

STATE OF NORTH CAROLINA

OFFICE OF THE STATE AUDITOR
BETH A. WOOD, CPA

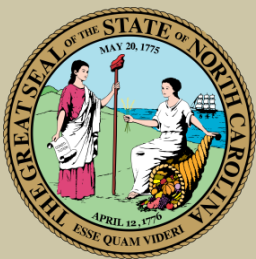


DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF HEALTH BENEFITS

MEDICAID LME-MCO CONTRACT MONITORING

PERFORMANCE AUDIT
MAY 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) monitoring of Local Management Entities-Managed Care Organizations (LME-MCOs) so that the Department can ensure North Carolina's interests are protected when it transitions to managed care for physical healthcare and pharmacy services.

BACKGROUND

North Carolina contracts with seven 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.

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. **The Department awarded \$6 billion in contracts to five MCOs in February 2019.**

Integration is expected to begin in November 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 did not monitor the operations and performance of LME-MCOs in accordance with state policies and best practices. Specifically,

- The Department did not obtain the reports needed to ensure services were provided, costs were reasonable, or that performance standards were met.
- The Department did not document how evaluations were performed, the results of the evaluations, or the feedback provided to LME-MCOs as a result of the evaluations.
- The Department did not compel the use of corrective action plans (CAPs) or assess penalties on LME-MCOs despite noted deficiencies.
- The Department did not monitor or follow-up on CAPs identified by the Department's external quality review (EQR)² contractor.

¹ Session Law 2015-245.

² Federal regulations require an annual external quality review (EQR) of each LME-MCO, conducted by an outside, independent organization.

EXECUTIVE SUMMARY (CONCLUDED)

KEY RECOMMENDATIONS

- The Department should develop a formal, centralized tracking mechanism to ensure the timely receipt and retention of all LME-MCO deliverables.
- The Department should design and implement formal policies and procedures for evaluating LME-MCO performance and for providing feedback to LME-MCOs as a result of Department evaluation and monitoring procedures.
- The Department should implement policies and procedures to compel the use of CAPs and penalties, when necessary, to hold LME-MCOs accountable for their performance and encourage improvement.
- The Department should monitor and follow-up on CAPs initiated through the EQR process prior to the next EQR review.

MATTERS FOR FURTHER CONSIDERATION

The risk to the State will increase exponentially if the Department of Health and Human Services (Department) does not take necessary corrective action to improve its monitoring of managed care organizations (MCO). The amount of Medicaid funds managed by MCOs will more than quadruple from **\$3.2 billion** to nearly **\$13.9 billion** in coming years which will increase the risk that quality services are not provided, costs are unreasonable, and performance standards are not met.

STATE OF NORTH CAROLINA
Office of the State Auditor



Beth A. Wood, CPA
State Auditor

2 S. Salisbury Street
20601 Mail Service Center
Raleigh, NC 27699-0600
Telephone: (919) 807-7500
Fax: (919) 807-7647
<http://www.ncauditor.net>

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 Monitoring. The audit objective was to identify weaknesses in the Department of Health and Human Services' (Department) monitoring of Local Management Entities-Managed Care Organizations (LME-MCOs) so that the Department can ensure North Carolina's interests are protected when it transitions to managed care for physical healthcare 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 18.

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 black ink that reads "Beth A. Wood".

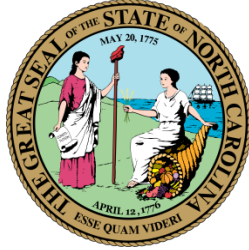
Beth A. Wood, CPA
State Auditor



**Beth A. Wood, CPA
State Auditor**

TABLE OF CONTENTS

	PAGE
BACKGROUND	1
OBJECTIVE, SCOPE, AND METHODOLOGY	2
RESULTS AND CONCLUSIONS.....	3
FINDINGS, RECOMMENDATIONS, AND RESPONSES	
1. DEPARTMENT DID NOT OBTAIN THE REPORTS NEEDED TO MONITOR LME-MCO PERFORMANCE.....	4
2. DEPARTMENT DID NOT SUFFICIENTLY DOCUMENT EVALUATIONS OF LME-MCO PERFORMANCE.....	8
3. DEPARTMENT DID NOT USE CORRECTIVE ACTION PLANS OR ASSESS PENALTIES.....	13
MATTERS FOR FURTHER CONSIDERATION	17
RESPONSE FROM THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.....	18
ORDERING INFORMATION.....	21



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,³ 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.⁴

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). **The Department awarded \$6 billion in contracts to five MCOs in February 2019.**

Integration is expected to begin in November 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 Services*⁵ - 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)*⁶ - 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.

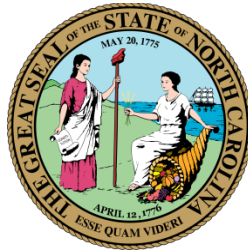
Local Management Entities-Managed Care Organizations (LME-MCOs) - The LME-MCOs were created by North Carolina General Statute 122C and are responsible for managing, coordinating, facilitating, and monitoring the provision of mental health, developmental disabilities, and substance abuse services across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

³ Session Law 2015-245.

⁴ 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.

⁵ <https://www.ncdhhs.gov/mission-vision>, <https://www.ncdhhs.gov/about/overview>.

⁶ <https://medicaid.ncdhhs.gov/>.



