Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

NORTH CAROLINA DID NOT REPORT AND RETURN ALL MEDICAID OVERPAYMENTS FOR THE STATE'S MEDICAID FRAUD CONTROL UNIT CASES

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

June 2024
A-06-23-04004

Office of Inspector General

https://oig.hhs.gov

The mission of the Office of Inspector General (OIG) is to provide objective oversight to promote the economy, efficiency, effectiveness, and integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of the people they serve. Established by Public Law No. 95-452, as amended, OIG carries out its mission through audits, investigations, and evaluations conducted by the following operating components:

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. The audits examine the performance of HHS programs, funding recipients, and contractors in carrying out their respective responsibilities and provide independent assessments of HHS programs and operations to reduce waste, abuse, and mismanagement.

Office of Evaluation and Inspections. OEI's national evaluations provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. To promote impact, OEI reports also provide practical recommendations for improving program operations.

Office of Investigations. OI's criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs and operations often lead to criminal convictions, administrative sanctions, and civil monetary penalties. OI's nationwide network of investigators collaborates with the Department of Justice and other Federal, State, and local law enforcement authorities. OI works with public health entities to minimize adverse patient impacts following enforcement operations. OI also provides security and protection for the Secretary and other senior HHS officials.

Office of Counsel to the Inspector General. OCIG provides legal advice to OIG on HHS programs and OIG's internal operations. The law office also imposes exclusions and civil monetary penalties, monitors Corporate Integrity Agreements, and represents HHS's interests in False Claims Act cases. In addition, OCIG publishes advisory opinions, compliance program guidance documents, fraud alerts, and other resources regarding compliance considerations, 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: June 2024
Report No. A-06-23-04004

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

North Carolina Did Not Report and Return All Medicaid Overpayments for the State's Medicaid Fraud Control Unit Cases

Why OIG Did This Audit

This audit is one of a series of audits to determine whether States had recovered, and returned the correct Federal share of, improper provider claim amounts. For this audit, we focused on North Carolina's Medicaid Fraud Control Unit (MFCU) actions related to the recoveries of Medicaid overpayments through legal judgments and settlements that the State had pursued under relevant Medicaid fraud statutes. North Carolina is required to report recoveries for these MFCU-determined Medicaid overpayments to CMS and to refund the Federal share to the Federal Government.

Our objective was to determine whether North Carolina reported and returned the correct Federal share of MFCU-determined Medicaid overpayments identified during the period October 1, 2019, through September 30, 2021.

How OIG Did This Audit

We reviewed 12 cases with MFCU-determined Medicaid overpayments for our audit period. We reviewed documentation supporting the reporting of the MFCU-determined Medicaid overpayments and reconciled the overpayments with the corresponding Forms CMS-64. We reviewed North Carolina's payment documentation to determine whether North Carolina returned the correct Federal share of its recoveries.

What OIG Found

North Carolina did not report and return the Federal share of all MFCU-determined Medicaid overpayments identified for the period October 1, 2019, through September 30, 2021. We determined that North Carolina should have reported MFCU-determined Medicaid overpayments totaling $41.4 million ($27.5 million Federal share) for 12 cases during the period that we reviewed. We found that North Carolina (1) did not report and return $30.4 million ($20.1 million Federal share) for seven cases on the Form CMS-64, (2) did not report $11.0 million ($7.3 million Federal share) for five cases within the required timeframe, and (3) correctly reported and returned $27,033 ($17,834 Federal share) for one case on the Form CMS-64. (One case is included as both late and unreported because this case was partially paid, but the remainder was unreported).

This occurred because North Carolina relied on the MFCU to provide the recovery information and did not have procedures in place to ensure that all MFCU-determined Medicaid overpayment case files were sent to North Carolina from the MFCU. Additionally, the MFCU was unaware that North Carolina was responsible for reporting the overpayments even if payments weren't collected from the providers and therefore did not send the recovery information to North Carolina for cases for which no payments were received.

What OIG Recommends and North Carolina Comments

We recommend that North Carolina (1) report and return the Federal share for the unreported cases, totaling $30.4 million ($20.1 million Federal share); (2) strengthen internal controls by expanding written policies and procedures to include procedures for requesting, recording, and reporting all MFCU-determined Medicaid overpayments within prescribed regulatory timeframes, and ensuring they received all case files; and (3) work with the MFCU to determine the Medicaid overpayments for cases after our audit period and ensure that all overpayments are reported on the Form CMS-64.

