JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON HEALTH AND HUMAN SERVICES

September 11, 2012
Room 643, Legislative Office Building

The Joint Legislative Oversight Committee on Health and Human Services met on Tuesday, September 11, 2012 at 10:00 A.M. in Room 643 of the Legislative Office Building. Members present were: Senator Louis Pate, Representative Nelson Dollar, and Representative Justin Burr, Co-Chairs; Senators Austin Allran, Doug Berger, Stan Bingham, Harris Blake, Jim Davis, Fletcher Hartsell, Martin Nesbitt, William Purcell, and Tommy Tucker; and Representatives William Brisson, William Current, Mark Hollo, Pat Hurley, Tom Murry, and Fred Steen. Representatives Marilyn Avila and Verla Insko were also present.

Lisa Hollowell, Denise Thomas, Donnie Charleston, Karlynn O'Shaughnessy, Theresa Matula, Amy Jo Johnson, Jan Paul, Susan Barham, Sara Kamprath, Barbara Riley, Joyce Jones, Pat Porter, Rennie Hobby, Candace Slate, and Dina Long provided staff support to the meeting. A Visitor Registration Sheet is attached and made a part of the minutes. (See Attachment 1)

Chairman Dollar called the meeting to order and welcomed members and guests. He asked for a moment of silence in recognition of the 11th anniversary of the 9-11 terrorist attacks on our nation.

Beth Wood, North Carolina State Auditor, said the audit was performed on the Department of Health and Human Services, the Division of Medical Assistance and selected contracts with vendors to identify improper payments in the Medicaid program. (See Attachment No. 2) Auditor Wood explained the scope of the audit and the focus which looked specifically at four contracts – International Business Machines, (IBM), SAS Institute, Inc. (SAS), Public Consulting Group, Inc. (PCG), and Health Management System, Inc. (HMS). She then reviewed the findings of each of the contracts and their deficiencies. In reviewing additional information on IBM, Auditor Wood referenced an additional attachment. (See Attachment No. 2a) Interesting points included:

IBM -

- The expectation on the return on investment under the contract proposal would be 900%. IBM was paid $6M, the return on investment was to be $54M but only $426,000 has been collected.
- Problems stem around the fact that contracts let by North Carolina are poorly monitored and are not being properly reviewed by an objective oversight group.

SAS –

- There was supposed to have been a report, a nominally alert given to the agency in November 2011. It was not delivered until March 2012 and then was for a "test" group. It was not fully operational as called for in the contract yet SAS was still paid.

PCG –

- PCG identified by using a third party vendor $38.5M of potential recoupment. The actual recoupment was $3.7M and $3.2 was paid to PCG.

Auditor Wood was asked the nature of the fraud related to the $60M identified to potentially be collected by the State yet IBM was paid $6M. She responded that she would have to get the information.

Auditor Wood said in the end, the fault lies with North Carolina and how we write contracts and how we monitor contracts.

Chairman Dollar asked Al Delia, Acting Secretary of DHHS and staff to review the responses made to the formal audit document and any other changes or additions since that time. Secretary Delia said that DHHS largely concurred with the recommendations that the Auditor has made regarding the contract management and oversight. He said that DHHS monitoring current contracts and those going forward to see that issues identified are rectified going forward. Regarding the contracts, the Secretary said that North Carolina was one of the leading states in the country in weeding out fraud and abuse in the Medicaid program. Points of interest include the following:

- As a result of the software that IBM developed, nearly 200M in potential fraud has been identified in out-patient behavioral health across the State.
- More referrals of potential fraud cases have been made to the Medicaid Investigative Unit of the Attorney General's Office than ever before, and the Attorney General has accepted more of those cases for criminal prosecution than ever before.
- On a third party basis there are only four options in going after fraud:
    - Fixed price contract
    - Incentive base contract
    - Fund DHHS to do the work
    - Not go after fraud at all
- The General Assembly will need to direct DHHS as to which option to follow.

