**Presentation to the Joint Legislation Oversight Committee on Health and Human Services**
**Update on BC Waiver Implementation**
**DHHS – Status Update**

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***Questions to be Addressed by the DHHS August 14th Presentation on the Implementation of the 1915 B-C Behavioral Health Waiver***

**Question 1.** Legislative members and staff have been contacted on numerous occasions by individuals with ongoing concerns about the ability of Western Highlands Network (WHN) to successfully operate as a managed care organization. When did the Department first become beware of problems at WHN?

**DHHS Response:**
DHHS receives a basic weekly report from WHN and other MCOs with updates on issues/concerns in major operational areas: claims processing, utilization management, care coordination, complaints/appeals, and provider network.

DHHS hosts a monthly monitoring meeting with WHN and all MCOs. At those meetings, we review on-going areas of correction identified by the Mercer reports. DHHS also reviews concerns/issues in major operational areas. At the March monitoring meeting, WHN reported a $1.6 million Medicaid surplus.

Using the reporting requirements from the PBH contract as a template, on a quarterly basis, DHHS receives a formal financial reporting package from each MCO. The report is required within 60 days after the quarter ends. The financial packet includes: Risk Reserve Analysis, IBNR (claims lag report), Analysis of Revenues and Expenses, and a Balance Sheet.

WHN submitted their March 31, 2012 quarterly financial packet in May 2012, the DMA financial staff initially identified the following issues:

- The balance of the IBNR report did not equal the balance of the liability fund on the balance sheet. This caused concern on the accuracy of the income statement with respect to expenses.
- The income statement was approximately a break even when comparing service revenues to service expenses. This raised the concern that WHN would not meet the minimum 2% excess revenues over expenses that is built into the PMPM rates.

When these initial concerns were identified, staff sent written inquires to WHN for explanations and additional information.

At the June 2012 monitoring meeting, WHN finance staff submitted additional financial supports that showed a Medicaid deficit back to January. In subsequent conversations, it was determined that WHN had not developed the IBNR reports accurately. Nor were standardized financial reports being used in-house to oversee managed care business.

DHHS initiated an onsite review by a team including Mercer financial, clinical and information system consultants, who were accompanied by DMA staff. Based on the review, the reporting requirements were enhanced to define specific financial reports that will be submitted on a weekly, monthly, and quarterly basis. This reporting requirement will be an amended requirement for all MCOs.

WHN and other MCOs began submitting encounter claims to HP in August 2012. DHHS is currently working with HP and MCOs to clean-up any errors in reporting. Encounter claims are one more tool used to be able to verify service access and financial analysis. DHHS will begin using that data for building monthly reports on service utilization and expenditures in order to enhanced monitoring of MCO performance.

**Question 2.** What is the total amount of the WHN shortfall as of June 30, 2012? Did WHN have enough reserve funds to cover the shortfall? If not, how was the shortfall addressed? Were any of WHN's FY 11-12 liabilities/obligations carried forward to be paid from their FY12-13 capitation fund? If so, what is the anticipated impact on their FY12-13 operating fund?

**DHHS Response:**
Financial Statements for the period ending, June 30, 2012 are not available at this time, as they are being audited as part of WHN year process. However the projected financial performance of the MCO services is presented below:

| | ***Six Months Ending 6/30/2012*** | ***12 Months Ending 12/31/2012*** | |
|---|---|---|---|
| | ***Forecast*** | ***Worst*** | ***Best*** |
| Services | $ (7,225,754) | $ (5,000,000) | $ 1,000,000) |
| Administration | $ 2,629,733 | $ 2,000,000 | $ 4,000,000 |
| TOTAL | $ (4,596,021) | $ (3,000,000) | $ 3,000,000 |

WHN has not asked to use risk reserve funds to fund any shortfall. A summary of the WHN fund balances and cash balances at the end of May is presented below:

| | **Fund Balance** | **Cash and Investments** |
|---|---|---|
| **Restricted** | | |
| **By State Statute** | $ 4,534,435 | |
| **Medicaid Risk Reserve** | 1,123,831 | 1,123,831 |
| **State Risk Reserve** | 155,300 | 155,300 |
| **Other** | $ 12,642,772 | $21,700,748 |
| **TOTAL at 5/31/12** | **$ 18,456,338** | **$22,979,879** |
| **TOTAL at 5/31/2011** | $ 15,987,791 | $16,062,985 |

The balances above are the sources that WHN has to fund operating shortfalls in the MCO operations.

WHN will continue to receive the same monthly capitation payment from Medicaid to cover the Medicaid business. In September 2012, DMA will begin the rate-setting process for the next contract cycle, which begins on January 1, 2013. The capitation payment will be based on the last 3 years of paid claims.

**Question 3.** Briefly describe the process DHHS undertook as of January 2012 to monitor WHN? When did DHHS first detect problems within WHN? What were the problems and what steps did DHHS take to address them?

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**Question 4.** Provide a summary of the problems that were identified in the Mercer review of the WHN operation.

