NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Office of the Internal Auditor

Follow-up Assessment of the PER-2018-4445 Medicaid LME-MCO Contract Provisions Performance Audit

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The Office of the Internal Auditor (OIA) has conducted a follow-up assessment of the Department of Health and Human Services' (Department) response to the findings and recommendations in the Medicaid LME-MCO Contract Provisions performance audit, PER-2018-4445. The report was issued by the Office of the State Auditor (OSA) on February 14, 2019.

Results
Both findings are partially resolved: The Division of Health Benefits (DHB) took some action to reduce identified risks. However, the corrective action taken is not sufficient to reduce risk to an acceptable level, and DHB continues to work to address the findings. OIA will follow up with DHB to ensure its work activities reduce risk to an acceptable level. A summary of OSA's findings and recommendations and OIA's follow-up results are included in the Appendix.

Objective
The objective of our follow-up assessment was to evaluate whether DHB took appropriate corrective action in response to OSA's findings and recommendations. Our follow-up assessment was conducted pursuant to G.S. 143B-216.51(g). The General Statute requires OIA to issue a report to the Secretary on the status of corrective action taken by the Department no later than six months after the State Auditor publishes any audit report pursuant to law. A copy of this report will be filed with the Joint Legislative Commission on Governmental Operations pursuant to the General Statute.

Scope
The scope of our follow-up assessment included a review of activities directed toward the resolution of OSA's findings and recommendations as well as the corrective action taken by DHB.

Methodology
We conducted this engagement in conformance with the *International Standards for the Professional Practice of Internal Auditing* issued by The Institute of Internal Auditors. In order to form an opinion on the current status of the two findings, we performed the following procedures:

- We reviewed OSA's audit report to gain a better understanding of the findings.
- We discussed the basis for the findings and the associated corrective action with DHB management.
- We conducted tests to evaluate whether corrective action taken by DHB reduced risk to an acceptable level.

Status Definitions

The status of each finding is categorized as follows:

- Resolved: We evaluated evidence that actionable items were completed and implemented to reduce risk to an acceptable level.
- Partially Resolved: We evaluated evidence that progress has been made toward the implementation of the actionable items in DHB's response and is ongoing to reduce risk to an acceptable level.
- Unresolved: Evidence was not provided to show progress has been made toward the implementation of the actionable items in DHB's response, to reduce risk to an acceptable level.

We express our appreciation to DHB management and staff and the Office of the State Auditor for their cooperation and assistance during this follow-up assessment.

David A. King
Director, Office of the Internal Auditor

CC: Matt Gross, Assistant Secretary for Governmental Affairs, DHHS

APPENDIX

SUMMARY OF FINDINGS AND RECOMMENDATIONS FROM OSA REPORT *(ITALICIZED)* AND OIA'S FOLLOW-UP RESULTS (BOLDED)

1. OSA FINDING AND RECOMMENDATION – *CONTRACT LACKS TERMS TO PROTECT THE STATE FROM EXCESS COSTS*

The Department of Health and Human Service's (Department) managed behavioral healthcare services contracts with Local Management Entity-Managed Care Organizations (LME-MCOs) did not contain contract terms that could protect the State from excess costs. Specifically, the contracts did not include terms to (1) define or recover excess LME-MCO savings, (2) define unreasonable administrative and service costs, or (3) limit profits from related-party transactions.

No Contract Terms to Define or Recover Excess LME-MCO Savings

The Department's managed behavioral healthcare services contracts did not include language to prevent LME-MCOs from retaining excess savings. Specifically, the contracts did not identify a target profit margin for LME-MCOs, define excess savings, or include language that allows the State to recover excess LME-MCO savings.

The Department pays LME-MCOs a capitation rate for each enrolled Medicaid member. Capitation rates are generally calculated to cover medical service costs, administrative expense, and a margin for risks and profit. The rate calculation is based on historical costs and actuarial expectations about future Medicaid cost and use trends.

However, actual Medicaid cost and use can potentially differ significantly from expectations. If Medicaid cost and use are significantly less than projected, then LME-MCOs could experience savings that far exceed the margins the State anticipated when setting the capitation rates.

North Carolina is at risk for errors in the assumptions and projections that it makes when setting capitation rate because, without contract language that addresses excess profits, the Medicaid funds will be unrecoverable and outside of state control. Federal law prohibits states from directing the expenditure of or recouping any unspent Medicaid funds allocated for delivery system or provider payment initiatives from the managed care plan.

The Centers for Medicare and Medicaid Services (CMS) reasons that:

> *"Managed care plans receive risk-based capitation payments to carry out the obligations under the contract….As funds associated with delivery system reform or performance initiatives are part of the risk-based capitation payment, any unspent funds remain with the MCO, PIHP, or PAHP."*

And the risk to North Carolina could be significant.