Mike Watson added that they concur with auditor's findings and that this is a new and very complex arena. The public integrity activities are new. Challenges exist with how to buy this service and often it is a public private partnership. How do you work with a private partner to take over this service of public integrity - what kind of incentives do you create for the people who do this. The contracts have become smaller with a fixed price and with a good chance of a significant return on the investment. As private partners develop these modules, they we own them and they provide leads for program integrity. How is this measured?

- HMS Contract, for example, has a 900% return on investment as it relates to 3rd party liability & recovery.
- Deterrence effect not measured. When you start auditing providers their billings go down.

Problems also exist with how you collect. We have a very provider friendly appeal system in North Carolina. When you try to recoup the money the providers go out of business. We have a good relationship with the Attorney General's office and there are increasing referrals for prosecution and an increasing action by them of acting on these referrals.

Secretary Delia said we don't have a good way of measuring the deterrence effect and would welcome the auditor taking a look at that. Chairman Dollar asked if a good measure would be looking at the overall amount of money spent when all variables are included. Secretary Delia concurred and stated that they are looking at that.

Chairman Dollar also asked Secretary Delia why the HMS contract shows a higher return on investment than the other contracts. Mike Watson said that the HMS contract's success is due to its operating in a more mature arena with much clearer and stable technology. SAS is very much working on the cutting edge technology wise in focusing on recipient fraud and abuse. There is also a cost to recoupment that state workers are no longer doing. PCG has had problems with extrapolation and quality control and DMA's oversight so they are working a plan of correction also.

Chairman Dollar also expressed his feeling (and that of other committee members) of the need to strike an appropriate balance between those legitimate providers working under difficult circumstances and those abusing the system. Chairman Dollar also asked what measures DHHS has taken for business entities that are working the system through new incorporations, etc. Mike Watson responded that they are trying to strike a balance. They are dealing with a small group (180) of providers out of thousands. As well they are trying to strike a balance between recoupment and educating providers. Mike Watson stated that they are working to create the right incentives so they get the right outcomes from providers. Also they are looking at the whole provider enrollment process and ways to catch people so they cannot close a business to avoid a recoupment and then set themselves up as the principal in a new business.

Representative Hurley wanted to know who writes the contracts, who reviews them and who signs them. Mike Watson responded that the contracts are a series of negotiations between the vendor and the departments. Oversight/review of the contract depends on the nature of the contract and approval goes through a whole chain of command with it ultimately coming to Mike Watson or the Secretary.

Representative Hurley further asked that since we own these systems do we have any follow up or are we on contract with them should there be any problems? Mike Watson said that we have an ongoing relationship with IBM for adding modules, etc. Secretary Delia stated as well that the IBM contract has gone from $6 million to $1.6 million and hopes that the current renewal discussion will bring it under $1 million.

Senator Bingham asked how legislators can better ensure that these recommendations are put in place. How do we implement these recommendations and not have the same problems down the road? Beth Wood responded that the Auditor's office would audit corrective actions in the future and report to the NC General Assembly. Mike Watson responded as well of the need to regularly report back on the implementation of the recommendations. Also they are working on a much more robust internal audit function at DHHS. They have 17,000 people with an audit team of 8 people. They need to be able to do a more robust job of looking at these issues internally, being able to uncover these things on their own and provide education and training internally as well.

Senator Bingham's concern was the initial contract and oversight and that it was not properly written. What could the General Assembly do on that end? Chairman Dollar stated that the General Assembly did take action on this in the recent past but there may be further need to look into this. Senator Hartsell stated that this arose from the Blue Cross contract and work by Program Evaluation. Program Evaluation is looking at this issue again in conjunction with DHHS and the State Auditor. There is discussion to look at addressing this in a much broader way and building a level of expertise for future contracts.

Senator Doug Berger asked what, in regard to the IBM contract, specifically allowed for the recovery of $250,000. What was the fraud? Secretary Delia stated that they did not have the information but would get it to him. The difference is between the three different sets of recoupment efforts. The SAS contract

deals with recipients so they are looking at a universe of about 1.3 million people. The approach is to prevent the expenditure of the money in the first place because recouping the money from individuals will be difficult. The IBM contract deals with providers and an approximate universe of 77,000. The recoupment efforts with those who are not criminally trying to avoid payment or recoupment will have greater success. The HMS contract deals with third party recoupments and that is the most mature of the markets. This deals with hundreds of targets in third party reimbursements that are typically insurance companies. These businesses have a stake in staying in business in North Carolina and it is much easier to recoup money from them.

