STATE OF NORTH CAROLINA

PERFORMANCE AUDIT

DEPARTMENT OF HEALTH AND HUMAN SERVICES – DIVISION OF MEDICAL ASSISTANCE - OVERSIGHT OF THE MENTAL HEALTH SERVICES UTILIZATION REVIEW CONTRACT

JULY 2008

OFFICE OF THE STATE AUDITOR

LESLIE W. MERRITT, JR., CPA, CFP

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The Honorable Michael F. Easley, Governor
Members of the North Carolina General Assembly
Dempsey Benton, Secretary, North Carolina Department of Health and Human Services
William W. Lawrence, Jr., MD, FAAP, Acting Medicaid Director
Division of Medical Assistance
Leza Wainwright and Michael Lancaster, Co-Directors
Division of Mental Health, Developmental Disabilities, and Substance Abuse Services

Ladies and Gentlemen:

We are pleased to submit this performance audit titled *Department of Health and Human Services – Division of Medical Assistance - Oversight of the Mental Health Services Utilization Review Contract*. The objectives of the audit were to determine whether the Department of Health and Human Services – Division of Medical Assistance properly developed and managed the utilization review contract for mental health services and whether proper protocols were established to ensure that the authorizations of services were managed effectively. Representatives from the Department have reviewed a draft copy of this report and have provided comments which are included in the report.

This audit was initiated by the Office of the State Auditor in response to growing concerns of the legislature, media, and public regarding the delivery of mental health services and the role played by the third-party contractor in that process.

We wish to express our appreciation to the staff of the Department for the courtesy, cooperation, and assistance provided to us during the audit.

Respectfully submitted,

Leslie W. Merritt, Jr.

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State Auditor

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SUMMARY

PURPOSE

Our audit objectives were to determine whether the Department of Health and Human Services – Division of Medical Assistance properly developed and managed the utilization review contract for mental health services and whether proper protocols were established to ensure that the authorizations of services were managed effectively.

RESULTS AND CONCLUSIONS

Our audit revealed several areas of concern:

- The Department of Health and Human Services – Division of Medical Assistance provided only limited documentation to support the strategic planning, implementation, and monitoring strategies of its outsourced Medicaid service authorization contract. As a result, we were unable to review the cost estimates and project expectations that would provide for effective evaluation of the third party contractor activity.

- The Department Health and Human Services – Division of Medical Assistance has not adequately documented its monitoring of the contract for utilization reviews of Medicaid-supported mental health services. As a result, there is an increased risk that services are not being performed as required in the contract.

- The Department Health and Human Services – Division of Medical Assistance disabled critical information system edits designed to prevent the payment of unauthorized claims for mental health services. As a result, potentially inappropriate claims for mental health services were paid.

- The Department Health and Human Services – Division of Medical Assistance did not adequately settle a claim related to over-billings by the contractor for the utilization reviews of Medicaid-supported mental health services. Furthermore, the Division either did not properly account for the recovering of the over-billings or did not recover the full amount agreed to in the settlement agreement. As a result, the Division may have overpaid for services under the contract.

Each of the issues is discussed in detail in Audit Findings and Responses section of this report.

AGENCY'S RESPONSE

The Department's responses follow each of the reported findings and recommendations.

INTRODUCTION

BACKGROUND

The North Carolina Medicaid program provides medical assistance to "families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services" as defined per the Social Security Act. Medical services provided encompass a variety of mental health services to categorically and medically needy populations, including those requiring mental health, developmental disabilities, and substance abuse services. Medicaid-funded mental health services are administered jointly by the Division of Medical Assistance and the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services within the North Carolina Department of Health and Human Services (Department).

Beginning January 1, 2002, the Department entered into an agreement with a third-party contractor to provide utilization review services for the State's Medicaid-eligible consumers. Utilization review activities help to ensure optimal health care delivery in a cost-effective manner to Medicaid-eligible consumers. The purposes of the utilization review are to safeguard against unnecessary and inappropriate medical care and to authorize services. Service requests are reviewed within the context of the consumer's medical history, for appropriateness of type and length of service. In addition, medical services and/or records are reviewed for medical necessity[1] and quality of care. Based on age criteria, Medicaid provides for a limited number of mental health service visits prior to receiving authorization. See Appendix for a basic overview of the Medicaid authorization process for mental health services.