OBJECTIVE, SCOPE, AND METHODOLOGY

The audit objective was to identify weaknesses in the Department of Health and Human Services' (Department) monitoring of Local Management Entities-Managed Care Organizations (LME-MCOs) so that the Department can ensure North Carolina's interests are protected when it transitions to managed care for physical healthcare and pharmacy services.

The audit scope included the Department's monitoring of LME-MCOs during state fiscal year 2018.

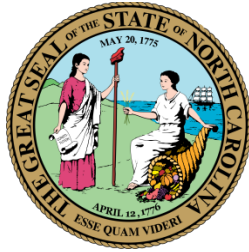
To accomplish the audit objective, the Office of the State Auditor (OSA) contracted with a subject matter expert in the field of Medicaid managed care, Navigant Consulting. Navigant Consulting identified areas of risk where other states have routinely lacked sufficient contract monitoring procedures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

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 non-statistical 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.

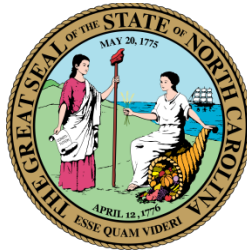
As a basis for evaluating internal control, auditors applied the internal control guidance contained in professional auditing standards. However, our audit does not provide a basis for rendering an opinion on internal control, and consequently, we have not issued such an opinion.

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 did not monitor the operations and performance of Local Management Entities-Managed Care Organizations in accordance with state policies and best practices.



FINDINGS, RECOMMENDATIONS, AND RESPONSES

1. DEPARTMENT DID NOT OBTAIN THE REPORTS NEEDED TO MONITOR LME-MCO PERFORMANCE

The Department of Health and Human Services (Department) did not obtain the reports needed to ensure that services were provided, costs were reasonable, and performance standards were met by Local Management Entities-Managed Care Organizations (LME-MCOs). As a result, the Department was limited in its ability to monitor LME-MCOs. Instead, the Department relied on annual evaluations by its EQR⁷ contractor to monitor the LME-MCOs. However, best practices and state contracts required monitoring and the timely submission of reports.

Did Not Obtain Reports to Ensure Services Were Provided

The Department did not obtain reports from LME-MCOs to support whether LME-MCOs provided services in accordance with state contracts. Specifically, the Department did not always obtain LME-MCO encounter data, Staff Incident Reports, or Provider Enrollment Reports.

LME-MCO Encounter Data

The Department was unable to provide evidence that it obtained complete encounter data submissions from the LME-MCOs in a timely manner.

Encounter data consists of the electronic record for every encounter between a network provider and an enrollee. Encounter data is used to develop LME-MCO capitation rates,⁸ measure the quality of services managed by LME-MCOs, assure compliance with State and federal regulations, and for oversight and audit functions.

The Society of Actuaries says that encounter data is “the single most important analytical tool for health plans and health programs. Without complete and timely encounter data, it is not possible to analyze costs, utilization or trends; evaluate benefits; or determine the quality of services being provided to members.”⁹

Staff Incident Reports

The Department was unable to provide evidence that it obtained all LME-MCO Staff Incident Reports in a timely manner.

Staff Incident Reports are quarterly reports from LME-MCOs that contain all the incidents in which providers failed to ensure adequate staff was available to provide services.

Without Staff Incident Reports, the Department doesn’t know whether providers have sufficient staff to provide quality services to members.

⁷ Federal regulations require an annual external quality review (EQR) of each LME-MCO, conducted by an outside, independent organization. The EQR process consists of three mandatory EQR-related activities including: 1) Review LME-MCO compliance with state standards for access to care, structure and operations, and quality measurement and improvement, 2) Validation of performance measures, and 3) Validation of performance improvement projects (PIPs).

⁸ “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](#).

⁹ Society of Actuaries, [Medicaid Encounter Data: The Next National Data Set](#), 2016.

Provider Enrollment/Termination Reports¹⁰

The Department was unable to provide evidence that it obtained all LME-MCO Provider Enrollment Reports in a timely manner.

These monthly reports are used to document when a provider is denied initial or renewal access to an LME-MCO's provider network.

Without these reports, the Department is unable to monitor whether LME-MCOs have terminated providers without due process, terminated providers with outstanding overpayments, or whether there are enough providers in a LME-MCO's network to provide quality services to members.

Did Not Obtain Reports to Ensure Costs Were Reasonable

The Department did not obtain reports from LME-MCOs to support whether LME-MCO costs were reasonable. Specifically, the Department did not receive Annual Budgets or Related Party Transaction and Obligation Reports.

Annual Budgets

The Department did not obtain annual budgets from any of the LME-MCOs.

The Annual Budget is each individual LME-MCO's plan to provide and spend money for specified programs, functions, and activities during a given year.

Without a copy of the LME-MCO Annual Budgets, the Department had no way of knowing whether the revenues and costs reported by LME-MCOs throughout the year were reasonable or in line with expectations. The Department's ability to monitor LME-MCO predicted spending and to identify potential problems was reduced.

Related Party Transactions and Obligations

The Department did not obtain reports from any of the LME-MCOs regarding related party transactions and obligations.

Related party transactions and obligations refer to payments and other transactions made to management companies or providers affiliated with the LME-MCOs. LME-MCOs can increase profits beyond the profit margin included in the State's capitation rates by purchasing services from related parties which may result in excess profits.