Senator Berger asked what individual or individuals were accountable for entering into a contract that costs rather than saves money for North Carolina. Secretary Delia responded that ultimately it is the Secretary who signs these contracts. Down the line, it is a variety of people. Each one looks at this from a different perspective. It depends on the issue or perspective and that may be a problematic area as to who is held accountable for that particular area. Secretary Delia stated that we are involved in something new for the State of North Carolina and that while they may have gotten the initial contract terms wrong, the early results are pretty impressive and point to a substantial return on the investment – particularly as it relates to the IBM contract.

Senator Berger expressed his disappointment with the lack of information as to what fraud was recovered and why these contracts are good for North Carolina.

Mike Watson responded that he agreed with the auditor's findings but that part of the issue is how we view the contracts. The returns on investments were generated by vendors and we need to take a long-term viewpoint as to savings generated by the contracts.

Representative Brisson asked about the current law as it relates to appeals by providers in the court system. Does the present law allow you to go back and review those that are in the court system. Secretary Delia responded that North Carolina is an appeals friendly state. There are things that could be tightened up. Mike Watson stated that they could come back with recommendations on this.

Beth Wood stated that in the case of PCG it was a lack of training to the third party vendor that people were wrongly assessed on recoupments. She also noted that the Secretary has invited her to look at the deterrent factor and that the budget of DHHS is the General Assembly's responsibility and that it is up to the General Assembly to measure it and it is up to the State Auditor to determine if those figures are correct.

Representative Brisson further asked Mike Watson that if we have questionable providers and a flag appears then can we audit them. Mike Watson responded that the issue is ensuring that we are dealing with the high risk providers and not burdening legitimate providers. Under new Medicaid rules, if we have a credible fraud allegation, we can suspend Medicaid payments. They can also put providers on prepayment review. Representative Brisson asked if we properly gave providers the needed guidance on paperwork and rules. Secretary Delia stated that when providers sign a provider enrollment agreement to join the Medicaid program they certify they understand the rules but that DHHS also spends a great deal of time as well on provider education. Also they need to have the analytical ability to focus their efforts on people who have a high probability of having a problem as it relates to potential fraud and abuse.

Representative Hollo asked Secretary Delia about what the state would need to do for DHHS to conduct their own fraud investigations. Secretary Delia stated that was a matter of staff and resources and the

relevant funding. Representative Hollo also asked beyond software how fraud cases were identified and referred to the Attorney General's office. Secretary Delia stated that there was a hotline and that many of their investigations come from complaints by providers reporting another or staff or a recipient reporting on a provider. Mike Watson added that recipient fraud is small on an individual basis so they are focused on preventing rather than recouping recipient fraud. Representative Hollo further asked how we tangibly prevent fraud. Secretary Delia stated that on the recipient fraud we don't have a good way to prevent it – that's why they entered into the contract with SAS. On the provider side they are trying to move beyond "paying and chasing." He believes that's why the effort at deterrence is important. Chairman Dollar stated that they would revisit this issue in future meetings.

Senator Doug Berger stated that we are not fully utilizing the services of our State Auditor and that we need a new model for how the legislator interfaces with the State Auditor – particularly in light of these recent contract audits.

Budget Implementation Report

Mike Watson reviewed his submitted report concerning efforts to increase Medicaid enrollment in CCNC, the DMA State Medicaid Plan Amendments, the 1915 (i) SCU Application, NC Medicaid Non-Emergency Medical Transportation and the Pharmacy State Plan Amendment. (See attachment No. 3, 3a)

Chairman Dollar asked in relation to the 1915 (i) SCU Application what was driving the $18 - $20 million in additional expenses and if DHHS had a breakdown of those expenses. Mike Watson responded that they have worked to implement the application per legislative intent and it does not include additional services. Steve Owen added that the $18 - $20 million figure represents increased costs on the 1915 (i) SCU Application and the impact on other services.