As part of its proposed mental health reform efforts, the Department decided to use a single vendor to provide utilization review activities for mental health services, certain developmental disabilities services, and substance abuse services for Medicaid-eligible consumers. These utilization review services had previously been provided by local management entities located throughout the State; however, those reviews did not include the expanded services array. With Medicaid accounting for approximately 70% of mental health services statewide, the implementation of this expanded services array, and the growth of the private provider community, the Department concluded that a single vendor would bring consistency and uniformity to utilization review functions for Medicaid services. A Request for Proposal was initiated in June 2005, resulting in the eventual selection of the same third-party contractor to provide the utilization review activities.

Beginning June 1, 2006[2], the third-party contractor became responsible for conducting utilization review for enhanced mental health services for all Medicaid consumers in addition to the Medicaid utilization review services already being performed. The approved amount of

[1] Medical Necessity: a determination, based on professional judgment, that the amount, duration and scope of a service are sufficient to reasonably achieve its purpose. Criteria for medical necessity are largely defined by each State. For mental health, substance abuse and developmental disability services in North Carolina, the Division of Mental Health defines medical necessity criteria by type of service.

[2] The third party contractor had a couple of months to phase-in its responsibilities beginning with June 1, 2006

the contract at that time was $41.8 million over five years. Effective with a date of service of September 1, 2006, responsibility for prior approval of all new Community Alternative Program for Mental Retardation/Developmental Disabled population and Early Periodic Screening, Diagnosis, and Treatment service reviews were added to the contract as part of Amendment #1. This resulted in an increase in the contract amount by $15.4 million (increasing the contract from $41.8 million to $57.2 million).

The provision of mental health services is a complex process involving multiple parties (clients, medical providers, a third-party contractor as the authorizer of services, the Department as the provider of program oversight, and an additional third-party contracted claims processor) navigating through a myriad of rules and regulations beginning with the initial service authorization through the payment for services rendered. In addition, the mental health reform efforts changed the types of mental health services to be provided, significantly expanded the number of providers that would be delivering services, and shifted some decision-making authority from the local management entities to the single source contractor.

In February 2007, the Department's review of mental health service costs identified that expenditures for Community Support[3] services were exceeding the Medicaid payments that were being made to hospitals, physicians, and prescription drugs. Preliminary results of audits and reviews conducted or authorized by the Department identified deficiencies on behalf of the providers in the areas of medical necessity and documentation of the services rendered. The result has been increased scrutiny of the overall delivery of mental health services in the State. Expectations have been placed on all parties to improve the quality of the mental health services being delivered and to correct identified abuses observed by the Department and the local management entities.

OBJECTIVES, SCOPE, AND METHODOLOGY

The audit objectives were to determine whether the Department of Health and Human Services – Division of Medical Assistance properly developed and managed the utilization review contract for mental health services and whether proper protocols were established to ensure that the authorizations of services were managed effectively.

The State Auditor initiated this audit in response to growing concerns of the legislature, media, and public regarding the delivery of mental health services and the role played by the third-party contractor in that process.

The audit scope covered the period June 1, 2006, when the third-party contractor began utilization reviews for enhanced mental health services for all Medicaid consumers, through December 31, 2007. We conducted the fieldwork from January 2008 to May 2008.

To accomplish our audit objectives, we observed operations at the Department and interviewed representatives from the Department, the third-party contractor, the North

[3] Community Support falls within the scope of enhanced mental health services authorized with the implementation of the new services array in March 2006.

Carolina General Assembly, advisory groups, and local management entities. We reviewed the contract, the contract file and contractor reports, and performed analyses and tests of other related information and documentation.

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 objectives.

We conducted this audit under the authority vested in the State Auditor of North Carolina by *North Carolina General Statute* 147.64.

