STATE OF NORTH CAROLINA

NORTH CAROLINA'S MANAGED CARE ORGANIZATION MODEL FOR BEHAVIORAL HEALTHCARE

(PBH – NOW DOING BUSINESS AS CARDINAL INNOVATIONS HEALTHCARE SOLUTIONS)

FINANCIAL RELATED AUDIT

DECEMBER 2012

OFFICE OF THE STATE AUDITOR

BETH A. WOOD, CPA

STATE AUDITOR

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AUDITOR'S TRANSMITTAL

December 4, 2012

The Honorable Beverly Eaves Perdue, Governor
The General Assembly of North Carolina
Board of Directors, Cardinal Innovations Healthcare Solutions
Pamela Shipman, Chief Executive Officer

This report presents the results of our financial related audit at PBH (now doing business as Cardinal Innovations Healthcare Solutions), which included matters related to the State of North Carolina's managed care organization model for behavioral healthcare. Our work was performed by authority of Article 5A of Chapter 147 of the *North Carolina General Statutes* and was conducted in accordance with the performance audit standards contained in *Government Auditing Standards*, issued by the Comptroller General of the United States.

The results of our audit disclosed internal control deficiencies and/or other matters that are considered reportable under *Government Auditing Standards*. These items are described in the *Audit Findings and Responses* section of this report.

North Carolina General Statutes require the State Auditor to make audit reports available to the public. Copies of audit reports issued by the Office of the State Auditor may be obtained through one of the options listed in the back of this report.

Beth A. Wood, CPA
State Auditor

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BACKGROUND

As authorized by Article 5A of Chapter 147 of the *North Carolina General Statutes*, we have conducted a financial related audit on North Carolina's managed care model for behavioral healthcare (PBH, now doing business as Cardinal Innovations Healthcare Solutions). The audit was conducted to address specific concerns communicated to the Office of the State Auditor regarding the general operations of PBH and its role as the model for the statewide expansion of the 1915(b) and (c) Medicaid waivers for persons with mental illness, intellectual and developmental disabilities, and substance abuse disorders (behavioral healthcare).

The 1915(b) and (c) Medicaid waivers refer to two sections of the Social Security Act that allow states to apply for waivers from federal Medicaid policy. The (b) waiver allows Medicaid recipients to enroll in managed care plans and allows Medicaid to limit the provider network based upon needs of recipients. The (c) waiver provides home and community-based care to Medicaid beneficiaries who would otherwise be institutionalized.

The Department of Health and Human Services' Division of Medical Assistance (DMA), the State Medicaid agency, is responsible for the operations of the 1915(b) and (c) Medicaid waivers. On April 1, 2005, the Department approved PBH (formally Piedmont Behavioral Healthcare - name changed March 2009) as the pilot program to offer managed behavioral healthcare services under the Medicaid waiver program for its region.

Managed Care Organizations (MCO) function as prepaid insurance health plans. As a Managed Care Organization, PBH is responsible for authorizing payments for services, processing and paying claims, and conducting utilization and quality management functions. Payments are made to MCOs on a per-member-per-month (PMPM) basis regardless of how many times the member seeks treatment or how many services the member might actually need. In essence, DMA is paying to insure the members for the covered services. Previously, the program operated on a fee-for-service basis.

Under federal requirements, a third-party actuary establishes a range of acceptable per-member-per-month rates, and DMA must contract with the MCO at rates that are within the approved range. The actuary also sets target rates considering base year rates, cost trends, and program changes. DMA uses this information to select proposed rates, which are then submitted to a departmental rate setting advisory committee for review before a final decision is made. The State has no control over how the MCOs use any surpluses built up from the payments made using the established rates.

The North Carolina General Assembly approved House Bill 916 during the 2011 session that required the Department to expand the 1915(b) and (c) Medicaid waivers for the statewide delivery of behavioral healthcare services. Key elements of the bill are:

- The system conversion is to be completed by July 1, 2013.

BACKGROUND (CONCLUDED)

- The Department "will maintain fidelity to the Piedmont Behavioral Health (PBH) demonstration model, a proven system for the operation of all public resources for mental health, developmental disabilities, and substance abuse services."
- The Department will establish accountability for the development and management of the local systems.