**DHHS Response:**

- The management reporting outputs of WHN do not provide WHN the ability to effectively manage care and finances as an efficient organization for Medicaid operations.
- The management team at WHN does not meet to discuss key management reports.
- The incurred but not reported (IBNR) claims expense calculation does not provide an accurate estimation of Medicaid medical expenses on an accrual basis.
- Claims processing system edits are still in the process of being developed. Some were implemented at different times in 2012.
- Currently, there is no claims audit process in place to validate the accuracy of claims processed. WHN has recently started to perform focused audits based on potential issues.
- Clinical staff does not have routine utilization reports and access to the data sources for queries in order to manage care effectively and efficiently. The process for report development is cumbersome.

**Question 5.** SL 2011-264 directs that the LME/MCOs employ a set of managed care strategies and maintain fidelity to the PBH model. The Mercer review revealed that WHN failed to comply with these fundamental directives. What steps are being taken to assure the General Assembly that the LMEs that have transitioned and those who will transition will be held to these standards?

**DHHS Response:**
Pursuant to the WHN contract with DMA, WHN is using the standardized protocols (i.e. provider contracting, monitoring, forms) in use at PBH today. The WHN problems do not center on following the PBH model which is only a framework for NC operations. The Mercer report identifies problems with WHN's ability to operate a managed care organization.

As previously mentioned, a Mercer-led team that includes DHHS staff review on site operations at each LME 120 and 60 days prior to implementation to determine whether the LME/MCO is prepared to begin operations. This process has ensured that the organization is employing appropriate managed care strategies and maintaining fidelity to the PBH model. An example of this model working can be seen at the last Sandhills review, where concerns were expressed about the claims payment system and delay was recommended. The organization has since delayed in order to implement a more appropriate claims payment system.

Based on lessons learned with WHN, Mercer has added additional monitoring areas to the standard readiness reviews. In addition, DMA has increased financial monitoring protocols.

LME-MCOs will be required to submit monthly financial reports and will receive clear, standardized direction on the development of all financial reports.

**Question 6.** What are the options available to the DHHS to resolve the WHN situation? Which of these options will be used? If you have elected to allow WHN to engage in a monitored plan-of-correction, what compelling evidence do you have that they will be able to remedy these significant problems in a timely manner?

**DHHS Response:**
The options available to the DHHS to resolve the WHN situation include immediate contract termination, thus reassigning operations to another LME/MCO, or a monitored corrective action plan. DHHS has issued a plan of correction to WHN, with specific tasks, assigned due dates, and required reports. The plan requires that WHN hire a managed care consultant to be approved by DHHS. It also requires specific monthly financial reports. Weekly monitoring of the plan of correction will be done by DHHS to ensure compliance.

The Director and CFO of DMA met with the WHN Board about the corrective action plan and WHN has attended an on-site meeting with DHHS to discuss the plan and monitoring protocol. WHN has responded to the corrective action plan with the support of their Board. WHN will be held to the due dates/benchmarks in the plan. Mercer and DHHS will perform another onsite review in 30-45 days to determine progress on the plan and to determine evidence of better management of the Medicaid business.

**Question 7.** What is the DHHS plan to pay WHN service providers for all work performed through June 30, 2012 while ensuring that WHN consumers continue to receive the services they need?

**DHHS Response:**
WHN is required to pay for any authorized services to providers in their network. As mentioned above, they can pay with unused administrative dollars or LME-fund balance. DHHS will closely monitor utilization trends and any proposed rate modifications. WHN is required to continue to authorize and pay for any medically necessary services for Medicaid eligibles in their catchment area.

**Question 8.** Attached is the waiver schedule update that the Department provided at the May 15th HHS LOC. JLOCHHS/Handouts/Waiver Update.pdf. Is this schedule still in effect?

**DHHS Response:**
Yes, the schedule is still in effect as indicated.

**Question 9.** According to the May 15th schedule, six MCOs, including those serving the largest population areas in the State, are scheduled to go on line January 1, 2013. What actions is the Department taking to ensure none of the problems that Mercer found in WHN will be repeated in the upcoming transition?

**DHHS Response:**
During the 120 and 60 day on site review of each of the six LME/MCOs scheduled to go live January 1, 2013, the Mercer review will include lessons learned from the WHN experience, including focus on accurate IBNR reporting, internal claims auditing, report requests including internal management reports, communication flow including among high level managers, and claims payment system readiness.

DHHS initiated an onsite review of WHN by a team including Mercer financial, clinical and information system consultants, who were accompanied by DMA staff. Based on the review, the reporting requirements will be enhanced for all MCO's to define specific financial reports that will be submitted on a weekly, monthly and quarterly basis.

WHN and other MCOs began submitting encounter claims to HP in August 2012. DHHS is currently working with HP and MCOs to clean-up any errors in reporting. DHHS will begin using that data for building monthly reports on service utilization and expenditures in order to enhanced monitoring of MCO performance.

**Question 10.** What support and technical assistance is being provided to the LMEs as they prepare to transition?

**DHHS Response:**
In addition to the monthly monitoring meetings with DMA and DMH staff and the 120 and 60 day Mercer readiness reviews, ongoing technical assistance has been provided to the LME/MCOs on an individual basis according to need. For example, Sandhills has received additional assistance with the claims processing system (subcontracted to HP), while DHHS staff have gone to Mecklenburg to assist with technical assistance around provider network, claims payment, and finance management. DHHS is partnering with the NC Council of Community Programs to provide on-going trainings to MCOs on Medicaid contract requirements and managed care business models.