1. DOCUMENTATION WAS LIMITED TO SUPPORT THE STRATEGIC PLANNING, IMPLEMENTATION, AND MONITORING STRATEGIES FOR THE OUTSOURCED MEDICAID SERVICE AUTHORIZATION CONTRACT

The Department of Health and Human Services – Division of Medical Assistance provided only limited documentation to support the strategic planning, implementation, and monitoring strategies of its outsourced Medicaid service authorization contract. As a result, we were unable to review the cost estimates and project expectations that would provide for effective evaluation of the third party contractor activity.

The transition of the Medicaid utilization review functions from the local management entities to a third-party contractor as the sole provider of these functions was a significant shift in the business processes related to the delivery of mental health services. As such, we expected to see evidence of a strategic plan to support the shifting of the utilization review functions to the third-party contractor; that is, a plan mapping out the implementation and monitoring strategies for the contract. However, the Division was unable to provide to us documentation of such a plan. Division personnel explained that most of the communications regarding the planning processes were done via e-mails and phone calls. The Division stated that this was necessary to expedite the implementation process in order to meet federally mandated time requirements.[4] The Division was unable to provide copies of the planning e-mails and provided only limited documentation to support the planning process.

In a Letter of Memorandum dated April 6, 2006, the former Secretary of the Department stated that the reason for transitioning to a single statewide vendor to perform the Medicaid utilization review functions for mental health services was to "ensure that utilization review for Medicaid services is conducted in a consistent, uniform way." However, it does not appear that defined measures were developed to evaluate whether the contractor actually is applying medical necessity criteria in a consistent and uniform way.

In addition to achieving statewide consistency and uniformity in the Medicaid utilization review process, there was also an assumption that the shift to a single vendor would result in overall cost savings. We did not find evidence of a comparable cost baseline that would allow the Division to sufficiently assess the potential cost savings associated with the contract. It appears that the Division placed emphasis on maintaining statewide consistencies for meeting federal requirements rather than on any direct cost savings that might have been achieved.

We also did not find evidence to support many of the assumptions related to the contract, particularly forecasts for service needs and anticipated budget needs. Industry standard practices suggest projecting, at a minimum, three years of program and budget data related to the delivery of services. In addition to providing both historical and

[4] The Centers for Medicare and Medicaid Services required the Department to implement the new services within 90 days of final federal approval

prospective data analysis, these forecasts allow for the establishment of project expectations that can more readily be monitored for variances between the projected and the actual data results. Multiple sources indicated that the Division significantly underestimated the projections. The Division has not been able to provide the files and records that summarize the forecast data and the methods that support the contract projections. Additionally, responsibilities to review the variances between projected and actual data have not been assigned and documented.

The final scope of the project changed significantly from the scope planned during the Request for Proposal period; however, it does not appear that these changes were properly addressed in the financial projections as the budget was established at a level significantly less than actual needs. Expenditures totaled $32.9 million from June 1, 2006, to December 31, 2007, which exceeded the anticipated three year budgeted amount of $32.5 million.

Furthermore, it does not appear that the technical information systems needs associated with the contract were fully analyzed. This became evident early in the contract period when the Medicaid claims payment system began rejecting a majority of mental health service claims due to problems in matching data elements in the contractor's authorization file with the Medicaid claims payment file. Therefore, it does not appear that the Division performed appropriate planning to gain an understanding of the data needs and system capabilities of the contractor to ensure accurate system integration.

Significant staff turnover within the Department of Health and Human Services has contributed to the lack of available information about the contracting process. The contract had five different contract administrators between June 2006 and December 2007 and has been overseen by two different department secretaries and three different division directors. Due to turnover, each staff member involved can provide only pieces of the information regarding the contract history and decisions that were made. The retention of key staff is important in establishing good administrative controls, and staff turnover allowed for a certain amount of documentation and continuity to be lost.

Effective project planning and financial controls are critical elements of project management, helping to manage risks and ensure the success of projects. The successful implementation of realistic project plans and schedules, financial projections and baselines, and procedures to manage changes in these elements throughout the project dramatically increases the likelihood of a successful project.

Auditor Recommendation:

For future major initiatives, the Department should maintain all necessary documentation to support the planning assumptions and decisions; the approved project scope and estimated costs; and the anticipated schedule for project implementation. Performance measures should be clearly documented at the onset of any program to ensure that program expectations are apparent and processes are put in place to adequately measure and monitor contractor performance. The Department should develop a defined set of performance measurements to assist it to more effectively monitor the current performance of its third-party contractor.