AUDIT SCOPE AND OBJECTIVES

The primary objective of this financial related audit was to address questions received by the Office of the State Auditor about PBH and the managed care program:

a. Is PBH spending service dollars for administrative purposes?

b. Is PBH complying with *North Carolina General Statute* 143-318.10(e) that requires public entities to "keep full and accurate minutes of all official meetings" and that "such minutes and accounts shall be public records?"

c. Is PBH generating revenue by charging other potential managed care organizations for the use of software that it developed while being funded with federal or state dollars?

d. Is there a conflict of interest in PBH's contracting with Daymark Recovery Services, Inc. to provide managed care services, as there was a prior relationship between the management of Daymark and PBH and the contract was not competitively bid?

e. Is the performance information provided by PBH to support its reported "savings" while operating as a managed care organization being monitored and verified?

f. If proposed changes to *North Carolina General Statute* Chapter 122C, Article 4 are implemented, would there be less transparency for PBH's activities?

While performing procedures to address the above questions, we also sought to identify improvements needed in internal control over selected fiscal matters related to the questions. Management is responsible for establishing and maintaining effective internal control. Internal control is a process designed to provide reasonable assurance that relevant objectives are achieved. Because of inherent limitations in internal control, errors or fraud may nevertheless occur and not be detected. Also, projections of any evaluation of internal control to future periods are subject to the risk that conditions may change or compliance with policies and procedures may deteriorate. Our audit does not provide a basis for rendering an opinion on internal control, and consequently, we have not issued such an opinion.

Our audit scope covered the period July 1, 2010 through December 31, 2011 and included selected internal controls at PBH, as well as the Department of Health and Human Services' Division of Medical Assistance (DMA) and Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH).

DMA, the State Medicaid agency, is responsible for the operations of the Medicaid waiver. In exercising this responsibility, DMA maintains an Intra-Departmental Monitoring Team to provide monitoring and project oversight throughout the course of the contract between DMA and PBH. The Intra-Departmental Monitoring Team includes representatives from DMA, DMH, PBH, and other impacted divisions within the North Carolina Department of Health and Human Services.

DMH has specific responsibilities for the provision of publicly funded services for individuals in North Carolina with mental health and substance abuse problems and/or with intellectual or developmental disabilities. DMH is responsible for the programmatic oversight of the use of state and federal funds allocated for these purposes.

Specific PBH accounts and internal control objectives included in our audit were:

Administrative Expenditures - These expenditures consist of salaries and benefits, contracted professional services, insurance, and other miscellaneous costs (including moving expenses) related to the general operations of PBH rather than the delivery of services. PBH incurred administrative expenditures of $32.7 million for the year ended June 30, 2011 and $47 million during our 18-month audit period. We examined internal control designed to ensure that PBH properly accounts for and reports these expenditures, and that such costs are adequately monitored by the Department of Health and Human Services in accordance with contract terms. We also examined controls to ensure that PBH was in compliance with state requirements applicable to salary administration.

Property Management Expense – These expenditures relate to the construction of the PBH administrative building and are a component of the total administrative expenditures reported above. For the year ended June 30, 2011, PBH reported expenditures of $11.3 million in this account. We examined internal control to ensure that PBH properly accounts for and reports these expenditures and that PBH complied with applicable state requirements for the purchase of the building, particularly the requirements for financing and holding title to property.

Service Expenditures – Medicaid - These expenditures are for services rendered to Medicaid eligible individuals with mental health, substance abuse and developmentally disability conditions within the PBH service area. For the year ended June 30, 2011, PBH reported expenditures of $95.9 million in this account. We examined internal control designed to ensure that PBH properly accounts for and reports these expenditures and that such costs are adequately monitored by the Department of Health and Human Services in accordance with contract terms.

Administration Revenue – Medicaid - These funds are a percentage of the total Medicaid payments to PBH. During fiscal year 2011, PBH generally allocated 13% of total Medicaid payments to this line item and reported $16.6 million in Medicaid administrative revenues. We examined internal control designed to ensure that PBH properly accounts for and reports these revenues and that the amounts paid were in accordance with federal and state guidelines.

Service Revenue – Medicaid - These funds are received from the Division of Medical Assistance (DMA) and allocated for services. The payments received are based on the approved per-member-per-month rate included in the contract with DMA. For the year ended June 30, 2011, PBH reported $111.1 million in Medicaid service revenue. We examined internal control designed to ensure that PBH properly accounts for and reports these revenues and that the amounts paid were in accordance with federal and state guidelines.

Note: For internal purposes, PBH continues to separate Medicaid revenue between administrative funds and funds for services. However, there are no external restrictions that require the moneys be used specifically for either purpose so long as proper services are provided to covered persons.

Subscription Revenue - These funds are received from other local management entities that have contracted with PBH for the use of the Cardinal Innovations Enterprise (CI) software application. For the year ended June 30, 2011, PBH reported $486,929 in subscription revenue. We examined internal control designed to ensure that PBH properly accounts for and reports these revenues.