If the Department does not obtain reports from LME-MCOs that detail related party transactions, the Department's ability to monitor related-party transactions and identify excess profits is reduced.

¹⁰ Referred to as "Attachment Z Terminations, Provider Enrollment Denials, Non-Renewals, Other Actions" in the contract.

Did Not Obtain Reports to Ensure Performance Standards Were Met

The Department did not obtain some reports to support whether performance standards were met. The Department was unable to provide evidence that it obtained Monthly Monitoring Reports from the State's largest LME-MCO from July 2017 through April 2018.

Monthly Monitoring Reports track various performance measures related to services provided under "(b) Waiver" services.¹¹ Examples of measures tracked include call center timeliness and abandonment rates,¹² follow-up after hospitalizations, claims (paid, denied, and appealed), and complaints/grievances.

Without Monthly Monitoring Reports, the Department cannot assess whether LME-MCOs are providing quality "(b) Waiver" services to its members.

Resulted in Limited Ability to Monitor LME-MCOs

If the Department does not obtain data from the LME-MCOs, its ability to ensure quality services are provided, costs are reasonable, and that performance standards are met is limited.

If data is unavailable, incomplete, or untimely the Department's ability to identify trends, performance problems, and risks to be addressed is weakened. As a result, the Department's ability to evaluate LME-MCO performance would be limited.

Performance issues that are not detected early on, or not detected at all, can escalate and increase the cost of care while jeopardizing quality of care.

Caused by Department Not Tracking or Enforcing Submission of Reports

The Department did not obtain all required reports from the LME-MCOs needed to monitor services, costs, and performance because it did not have a centralized tracking mechanism in place to ensure the timely receipt and retention of required reports.

Also Caused by Department's Reliance on EQR Contractor

Additionally, the Department relied on its external quality review (EQR) contractor to identify performance issues and to monitor the implementation of corrective action plans (CAPs).

The Department stated that it provided feedback and CAPs for identified issues through the EQR and that the Department's only policies and procedures related to CAPs were through the EQR process.

However, the EQR contractor only performs annual evaluations. Consequently, any performance problems that the EQR contractor identifies could continue for a full year before the next evaluation if the Department does not perform its own monitoring responsibilities.

¹¹ Waivers are federally-approved exemptions to regulations for new or different Medicaid programs. All Medicaid services managed by LME-MCOs fall under either the "(b) Waiver" (entitlement services) or "(c) Waiver" (optional services, also known as Innovations services).

¹² Abandonment rates are the percentage of inbound phone calls made to a call center or service desk that are abandoned (hung up or ended) by the customer before speaking to an agent.

The table below illustrates why frequent evaluations and timely feedback are necessary.

Activity	Frequency of Evaluation		Potential Impact of Not Monitoring
	Department Monitoring Responsibility ¹³	EQR ¹⁴	
Validation of Encounter Data for accuracy and completeness	Monthly	Annually	Without complete and accurate encounter data, it is not possible to analyze costs, utilization or trends; evaluate benefits; or determine the quality of services being provided to members.
Evaluation and feedback about LME-MCO: <ul style="list-style-type: none"> • call center timeliness • abandonment rates • follow-up after hospitalizations • claims (paid, denied, and appealed) • complaints/grievances 	Monthly	Annually	If evaluation is not completed timely, the Department cannot assess whether LME-MCOs are providing quality "(b) Waiver" services to members.
Evaluation and feedback regarding LME-MCO provider enrollment and terminations	Monthly	Annually	If the evaluation is not completed timely, the Department is unable to monitor whether LME-MCOs have terminated providers without due process, terminated providers with outstanding overpayments, or whether there are enough providers in a LME-MCO's network to provide quality services to members.

Best Practices and State Contracts Require Monitoring and Submission of Reports

Best practices require contract monitoring. According to the National State Auditors Association's Best Practices for Contracting Services:

"Contract monitoring is an essential part of the contracting process. Without a sound monitoring process, the contracting agency does not have adequate assurance it receives what it contracts for. To properly monitor the contract, the agency **should ensure that deliverables are received on time and document the acceptance or rejection of deliverables.**" (*Emphasis Added*)

¹³ Based on provisions in the State's LME-MCO contracts, frequency of LME-MCO reports received, and Department inquiry.

¹⁴ Documentation examined as part of an EQR is anywhere from 3 to nearly 18 months old when the final EQR report is issued.

And the State contracts require LME-MCOs to submit reports so the Department can monitor operations and performance. For example, LME-MCOs are required to submit:

- Encounter data - “within fifteen (15) Business Days of the close of the month in which the encounter occurred, was paid for, or was processed, whichever is later.”
- Provider Enrollment/Termination Reports¹⁵ - “by 11:59 p.m. on the tenth (10th) of each month.”
- Annual Budgets – “prior to the start of each fiscal year for which this Contract is in effect (and, also, within thirty (30) calendar days from the date of execution of this Contract).”

RECOMMENDATIONS

The Department should develop a formal, centralized tracking mechanism to ensure the timely receipt and retention of all LME-MCO deliverables.

AGENCY RESPONSE

See page 19 for the Department’s response to this finding.

