

STATE OF NORTH CAROLINA

OFFICE OF THE STATE AUDITOR

BETH A. WOOD, CPA

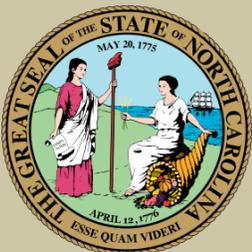


DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF HEALTH BENEFITS

MEDICAID LME-MCO CONTRACT PROVISIONS

PERFORMANCE AUDIT
FEBRUARY 2019



NCOSA
The Taxpayers' Watchdog

EXECUTIVE SUMMARY

PURPOSE

The purpose of this audit was to identify weaknesses in the Department of Health and Human Services' (Department) behavioral health managed care contracts so that the Department can ensure North Carolina's interests are protected when implementing managed care contracts for physical health care and pharmacy services.

BACKGROUND

North Carolina contracts with seven Local Management Entities-Managed Care Organizations (LME-MCOs) to operate the managed **behavioral healthcare services** under the Medicaid waiver through a network of licensed practitioners and provider agencies.

LME-MCOs manage, coordinate, facilitate, and monitor the provision of mental health, developmental disabilities, and substance abuse services for members across the State's 100 counties.

As directed by the North Carolina General Assembly,¹ the State is transitioning its Medicaid and NC Health Choice programs' care delivery system for most beneficiaries and services from a predominately Medicaid Fee-for-Service model to a Medicaid managed care model.

The Medicaid managed care model, which will integrate **physical healthcare services** and **pharmacy services** with behavioral healthcare services, will be operated and managed by MCOs that contract with the Department. A request for proposal was released by the Department in August 2018.

Integration is expected to begin in 2019. Once completed, most of the State's \$13.9 billion Medicaid program and 2.1 million beneficiaries will transition to Medicaid managed care.

KEY FINDINGS

The Department's managed behavioral healthcare services contracts did not always contain clear contractual requirements to sufficiently protect the State nor ensure compliance with all federal and state requirements. Specifically:

- The contracts did not include terms to define or recover excess LME-MCO savings, define unreasonable administrative and service costs, or limit profits from related-party transactions
- The contracts did not contain all federally required provisions. Some provisions lacked sufficient language, were written incorrectly or were missing

¹ Session Law 2015-245.

EXECUTIVE SUMMARY (CONCLUDED)

KEY RECOMMENDATIONS

- The Department should include language in its contracts that limits the profit that private MCOs can retain. The contracts should address the degree to which each party keeps any MCO profit in excess of an agreed-upon amount. The profit limit should be negotiated to offer the State protection against financial risks while not deterring the efficient management of costs by MCOs. The Department should ask the Legislature to enact a state law that would limit excess MCO profits by requiring profit that exceeds a defined amount to be shared with the State
- The Department should include language in its contracts that requires reporting of program administrative costs pursuant to federal cost principles
- The Department should include language in its contracts that explicitly defines an allowable profit component between the MCOs and their affiliated parties for medical expenses
- The Department should ensure that all federally required provisions and components for specified managed care regulations are incorporated into current and future Medicaid managed care contracts

The key findings and recommendations in this summary may not be inclusive of all the findings and recommendations in this report.

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Office of the State Auditor



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AUDITOR'S TRANSMITTAL

The Honorable Roy Cooper, Governor
Members of the North Carolina General Assembly
Dr. Mandy K. Cohen, Secretary
Dave Richard, Deputy Secretary for NC Medicaid, Division of Health Benefits

Ladies and Gentlemen:

We are pleased to submit this performance audit report titled Medicaid LME-MCO Contract Provisions. The audit objective was to identify weaknesses in the Department of Health and Human Services' (Department) behavioral health managed care contracts so that the Department can ensure North Carolina's interests are protected when implementing managed care contracts for physical health care and pharmacy services.

The Department of Health and Human Services Secretary, Dr. Mandy Cohen, reviewed a draft copy of this report. Her written comments are included starting on page 14.