In written comments on our draft report, North Carolina concurred with all of our recommendations. North Carolina stated that it will refund the Federal share for the unreported cases on the Form CMS-64 and described steps it will take to address our procedural recommendations.

TABLE OF CONTENTS

INTRODUCTION

WHY WE DID THIS AUDIT

This audit is one of a series of audits to determine whether States had recovered, and returned the correct Federal share of, improper provider claim amounts.[1] For this audit, we focused on North Carolina's Medicaid Fraud Control Unit (MFCU) actions related to the recoveries of Medicaid overpayments through legal judgments and settlements that the State had pursued under relevant Medicaid fraud statutes.[2] We refer to these recoveries as "MFCU-determined Medicaid overpayments." The North Carolina Department of Health and Human Services (State agency) is required to report these recoveries to the Centers for Medicare & Medicaid Services (CMS) on the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (Form CMS-64) and to refund the Federal share of those recoveries to the Federal Government.

OBJECTIVE

Our objective was to determine whether the State agency reported and returned the correct Federal share of MFCU-determined Medicaid overpayments identified during the period October 1, 2019, through September 30, 2021 (Federal fiscal years (FYs) 2020 and 2021).

BACKGROUND

Medicaid Program and Medicaid Fraud Control Units

The Medicaid program provides medical assistance to certain 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, CMS administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. The State plan establishes which services the Medicaid program will cover. Although a State has considerable flexibility in designing and operating its Medicaid program, it must comply with Federal requirements.

The Federal Government pays its share of a State's medical assistance costs (Federal share) under the Medicaid program on the basis of the Federal medical assistance percentage (FMAP), which changes each FY and varies depending on the State's relative per capita income. The State agency is responsible for computing and reporting the Federal share, which is based on

[1] See Appendix B for a list of related Office of Inspector General reports.

[2] MFCUs, which are required by Federal statue, investigate and prosecute Medicaid provider fraud and patient abuse and neglect in health care facilities and board and care facilities.

the total computable amount multiplied by the FMAP.[3] The total computable amount and the Federal share are both reported on the Form CMS-64.

Section 1902(a)(61) of the Act requires each State to operate a MFCU or receive a waiver. The Act, section 1903(q), specifies that the function of State MFCUs is to investigate and prosecute Medicaid provider fraud and patient abuse and neglect in facility settings. The North Carolina MFCU operates thru the North Carolina Department of Justice Medicaid Investigations Division.

Federal Requirements Concerning Reporting of Medicaid Overpayments

Federal regulations implementing sections 1903(d)(2) and (3) of the Act specify that State agencies have 1 year from the date of discovery to recover Medicaid overpayments before the Federal share must be refunded to CMS. These regulations generally direct State agencies to make adjustments for the overpayments after 1 year whether or not the State has recovered the overpayment from the provider (42 CFR part 433, subpart F).

Federal regulations also state that for cases involving fraud in which a State is unable to recover a Medicaid overpayment within 1 year of discovery[4] because the relevant court has not determined the overpayment amount, the State is not required to report the Federal share of the overpayment until 30 days after the date of the final judgment. Once the court has determined the overpayment amount (that is, reached a final judgment, including, if applicable, a final determination on appeal), the State then has 30 days to collect the overpayment from the provider before reporting that amount on the Form CMS-64 for adjustment (42 CFR § 433.316(d)(2)).

Reporting of Fraud-Related Medicaid Overpayments

States use the Form CMS-64 to report actual Medicaid expenditures for each quarter. In turn, CMS uses the Form CMS-64 to reimburse States for the Federal share of Medicaid expenditures. The amounts that States report on the Form CMS-64 and its attachments must be actual expenditures with supporting documentation (42 CFR § 430.30).

CMS's *State Medicaid Manual*, Pub. No. 45, instructs State agencies to apply the FMAP rate at which the original expenditure was matched when reporting recoveries (chapter 2, §§ 2500 (D)(2) and 2500.6(B)). If the expenditure cannot be immediately tied to a specific period, State agencies are to compute the Federal share at the FMAP rate in effect at the time the refund was received.