2. DEPARTMENT DID NOT SUFFICIENTLY DOCUMENT EVALUATIONS OF LME-MCO PERFORMANCE

The Department of Health and Human Services (Department) did not sufficiently document evaluations of the State’s Local Management Entities-Managed Care Organizations (LME-MCOs) or the performance feedback provided to LME-MCOs. As a result, the Department was limited in its ability to know whether its evaluation process was effective. The lack of documentation occurred because the Department did not have a formal evaluation process in place. Instead, the Department relied on its EQR¹⁶ contractor to monitor LME-MCOs. However, best practices require sufficient documentation of the Department’s evaluation and feedback processes.

Did Not Document LME-MCO Performance Evaluations

The Department was unable to provide documentation to support most of their evaluations of LME-MCO performance. Auditors found no documented analysis, evaluations, or reviews from the Department for 24 of 26 (92%) LME-MCO reports that auditors reviewed.

For example, the Department did not provide any documented analysis related to their evaluations of the following:

¹⁵ Referred to as “Attachment Z Terminations, Provider Enrollment Denials, Non-Renewals, Other Actions” in the contract.

¹⁶ Federal regulations require an annual external quality review (EQR) of each LME-MCO, conducted by an outside, independent organization. The EQR process consists of three mandatory EQR-related activities including: 1) Review LME-MCO compliance with state standards for access to care, structure and operations, and quality measurement and improvement, 2) Validation of performance measures, and 3) Validation of performance improvement projects (PIPs).

LME-MCO Encounter Data

The Department was unable to provide evidence that the Department validated LME-MCO encounter data for accuracy or completeness.

Encounter data consists of the electronic record for every encounter between a network provider and an enrollee. Encounter data is used to develop LME-MCO capitation rates, measure the quality of services managed by LME-MCOs, assure compliance with State and federal regulations, and for oversight and audit functions.

The Society of Actuaries says that encounter data is “the single most important analytical tool for health plans and health programs. Without accurate and timely data, it is not possible to analyze costs, utilization or trends; evaluate benefits; or determine the quality of services being provided to members.”¹⁷

LME-MCO Performance Measures

The Department was unable to provide evidence that it consistently evaluated LME-MCO performance measures related to services provided under “(b) Waiver” services.¹⁸

Examples of measures tracked include call center timeliness and abandonment rates,¹⁹ follow-up after hospitalizations, claims (paid, denied, and appealed), and complaints/grievances.

If the Department does not evaluate LME-MCO performance measures, the Department cannot assess whether LME-MCOs are providing quality “(b) Waiver” services to members.

Provider Enrollments and Terminations

The Department was unable to provide evidence that it consistently evaluated LME-MCO provider enrollments and terminations.

LME-MCOs contract with a network of providers to deliver care and services to its members. Providers enroll and can be terminated from the LME-MCO provider network.

If the Department does not evaluate enrollments and terminations, the Department is unable to monitor whether LME-MCOs have terminated providers without due process, terminated providers with outstanding overpayments, or whether there are enough providers in a LME-MCO’s network to provide quality services to members.

Quality/Performance Improvement Program Projects

The Department was unable to provide evidence that it consistently evaluated Quality/Performance Improvement Program Projects (QIP/PIP).

¹⁷ Society of Actuaries, Medicaid Encounter Data: The Next National Data Set, 2016.

¹⁸ Waivers are federally-approved exemptions to regulations for new or different Medicaid programs. All Medicaid services managed by LME-MCOs fall under either the “(b) Waiver” (entitlement services) or “(c) Waiver” (optional services, also known as Innovations services).

¹⁹ Abandonment rates are the percentage of inbound phone calls made to a call center or service desk that are abandoned (hung up or ended) by the customer before speaking to an agent.

QIP/PIP projects are short-term and long-term activities and projects determined jointly by the LME-MCOs and the Department designed with the aim of improving health outcomes and member satisfaction. Examples of QIP/PIPs include efforts targeted at prevention of mental illness and improvement of the quality of patient encounters.

If the Department does not evaluate these projects, the Department cannot monitor the status or success of these improvement plans. There is an increased risk that plans designed to improve health outcomes and member satisfaction do not achieve desired results.

Complaints and Grievances

The Department was unable to provide evidence that it consistently evaluated LME-MCO complaints and grievances.

Periodically, LME-MCOs receive complaints or grievances from members or their representatives. Complaints and grievances are received for a number of reasons including poor quality of service at a provider, the lack of sufficient providers in the LME-MCO's provider network, or to appeal an LME-MCO's decision to deny a service.

If the Department does not evaluate complaints and grievances, the Department may be unaware of substantial performance or quality issues in a LME-MCO provider network. There is an increased risk that performance or quality issues at LME-MCOs go unnoticed and uncorrected.

Did Not Document Feedback to LME-MCOs

The Department was unable to provide evidence that it provided performance feedback to LME-MCOs as a result of their evaluations. Instead, the Department's method of providing feedback to LME-MCOs was informal and undocumented.

According to the Department, the majority of its feedback is provided to LME-MCOs through scheduled and unscheduled phone calls and email communications.

However, the Department did not maintain any evidence that detailed the interaction with the LME-MCOs including the date of the phone calls with LME-MCOs, who was present on the call, what was discussed, and any expected resolution. Similarly, there was no tracking of emails sent and received to and from the LME-MCOs, and none of the emails are maintained in a contract monitoring file.