This audit was conducted in accordance with Article 5A of Chapter 147 of the *North Carolina General Statutes*.

We appreciate the courtesy and cooperation received from management and the employees of the Department of Health and Human Services and the Division of Health Benefits during our audit.

Respectfully submitted,

A handwritten signature in cursive script that reads "Beth A. Wood".

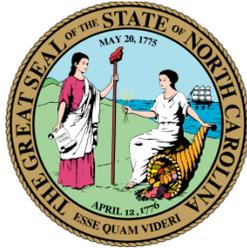
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BACKGROUND

North Carolina contracts with seven Local Management Entities-Managed Care Organizations (LME-MCOs) to operate the managed **behavioral healthcare services** under a Medicaid waiver through a network of licensed practitioners and provider agencies.

LME-MCOs manage, coordinate, facilitate, and monitor the provision of mental health, developmental disabilities, and substance abuse services for members across the State's 100 counties.

Each month the State pays the LME-MCOs a capitation or fixed rate per person based on historical utilization of medical services. The per-member-per-month (PMPM) payments to LME-MCOs accounted for \$2.6 billion (19%) of the \$13.6 billion in Medicaid expenditures for state fiscal year 2017 and \$3.2 billion (23%) of \$13.9 billion for state fiscal year 2018.

As directed by the North Carolina General Assembly,² the State is transitioning its Medicaid and NC Health Choice programs' care delivery system for most beneficiaries and services from a predominately Medicaid Fee-for-Service model to a Medicaid managed care model.³

The Medicaid managed care model, which will integrate **physical healthcare services** and **pharmacy services** with behavioral healthcare services, will be operated and managed by MCOs that contract with the Department of Health and Human Services (Department). A request for proposal was released by the Department in August 2018.

Integration is expected to begin in 2019. Once completed, most of the State's \$13.9 billion Medicaid program and 2.1 million beneficiaries will transition to Medicaid managed care.

Responsible parties discussed in this report include:

North Carolina Department of Health and Human Services⁴

The Department's mission is to improve the health, safety, and well-being of all North Carolinians. The Department helps provide specific services to special populations including individuals who are deaf, blind, developmentally disabled, mentally ill, or economically disadvantaged.

The Department is divided into 30 divisions and offices that fall under four broad service areas: health, human services, administrative, and support functions. The Department also oversees developmental centers, neuro-medical treatment centers, psychiatric hospitals, alcohol and drug abuse treatment centers, and two residential programs for children.

Division of Health Benefits (Division)⁵

The Division's mission is to help low-income parents, children, seniors, and people with disabilities receive care and services to improve their health and well-being. Overseen by the Department of Health and Human Services, the Division manages North Carolina's Medicaid program.

Local Management Entities-Managed Care Organizations (LME-MCOs)

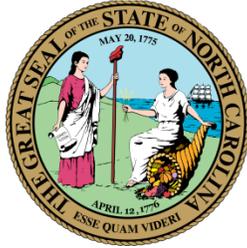
The LME-MCOs were created by North Carolina General Statute 122C and are responsible for managing, coordinating, facilitating, and monitoring the provision of mental health, developmental disabilities, and substance abuse services across North Carolina.

² Session Law 2015-245.

³ Medicaid managed care is a system organized to manage cost, utilization, and quality of services with the intent of reducing costs and improving participant health.

⁴ <https://www.ncdhhs.gov/mission-vision>, <https://www.ncdhhs.gov/about/overview>.

⁵ <https://medicaid.ncdhhs.gov/>.



OBJECTIVE, SCOPE, AND METHODOLOGY

The audit objective was to identify weaknesses in the Department of Health and Human Services' (Department) behavioral health managed care contracts so that the Department can ensure North Carolina's interests are protected when implementing managed care contracts for physical health care and pharmacy services.

The audit scope included the Department's contracts with LME-MCOs executed on July 1, 2017 for state fiscal year 2018.