Department Response:

DHHS recognizes that the State Auditor was not able to fully assess the full complement of information relating to planning assumptions and decisions for utilization review of Medicaid supported mental health services, project scope and schedule due to difficulties gathering all relevant records and conversations from the Divisions. It is commonly known that consistency in utilization review was a primary concern identified for the Mental Health Reform effort. Furthermore, it is well recognized that the Centers for Medicare and Medicaid Services (CMS) communicated during negotiations for the State Plan Amendment 05-005 that consistency in utilization review was a requirement. Additional rationale is stated in the April 6, 2006 memorandum referenced on page 5 of this performance report.

The audit report does not mention that the scope of service for this vendor changed significantly when none of the Local Management Entities (LMEs) were successful in demonstrating their capability to carry out utilization review functions in a manner that would satisfy all state and federal requirements. However, it is important to note that this fact contributed an unpredictable challenge to the scope and magnitude of work ultimately undertaken by the vendor. A foreshortened timeline for implementation and the refusal to allow overlap of old and new services by CMS also altered the initial plan of action and available alternatives in March 2006.

DMA acknowledges signficant staff turnover in the Division and the Department during the period of June 2006 through December 2007; however, the leadership of the DMA Contract Unit was stable during that time and was integrally engaged throughout this contractual process. Turnover at the Department level and the Division Director level should have contributed minimally to the fundamental performance and monitoring aspects of this contract. However, personnel turnover invariably contributes to some instances where it is difficult to locate certain relevant documentation or have a firm understanding of operations history due to every contact and event not being reduced to writing.

The RFP cost evaluation criteria represent fairly detailed contract performance measures. These cost evaluation criteria were classified into approximately 23 groups or categories and then each of these 23 groups or categories of service were further divided into

specific services, resulting in 39 services in all. Performance measures for each of these individual services were developed and expressed in terms of units, each unit having a quantified contract value. These amounts were then projected over a five year period, by service category

In aggregate, the value and quantity of these services became the benchmark for the contract and would serve as a performance measure to determine how services delivered compared with the identified services required. The detail performance measures for how the services were to be provided were also spelled out in the contract including items such as licensure requirements, background experience, etc.

The Department agrees that the Auditor's recommendations are contributory to effective project management. Many of the measures identifed as desirable were present, though perhaps inadequately documented, during the proceedings of the current thrid-party vendor contract. Those process and practices can always be improved to be performed with more efficiency and effectiveness in the future.

2. IMPROVEMENT NEEDED IN THE DIVISION'S CONTRACT MONITORING PROCESSES FOR ITS THIRD-PARTY UTILIZATION REVIEW CONTRACTOR

The Department Health and Human Services – Division of Medical Assistance has not adequately documented its monitoring of the contract for utilization reviews of Medicaid-supported mental health services. As a result, there is an increased risk that services are not being performed as required in the contract.

We identified deficiencies related to the overall contract monitoring plan and the documentation of the Division's performance and fiscal monitoring activities. The Department's *General Contracting Manual* provides that some form of monitoring schedule be in place for each contract and that "frequent monitoring and communication with the contractor is necessary to determine whether the terms and goal(s) of the contract will be met." While there may have been frequent communications with the contractor, contract monitoring documentation needs improvement.

A monitoring plan defines the specific monitoring methods appropriate to the particular service and the monitoring activities necessary to be completed. The plan generally identifies the processes for collecting information, the tools to be used to measure and assess contract performance and compliance, and the contract management resources necessary to ensure adequate oversight. We did not find evidence that the Division developed a formal monitoring plan for the contract to address these issues. Multiple sections within the Division either interact with or are affected by the actions governed by the contract; therefore, clearly defined roles and responsibilities are essential for the successful management of the contract. As monitoring responsibilities were not clearly assigned during the planning of the contract, performance monitoring was limited to the receipt and review of contractor-generated reports. Our review of the Division's contract

file failed to identify specific monitoring tools developed to document measurement criteria or the performance of the monitoring activities.

