JOINT LEGISLATIVE OVERSIGHT COMMITTEE
ON MEDICAID AND NC HEALTH CHOICE

Audit of County Medicaid Eligibility Determinations

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Objectives of SL 2017-57 Section 11H.22(e) Report

- Develop accuracy and quality assurance standards for eligibility determinations performed by county DSS
- Establish an audit methodology to measure counties' performance
- Establish an annual audit schedule to review counties' performance

Proposed Accuracy Standards

- Medicaid applicants approved for benefits when truly ineligible - 3.2% error rate threshold (derived from federal standard)
- Medicaid applicants denied benefits when truly eligible - 3.2% error rate threshold (derived from federal standard)
- Eligibility determination errors not impacting eligibility decision – 10% initial error rate threshold

Quality Assurance (QA) Standardized Processes

Counties completing these five items follow the established QA process:

- Standardized 2nd Party Review Procedures
- Standardized detailed review worksheet
- State-directed sample size by county
- Quarterly reporting to State on review results
- Results used to determine targeted training needs

Current Audits of Eligibility Determination

- Payment Error Rate Measurement PERM (CMS)
- Medicaid Eligibility Quality Control Reviews (CMS & Medicaid)
- Corrective Action Record Reviews (Medicaid)
- State Single Audit (OSA in conjunction with local CPAs)

Current Audits - Enhancements Underway

- Corrective Action Record Reviews (Medicaid)
  - Expanding number of cases reviewed and fine tuning review details and follow-up processes
- State Single Audit (OSA in conjunction with local CPAs)
  - State Auditor will dictate sample items to be reviewed
  - Review tool is updated by Department in consultation with OSA
  - State Auditor performing quality review of local CPA performance

Auditing 100 Counties Per Year

- Current legislation describes a new annual audit effort of all 100 counties.
- If funding is provided, based on work plan utilized by OSA in the performance audit issued January 2017, such an annual review would cost approximately $11.2 million

	Hours	Total Cost
Contractor Review	175,000	$7,875,000
DHHS Oversight (25% of audit effort)	43,750	$3,281,250
Total	**218,750**	**$11,156,250**

- Effort would entail reviewing 50,000 eligibility determinations at an average review time of 3.5 hours each
- Effort would also require approximately 26 additional DHHS staff to oversee the contractor's work in a timely manner.

Challenges with Auditing 100 Counties

- For DHHS to conduct efficient review of an eligibility determination
  - Reviewer must possess experience with eligibility determination process
  - Personnel with such experience are limited to retired and existing county and state workers
- OSA utilized a staffing contractor that was able to retain the expertise from available county workers with Medicaid experience

Proposed Alternative Audit Plan

- If funding is provided, DHHS could:
  - Follow Medicaid sampling methodology, use sample size of 200 cases per county

    (100 new applications and 100 re-certifications)
  - Rotate county audits over a three-year cycle
- Staffing options:
  - Contract with experienced vendor
    - Annual audit costs: $1.6M
    - Requires 5 additional DHHS staff for oversight
  - Hire DHHS permanent staff
    - Annual audit costs: $2.34M
    - Requires 19 additional DHHS staff