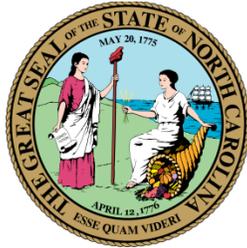
To accomplish the audit objective, the Office of the State Auditor (OSA) contracted with a subject matter expert in the field of Medicaid managed care, Navigant Consulting. Navigant Consulting identified areas of risk where other states have routinely lacked sufficient contract provisions and assisted with evaluating the sufficiency of the Department's contract provisions.

Additionally, to accomplish the audit objective, auditors interviewed personnel; reviewed federal and state regulations, waivers, manuals, and templates; and examined contracts and referenced documentation. Whenever sampling was used, auditors applied a nonstatistical approach. Therefore, results could not be projected to the population. This approach was determined as adequate to support audit conclusions.

Because of the test nature and other inherent limitations of an audit, together with limitations of any system of internal and management controls, this audit would not necessarily disclose all performance weaknesses or instances of noncompliance.

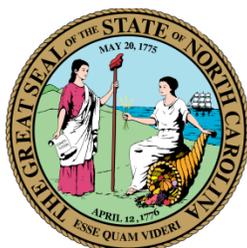
As a basis for evaluating internal control, auditors applied the internal control guidance contained in professional auditing standards. However, our audit does not provide a basis for rendering an opinion on internal control, and consequently, we have not issued such an opinion.

We conducted this performance audit in accordance with Generally Accepted Government Auditing Standards. 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 findings and conclusions based on our audit objective.



RESULTS AND CONCLUSIONS

The Department of Health and Human Services' managed behavioral healthcare services contracts did not always contain clear contractual requirements to sufficiently protect the State nor ensure compliance with all federal and state requirements.



FINDINGS, RECOMMENDATIONS, AND RESPONSES

1. CONTRACT LACKS TERMS TO PROTECT THE STATE FROM EXCESS COSTS

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

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

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

The Department pays LME-MCOs a capitation rate⁶ for each enrolled Medicaid member. Capitation rates are generally calculated to cover medical service costs, administrative expense, and a margin for risks and profit.⁷ The rate calculation is based on historical costs and actuarial expectations about future Medicaid cost and use trends.

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

For example, California's managed care organizations experienced billions of dollars in unexpected profits when Medicaid costs did not increase as much as the State projected.

In 2017, the Los Angeles Times reported on the profits:⁸

"Overall, Medicaid insurers in the Golden State made \$5.4 billion in profits from 2014 to 2016, in part because the state paid higher rates during the inaugural years of the nation's Medicaid expansion under the Affordable Care Act, or Obamacare. Last year, they made more money than all Medicaid insurers combined in 34 other states with managed care plans."

"Traditionally, these insurance contracts have yielded slim profit margins of 2% to 3%. California said it aims for 2% when setting rates, based on prior claims experience and projected costs.

But in the years since the health law took effect, many health insurers have posted margins two or three times that benchmark."

⁶ A monthly fee paid for each member assigned or each event (for example, maternity delivery) regardless of the number or actual cost of services provided under a system of reimbursement for MCOs [managed care organizations]." [Actuarial Standards Board](#).

⁷ Profit by definition is equivalent to savings, which refers to the unspent funds remaining from capitated payments received by the LME-MCOs.

⁸ [Insurers make billions off Medicaid in California during Obamacare expansion](#), LA Times, November 5, 2017.

The Los Angeles Times also reported on why the profits occurred:

“In anticipation of the Obamacare rollout, **officials in California** and elsewhere boosted their payments to managed-care companies because they **expected Medicaid costs to increase** as newly insured patients rushed to the doctor or emergency room after going years without coverage. **But those sharply higher costs didn’t materialize — and insurers pocketed more money as a result**, especially in California.” [*Emphasis Added*]

Similarly, North Carolina is at risk for errors in the assumptions and projections that it makes when setting capitation rate because, without contract language that addresses excess profits, the Medicaid funds will be unrecoverable and outside of state control. Federal law prohibits states from directing the expenditure⁹ of or recouping¹⁰ any unspent Medicaid funds allocated for delivery system or provider payment initiatives from the managed care plan.