To illustrate, a recent Office of the State Auditor (OSA) audit noted that LME-MCOs accumulated $439.2 million of excess savings from state fiscal years (SFY) 2015 through 2017. And federal law allows the private MCOs to keep and spend the excess profits at their discretion.

But the use of contract provisions and state law could prevent North Carolina's managed care organizations from retaining excess profits.

For example, the State could use the contract strategy suggested by the federal Department of Health and Human Services to limit profits. In its publication, Contracting for Managed Substance Abuse and Mental Health Services: A Guide for Public Purchases*, the department suggests:*

> *"The purchaser may contractually limit the profits and/or losses an MCO may experience. In the case of profit limits, the purchaser must determine early the amount of profit it is willing to allow the MCO to make and how this profit may be achieved. The contract documents between the parties should address the degree to which each party keeps any MCO profit in excess of the agreed-upon amount."*

No Contract Terms to Define Unreasonable Administrative and Service Costs

The Department's managed behavioral healthcare services contracts did not include language that explicitly defined the cost principles that LME-MCOs must use for administrative and service costs.

LME-MCOs are not subject to the federal law that specifies what state agencies can claim as administrative and service costs.

Consequently, if the State does not clearly define cost principles, LME-MCOs can show higher costs and lower profit margins by including expenses in the administrative cost category that the State might not otherwise allow.

The disallowed or unreasonable expenses would then be used to calculate the next year's capitation rates, which would increase the risk that the capitation rates could be set too high and increase cost to the State.

Contract provisions can help prevent unreasonable and unnecessary spending by LME-MCOs.

For example, North Carolina could use the contract strategy suggested by the federal Department of Health and Human Services for financial reporting in accordance with cost principles. In its publication, Contracting for Managed Substance Abuse and Mental Health Services: A Guide for Public Purchases*, the department suggests:*

> *"Clearly spell out the requirements for reporting financial expenditures for both administrative and service costs.*
>
> *Require reporting of program administrative costs pursuant to OMB Circular A-87 and the principles for cost accounting in OMB Circular A-133, which require the reporting of costs by program and set standards for the allocation of overhead and shared administrative costs."*

No Contract Terms to Limit Profits From Related Party Transactions

The Department's managed behavioral healthcare services contracts did not include sufficient provisions for related party transactions. While the State's contracts require LME-MCOs to report related-party transactions, nothing in the contract explicitly defines an allowable profit component between the LME-MCOs and their affiliated parties for medical expenses.

If an allowable profit component between affiliated parties is not defined, LME-MCOs can increase profits beyond the State's established capitation rates by purchasing services from related parties.

In an August 27, 1993, memorandum, the federal Department of Health and Human Services, Office of the Inspector General stated:

"To prevent managed care plans from artificially reducing their earnings through less than arm's-length transactions, all related party transactions should not only be identified in the financial statements, but also be reviewed by either the State agency or an independent auditor to determine if they are arm's-length. The State agency should consider the costs of all related party transactions that are determined to be unreasonable as earnings in determining the plan's profit margin."

Contract provisions can help prevent LME-MCOs from using related-party transactions to earn excess profits.

Additionally, North Carolina could include contract language similar to the Medicare regulations that govern related-party transactions. The Medicare regulations require:

"(i) A showing that the costs of the transactions listed…do not exceed the costs that would be incurred if these transactions were with someone who is not a party in interest; or (ii) If they do exceed, a justification that the higher costs are consistent with prudent management and fiscal soundness requirements."

OSA recommended the Department should:

a. *Include language in its contracts that limits the profit that private MCOs can retain. The contracts should address the degree to which each party keeps any MCO profit in excess of an agreed-upon amount. The profit limit should be negotiated to offer the State protection against financial risks while not deterring the efficient management of costs by MCOs.*
b. *Alternatively, ask the Legislature to enact a state law that would limit excess MCO profits by requiring profit that exceeds a defined amount to be shared with the State.*
c. *Include language in its contracts that requires reporting of program administrative costs pursuant to federal cost principles.*
d. *Include language in its contracts that explicitly defines an allowable profit component between the MCOs and their affiliated parties for medical expenses.*

Department Response

The Department agrees with the State Auditor's assertion that contract language and state law should protect the State against financial risks while not deterring the efficient management of costs by MCOs. Under the new managed care program, the Department, as directed by the NC Legislature, has established a minimum Medical Loss Ratio (MLR) which will include a remittance requirement for Prepaid Health Plans (PHPs) that do not meet the MLR. The Department will continue to use other tools that enhance its ability to drive PHP performance while effectively managing costs to the State. The Department is open to limiting profits of PHPs and their affiliate parties above a reasonable threshold so long as it is supported by legislation and allows the Department to retain the levers necessary to incentivize plans to manage costs and meet or exceed our health outcomes goals. Additionally, the Department will require PHPs to report program administrative costs pursuant to federal cost principles within its monthly financial reporting template which will be used as a tool for monitoring PHP financial metrics.