[3] CMS's *2018 Payment Error Rate Measurement Manual* defines the Form CMS-64 "total computable amount" as the Federal share plus the State share of Medicaid costs.

[4] Under 42 CFR § 433.316(d)(1), an overpayment that results from fraud is discovered on the date of the final written notice, as defined under 42 CFR § 433.304, of the State's overpayment determination.

State Agency Policies and Procedures for Reporting Medicaid Fraud Control Unit-Determined Overpayments

The State agency has written procedures concerning preparation and submission of the Form CMS-64, which include procedures for reporting Medicaid overpayments. During our audit period, the State agency received only the final judgments and settlements from the MFCU if the MFCU received any payment from the provider for the case. The MFCU also sent a memo to the State agency detailing the amount of Federal share owed for the case. The MFCU collects the provider payments and sends the check to the State Agency's Controller's office. The Controller's office sets up an accounts receivable account when it receives case information from the MFCU. State officials report the MFCU-determined Medicaid overpayments on the Form CMS-64 after 365 days regardless of whether they have collected the amounts owed. The State agency relies on the information provided by MFCU when setting up an accounts receivable.

HOW WE CONDUCTED THIS AUDIT

We determined that during our audit period (October 1, 2019, through September 30, 2021), MFCU-determined Medicaid overpayments totaled $41,408,088 ($27,495,987 Federal share) for 15 cases.[5] During our review, we identified 3 cases that did not have Medicaid restitution.[6] We reviewed the remaining 12 cases with MFCU-determined Medicaid overpayments totaling $41,383,314 ($27,495,987 Federal share).

We reviewed the case files provided by the State agency and the MFCU and worked with the State agency to determine whether the MFCU-determined Medicaid overpayments were reported on the Forms CMS-64.[7] We reviewed the State agency's documentation supporting its reporting of the MFCU-determined Medicaid overpayments and reconciled the overpayments to the corresponding Forms CMS-64. We reviewed State agency payment documentation to determine whether the State agency returned the correct Federal share of its recoveries.

[5] Some cases with MFCU-determined Medicaid overpayments were for defendants that had joint and several liability with other defendants in our audit period. Joint and several liability means all defendants are responsible for the act and for the damages. Each defendant may be awarded different restitution amounts, but once the full amount of restitution awarded is paid (either by just one defendant or multiple defendants) the restitution is considered to be paid. For cases that were joint and several, we recorded the highest amount owed by any of the defendants as the amount of Medicaid overpayment the State was responsible to pay. We considered all related joint and several cases as 1 case.

[6] For these three cases, one case did not have any restitution ordered and the other two cases had restitution ordered to the victims. Therefore, there was no restitution that was payable to Medicaid for which the State agency would have been responsible to report and return on the Form CMS-64.

[7] Based on information provided by MFCU officials, the 12 cases with MFCU-determined Medicaid overpayments totaling $41,383,314 did not include judgments on appeal.

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.

See Appendix A for details on our audit scope and methodology.

FINDINGS

The State agency did not report and return the Federal share of all MFCU-determined Medicaid overpayments identified for FYs 2020 and 2021. We determined that the State agency should have reported MFCU-determined Medicaid overpayments totaling $41,383,314 ($27,495,987 Federal share) for 12 cases during the period that we reviewed.

We found that the State agency:

- did not report and return $30,352,630 ($20,134,402 Federal share) for seven cases on the Form CMS 64,

- did not report and return $11,003,651 ($7,343,751 Federal share) for five cases within the required timeframe, and

- correctly reported and returned $27,033 ($17,834 Federal share) for one case on the Form CMS-64.[8]

This occurred because the State agency relied on the MFCU to provide the case files and overpayment information and did not have procedures in place to ensure that all MFCU-determined Medicaid overpayment case files were sent to the State agency from the MFCU. Additionally, the MFCU was unaware that the State agency was responsible for reporting the overpayments, even if payments weren't collected from the providers, and therefore did not send the case files and overpayment information to the State agency for cases for which no payments were received.

FEDERAL REQUIREMENTS AND GUIDANCE REGARDING THE REPORTING OF MEDICAID FRAUD CONTROL UNIT-DETERMINED MEDICAID OVERPAYMENTS

Federal regulations implementing sections 1903(d)(2)(C) and (D) of the Act state:

[8] One case is included as both late and unreported because this case was partially paid but the remainder was unreported.

