

STATE OF NORTH CAROLINA

PERFORMANCE AUDIT

DEPARTMENT OF HEALTH AND HUMAN SERVICES –
DIVISION OF MEDICAL SERVICES

MEDICAID

JANUARY 2013

OFFICE OF THE STATE AUDITOR

BETH A. WOOD, CPA

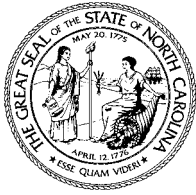
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January 31, 2013

The Honorable Pat McCrory, Governor
Members of the North Carolina General Assembly
Dr. Aldona Wos, Secretary, Department of Health and Human Services
Mrs. Carol Steckel, Director, Division of Medical Services

Ladies and Gentlemen:

We are pleased to submit this performance audit titled "*Department of Health and Human Services, Division of Medical Services - Medicaid.*" The audit objectives were (1) to determine if the Divisions' administrative functions, including assigned internal and external resources, complied with the Medicaid State Plan and federal requirements, and provided for an efficient use of State and federal funds; (2) to evaluate the Divisions' processes for preparing annual budgets and monitoring expenditures to determine if the Divisions is accurately predicting and assessing program costs; (3) to review the process by which the Division made State Plan Amendments from initiation to final Center for Medicare and Medicaid Services approval for compliance with federal requirements; and (4) to assess the timeliness, completeness and flow of budget and expenditure information from the Division to other stakeholders, including the Department Secretary, The Governor, and the General Assembly.

Secretary Wos reviewed a draft copy of this report. Her written comments are included in the appendix.

The Office of the State Auditor initiated this audit at the request of the North Carolina General Assembly.

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

Respectfully submitted,

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

Beth A. Wood, CPA
State Auditor

TABLE OF CONTENTS

	PAGE
SUMMARY	2
INTRODUCTION	
BACKGROUND.....	13
OBJECTIVES, SCOPE, AND METHODOLOGY	15
FINDINGS AND RECOMMENDATIONS	
ADMINISTRATIVE FUNCTIONS.....	17
BUDGET FORECASTING	32
STATE PLAN AMENDMENTS.....	56
REPORTING	62
APPENDICES	
A. DMA ADMINISTRATIVE CONTRACTS.....	65
B. DEPARTMENT RESPONSE.....	66
ORDERING INFORMATION	75

PERFORMANCE AUDIT

PURPOSE

The audit objectives were (1) to determine if the Division of Medical Assistance's (DMA) administrative functions, including assigned internal and external resources, complied with the Medicaid State Plan and federal requirements, and provided for an efficient use of State and federal funds; (2) to evaluate DMA's processes for preparing annual budgets and monitoring expenditures to determine if DMA is accurately predicting and assessing program costs; (3) to review the process by which DMA made State Plan Amendments from initiation to final Center for Medicare and Medicaid Services approval for compliance with federal requirements; and (4) to assess the timeliness, completeness and flow of budget and expenditure information from the Division to other stakeholders, including the Department Secretary, the Governor, and the General Assembly.

SUMMARY OF RESULTS

Administrative Functions

When compared to states with similar size medical assistance payment (MAP) spending, the state fiscal year (SFY) aggregate administrative costs (ADM) of the North Carolina Medicaid program as a percentage of MAP is significantly greater. In SFY 2011, North Carolina Medicaid incurred administrative expenses of approximately \$648.8 million which when compared to MAP spending of \$10.3 billion produced an ADM/MAP percentage of 6.3 percent. This percentage was significantly greater than the ratio for states with comparable spending. Other state's ratio ranged from 1.73 percent in Arizona to 5.44 percent in New Jersey.

One possible reason for the high amount of North Carolina's administrative spending relative to other states is due to the high level of Medicaid administrative expenses being incurred by other divisions within the Department of Health and Human Services (DHHS). For example, of the \$781 million in Medicaid administrative costs claimed during SFY 2012, only \$256.7 million or about 33 percent of the total were for costs incurred by DMA. Of the \$524.3 million in costs incurred by the other DHHS Divisions, the three (3) divisions that spent the largest amounts were the Division of Social Services at \$238.3 million, the Division of Mental Health at \$96.7 million, and the Division of Central Administration at \$164.8 million.

While important administrative functions such as eligibility determinations, administrative case management and Medicaid Management Information System (MMIS) design, development, and implementation occur at these other DHHS Divisions, these functions are not under the administrative control of DMA. As a result, DMA is not afforded the opportunity to control these costs.

Another contributing factor to the high amount of North Carolina's administrative spending is insufficient monitoring of administrative services that are contracted out by DMA.

Private contractor payments represent about \$120 million (46.7%) of DMA's \$257 million in administration expenditures for SFY 2012. It is always important for a state government to

PERFORMANCE AUDIT

exercise sound management practices with regard to the contracted services, but it becomes even more critical when almost half of the administrative expense is made up of contract payments.

Although contract payments represent a high percentage of its administrative budget, DMA was not able to provide a listing of contracts and the related expenditures in each SFY under review for this audit. DMA's inability to provide this information is indicative of its inadequate oversight of contractual expenditures. The initial list DMA provided only included amounts expended to date per contract. However, we were able to eventually obtain contracted service expenditures for FY12 and compile this information.

While our review of Medicaid contracted services was limited to DMA, insufficient monitoring of contracted administrative services could be an issue at other DHHS divisions. As noted above, \$524.3 million in Medicaid administrative costs were incurred by other DHHS Divisions in SFY 2012.

Additionally, DMA did not track contract expenditures by year against their yearly certified budget to monitor whether and when they were approaching the limit of their authority. As such, DMA did not know when to invoke corrective actions to avoid exceeding their certified budget such as issuing stop work orders and/or cease entering into additional contractual obligations.

Consequently, DMA has consistently exceeded budgeted amounts for contracted administrative costs and interagency transfers¹. DMA expenditures in fund² 1102, in which the vast majority relate to Medicaid, have significantly exceeded its certified budgets for contracts and other interagency transfers every year for the four SFYs 2009-2012 as follows:

	Amount exceeded in 2012	Amount exceeded in 2011	Amount exceeded in 2010	Amount exceeded in 2009
Contracted Admin.	\$25.9 million	\$28 million	\$21.4 million	\$37.2 million
Interagency Transfers ²	\$12.2 million	\$23 million	\$0.5 million	\$18.1 million

It's also important to note that DHHS does not have two tools that could help it better monitor and control Medicaid administrative costs – (1) a comprehensive Public Assistance Cost Allocation Plan (PACAP) and (2) a DMA cost allocation plan.

¹ Interagency transfers are expenditures DMA incurs when transferring funds to another division or agency to reimburse them for a Medicaid administrative expenditure made on behalf of DMA.

² Funds are set up to account for revenues and expenditures for specific activities within the overall Medicaid Program.

PERFORMANCE AUDIT

Federal regulations define a cost allocation plan as “a narrative description of the procedures that the State agency will use in identifying, measuring, and allocating State agency costs incurred in support of all programs administered or supervised by the State agency.”

Because a large amount of Medicaid administrative expense is incurred by divisions other than DMA, it is important to establish and monitor the Medicaid cost allocation plans. DHHS is the single State agency responsible for the supervision of the administration of the State’s Medicaid Plan, and DHHS has many divisions under its authority that allocated significant administrative costs to the Medicaid program in SFY 2012.

However, DHHS does not have a comprehensive PACAP that can be reviewed from a Medicaid perspective to ensure that costs are allocable and allowable for the proper and efficient administration of the Medicaid State Plan.

Although the divisions (except for DMA) have individual PACAPs, the lack of a single comprehensive controlling document weakens the ability to monitor Divisional allocations to Medicaid and prevent inappropriate cost shifting and inappropriate federal claiming. Furthermore, the lack of a comprehensive PACAP presents an increased risk of federal scrutiny and the potential for cost disallowances.

Similarly, DMA does not have a cost allocation plan for appropriately allocating indirect expenditures and tracking expenditures eligible for increased federal funding.

According to its Assistant Director of Budget Management, the Division’s position is that it is not required to have a cost allocation plan because all of its expenditures are direct to Medicaid.

While it is true that most of DMA’s expenditures are for Medicaid program services costs, Medicaid is not the only activity or program benefiting from the Division’s administrative costs. There are several grant programs that are administered by DMA. Most of these programs are relatively small and may be considered immaterial; however, the North Carolina Health Choice (NCHC) incurred about \$14 million in Medicaid administrative costs for SFY 2012.

Consequently, the lack of a DMA cost allocation plan could also result in inappropriate cost shifting, inappropriate federal claiming, and the potential for cost disallowances.

Recommendations:

1. DHHS and DMA need to ensure that proper measures are in place to monitor other divisions’ Medicaid spending. Interagency memorandums of understanding (IMOU) or cost allocation plans (CAP) should address the Medicaid program costs being necessary for the proper and efficient administration of the Medicaid State Plan and not the responsibility of a non-Medicaid program.
2. Beginning in SFY 2013, DMA began tracking current year expenditures against total claimed amounts for the year by individual contract to identify cases where no

purchase order is on file, no current claim is in NCAS or the amount is questionable, or the contract is over budget. As a result, three months into SFY 2013, DMA discovered it was already over budget for contracts. While DMA has taken a step in the right direction by tracking costs against individual contracts, DMA still needs to ensure expenditures do not exceed certified budgeted amounts by contract.

3. As the Medicaid single state agency, DHHS should include a Medicaid PACAP in its department-wide comprehensive PACAP, and incorporate the other divisional PACAPs through reference. In addition, DHHS should have individuals with a Medicaid programmatic and financial understanding review the comprehensive PACAP to ensure that costs from other divisional PACAPs are allocable and allowable for the proper and efficient administration of the State Plan.
4. As the Medicaid single state agency, DHHS should incorporate only Medicaid costs at the DHHS level into its comprehensive PACAP and then reference a DMA PACAP (for costs incurred at the DMA level) as well as other Divisional PACAPs that incur Medicaid costs. A DMA PACAP would serve to allocate costs to all benefiting programs, especially NCHC, as well as support the allocation of Medicaid administrative costs to activities with increased FFP and identify costs from outside agencies that are also being claimed for Medicaid administrative reimbursement.

Budget Forecasting

DMA's budget development and administrative practices do not ensure division and legislative accountability for public expenditures.

Incomplete Financial Projections

Most of DMA's expenditures support the North Carolina Medicaid program. Budget Code 14445 designates Medicaid budgets. The Budget Code 14445 includes 14 separate funds to account for Medicaid revenues and expenditures. Funds 1101 and 1102 account for the Medicaid administration funds expended by DMA. Fund 1310 includes current year medical claims and certain other payments, such as Medicare Part D and payments to the DHHS Controller. These are the principle funds that are responsible for Medicaid expenditures and account for a significant part of DMA's shortfalls in State General Fund. However, all of the DMA funds are important and significant shortfalls in total budget authority and State General Fund expenditures occur in Funds other than 1310. This makes it important for Office of State Budget and Management (OSBM) and the General Assembly to understand these budget accounts and receive an accounting for what occurs in all of them throughout the fiscal year.

But prior to July 2012, DMA did not project costs for other expenses that have had a significant impact on total Medicaid expenses.

For example, DMA did not include Fund 1330 (drug rebates and program integrity receipts) in its financial projections. Yet, Fund 1330 has experienced a significant State General Fund

PERFORMANCE AUDIT

shortfall for the past three years. In 2012, the shortfall was \$96.5 million; in 2011, it was \$40.5 million; and in 2010, it was \$16.4 million.

Additionally, DMA did not include Fund 1992 (receipts from prior year federal payments) in its financial projections. DMA did not budget any State General Fund expenditures for this fund from 2010-2012. However, the program used \$93.2 million in 2012, \$78.2 million in 2011, and \$69.5 million in 2010.

Furthermore, DMA did not include Fund 1320 (cost settlements paid to Medicaid providers) in its financial projections. The fund spent far less than the State General Fund budget amount, but it is as important to be aware of potential surpluses as it is to be aware of potential shortfalls. General Fund surpluses in Fund 1320 could be used to offset shortfalls in other Division funds, reducing the total amount of funding needed. In the past three years, the General Fund surpluses in this Fund 1320 have been: \$127.5 million in 2012, \$35.6 million in 2011, and \$110 million in 2010.

Carried Debt Forward

In 2012, DMA carried state debt into the next fiscal year by retaining \$131.8 million of federal funds in violation of state law.

On May 24, 2012, the General Assembly passed Senate Bill 797, which required that “neither the Director of the Budget nor any other state official, officer, or agency shall draw down or transfer unearned or borrowed receipts or other funds if doing so would create or increase a financial obligation for the 2012-2013 fiscal year.”

The General Assembly’s intent was clear. Personnel from OSBM, Fiscal Research, and DMA all stated that the purpose of the clause cited above was to prevent the State from retaining 2012 drug rebate revenues that were payable to the federal government.

OSBM told DMA not to retain the federal funds. OSBM stated that DMA said it intended to repay the 2012 drug rebates in 2013 because this was DMA’s “normal accounting process.” However, in an interview with auditors, the DMA Chief Business Operations Officer said that not repaying federal funds represented a change from normal accounting practices. The Chief Business Operations Officer also said that retaining the federal funds was done with the knowledge of “legislative leadership,” so the Division believed it was permissible. But OSBM cautioned the Division not to carry the 2012 debt forward into 2013.

Nevertheless, DMA failed to repay in SFY 2012 the federal government for the funds owed in SFY 2012. When the DMA budget was closed for SFY 2012, the federal Medicaid grant remained overdrawn by approximately \$131.8 million. About \$106.2 million was for the federal share of drug rebate revenues collected during May and June 2012. The remaining \$25.6 million represented the federal share of medical assistance accounts receivable collections. Although these funds were owed to the federal government prior to the end of SFY 2012, the Division did not repay the funds until SFY 2013, resulting in a \$131.8 million SFY 2013 beginning budget shortfall.

Unreliable Forecasts

Another problem is that DMA's budget forecasting methodology has not incorporated comprehensive multiyear projections and does not provide an accurate picture of the current year's financial position. Reliable forecasts require state agencies to forecast major revenues and expenses using complete data. However, DMA only prepares formal forecasts for one of their 14 funds, 1310 - Medical Assistance Payments. Only preparing a forecast for one major expenditure does not provide an accurate picture of the Medicaid program's status in complying with the Certified Budget or achieving State General Fund reductions that have been mandated by the General Assembly.

Additionally, DMA's forecasting methodology does not allow for reliable forecasts beyond the current fiscal year. As previously noted, DMA does not formally forecast for funds other than 1310 - Medical Assistance, so the only projections available for other Medicaid funds are the amounts in the Certified Budgets. Expenditures that DMA knew would occur have been omitted from these budgets in the past, so the budgeted amounts cannot be relied upon as reliable projections.

Furthermore, DMA has not provided evidence that it compares forecasts to actual budget performance. While DMA only forecasts for one fund - Medical Assistance Payments, it is the largest expenditure. Therefore, a comparison of forecasts to actual budget performance is important to identify the source of variances for actual expenditures.

Costs Not Managed

DMA does not appropriately manage Medicaid costs that are subject to agency control. Three significant cost drivers are (1) caseload, (2) price (the reimbursement rate provided to the medical provider), and (3) consumption (the Medicaid recipient's utilization of services).

Medicaid is an entitlement program, thus caseload is a cost driver that DMA can only control through good fraud detection to prevent individuals who are not truly eligible from qualifying for and using services.

Price (reimbursement rates) is a cost driver that DMA could make improvements to control. The current reimbursement methodologies allow rates to increase automatically unless action is taken to stabilize or reduce rates. However, it is possible to structure reimbursement methodologies so that rates remain stable unless positive action such as legislation is taken to increase them. This strategy provides greater control of the price component of medical services costs.

While North Carolina Medicaid relies on several strategies to control consumption, the single strategy that is invested with creating the greatest cost savings is Community Care of North Carolina (CCNC). The State expected to save \$90 million per year with CCNC during SFYs 2012 and 2013, but fell \$39.5 million short of its goal in 2012. CCNC is a form of managed care that provides case management services in a medical home environment. It is assumed to provide savings in providing medical services to participants. More than a decade of data exists that would allow a study by medical researchers on whether the medical home

model truly saves money and/or results in better medical outcomes. It would be a service to the nation as well as North Carolina to use this data to genuinely evaluate the questions associated with medical homes.

Lastly, a cultural change may be necessary to improve Medicaid cost management. In September 2010, OSBM issued a report titled *Analysis of Medicaid Staffing and Organization*. In that report, OSBM found that cost containment was not an organizational priority. The report stated, “Historically the Medicaid program has been more concerned about how to provide more services to more people than in containing costs.”

Inflationary Increases Not Eliminated

DMA failed to comply with a legislative mandate to eliminate inflationary increases for nursing facilities. The 2011–2013 budget, as reported in the Senate Appropriation Committees substitute for HB 200, included Item 52 for the DMA budget which “[e]liminates automatic inflation increases for Medicaid providers. The Division of Medical Assistance is not to authorize any inflationary increases to Medicaid provider rates during the 2011-13 biennium, except as provided for in Section 10.43.”

However, following the close of state fiscal year 2011, DMA reported to OSBM that Item 52, which was projected to save \$62.9 million in 2012, failed to reach its target by \$36 million. Included in the \$36 million shortfall was \$12.9 million that was attributed to “DHHS Decision” to include inflationary increases in nursing facility reimbursement for 2012.

DMA said that it could not eliminate inflationary increases and achieve the budgeted savings because of the complex “case mix” methodology used to reimburse nursing facilities. In a document submitted to Fiscal Research dated November 8, 2011, DMA made the following statement in response to a legislative inquiry about whether the Division had eliminated inflationary increases as mandated by S.L. 2011-145:

The cost included in the inflation amount related to skilled nursing facilities was not based upon increases due to inflationary costs, but rather increased acuity of patients served in the nursing facilities. The Legislature adopted an approach called “case mix” for reimbursing nursing facilities several years ago. Under this approach, nursing facilities are reimbursed based upon the medical complexity or acuity of the patients in the facility. The elimination of the projected change in costs for increased acuity of the patients would effectively eliminate case mix reimbursement; as a result, DHHS was informed that the elimination of the case mix was not anticipated or desired by the Legislature. This impacts the targeted budget amount by \$12 million.

While it is true that the nursing facility reimbursement methodology is complex, it is not true that eliminating inflationary increases in the nursing facility would necessitate “a change in the overall reimbursement system for nursing home service” or that it would eliminate adjustments to nursing facility rates based on acuity.