The Centers for Medicare and Medicaid Services (CMS) reasons that:¹¹

“Managed care plans receive risk-based capitation payments to carry out the obligations under the contract....As funds associated with delivery system reform or performance initiatives are part of the risk-based capitation payment, **any unspent funds remain with the MCO, PIHP,¹² or PAHP.¹³**” [*Emphasis Added*]

And the risk to North Carolina could be significant.

To illustrate, a recent Office of the State Auditor (OSA) audit¹⁴ noted that LME-MCOs accumulated \$439.2 million of excess savings from state fiscal year (SFY) 2015 through 2017. And federal law allows the private MCOs to keep and spend the excess profits at their discretion.

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

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

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

⁹ 42 CFR 438.6(c)(1).

¹⁰ 42 CFR 438.6(c)(2)(ii)(D).

¹¹ Federal Register, Volume 81, No. 88, Friday, May 6, 2016, pg. 27587.

¹² Prepaid Inpatient Health Plan

¹³ Prepaid Ambulatory Health Plan

¹⁴ <https://www.ncauditor.net/EPSWeb/Reports/Performance/PER-2017-4445B.pdf>.

To illustrate, Texas uses this strategy in its *Uniform Managed Care Contract*. Texas's contract states:

“HHSC¹⁵ and the MCO will share the consolidated Net Income Before Taxes for its HHSC programs as follows:

1. The MCO will retain all the Net Income Before Taxes that is equal to or less than 3% of the total Revenues received by the MCO;
2. HHSC and the MCO will share that portion of the Net Income Before Taxes that is over 3% and less than or equal to 5% of the total Revenues received, with 80% to the MCO and 20% to HHSC.
3. HHSC and the MCO will share that portion of the Net Income Before Taxes that is over 5% and less than or equal to 7% of the total Revenues received, with 60% to the MCO and 40% to HHSC.
4. HHSC and the MCO will share that portion of the Net Income Before Taxes that is over 7% and less than or equal to 9% of the total Revenues received, with 40% to the MCO and 60% to HHSC.
5. HHSC and the MCO will share that portion of the Net Income Before Taxes that is over 9% and less than or equal to 12% of the total Revenues received, with 20% to the MCO and 80% to HHSC.
6. HHSC will be paid the entire portion of the Net Income Before Taxes that exceeds 12% of the total Revenues.”

Alternatively, North Carolina could use a state law like Florida's “achieved savings rebate” statute¹⁶ that requires MCOs to share profits greater than 5% with the state. Specifically, the law states:

“...the achieved savings rebate is established by determining pretax income as a percentage of revenues and applying the following income sharing ratios:

1. One hundred percent of income up to and including 5 percent of revenue shall be retained by the plan.
2. Fifty percent of income above 5 percent and up to 10 percent shall be retained by the plan, and the other 50 percent refunded to the state and transferred to the General Revenue Fund, unallocated.
3. One hundred percent of income above 10 percent of revenue shall be refunded to the state and transferred to the General Revenue Fund, unallocated.”

No Contract Terms to Define Unreasonable Administrative and Service Costs

The Department's managed behavioral healthcare services contracts did not include language that explicitly defined the cost principles¹⁷ that LME-MCOs must use for administrative and service costs.

¹⁵ Texas Health and Human Services Commission.

¹⁶ <https://www.flsenate.gov/Session/Bill/2011/7107/Analyses/h7107z.HHSC.PDF>.

¹⁷ Federal cost principles provide guidelines to evaluate whether certain costs are necessary and reasonable.

LME-MCOs are not subject to the federal law¹⁸ that specifies what state agencies can claim as administrative and service costs.