> (1) … [A] State Medicaid agency has 1 year from the date of discovery of an overpayment to a provider to recover or seek to recover the overpayment before the Federal share must be refunded to CMS.
> (2) The State Medicaid agency must refund the Federal share of overpayments at the end of the 1-year period following discovery in accordance with the requirements of this subpart, whether or not the State has recovered the overpayment from the provider. (42 CFR § 433.312(a)).

Federal regulations also state that for cases involving fraud in which a State is unable to recover a Medicaid overpayment within 1 year of discovery because the relevant court has not yet been determined through a judicial or administrative process, the State is not required to return the Federal share of the overpayment until 30 days after the date of the final judgment. Once the court has determined the overpayment amount (that is, has reached a final judgment, including, if applicable, a final determination on appeal), the State then has 30 days to collect the overpayment from the provider before reporting that amount on the Form CMS-64 for adjustment (42 CFR § 433.316(d)(2).

Appendix C contains the Federal requirements and guidance related to the reporting of MFCU-determined Medicaid overpayments.

THE STATE AGENCY DID NOT REPORT AND RETURN THE FEDERAL SHARE OF ALL MEDICAID FRAUD CONTROL UNIT-DETERMINED MEDICAID OVERPAYMENTS

The State agency did not report and return the Federal share of MFCU-determined Medicaid overpayments totaling $30,352,630 ($20,134,402 Federal share) for seven cases on the Form CMS-64. The State agency did not receive the case files with the overpayment information from the MFCU and therefore did not have the information to report the overpayments on the Form CMS-64. Because these cases involved fraud, the State had 30 days after the date of the final judgment to collect the overpayment from the provider before reporting on the Form CMS-64. The State agency relied on the MFCU to provide the case files and overpayment information and did not have procedures in place to ensure that all MFCU-determined Medicaid overpayment case files were sent to the State agency from the MFCU. Additionally, the MFCU was unaware that the State agency was responsible for reporting the overpayments if payments weren't collected from the providers and therefore did not send the case files and overpayment information to the State agency for cases for which no payments were received. As a result, the Federal Government did not receive it's share totaling $20,134,402.

THE STATE AGENCY DID NOT REPORT MEDICAID FRAUD CONTROL UNIT-DETERMINED MEDICAID OVERPAYMENTS WITHIN THE REQUIRED TIMEFRAME

The State agency was late in reporting and returning $11,003,651 ($7,343,751 Federal share) of MFCU-determined Medicaid overpayments for 5 of the 12 cases we reviewed. Of these cases:

- two cases were reported six quarters late,

- one case was reported five quarters late, and

- two cases were reported four quarters late.

These cases were reported late because State agency officials believed that once the court had made its final determination, the State agency had an additional 1 year to report MFCU-determined Medicaid overpayments. However, the specified timeframe for these cases is 30 days after the date on which a final judgment (including, if applicable, a final determination on an appeal) is made (42 CFR § 433.316(d)(2)). As a result, the Federal Government did not receive its share of the MFCU-determined Medicaid overpayments in a timely manner.

RECOMMENDATIONS

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

- report and return the Federal share for the seven unreported cases, totaling $30,352,630 ($20,134,402 Federal share);

- strengthen internal controls by expanding written policies and procedures to include procedures for requesting, recording, and reporting all MFCU-determined Medicaid overpayments within prescribed regulatory timeframes, and ensuring they received all case files; and

- work with the MFCU to determine the Medicaid overpayments for cases after our audit period and ensure that all overpayments are reported on the Form CMS-64.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred with our recommendations and described the corrective actions that it has taken to address them.

In response to our recommendation to report and return the Federal share for the seven unreported cases, totaling $30,352,630 ($20,134,402 Federal share), the State agency responded that it is working through its internal review process and will refund the Federal share as required on the Form CMS-64.

In response to our second recommendation to strengthen internal controls, the State agency stated that it is reviewing the current workflow processes to streamline and strengthen the internal controls to ensure return of the Federal share in a timely manner.

In response to our third recommendation to work with the MFCU to determine the Medicaid overpayments for cases after our audit period and ensure that all overpayments are reported on the Form CMS-64, the State agency responded that it is reviewing the current workflow

processes to streamline and strengthen the internal controls to ensure return of the Federal share in a timely manner. The State agency said that during this review process, it will identify any unreported overpayments from the MFCU and process the return of the Federal share in a timely manner.