Fund Balance Restricted for Medicaid Risk Reserve and Committed Fund Balances – Fund balance is reported in classifications reflecting limits on the use of the money. Restricted fund balances have constraints placed on their use by external grantors or contributors. Committed fund balances can only be used for specific purposes as directed by the governing board. For the year ended June 30, 2011, PBH reported restricted fund balance of $19.2 million for the required Medicaid Risk Reserve (15% of Medicaid payments received) and committed fund balances of $21.9 million. We examined internal control designed to ensure that PBH properly classified these fund balance amounts; amounts were in accordance with federal, state, or local requirements; and that the fund balances were reasonable and necessary.

Department Oversight of PBH Operations – We examined the activities of the Department of Health and Human Service's oversight agents, the Division of Medical Assistance (DMA) and the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH), to ensure that monitoring efforts were in accordance with federal, state, and contract guidelines and provisions.

METHODOLOGY

To accomplish our audit objectives, we gained an understanding of internal control over matters described below and evaluated the design of the internal control. We then performed substantive procedures that provide evidence about our audit objectives. Specifically, we performed procedures such as interviewing personnel, observing operations, reviewing policies, inspecting documentation, and analyzing accounting records.

As a basis for evaluating internal control, we applied the internal control guidance contained in professional auditing standards. As discussed in the standards, internal control consists of five interrelated components, which are (1) control environment, (2) risk assessment, (3) control activities, (4) information and communication, and (5) monitoring. As a basis for drawing other conclusions, we consulted federal regulations and correspondence, state laws, and contract provisions.

We conducted this audit in accordance with generally accepted government auditing standards applicable to performance audits. 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 conclusions based on our audit objectives.

RESULTS AND CONCLUSIONS

As a result of our audit, we identified several opportunities for the Department of Health and Human Services to improve North Carolina's managed care organization model for providing behavioral healthcare. Specifically:

- The Department of Health and Human Services should thoroughly monitor each managed care organization's financial position and administrative costs and use the information when setting future funding rates.

- The Department of Health and Human Services should update standard contracts to eliminate inapplicable provisions.

- The Department of Health and Human Services should take measures to manage the risks associated with transitioning to a managed care system. Risk management measures to consider include leveraging existing information technology systems and operating policies and procedures, as well as standardizing systems throughout the State to the extent possible. Organizations should not be transitioned to managed care organizations until they are deemed ready for the transition.

Details about these matters are reported in the *Audit Findings and Responses* section of this report. Our conclusions regarding specific questions received by the Office of the State Auditor about PBH and the managed care model are presented below:

Is PBH spending service dollars for administrative purposes?

Unlike a grant arrangement, whereby recipients must use moneys for specified purposes, in a managed care situation the Medicaid program pays a per-member-per-month fee for eligible persons to the Managed Care Organizations (MCO). So long as the organization provides the covered services appropriately, there are no restrictions on the use of the funds provided. Federal guidelines do not prohibit Managed Care Organizations (MCO) from accumulating fund balances and using the accumulated resources in any manner they see fit.

In the *Audit Findings and Responses* section of this report, we have recommended that the Department of Health and Human Services monitor MCO administrative expenses for reasonableness and necessity and use that information when setting future payment rates. Rate setting is the primary mechanism available to the Department for controlling the accumulation and use of fund balances.

Is PBH complying with *North Carolina General Statute* 132-6(a), which requires that "every custodian of public records shall permit any record in the custodian's custody to be inspected and examined at reasonable times and under reasonable supervision by any person, and shall, as promptly as possible, furnish copies thereof upon payment of any fees as may be prescribed by law?"

The question received by the Office of the State Auditor related to PBH's response to a public records request seeking to obtain copies of board minutes. The initial request was for electronic copies, which were not available because PBH had maintained the minutes only in paper form until 2010. The Attorney General's guidance on the law outlined in *Guide to Open Government and Public Records* indicates that "agencies are not required to put a record into electronic form if that record is not already kept in that medium." PBH completed a conversion to an electronic records system in June 2011, at which time the minutes were scanned into a database.

We determined that PBH ultimately released minutes to the requestor and also noted that PBH has made board minutes available on its website since August 2011.

Is PBH generating revenue by charging other potential Managed Care Organizations (MCO) for the use of software that it developed while being funded with federal or state dollars?