Monitoring activities should occur throughout the year and may take various forms[5] such as:

- Reporting – The review of financial and performance reports submitted by the contractor.

  The contractor submitted various reports; however, we did not find sufficient evidence that the Division verified the accuracy of the reported data.

- Site Visits – The performance of a site visit to the contractor's location to review financial and programmatic records and to observe operations.

  We did not find evidence where this type of review was performed.

- Regular Contact – Regular communications with the contractor and making appropriate inquiries concerning contract/program activities.

  The monitoring that occurred appears to have been informal and problem generated. The contract oversight responsibilities were transferred among Division staff. Monitoring activities consisted of phone conversations, e-mails, and meetings, many for which documentation was not provided.

Adequate documentation is essential for effective contract monitoring. Contract files should include copies of key letters, e-mails, meeting notes, and documentation of phone conversations as evidence that monitoring has occurred during the contract period. Monitoring deficiencies should be tracked through resolution by appropriate corrective action plans.

Effective contract monitoring consists of both program and fiscal monitoring activities. Program monitoring deals with compliance with the program requirements including performance outcomes and goals that are identified in the contract. Fiscal monitoring includes a review of the contractor's invoices and supporting documentation. Deficiencies were noted in the Division's documentation of both of these monitoring efforts.

The contract states that the Division will monitor compliance through audits based on the performance standards outlined in Section 3.16 of the contract. This section of the contract sets efficiency benchmarks for the contractor's performance in process-driven areas such as timeliness of reviews, timeliness of notifications, and telephone accessibility. However, we did not find evidence that these audits have been performed as of the period of our review. We inquired of officials in both the Division's Clinical

[5] Taken from Office of Management and Budget Circular A-133 Compliance Supplement, Part 3, Compliance Requirements.

Policy Section and Contracts Office as to what types of compliance audits were being performed and who had the responsibility to perform those audits. Each stated that the audits were the responsibility of the other.

As noted previously, the Division receives and reviews various reports submitted by the contractor, including weekly reports of authorization activities. The contractor's reports included data related to:

- the number/percent of authorization requests, denials, and reductions;
- total service units approved;
- timeliness of authorization request reviews;
- call abandonment rates;
- and the timeliness of answering phone calls.

While it is important to require the contractor to submit reports related to its activities, it is also important to validate the accuracy of the data being reported by the contractor. Although the Division's contract administrator stated that she conducts "look-behinds" to verify the accuracy of the reports, there was no documented evidence to support the verification of the underlying data provided in the reports.

Although the contract includes performance standards for efficiencies, it does not appear to include standards for effectiveness related to one of the key reasons for the contract – to have a centralized, standard mental health services authorization process. Division personnel stated that statewide consistency and uniformity were critical in the decision to centralize the Medicaid authorization process. One of the most effective means of measuring consistency of authorization decisions is through an assessment of inter-rater reliability[6]. During the period of our review, there was no documented evidence that the Division was obtaining and reviewing contractor reports to assess inter-rater reliability on the contractor's clinical decisions.

Fiscal monitoring involves performing financial analysis based on expected budgeted results, as well as reviewing the contractor's requests for payment to ensure the accuracy of billed charges. During the first year of the contract, evidence suggests that the Division was not adequately performing these necessary fiscal monitoring procedures. For example, Amendment #1 to the contract added Medicaid authorization reviews for additional service types not included in the original contract and revised the budget to include those reviews. Within six months of beginning new service reviews, the contractor had billed seven times (698%) more than the budgeted annual amount established for these services. From October 2006 to March 2007, the contractor billed 84% ($13 million of $15.4 million) of the total Amendment #1 budget amount for

[6] Inter-Rater Reliability: assesses the degree to which different raters or observers give consistent measurements of the same or similar data or circumstances.

specified service authorization reviews (Community Alternative Program for Mental Retardation / Developmental Disabled or CAP-MR/DD). This analysis suggests that the Division should have questioned the level of billings for the October 2006 to March 2007 time period. In April 2007, the contractor discovered that it had been over-billing for the specified service authorizations while reviewing its revenues. The contractor alerted the Division of their finding and proceeded to negotiate a settlement. (See finding 4, Settlement Agreement)