PERFORMANCE AUDIT

Of the four annual inflationary increases included in the nursing facility rate setting methodology, only one is related to a case mix adjusted portion of the nursing facility rates. However, it would be possible to eliminate inflationary adjustments to this portion of the rate without eliminating the case mix adjustment. In fact, this can be accomplished in a variety of ways without increasing overall nursing facility reimbursement. And the remaining three inflationary adjustments have nothing to do with the portion of the rate that is case-mix adjusted.

Therefore, it appears that the former DHHS Secretary's decision not to eliminate inflationary increases for Skilled Nursing Facilities may be based solely on the perception that this "would have an adverse impact on nursing facilities and the resulting access and care for Medicaid enrollees." However, no support has been offered for this perception.

Recommendations:

1. DMA and the DHHS should be required to submit reasonable estimates for all known Medicaid expenditures in their agency budget requests. If expenditures exceed allowable limits, DHHS, the Governor, or the General Assembly should take actions to reduce expenditures to stay within spending caps, rather than omit known expenditures from the budget.
2. DMA's agency request budget should adjust expenditures for all known costs that increase or decrease with fluctuations in caseload, including costs in administrative funds 1101 and 1102. These requests should be accompanied by appropriate documentation.
3. When DMA perceives that the General Assembly has included unachievable savings in their budgets, DMA should provide OSBM with documentation of this at the beginning of the biennium or fiscal year, along with a forecast of the additional total dollars and State General Fund that will be required to cover this unachievable savings.
4. DMA should discontinue the practice of incurring liabilities for the State at the beginning of the fiscal year because they have overdrawn federal funds in the prior fiscal year to offset State General Fund shortfalls.
5. Because Medicaid is such a large and complex program with a significant impact on the State budget, DMA may require more oversight than any individual Department Secretary with multiple other divisions and programs can provide. The General Assembly should consider organizational changes that could provide the oversight needed to ensure that the Medicaid program is operated in compliance with legislative mandates.
6. DMA should forecast for all Medicaid funds and these forecasts should be provided in an agreed upon format to OSBM and Fiscal Research Division at least quarterly.

PERFORMANCE AUDIT

7. DMA should maintain a comparison of forecasted expenditures and revenues to actual expenditures and subject it to analysis that can improve the ability to project expenditures.
8. DMA should prepare a five-year analysis to contribute to the Governor's budget message and should routinely forecast expenditures and revenues for a minimum of three years in the future.
9. Because caseload is a significant cost driver for Medicaid, DMA should perform multiyear caseload projections to support multiyear expenditure forecasts, and these forecasts should be tracked against actual caseload growth to evaluate the accuracy of the forecasting methodology.
10. DMA should perform a study to evaluate reimbursement methodology reform which should have a goal of establishing stable reimbursement methodologies that do not increase automatically but are only increased by actions approved by the General Assembly.
11. The State of North Carolina should engage medical researchers to perform a scientifically valid study based upon actual data to determine whether the CCNC model saves money and improves health outcomes.
12. Actions should occur, probably from outside the agency, to enforce a change in Division organizational culture to provide a focus on a health insurance perspective that encourages cost containment in an environment of increasing medical services and expanding payments to providers.
13. DMA should give complete and accurate information to the General Assembly when seeking approval to not comply with legislative mandates. Approval by the General Assembly should occur in a recognized forum with authority to provide this approval, rather than in informal discussions with individual legislators.

State Plan Amendments

The State Plan is a comprehensive written statement describing the nature and scope of its Medicaid program and giving assurance that it will be administered in accordance with federal and state laws. The State Plan contains all information necessary for the Center for Medicare and Medicaid Services (CMS) to determine whether the plan can be approved to serve as a basis for federal financial participation (FFP) in the State Program.

An approved Medicaid State Plan is allowed to be amended, if necessary, due to changes in laws, regulations, policies, court decisions, operations, or organization. State Plan Amendments (SPAs) should be promptly submitted for review, as sometimes mandated by the State Legislature as part of a budget or other bill, to the Associate Regional Administrator with CMS.

PERFORMANCE AUDIT

DMA is budgeting for savings related to SPAs upon mandate by the Legislature and in most cases failing to achieve the budgeted amounts. DMA submitted 44 SPAs to CMS for approval. According to DMA documentation, the amendments were budgeted to save \$72.2 million but only saved \$34.2 million (or \$38 million less than budgeted). Once the savings are not achieved, DMA excuses much of the lost savings to delays in the SPA process.

However, the cost savings incorporated into the budget for specific SPAs are not always realized due to varying factors - some within DMA's control. For example, given that CMS has 90 days to either approve a SPA or ask for additional information, DMA documentation indicates that some SPAs were not submitted in time to be approved and implemented by the budgeted implementation date. Furthermore, DMA did not plan for retroactively implementing SPAs in cases where DMA should have been reasonably certain that the SPA would not be approved and implemented by the budgeted implementation date. As a result, cost savings opportunities afforded to the State, commensurate with CMS' approval of the amendments, were not pursued and, therefore, the State did not realize the savings.

Recommendation:

The savings incorporated into the state budget need to be more realistically calculated by the DMA and DHHS with consideration of implementation costs and realistic implementation dates given current system constraints.

Reporting

DMA does not issue readily understandable and timely Medicaid performance reports to government officials who oversee the Medicaid program.

DMA provides periodic reports with detailed Medicaid financial data to the DHHS Secretary, Fiscal Research, and OSBM. The reports include detailed financial data regarding medical claims payments, cash flow, and monthly fees.

However, DMA does not provide clear, succinct, summarized information showing the year-to-date fiscal status and projections for the Medicaid program and reasons for deviations from the certified budget. To draw conclusions from the detailed data, report users must perform their own analyses or seek additional information.

Fiscal Research and OSBM report users are not satisfied with the usefulness and timeliness of the reports. Report users have noted a lack of targeted information to help them quickly identify unanticipated events or outlays that could indicate Medicaid program expenditures will differ significantly from established forecasts and budgets. Report users also noted that reports have been delayed or not available prior to scheduled meetings. The lack of timeliness has reduced report users' ability to prepare for meetings about Medicaid's financial status.

Recommendations:

1. DMA should consult with the DHHS Secretary, Office of the Governor, OSBM, and Fiscal Research Division of the North Carolina General Assembly to determine the informational needs of those charged with governance over the State's Medicaid program. Medicaid reporting requirements, including report formats and timeframes, should be formally established and followed.
2. Once reporting formats and timeframes have been established, the DHHS Secretary should ensure DMA is held accountable for providing accurate and timely reports to stakeholders.

AGENCY'S RESPONSE

The Agency's response is included in Appendix B.

INTRODUCTION

BACKGROUND

The North Carolina Department of Health and Human Services (“DHHS” or “Department”) has been designated in the North Carolina Medicaid State Plan as the single State Medicaid agency. The Centers for Medicare and Medicaid Services (CMS) require that each State name a single agency that is responsible to the Federal government for the Medicaid program. However, most of the responsibility for administering the Medicaid program has been delegated to the Division of Medical Assistance (DMA or Division) within DHHS.

Medicaid was established by Title XIX of the Social Security Act in 1965. It is a partnership between the Federal government and the various States. The Federal government provides a portion of the funds for providing medical services and administering the program. The States have the option of determining whether or not they will participate in Medicaid. All 50 States, as well as the District of Columbia and several U.S. territories, have Medicaid programs. If a State elects to participate in Medicaid, it must comply with all requirements of the Social Security Act and the Code of Federal Regulations. While these laws and regulations require all Medicaid programs to establish minimum levels of eligibility and provision of medical services, the States have broad latitude to offer eligibility to additional groups, to provide optional medical services, and to design service delivery systems.

In recent years, Medicaid budgets have been growing while revenues in many States have been shrinking. In most States, Medicaid represents the second largest expenditure behind education. Medicaid grows inversely with the health of the economy. As economic indicators such as employment decline, Medicaid caseloads increase. As caseloads increase, total Medicaid expenditures increase. State legislatures throughout the nation have been exploring methods for slowing the growth of Medicaid expenditures and have introduced a variety of measures to reduce Medicaid budgets.

This cost consciousness has affected the philosophy of many Medicaid managers. Where once Medicaid may have been viewed as a welfare program with emphasis on providing as much service to as many people as possible, today Medicaid is regarded by many as a governmental insurance program that should encourage cost containment.

Revenues and expenditures for North Carolina’s Medicaid program are included in 14 funds³ in Budget Code 14445. In 2012 the total Medicaid budget expended more than \$14 billion, which included more than \$3 billion in State General Fund. The Medicaid budget has grown 23 percent over the past four years, and it has experienced significant State General Fund shortfalls in each of the past three years. In 2012, the General Fund shortfall was more than \$400 million at year end. The General Assembly had to appropriate an additional \$200 million for DMA. Additionally, State funds were transferred from other DHHS

³ Funds are set up to account for revenues and expenditures for specific activities within the overall Medicaid Program

PERFORMANCE AUDIT

agencies, and Federal revenues were retained in 2012 that had to be repaid in State Fiscal Year 2013.

In October 2011, DMA testified before a legislative committee that they anticipated a State General Fund shortfall in Medicaid of \$139 million. In January 2012, DMA reported to a legislative subcommittee that they anticipated a \$149 million General Fund shortfall in Medicaid. The actual General Fund shortfall was more than \$400 million. In 2011, the General Fund shortfall also exceeded \$400 million and in 2010 it was more than \$300 million.

Medicaid has also incurred significant costs because of required repayments of funds to the Federal government. In 2012 DMA had to repay \$41 million for disallowances for Federal payments for personal care services. In 2010 DMA received a \$15 million disallowance for Federal payments on community support services. In 2009 DHHS erroneously drew \$300 million in Federal funds, resulting in installment payments to CMS of \$40 million each year in 2011 and 2012 and \$30 million in 2013.

PERFORMANCE AUDIT

OBJECTIVES, SCOPE, AND METHODOLOGY

The audit objectives were: (1) To determine if the Division's administrative functions, including assigned internal and external resources, complied with the Medicaid State Plan and Federal requirements, and provided for an efficient use of State and Federal funds; (2) To evaluate the Divisions' processes for preparing annual budgets and monitoring expenditures to determine if DMA is accurately predicting and assessing program costs; (3) To review the process by which the Division made State Plan Amendments (SPAs) from initiation to final CMS approval for compliance with Federal requirements; and (4) To assess the timeliness, completeness and flow of budget and expenditure information from the Division to other stakeholders, including the Department Secretary, the Governor, and the General Assembly.

The Office of the State Auditor initiated this audit in accordance with Section 10.9A(a) through (b) of the 2012–2013 North Carolina State Budget.

The audit scope included a review of the Division's administrative functions, budget forecasting, State Plan Amendments, and reporting for the period of time beginning July 31, 2009 through July 31, 2012. We conducted the fieldwork from August 2012 through October 2012.

To evaluate the administrative functions, we conducted interviews of Department and Division personnel, reviewed organizational charts, reviewed vendor contracts, and reviewed administrative expenditures of North Carolina and other States.

To evaluate the budgeting and monitoring processes, we interviewed Department and Division personnel, interviewed North Carolina Office of State Budget and Management (OSBM) personnel, interviewed North Carolina General Assembly Fiscal Research Division (Fiscal Research) personnel, reviewed budgets and actual expenditures, and reviewed the causes of actual budget shortfalls.

To evaluate the SPA process, we interviewed Division personnel, and reviewed documents related to SPAs with significant fiscal impact.

To evaluate fiscal reporting, we interviewed Department and Division personnel, interviewed North Carolina Office of State Budget and Management (OSBM) personnel, interviewed North Carolina General Assembly Fiscal Research Division (Fiscal Research) personnel, reviewed actual Federal and State reports, and reviewed the communications regarding actual budget shortfalls.

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 lack of compliance.

As a basis for evaluating internal control, we applied the internal control guidance contained in professional auditing standards. As discussed in the standards, internal control consists of five interrelated components, which are (1) control environment, (2) risk assessment, (3) control activities, (4) information and communication, and (5) monitoring.

PERFORMANCE AUDIT

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.

FINDINGS AND RECOMMENDATIONS

ADMINISTRATIVE FUNCTIONS

The Federal financial participation (FFP) matching portion of most administrative functions is 50 percent. However, some administrative functions, such as operating an approved Medicaid Management Information System (MMIS), are matched at rates greater than 50 percent FFP. For these costs, some stringent Federal requirements have been imposed on the State Medicaid programs to limit their administration costs claimed for specific types of cost that either: (1) receive enhanced rates of FFP higher than 50 percent or (2) pertain to specific areas of cost that Congress deems to be worthy of special attention.

Enormous variation exists among how state governments have chosen to organize the administration of their Medicaid programs. Although the federal matching rates for the amounts spent by the states on Medical Assistance Payments (MAP) for the costs of covered services in each state's approved State Medicaid Plan varies by state, the federal matching rates for administrative costs are the same for all states.

For the largest portion of administrative costs for which the State will receive the 50 percent FFP rate, Congress stipulates in section 1903(a) (7) of the SSA that each state shall be paid "...an amount equal to 50 per centum of the remainder of the amounts expended during such quarter as found necessary by the Secretary for the proper and efficient administration of the State plan." (Underlining supplied for special emphasis.)

It is the expression "proper and efficient administration" that has afforded the states such broad flexibility in accomplishing the administration of their Medicaid program without jeopardizing the availability of their Federal financial participation (FFP) in those administrative costs. If a State Medicaid program incurs administrative costs for which it is only claiming FFP at the 50 percent rate, it can be difficult for the Federal government to disallow that FFP based on the argument that the cost was not necessary for the State in the course of properly and efficiently administering its State Medicaid Plan. The natural result is tremendous variation among State Medicaid programs' administrative costs.

Comparison with Other State Medicaid Programs

When compared to states with similar size medical assistance payment (MAP) spending, the state fiscal year (SFY) aggregate administrative costs of the North Carolina Medicaid program as a percentage of MAP is significantly greater, as shown in the following table:

FINDINGS AND RECOMMENDATIONS

Total Administrative Cost Comparison

State	Total Cost (\$)	Administrative Cost (\$)	Admin to Total
Tennessee	7,969,998,389	413,622,139	5.19%
Missouri	8,011,172,212	286,268,889	3.57%
Georgia	8,064,611,365	400,415,522	4.97%
Arizona	8,988,386,558	155,835,205	1.73%
North Carolina	10,297,057,563	648,762,805	6.30%
New Jersey	10,501,136,233	571,374,290	5.44%
Michigan	12,062,932,510	515,345,364	4.27%
Illinois	12,835,985,780	678,614,042	5.29%
Massachusetts	13,007,366,707	555,838,633	4.27%
Average	\$10,193,183,035	\$469,564,099	4.56%

Source: Center for Medicare and Medicaid Services reports and auditor calculations

In SFY 2011, North Carolina Medicaid incurred administrative expenses of approximately \$648.8 million, which when compared to MAP spending of \$10.3 billion produced an ADM/MAP percentage of 6.30 percent. This percentage was significantly greater than the ratio of other states.

Additionally, states that came the closest to spending as much in Medicaid administration as North Carolina's \$648.8 million are Illinois at \$678.6 million, Massachusetts at \$555.8 million, and New Jersey at \$571.4 million. However, all three of these states have larger total cost, and therefore larger Medicaid programs to be administered. For example, only Illinois spent more than North Carolina in administrative costs; however, because they were administering a program almost \$3 billion larger, their percentage of administrative costs is still below North Carolina's, at 5.29%. Similar results were also found with comparisons made to the same states in SFYs 2009 and 2010.

Core Administrative Functions

To better understand and appreciate the North Carolina Division of Medical Assistance's (DMA) performance for its portion of the administration of the State Medicaid program, it is important to understand the required administrative functions for operating a proper and efficient state Medicaid program. The Kaiser Foundation's "The Medicaid Resource Book" examined the Federal guidelines and surveyed various State Medicaid programs, and they reached the conclusion that a State Medicaid program has the following nine core administration functions:

- (1) **Beneficiary Outreach and Enrollment:** States must identify and inform the individuals who are potentially Medicaid eligible of their potential eligibility, and then enroll those applicants who are deemed eligible.
- (2) **Defining the Scope of Covered Benefits:** States must determine what benefits the plan will cover and in what settings. The type and scope of each service that a

FINDINGS AND RECOMMENDATIONS

state offers to its Medicaid beneficiaries must be specified in its State Medicaid plan. Any additions, deletions, or modifications of this benefits package must be done through the submission of an amendment to the State Medicaid plan (State Plan Amendment, or SPA), which must be approved by CMS to ensure the requirements for FFP matching funds are still being satisfied.

(3) **Setting Provider and Plan Payment Rates:** States must determine how much the plan will pay for the Medicaid benefits it covers and whether it will buy those benefits/services from fee-for-service (FFS) providers and/or managed care plans. A state's Medicaid reimbursement policies (FFS or risk-based) must be defined in its State Medicaid plan, and any changes in those policies and institutional reimbursement plans must be reflected in SPAs and must receive prior federal approval before the FFP can be claimed for the corresponding changes.

(4) **Enrolling Providers and Plans:** States must establish standards for the providers and managed care plans from which they will purchase covered benefits and enroll (or contract with) those which meet the standards.

(5) **Payment of Providers and Plans:** States must process and pay the Medicaid reimbursement claims received from fee-for-service providers and make capitation payments to the managed care plans.

(6) **Monitoring Service Quality:** States must monitor the quality of the services the plans purchase to ensure that beneficiaries are protected from, and that Federal taxpayers are not subsidizing, substandard care.

(7) **Ensuring Program Integrity:** States must ensure that state and federal health care funds are not spent improperly or diverted by fraudulent providers. Program integrity related activities include not only the pursuit of recoveries from the abusive providers and beneficiaries, but also activities designed to prevent the inappropriate payments from being made in the first place.

(8) **Processing Appeals:** States must have a process for resolving grievances by applicants, beneficiaries, and providers.

(9) **Collection and Reporting of Information:** States must collect and report information necessary for effective administration and program accountability.

In North Carolina, approximately 33 percent (\$256.7 million) of the Medicaid program administration costs claimed for FFP during the SFY12 was within DMA control. The remaining 67 percent (\$524.3 million) is claimed by other Department of Health and Human Services (DHHS) agencies (see Table on the next page). DMA has very little input and control over the manner in which other DHHS divisions perform their duties and the amount of administrative expenditures they incur on behalf of the Medicaid program. As the single state agency for the NC Medicaid program, DHHS is responsible for overseeing all its divisions and for consolidating all division Medicaid program administrative expenditures into one consolidated Federal Medicaid expenditure report (i.e. Form CMS 64 report).