PBH charged Five County Mental Health Authority (Five County) and Orange-Person-Chatham (OPC) Mental Health, Developmental Disabilities, and Substance Abuse Authority on a monthly basis to use PBH's Cardinal Innovations Enterprise (CI) software application. The funds are recorded as subscription revenue and are used to offset expenditures of the CI Enterprise Department responsible for maintaining the software. However, PBH has expanded to the Five County and Orange-Person-Chatham (OPC) areas, and these areas are now part of PBH. Accordingly, these local management entities will no longer make payments for use of the CI system.

PBH is also charging East Carolina Behavioral Healthcare (ECBH) to use the CI System. ECBH is currently operating as a MCO. We met with officials of ECBH to discuss this business relationship. Officials noted that in its changeover to a MCO, there was a need to upgrade its billing software to handle some of the newer billing requirements. Rather than spend money on reconfiguring its current software, ECBH chose to lease the use of the PBH CI software. Indications were that the monthly fee was not out of line with costs that would be incurred had ECBH been running and maintaining its own billing software. Officials also indicated that while leasing the software, it allowed them the option to review other software billing products that ECBH could choose to purchase in the future.

The CI software is an internally-developed application designed to manage data processes for PBH. Providers use CI to electronically communicate consumer information, claims, authorization requests, and consumer clinical documentation with PBH.

While it is true that PBH used its federal and state revenue to develop its CI software, each of the other local management entities was also incurring similar expenses related to either the development or purchase of similar billing systems. Therefore, paying PBH did not significantly impact overall costs to the program.

In the *Audit Findings and Responses* section of this report, we have recommended that the Department of Health and Human Services monitor MCO fund balances and use the information when setting future payment rates. If the revenue generated from charges for using the software result in excessive fund balances, future payment rates should be reduced.

Is there a conflict of interest in PBH's contracting with Daymark Recovery Services, Inc. (Daymark) to provide managed care services, as there was a prior relationship between the management of Daymark and PBH and the contract was not competitively bid?

We did not identify any improprieties regarding the contract between PBH and Daymark. Daymark provides behavioral healthcare services in North Carolina, and derives nearly all of its revenues from contracts with PBH, Sandhills Center, and Centerpoint Human Services. The latter two organizations are local management entities. Daymark's management had prior business relationships with administrators of Piedmont Behavioral Healthcare (now PBH).

PBH has a policy that requires its board members to annually identify any potential conflicts of interest. There were no reported conflicts related to Daymark. We compared board members for PBH and Daymark and reviewed the composition of the management teams for both organizations. Nothing was identified that would suggest a conflict of interest.

PBH's contract with the Department of Health and Human Services' Division of Medical Assistance requires that PBH maintain a network of competent service providers. There is no requirement that providers be subject to a competitive bid process. In fact, the managed care system allows PBH to limit the provider network to include only the most qualified providers rather than any willing provider, as required under the Medicaid fee-for-service delivery system.

The Department monitors the provision of services by managed care organizations. It can also monitor the reasonableness and necessity of expenses, as we suggest in the *Audit Findings and Responses* section of this report. Effective monitoring of services and costs should help mitigate risks associated with PBH or other managed care organizations contracting with related parties.

Is the performance information provided by PBH to support its reported "savings" while operating as a managed care organization being monitoring and verified?

PBH is monitored by several different groups as required by federal regulations.

Intra-Departmental Monitoring Team

PBH's contract requires that the Department of Health and Human Services' Division of Medical Assistance (DMA) monitor it throughout the contract period. The main avenue for DMA's monitoring efforts is through its Intra-Departmental Monitoring Team. This monitoring team is comprised of representatives from DMA, the Department of Health and

Human Services' Division of Mental Health (DMH), PBH, and other Department representatives from the offices of controller and budget.

The monitoring team is required to meet quarterly and perform an annual on-site monitoring review. Items to be reviewed are established in the contract and include performance (financial and data performance), expenditures (PBH as well as any contracted services), and the need for changes or corrective actions related to PBH operations. Our audit included looking at documentation supporting that the DMA monitoring activities were occurring as required.

Department of Health and Human Services' Division of Mental Health (DMH)

DMH monitors PBH's performance as measured against system-established expectations and in comparison to the performance of other local management entities. DMH has a variety of reports that it uses to measure consumer access, cost of services, and system effectiveness (performance of services, consumer outcomes, and consumer satisfaction).

Other Parties

There are additional contracted parties that are also involved in the monitoring and oversight of PBH activities. DMA has contracted with Mercer Human Services Consulting to work jointly with the Intra-Departmental Monitoring team to conduct annual reviews of PBH. Those reviews address compliance with contract requirements, compliance with federal and state Medicaid requirements, and the cost effectiveness of services provided.