OIA Follow-up Results

The Division of Health Benefits (DHB) has partially implemented procedures to address the finding. DHB met with the LME/MCO CEOs to discuss solvency and reinvestment plans. The Department has drafted a white paper that proposes contract changes to address LME/MCO cash management and reinvestment plans. The Department's goal is for the changes outlined in the white paper to be included in the November 1, 2019 contracts.

The proposal includes increased oversight of the LME/MCOs' reinvestment plans, such as formally reviewing reinvestment plans, tracking actual reinvestment expenditures, and requiring corrective action plans when thresholds are not met. The proposal also includes increased oversight over financial stability and solvency, such as establishing benchmarks and requiring corrective action when standards are not met. Medical Loss Ratio (MLR) changes are being discussed and may include the addition of a rebate and/or reinvestment requirement when a minimum MLR threshold is not met. The Department continues to develop the proposed changes.

DHB has mitigated the risk that for-profit Medicaid managed care Prepaid Health Plans (PHPs) will accumulate excess savings/profits by requiring PHPs to remit and/or reinvest funds when the minimum MLR threshold of 88% is not met. OIA reviewed the Request for Proposal (RFP) for the Medicaid Managed Care Prepaid Health Plan and verified the inclusion of the MLR provisions. The RFP defines the numerator and denominator for calculation of the MLR. The MLR requirement ensures the PHPs are directing a sufficient portion of the capitation payments received from the Department to services and activities that improve health in alignment with the Department's program goals and objectives.

DHB updated the financial reporting template used by LME/MCOs to provide DHB with financial data. Two schedules were added to the financial reporting template to include more detailed administrative expense categories. The corresponding instructions were also updated to provide guidance on reporting administrative activities. The updated instructions specify that the LME/MCOs' reported expenses are subject to a financial review to ensure allowability under federal cost principles defined in 2 CFR 200.400-475.

DHB plans to include language in the November 1, 2019 LME/MCO contracts that defines profit parameters for LME/MCOs and their affiliated parties. The language is still being discussed and has not yet been drafted.

Once DHB finalizes the LME/MCO contracts, with the inclusion of the planned contract provisions, the Department will have taken adequate steps to reduce the risk associated with OSA's finding. OIA considers this finding partially resolved, with an expected completion date of March 1, 2020.

2. **OSA FINDING AND RECOMMENDATION – *MANAGED BEHAVIORAL HEALTHCARE SERVICE CONTRACTS DID NOT CONTAIN ALL FEDERALLY REQUIRED PROVISIONS***

The Department of Health and Human Services' (Department) managed behavioral healthcare services contracts with Local Management Entity-Managed Care Organizations (LME-MCOs) did not contain all required contractual provisions to ensure compliance with federal requirements for Medicaid managed care. As a result, the Department's ability to hold LME-MCOs accountable for the delivery of timely and appropriate healthcare at the most economical means is limited.

Managed Behavioral Health Contracts Contained Inadequate Contract Provisions
Auditors sampled 262 of 470 federally required contract provisions and identified 12 (4.58%) instances where provisions lacked sufficient language, were written incorrectly, or were missing.

Insufficient Contract Language

Contract provisions for the Medical Loss Ratio, Billing, and Appeals lacked sufficient language to fully comply with federal requirements.

Medical Loss Ratio

Four Medical Loss Ratio (MLR) contract provisions failed to provide sufficient information to the LME-MCOs for calculation of the MLR or sufficient guidance for providing accurate MLR information to the State.

The MLR measures the funds spent on providing health care services compared to administrative or overhead costs. The Affordable Care Act requires large group health insurers to spend at least 85% of premium income on medical care and health care quality improvement. The remaining 15% may be spent on items such as administration, marketing, and overhead.

Without sufficient information and guidance, such as the methodologies LME-MCOs should use to allocate expenditures in their MLR calculation, LME-MCOs could record administrative expenditures as medical expenditures. This could result in inflated MLRs and LME-MCOs reporting that they met the MLR standard when they did not.

Billing

One contract provision for billing was insufficiently written. The contract properly limits LME-MCO balance billing but fails to include providers.

Balance billing is the practice of a healthcare provider billing a participant for the difference between what the LME-MCO pays and what the provider charges. Providers are required to accept payment in full from the LME-MCO and not bill participants for covered services.

Without sufficient contract language, low-income Medicaid participants are at increased risk of being billed, creating an unnecessary financial burden. Additionally, the Department is at an increased risk for unnecessary administrative costs to address complaints from participants.