FINDINGS AND RECOMMENDATIONS

Department of Health and Human Services Medicaid Administrative Expenses

To categorize DMA funds, staff, and other resources into these nine core administrative function categories, we used the DMA organizational chart, human resource and financial data gathered from internal reports, and input from DMA personnel. Since all organizations have staff who perform general administrative duties, which are allocated to all the activities of the organization, we have added a 10th function that we call General Administration (GA) for purposes of this report. The following table provides a summary of Medicaid expenditures in SFY12 for DMA and other DHHS agencies claiming Medicaid administrative costs.

Title XIX Administrative Resources Expended for the SFYE 6/30/12									
#	Medicaid Administrative Functions	# of Staff	PERSONAL SERVICES	OTHER IN-HOUSE	OUTSOURCED CONTRACTS	TOTAL COMPUTABLE EXPENDITURE(1)	FEDERAL SHARE	NON-FEDERAL SHARE(2)	TC %
1a	Beneficiary Outreach and Enrollment	53.54	3,350,916.94	1,082,891.28	614,483.09	5,048,291.31	2,818,623.63	2,229,667.68	2.5%
1b	Medicaid Admin Claiming (MAC) for School-Based Services (SBS)	-	-	-	47,034,695.29	47,034,695.29	23,517,347.64	23,517,347.65	23.1%
1	Subtotal: Beneficiary Outreach and Enrollment	53.54	3,350,916.94	1,082,891.28	47,649,178.38	52,082,986.60	26,335,971.27	25,747,015.33	25.6%
2	Defining the Scope of Covered Benefits	51	4,422,816.37	61,284.51	242,386.98	4,726,487.86	3,514,610.92	1,211,876.94	2.3%
3	Setting Provider and Plan Payment Rates	26.5	1,799,740.44	71,452.75	4,994,018.24	6,865,211.43	3,845,053.60	3,020,157.83	3.4%
4	Enrolling Providers and Plans	25.46	1,580,127.88	558.17	-	1,580,686.05	790,343.39	790,342.66	0.8%
5	Payment of Providers and Plans	26	2,653,801.00	(1,095.60)	54,492,245.59	57,144,950.99	41,324,222.71	15,820,728.28	28.0%
6	Monitoring Service Quality	32	2,347,461.18	84,386.25	217,627.30	2,649,474.73	1,536,658.08	1,112,816.65	1.3%
7	Ensuring Program Integrity	53	3,477,530.84	1,287,744.60	55,324,260.62	60,089,536.06	41,217,923.89	18,871,612.17	29.5%
8	Processing Appeals	42.5	3,134,469.13	4,874,775.33	-	8,009,244.46	4,027,722.02	3,981,522.44	3.9%
9	Collection and Reporting of Information	1	186,971.76	-	3,289,245.17	3,476,216.93	2,005,490.33	1,470,726.60	1.7%
GA	General Administration	49	3,897,084.71	2,782,454.70	671,797.44	7,351,336.85	3,675,668.43	3,675,668.43	3.6%
	DMA's Total Title XIX Admin Resources	360	26,850,920.25	10,244,451.99	166,880,759.72	203,976,131.96	128,273,664.64	75,702,467.33	100.00%
	Other DMA Claimed Title XIX Expenditures (3)	-	-	52,692,458.69	-	52,692,458.69	51,381,572.10	1,310,886.60	
	Total DMA Resources	360(4)	26,850,920.25	62,936,910.68	166,880,759.72	256,668,590.65	179,655,236.73	77,013,353.92	

FINDINGS AND RECOMMENDATIONS

Administrative Costs Incurred in Other DHHS Divisions									
	Disability Determination Section					5,317,998.64	2,658,999.32	2,658,999.32	
	Division of Public Health					9,879,947.62	5,564,278.98	4,315,668.64	
	Division of Central Administration					164,814,047.00	141,029,132.16	23,784,914.84	
	Division of Aging					1,251,001.85	625,500.93	625,500.92	
	Division of Child Development					49,304.63	24,652.32	24,652.31	
	Office of Education Services					63,156.00	31,578.00	31,578.00	
	Division of Social Services					238,290,743.33	119,403,365.23	118,887,378.10	
	Division of Health Services Regulation					7,911,281.82	4,652,223.64	3,259,058.18	
	Division of Vocational Rehabilitation Services					83,124.67	41,562.34	41,562.33	
	Division of Mental Health					96,689,334.43	52,560,655.54	44,128,678.89	
	TOTAL TITLE XIX ADMIN EXPENDITURES					781,018,530.64	506,247,185.19	274,771,345.45	

NOTES:

- (1) Total Computable Expenditure is the total of both federal and state expenditures
- (2) Non-Federal Share is the State's portion of expenditures
- (3) Other DMA claimed expenditures consist mostly of 100% federally funded payments
- (4) Position counts do not include vacancies

The table above shows that \$166.8 million of total DMA expenditures were for outsourced contracts. These outsourced expenditures were made up of \$47 million in Medicaid Administrative Claiming (MAC) for School-Based Services and about \$120 million of additional private contracts. Since the non-Federal share of the MAC expenditures is the responsibility of the public schools and/or counties and is not a responsibility of DMA, this \$47 million claimed for the MAC at the schools skews this analysis regarding DMA's resources. When we remove the \$47 million of MAC, the remaining \$120 million of private contractor payments still represents 46.7% of the total Division administration expenditures. This represents a high percentage of its budget. See Appendix A for an inventory of DMA Medicaid administrative contracts.

It is always important for a state government to exercise sound management practices with outsourced contracts, but it becomes even more critical when almost half of the annual budget is contract payments. And, as will be explained in more detail later in this report, these contract expenditures were not effectively managed by DMA. As a result, the strain on the State's annual budget due to Medicaid budget shortfalls in recent years has been exacerbated by these contract expenditures exceeding the certified budgeted amounts for the SFY. We will now take a closer look below at the make-up of the Division's internal resources and outsourced contracts, as expended in SFY12 to accomplish each of the nine core Medicaid administrative functions:

FINDINGS AND RECOMMENDATIONS

(1) Beneficiary Outreach and Enrollment: Of the total spent for this function, \$47 million is for MAC performed at the schools. We categorized this expenditure amount here because a significant portion of the tasks performed by these school-based employees involves outreach to the Medicaid-eligible school children. And, because the non-federal share of these expenditures does not come out of the Division's budget, we only address the remaining \$5 million spent primarily for the salaries and other in-house costs for 54 staff, who report to the various Clinical Services components on the organizational chart, and the costs for these staff are captured in five Responsibility Cost Centers (RCCs). After removing the MAC, DMA's expenditures were \$5 million for this administrative function because most of the State's cost for the eligibility related activities is incurred by the Division of Social Services at the county level.

(2) Defining the Scope of Covered Benefits: DMA's expenditures for this function include salaries for 51 skilled professional medical personnel (SPMP) claimed by DMA at the 75 percent FFP rate. Congress encourages states to employ the services of medical professionals for these duties, so states have been authorized to claim 75 percent FFP for their salaries and other benefits so that the states will be willing to pay the higher salaries that SPMP can demand in the work place. Although these SPMP are scattered throughout many of the Clinical Services components of the organizational chart, the personnel costs have been captured in one RCC to ensure their costs are easily identified for proper reporting on the Form CMS 64 category line for SPMP claimed at the 75 percent FFP rate.

(3) Setting Provider and Plan Payment Rates: DMA's in-house costs for this function contained about \$1.8 million in salaries and benefits for 27 staff that were classified primarily as auditors, who work in the various organizational components within DMA's business office. Their duties mostly include activities to ensure that provider reimbursement rates are appropriate in accordance with the approved State Plan provisions. However, almost \$5 million was paid to outsourced contractors for services such as hospital field audits used in rate determinations and cost benefit comparisons for various provider types. Many State Medicaid agencies choose to outsource these highly specialized, analytical services because in-house personnel typically don't have the same level of expertise as the consulting firms.

(4) Enrolling Providers and Plans: We identified the smallest amount of DMA administrative expenses for this function because it is very difficult to separate these costs from those assigned to the administrative functions **(5)** and **(6)** below.

\$1.6 million includes salaries and benefits for the 25 staff in two RCCs that have staff positioned throughout various Clinical Services organizational components.

(5) Payment of Providers and Plans: DMA expenditures for this administrative function represent 28 percent of DMA's expenditures primarily due to outsourced contracts expenditures. Most of the \$57 million for this function was claimed in one RCC for the fiscal agent contract and related services. These fiscal agent fees have been claimed by DMA at the 75 percent Federal matching rate allowed for the State's operational costs incurred for its Medicaid Management Information System (MMIS). Also included in this function are two other smaller contracts expenditures, one for about \$2.4 million for PASARR (Preadmission Screening and Annual Resident Review) related screenings (also claimable at the 75 percent

FINDINGS AND RECOMMENDATIONS

FFP rate) and the other at just over \$1 million paid for verification of the nursing facility minimum data set assessments and supporting documentation.

(6) Monitoring Service Quality: DMA expenditures for this function include salaries and benefits for 32 staff that are captured in three RCCs claimed by DMA at the 75 percent FFP rate. One of the RCCs had 10 staff performing oversight and administration of the Health Information Technology (HIT) initiative claimed at the 90 percent FFP rate. This federally mandated initiative promotes the nationwide adoption of the uniform electronic health record for patients to be used by medical providers to improve the medical outcomes for patients and to facilitate better distribution of patient health records. The other RCC had the salaries and benefits for 19 quality analysts scattered throughout various clinical services organizational components.

(7) Ensuring Program Integrity: The Program Integrity (PI) function is the administrative function for which the DMA incurred the largest expenditures in SFY12 – more than 29 percent of DMA administrative expenditures. This amount does not include the State’s Medicaid PI-related expenditures claimed by the Division of Information Resource Management (DIRM). As with function (5) above, the primary reason for this high percentage is \$55 million for outsourced contracts with private firms and information technology companies like IBM. Based on the input received from the DMA, we assigned 15 of the DMA’s RCCs to the PI function, and 11 of them were RCCs used for the expenditures incurred for outsourced contracts. Two of these contracts were not competitively procured: (i) the IBM contract (\$1.1 million in SFY12) for development of the Fraud and Abuse Management System (FAMS); and (ii) Carolinas Center for Medical Excellence (CCME) contract (\$10.5 million in SFY12) for the independent assessments of individuals applying for in-home personal care services (PCS). For DMA’s in-house PI related costs, 53 staff members contained in the other 4 RCCs were scattered throughout many of the clinical services organizational components. The salaries and benefits for 27 staff in one of the RCCs have been claimed as SPMP at the 75 percent FFP rate because their duties require them to use their medical expertise to make decisions about the medical necessity of the providers’ services during the PI related reviews. The other 26 staff positions are in RCCs for the normal PI and for third party liability costs.

(8) Processing Appeals: The DMA’s \$8 million of in-house costs for this function included about \$3.1 million of salaries and benefits for 43 staff, plus \$4.9 million for other purchased services. The in-house staff positions were assigned in three RCCs, but the staff were actually scattered throughout the clinical services organizational components. No outsourced contracts were identified for this administrative function.

(9) Collection and Reporting of Information: The SFY12 expenditures identified for this administration function represented only 1.7 percent of the total DMA expenditures because a significant amount of the personnel involved in the collection and reporting of information were assigned to the General Administration (GA) function. Some of those 49 GA staff positions performed significant amounts of information gathering and reporting. However, because they were assigned to the two RCCs that were identified as primarily engaged in GA activities that are allocable to all the functions, it would not have been practical to split them

FINDINGS AND RECOMMENDATIONS

into this function. As a result, only one staff position was allocated to this function. \$3.3 million of this function's identified costs were incurred for four outsourced contracts.

(10) General Administration: The expenditures remaining in this GA function represent 3.6 percent of DMA's administrative expenditures because the vast majority of the staff assigned to work in the business office, including the State Medicaid Director's office and his supporting staff, were allocated to this administrative function. 49 staff member salaries and benefits from two RCCs accounted for the \$3.9 million personal services expenditures.

Finding #1: The Division has consistently exceeded budgeted amounts for contracted administrative costs and interagency transfers due to an apparent lack of oversight.

DMA expenditures in Fund 1102 (for contracts for the fiscal agent and other private vendors, as well as interagency transfers⁴) have significantly exceeded their certified budgets every year for the four SFYs 2009-2012 as follows:

	Amount exceeded in 2012	Amount exceeded in 2011	Amount exceeded in 2010	Amount exceeded in 2009
Contracted Admin.	\$25.9 million	\$28 million	\$21.4 million	\$37.2 million
Interagency Transfers ²	\$12.2 million	\$23 million	\$0.5 million	\$18.1 million

As previously described, about half of the administrative expenses within DMA are for contracted services. There is an overall need for more precise monitoring of administrative costs with both DMA and DHHS. The General Assembly's budget expects agencies to comply with amounts certified in each fund. (Note: Further details regarding budgeting requirements are discussed in the Budgeting Section of the report; here we address only the administrative costs.)

Prior to FY13, DMA did not track current year contract expenditures against current year certified budget amounts by contract to manage contract expenditures to stay within budget. As a result, DMA's contractual obligations exceeded the certified budget amounts as indicated in the table above. Therefore, DMA was not able to identify if any corrective actions were necessary to avoid exceeding its certified budget on a contract-by-contract basis, such as issuing stop work orders and/or ceasing to enter into additional contractual obligations. DMA management noted that they have begun monitoring individual contractual expenditures in FY13.

To cover contract amounts that exceed the certified budget, DMA must obtain approval through the budget revision system in DHHS and OSBM to transfer budget authority from other funds into Fund 1102 so expenditure overages can be covered. If budget authority from

⁴ Interagency transfers are expenditures DMA incurs when transferring funds to another agency or division to reimburse them for a Medicaid administrative expenditure made on behalf of DMA.

FINDINGS AND RECOMMENDATIONS

other funding sources cannot be found, DMA would obligate the State debt beyond the authority of its legislative approved budget.

Recommendation:

Beginning in SFY 2013, DMA began tracking contract expenditures to date against total claimed amounts over the term of individual contracts to identify cases where no purchase order is on file, no current claim is in NCAS or the amount is questionable, or the contract is over budget. As a result, three months into SFY 2013, DMA discovered it was already over its certified budget for contracts. While DMA has taken a step in the right direction by tracking costs against certified budget limits, DMA needs to ensure expenditures do not exceed certified budgeted amounts.

Finding #2: Other Department of Health and Human Services (DHHS) division administrative spending is not controlled by DMA and is not sufficiently monitored by DHHS to ensure proper drawdown of federal funds.

One possible reason for the high amount of North Carolina's administrative spending relative to other states is the high level of Medicaid administrative expenses being incurred by other divisions within DHHS.

For example, of the \$781 million in Medicaid administrative costs claimed during SFY 2012, only \$256.7 million, or about 33 percent of the total, was for costs incurred by DMA. Of the \$524.3 million in costs incurred by the other DHHS divisions, the three (3) divisions that spent the largest amounts were the Division of Social Services at \$238.3 million, the Division of Mental Health at \$96.7 million, and the Division of Central Administration at \$164.8 million.

While important administrative functions such as eligibility determinations, administrative case management and MMIS design, development, and implementation occur at these other DHHS divisions, DMA does not control these costs.

The main issue with Medicaid administrative claim expenses in other divisions pertains to oversight and responsibility. That is, to be allowable costs covered under the Medicaid program, costs must be necessary for the proper and efficient administration of the Medicaid State plan and not the responsibility of a non-Medicaid program. Currently, DHHS could not provide any evidence that DHHS as the Single State agency is fulfilling this oversight role, nor that DMA as the Medicaid unit has assumed this responsibility.

There are additional deficiencies regarding DHHS procedures for funding the non-Federal share of administrative costs and medical assistance transportation costs under the Medicaid State Plan by other DHHS divisions, as well as options for acceptable Medicaid financing for these costs.

DHHS includes DMA and a number of other divisions that may provide health care services (transportation) and administrative costs as part of the State Medicaid Plan. Under the current

FINDINGS AND RECOMMENDATIONS

arrangements, when administrative costs and medical assistance transportation costs are incurred by another division, funding for the costs is appropriated by the General Assembly to that division. The division then bills the DHHS Controller's Office for the costs incurred based on the corresponding federal financial participation (FFP) rates. In turn, the DHHS Controller's Office draws federal funds for FFP based on the bill from the division, and provides the FFP to the division.

Under this arrangement, the division does not transfer funds to DMA to fund the non-Federal share, nor is there any type of certification of public expenditure from the division other than posting costs to the North Carolina Accounting system (NCAS).

This process does not appear to comply with Federal regulations governing expenditures in the Medicaid program. As defined at 45 CFR 95.13(b) and (d), a Medicaid expenditure for a medical service occurs when any state agency makes a payment to the service provider. A Medicaid expenditure for administration occurs in the quarter in which payment was made by a State agency or in which costs were allocated in accordance with regulations. Pursuant to 42 CFR 433.10(a), the expenditure must be a total computable payment, including both Federal and state share, which forms the basis of the claim to draw down the corresponding FFP in accordance with the Federal Medical Assistance Percentage (FMAP) rate.

Federal regulations require that there be one designated agency that administers and controls the Medicaid funds. DHHS has been designated this single state agency. Even though all the divisions providing Medicaid administration and/or Medicaid services are within DHHS, the division budgets are appropriated independently and remain under the control of each individual division. DMA serves as the Medicaid agency in making payments to the provider, and as a result, the funds used to make the total computable payment to the other divisions should be under the administrative control of DMA. 42 CFR 433.51 requires that before DMA may make a total computable payment to another state division (administrative or medical assistance payment), one of two things must occur: (1) DMA must possess the non-Federal share; or (2) the other division must certify its expenditures eligible for FFP (subject to cost reconciliation).

In interviews, the DHHS Controller's Office indicated that a division's act of booking expenditures in NCAS was sufficient documentation to support a payment of FFP only. The DHHS Controller's Office believes that this satisfies the requirement for the division to certify its expenditures. However, the booking of expenditures in NCAS is not sufficient documentation of the certifying of expenditures. For the DHHS Controller's Office to pay the division only the FFP under a Certified Public Expenditure (CPE) arrangement, an inter-agency memorandum of understanding (IMOU) between DMA/DHHS and the other division needs to detail the services purchased, the basis for billing, and billing based on actual costs subject to reconciliation. As a result, the current practices of paying only the FFP to other divisions and the current processes for funding the non-federal share of Medicaid expenditures are not consistent with section 1903(w)(6)(A) of the Social Security Act (the Act), nor with the federal regulations at 42 CFR 433.10, 42 CFR 433.51 and 45 CFR 95.13(b).