Amendment #1 Budget Amounts Compared to Actual Expenses

amounts in thousands

Month	CAP- MR/DD Billed Amount	Average Monthly Budget	% Over
Oct 2006	$2,193.5	$309.6	708%
Nov 2006	$1,881.0	$309.6	607%
Dec 2006	$2,136.1	$309.6	690%
Jan 2007	$1,566.8	$309.6	506%
Feb 2007	$2,189.2	$309.6	707%
Mar 2007	$2,999.6	$309.6	968%
Totals	**$12,966.2**	**$1,857.6**	**698%**
Total CAP- MR/DD Billed Amount			**$12,966.2**
Total Budget for Amendment #1			**$15,425.7**
% of Total Budget Billed			**84%**

After the contractor's notification of over-billing issues, the Division's Contracts Office began asking more detailed questions about the invoices being submitted by the contractor. The Division obtained the data from the contractor related to the prior billings and determined that some services were either being duplicated or charged at the incorrect rate. These issues were added to the settlement discussions noted above. However, the greater concern is that the Division had not been obtaining evidence throughout the contract period that would have allowed proper fiscal monitoring of the contract.

The level of contract monitoring is influenced by many factors – the dollar amount awarded, the complexities of the program or contract requirements, the experience level of the contractor, etc. Also, the level of monitoring should be commensurate with the importance and sensitivity of the service being contracted. The contract was a major shift in the way the Division was performing the Medicaid utilization reviews for mental health services. The dollar amounts involved were significant, the program requirements involved multiple levels of complexities, and there was an expansion of the service arrays. These factors should have resulted in a higher risk assessment for the service types under contract and more proactive contract monitoring procedures should have been put into place prior to the initiation of services.

Auditor Recommendation:

The Division should create a proactive contract monitoring plan for the contract that identifies the activities to be monitored and assigns appropriate roles and responsibilities to both the Division and the contractor. The plan should include scheduled monitoring activities; monitoring measurements and the assessment tools to be used; and identify

how the monitoring results will be communicated. Monitoring efforts should include both programmatic and fiscal assessments. Documentation of the monitoring activities should be retained as part of the contract file to support the Division's assessment of contract performance. The results of monitoring activities should support the need for any corrective actions, including penalties, that might be necessary related to contractor performance.

Department Response:

DHHS agrees with the Auditor's recommendations regarding more proactive contract monitoring and coordination of roles and responsibilities. However, the ability to be more proactive is constrained by limited personnel resources for this function. DMA leadership has previously identified such as an area of focus and has initiated efforts to improve the communications and collaborations that support effective contract monitoring. Expectations have been shared with the current team and a new leader assumed the responsibility for the DMA Contract Unit on June 30, 2008.

As noted in the auditor's report, monitoring activities should occur throughout the year and may take various forms such as reporting, site visits and regular contact. The division has performed extensive monitoring activities relating to reporting, visits, meetings, e-mails and phone conversations, much of which can be documented by laboriously going through individual files, correspondence and thousands of e-mails. While idealistic, it is not practical to reduce all of these contractor interactions to a single file; however, we agree in principle that both monitoring and associated documentation can be improved.

It should also be recognized that the contractor has long-standing policies and procedures relating to assessment of inter-rater reliability that has been shared with the auditors. The contractor has a medical doctor on staff to perform and oversee this function and who personally conducts training. Cases are pulled for clincal review and during the first three months of an employee's employment, cases are pulled more frequently to ensure good quality control. This type of internal quality control process reduces some of the risk associated with a vendor.

Regarding the auditor comment which classified the service array as "high risk", it should be noted that the CPA firm of KPMG was engaged to perform a SAS 70 audit for the period January 1, 2007 through November 30, 2007. KPMG issued a "clean" report in December 2007, stating that in their opinion, the controls described in the audit report had been placed in operation. These controls were divided between administrative, application and general controls and the audit was performed in accordance with AICPA standards. The fact that the contractor has strong control functions in place does not lend support the auditor's inference that this is a high risk vendor. While a SAS 70 audit alone does not preclude the need for an effective monitoring plan; it does provide certain assurances and reduces the need for certain monitoring. We do agree that the service array is high risk but that does not necessarily translate into a higher risk designation for monitoring this contractor.