Every three years, the Carolinas Center for Medical Excellence conducts an external quality review (EQR) to determine if PBH is in compliance with federal Medicaid managed care regulations, validate PBH's performance measures, and to verify the delivery of services as mandated in PBH's contract with DMA.

> Note: We confirmed that a monitoring system is in place. However, we did not determine whether or not proper services are being provided to covered individuals. This objective may be addressed in a future audit.

If proposed changes to *North Carolina General Statute* Chapter 122C, Article 4 are implemented, would there be less transparency for PBH's activities?

North Carolina General Statute Chapter 122C, Article 4 was amended by Session Law 2012-151, which provides new requirements for area authorities.

We concluded that the amendment does not significantly reduce the transparency of PBH's operations. The most obvious change that could affect transparency is one that makes "competitive health care information" (for example in contracts between area authorities and health care providers) confidential and not subject to the public records law. This information is not directly related to an area authority's operations and seems to be an appropriate exclusion from the public records law. Also, the revised law states that the Attorney General,

State Auditor, and elected bodies having responsibility for the area authority have access to the information. Finally, the revised law describes an appeals process to have a court rule on whether information constitutes "competitive health care information," so a remedy is available should an area authority attempt to misuse the exclusion.

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RESPONSES TO RESULTS AND CONCLUSIONS

PBH Response:

We are in agreement with the *Results and Conclusions* presented above regarding the six questions received by the Office of the State Auditor about PBH (now doing business as Cardinal Innovations Healthcare Solutions) and the managed care program.

As there are no *Audit Findings* applicable to PBH as a result of the audit performed by Office of the State Auditor, we offer below the following additional information solely with respect to each of the questions included in the accompanying *Results and Conclusions*:

Is PBH spending service dollars for administrative purposes?

We agree that any savings generated by an MCO under the at-risk model accrue to the reserves of the MCO in the year that the savings are generated. We also agree that Federal guidelines do not prohibit MCO's from accumulating fund balances and using the accumulated resources in a manner determined by management of the MCO and its Governing Board.

We also note that when savings are generated in a particular year and increase the reserves of the MCO in that year, the funding provided to the MCO in the subsequent year is reduced and, accordingly, those savings effectively accrue to the State in perpetuity.

Even while generating significant savings, the PBH approval rate for services is very high. With respect to spending related to services, the current denial rate for Medicaid service requests is 0.4%; that is, PBH authorizes 99.6% of all Medicaid services that are properly requested.

We also respectfully submit that the rate setting process employed by DMA, in conjunction with Mercer, is a very thorough and detailed process which we believe has resulted in reasonable PMPM rates on a historical basis. One way this can be evidenced is by reviewing the change in PBH fund balance over the past six years in comparison to the level of budgets over the same time period. Over the six fiscal years 2006-2011, the PBH unrestricted fund balance grew at an average annual rate equal to approximately 2% of the annual budget, which we believe is a very reasonable level.

Is PBH complying with North Carolina General Statute 132-6(a), which requires that "every custodian of public records shall permit any record in the custodian's custody to be inspected and examined at reasonable times and under reasonable supervision by any person, and shall, as promptly as possible, furnish copies thereof upon payment of any fees as may be prescribed by law"?

As noted in the audit results, PBH completed a conversion to an electronic records system in June 2011. Once the conversion was completed, minutes for meetings held after the conversion were then scanned into a database and, consistent with *North Carolina General*

Statute 132-6(a) and the Attorney General's guidance on the law outlined in *Guide to Open Government and Public Records*, PBH has made board minutes available on its website since August 2011.

Is PBH generating revenue by charging other potential Managed Care Organizations (MCO) for the use of software that it developed while being funded with federal or state dollars?

We agree with the conclusion reached that any charges by PBH to ECBH did not significantly impact overall costs to the program. These charges related to ongoing monthly support costs only, and did not include any charges for the recoupment of development costs. Additionally, we note that the current support relationship between PBH and ECBH is scheduled to terminate later in calendar 2012, after which time, PBH will not be engaged with any other entities for systems support.

Is there a conflict of interest in PBH's contracting with Daymark Recovery Services, Inc. (Daymark) to provide managed care services, as there was a prior relationship between the management of Daymark and PBH and the contract was not competitively bid?

We agree that there is no requirement that providers are subject to a competitive bid process; in fact, allowing MCO's to limit the provider network to include only the most qualified providers, rather than any willing provider, is a cornerstone of the managed care framework.

We also note that during the conduct of the audit, there were no identified improprieties regarding the contract between PBH and Daymark (who also derives revenues from other MCO's), and that there was nothing identified that would suggest a conflict of interest.