Additionally, the Department stated that feedback was provided to LME-MCOs during Intra-Departmental Monitoring Team (IMT)²⁰ phone calls.

The IMT holds quarterly calls with each LME-MCO. Each LME-MCO prepares and submits a presentation following the agenda provided by the Department. During the call, the LME-MCO presents information to the Department that should have been previously reported via required deliverables during the quarter.

²⁰ The IMT is comprised of several Department employees from each areas of responsibility outlined in the LME-MCO contracts. Including, but not limited to: Contract Managers, Clinical Policy, Program Integrity, Finance, and Business Technology.

However, the Department did not provide evidence that showed that formal feedback was provided to LME-MCOs during these calls. The Department did not lead the call and did not supply feedback on LME-MCO deliverables or reported performance.

Resulted in Limited Ability to Know If Evaluation Process Was Effective

Failure to sufficiently document evaluations of LME-MCO performance and the feedback provided to LME-MCOs limited the Department's ability to know whether the processes were working properly.

For example, without sufficient documentation there is no way to know whether:

- Evaluations were performed
- Evaluations were performed properly
- Evaluations were performed timely
- Feedback was provided
- Feedback was sufficient and appropriate
- Feedback was provided timely

Caused by the Lack of a Formal Evaluation and Feedback Process

The Department did not have a standard or formalized process in place that outlined how evaluations should be performed, how to analyze results of the evaluations, or how to provide feedback to LME-MCOs as a result of the evaluations.

Also Caused by Department's Reliance on EQR Contractor

Additionally, the Department relied on its external quality review (EQR) contractor to identify performance issues and to monitor the implementation of corrective action plans (CAPs).

The Department stated that it provided feedback and CAPs for identified issues through the EQR and that the Department's only policies and procedures related to CAPs were through the EQR process.

However, the EQR contractor only performs annual evaluations. Consequently, any performance problems that the EQR contractor identifies could continue for a full year before the next evaluation if the Department does not perform its monitoring responsibilities.

The table below illustrates why frequent evaluations and timely feedback are necessary.

	Frequency of Evaluation		
Activity	Department Monitoring Responsibility ²¹	EQR ²²	Potential Impact of Not Monitoring
Validation of Encounter Data for accuracy and completeness	Monthly	Annually	Without complete and accurate encounter data, it is not possible to analyze costs, utilization or trends; evaluate benefits; or determine the quality of services being provided to members.
Evaluation and feedback about LME-MCO: <ul style="list-style-type: none"> • call center timeliness • abandonment rates • follow-up after hospitalizations • claims (paid, denied, and appealed) • complaints/grievances 	Monthly	Annually	If evaluation is not completed timely, the Department cannot assess whether LME-MCOs are providing quality “(b) Waiver” services to members.
Evaluation and feedback regarding LME-MCO provider enrollment and terminations	Monthly	Annually	If the evaluation is not completed timely, the Department is unable to monitor whether LME-MCOs have terminated providers without due process, terminated providers with outstanding overpayments, or whether there are enough providers in a LME-MCO's network to provide quality services to members.

Best Practices Require Sufficient Documentation of Evaluations and Feedback

Internal control best practices state that adequate documentation is necessary for the proper review of an entity's processes and to ensure that the processes are being performed properly. Specifically, the “Internal Control – Integrated Framework” issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO)²³ states:

“Documentation also provides evidence of the performance of activities that are part of the system of internal control, enables proper monitoring, and supports reporting on internal control effectiveness, particularly when evaluated by other parties interacting with the entity, such as regulators, auditors, or customers.”

²¹ Based on provisions in the State's LME-MCO contracts, frequency of LME-MCO reports received, and Department inquiry.

²² Documentation examined as part of an EQR is anywhere from 3 to nearly 18 months old when the final EQR report is issued.

²³ The Committee of Sponsoring Organizations of the Treadway Commission (COSO) is a joint initiative of five private sector organizations and is dedicated to providing thought leadership through the development of frameworks and guidance on enterprise risk management, internal control, and fraud deterrence.

RECOMMENDATIONS

The Department should design and implement formal policies and procedures for evaluating LME-MCO performance and for providing feedback to LME-MCOs as a result of Department evaluation and monitoring procedures.

AGENCY RESPONSE

See page 19 for the Department's response to this finding.

3. DEPARTMENT DID NOT USE CORRECTIVE ACTION PLANS OR ASSESS PENALTIES

The Department of Health and Human Services (Department) did not use corrective action plans (CAPs),²⁴ assess penalties for noted performance issues,²⁵ or monitor CAPs identified by the external quality review (EQR) contractor.²⁶ As a result, there was an increased risk of uncorrected performance issues with Local Management Entities-Managed Care Organizations (LME-MCOs). The Department preferred not to use CAPs or penalties and instead relied on its EQR contractor to monitor LME-MCOs. However, state policy and contracts recommend and authorize the Department to take corrective action.

Did Not Use CAPs or Assess Penalties for Noted Performance Issues

The Department did not compel the use of CAPs or assess penalties on LME-MCOs despite noted deficiencies related to quarterly "Super Measures."²⁷

The Department's SFY 2017 1st Quarter DMA MCO Super Measures Report that showed 6 of 7 (86%) LME-MCOs did not meet at least one required Super Measures benchmark. Specifically,

- Six of 7 (86%) LME-MCOs did not ensure that at least 40% of individuals admitted for mental health treatment received a follow-up visit with a behavioral health practitioner within seven days of discharge.
- Five of 7 (71%) LME-MCOs did not ensure that at least 40% of individuals admitted for substance use disorder treatment received a follow-up visit with a behavioral health practitioner within seven days of discharge.