FINDINGS AND RECOMMENDATIONS

The State needs to act quickly to ensure that there is proper funding for the State share of expenditures related to services provided to Medicaid beneficiaries. The lack of appropriate funding may prevent approval of future SPAs and may result in further financial management reviews and potential deferrals and/or disallowances by CMS/OIG.

Recommendation:

DHHS and DMA need to ensure that proper measures are in place to monitor other divisions' Medicaid spending. Interagency memorandums of understanding (IMOU) or cost allocation plans (CAP) should address the Medicaid program costs being necessary for the proper and efficient administration of the Medicaid State Plan and not the responsibility of a non-Medicaid program.

Finding #3: The Department does not have a comprehensive Public Assistance Cost Allocation Plan that can be reviewed from a Medicaid perspective to ensure that costs are allocable and allowable for the proper and efficient administration of the Medicaid State Plan.

The Department of Health and Human Services (DHHS) does not have a Public Assistance Cost Allocation Plan (PACAP) that allows for the effective monitoring of expenditures allocated to the Medicaid program by the various Divisions within DHHS. Therefore, there is an increased risk of inappropriate cost shifting, which can strain the Medicaid budget, and may lead to improper claims for the Federal Financing Participation (FFP).

A cost allocation plan is defined by 45 CFR § 95.505 as “a narrative description of the procedures that the State agency will use in identifying, measuring, and allocating State agency costs incurred in support of all programs administered or supervised by the State agency.” 2 CFR Part 225 (formerly OMB Circular A-87) Appendix C speaks to the purpose of a cost allocation plan. It is a “process whereby these central service costs can be identified and assigned to benefitted activities on a reasonable and consistent basis.”

2 CFR Part 225 Appendix D is specific to PACAPs, and extends the requirements of Appendix C to “all Federal agencies whose programs are administered by a State public assistance agency.” Such programs include Medicaid, Temporary Assistance to Needy Families (TANF), and Food Stamps.

DHHS is designated as the single State agency responsible for the supervision of the administration of the North Carolina State Plan for Medical Assistance (State Plan). According to 42 CFR § 433.34, the “single or appropriate Agency will have an approved cost allocation plan on file with the Department in accordance with the requirements contained in subpart E of 45 CFR part 95.”

According to 42 CFR § 95.505:

State agency means the State agency administering or supervising the administration of the State plan for any program cited in § 95.503. A State agency may be an organizational part of a larger State department that also

FINDINGS AND RECOMMENDATIONS

contains other components and agencies. Where that occurs, the expression State agency refers to the specific component or agency within the State department that is directly responsible for the administration of, or supervising the administration of, one or more programs identified in § 95.503.

DHHS has many divisions under its authority, including the following that allocated significant dollars to the Medical Assistance program in SFY 2012:

- Disability Determination Section (DDS)
- Division of Public Health (DPH)
- Division of Central Administration (DCA)
- Division of Social Services (DSS)
- Division of Health Services Regulation (DHSR)
- Division of Mental Health (DMH)
- Division of Medical Assistance (DMA)

The divisions, except for DMA, have individual PACAPs. However, none of the divisions are the single State agency responsible for the supervision or the administration of the Medical Assistance program. The lack of a DMA PACAP is discussed as a separate finding.

While the DHHS Controller's Office has oversight responsibility with respect to the Divisions' PACAPs, the lack of a single comprehensive controlling document weakens the ability to monitor Divisional allocations to Medicaid and prevent inappropriate cost shifting and inappropriate federal claiming. The existence of a comprehensive PACAP would demonstrate that proper oversight of the administrative costs billed to Medicaid is being performed by State Medicaid personnel that have the proper knowledge of the Medicaid program requirements to ensure that they are both allocable and allowable. The lack of a Single State agency PACAP presents an increased risk of Federal scrutiny and the potential for cost disallowances. According to 45 CFR § 95.519, "[i]f costs under a Public Assistance program are not claimed in accordance with the approved cost allocation plan (except as otherwise provided in § 95.517), or if the State failed to submit an amended cost allocation plan as required by § 95.509, the costs improperly claimed will be disallowed."

The proper allocation and claiming of Medical Assistance administrative costs is an area of review by the US DHHS Office of Inspector General (HHS-OIG). HHS-OIG's annual Work Plans for 2009-2012 indicated that reviews of Medicaid administrative expenses will be conducted "to determine whether they were properly allocated and claimed or directly charged to Medicaid."

Our discussions with representatives from the DHHS Controller's Office with cost allocation oversight responsibilities confirmed their use of a decentralized approach to cost allocation. They also indicated that this approach had not been previously questioned.

FINDINGS AND RECOMMENDATIONS

Recommendation:

DHHS should prepare a department-wide comprehensive PACAP, even if to incorporate the divisional PACAPs through reference. In addition, DHHS should have individuals with a Medicaid programmatic and financial understanding review the comprehensive PACAP to ensure that costs are allocable and allowable for the proper and efficient administration of the State Plan.

Finding #4: DMA does not have a cost allocation plan for appropriately allocating indirect expenditures and tracking expenditures eligible for increased federal funding.

DMA does not have a cost allocation plan. According to their Assistant Director of Budget Management, the Division's position is that it is not required to have a cost allocation plan because all of its expenditures are direct to Medicaid. A cost allocation plan distributes indirect costs (expenditures that benefit two or more activities) in reasonable proportion to the amount of benefit the expenditures provide to each activity. General requirements for allocation of indirect costs to federal grants are included in 2 CFR Part 225 (formerly OMB Circular A-87). This regulation requires that all activities which benefit from a governmental unit's indirect costs must receive an appropriate allocation of indirect costs.

Allocation Between Programs

While it is true that most of DMA's expenditures are for Medicaid program services costs, it is not correct that Medicaid is the only activity or program benefiting from the Division's administrative costs. There are several grant programs that are administered by DMA. Most of these programs are relatively small and may be considered immaterial; however, the costs incurred for the North Carolina Health Choice (NCHC) program (North Carolina's Children's Health Insurance Program (CHIP)) are substantially greater than for the other grants. If the administrative costs are proportionate to the percent of medical costs incurred by NCHC, some \$14 million in administrative costs attributable to NCHC are being charged to Medicaid. CMS may not allow classification of the NCHC indirect costs as direct Medicaid costs for three reasons:

1. The total amount could be considered significant, and CMS would require these costs to be charged to the appropriate grant and covered by the appropriate federal appropriation.
2. There is a cap on administrative expenditures for CHIP. Per Social Security Act (SSA) Section 2105(c)(2), no more than 10 percent of total program expenditures can be paid for administration. If the State is not charging all of its costs, including indirect costs, to the CHIP program, CMS cannot determine whether the State has remained within the limitations on administrative spending. If the CHIP expenditures exceed the administrative cap, they are currently reimbursed by Medicaid. However, the State is not entitled to any federal reimbursement for CHIP costs that exceed the administrative cap.

FINDINGS AND RECOMMENDATIONS

3. Each state is given an allocation of federal funds for the CHIP program each year in accordance with Section 2104(m) of the SSA. Unless some states spend less than their allocation and the excess funds are redistributed to other states, the initial allocation is the maximum amount of federal funding that is available to the state, no matter what it actually spends. Even if redistribution does occur, there is no assurance that the State would receive all the funds need to cover its CHIP expenditures. If North Carolina is charging expenditures to Medicaid, which has no limitation on federal funding, that should be charged to CHIP, which has a limitation on federal funding, the State could be receiving federal funds it is not entitled to.

It is unknown whether the State would receive significant additional revenues from properly allocating costs among the different grant programs. 2 CFR Part 225 does allow that a governmental unit is not required to classify a cost as indirect if accounting for it would require “efforts disproportionate to the benefits received.” The North Carolina DHHS Controller’s office stated that they performed an analysis of the impact of a CAP on their administrative costs and determined that it was not significant enough to warrant a CAP.

Allocation to Increased FFP Activities

Attachment D to 2 CFR Part 225 indicates that the federal Department of Health and Human Services requires certain public assistance programs that receive federal funding to have a Public Assistance Cost Allocation Plan (PACAP) that meets specific requirements with respect to development, documentation, submission, negotiation, and approval. These requirements are set forth in 45 CFR 95, Subpart E. States receiving federal Medicaid funds are required to have a PACAP.

Whether a qualifying PACAP is submitted by DHHS or DMA, the plan must address “[t]he procedures used to identify, measure, and allocate all costs to each benefiting program and activity (including activities subject to different rates of FFP).” FFP, or federal financial participation, is the percentage of the total expenditure that the federal government pays. Medicaid administration has a variety of FFP rates, which are identified in Section 1903 of the SSA. The rates vary for the activity, and include MMIS operations and maintenance (75%), Skilled Professional Medical Personnel (75%), MMIS implementation under an approved Advanced Planning Document (90%), family planning (90%), resident review (75%), preadmission screening (75%), immigrant status (100%), and external review (75%). All Medicaid administration that does not have a specific increased FFP assigned to it by federal law receives a 50 percent federal match. In order to claim the increased FFP, North Carolina must have a PACAP for Medicaid that demonstrates how these costs are measured, per 45 CFR 95.507(b)(4). North Carolina does not have this in place.

In the case of skilled professional medical personnel, certain licensed employees are eligible, and their costs can only be claimed for that time spent on activities that require use of their medical expertise. Travel and training expenditures can be reimbursed, as can the time of clerical staff assigned to the skilled staff, when the clerical personnel are supporting activities that required medical expertise. DMA currently is not tracking time that skilled medical

FINDINGS AND RECOMMENDATIONS

professionals spend on tasks requiring their medical expertise. However, DMA declared \$7.3 million for costs of skilled medical professionals on the CMS 64 for quarter ending June 30, 2012. Some or all of these costs could be subject to disallowance because DMA has no methodology for tracking them.

Additionally, DMA may not be charging all allowable expenses at an increased FFP. For example, skilled medical professional time in other agencies may be charged, if an appropriate agreement is in place and these staff can track their time that is spent on Medicaid activities. Costs of DMA administrative staff may be charged at 75 percent FFP for a variety of approved activities, including contract administration, if the time can be appropriately tracked.

Recommendation:

DHHS should reassess their conclusion that a DMA CAP is not necessary. A DMA CAP would serve to allocate costs to all benefiting programs, especially NCHC, as well as support the allocation of Medicaid administrative costs to activities with increased FFP.

FINDINGS AND RECOMMENDATIONS

BUDGET FORECASTING

The Budget Process

In the 2006 GASB White Paper: Why Governmental Accounting and Financial Reporting Is – and Should Be – Different, The Governmental Accounting and Standards Board (GASB) states:

[T]he budget is the principal source of control over operations in government. The budget generally is a legal document that authorizes the government to utilize its resources to conduct operations and provide services....budgets of governments are public documents that express public policy priorities and financial intent. Citizens and their elected representatives have the right to know whether the government actually used funds and resources in accordance with the approved budget. Demonstrating accountability for compliance with budget authority is a distinguishing objective of governmental financial reporting.

The budget process is the primary method that North Carolina's elected officials have for establishing and enforcing priorities in State government. The budget process begins in the individual agencies of the State's three governmental branches and moves through a consolidation process to the Office of State Budget and Management (OSBM), where a governor's recommended biennial budget is developed and presented to the General Assembly. The North Carolina General Assembly has the final word on how the State's revenues are raised and funds are expended when it ratifies a biennial budget during the regular legislative session in each odd-numbered year. After the budget is signed by the Governor, OSBM certifies the budget to each agency. The Certified Budget becomes the spending plan for the State, against which actual revenue collections and expenditures are monitored. The Certified Budget for the second year of the biennium is amended during the shorter legislative session which convenes each even-numbered year. Thus, the Certified Budgets approved by the North Carolina General Assembly are the principle means by which State government priorities are established, and they are the standard against which these priorities are enforced. The Certified Budget passed by the North Carolina General Assembly is, perhaps, the single most critical action in providing State government accountability to its citizens.

Generally, legislatures formally stipulate that agencies and individuals acting on their behalf must comply with the approved budget. In North Carolina, this legal stipulation resides in the State Budget Act (North Carolina General Statute, Chapter 143C), which makes the Governor or his or her delegate, the Office of State Budget and Management (OSBM), responsible for enacting the budget as it is adopted by the General Assembly.

Accountability, thus, distinguishes governmental financial management. Public monies must be on the table and clearly visible to all who choose to view them. North Carolina's State government seeks to achieve this accountability, and the transparency that is required to support it, in the following manner:

FINDINGS AND RECOMMENDATIONS

1. The General Assembly enacts a Certified Budget during the regular legislative session that provides the legal basis for State expenditures during the biennium.
2. The General Assembly rebases⁵ the Certified Budget in its short session to respond to additional information available for the second year of the biennium.
3. By authority of the State Budget Act, OSBM oversees administration of the Certified Budget and revisions that may be required based on new information during the biennium.
4. Through the State Budget Act, the General Assembly requires agencies to administer the Certified Budget as it is written and to comply with all requirements of OSBM.
5. Revisions to Certified Budgets may only be made by the limited authorization of OSBM or through approval by the General Assembly.

DMA Budgets

In its 2011 session, the North Carolina Legislature appropriated nearly \$20 billion per year in General Funds for operations of State government. The Department of Health and Human Services received nearly 23 percent of the total State General Fund Appropriation. The Division of Medical Assistance, which administers North Carolina's Medicaid program, comprised over 65 percent of the Department operating budget and over 15 percent of the State's total General Fund Appropriation.

Most of the Division's expenditures support the North Carolina Medicaid program. Budget Code 14445 designates Medicaid budgets. The total Certified Budgets for 14445 Medicaid budgets have increased from \$11.4 billion in 2008 to \$12.9 billion in 2012, an increase of 12.7%. Actual expenditures have increased from \$11.6 billion in 2008 to \$14.2 billion in 2012, almost 23%. Medicaid spending has exceeded budget amounts in all of the past four years. In 2011 and 2012, total expenditures exceeded the Certified Budget by \$1.4 billion each year and in 2010 the certified budget was exceeded by \$1.8 billion, as shown in the following table.

⁵ A rebasing is adjustments to the budget during the second year of the biennium to accommodate changes in program operating requirements, such as enrollment changes and inflation.

FINDINGS AND RECOMMENDATIONS

DMA Budget Code 14445				
Budgeted vs Actual Expenditures 2009 - 2011				
Fiscal Year	Actual	Certified Budget	Variance	Percent Over Certified Budget
2012	\$14,241,450,471	\$12,885,349,949	\$1,356,100,522	10.52%
2011	\$13,270,350,502	\$11,903,629,348	\$1,366,721,154	11.48%
2010	\$12,838,121,597	\$11,046,775,749	\$1,791,345,848	16.22%
2009	\$12,623,281,487	\$11,769,988,426	\$853,293,061	7.25%

The Budget Code 14445 includes 14 separate funds⁶ to account for Medicaid revenues and expenditures. In State Fiscal Years 2010 and 2011, a 15th fund, 1R17, was added to account for certain monies realized from passage of the American Recovery and Reinvestment Act of 2009 (ARRA), but this fund was no longer in use in 2012. Funds 1101 and 1102 account for the Medicaid administration funds expended by the Division of Medical Assistance (Division). Fund 1310 includes current year medical claims and certain other payments, such as Medicare Part D and payments to the DHHS Controller. These are the principle funds that are responsible for Medicaid expenditures and account for a significant part of the Division's shortfalls in the State General Fund. However, all of the Division funds are important, and significant shortfalls in total budget authority and State General Fund expenditures occur in Funds other than 1310. This makes it important for OSBM and the General Assembly to understand these budget accounts and receive an accounting for what occurs in all of them throughout the fiscal year. The Medicaid budgets, Code 14445, are described in the following table.

Fund	Fund Title	Purpose
1101	Division of Medical Assistance Administration	Division salary and operating costs except for contracts and interagency transfers in Fund 1102
1102	Division Admin Contracts and Interagency Transfers	Contracts for fiscal agent and other private vendors; transfers to other agencies
1210	Medical Assistance County Administration	Non-emergency transportation costs managed by the counties
1310	Medical Assistance Payments	Payments to providers for medical claims; supplemental payments
1320	Medical Assistance Cost Payments	Cost settlements paid to Medicaid providers

⁶ Funds are set up to account for revenues and expenditures for specific activities within the overall Medicaid Program

FINDINGS AND RECOMMENDATIONS

1330	Medical Assistance Adjustments & Refunds	Drug rebates & program integrity
1336	Disproportionate Share Hospital (DSH) Payments	DSH payments
1340	Undispositioned Refunds	Refunds and recoveries of Medicaid payments whose source has not been identified or credited
1350	Periodic Interim Payments	Provider advance payments
1810	Revenue Clearing Account	Deposits and disbursements of Federal funds
1910	Reserves & Transfers	Transfer of non-tax revenues and miscellaneous receipts to State Controller
1991	Federal Indirect Reserves	Federal share of Department of Health and Human Services Statewide Cost Allocation Plan
1992	Prior Year Revenue Earned	Receipts from prior year Federal payments
1993	Prior Years Audits and Adjustments	Payments or recoveries from prior year audits and adjustments
1R17	American Recovery and Reinvestment Act of 2009 (ARRA) DSH	Temporary fund for 2010 and 2011 established to account for additional DSH funds provided by ARRA

DMA Budget Forecasting

Most of the Medicaid funds in Budget Code 14445 contribute significant expenditures or, in some cases, revenues to the State. However, DMA does not routinely budget for at least five of the funds and forecasts expenditures only for Fund 1310 – Medical Assistance. The only routine forecast provided for the Medicaid funds projects expenditures by 14 different eligibility categories.

Medical claims costs are forecast for these groups by budget line item, which include costs for various provider types (hospital inpatient general, hospital inpatient specialty, outpatient hospital general, podiatry, etc.) Year-to-date (YTD) expenses for each line item/provider type are divided by YTD average monthly caseload to calculate an actual monthly cost per eligible (CPE) for the line item. This CPE is adjusted for inflation and an economic factor, if appropriate. Inflation is the percentage increase or decrease in reimbursement that is anticipated. The economic factor is the increase or decrease in cost due to policy changes, code updates or new codes, times a percentage adjustment for consumption which projects that actual number of eligibles who are receiving services.