Is the performance information provided by PBH to support its reported "savings" while operating as a managed care organization being monitoring and verified?

We agree with the confirmation provided in audit results that a monitoring system is in place. We respectfully submit that, in addition to internal monitoring activities and continuous quality improvement (CQI) reviews, PBH is heavily monitored by many different groups as required by various regulations and policies, including:

- Intra-Departmental Monitoring Team (DMA, DMH and representatives from the offices of controller and budget) reviews,
- DMA reporting and requests,
- DMH reporting and requests,
- Mercer reviews, including review of capitation and expenditures for services and administrative costs in conjunction with rate setting activities,
- National Committee on Quality Assurance (NCQA) reviews,
- Carolina's Center for Medical Excellence External Quality (EQR) reviews, and

- Annual financial audits, which are submitted to the Local Government Commission.

Also, with respect to the note regarding whether or not proper services are being provided to covered individuals, as indicated above, we respectfully submit that the current denial rate for Medicaid service requests is 0.4%; that is, PBH authorizes 99.6% of all Medicaid services that are properly requested.

If proposed changes to North Carolina General Statute Chapter 122C, Article 4 are implemented, would there be less transparency for PBH's activities?

We agree with the conclusion reached that changes to *North Carolina General Statute* Chapter 122C, Article 4, which was amended by Session Law 2012-151, do not significantly reduce the transparency of PBH's operations.

DHHS Response:

The Department agrees with the various statements and conclusions offered by OSA within the Results and Conclusions section of the report:

- With respect to revenues for non-MCO business, the Division of Medical Assistance uses Medicare Cost reporting guidelines in that all revenues and expenses for activities not related to the operation of the MCO would be disallowed in the calculation of the allowable expenses as the basis for the development of future payment rates.
- DHHS will continue the monitoring efforts noted above as well as seek opportunities to more efficiently monitor all MCO sites. In addition, we have also established the Departmental Waiver Advisory Committee, an oversight committee consisting of multiple stakeholder representatives, including consumers and providers.

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AUDIT FINDINGS AND RESPONSES

Department of Health and Human Services

1. DEPARTMENT SHOULD MONITOR MANAGED CARE ORGANIZATIONS' (MCO) FINANCIAL POSITION AND USE THE INFORMATION WHEN SETTING FUNDING RATES

   The Department of Health and Human Services should monitor each MCO's financial position and use the information when setting the rates in future contracts. If an MCO is building up excessive fund balances, this may indicate that rates need to be lowered within the actuarially determined ranges.

   We identified a trend of increasing fund balances at PBH since it began operating as an MCO. PBH's fund balances have increased from $19.2 million in fiscal year 2005 to $49.5 million in fiscal year 2011. Some increase was expected since PBH was required to establish a Medicaid Risk Reserve equal to 15% of the annual Medicaid payments received. At June 30, 2011, PBH's fund balance accounts included the following:

Restricted - Medicaid Risk Reserve	$19.2 million
Restricted - State Statute 159-8(a)	$3.2 million
Committed - General Medicaid Risk Reserve	$7.4 million
Committed - Renovations of Crisis Recovery Centers	$4.5 million
Committed - Service Development	$1.5 million
Committed - Medicaid Service Reserve	$1 million
Committed - Start-Up Expansion	$3.5 million
Committed - IT Infrastructure	$2.5 million
Committed - Support Needs Matrix Tansition	$1.5 million
Nonspendable	$0.2 million
Uncommitted and Unassigned	$5 million
Total	**$49.5 million**

   Restricted fund balances represent limits imposed by external parties, and committed fund balances represent plans made by the highest level of decision-making authority within the entity. Organizations should have documentation to justify committed fund balance amounts. While the committed fund balances shown above may represent legitimate needs of the organization, PBH provided limited documentation to justify the determination of amounts or the necessity of the projects.

   Under the managed care approach, organizations receive a per-member-per-month payment to perform the required services. Federal interpretation of the Medicaid waiver authority indicates that when savings are realized by the MCO under an established funding rate, the State may not dictate to the MCO what purpose or services for which the funds may be used.

The only mechanism available to the State to control a build-up of fund balances within managed care organizations is through the effective monitoring of their financial position and the approval of appropriate pay rates. We noted that the Department of Health and Human Services' Division of Medical Assistance (DMA) has been consistently approving a pay rate for PBH in the middle of the rate range established by the third-party actuary. Discussions with DMA staff indicated that they are currently reviewing their oversight processes involving the approval of the pay rate.