No CAPs were imposed even though the contract allowed the Department to impose CAPs for any LME-MCOs that did not meet these benchmarks.

²⁴ A step-by-step plan of action that is developed to achieve targeted outcomes for resolution of identified errors.

²⁵ The contract prescribes the use of CAPs and penalties (including triggering events, durations, and amounts).

²⁶ Federal regulations require an annual external quality review (EQR) of each LME-MCO, conducted by an outside, independent organization. The EQR process consists of three mandatory EQR-related activities including: 1) Review LME-MCO compliance with state standards for access to care, structure and operations, and quality measurement and improvement, 2) Validation of performance measures, and 3) Validation of performance improvement projects (PIPs).

²⁷ The "Super Measures" are three defined home and community-based services that have associated benchmarks and penalties. Specific benchmarks and penalties are outlined in the LME-MCO contract Attachment K, Section H.

Did Not Monitor CAPs Identified by EQRs

The Department did not monitor or follow-up on CAPs identified by their contracted EQR contractor. The Department's 2016 and 2017 External Quality Review reports indicated several areas in which corrective action was recommended:

- **Encounter Data** - The EQR found that 4 of 7 (57%) LME-MCOs needed corrective actions to resolve issues with incomplete, inaccurate, and noncompliant encounter data.
- **Provider Claims Audits** - The EQR found that one LME-MCO only conducted audits of denied claims that were overridden. The LME-MCOs should have conducted audits of all overridden claims.
- **Provider Qualifications** - The EQR found that multiple LME-MCOs had weaknesses in the credentialing/re-credentialing process. Documents and queries required by the LME-MCO contract were missing.
- **Corrective Action from Previous Years** - The EQR found that corrective actions recommended in previous years were not implemented at multiple LME-MCOs.

Although the EQR reported these deficiencies, the Department did not follow-up with the LME-MCOs to determine whether corrective action was taken. As a result, deficiencies could have remained uncorrected until the EQR contractor performed follow-up procedures at the next scheduled annual review.

Resulted in Increased Risk of Uncorrected Performance Issues

Because the Department did not use CAPs or assess penalties there is an increased risk that LME-MCO performance issues, including unreasonable costs and inadequate access to quality of care, would not be corrected in a timely manner.

Corrective action would not be formally verified until the next EQR. As a result, performance problems could have continued for a full year before reevaluation. The Department said that it can choose to monitor CAPs before the next EQR, but the EQR contractor is responsible for following-up on each CAP as part of the next year's review. Further, the Department did not provide evidence that it monitored the EQR CAPs before the next EQR review.

Caused by Department Strategy Not to Use CAPs or Penalties

The Department has not consistently used CAPs or assessed penalties on LME-MCOs to improve performance because it is not their strategy to do so.

According to the Department, it prefers to work with the LME-MCOs to resolve the issues rather than instituting CAPs or penalties.

Also Caused by Department's Reliance on EQR Contractor

Additionally, the Department relied on its external quality review (EQR) contractor to identify performance issues and to monitor the implementation of corrective action plans (CAPs).

FINDINGS, RECOMMENDATIONS, AND RESPONSES

The Department stated that it provided feedback and CAPs for identified issues through the EQR and that the Department's only policies and procedures related to CAPs were through the EQR process.

However, the EQR contractor only performs annual evaluations. Consequently, any performance problems that the EQR contractor identifies could continue for a full year before the next evaluation if the Department does not perform its monitoring responsibilities.

The table below illustrates why frequent evaluations and timely feedback are necessary.

Activity	Frequency of Evaluation		Potential Impact of Not Monitoring
	Department Monitoring Responsibility ²⁸	EQR ²⁹	
Validation of Encounter Data for accuracy and completeness	Monthly	Annually	Without complete and accurate encounter data, it is not possible to analyze costs, utilization or trends; evaluate benefits; or determine the quality of services being provided to members.
Evaluation and feedback about LME-MCO: <ul style="list-style-type: none"> • call center timeliness • abandonment rates • follow-up after hospitalizations • claims (paid, denied, and appealed) • complaints/grievances 	Monthly	Annually	If evaluation is not completed timely, the Department cannot assess whether LME-MCOs are providing quality "(b) Waiver" services to members.
Evaluation and feedback regarding LME-MCO provider enrollment and terminations	Monthly	Annually	If the evaluation is not completed timely, the Department is unable to monitor whether LME-MCOs have terminated providers without due process, terminated providers with outstanding overpayments, or whether there are enough providers in a LME-MCO's network to provide quality services to members.

²⁸ Based on provisions in the State's LME-MCO contracts, frequency of LME-MCO reports received, and Department inquiry.

²⁹ Documentation examined as part of an EQR is anywhere from 3 to nearly 18 months old when the final EQR report is issued.

State Policy Recommends and Contracts Give Authority to Take Corrective Action

The Department is responsible for monitoring its contracts and complying with guidance issued by the Department of Administration, Purchase and Contract Division (P&C).