Appeals

One contract provision for appeals failed to ensure that providers and participants were allowed to request expedited appeals of adverse benefit determinations, such as medical necessity or prior authorization denials.

In the event a participant's needed service is denied by the LME-MCO, creating an immediate hardship, the participant's provider could be excluded from helping expedite the appeal. This increases the risk that participants will not have access to timely and appropriate care.

Incorrectly Written Contract Provisions

Four contract provisions regarding sanctions, or financial penalties for LME-MCO non-compliance, are incorrectly written. Current provisions allow the Department to assess penalties that are too high.

The Department is allowed to impose civil monetary penalties for certain offenses, such as falsifying information or discriminating among participants based on their need for services.

Based on wording in the contract, the Department could penalize LME-MCOs more than what is allowable under the federal regulations.

Missing Contract Provisions

Two provisions regarding physician incentive plans were missing from the Department's managed behavioral healthcare services contracts. One provision would prevent LME-MCO payments to

physicians that would incentivize reducing medically necessary services. The other provision would require physicians to maintain adequate stop-loss financial protection.

Physician incentive plans typically involve doctors or practices being awarded bonuses for meeting agreed-upon performance measures. If not implemented correctly, a physician incentive plan can incentivize physicians to reduce or limit necessary services provided to participants and increase risk of fraudulent, wasteful, or abusive incentive payments. It can also put a doctor or practice without stop-loss protection at serious financial risk.

While no LME-MCOs are currently operating physician incentive plans, they were not precluded from initiating one during the contract period. State contracts should include language to ensure proper implementation and compliance.

Caused by Department's Insufficient Contract Development Process

The Department's managed behavioral healthcare services contracts with LME-MCOs did not contain all required contractual provisions to ensure compliance with federal requirements because the Department's contract preparation and review process was deficient.

The process separated the federally-required contract provisions into subject areas. A team was assigned to each area to ensure that area's requirements were incorporated into the contract language. Each team's work was then combined into one contract document.

However, there was no centralized oversight, review, or approval of the combined contract by the Department to ensure all federal requirements were fully incorporated.

Regulations Require Complete and Sufficient Managed Care Contracts

The federal Centers for Medicare and Medicaid Services (CMS) requires the Department's contracts with LME-MCOs to include provisions for specified managed care regulations.

CMS' publication, the State Guide to CMS Criteria for Medicaid Managed Care Contract Review and Approval dated January 20, 2017, specifies the regulations and "help[s] states verify that contracts with Medicaid managed care entities meet all CMS requirements."

OSA recommended the Department should ensure that all federally required provisions and components for specified managed care regulations are incorporated into current and future Medicaid managed care contracts.

Department Response

The Department agrees that additional contract review and approval efforts within the Department would ensure that all federally required provisions are specified in the LME/MCO contracts before delivery to CMS for approval. The Department will ensure LME/MCO contracts are formally reviewed in accordance with CMS' State Guide for Medicaid Managed Care Contract Review and Approval tool.

During the development of the new PHP Contracts, the Department utilized CMS' State Guide for Medicaid Managed Care Contract Review and Approval tool, performing a cross walk of each CMS requirement to the associated PHP Contract requirements to confirm adherence. This process will be implemented for the LME/MCO contracts.

OIA Follow-up Results

DHB has partially implemented procedures to address the finding. DHB has drafted an LME-MCO Medicaid managed care contract. DHB is currently reviewing and updating the draft contract, which will be effective November 1, 2019. OIA reviewed the draft contract and noted that the following have been incorporated:

- **The methodology LME-MCOs should use to calculate the Medical Loss Ratio**
- **A provision to allow participants or providers to request expedited appeals of adverse benefit determination**
- **A provision to prevent payments to physicians that would incentivize reducing medically necessary services**

The following has not yet been incorporated into the draft:

- **Language limiting providers from undertaking balance billing**
- **Sanctions or financial penalties that align with federal requirements**
- **A requirement for physicians to maintain adequate stop-loss financial protection**

DHB is using CMS's State Guide for Medicaid Managed Care Contract Review and Approval to perform a cross walk of each CMS requirement to the associated provision in the draft contract to ensure all federal requirements are incorporated. The contract draft will be reviewed internally by DHB representatives from various sections including business, budget and finance, rate setting, actuarial, legal, and contracts. Once a final contract is negotiated with the LME-MCOs, it will be routed for DHB executive approval.

Once DHB completes its review process and fully incorporates the federally required contract provisions into the LME-MCO Medicaid managed care contracts, the Department will have taken adequate steps to reduce the risk associated with OSA's finding. OIA considers this finding partially resolved, with an expected completion date of November 1, 2019.