Auditor Recommendation: The Department should monitor MCO fund balances, including support for committed amounts, and use the information when selecting a pay rate within the actuarially determined range. Rates should be set at a level that allows for providing all of the necessary services and paying reasonable administrative and support expenses.

HHS Response: The Department agrees with the finding and recommendations. The rate development process includes using three years of PBH's historical expenditures trended forward to the current rate year. While the fund balances are not directly taken into account, the process of setting the rates takes into account previous year's savings and projects them forward into the new rate. Using this method of rate setting, PBH has experienced a reduction in their PMPM rate from SFY 2009 to current SFY 2013 of $32.75; which represents a cumulative reduction of 23.65%. While the members have grown during this same period by 32.6%, the actual cost has only increased by 1.24%. This represents a savings in SFY 2013 of $25,148,136 when comparing SFY 2013 to SFY 2009.

Additionally, the Department monitors the Risk Reserve fund to ensure that PBH complies with the contractual requirement that the fund balance must be not less than 15% of the annualized revenue. PBH has met this requirement for June 2011. With respect to the other funds, the Department is aware of the funds and that the funds are either committed or unrestricted. We agree with the State Auditor that PBH must supply sufficient documentation that their Board of Directors has restricted funds for specific purposes.

DMA has adopted a Financial Reporting Guide comprised of reporting instructions and templates for the MCOs use. This Guide has been shared with all MCOs and DMA is currently reviewing comments received before releasing the final version.

2. DEPARTMENT SHOULD MONITOR MANAGED CARE ORGANIZATIONS' (MCO) ADMINISTRATIVE COSTS AND USE THE INFORMATION WHEN SETTING FUNDING RATES

The Department of Health and Human Services should monitor each MCO's administrative costs and use the information when setting the rates in future contracts. To the extent possible, service expenditures should be maximized and administrative costs minimized.

While federal guidelines provide that the State may not dictate the purposes for which any Medicaid savings may be spent, including the investment of those savings for administrative infrastructure or other administrative needs, the State can set rates at levels that only provide for reasonable and necessary expenditures. Circumstances that indicate funding rates may be reduced include:

- Administrative spending is significantly higher than the administrative allowance included in the third-party actuary's determination of acceptable rate ranges.
- There is a significant increase in the ratio of administrative costs to service expenditures.
- Administrative costs are incurred that are judged to be extravagant or unnecessary.

In monitoring administrative costs, the Department should pay close attention to capital expenditures. We noted that PBH expended significant funds to construct its administrative office building. The building was constructed using loan proceeds of $4 million and accumulated savings of $7.3 million. While PBH obtained all the necessary approvals and the transaction was legal, care must be taken to ensure that capital outlay costs are reasonable and necessary.

Auditor Recommendation: The Department should monitor MCO administrative costs, with emphasis on capital outlay costs, and use the information when establishing pay rates. Rates should be set at a level that allows for providing all of the necessary services and paying reasonable administrative and support expenses.

HHS Response: The Department agrees with the finding and recommendations. As part of the rate setting process, DMA monitors both the administrative and services expenses of PBH and evaulates whether a change is needed. When PBH began in 2005, they received a general administrative percentage of 9.5%. In SFY 2009, the general administrative percentage was reduced to 8.5%. DMA monitors the administrative expenses and calculates the Medical Loss Ratio to ensure it does not fall below 80%.

3. REVISE CONTRACTS TO INCLUDE ONLY APPLICABLE AND DESIRED PROVISIONS

We identified contract provisions that were not being adhered to by either the Department of Health and Human Services' Division of Medical Assistance (DMA) or PBH. DMA officials indicated that the following sections of its 2011 contract were either not applicable and/or should be "readdressed" considering PBH's conversion to a managed care organization:

- *Attachment B Scope of Work, Section 1.10 Financial Reporting and Viability Measures* addresses PBH's maintenance of fund balance. DMA officials noted that this section was no longer applicable. Additionally, the DMA contract refers to a Division of Mental Health policy regarding a local management entity's fund

balance (which is not applicable to the MCO) and an outdated memo from a former controller staff regarding fund balance.

- *Attachment B Scope of Work, Section 10.6 Recoupment* addresses the recoupment of overpayments to providers. DMA officials have noted that this issue needs to be reviewed to determine how it should be applied under the MCO structure. For the period July 1, 2010 to June 30, 2011, PBH had recouped $890,000 in overpayments to providers due to erroneous claims. Funds from provider audit paybacks are currently deposited in PBH's General Medicaid Risk Reserve account. If the revenue generated and retained from the recoupment of overpayments result in excessive fund balances, future payment rates should be reduced.

During the audit, DMA officials requested policy staff to review and address any inapplicable sections of the contract.