P&C's *Contract and Administration Monitoring Guide* states:

“Agencies will design a system that includes criteria to be used to evaluate contract performance and defined follow-up actions as needed for each contract. The goal of follow-up is to bring the contractor back into compliance with the contract requirements. **Follow-up is essential as the problem will not correct itself simply because it has been identified and included in the monitoring report.**” (*Emphasis Added*)

Additionally, the Department's managed behavioral healthcare services contracts with the LME-MCOs give the Department the authority to continuously monitor LME-MCO performance including the development and monitoring of corrective action plans. Section 1.5.1 of the contract specifies that the Department shall:

“conduct routine and random monitoring to: Identify problems, deficiencies, and barriers to desired performance; **Develop improvement strategies; Determine the need for Corrective Action Plans; and Monitor any Corrective Action Plans in place.**” (*Emphasis Added*)

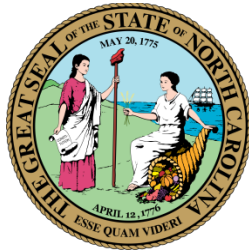
RECOMMENDATIONS

The Department should implement policies and procedures to compel the use of CAPs and penalties when necessary to hold LME-MCOs accountable for their performance and encourage improvement.

The Department should monitor and follow-up on CAPs initiated through the EQR process prior to the next EQR review.

AGENCY RESPONSE

See page 20 for the Department's response to this finding.



MATTERS FOR FURTHER CONSIDERATION

Improved Oversight Needed as State Transitions to Managed Care

The risk to the State will increase exponentially if the Department of Health and Human Services (Department) does not take necessary corrective action to improve its monitoring of managed care organizations (MCO). The amount of Medicaid funds managed by MCOs will more than quadruple from **\$3.2 billion** to nearly **\$13.9 billion** in coming years which will increase the risk that:

- Quality services are not provided
- Costs are unreasonable
- Performance standards are not met

In November 2019, the State is expected to begin transitioning most of the State's Medicaid beneficiaries and services to a Medicaid managed care model. The model will integrate physical healthcare services and pharmacy services with behavioral healthcare services.

However, this audit found that the Department does not adequately monitor the operations and performance of Local Management Entities-Managed Care Organizations (LME-MCOs) that currently operate and manage behavioral healthcare services. Specifically,

- The Department did not obtain the reports needed to ensure services were provided, costs were reasonable, or that performance standards were met.
- The Department did not document how evaluations were performed, the results of the evaluations, or the feedback provided to LME-MCOs as a result of the evaluations.
- The Department did not compel the use of corrective action plans (CAPs) or assess penalties on LME-MCOs despite noted deficiencies and did not monitor or follow-up on CAPs identified by the Department's external quality review (EQR)³⁰ contractor.

In addition, recent OSA audits have noted additional weaknesses in the Department's monitoring and oversight of the State's LME-MCOs:

- LME-MCO contracts did not always contain clear contractual requirements to sufficiently protect the State nor ensure compliance with all federal and state requirements.³¹
- LME-MCOs accumulated \$439.2 million in excessive savings based on Medicaid capitation rates.³²
- The State's largest LME-MCO spent money to explore strategic opportunities outside of its core mission, paid approximately \$1.2 million in CEO salaries without proper authorization, and incurred extravagant and unreasonable expenses.³³

The Department should improve its monitoring so that the State's interest is protected when the transition to managed care is completed and most of the State's **\$13.9 billion** of annual Medicaid expenditures is managed by MCOs that contract with the Department.³⁴

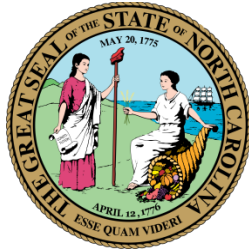
³⁰ Federal regulations require an annual external quality review (EQR) of each LME-MCO, conducted by an outside, independent organization.

³¹ <https://www.ncauditor.net/EPSWeb/Reports/Performance/PER-2018-4445.pdf>.

³² <https://www.ncauditor.net/EPSWeb/Reports/Performance/PER-2017-4445B.pdf>.

³³ <https://www.ncauditor.net/EPSWeb/Reports/Performance/PER-2017-4445.pdf>.

³⁴ The Department awarded \$30 billion of contracts to five MCOs in February 2019.



RESPONSE FROM DEPARTMENT OF HEALTH AND HUMAN SERVICES



STATE OF NORTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

ROY COOPER
GOVERNOR

April 30, 2019

MANDY COHEN, MD, MPH
SECRETARY

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 Monitoring, 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 Department recognizes the need to improve our contract oversight for LME/MCOs. The Department will implement improvements identified during our design of the oversight model for the new Prepaid Health Plans (PHP). The Department is instituting a contract management plan that will identify each deliverable and ensure the proper staff receive, analyze and respond to each contract deliverable. The plan will include an automated tracking system to clearly document responses.

In addition, the Department has hired staff with expertise in health plan oversight and contract management, including our Assistant Secretary of Transformation and Director of Operations. The Department is in the process of hiring an associate director of Behavioral Health/Intellectual or Development Disabilities (BH/IDD) who will lead Medicaid's oversight of the LME-MCO's in coordination with the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (MHDDSAS).

The following represents our response and corrective action plan to the Audit Findings and Recommendations.