Representative Hurley questioned Mike Watson about transportation brokers and why with the movement of individuals to communities instead of statewide, why we would want to put it back. Chairman Dollar responded that this was put in the legislation because every state that has implemented this program has saved millions of dollars. These are state and federal dollars that we are responsible for at the state level. Mike Watson also responded that the other issues are that two CCNC audits point out the difficulty of managing the program across 100 different sites in North Carolina. By having this on a state level you have a level of savings and consistent enrollment with the same level of documentation and safety and security checks.

Representative Hurley asked how this was working in other states. DHHS said that in surveying other states, the level of satisfaction to the broker system is good.

Chairman Pate asked for Mike Watson to comment further on the Hemophilia Specialty Pharmacy Program. How are pharmacies selected for this program? Mike Watson responded that they are not selected. It's a pharmacy service. Some are very small. By looking at the how these medicines are dispensed we can save money. Chairman Pate asked and Mike Watson affirmed that the discussion is to ensure the right amount of medication is dispensed.

Senator Bingham asked Mike Watson for the status of the RFP on the transportation system. Mike Watson said that the objective was to issue the RFP by October 15 per legislative direction.

Chairman Burr asked about the ABD enrollment and how far away are they from meeting their target goals. Mike Watson responded that it started the previous week and that CCNC is doing things to identify high cost high risk people who are not enrolled. The efforts with the adult care homes will also help. Educational activities will help with disenrollment along with auto-enrollment.

Chairman Burr further asked about the smart card pilot and the status. DHHS said they have a RFP stakeholders group and that they hope to have an RFP out by November.

Chairman Dollar recognized Steve Owen to make his presentation concerning the Financial Update and Status of the Medicaid Program. Steve Owen reviewed the report he submitted to the committee. Chairman Dollar asked and Steve Owen affirmed that as far as the first two months we are in a better financial state than we have been in previous years at the same point. (See Attachment No. 4)

Chairman Burr asked about the fiscal year 2011-12 and how much money budgeted for Medicaid was returned? Steve Owen said he could get that figure and other requested Medicaid financial data for Chairman Burr.

Chairman Pate noted that the total variance was a positive number but asked Steve Owen if this is something random because it depends so much on what the population is that enrolls and how sick they are. Steve Owen responded that they are tracking this weekly to make sure that they can track the variance and put things back on a positive track if needed.
Representative Hurley asked about provider workers needing to work 37 hours to acquire benefits. Steve Owen said he was not familiar with this and it sounded like a change by a specific provider.

The committee adjourned for lunch.

Update from DHHS on DOJ Settlement Agreement

Chairman Dollar called the committee back to order. He recognized Dr. Beth Melcher and Emery Milliken, General Counsel to DHHS, to speak to the committee on the DOJ Settlement Agreement. Emery Milliken spoke on the agreement itself while Dr. Melcher spoke via her prepared remarks/presentation concerning the plan and implementation. (See Attachment No. 5)

Emery Milliken noted that the United States Department of Justice's investigation into North Carolina's mental health system led to the August 2012 private settlement agreement. Overall the DOJ found that North Carolina failed to provide services to individuals with mental illness in the most integrated setting appropriate to their needs and was violating the ADA as a result. The current Secretary who was not the Secretary at the time gave directions for negotiating the settlement. He directed that the settlement should not be a settlement for settlement's sake, it should be good policy for North Carolina, any agreement needed to be built upon existing infrastructure and that the state should, as much as possible, maintain control of the agreement and not hand it over to a monitor or federal court judge.

As long as North Carolina does not violate the agreement there is no federal court involvement. If the federal government believes the state has failed to perform as promised it must prove to a federal court judge that the state is in breach before it can ask the federal court judge to ask the state to perform what it has agreed to under the contract.

There is no court monitor. North Carolina agreed to hire a reviewer who is under contract with the State. It is their duty to do a baseline study now as North Carolina begins to operate under the agreement and then annually every year thereafter while under the agreement to assure that the State is meeting the agreement's benchmarks.