FINDINGS AND RECOMMENDATIONS

Projection Methodology for Eligibility Categories:

YTD Expenses / YTD average monthly caseload = YTD CPE

YTD CPE x Economic Factor X Inflation = Adjusted CPE

Adjusted CPE X Average Monthly Projected Caseload for the Remainder of the Year X Months Remaining in Year = Total Projected Expenditures for Remainder of the Year

YTD Expenses + Projected Expenditures Remainder of the Year = Projected Expenditures for Fiscal Year

The projected expenditures for all eligibility categories are aggregated on a worksheet entitled "All Eligibles." Payments and adjustments made outside the claims payment system, such as Medicare Part D and payments to the Office of the State Controller, are added to the aggregated medical services costs for the eligibility categories to yield total projected expenditures for the fiscal year. Revenue projections from all sources other than the appropriations are summed to yield expected receipts from Other Revenues. Other Revenues are subtracted from Total Expenditures to estimate the State General Fund Appropriation required to support Fund 1310.

Total Projection of Fiscal Year:

Sum of Aggregated Eligibility Category Costs + Other Payments and Adjustments = Total Projected Expenditures

Total Projected Expenditures – Sum of Other Revenues = Estimated Appropriation Requirement

The Medicaid budget and current year projections depend on a caseload projection that is made using SAS forecasting software. Caseload projections are made for each eligibility category used in the budget projection. Caseload is the only element of Medicaid forecasting that depends on a software application.

Medicaid Budget Shortfalls

The Medicaid budget shortfalls in the past three fiscal years have been significant, both in total expenditures and State General Fund requirements. They have not been confined to Fund 1310 – Medical Assistance Payments, but have been attributable to a variety of factors aside from unpredicted increases caseload or medical claims.

For 2012, OSBM provided documentation that the total shortfall was \$375,369,958. This was offset by unanticipated revenues from Qualified Public Hospitals Claims and the Medicaid Hospital Gap Plan in the amount of \$88,965,547, plus an appropriation from the Health and Wellness Trust Fund of \$10,904,411. This left \$275,500,000 in General Fund that had to be acquired through a combination of additional appropriations and transfers from other agencies. However, the Department also failed to refund drug rebate revenues and various receivables that were collected in 2012 to the Federal government, resulting in an overdraw of

FINDINGS AND RECOMMENDATIONS

\$131,802,454. These Federal funds were used to offset State expenditures in 2012 and were paid back from State funds in 2013. The State General Fund shortfall in 2012 was:

Operating Shortfall	\$375,369,958
Minus Unbudgeted Revenues (QPH & Gap)	(88,965,547)
Plus Federal funds used for State expenditures	<u>131,802,454</u>
Total State General Fund shortfall 2012	\$418,206,865

OSBM calculated the 2011 Medicaid shortfall at \$601,259,304. \$271,005,067 was due to a debt carried forward from 2010, when the Division used Federal DSH funds for 2011 and Federal revenues from drug rebates earned after June 21 to pay the State share of 2010 expenditures. However, the Division was able to fund \$197,404,307 of this shortfall with State General Fund savings on claims payments:

ARRA FMAP shortfall	\$222,402,035
Repayment of 2010 DSH / rebate funds	271,005,067
Repayment of 2009 Federal overdraw	41,326,752
Contracts, settlements, other	66,259,304
Division internal savings	<u>(197,404,307)</u>
Total State General Fund shortfall 2011	\$403,588,851

OSBM documents indicate that the State General Fund shortfall in 2010 was \$316,667,659. Most of this was covered by using \$203,014,184 in Federal funds for DSH that were drawn in 2010 for payments to be made in the first quarter of 2011. An additional \$67,014,184 in Federal drug rebates collected after June 21, 2010, were also used to offset the State shortfall. These funds had to be repaid with State General Fund in 2011 and contributed significantly to the subsequent fiscal year's General Fund shortfall.

In 2009 the Division had a surplus in State General Fund. Because ARRA was passed in February 2009 and was retroactive to October 1, 2008, enhanced Federal Medical Assistance Percentage (FMAP) provided by the bill substantially reduced State General Fund requirements for Medicaid expenditures.

Finding #1: The Division's budget development and administration practices are potentially non-compliant with State statutes that have been enacted to ensure agency and legislative accountability for public expenditures.

DMA's actual expenditures have significantly exceeded Certified Budget authority in each of the past four fiscal years. In State governments, General Fund expenditures tend to dominate the focus of policy makers and financial managers because State General Fund expenditures create the necessity to raise State revenues. However, all of the funds in the budget are important. The North Carolina Certified Budget serves as the financial and operations plan of

FINDINGS AND RECOMMENDATIONS

the State. It outlines how the State will use all of the resources available to it, including resources that are available from sources other than State revenues. The Certified Budget is the General Assembly's plan, and when a single agency's deviation from the Certified Budget exceeds a billion dollars a year, the agency is operating outside the planning authority of the General Assembly. Governmental accountability has been put at risk.

The State Budget Act mandates that, "In accordance with Section 5(3) of Article III of the North Carolina Constitution, the Governor shall administer the budget as enacted by the General Assembly." DMA's dramatic variance from the Certified Budget in the past three years suggests that the budget enacted by the General Assembly has not been implemented. DMA provided accountings for shortfalls in the total Certified Budget for fiscal years 2010, 2011, and 2012. Many of the items creating the shortfalls were not requested in the agency expansion budget. Fund 1310 – Medical Assistance is the only fund that the Division rebases to increase expenditures in the budget. Items outside Fund 1310 must be requested in the expansion budget. For the 2012-2013 biennium, DMA's only expansion request was for 76 new positions. DHHS did not submit this request to OSBM to be included in the biennial budget.

DMA representatives gave a variety of explanations as to why the agency exceeded its Certified Budget and incurred State General Fund shortfalls in the past three years. For example:

- Though they knew an expenditure would be incurred, they did not know the exact amount of the expenditure, so they didn't budget anything. DHHS stated that the reason the disallowance for personal care services was not included in the agency request budget is because, though they knew the expenditures would occur, they did not know the exact cost.
- DMA has not been allowed to rebase Fund 1102 to account for changes in enrollment that increase the cost of claims processing and prior authorizations.
- The General Assembly has included unachievable cost savings in the budget.
- DHHS did not include known expenditures in the budget, including the installment repayments to CMS.

DMA has stated repeatedly that variances in their budget are approved by OSBM. However, the State Budget Act does not allow OSBM unlimited authority to approve changes in the Certified Budget. According to the State Budget Act: "under no circumstances shall the total requirements for a State department exceed the department's certified budget for the fiscal year by more than three percent (3%) without prior consultation with the Joint Legislative Commission on Governmental Operations." The DMA budget variations in 2010, 2011, and 2012 exceeded 3 percent of the total DHHS budget. It is not apparent how changes are tracked to alert DMA when it will exceed 3 percent of the departmental budget. Because of the substantial variances in different DMA funds, approval of a series of single variations could result in a cumulative variance that created the need for legislative approval.

FINDINGS AND RECOMMENDATIONS

Drug Rebates and Senate Bill 797

When DMA's budgets closed for State Fiscal Year 2012, the federal Medicaid grant was overdrawn by \$131,802,454.20. This represented funds that were owed to the federal government prior to June 30, 2012, but were not repaid until State Fiscal Year 2013. \$106,184,205 was for the federal share of drug rebate revenues collected during May and June 2012. The remaining \$26 million represented the federal share of accounts receivable collections of medical assistance.

On May 24, 2012, the General Assembly passed SB 797 which required that "neither the Director of the Budget nor any other State official, officer, or agency shall draw down or transfer unearned or borrowed receipts or other funds if doing so would create or increase a financial obligation for the 2012–2013 fiscal year." Representatives of OSBM, Fiscal Research, DHHS, and DMA all stated that the purpose of this clause was to prevent the State from retaining 2012 drug rebate revenues that were payable to the Federal government. Nevertheless, DMA delayed repaying the Federal government for the funds owed in 2012.

When representatives of the DHHS Controller were interviewed, they stated they did not have any knowledge of whether the revenues were returned to the Federal government in 2012, though the Federal rebates were declared correctly on the CMS 64 for the quarter ending June 30, 2012. When the DHHS Director of Budget Analysis was interviewed, he stated that only a small amount of the rebates for June were left unpaid in 2012 and, for this reason, they felt that they had followed SB 797. He stated that OSBM was "at the table" when this decision was made. When the DMA Chief Business Operations Officer was interviewed, he acknowledged that \$131.8 million in drug rebates and other recoveries were not repaid to the Federal government and this represented a change from their normal accounting practice. He stated that this was done with the knowledge of "legislative leadership," so the agency believed it was permissible. OSBM stated that the DMA told them that they intended to repay the 2012 drug rebates in 2013 because this was their "normal accounting process." OSBM cautioned DMA to follow the provisions of SB 797 by not carrying 2012 debt forward into 2013. Fiscal Research stated that DMA's action was not compliant with SB 797. The staff who are conducting the Single Audit for the Office of the State Auditor have stated that the 2012 Single Audit will include a finding that retaining the federal drug rebate and receivables revenue in 2012 and repaying it in 2013 is not compliant with approved federal cash management practices.

Drug rebate revenues are returned to the federal government by offsetting a federal draw for Medicaid expenditures that have already occurred by the amount of money owed to the Federal government. The DMA staff member who has been responsible for this activity stated that his normal practice has been to estimate the amount of drug rebates owed the federal government for a month in the third week of that month. This estimate would be deducted from the Federal draw for Medicaid expenditures. After month end, when the actual amount of drug rebate revenue owed the Federal government became known, DMA would do a true-up draw to adjust the refunds to the federal government. This staff member was told by his supervisor not to return drug rebate revenues for May or June 2012. This represented a change from the process that he had been using since he had begun doing these tasks. It

FINDINGS AND RECOMMENDATIONS

should be noted that the federal share of drug rebate revenues for April 2012 were not paid until late in June.

While acknowledging that it retained these federal revenues from May and June 2012 and did not repay them until State Fiscal Year 2013, DMA provided the following written explanation for this:

The decision in June 2012 was that DMA had substantially met its obligation for returning the Federal share of rebates to CMS during SFY 2012. Decisions regarding return of rebates at year end 2012 were made in consultation with DMA, DHHS, and OSBM. There was also consultation with Legislative leadership prior to a final decision.

It is not clear why DMA felt that that North Carolina Medicaid had “substantially met its obligation for returning the Federal share of rebates to CMS during 2012” when \$106 million in drug rebates and an additional \$26 million in miscellaneous revenues remained unpaid. However, it does appear that this action was potentially non-compliant with SB 797. While DMA seems to imply that their “consultation” with OSBM and legislative leadership constituted some sort of approval for their action, this “consultation” did not give the agency license to not follow the statute. SB 797 clearly prohibited State agencies from carrying forward debt from 2012 to 2013, and it did not include any provision that allowed OSBM or individual legislators to authorize DMA to interpret the statute this way.

In 2010, DMA drew federal revenues for hospital DSH payments that were to be paid in 2011. They also retained \$67 million in federal drug rebate revenues earned after June 21, 2010. This federal revenue was used to offset a State General Fund shortfall in 2010. This resulted in the State repaying the federal drug rebate revenues in State Fiscal Year 2011 and paying the first DSH payments of 2011 with 100 percent State fund. This contributed \$271 million to DMA’s State General Fund shortfall in 2011.

OSBM indicated that they were aware that these funds were drawn in 2010, and the Division planned to use them to offset the State shortfall. OSBM understood that the Federal DSH revenues were earned revenue because the State had already drawn them and believed this quarterly DSH draw and the repayment of the drug rebates earned after June 21 were part of DMA’s normal processes. However, federal revenue is supposed to be drawn as it expended, not in the quarter prior to the expenditure. It is unclear whether refunding federal drug rebates earned after June 21 in the following fiscal year was, at the time, the normal accounting process for DMA. However, it is quite clear that using the drug rebate revenues to offset a shortfall in 2010 resulted in a \$67 million liability for the State as it started Fiscal Year 2011.

CCNC Savings Not Realized

The 2011–2013 budget included \$90 million per year in General Fund savings for “budget savings to be achieved by DHHS, in conjunction with CCNC Networks and North Carolina Community Care, Inc., through the cooperation of Medicaid health care providers” (Senate Appropriations Committee Report HB 200). In interviews, DMA representatives stated that

FINDINGS AND RECOMMENDATIONS

the Community Care of North Carolina (CCNC) cost savings did not have the support of DMA. DMA representatives stated that they knew that they could not achieve \$90 million in State General Fund cost savings through CCNC in 2012. In October 2011, DMA informed the General Assembly that they expected a shortfall of \$39 million in General Fund savings for CCNC. At year end, DMA reported that their General Fund shortfall for the CCNC cost savings item was \$39,518,804.

HB 200 included the following statement regarding the CCNC cost savings: “To the extent these savings are not achieved, DHHS is to undertake whatever actions necessary to affect the savings, including: 1) reducing provider rates; and 2) eliminating or reducing the level or duration of optional Medicaid services.”

DHHS did not take actions to make up for the remaining \$39 million CCNC projected saving; however, DHHS does not agree that it failed to take the additional steps required by the state budget. DHHS said it presented various proposals for reducing rates and optional services to offset the unachieved CCNC savings in December 2011. DHHS said the actions were not implemented based on discussions between the DHHS Secretary and Legislative leadership. Furthermore, DHHS says any changes made to provider rates and optional services would not have been implemented in time to impact state fiscal year 2012 shortfalls.

Federal Cash Management Procedures

The Statewide Single Audit is a federally mandated audit of all Federal funds received by North Carolina. It is conducted annually by the Office of the State Auditor. Between 2009 and 2011, DMA had findings in the Single Audit pertaining to deficiencies in their federal cash management procedures for the Medicaid programs. In 2012 DMA will again have a finding of deficiency pertaining to its failure to return Federal drug rebate and miscellaneous receivables to the Federal government in a timely manner.

In 2011, the finding indicated that DMA failed to minimize the time elapsed between drawing down federal funds and disbursing federal cash. The agreement between the State and the U.S. Treasury requires that rebates and refunds must be returned to the federal government before additional federal funds are drawn to pay for State disbursements. Particularly with respect to drug rebates, this process was not followed on at least three occasions during fiscal 2011. The audit report notes that DMA “implemented new procedures to incorporate drug rebate credits into the drawdown process effective May 2011.” Yet, at the end 2012, DMA repeated the practice of failing to return rebates and refunds prior to drawing Federal cash to cover disbursements.

In 2010, the Single Audit noted that, “Our review of the Department’s Cash Management Improvement Act spreadsheets identified significant positive federal cash balances that exceeded the three-day rule throughout the fiscal year.” This finding shows that DMA has drawn in federal Medicaid funds and failed to fully disburse them in a timely manner. The audit stated that there had been similar cash management findings in the past two years.

FINDINGS AND RECOMMENDATIONS

In 2009, the Single Audit again noted deficiencies in federal cash management procedures. In 2009, DMA overdrew \$321 million in federal funds, which the agency has been repaying in installments over the past three years and will finally fully repay in fiscal 2013. The finding also noted that reconciliation procedures were insufficient to assure that federal draws did not exceed federal expenditures and noted that there were positive cash balances for federal funds in January 2009 and at year end.

These findings demonstrate that DMA has an established history of mismanaging federal funds. In some cases, this mismanagement is deliberate, as with the retention of federal receipts at 2012 yearend and the use of federal DSH funds to pay state expenditures in 2010. In other cases, it appears that the mismanagement results from deficient cash management procedures, as with the \$321 million overdraw of federal funds in 2009. In either case, this mismanagement jeopardizes the financial position of the State because, ultimately, federal funds that are improperly drawn or used must be repaid with General Funds.

Recommendations:

1. DMA and DHHS should be required to submit reasonable estimates for all known Medicaid expenditures in their agency budget requests. If expenditures exceed allowable limits, DHHS, the Governor, or the General Assembly should take actions to reduce expenditures to stay within spending caps, rather than omit known expenditures from the budget.
2. DMA's agency request budget should adjust expenditures for all known costs that increase or decrease with fluctuations in caseload, including costs in administrative funds 1101 and 1102. These requests should be accompanied by appropriate documentation.
3. When DMA perceives that the General Assembly has included unachievable savings in their budgets, DMA should provide OSBM with documentation of this at the beginning of the biennium or fiscal year, along with a forecast of the additional total dollars and State General Fund that will be required to cover this unachievable savings.
4. DMA should discontinue the practice of incurring liabilities for the State at the beginning of the fiscal year because they have overdrawn federal funds in the prior fiscal year to offset State General Fund shortfalls.
5. Because Medicaid is such a large and complex program with a significant impact on the State budget, DMA may require more oversight than any individual Department Secretary with multiple other divisions and programs can provide. The General Assembly should consider organizational changes that could improve the oversight needed to ensure that the Medicaid program is operated in compliance with legislative mandates.

FINDINGS AND RECOMMENDATIONS

Finding #2: The Division’s budget forecasting methodology has not incorporated comprehensive multiyear projections and does not provide an accurate picture of the current year’s financial position.

The Division prepares formal forecasts for only one of their funds, 1310 – Medical Assistance Payments. This does not provide a complete picture of the Medicaid program’s status in complying with the Certified Budget or achieving State General Fund reductions that have been mandated by the General Assembly.

In 2012, OSBM’s documentation showed the following shortfalls in Medicaid funds:

- \$264,638,431 in medical payments and operating shortfall.
- \$40,932,072 for the 2012 installment to repay the Federal government for the \$321 million overdraw in 2009.
- \$41,734,368 to repay the Federal government for a disallowance for personal care services.
- \$28,074,087 to pay the Federal government for drug rebates under new rules established by the Affordable Care Act (ACA).