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

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

According to information provided by the MFCU, during our audit period (October 1, 2019, through September 30, 2021), we determined that the North Carolina MFCU received final determinations for 15 criminal cases that resulted in MFCU-determined Medicaid overpayments totaling $41,408,088 ($27,495,987 Federal share).[9] Of the 15 cases, 3 cases did not have Medicaid restitution.[10]

This audit covers the remaining 12 cases with associated MFCU-determined Medicaid overpayments totaling $41,383,314 ($27,495,987 Federal share).

We did not audit the State agency's overall internal control structure. Rather, we reviewed only those internal controls related to our audit objective. To evaluate these internal controls, we interviewed State agency officials to determine what policies and procedures were related to collecting, recording, and returning MFCU-determined Medicaid overpayments.

We performed our audit work from November 2022 through April 2024.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws and regulations;
- conducted interviews with State agency staff to determine the policies and procedures for collecting, recording, and returning MFCU-determined Medicaid overpayments;
- conducted interviews with MFCU staff to determine their policies and procedures for reporting case information to the State agency;

[9] Some cases with MFCU-determined Medicaid overpayments were for defendants that had joint and several liability with other defendants in our audit period. Joint and several liability means all defendants are responsible for the act and for the damages. Each defendant may be awarded different restitution amounts, but once the full amount of restitution awarded is paid (either by just one defendant or multiple defendants), the restitution is considered to be paid. For cases that were joint and several, we recorded the highest amount owed by any of the defendants as the amount of Medicaid overpayment the State was responsible to pay. We considered all related joint and several cases as one case.

[10] For these three cases, one case did not have any restitution ordered and the other two cases had restitution ordered to the victims. Therefore, there was no restitution that was payable to Medicaid for which the State agency would have been responsible to report and return on the Form CMS-64.

- evaluated policies and procedures for recording the MFCU-determined Medicaid overpayments and determined how the overpayments flowed through the State's accounting system and were reported on the Form CMS-64;

- obtained a list from the MFCU of finalized cases for our audit period;

- obtained the case files for the judgments and settlements that the MFCU finalized during our audit period;

- reviewed case files to identify the amount the State agency should have reported on the Form CMS-64;

- reconciled State agency payment records with Medicaid overpayments reported on the Form CMS-64 to determine whether all payments were reported in accordance with Federal requirements; 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
Colorado Did Not Report and Refund the Correct Federal Share of Medicaid-Related Overpayments for 70 Percent of the State's Medicaid Fraud Control Unit Cases	A-07-21-02834	10/25/2022
Texas Did Not Report and Return All Medicaid Overpayments for the State's Medicaid Fraud Control Unit's Cases	A-06-20-04004	5/25/2022
Nebraska Did Not Report and Refund the Correct Federal Share of Medicaid-Related Overpayments for 76 Percent of the State's Medicaid Fraud Control Unit Cases	A-07-18-02814	6/10/2021
Wisconsin Did Not Report and Refund the Full Federal Share of Medicaid-Related Settlements and a Judgment	A-05-17-00041	12/13/2018

APPENDIX C: FEDERAL LAWS AND REGULATIONS

FEDERAL LAWS

Section 1903(d)(2)(A) of the Social Security Act (the Act) provides that "[t]he Secretary [of Health and Human Services (HHS)] shall . . . pay to the State, in such installments as he may determine, the amount so estimated, reduced, or increased to the extent of any overpayment or underpayment which the Secretary determines was made under this section to such State for any prior quarter and with respect to which adjustment has not already been made under this subsection."

Section 1903(d)(3)(A) of the Act provides that "[t]he pro rata share to which the United States is equitably entitled, as determined by the Secretary, of the net amount recovered during any quarter by the State or any political subdivision thereof with respect to medical assistance furnished under the State plan shall be considered an overpayment to be adjusted under this subsection."

FEDERAL REGULATIONS

Federal regulations (42 CFR § 433.300(b)) state:

> Section 1903(d)(2)(C) and (D) of the Act . . . provides that a State has 1 year from discovery of an overpayment for Medicaid services to recover or attempt to recover the overpayment from the provider before adjustment in the Federal Medicaid payment to the State is made; and that adjustment will be made at the end of the 1-year period, whether or not recovery is made, unless the State is unable to recover from a provider because the overpayment is a debt that has been discharged in bankruptcy or is otherwise uncollectable.