Chairman Pate asked if an adult care home is determined to be an IMD will Medicaid funding then be cut off to the previously authorized Medicaid patients in that home. He also asked that if a patient has been identified and the home is designated as an IMD and the Medicaid funding is turned off immediately, does that mean that it is going to take 90 days to move that patient out? Beth Melcher responded that they are dealing with several issues – the IMDs, DOJ settlement and PCS. Where there is a slight overlap is with the IMDs and if a home is determined to be an IMD then North Carolina is obligated to make them a priority to do inreach and to help them to do transition planning. That transition planning has to be done within 90 days.

Chairman Dollar asked if the discharge for a DOJ settlement, IMD or PCS would all follow the same process. Beth Melcher responded that when an adult care is determined to be an IMD, individuals begin to make choices right then and DHHS needs to be prepared to provide assistance at a shorter period than 90 days and can do a fuller planning process as they go. The first responsibility is to make sure people are safe. Chairman Dollar further asked if DHHS will work with IMD defined houses and the associated individuals and use the resources the General Assembly provided to get those individuals in a housing situation. Beth Melcher responded that they will give priority to individuals in an IMD to get one of the slots. Priority will be further given to those with a mental illness.

Senator Tucker asked how an individual in an IMD has choice. Beth Melcher responded that choice was in respect to the agreement between the State and DOJ. Senator Tucker further asked if he was correct that an adult care home could have no more than 16 people with three only having a mental illness. Beth Melcher responded that she thought Senator Tucker was referring to the definition of an IMD institution for mental disease and what is counted there is an institution with more than 16 beds so 17 plus beds and more than 51% of the population is there primarily as a result of mental illness. Senator Tucker also asked about the possibility of looking at vacated downtown buildings to rehabilitate for housing options. Beth Melcher said that as it relates to housing they are not looking at building facilities. To qualify as a slot, USDOJ wants independent scattered sites and making downtown living spaces into a type of a "dorm" would be a congregate living space and as such the DOJ would not support. The possibility exists with housing individuals in apartments and providing people with a subsidy to acquire that housing. Emery Milliken added that with the ADA there is an integration mandate and that generally congregation settings don't meet this mandate. Only 20% of the people in apartment type settings can have a mental illness.

Representative Avila asked who the 12,000 figure represents. DHHS responded that there are three issues. One is the IMD issue which is driven by CMS and the requirement that CMS has imposed upon the State to designate facilities that meet the definition of an IMD. That will affect mostly adult care homes with the latest round affecting about 135 facilities and less than 400 people. Then there is the DOJ issue and integrating people by choice into the community. Over eight years the State will create 3000 slots and move 3000 people into those slots. Then there is the PCS issue that services must be provided equally regardless of where an individual lives. The 12,000 figure relates to the PCS issue.

Representative Avila asked that as it relates to the IMD, when they move enough patients to fall below the label of an IMD does that take the pressure off the concern of people losing their Medicaid. DHHS

said that this does make a difference. They are notified that they are no longer an IMD. But DHHS is required by CMS to monitor the facilities status to ensure they do not become an IMD again. But when a facility becomes an IMD, they are obligated by CMS to cut off payment to the facility and cut off the eligibility to people in that facility to Medicaid services. The facilities are notified that their services will be cut off about a week later but can remain enrolled in Medicaid without services for about 30 days. If they fall under the IMD label within those 30 days then services are reinstated for the facilities and its residents. After 30 days they have to reapply.

1915 B/C Waiver Update

Chairman Dollar recognized Kelly Crosbie to make her presentation to the committee which was provided to members. (See Attachment No. 6)

Chairman Dollar stated that he believed that if it was looking as if an LME is not going to be able to successfully convert, then they should look at, as allowed under the enabling legislation at merging it with an LME/MCO that is going to be successful. He also stated that on the business side he believes there has not been enough standardization.

Chairman Pate asked Kelly Crosbie about updating the dates that the LMEs will go live.

Chairman Burr requested if he could get the cost broken down per LME. He also hopes that DHHS will push the LMEs to move forward and that dragging their feet could put them at risk of losing their local control.