AUDIT FINDINGS, RECOMMENDATIONS, AND RESPONSES

1. THE DEPARTMENT DID NOT OBTAIN THE REPORTS NEEDED TO MONITOR LME-MCO PERFORMANCE

Recommendations:

The Department should develop a formal, centralized tracking mechanism to ensure the timely receipt and retention of all LME-MCO deliverables.

WWW.NCDHHS.GOV
TEL 919-855-4800 • FAX 919-715-4645
LOCATION: 101 BLAIR DRIVE • ADAMS BUILDING • RALEIGH, NC 27603
MAILING ADDRESS: 2001 MAIL SERVICE CENTER • RALEIGH, NC 27699-2001
AN EQUAL OPPORTUNITY / AFFIRMATIVE ACTION EMPLOYER

Auditor Beth Wood
April 30, 2019
Page 2 of 3

Agency Response:

The Department agrees with the State Auditor's recommendation to employ a formal, centralized tracking mechanism for LME-MCO deliverables. Tracking and monitoring of LME-MCO deliverables was decentralized in accordance with the multiple business units overseeing specific sections of the LME-MCO contracts. While the business units did monitor to ensure timely receipt of the varied deliverables in many instances, timestamp data was not specifically maintained as to when deliverables were received, leading to the main issue identified in the findings of this report.

The Department has designed a new system to provide oversight for managed care organizations including LME-MCO's. The department will have a contract management plan for each PHP and LME-MCO. The plan will be managed by a contract specialist who is responsible for ensuring all deliverables are received and evaluated by the appropriate staff. Paired with the contract management specialist will be a health plan subject-matter expert (SME) who will work with other assigned SMEs to hold the PHPs and LME-MCOs accountable for contract requirements. To support the oversight teams, the Department has developed a contract management system that will automate the receipt, distribution and workflow tracking of contract deliverables from PHPs and LME-MCOs.

Additionally, the Department has established and is in the process of recruiting an Associate Director of BH/IDD that will have direct leadership responsibility for all LME-MCO oversight activities.

2. THE DEPARTMENT DID NOT SUFFICIENTLY DOCUMENT EVALUATIONS OF LME-MCO PERFORMANCE

Recommendations:

The Department should design and implement formal policies and procedures for evaluating LME-MCO performance and for providing feedback to LME-MCOs as a result of Department evaluation and monitoring procedures.

Agency Response:

The Department agrees that evaluations of LME-MCO performance could be more formally documented. As noted in the report, the Department did conduct evaluations of LME-MCO performance through routine meetings and email communications with LME-MCO personnel and executive leadership.

As part of the transition planning for managed care, the Department developed a "Management and Oversight Plan" tool which lays out the full body of activities and timelines (objectives, deliverables, meetings, evaluations, corrective action processes, etc.) required to provide effective oversight to the PHPs. Use of the tool will be mandatory for each business unit assigned oversight responsibilities for the PHP contract. The Department will implement a similar tool for oversight of LME-MCO contracts which will result in more formal documentation of performance evaluations and feedback.

3. THE DEPARTMENT DID NOT USE CORRECTIVE ACTION PLANS OR ASSESS PENALTIES

Recommendations:

The Department should implement policies and procedures to compel the use of CAPs and penalties when necessary to hold LME-MCOs accountable for their performance and encourage improvement.

Auditor Beth Wood
 April 30, 2019
 Page 3 of 3

The Department should monitor and follow-up on CAPs initiated through the EQR process prior to the next EQR review.

Agency Response:

The Department agrees that policies and procedures for LME-MCO corrective action plans could be strengthened. While the Department did follow up on outstanding corrective action plans during the routine monitoring meetings with the LME-MCOs, we recognize that a more formal approach to documenting and tracking the outstanding corrective actions would ensure items are addressed timely.

As noted above, the Department will formalize a management and oversight plan under the new Associate Director of BH/IDD that will ensure adequate, documented corrective actions are taken when necessary. The management and oversight plan will follow the same principles implemented in the PHP management and oversight tool.

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) 527-7701.

Sincerely,



Mandy Cohen, MD, MPH
 Secretary

MC:jet

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
 Lisa Corbett, General Counsel
 Laketha M. Miller, Controller
 David King, Director, Office of the Internal Auditor
 Lisa Allnutt, Senior Audit Manager, Risk Mitigation & Audit Monitoring

ORDERING INFORMATION

COPIES OF THIS REPORT MAY BE OBTAINED BY CONTACTING:

Office of the State Auditor
State of North Carolina
2 South Salisbury Street
20601 Mail Service Center
Raleigh, North Carolina 27699-0600

Telephone: 919-807-7500
Facsimile: 919-807-7647
Internet: <http://www.ncauditor.net>

To report alleged incidents of fraud, waste or abuse in state government contact the
Office of the State Auditor Fraud Hotline: **1-800-730-8477**
or download our free app.



<https://play.google.com/store/apps/details?id=net.ncauditor.ncauditor>



<https://itunes.apple.com/us/app/nc-state-auditor-hotline/id567315745>

For additional information contact:
Brad Young
Director of External Affairs
919-807-7513



This audit required 2,384.5 hours of auditor effort at an approximate cost of \$245,603.50. The cost of the specialist's effort was \$27,250. As a result, the total cost of this audit was \$272,853.50.