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

For example, a recent OSA audit¹⁹ noted unreasonable spending of Medicaid funds that included:

- \$113,505 on board retreats at luxury resorts
- \$94,184 on board meetings at high-end venues
- \$7,702 on chartered flights

Additionally, LME-MCOs have reported spending approximately \$369,000 of Medicaid funds on lobbying contracts throughout FY 2015 and 2016.²⁰ Lobbying costs are disallowed according to the federal cost principles.

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

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

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

“Clearly spell out the requirements for reporting financial expenditures for both administrative and service costs.

Require reporting of program administrative costs pursuant to OMB Circular A-87 and the principles for cost accounting in OMB Circular A-133,²¹ which require the reporting of costs by program and set standards for the allocation of overhead and shared administrative costs.”

¹⁸ 2 CFR part 200 Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards.

¹⁹ <https://www.ncauditor.net/EPSWeb/Reports/Performance/PER-2017-4445.pdf>

²⁰ According to LME-MCO monthly financial reports submitted to the Department.

²¹ Both OMB Circular A-133 and A-87 are superseded by 2 CFR part 200 Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards.

To illustrate, Texas uses this strategy in its *Uniform Managed Care Contract*. Texas' contract states:

"All costs, fees, assessments, Affiliate transactions, and Subcontracts are subject to the allowability tests and requirements as set forth in the FAR (48 C.F.R Part 31) and 2 C.F.R. Part 200..."

"To be allowable, expenses must conform to the requirements of this Chapter, which include being reasonable and allocable."

"Reasonable Cost means a cost that, in its nature and amount, does not exceed that which would be incurred by a prudent person under the circumstances prevailing at the time the decision was made to incur the cost. In determining reasonableness of a given cost, consideration must be given to:

- (1) whether the cost is of a type generally recognized as ordinary and necessary for the operation of the MCO or the performance of the services required under the Contract;
- (2) the restraints or requirements imposed by such factors as: sound business practices; arm's length bargaining; federal, state, and other laws and regulations; and, terms and conditions of the Contract;
- (3) market prices for comparable goods or services;
- (4) whether the individuals concerned acted with prudence in the circumstances considering their responsibilities to the MCO, its employees, the public at large, and the State of Texas; and
- (5) significant deviations from the established practices of the industry which may unjustifiably increase the cost incurred by the MCO to provide the services required under the Contract."

No Contract Terms to Limit Profits From Related Party Transactions

The Department's managed behavioral healthcare services contracts did not include sufficient provisions for related party transactions.²² While the State's contracts require LME-MCOs to report related-party transactions, nothing in the contract explicitly defines an allowable profit component between the LME-MCOs and their affiliated parties for medical expenses.

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

Problems with related-party transactions and the excess profits they can produce in Medicaid settings have been identified before.

²² Refers to payments and other transactions made to management companies or providers affiliated with the LME-MCOs. These transactions should not include a profit component or be higher than the rate paid to unrelated providers for similar services.

In a 2014 performance audit of its Health Care Authority's (HCA) oversight,²³ the Washington State Auditor's Office wrote:²⁴

"Given that related-party transactions are not governed by arms-length negotiations of price, it is always possible that unreasonable profit components might be included in these transactions, resulting in overstated costs. Since a profit component is already factored into the premium rates calculated by the state's actuary, the risk to HCA is that managed care organizations could be generating multiple layers of profits through including additional profit components in related-party transaction costs."
[Emphasis Added]

And in an August 27, 1993, memorandum, the federal Department of Health and Human Services, Office of the Inspector General stated:²⁵

"In our HealthPASS review, we determined that the contractor had identified related party transactions in the financial statements but did not report that they were [not] arm's-length. Neither did the independent auditor that audited the financial statements. Our review showed that millions of dollars in payments were made to owners/directors and affiliated companies of the contractor. These payments did not threaten the contractor with insolvency. The payments did, however, increase the administrative costs of the HealthPASS program, and significantly reduced the contractor's pretax earnings that were reported to the State agency."