The total shortfall for these four items was \$375,369,958 in State General Fund. On October 27, 2011, the Division testified before the Joint Legislative Committee on Governmental Operations that they anticipated a shortfall of \$139 million as follows:

Unbudgeted Liabilities

Repayment of Overdraw 2009	\$41 million
Repayment PCS Disallowance	42 million
Payment of Federal drug rebates ACA	28 million
Other Federal payments	9 million
PCS claims paid for services under appeal	<u>6 million</u>
Total Unbudgeted Liabilities	<u>\$126 million</u>

Unbudgeted Revenues

Retroactive hospital provider taxes	(\$22 million)
Qualified Public Hospital claims	<u>(62 million)</u>
Total Unbudgeted Revenues	<u>(\$84 million)</u>

FINDINGS AND RECOMMENDATIONS

Shortfalls from Medicaid Budget Cuts

CCNC savings	\$39 million
Inflationary adjustments	36 million
Provider assessment recoveries	13 million
Expansion 1915b/c waiver	9 million
Provider rate cuts	2 million
Mandatory and optional services	<u>7 million</u>
Total Shortfall from Medicaid Budget Cuts	<u>\$106 million</u>
Net Budget Shortfall	<u>\$148 million</u>

As stated earlier, the Division reported that their expected budget shortfall on October 27, 2011 would be \$139 million. The explanation for the difference between the calculated amount of \$148 million and the stated shortfall of \$139 million is unknown.

Budget Forecasting

In the documentation request for this audit, the Office of State Auditor requested two types of budget forecasts from the Division:

- Multiyear budget forecasts or projections provided to the Office of State Budget and Management or other State agencies.
- Budget forecasts for Medicaid medical services produced during SFY 2010, 2011, and 2012 to support projected expenditures for the current fiscal year.

The only forecasts received from the Division were monthly projections pertaining to Fund 1310. These forecasts showed that Fund 1310 would experience the following projected shortfalls:

- September 2011 - \$152.8 million
- October 2011 - \$98.7 million
- November 2011 - \$104.5 million

DMA has stated that they used SAS forecasting software to forecast caseload. Caseload is a critical cost driver in Medicaid expenditures because it is the chief factor in determining the quantity of services provided and because it is a factor over which Medicaid managers can exercise little or no control. In its forecasts, DMA uses actual caseload for that portion of the year which actual numbers are available and caseload forecasts for the remainder of the year to project expenditures.

FINDINGS AND RECOMMENDATIONS

DMA's forecasting methodology does not allow for reliable forecasts beyond the current fiscal year. As previously noted, DMA does not formally forecast for funds other than 1310 – Medical Assistance Payments, so the only projections available for other Medicaid funds are the amounts in the Certified Budgets. Expenditures DMA knew would occur have been omitted from these budgets in the past, so the budgeted amounts cannot be relied upon as reliable projections.

When compiling the budget rebase for Fund 1310 – Medical Assistance Payments, the Division sometimes includes a two-year forecast and sometimes does not; however, when the second year forecast has been included it has not been complete:

- In the 2012 rebase, the forecast for 2013 did not include a 2013 caseload projection. Expenditure projections for 2013 used the caseload forecast for 2012.
- In the 2011 rebase, there was no expenditure projection for 2012.
- In the 2010 rebase, expenses and revenues were projected for 2011, but no documentation was provided to the auditors to support the projections.

In the 2010 rebase, DMA included adjustments for funds in addition to 1310 – Medical Assistance. While adjustments were requested in the administrative funds 1101 and 1102, there was no request for additional costs for caseload increases, for claims processing, or for programming for the MMIS contract. DMA stated that their inability to include these costs has resulted in the most significant shortfalls in the administrative budgets; however, DMA has provided no evidence that they forecast for these costs or that they requested funding to pay for them.

No Comparison of Forecasts to Actual Expenses

DMA does not follow best practices to improve its forecasting methodology. Specifically, DMA has not provided evidence that it compares forecasts to actual budget performance after the close of the forecast period to determine why projected amounts vary from actual expenditures.

If performed, a forecast-to-actual comparison would allow DMA to revise its forecast methodology to more accurately project expenditures. DMA revises the data it uses in its forecasts on a monthly basis. However, DMA has not significantly revised its forecast methodology since July 2009 in spite of substantial variances between forecasted and actual expenditures.

The Government Finance Officers Association (GFOA) recommends that governments compare forecasts to actual results. The GFOA states:

To improve future forecasting, the variances between previous forecast and actual amounts should be analyzed. The variance analysis should identify the

FINDINGS AND RECOMMENDATIONS

factors that influence revenue collections, expenditure levels, and forecast assumptions.⁷

Failure to compare forecasts to actual results may prevent DMA from identifying ways to improve its forecasting methodology. Consequently, the State's Medicaid expense forecast may not be as accurate and reliable as possible. Reliance on inaccurate and unreliable forecasts could force the State to search for funds to meet unanticipated Medicaid expenses.

No Multiyear Financial Projections

DMA does not follow best practices to improve the reliability and usefulness of its Medicaid forecasts. Specifically, DMA does not provide forecasts of expenditures for years beyond the current biennium. Such comparisons are necessary to provide an early warning of issues and problems because "Budget issues and problems are not limited to a single fiscal year, they trend over several years."⁸ Best practices recommend multiyear forecasts to allow the State policymakers to engage in informed long-term planning. The State Budget Act requires the Governor to include a five-year fiscal analysis as part of the budget message, and the State's budget outlook for the next five years cannot be assessed without consideration of Medicaid's anticipated expenditures.

The GFOA recommends that governments produce multiyear financial forecasts. The GFOA states:

The GFOA recommends that governments at all levels forecast major revenues and expenditures. The forecast should extend at least three to five years beyond the budget period and should be regularly monitored and periodically updated. The forecast, along with its underlying assumptions and methodology, should be clearly stated and made available to participants in the budget process.⁹

The "Best Practices Guide for Preparation of Medicaid Budget Estimates" provides another reason for preparing multiyear financial forecasts. The guide states:

Particular benefit changes may be phased-in according to a schedule set by legislation. Such peeks into the future should be sought and utilized wherever possible. It is a statistically sound observation that a peek is worth two fesses in bridge and more in projecting the cost of health care programs.¹⁰

Failure to prepare multiyear financial projections may prevent DMA from timely identification of problematic issues and trends. Consequently, the Governor and General Assembly may not have the information needed to facilitate long-term planning and decision-making.

⁷ GFOA, Financial Forecasting in the Budget Preparation Process, 1999

⁸ Michigan GFOA, Multi-year Budgeting and Long-term Financial Forecasting, 2010 (presentation)

⁹ GFOA, Financial Forecasting in the Budget Preparation Process, 1999

¹⁰ Actuarial Research Corporation, Best Practices Guide for Preparation of Medicaid Budget Estimates

FINDINGS AND RECOMMENDATIONS

Recommendations:

1. DMA should forecast for all Medicaid funds, and these forecasts should be provided in an agreed upon format to OSBM and Fiscal Research Division at least quarterly.
2. DMA should maintain a comparison of forecasted expenditures and revenues to actual year end budget performance and subject it to analysis that can improve the ability to project expenditures and revenues.
3. DMA should prepare a five-year analysis to contribute to the Governor's budget message and should routinely forecast expenditures and revenues for a minimum of three years in the future.

Finding #3: The Division of Medical Assistance does not appropriately manage Medicaid costs that are subject to agency control.

Medicaid Cost Overview

Medicaid is an entitlement program. This means that North Carolina residents who qualify for Medicaid under the State's eligibility rules must be placed on the Medicaid rolls. Once a resident is approved for Medicaid, that person must be provided with all benefits that are available to his or her eligibility group under the North Carolina Medicaid State Plan. Both American Recovery and Reinvestment Act (ARRA) and later, the Affordable Care Act imposed maintenance of eligibility requirements on the states that do not currently allow them to make their eligibility rules more restrictive if the State wishes to benefit from enhanced Federal matching rates available through the Acts.

Caseload for existing Medicaid eligibility groups is, thus, a Medicaid cost driver that the Division can only control through fraud detection to prevent individuals who are not truly eligible from qualifying for and using services. Costs due to expansion of eligibility to new groups are avoidable; however, the North Carolina Medicaid program has not expanded eligibility in the past four years.

Caseload is one of three significant cost drivers for claims-based medical services. The other two cost drivers are price (the reimbursement rate provided to the medical provider) and consumption (the Medicaid recipient's utilization of services). The Division can exercise some degree of control over price and consumption. The State has considerable latitude in setting reimbursement rates. The Social Security Act Section 1902(a)(30)(A) stipulates that Medicaid "payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." Within these broad guidelines, the states may structure their own rate methodologies (subject to CMS approval) and, thus, control the price variable.

There are a variety of methodologies for controlling consumption. Some of the most effective include prior authorization of costly services, fraud and abuse detection, imposing cost sharing, and limiting optional services offered by the program. Managing care, through

FINDINGS AND RECOMMENDATIONS

programs such as risk-based commercial managed care or case management through medical homes or commercial administrative services organizations, are options that are employed by states to control medical services cost, but there is controversy concerning their short- and long-term effectiveness in controlling medical services costs.

Cost Per Eligible

The price and consumption components of medical services are represented in the Cost per Eligible statistic (CPE). CPE is the average cost of providing services to an average Medicaid eligible over a specified period. North Carolina's annual CPE is the highest in Federal Region IV and it is more than 10% higher than the US average, which indicates that the NC Medicaid program provides a rich benefit package.

Annual Cost Per Eligible (CPE) 2009						
Region IV Medicaid Program						
State	Aged	Disabled	Adults	Children	Total	Rank
North Carolina	\$10,664	\$16,050	\$4,059	\$2,796	\$6,098	1
Kentucky	\$9,759	\$10,430	\$4,649	\$2,952	\$5,890	2
South Carolina	\$10,936	\$13,331	\$3,254	\$2,312	\$5,181	3
Mississippi	\$9,775	\$9,697	\$3,352	\$2,225	\$4,890	4
Tennessee	\$7,484	\$9,826	\$4,115	\$2,376	\$4,742	5
Florida	\$7,917	\$10,883	\$2,569	\$1,627	\$4,168	6
Alabama	\$8,265	\$7,020	\$2,035	\$2,398	\$4,081	7
Georgia	\$8,183	\$8,999	\$4,424	\$1,811	\$3,979	8
US	\$13,186	\$15,453	\$2,926	\$2,313	\$5,535	

Optional services play a role in a North Carolina's high cost per eligible. In a September 9, 2011 presentation to North Carolina's Medical Care Advisory Committee, Division staff provided statistical data showing that North Carolina spent 29 percent of Medicaid dollars on optional services compared to the U.S. average of 13 percent.

FINDINGS AND RECOMMENDATIONS

Reimbursement Rates

Reimbursement rates play a role in North Carolina's high cost per eligible. Many of Medicaid's rate methodologies provide for automatic rate adjustments every year, which typically results in increases in rates annually. For example:

- Inpatient hospital rates are paid according to Diagnostic Related Groups (DRG) and the group is updated annually with Medicare updates.
- Inpatient psychiatric rates are based on costs and adjusted annually for inflation.
- Outpatient hospital and clinics are paid cost-based rates. Costs tend to increase annually.
- Nursing facilities receive case mix and inflationary adjustments. This resulted in a cost of \$12.9 million in State General Fund in 2012.
- Physician rates are based on the Medicare fee schedule in effect on the date of service. The Medicare fee schedule tends to increase annually.
- Personal care services, independent laboratory services, durable medical equipment, private duty nursing, and other practitioner services receive an annual inflationary increase.

The 2011-2013 budget, as reported in the Senate Appropriation Committee substitute for HB 200, included an item to address accelerating Medicaid reimbursement rates:

Item 53 – Adjust Provider Rates: “Reduces Medicaid provider reimbursement rates. The Division of Medical Assistance is to reduce Medicaid provider rates by 2%, except as provided for in Section 10.37.” This was estimated to save the State General Fund \$46.4 million in 2012 and \$46.5 million in 2013.

The current reimbursement methodologies allow rates to increase automatically unless action, such as that cited above, is taken to stabilize or reduce rates. However, it is possible to structure reimbursement methodologies so that rates remain stable unless positive action is taken to increase them. This strategy provides greater control of the price component of medical services costs.

Community Care of North Carolina (CCNC)

While North Carolina Medicaid relies on several strategies to control consumption, the single strategy that is invested with creating the greatest cost savings is Community Care of North Carolina (CCNC). CCNC is a form of managed care that provides case management services in a medical home environment. It is assumed to provide savings in providing medical services to participants. In the 2011-2013 budget, the General Assembly budgeted \$90 million dollars per fiscal year in cost savings for “[b]udget savings to be achieved by DHHS, in conjunction with CCNC Networks and North Carolina Community Care, Inc., through the cooperation of Medicaid health care providers.” When the 2013 budget was

FINDINGS AND RECOMMENDATIONS

rebased and enacted during the General Assembly's short session, the amount of State General Fund savings to be created by CCNC was increased by \$59 million to \$149 million for fiscal 2013.

In October 2011, the Division estimated that it would miss meeting the targeted General Fund savings for CCNC by \$39 million. At the end of the fiscal year, the Division stated it was \$39.5 million short of meeting the \$90 million target. In spite of the 2012 savings deficit, the Division stated it was confident it would realize the \$149 million in State General Fund savings from CCNC operations that is budgeted for 2013. When the Division was asked what evidence it had that CCNC saves money, officials stated that the only evidence in is an actuarial analysis done by Milliman, Inc. Division representatives stated that they used the Milliman study as a basis for determining that they could realize the \$149 million cost savings in the 2013 budget, stating that the study provided CPE for use in budgeting. However, Milliman includes a disclaimer in the study that cautions against using it for any purpose except to estimate cost savings for the years of the study based on the actuarial assumptions that were employed in the study.

North Carolina's managed care system is unique. North Carolina is the home of the medical home. Unlike any other state, it has employed a medical home model for patient care management since at least 1998. This is a model that other states are exploring to create savings through care management. Recent budget actions by the General Assembly have assumed that the model saves significantly on Medicaid expenditures. However, North Carolina's Medicaid cost per eligible is higher than any other state in Region IV and is higher than the national average. The question should arise, if CCNC saves significantly on Medicaid expenditures, why does North Carolina spend so much more on Medicaid than comparable states?

North Carolina's unique Medicaid delivery system offers a unique opportunity. More than a decade of data exists that would allow a study by medical researchers on whether the medical home model truly saves money and/or results in better medical outcomes. The actuarial study performed by Milliman is based on assumptions and adjustments to data. For instance, it adjusts the health status of relatively healthy adults and children in CCNC to be comparable to non-CCNC participants. However, this requires an assumption that the CCNC participants are much unhealthier before comparing the projected costs of the theoretically unhealthy population to the non-CCNC population. While such an exercise may be actuarially sound, it does not provide the same quality of data that could be derived from medical research. Nationally, the states are looking to medical homes as a possible vehicle for reducing health care costs and improving outcomes. It would be a service to the nation as well as North Carolina to use its data to genuinely evaluate the questions associated with medical homes.

In September 2010, OSBM issued a reported titled "Analysis of Medicaid Staffing and Organization." In that report, OSBM found that cost containment was not an organizational priority. The reported states, "Historically the Medicaid program has been more concerned about how to provide more services to more people than in containing costs." Providing more services may or may not benefit the recipient receiving the services; however, providing more services benefits the providers, who receive more total reimbursement for more for providing

FINDINGS AND RECOMMENDATIONS

more units of service. The Medicaid program, which is a government health insurance program, should encourage controlling the cost of medical services.

Recommendations:

1. Because caseload is a significant cost driver for Medicaid, DMA should perform multiyear caseload projections to support multiyear expenditure forecasts, and these forecasts should be tracked against actual caseload growth to evaluate the accuracy of the forecasting methodology.
2. DMA should perform a study to evaluate reimbursement methodology reform which should have a goal of establishing stable reimbursement methodologies that do not increase automatically, but are only increased by actions approved by the General Assembly.
3. The State of North Carolina should engage medical researchers to perform a scientifically valid study based on actual data to determine whether the CCNC model saves money and improves health outcomes.
4. Actions should occur, probably from outside the agency, to enforce a change in Division organizational culture to provide a focus on a health insurance perspective that encourages cost containment in an environment of increasing medical services and expanding payments to providers.

Finding #4: DMA failed to comply with a legislative mandate to eliminate inflationary increases for nursing facilities.

The 2011–2013 budget, as reported in the Senate Appropriation Committees substitute for HB 200, included Item 52 for the DMA budget which “Eliminates automatic inflation increases for Medicaid providers. The Division of Medical Assistance is not to authorize any inflationary increases to Medicaid provider rates during the 2011-13 biennium, except as provided for in Section 10.43.” Following the close of fiscal year 2012, DMA reported to OSBM on the composition of their General Fund operating shortfall. The Division stated that Item 52, which HB 200 projected to save \$62.9 million in 2012, failed to reach its target by \$36 million. Included in the \$36 million shortfall was \$12.9 million that was attributed to “DHHS Decision.”

During the course of this audit, DMA was asked to explain which “DHHS Decision” resulted in a budget shortfall of \$12.9 million in State General Fund. The Division provided the following explanation:

This amount was reflected as increased cost for the Nursing Case Mix index which was included as inflation in the Medicaid rebase, since it is an increased cost that is not in the control of DMA without a change in the overall reimbursement system for nursing home services. “Inflation” was removed by the Legislature from the Medicaid budget/rebase.

FINDINGS AND RECOMMENDATIONS

The nursing home reimbursement system is built on a complex formula that separates direct costs from indirect costs and identifies separate costs for capital related expenditures for each facility. Each is developed separately, with the final element of the formula being a quarterly adjustment for individual facility case mix index average for Medicaid residents. The decision was made that excluding this component from the rate methodology would have an adverse impact on nursing facilities and the resulting access and care for Medicaid enrollees.

In a document submitted to Fiscal Research dated November 8, 2011, DMA made the following statement in response to a legislative inquiry about whether the Division had eliminated inflationary increases as mandated by S.L. 2011-145:

The cost included in the inflation amount related to skilled nursing facilities was not based upon increases due to inflationary costs, but rather increased acuity of patients served in the nursing facilities. The Legislature adopted an approach called “case mix” for reimbursing nursing facilities several years ago. Under this approach, nursing facilities are reimbursed based upon the medical complexity or acuity of the patients in the facility. The elimination of the projected change in costs for increased acuity of the patients would effectively eliminate case mix reimbursement; as a result, DHHS was informed that the elimination of the case mix was not anticipated or desired by the Legislature. This impacts the targeted budget amount by \$12 million.

Some nursing facilities provide care for patients who are sicker or more medically complex than those in other facilities. This degree of medical complexity is labeled acuity. Case mix adjustments give increases or decreases in per diem rates based on the average acuity, or case mix, in each facility. Therefore, a nursing facility that has patients with a high average level of acuity would receive a higher adjustment for case mix to a portion of its per diem rate than a facility with a low level of average acuity.