Auditor Recommendation: The Department should thoroughly review the terms and conditions of its contract with PBH to ensure that all provisions are applicable and enforceable under federal and state guidelines. Any contractual changes would also be applicable to other managed care organizations as they enter the mental health network.

HHS Response: The Department agrees with the finding and recommendations. Section 1.10 is being revised to remove reference to an outdated memo. We are amending the contract and should have an amendment in place by January 1, 2013. The amended contract will be effective April 1, 2013. Section 1.10 will read as follows:

> "All funds received by the Contractor pursuant to this Contract shall be accounted for by tracking Title XIX Medicaid expenditures separately from services provided using other funding, as specified in the Financial Reporting Requirements, Attachment W.
>
> DMA shall monitor the Services Expense Ratio and the Administrative Cost Percentage. These expenses shall be analyzed as part of DMA's due diligence in financial statement monitoring and in order to enable DMA to report financial data to CMS."

The capitation payments paid to PBH utilizes historical claims data. Adjustments and/or recoupments that are reflected in the claims data would be reflected in the data that is used to establish the PMPM. Also, annually DMA requests any payments that are made outside of the system. This is also utilized in the rate development calculation.

4. ENSURE READINESS FOR TRANSITION TO MANAGED CARE SYSTEM

As with any significant change, making the transition from operating on a fee-for-service basis to a system of Managed Care Organizations (MCO) creates risks, including both service risks and financial risks. The Department of Health and Human Services must

manage these risks and ensure that the transition to the managed care system is as problem-free as possible.

Consultant's Report on Readiness for Transition

In 2010, the Department contracted with a consultant to assist in the review of four local management entities to determine their readiness for operating as MCOs. The consultant only recommended that one of the four entities be considered for conversion to the managed care system at that time.

Western Highlands Network was one of the entities identified in the consultant's report that might have difficulties transitioning to the managed care system, though the report indicated that it might could be ready for the change within one to one and a half years (i.e. by approximately January 2012). Western Highlands was subsequently selected by the Department to begin the transition to a MCO and began operating under the new managed care system in January 2012. However, it is already experiencing significant financial difficulties. As of the date of our audit, Western Highlands was projecting a budget shortfall of $3 million for its current fiscal year.

The Department is increasing its oversight and contracting with consultants to assist Western Highlands as it attempts to correct the situation. However, if similar difficulties occur in other organizations, the Department may not have sufficient resources to properly address the problems.

Information Technology (IT) Systems

One of the consistent deficiencies noted in the consultants report was inadequacy of the IT systems needed for the local entities to function as health plan administrators. Also, in a 2005 audit report on New Vistas (an area authority for behavioral health services), we reported that a major complaint by providers doing business within the State's mental health care network is the need for standard systems and processes across the network.

There are currently at least three different systems being used within the local management entity environment for processing claims. Even as the State moves to a smaller number of new managed care organizations overseeing services within the system, it appears that there will continue to be multiple IT systems across the state. During the early stages of the transition to a managed care system, there is an opportunity to leverage existing IT systems and standardize the systems. Such standardization could help mitigate risks associated with the transition.

Other Opportunities for Standardization

Throughout our discussions with PBH and Department officials, it was noted that PBH had already developed policies and procedures, training materials, and reporting formats that were necessary to transition to the managed care environment. The Department has the opportunity to leverage this material and standardize many of the processes needed

by each of the managed care organizations as they start up in the system. Such standardization could help mitigate risks associated with the transition.

Auditor Recommendation: The Department should continue to re-evaluate the readiness of the various local management entities and the level of assistance necessary to successfully transition to the managed care network. Organizations should not make the transition until judged ready. Further, the Department should consider opportunities for standardization as the new managed care system is being created.

HHS Response: The Department agrees with the finding and recommendations. Currently, the DHHS Intradepartmental Monitoring Team (IMT) meets face to face with PBH on a quarterly basis. The Department is implementing onsite monitoring visits in lieu of the first quarterly IMT meeting in order to monitor all aspects of functioning. The Department has already begun this process with ECBH. In addition, we have amended the financial reporting requirements and program integrity requirements to strengthen the process.

Efforts toward standardization have been made with provider applications, credentialing, enrollment, and monitoring; PBH has been the model for all of these standardization attempts. There are currently three IT different systems in use for information technology across the eleven sites, and efforts are being made to make them as similar as possible for providers.

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This audit required 2,702 audit hours at an approximate cost of $194,544. The cost represents 0.15% of the approximately $127.7 million of Medicaid funds received by PBH for the year ended June 30, 2011.