We believe that safeguards over related party transactions are needed if ever there is to be a true picture of the profitability of managed care plans. Without such a picture, identification of cost savings opportunities might well be missed. In the case of HealthPASS, we reported to the State agency what we believe the actual earnings of the contractor were for a 33-month period of operation. We recommended that the State agency consider the adjusted pretax earnings during its annual renegotiation of the current HealthPASS contract.

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

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

²³ Health Care Authority's Oversight of the Medicaid Managed Care Program, April 14, 2014.

²⁴ https://www.sao.wa.gov/state/Documents/PA_Medicaid_Managed_Care_ar1011450.pdf.

²⁵ <https://oig.hhs.gov/oas/reports/region3/39300200.pdf>.

For example, when identifying best practices, the Washington State Auditor's Office recommended clearly defining cost principles:²⁶

“Linking Medicaid-allowable cost principles to Medicare and Federal Acquisition Regulations (FAR) principles helps supplement Medicaid rules and gives the managed care organization more complete definitions for allowable costs and treatment of other cost and revenue components, including payments made to related parties. Medical providers continue to consolidate and develop new operating structures resulting in related party transactions. **Guidance should be given as to the expectations, allowability and reporting of payments to related parties to prevent an unintended layering of profits earned by the organization.**” [*Emphasis Added*]

Additionally, North Carolina could include contract language similar to the Medicare regulations that govern related-party transactions. The Medicare regulations²⁷ require:

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

RECOMMENDATIONS

The Department should include language in its contracts that limits the profit that private MCOs can retain. The contracts should address the degree to which each party keeps any MCO profit in excess of an agreed-upon amount. The profit limit should be negotiated to offer the State protection against financial risks while not deterring the efficient management of costs by MCOs.

Alternatively, the Department should ask the Legislature to enact a state law that would limit excess MCO profits by requiring profit that exceeds a defined amount to be shared with the State.

The Department should include language in its contracts that requires reporting of program administrative costs pursuant to federal cost principles.

The Department should include language in its contracts that explicitly defines an allowable profit component between the MCOs and their affiliated parties for medical expenses.

AGENCY RESPONSE

See page 15 for the Department's response to this finding.

²⁶ Health Care Authority's Oversight of the Medicaid Managed Care Program, April 14, 2014.

²⁷ 42 CFR 422.516(b).

2. MANAGED BEHAVIORAL HEALTHCARE SERVICE CONTRACTS DID NOT CONTAIN ALL FEDERALLY REQUIRED PROVISIONS

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

Managed Behavioral Health Contracts Contained Inadequate Contract Provisions

Auditors sampled 262²⁸ of 470 federally required contract provisions²⁹ and identified 12 (4.58%) instances where provisions lacked sufficient language, were written incorrectly, or were missing.

Insufficient Contract Language

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

Medical Loss Ratio

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

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

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

Billing

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

²⁸ Navigant Consulting, using their expertise and prior experience with managed care contracts, assisted the auditors with identifying the areas of risk. Risk areas were based on impacts in other states that failed to include adequate provisions in the contracts. The auditors focused their test procedures on the following areas of risk: (1) Case Management, (2) Provider Network/Network Adequacy, (3) Quality Assessment and Performance Improvement, (4) Reporting, (5) Finance/Solvency, (6) Medicaid Management Information System (MMIS)/Encounter Data, (7) Grievance and Appeals, and (8) Admin: Termination; Subcontracts; Penalties/Sanctions.

²⁹ The State Guide to Centers for Medicare and Medicaid Services (CMS) Criteria for Medicaid Managed Care Contract Review and Approval dated January 20, 2017 details "the criteria for contract approvals and to help states verify that contracts with Medicaid managed care entities meet all CMS requirements."