While it is true that the nursing facility reimbursement methodology is complex, it is not true that eliminating inflationary increases in the nursing facility would necessitate “a change in the overall reimbursement system for nursing home service” or that it would eliminate adjustments to nursing facility rates based on acuity. It is unclear what DMA meant when it stated that “[i]nflation was removed by the Legislature from the Medicaid budget/rebase” and that “[t]he costs included in the inflation amount related to skilled nursing facilities was not based upon increases due to inflationary costs.” If the nursing facilities were reimbursed according to the Medicaid State Plan, which was not amended in 2011-2012 to alter inflationary adjustments for this provider type, all of the inflationary components in the Plan were paid to the nursing facilities in fiscal year 2012.

North Carolina’s nursing facility per diem rates are different for each facility. They are based on expenditures included in a cost report that must be filed by all Medicaid nursing facility providers each year. Nursing facility rates include the following components:

- **Direct Care Rate:** The Direct Care Rate is generally the cost of operating the nursing facility. It includes two types of costs. The first type is called “case mix adjusted

FINDINGS AND RECOMMENDATIONS

costs” in the Medicaid State Plan. This is the cost of medical personnel, both staff and contracted. As the name implies, these costs receive a case mix adjustment when setting per diem rates. The second type of costs included in the Direct Care Rate is called “non-case mix adjusted costs.” These include items such as nursing supplies, social services, food services, and other costs associated with operating the nursing facility. Non-case mix adjusted costs do not receive a case mix adjustment.

- Fair Rental Value Payment for Capital: This includes costs related to land, land improvements, renovations, repairs, buildings and fixed equipment, and major moveable equipment. This portion of the payment does not receive a case mix adjustment.
- Adjustment of Provider Assessments: North Carolina assesses a provider fee on nursing facilities. Per diem rates to each facility are adjusted based on these payments. This portion of the rates does not receive a case mix adjustment.

Nursing facility rates are set quarterly. According to the State Plan, the rates are derived using audited cost reports from a base year selected by DMA. In 2008, the base year was 2005. While the Division has the latitude to set the base year, the base year usually moves forward each year as audited cost reports from a new year become available. DMA determines a Direct Care Rate for each facility based on non-capital costs. Both the case-mixed adjusted costs and the non-case mix adjusted costs receive an inflationary adjustment each quarter based on the Skilled Nursing Facility Market Basket published by Global Insight. This percentage adjustment is published quarterly and historically has consistently trended upward annually.

The Medicaid State Plan includes a Direct Care Ceiling, which is the Medicaid direct care per diem cost for the base year times 1.026. There is a separate rate for case mix adjusted and non-case mix adjusted portions of the Direct Care Ceiling. This represents an inflationary increase in two ways: (a) when the base year changes from one year to the next, the base costs will increase; and (b) 2.6 percent is added to the new base year cost. The Direct Care Ceiling is used to limit the amount that nursing facility rates for the current year can increase.

The Fair Rental Value portion of the rate is set annually. It is based on replacement construction costs of \$127 per square foot in 2007, which is adjusted each year by a national construction cost data index. It includes a \$5,000 increase per licensed bed and percentage adjustments for land value and depreciation based on facility age. The Fair Rental Value is the replacement construction cost adjusted by the three-year rolling average interest rates on U.S. Treasury bonds.

If inflation is understood as the increase in prices over a given period of time, the following annual inflationary increases are included in the nursing facility per diem rate setting methodology:

FINDINGS AND RECOMMENDATIONS

- The Direct Care Ceiling, controlling the maximum amount that nursing facility rates can increase, will generally go up as the base year used to calculate the ceiling changes from one year to the next.
- The Direct Care Ceiling increases base year costs by 2.6% each year.
- The facility per diem rates, both the case mix adjusted and the non case-mix adjusted portions, receive percentage increases based on nursing facility cost increases reported in the Skilled Nursing Facility Market Basket. (It is theoretically possible that the Market Basket rates could decrease; however, according to the CMS website where the rates are posted, this has not occurred since 2004 and is not anticipated to occur.)
- The Fair Rental Value receives adjustments based on a construction cost index and the U.S. Treasury Bond interest rate.

Only one of these inflationary increases is related to a case mix adjusted portion of the nursing facility rates. However, it would be possible to eliminate inflationary adjustments to this portion of the rate without eliminating the case mix adjustment. The case mix adjustments could be based on base year rates without the inflation adjustment. Since DMA has the latitude to select the base year, it could use the same base year in 2012 and 2013 that it used in setting 2011 rates. There are other methodologies that could be used as well because case mix adjustments reflect the difference in acuity among the various facilities, with higher acuity facilities receiving more reimbursement than lower acuity facilities. This can be accomplished in a variety of ways without increasing overall nursing facility reimbursement. The remaining three inflationary adjustments have nothing to do with the portion of the rate that is case-mix adjusted.

Eliminating the inflationary adjustments for Fair Rental Value and the 2.6% increase in the Direct Case Ceiling would probably require a State Plan Amendment. This should represent no more difficulty than the other State Plan Amendments that were submitted for nursing facility reimbursement in 2011–2012. In fact, DMA included a proposal to retain the Direct Care Ceiling at 100% of the base year rate (as opposed to 102.6 percent) in a document of cost saving initiatives, suggesting the Division did not foresee a problem with eliminating the inflationary increase in the Direct Care Ceiling.

It is likely that the inflationary adjustments pertaining to the Skilled Nursing Facility Market Basket could be eliminated without a State Plan Amendment. With respect to this adjustment (which is called Index Factor), the State Plan says the following:

The index factor shall be based on the Skilled Nursing Facility Market Basket without Capital Index published by Global Insight.The index factor shall not exceed that approved by the North Carolina General Assembly.

FINDINGS AND RECOMMENDATIONS

Since the General Assembly stipulated that there would be no inflationary increases, it is likely that CMS would allow elimination of these increases without amending the State Plan.

It appears that the DHHS Secretary's decision not to eliminate inflationary increases for Skilled Nursing Facilities may be based solely on the perception that this "would have an adverse impact on nursing facilities and the resulting access and care for Medicaid enrollees." No support has been offered for this perception. However, nursing facilities tend to be less likely than many providers to develop access issues as a result of rate reductions. Nationwide, Medicaid provides 70 percent of the reimbursement that nursing facilities receive. In most states, Medicaid is the single largest payer. While nursing facilities may state they will discontinue serving Medicaid recipients if they receive unfavorable action on their rates, few are able to continue operating without Medicaid reimbursement because it represents a significant amount of their income.

Recommendation:

DMA should give complete and accurate information to the General Assembly when seeking approval to violate legislative mandates. Approval by the General Assembly should occur in a recognized forum with authority to provide this approval, rather than in informal discussions with individual legislators.

FINDINGS AND RECOMMENDATIONS

STATE PLAN AMENDMENTS

Overview of the State Plan Amendment Process

In accordance with Section 1915 of the Social Security Act and stated in the Code of Federal Regulations (CFR 430.10 through 430.25), “The State Plan is a comprehensive written statement submitted by the agency describing the nature and scope of its Medicaid program and giving assurance that it will be administered within the specific requirements of title XIX, the regulations in this Chapter IV, and other applicable official issuances of the Department. The State Plan contains all information necessary for CMS to determine whether the plan can be approved to serve as a basis for Federal financial participation (FFP) in the State Program.” The State Plan is subject to a Governor’s review, or review by designee of the Governor. Then any comments from the Governor must be submitted to CMS with the plan or plan amendment.

CMS regional staff review all state plans and plan amendments for approval. The CMS regional staff will discuss any issues with the Medicaid agency and consult with CMS central office staff on federal policy questions. Federal statutes and regulations, including guidelines in the interpretation of the regulations are used as requirements for approval. The regional administrator has delegated authority to approve or disapprove the State Plan, including previously approved material no longer meeting requirements for approval, and plan amendments.

An approved Medicaid State Plan is allowed to be amended, if necessary, due to changes in laws, regulations, policies, court decisions, operations, or organization. State Plan Amendments (SPAs) should be promptly submitted for review, as sometimes mandated by the State Legislature as part of a budget or other bill, to the Associate Regional Administrator with CMS. The submission is considered received by CMS when an electronic receipt is issued to the state.

CMS must approve, send a written notice of disapproval, or send a written notice to request additional information on a submitted plan amendment within 90 days of submission or otherwise, the plan amendment is considered approved. The 90-day calculation per CMS is noted on the confirmation electronic receipt. If CMS sends a written notice for additional information, the 90-day period begins again after submission of the additional documentation to CMS.

If a state is not satisfied with the CMS Regional Administrator’s action, it may request reconsideration within 60 days after receipt of the notice. Within 30 days after the receipt of the request, the Administrator notifies the state of the time and place of the hearing that will occur not less than 30 days or more than 60 days after the date of the notice.

For an approved SPA, the effective date may not be earlier than the first day of the quarter in which an approvable plan is submitted to the regional office. Expenditures for medical assistance although, may not be earlier than the first day on which the plan is in operation on a statewide basis.

FINDINGS AND RECOMMENDATIONS

In addition to the timeline above per CMS and Federal Regulations, the State of North Carolina State Plan requires presenting the potential SPA to Native American tribes and to provide them with a 60-day waiting period to respond with comments.

SPAs are typically changes made to the state plan regarding eligibility, covered services, benefit structure, adding or removing optional services and changes in provider payment rates. The results of some of these amendments impact the program financially and therefore changes within the budget are needed. The budgeted amounts may include savings to the program that need to be accounted for in the budget. The amount of savings estimated varies based on the dates of approval, the effective dates, and the dates of implementation.

A SPA is created within DMA through a collaborative effort of the Medicaid Director, the Chief Business Operations Officer, the Chief Clinical Operations Officer, the SPA Coordinator, and others. DMA prepares a CMS 179 Form and attaches supporting documentation for the SPA including the existing pages from the State plan to be changed and the updated language for the change. Once DMA has completed the SPA, it is then sent to the DHHS for their approval. Upon DHHS's approval, the SPA is submitted to CMS to go through their approval process described above.

Impact of SPAs on Budgeted Savings

DMA and DHHS have frequently asserted that delays in the SPA approval process contributed to the budget short falls. The DHHS Secretary made statements through Memorandum on January 17th, 2010, in a Joint Legislative Commission on Governmental Operation Subcommittee meeting on January 19th, 2010, and in a Joint Legislative Commission on Governmental Operations meeting on January 20th, 2010 regarding delays in the SPA process for fiscal year end 2010 causing budgeted savings to not be achieved. The Secretary stated that for many budget reductions efforts state plan amendments must be submitted and cannot be implemented until CMS approval. He said they have submitted numerous SPAs required by the General Assembly's budget but had only received approval for rate reductions as of January 2010, and the lack of additional approvals has caused a delay of over \$90 million in reductions. The Secretary also stated that the rate reductions were in place in the preceding October, before CMS' approval of the SPAs. He planned to reimburse the providers if the SPAs were not approved. He also stated SPAs were still outstanding from 2005 and 2007.

The Secretary's statement above was made in January of the state fiscal year 2010. The submission dates for the rate reduction SPAs were 9/29/2009 and all but one SPA had an effective date of 7/1/09, which means any savings for the full budget year could be achieved. The Secretary noted that DMA went ahead and implemented the rate reductions on 10/1/09 although they could go back to the effective date of 7/1/09 retroactively and recoup any savings as the reductions could have been calculated back to that date. The remaining SPAs during this fiscal year prior to the Secretary's statements were approved and effective within a reasonable timeline by CMS. Based on our review of SPAs provided by the DMA, there was no indication that there were SPAs still outstanding from 2005 and 2007.

FINDINGS AND RECOMMENDATIONS

Similar statements are found in the October 27, 2011 Presentation to the Joint Legislative Committee on Government Operations, Department Response to Questions Directed from Legislative Fiscal Research, and in the minutes from the January 25, 2012 meeting of the Joint Legislative Oversight Committee on Health and Human Services.

From interviews with DMA personnel, we noted several explanations as to how the SPA process contributed to the budget shortfalls. Below is a table indicating the Division's assertion and the results of our analysis.

Division Assertion	Results of Audit Review
Staff stated that being unable to submit a SPA until the Legislature approved state budget, which can occur late September and early October, prevented budgeted savings related to SPAs to be effective as of July 1 st for 12 months of savings. The earliest possible submission date would be October 1 st for 9 months of savings. This timing is due to the federal guideline that the effective date may not be earlier than the first day of the quarter in which an approvable plan is submitted to the regional office.	We performed a detailed review of SPAs that the Division documented as having budgeted savings in which the actual savings were less for fiscal years 2011 and 2012. We reviewed dates of submission, effective dates, and planned implementation dates by the Division. In each case of a SPA being submitted shortly after the beginning of the second quarter (October 1), where the legislative budget approval could have been an issue, it was noted that either the SPA did not have significant savings budgeted or the effective date set by CMS was also the planned implementation date set by the Division. This concern did not have a significant impact on budget shortfalls.
Staff noted the system of CMS approving SPAs sequentially has delayed SPAs budgeting savings if a SPA numbered ahead of those is being held up.	Upon our detailed review of submission, approval, implementation, and effective dates, there were no SPAs that had significant savings built into the budget that would have fallen into this area of not being approved due to the prior numbered SPA not being yet approved.
Staff noted a SPA waiting period can be extended before being sent to CMS due to the 60-day period the state has to allow Tribes to comment if their population is impacted by the SPA.	<p>a. Upon our detailed review of submission, approval, implementation, and effective dates, there were no SPAs that had significant savings built into the budget that would have fallen into this area.</p> <p>b. We reviewed the Division's explanations as to why the SPAs savings were not achieved and this issue was not noted in any of the cases.</p>

FINDINGS AND RECOMMENDATIONS

<p>Staff noted that there are instances in which the Legislature does not order a specified SPA but rather provides a dollar amount of savings necessary to reduce the budget and leaves the Division to decide how the savings will be met.</p>	<p>a. Upon our detailed review of submission, approval, implementation, and effective dates, there were no SPAs that had significant savings built into the budget that would have fallen into this area.</p> <p>b. We reviewed the Division's explanations as to why the SPAs savings were not achieved and this issue was not noted in any of the cases.</p>
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DMA provided us with a list of all SPAs submitted for fiscal years 2009 through 2012. The list included details about each SPA including submission dates, approval dates, effective dates, and requests for more information. For fiscal years 2011 and 2012, the list of SPAs included details on the proposed budget savings for each SPA and the estimated actual program savings achieved. We performed a detailed analysis of significant SPAs that included budgeted savings for fiscal years 2011 through 2012. This analysis included reviews of the dates occurring within the process and the Division's explanations for any unachieved savings related to these SPAs.

Finding: The cost savings incorporated into the budget for specific State Plan Amendments (SPAs) are not always realized due to varying factors - some within DMA's control.

DMA did not take the necessary actions to realize budgeted savings in the following ways:

- DMA submitted SPAs with unreasonable effective dates given the time needed for the CMS approval process.
- These SPAs would have required retroactive implementation that DMA had no intention of doing. DMA did not plan for retroactively implementing SPAs in cases where DMA should have been reasonably certain that the SPA would not be approved and implemented by the budgeted implementation date.

For example, DMA submitted nine SPAs with budgeted cost-savings to CMS for approval in SFY 2011.¹¹ According to DMA documentation, the amendments were budgeted to save \$72.2 million but only saved \$34.2 million (or \$38 million less than budgeted). Once the savings were not achieved, DMA excused much of the lost savings to delays in the SPA process.

However, a review of the nine SPAs indicates that \$31.9 million of the \$38 million in unachieved savings corresponds to only three SPAs. The additional savings would have been realized from the following SPAs:

¹¹ Presentation to Joint Legislative Committee on Governmental Operations, October 27, 2011

FINDINGS AND RECOMMENDATIONS

- SPA 10-031: Reform the personal care services program - \$25.8 million.
- SPA 11-001: Eliminate reimbursement for preventable medical issues - \$5 million.
- SPA 10-024: Improve the pharmacy program - \$1.1 million.

Given that CMS has 90 days to either approve a SPA or ask for additional information, DMA documentation for the three SPAs indicates that the SPAs were not submitted in time to be approved and implemented by the budgeted implementation date.

The table below shows that the SPAs were not submitted to CMS within 90 days of the budgeted implementation date. Consequently, it was not reasonable for DMA to believe that the SPAs would be approved and implemented in time to achieve the expected savings, as shown in the following table:

SPA	Submission Date	Budget Implementation Date	CMS Approval
10-031	10/25/2010	1/1/2011	4/15/2011
11-001	3/24/2011	1/1/2011	1/17/2012
10-024	9/1/2010	11/1/2010	3/21/2011

Knowing that the SPAs would not likely be approved and implemented by the budgeted implementation date, DMA could only achieve the savings corresponding to the above mentioned SPAs by implementing them retroactively. Federal law allows states to retroactively implement Medicaid program changes back to the “effective date” which can be earlier than the CMS approval date.¹² Retroactive implementation would have allowed DMA to achieve the planned savings because the “effective date” for each SPA was either the same as or earlier than the SPAs budget implementation date. In other words, DMA could have met its budget implementation date through retroactive implementation.

However, DMA had not planned for retroactive implementation. As such, cost savings opportunities afforded to the State, commensurate with CMS’ approval of the amendments, were not pursued and, therefore, the State did not realize the savings.

DMA provided the following reasons for not retroactively implementing the SPAs:

- Attempts to retroactively implement the amendments and collect overpayments from medical providers who had already provided services and been paid could result in lawsuits and appeals.
- The current Medicaid Management Information System (MMIS) does not have the capacity to process the number of transactions necessary to retroactively implement

¹² Code of Federal Regulations, Title 42 Section 447.256(c).

FINDINGS AND RECOMMENDATIONS

the changes. Division management indicated that the new MMIS under development will be able to handle retroactive transactions efficiently.

- The administrative cost to the Department and providers was cost prohibitive to retroactively implement all changes.

Therefore, DMA's plan for saving \$72.2 million through these SPAs was never reasonable to achieve.

Recommendation:

The savings incorporated into the state budget need to be more realistically calculated by the DMA and DHHS with consideration of costs of implementation and realistic implementation dates given current system constraints.

FINDINGS AND RECOMMENDATIONS

REPORTING

In the 2006 GASB White Paper: Why Governmental Accounting and Financial Reporting Is – and Should Be – Different, The Governmental Accounting and Standards Board (GASB) states:

Accounting and financial reporting requirements focus on the needs of the users of financial reports. Citizens and their elected representatives, such as legislatures, and other oversight organizations...are primary beneficiaries of the information in governmental financial reports. The needs of citizens and oversight organizations emphasize accountability for resources entrusted to the government.