The example of CAP-MR/DD spending referenced in this report is presented in an incomplete context. Because CAP-MR/DD authorizations were not expected to be performed on a statewide basis at the time of the original RFP and budget projections, it was not a surprise that the expenditures might exceed projections. This issue is documented in the April 6, 2006 memorandum refereced on page 7 of this performance report. Nevertheless, the Division agrees that internal controls should be continually assessed and could have addressed the magnitude of any variances prior to the vendor recognizing a mistake.

3. MANAGEMENT OVERRIDE OF CRITICAL SYSTEM CONTROLS FOR CLAIMS PROCESSING

The Department Health and Human Services – Division of Medical Assistance disabled critical information system edits designed to prevent the payment of unauthorized claims for mental health services. As a result, potentially inappropriate claims for mental health services were paid.

The disabled system edits governed payments to providers for Enhanced Services, Residential Child Care Services, and Outpatient Hospital mental health services, all of which required prior approval from the utilization review contractor for Medicaid-supported mental health services before the Division's Medicaid claims processing system would allow the claims to be paid.

The Division determined that the removal of the edits was necessary to temporarily resolve a file matching conflict between the contractor's authorization file and the Medicaid claims payment file. The two aforementioned files must match and agree to effectively determine if a service rendered by a provider is authorized allowing for the claim to be paid. The mismatch in the two files caused a large percentage of mental health provider claims to not be paid. The Division stated that the system edits were disabled to preserve access to care for recipients during a time of mental health system instability as well as to avoid noncompliance with federal guidelines.

E-mails dated in August 2006 indicated that the Division was trying to resolve the claims payment issues. With no immediate resolution, the Division decided in September 2006 to disable the payment edits, which allowed for services to be paid without verification of the required service authorization. The Division has worked closely with its Medicaid claims processor to address the claims payment issues and the effective re-activation of the payment edits. The payment edits for child services were re-activated in November 2007, while the edits for adult services were being addressed at the time of the release of this audit. Other Medicaid mental health services were not affected by the management override of the system edits.

The contractor continued to perform the mental health services authorization requests throughout the period of time that the edits were disabled and, as of December 2007, was paid approximately $32.9 million for its services rendered. However, information is

lacking to quantify whether the Division has derived complete value from the contract. By disabling the system edits, the Division chose for the reasons stated to bypass a critical system control designed to prevent inappropriate payments for these specific mental health services.

The U.S. Government Accountability Office's Internal Control Standards state: "Any intervention or overriding of internal control should be fully documented as to reasons and specific actions taken." The standards further state: "Automated edits and checks as well as clerical activities are used to help control accuracy and completeness of transaction processing."

Auditor Recommendation:

Payment edits for mental health adult Enhanced Services should be properly tested and re-activated. Proper protocols should exist to identify and address data verification problems between the authorization contractor and the Medicaid claims payment processor. Compensating controls should be in place to ensure that providers are paid for only those services that have received prior authorization. The Division should identify and recoup payments for unauthorized services in accordance with applicable federal regulations.

Department Response:

We agree with this recommendation. However, it is important to note that claims were not processing appropriately with the initial, flawed or malfunctioning system edits in place and providers were being denied payment for appropriately delivered and billed services. There were two fundamental factors involved in the decision to override certain MMIS edits for the processing of mental health claims which are not fully recognized in this report:

1) The Department was committed to assuring that recipients of NC Medicaid would not experience significant disruptions in service during the planned transition related to mental health reform. Given a very significant risk of adverse impact on consumers due to this particular technology challenge, the decision made was to err on the side of serving consumers' needs first, rather than allowing a potentially insurmountable barrier to their access to care.

2) At the same time that these mental health services were being implemented, the Division was receiving additional information from the Centers for Medicare and Medicaid services regarding the interpretation and implementation of federal EPSDT guidance. Simultaneously, the Division faced the specter of local legal actions in regard to compliance with EPSDT. The denials that would be incorrectly processed by these edits could have violated the appropriate implementation of EPSDT guidance.

