corrections Process

- **The County DSS should not take corrective action, on cases selected for the audit, until the DHB-7002 is provided with audit findings. Per CMS directive, no corrective actions should be taken on cases selected for testing prior to case review**
- **Upon notification of audit findings on the DHB-7002, the County should immediately initiate case corrections for error(s) cited**
    - **If a County is unsure of appropriate corrective actions, it is imperative that the County reach out to their OST Representative for guidance BEFORE initiating corrections and submitting the DHB-7005 Correction Verification form to QA**
    - **Improper corrective actions could get pulled into an audit and could result in additional audit errors and County-responsible overpayments as well**
- **If a case is cited with multiple errors and the County submits a rebuttal request for one error, the County should immediately initiate case corrections for any other error(s) cited on the case**

Corrections Process – Cont'd

- **Counties are allowed no more than 20 calendar days, from the date of the initial DHB-7002 Case Findings Report, to submit the DHB-7005 Case Correction Verification to the QA auditor**
  - **If corrections cannot be completed within the 20 calendar days, the County must document the corrective action they have initiated, along with the anticipated completion date, and submit the DHB-7005 to the QA auditor <u>on or before</u> the 20-calendar day deadline**
  - **Do not delay submission of the DHB-7005 as corrections will be reviewed and feedback provided if corrections do not appear adequate, per policy**
  - **Delays can also result in continued erroneous benefits and/or additional County-responsible overpayments**
- **Improper corrective actions, or delays in completing adequate and timely case corrections, not only potentially impact County-responsible overpayments but may impact the potential for error adjustments on the back-end of the audit**

Reporting Process

- Auditor will provide a monthly Summary of the County's accuracy rates
- Auditor will conduct a monthly consultation call to discuss the County's performance
  - Counties may opt to attend consultation calls on a quarterly basis; Monthly consultations are recommended
  - Counties are encouraged to actively participate in monthly consultation meetings as well as analyze audit finding data provided by their QA Auditor
  - Counties are also encouraged to take immediate action to implement internal control activities, continue to use internal controls developed during the AIP process, reassess current improvement initiatives, and make any adjustments to their Internal Control Processes to mitigate risk, reduce improper eligibility determination actions, and safeguard assets
  - QA will monitor and track the County's improvement efforts and results during the 10-month audit to determine the impact to a required AIP

Reporting Process – Cont'd

- **At the completion of each quarter, the County will be provided their updated quarterly accuracy rates**
  - **Updated quarterly accuracy rates will include potential error finding adjustments based on the County's corrective actions and the impact to the original eligibility decision**
  - **Therefore, it is crucial that Counties immediately react to error(s) cited and take timely, adequate corrective actions**
  - **Reminder: Please reach out to your OST Representative should you need guidance/policy clarification BEFORE initiating case corrections**
- **At the completion of the 10-month audit process, the county will be provided their annual accuracy rates**
- **The Department will submit an annual report to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice detailing the county's performance**

Recoupment Methodology (PHE/CCU) County Overpayment Calculation

The state will conduct a review of state expenditures paid for the month of initial determined eligibility through the month of audit review

Recoupment Methodology (Not PHE/CCU) County Overpayment Calculation

The state will conduct a review of state expenditures paid for the month of initial determined eligibility through the month of case correction/termination to calculate the overpayment

QUESTIONS

Joint Accuracy Improvement Plan (AIP)

- If a County DSS does not meet the accuracy standards, an AIP will be implemented

- Key Stakeholders for developing the AIP
  - County DSS (Director and Identified Staff)
  - NC Medicaid Office of Compliance & Program Integrity
  - NC Medicaid Operational Support Team
  - NC Medicaid Eligibility Services

Responsibilities & Review Process Quality Assurance Team

- Conduct Medicaid eligibility determination reviews, in accordance with SL 2017-57 guidelines
- Communicate with the County DSS liaisons identified by the county
- Provide monthly audit findings to the County DSS
- Share all audit communications with County DSS, OCPI/QA Staff & OST within required timeframes

Responsibilities & Review Process Quality Assurance Team – Cont'd

- QA Manager/Lead Analyst review rebuttal requests
- Report findings to OST/ES
- Joint State/Local Agency Accuracy Improvement Plan (QA, OST, ES, and County DSS)
- Conduct a monthly review of auditor's accuracy and adherence to audit processes

Responsibilities & Review Process County DSS

- Identify two county liaisons for audit questions and resolutions
- Ensure all case documentation and verification is available in NC FAST (within the initial 5-workday time period)
- Make case corrections, for cases cited in error, within 20 calendar days <u>or less</u>
- Take proactive measures to improve annual accuracy rate
  - Conduct a Root Cause Analysis to identify the cause of the error
  - Immediately initiate training
  - Implement internal control activities to mitigate errors

QUESTIONS

<u>COMING SOON</u>

- **April 2023 – Cycle 2, Round 2 Commences**
- **Today's Webinar, "<u>Recipient Eligibility Determination Audit (REDA) – Round 2, Cycle 2 (March 2023)</u>," will be posted to the NC Medicaid Division of Health Benefits website**

Resources for Reference

Session Law 2017-57, Section 11H.22.(e)
SL 2017-57, Section 11H.22.(e) - Report on Support Improvement in the Accuracy of Medicaid Eligibility Determinations Audit of County Medicaid Determinations

Dear County Director Letter (DCDL), March 31, 2022, Audit of County Medicaid Eligibility Determinations
https://medicaid.ncdhhs.gov/media/11251/download?attachment

Cycle 2, Round 2 – REDA Webinar and FAQs
https://medicaid.ncdhhs.gov/counties/nc-medicaid-eligibility-training

Alex Sunset Provision: Subchapter 23C – Application for Medicaid Benefits, Section .0100 – Application Process

Future Questions

Do Not Hesitate to Reach Out

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