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

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

Appeals

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

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

Incorrectly Written Contract Provisions

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

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

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

Missing Contract Provisions

Two provisions regarding physician incentive plans were missing from the Department's managed behavioral healthcare services contracts. One provision would prevent LME-MCO payments to physicians that would incentivize reducing medically necessary services. The other provision would require physicians to maintain adequate stop-loss financial protection.

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

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

Caused by Department's Insufficient Contract Development Process

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

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

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

Regulations Require Complete and Sufficient Managed Care Contracts

The federal Centers for Medicare and Medicaid Services (CMS) requires the Department's contracts with LME-MCOs to include provisions for specified managed care regulations.³⁰

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

RECOMMENDATIONS

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

AGENCY RESPONSE

See page 15 for the Department's response to this finding.

³⁰ The majority of the regulations are codified at 42 CFR 438.



RESPONSE FROM DEPARTMENT OF HEALTH AND HUMAN SERVICES



STATE OF NORTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

ROY COOPER
GOVERNOR

MANDY COHEN, MD, MPH
SECRETARY

February 8, 2019

The Honorable Beth A. Wood, State Auditor
Office of the State Auditor
2 South Salisbury Street
20601 Mail Service Center
Raleigh, North Carolina 27699-0601

Dear Auditor Wood:

We have reviewed the draft performance report titled Medicaid LME-MCO Contract Provisions, covering the Department's contracts with Local Management Entities-Managed Care Organizations (LME-MCOs) executed on July 1, 2017 for state fiscal year 2018. The following represents our response and corrective action plan to the Audit Findings and Recommendations including our comments regarding the Matters for Further Consideration.

AUDIT FINDINGS, RECOMMENDATIONS, AND RESPONSES

1. CONTRACT LACKS TERMS TO PROTECT THE STATE FROM EXCESS COSTS

Recommendations:

The Department should include language in its contracts that limits the profit that private MCOs can retain. The contracts should address the degree to which each party keeps any MCO profit in excess of an agreed-upon amount. The profit limit should be negotiated to offer the State protection against financial risks while not deterring the efficient management of costs by MCOs.

Alternatively, the Department should ask the Legislature to enact a state law that would limit excess MCO profits by requiring profit that exceeds a defined amount to be shared with the State.

The Department should include language in its contracts that requires reporting of program administrative costs pursuant to federal cost principles.

The Department should include language in its contracts that explicitly defines an allowable profit component between the MCOs and their affiliated parties for medical expenses.

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Honorable Beth A. Wood
February 8, 2019
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Agency Response:

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

2. MANAGED BEHAVIORAL HEALTHCARE SERVICE CONTRACTS DID NOT CONTAIN ALL FEDERALLY REQUIRED PROVISIONS

Recommendations:

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

Agency Response:

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

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

We appreciate the assistance and professionalism provided by your staff in the performance of this audit. If you need any additional information, please contact John Thompson at (919) 814-0123.

Sincerely,



Mandy Cohen, MD, MPH
Secretary

MC;jet

Honorable Beth A. Wood
February 8, 2019
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cc: Susan Perry-Manning, Principal Deputy Secretary
Rob Kindsvatter, Chief Financial Officer
Mark Benton, Deputy Secretary for Health Services
Dave Richard, Deputy Secretary, NC Medicaid, Division of Health Benefits
Roger Barnes, Chief Financial Officer, NC Medicaid, Division of Health Benefits
Mona Moon, Chief Operating Officer, NC Medicaid, Division of Health Benefits
Sandra Terrell, Director, Clinical and Operations, NC Medicaid, Division of Health Benefits
John E. Thompson, Director, Office of Compliance and Program Integrity, NC Medicaid, Division of Health Benefits
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For additional information contact:
Brad Young
Director of External Affairs
919-807-7513



This audit required 1,380.5 hours of auditor effort at an approximate cost of \$142,191.50. The cost of the specialist's effort was \$30,375. As a result, the total cost of this audit was \$172,566.50.