Chairman Dollar stated that he believes that there has to be a determination made with all these readiness reports that are done – will the LME be able to transition to an MCO and what our contingencies are if we don't have 11 LMEs converting.

Senator Bingham asked for an update on Mecklenburg. Kelly Crosbie said that a readiness review was done. They have a new CEO but still have a lot of staff to bring on along with implementing an IT system. They will continue to monitor them.

Senator Tucker asked if an individual transfers from Haywood County to Pitt County would they encounter the same forms/process. Kelly Crosbie stated that there are some very basic things that are similar. The basic Medicaid benefits, the innovations-waiver services, the care coordination model and the forms the provider will use are the same. They are working towards having the same contracts for all providers. There are still some things that need to be standardized to meet the PBH model and to make things easier for providers and recipients. There will still be some differences due to separate benefit plans managed separately depending on the needs of the individual in the community.

Representative Brisson asked who did the projections as to the January LME to MCOs. Kelly Crosbie said that the January date was what they put in the RFP for interested LMEs to apply to do the project. That was the final date when everyone was supposed to be ready per the RFP. Representative Brisson asked about the $750,000 savings and if that was per LME or overall. Mike Watson said that it was a monthly figure per each LME.

MMIS Status Report

Paul Guthrey, Senior Program Manager for MMIS, reviewed answers provided by DHHS as asked by the committee and staff. Committee members received a copy of the presentation. (See Attachment No. 7, 8)

Senator Brock asked about how the test of the multi-payer part was proceeding and any successes and failures. Paul Guthrey responded that the multi-payer part has not been fully tested yet. They have tested the claims engine since May. They have processed several multi-payer claims successfully. They are more difficult to recreate than they anticipated but they haven't run into any significant issues.

Senator Tucker asked how much more money it will cost to bring the system online. When is the finality and when the savings will be realized. Is this system like the one in New York that has failed? Are we looking at any potentials and have we learned anything from that system in New York? Paul Guthrey responded that savings start on the first day of operations. We then start accruing the $3 million a month in savings. Mr. Guthrey stated that he was not correct person to answer how much the system has cost to bring online over the seven years. New York was the baseline system. One of the reasons for the delay was that we only used 32% rather than 72% of that solution. This system has been significantly reworked to fit the needs of North Carolina.

Senator Tucker asked about what the cost "overruns" are as they relate to the project. Different figures and project changes were discussed.

Representative Avila asked why we built a new system on top of a legacy system. Where there financial issues that guided this decision? Paul Guthrey stated that he was not involved in the procurement of the system but that Medicaid management information systems are typically procured from a baseline solution that is working in another state.

Senator Brock asked if there were any employees for MMIS or in this system that are being paid any bonuses or for comp time. Secretary Delia said that there no employees being paid bonuses and there are about ten employees that are being paid comp time straight time for the amount of time they have put in above 40 hours a week. Senator Brock further inquired as to whether this included any exempt employees. Secretary Delia said he believes they are all exempt employees.

Chairman Dollar asked if Secretary Delia could provide the committee with the amount of comp time that has been utilized over the past year.

Chairman Dollar asked Paul Guthrey about the change orders put into the old system and if they are going to be able to convert over to the new system when the hard stop is done and you go live. Paul Guthrey said that the short answer is no. The freeze date was May 2, 2012. The goal was to incorporate all the changes made to legacy system into the replacement system. The reality is that the changes to the legacy system occurred at too high a rate for the replacement project to keep up with. They are working to implement the right changes currently. They are looking for manual workarounds and policy alternatives until they can get release two available. The goal is to not miss the implementation date.

Secretary Delia updated a previous question posed by Senator Tucker as to program costs. The original contract was 90.8 million. The revisions to that contract and the changes in scope added another $105.8 million so the total is $196.6 million which does not include the operational costs.

Chairman Dollar adjourned the meeting.

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Senator Louis Pate, Co-Chair

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Representative Justin Burr, Co-Chair

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Representative Nelson Dollar, Co-Chair

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Joey Stansbury, Committee Clerk