Federal regulations state: "The date on which an overpayment is discovered is the beginning date of the 1-year period allowed for a State to recover or seek to recover an overpayment before a refund of the Federal share of an overpayment must be made to CMS" (42 CFR § 433.316(a)).

Under 42 CFR § 433.316(d)(1), an overpayment that results from fraud is discovered on the date of the final written notice, as defined under 42 CFR § 433.304, of the State's overpayment determination.

Federal regulations (42 CFR § 433.316(d)(2)) state:

> When the State is unable to recover a debt which represents an overpayment (or any portion thereof) resulting from fraud within 1 year of discovery because no final determination of the amount of the overpayment has been made under an administrative or judicial process (as applicable), including as a result of a

judgment being under appeal, no adjustment shall be made in the Federal payment to such State on account of such overpayment (or any portion thereof) until 30 days after the date on which a final judgment (including, if applicable, a final determination on an appeal) is made.

APPENDIX D: STATE AGENCY COMMENTS

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Health Benefits

ROY COOPER • Governor
KODY H. KINSLEY • Secretary
JAY LUDLAM • Deputy Secretary, NC Medicaid

May 21, 2024

Patricia Wheeler
Regional Inspector General for Audit Services
Office Of Audit Services, Region VI
1100 Commerce Street, Room 632
Dallas, TX 75242

Re: Report Number: A-06-23-04004

Dear Ms. Wheeler:

We have reviewed your draft report *North Carolina Did Not Report and Return All Medicaid Overpayments for the State's Medicaid Fraud Control Unit Cases* (Report) covering the audit period October 1, 2019, through September 30, 2021. The Department agrees with the findings noted in the report. The following represents our response and corrective action plan to the Recommendations.

RECOMMENDATIONS

I. **REPORT AND RETURN THE FEDERAL SHARE FOR THE SEVEN UNREPORTED CASES, TOTALING $30,352,630 ($20,134,402 FEDERAL SHARE).**

The Department agrees with the recommendation. The Department is working on the seven cases through the internal review process and will refund the federal share as required on the CMS-64.

Anticipated Completion Date: September 30, 2024

II. **STRENGTHEN INTERNAL CONTROLS BY EXPANDING WRITTEN POLICIES AND PROCEDURES TO INCLUDE PROCEDURES FOR REQUESTING, RECORDING, AND REPORTING ALL MFCU-DETERMINED MEDICAID OVERPAYMENTS WITHIN PRESCRIBED REGULATORY TIMEFRAMES, AND ENSURING THEY RECEIVED ALL CASE FILES.**

The Department agrees with the recommendation. The Department is reviewing the current workflow processes surrounding the MFCU overpayment tracking and reporting to streamline and strengthen the internal controls to ensure timely return of the federal share. The updated policies, procedures and training will be implemented for each impacted business unit, including the NC MFCU.

Anticipated Completion Date: September 30, 2024

III. **WORK WITH THE MFCU TO DETERMINE THE MEDICAID OVERPAYMENTS FOR CASES AFTER OUR AUDIT PERIOD AND ENSURE THAT ALL OVERPAYMENTS ARE REPORTED ON THE FORM CMS-64.**

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. The Department is reviewing the current workflow processes surrounding the MFCU overpayment tracking and reporting to streamline and strengthen the internal controls to ensure timely return of the federal share. During the review process, the Department will identify any unreported overpayments from the MFCU and process the return the federal share in a timely manner.

Anticipated Completion Date: September 30, 2024

While the Department seeks to remedy any identified risks as soon as possible, implementation dates for the above corrective actions are projected beyond 90 days due to competing new program launch initiatives with already strained staffing resources. The Department anticipates completion of the corrective actions before the proposed completion dates.

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

If you need additional information, please contact Dennis Farley at (919) 500-2885.

Sincerely,

DocuSigned by:
Jay Ludlam
Jay Ludlam
06B5...F4C8...

cc: Melanie Bush, Deputy Medicaid Director
Lotta Crabtree, Chief Legal Officer
Sarah Gregosky, Chief Operating Officer
Adam Levinson, Chief Financial Officer
John E. Thompson, Chief Compliance Officer