Thus, allowing malfunctioning edits and audits to deny valid claims would have been totally inappropriate and irresponsible for the reasons previously stated.

These critical factors must be acknowledged when addressing the Division's choice to "*bypass a critical system control designed to prevent inappropriate payments*". While appropriate payments and controls are of paramount importance to the Department, the Auditor's Introduction to this report clearly states that the foremost responsibility of the agency is to provide medical assistance to families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services.

The State's contract Medicaid fiscal agent has been working on rectifying this problem since the malfunctioning issue was first identified and had to be turned off in order to pay valid claims. Corrective measures have continued to be taken to validate appropriate edits without compromising payment for appropriately billed services.

Auditor Addendum: *Additional test and follow-up procedures will be performed by the Office of the State Auditor in an effort to determine the impact, both financial and performance, of disabling the payment edits for the enhanced mental health services. A follow-up report will be issued to detail the results of those procedures.*

4. SETTLEMENT AGREEMENT NOT PROPERLY DOCUMENTED OR MONITORED

The Department Health and Human Services – Division of Medical Assistance did not adequately resolve a settlement related to over-billings by the contractor for the utilization reviews of Medicaid-supported mental health services. Furthermore, the Division either did not properly account for the recovering of the over-billings or did not recover the full amount agreed to in the settlement agreement. As a result, the Division may have overpaid for services under the contract.

The contractor had identified the billing errors in its review of contract revenues. The former Division contract administrator requested that the contractor perform a full analysis of all invoiced billings and implemented a payment hold-back, based on a percentage of billings, until the extent of the error could be determined. Effective October 2007, the Division began withholding 30% of the monthly invoiced amounts.

The Division entered into a settlement agreement with the contractor dated January 28, 2008, for $5.2 million that was to be recovered through billing credits and a one-time payment of $275,000. We requested settlement information from both the Division and the contractor; however, neither party was able to provide sufficient evidence for the methodology in determining the actual settlement amount. Division personnel stated they reached a "confidence level" as to the settlement amount and signed

the agreement with the contractor. However, it appears that the Division relied on the data analysis performed by the contractor to derive the settlement amount without verifying the accuracy or completeness of the data.

In following up with Division on the status of the settlement, we identified deficiencies in the tracking of the settlement recovery. The settlement agreement states that there had been previously issued credits with respect to over-billings totaling $5.2 million, and that receipt of which was acknowledged by the Department. However, as of April 2008, the accounting system only reflects $4.5 million in credits that have been applied against the contract payments. The outstanding balance of $672,000 either has not been received or has not been accounted for properly. Inquiries of the Division's Assistant Director for Budget and Finance and contracting staff did not result in additional evidence to support that the full amount of the credits had been applied.

Auditor Recommendation:

The Division should implement procedures to ensure that supporting documentation is obtained and properly reviewed for contractor invoices in a timely manner. Any discrepancies resulting in the need for recoupment should be identified to the proper levels of management, including the Department's Office of Controller, to ensure disclosure and accountability for the recoupment. The Division should investigate the identified variances related to the recovery of the settlement amounts and take appropriate action to resolve the outstanding amounts.

Department Response:

DHHS agrees with this recommendation and has spent many hours reviewing and verifying invoice billings, a process that continues to-date. The settlement negotiations were conducted by persons with skills and knowledge in the subject areas and which was reviewed by legal counsel. The Department correctly relied on the professional judgment of all these parties, as it does in all settlements. The Department recognizes the need to resolve the remaining balance of the settlement agreement in a timely manner with the contractor and to adequately reflect the recovery of the outstanding funds in the accounting records.

However, it should be noted that there is an amount in question ($154,242) as to the validity of a portion of the remaining credits that have not been applied that requires resolution. In addition, the Division of Medical Assistance has withheld payments to the vendor of approximately $2.9 million which will be paid to the vendor as invoices are reviewed and verified. Thus, the Division owes the vendor considerably more than the credits referenced as not being applied to-date. The Division will continue to work to resolve any outstanding issues.

ORDERING INFORMATION

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