Accountability is the distinguishing characteristic of governmental accounting, and reporting is how the accountability is achieved. North Carolina's Certified Budget is the operations plan for the State and the standard against which financial performance is measured. To achieve the desired accountability, public agencies must provide periodic information demonstrating how well they are performing.

In interviews, DMA and DHHS financial managers have suggested that, in many ways, Medicaid spending is beyond their control. Administratively, they have been unable to control programming and other costs associated with the Medicaid Management Information System (MMIS). They have been unable to control the costs associated with federal actions to recover funds. They have been unable to realize the full amount of cost savings that the General Assembly placed in their budget. To the extent that costs are driven by caseload or by unforeseeable events, they may, in fact, be beyond the control of financial managers. This makes frequent and complete reporting all the more important.

Finding: Medicaid reports do not provide easily understood and timely data.

DMA does not issue readily understandable and timely Medicaid performance reports to government officials who oversee the Medicaid program.

DMA provides periodic reports with detailed Medicaid financial data to the DHHS Secretary, the Fiscal Research Division, and OSBM. For example, the reports include detailed financial data regarding medical claims payments, cash flow, and monthly fees.

However, DMA does not provide clear, succinct, summarized information showing the year-to-date fiscal status and projections for the Medicaid program and reasons for deviations from the certified budget. To draw conclusions from the detailed data, report users must perform their own analyses or ask additional follow-up questions to obtain the necessary information.

Report users from Fiscal Research and OSBM are not satisfied with the usefulness and timeliness of the reports. Report users have noted a lack of targeted information to help them quickly identify unanticipated events or outlays that could indicate Medicaid program expenditures will differ significantly from previously established forecasts and budgets. Report users also noted that reports have been delayed or not available prior to scheduled

FINDINGS AND RECOMMENDATIONS

meetings. The lack of timeliness has reduced report users' ability to prepare for meetings about Medicaid's financial status.

Best practices recommend that a government agency's external performance reports provide readily understandable and timely information.

For example, the Governmental Accounting Standards Board (GASB) provides guidelines for voluntary service efforts and accomplishments (SEA) reporting that are applicable to the Department's external Medicaid performance reporting. The GASB guidelines state:

In order for the information presented within an SEA report to be understandable, it needs to be expressed simply and clearly. Users have different purposes for reviewing SEA performance information, as well as different interests, needs, and levels of understanding, education, and public involvement. Governments, therefore, need to obtain feedback from actual or potential users of an SEA report in order to enhance the understandability of reported SEA performance information. It also is important to communicate SEA performance information in different forms and at different levels of detail so that the information can be understood by those who may not have a detailed knowledge of a government's programs and services.

In addition, the GASB guidelines recommend that government agency external performance reports provide timely information. The GASB guidelines state:

Effective SEA reports provide SEA performance information to users before it loses its value for assessing accountability and affecting decisions.

Without readily understandable and timely information, government officials who oversee the Medicaid program may not have the information they need to make decisions and ensure medical services are provided to North Carolina's citizens in an economical and cost-effective manner.

Recommendations:

1. DMA should consult with the DHHS Secretary, Office of the Governor, OSBM, and Fiscal Research Division of the North Carolina General Assembly to determine the informational needs of those charged with governance over the State's Medicaid program. Medicaid reporting requirements, including report formats and timeframes, should be formally established and followed.
2. Once reporting formats and timeframes have been established, the DHHS Secretary should ensure DMA is held accountable for providing accurate and timely reports to stakeholders.

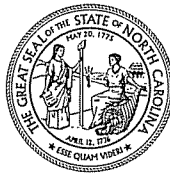
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APPENDIX

DMA Administrative Contracts with Expenditures in State Fiscal Year 2012

CONTRACT TYPE	CONTRACTOR	BRIEF DESCRIPTION SCOPE OF WORK	CONTRACT START DATE	CONTRACT END DATE (1)	STATE FISCAL YEAR 2012 EXPENDITURES
DMA Fiscal Agent and Related Services	HP Enterprise Services	Process Medicaid claims	1/17/1989	12/31/2013	\$52,048,432
Independent Assessments for Personal Care Services	Carolinas Center for Medical Excellence	Provide independent assessments of all individuals applying for in-home personal care services	10/11/2009	6/30/2013	\$10,544,102
Behavioral Health Utilization Review	Value Options	Utilization management and prior authorization of Medicaid and HC covered mental health and substance abuse rehab treatment services	9/20/2011	9/19/2016	\$9,696,957
Post Payment Reviews	Public Consulting Group	Conduct post payment reviews of providers with suspected abusive or aberrant billing practices	7/1/2010	10/28/2013	\$6,814,906
Third party recovery	Health Management Systems	Third party recovery for Medicaid and Health Choice	4/1/2010	12/31/2012	\$3,175,538
ACS State Healthcare	Xerox (formerly ACS)	Pharmacy prior approval and help desk services	12/12/2001	12/31/2013	\$3,173,018
Uniform Screening/PASRR	HP Enterprise Services	Preadmission screening and resident review (PASRR)	8/15/2006	12/24/2012	\$2,358,817
Analytical & Clinical Services	Mercer Health & Benefits, LLC	Provide financial analysis, cost savings and cost benefit comparisons for pharmacy initiatives	12/1/2010	6/30/2014	\$2,184,240
Prepayment Claims Review	Carolinas Center for Medical Excellence	Identify and perform cost avoidance for claims payments for clinically inappropriate care	11/2/2009	12/31/2013	\$1,915,719
Authorization for Specialized Therapies	Carolinas Center for Medical Excellence	Prior approval and post payment validation of Outpatient Specialized therapies	11/1/2009	10/31/2012	\$1,833,143
Actuarial & Analytical Services	Mercer Health & Benefits, LLC	Review/interpret the impact of various budget and policy issues and provide financial analysis/cost savings/cost benefit comparisons for PACE and PBH LME, PIHP and MedSolutions	1/1/2011	12/31/2013	\$1,649,790
Utilization Review & Management	Durham Center	Utilization reviews, utilization management, and service authorizations for publicly funded mental health, developmental disabilities and substance abuse services	9/20/2010	9/19/2013	\$1,188,570
Auditing Services	Myers & Stauffer, LLC	Provide auditing services, perform field audits on Medicaid cost reports and recalibrate hospital Medicaid diagnosis related group weights	1/15/2009	1/15/2014	\$1,159,987
FAMS	IBM	Fraud and Abuse Management System	11/15/2011	9/30/2012	\$1,108,000
NC FADS	Ingenix	Fraud and Abuse Detection System	9/22/1999	12/31/2012	\$1,071,954
DRIVE	Ingenix	DRIVE database - DMA Decision Support System	8/5/1997	12/31/2013	\$1,069,527
MDS Validation Program	Myers & Stauffer, LLC	Verify the Minimum Data Set (MDS) assessments and supporting documentation for nursing facilities	9/11/2009	9/10/2013	\$1,024,832
Smart PA, Evidence based pharmacy Pas	Xerox (formerly ACS)	Provide evidence based pharmacy automated prior approvals	6/12/2007	12/31/2013	\$997,923
Utilization Review & Management	Eastpointe	Utilization Reviews, Utilization Management and service authorizations for publicly funded mental health, developmental disabilities and substance abuse services	9/20/2010	9/19/2013	\$798,169
HIV Case Management	Carolinas Center for Medical Excellence	HIV case management	6/29/2011	6/28/2013	\$614,483
CCNC Network Cost Savings Study	Milliman, Inc.	Study to determine cost savings with CCNC Network	12/21/2010	12/31/2013	\$542,500
Review of Emergency Services for Aliens	Maximus	Medical reviews of emergency cases for undocumented aliens and legal aliens not qualifying for full Medicaid benefits	9/22/2011	10/1/2013	\$536,599
SAS OnDemand	SAS Institute Inc.	SAS OnDemand licenses and services	12/20/2010	3/19/2013	\$500,000
Fiscal Management Services	GT Financial Services	Serve as fiscal/employer agent to administer funds and manage payroll for participants in the self-directed options of Medicaid waiver programs	5/15/2010	6/16/2013	\$418,597
SAS Forecasting	SAS Institute Inc.	SAS forecasting implementation and consultation services	9/1/2011	6/30/2013	\$120,081
North Carolina Physicians Advisory Group, Inc.	NCPAG	Advise NC DHHS on ways to expand access to quality cost-effective health care services. Contract for NCPAG is mandated through legislation	9/21/2011	6/30/2013	\$94,013
Rapid Resource for Families	Easter Seals UCP NC and VA	Evaluate the effectiveness of intensive treatment interventions provided in therapeutic foster care settings for severely emotionally and behaviorally disturbed children and adolescents	1/4/2012	1/3/2014	\$76,080
CAHPS Survey	UNC-Charlotte	Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey	6/9/2011	4/30/2014	\$57,136

Note: (1) Contracts may have been renewed or extended beyond the end dates listed here
Source: Supplied by Division of Medical Assistance



North Carolina Department of Health and Human Services

Pat McCrory
Governor

Aldona Z. Wos, M.D.
Ambassador (Ret.)
Secretary DHHS

January 30, 2013

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 your report on the findings and recommendations that resulted from the Division of Medical Assistance – Performance audit of the Department of Health and Human Services as outlined in Section 10.9A.(a) through (b) of the 2012-2013 North Carolina State Budget. We appreciate the work you have done on behalf of the people of North Carolina and look forward to our continued work together as we improve the operations of the Division of Medical Assistance. The following represents our responses to the Report Findings and Recommendations.

SUMMARY OF RESULTS

ADMINISTRATIVE FUNCTIONS

Finding #1: The Division has consistently exceeded budgeted amounts for contracted administrative costs and interagency transfers due to an apparent lack of oversight.

General Response: The Department agrees with this recommendation. The Division will be implementing, within the next month, a system to track contract requirements and expenditures on a weekly basis. Under no circumstances will contractors be allowed to exceed the budgeted contract amounts without an approved amendment to the contract. In order to correct historical issues with the budget, we will be requesting a review of our certified budget to ensure that contracted amounts reflect accurate operational costs. For example, the line item for Hewlett Packard (HP) services has been held at the 2005 contracted amount; however, with the increase in the number of Medicaid eligibles and providers this contract amount has increased yet is not reflected in the budgeted line item for this contract.

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Recommendations:

Beginning in SFY 2013, DMA began tracking contract expenditures to date against total claimed amounts over the term of individual contracts to identify cases where no purchase order is on file, no current claim is in North Carolina Accounting System (NCAS) or the amount is questionable, or the contract is over budget. As a result, three months into SFY 2013, DMA discovered it was already over its certified budget for contracts. While DMA has taken a step in the right direction by tracking costs against certified budget limits, DMA needs to ensure expenditures do not exceed certified budgeted amounts.

DHHS Response: *The Department agrees with this recommendation in concept; however, as discussed in the previous recommendation, the line items for the budget must reflect approved amounts.*

Finding #2: Other Department of Health and Human Services (DHHS) division administrative spending is not controlled by DMA and is not sufficiently monitored by DHHS to ensure proper drawdown of federal funds.

General Response: *The Department agrees with the statement that other DHHS division administrative spending is not controlled by DMA. The Department will develop operating procedures which comply with the recommendation of this audit and as part of the development of the cost allocation plan.*

Recommendations:

DHHS and DMA need to ensure that proper measures are in place to monitor other divisions' Medicaid spending. Interagency memorandums of understanding (IMOU) or cost allocation plans (CAP) should address the Medicaid program costs being necessary for the proper and efficient administration of the Medicaid State Plan and not the responsibility of a non-Medicaid program.

DHHS Response: *The Department agrees with the recommendations. DMA provides a pass-through function for other DHHS Divisions to appropriately access federal Medicaid matching funds for administrative functions relating to Medicaid recipients. Other Divisions with administrative services that support the Medicaid program record expenditures in the NCAS in order to draw federal funds. The Cost Allocation Branch of the Office of the Controller, in conjunction with Division Budget Offices, maintains comprehensive cost allocation plans (CAPs) to ensure accurate and allowable allocations to the Medicaid program. The CAPs are submitted to the U.S. DHHS Division of Cost Allocation for distribution to Federal partners including CMS for approval. Expenditures that are eligible for Medicaid federal match are included on the CMS 64 report based on amounts recorded in NCAS.*

DMA does not directly audit other Divisions' expenditures for accuracy. However, financial reports are available that provide detail of the expenditures. The Division of Medical Assistance will work with other Divisions in order to ensure compliance with all Federal and State requirements. Program managers who have only been monitoring

program issues will have their role increased to monitor compliance with financial requirements.

Finding #3: The Department does not have a comprehensive Public Assistance Cost Allocation Plan that can be reviewed from a Medicaid perspective to ensure that costs are allocable and allowable for the proper and efficient administration of the Medicaid State Plan.

General Response: The Department agrees with the finding. We will develop and implement a Public Assistance Cost Allocation Plan (PACAP) effective July 1, 2013.

Recommendations:

DHHS should prepare a department-wide comprehensive PACAP, even if to incorporate the divisional PACAPs through reference. In addition, DHHS should have individuals with a Medicaid programmatic and financial understanding review the comprehensive PACAP to ensure that costs are allocable and allowable for the proper and efficient administration of the State Plan.

DHHS Response: The Department agrees with the recommendation. As discussed above, the Division will implement a PACAP July 1, 2013.

Finding #4: DMA does not have a cost allocation plan for appropriately allocating indirect expenditures and tracking expenditures eligible for increased federal funding.

General Response: The Department agrees with the finding in regards to indirect cost. The Division direct charges expenditures wherever there is a basis to do so. Allocating indirect expenditures would augment the current process.

Recommendations:

DHHS should reassess their conclusion that a DMA CAP is not necessary. A DMA CAP would serve to allocate costs to all benefiting programs, especially NCHC, as well as support the allocation of Medicaid administrative costs to activities with increased FFP.

DHHS Response: The Department agrees with the recommendation. As discussed above, the Division will implement a PACAP by July 1, 2013.

BUDGET FORECASTING

Finding #1: The Division's budget development and administration practices are potentially non-compliant with State statutes that have been enacted to ensure agency and legislative accountability for public expenditures.

General Response: *The Department agrees with the finding. The Division will implement, within 30 days, an operational policy in which the certified budget is compared to current expenditures by fund and budget code. This report will be updated no less frequently than once a month.*

Recommendations:

1. DMA and DHHS should be required to submit reasonable estimates for all known Medicaid expenditures in their agency budget requests. If expenditures exceed allowable limits, DHHS, the Governor, or the General Assembly should take actions to reduce expenditures to stay within spending caps, rather than omit known expenditures from the budget.

DHHS Response: *The Department agrees with the recommendations. The Division of Medical Assistance (DMA) agrees that reasonable estimates should be requested for all Medicaid expenditures. Beginning immediately, the Division will not only provide estimates for all costs/liabilities anticipated within the Medicaid program but will also provide detailed explanations regarding the expenditures.*

2. DMA's agency request budget should adjust expenditures for all known costs that increase or decrease with fluctuations in caseload, including costs in administrative funds 1101 and 1102. These requests should be accompanied by appropriate documentation.

DHHS Response: *The Department agrees with this recommendation. Beginning immediately, the Division will not only provide estimates for all costs/liabilities anticipated within the Medicaid program but will also provide detailed explanations regarding the expenditures.*

3. When DMA perceives that the General Assembly has included unachievable savings in their budgets, DMA should provide OSBM with documentation of this at the beginning of the biennium or fiscal year, along with a forecast of the additional total dollars and State General Fund that will be required to cover this unachievable savings.

DHHS Response: *The Department agrees with this recommendation. The Division will provide detailed, documented information regarding decisions before the General Assembly.*

4. DMA should discontinue the practice of incurring liabilities for the State at the beginning of the fiscal year because they have overdrawn federal funds in the prior fiscal year to offset State General Fund shortfalls.

DHHS Response: *The Department agrees with this recommendation. DMA will work with the Department, OSBM and Fiscal Research to manage cash and expenditures as appropriate.*

5. Because Medicaid is such a large and complex program with a significant impact on the State budget, DMA may require more oversight than any individual Department Secretary with multiple other divisions and programs can provide. The General Assembly should consider organizational changes that could improve the oversight needed to ensure that the Medicaid program is operated in compliance with legislative mandates.

***DHHS Response:** The Secretary and the Medicaid Director are committed to ensuring access to any and all information regarding the operations of the Medicaid program.*

Finding #2: The Division's budget forecasting methodology has not incorporated comprehensive multiyear projections and does not provide an accurate picture of the current year's financial position.

***General Response:** The Department agrees that the forecasting methodology does not allow for multiyear forecasting. However, the Department agrees that the process can always be improved as to budget forecasting methodology. The Division will improve its budget forecasting methodology. However, given the dramatic changes in the Medicaid program over the next two years, a long-term multiyear projection will decrease the accuracy of the forecast.*

Recommendations:

1. DMA should forecast for all Medicaid funds, and these forecasts should be provided in an agreed upon format to OSBM and Fiscal Research Division at least quarterly.

***DHHS Response:** The Department agrees with this recommendation. We will convene a discussion with the Office of State Budget and Management (OSBM), Fiscal Research and the Department to develop a consistent reporting package that addresses the needs of these entities.*

2. DMA should maintain a comparison of forecasted expenditures and revenues to actual year end budget performance and subject it to analysis that can improve the ability to project expenditures and revenues.

***DHHS Response:** The Department agrees with this recommendation. DMA will implement a process that incorporates the comparison of forecasts prepared in one period to forecasts prepared in subsequent periods to determine the source of changes in forecasting outcome. This will create opportunities for improvement. DMA prepares detailed analyses every month of variances between actual, forecasts and budget.*

3. DMA should prepare a five-year analysis to contribute to the Governor's budget message and should routinely forecast expenditures and revenues for a minimum of three years in the future.

***DHHS Response:** The Department agrees with this recommendation. As discussed previously the Division will improve its budget forecasting methodology. However, given*

the dramatic changes in the Medicaid program over the next two years, a long-term multiyear projection will decrease the accuracy of the forecast.

Finding #3: The Division of Medical Assistance does not appropriately manage Medicaid costs that are subject to agency control.

General Response: The Department agrees that improvements outlined in the recommendations would improve the management of Medicaid costs.

Recommendations:

1. Because caseload is a significant cost driver for Medicaid, DMA should perform multiyear caseload projections to support multiyear expenditure forecasts, and these forecasts should be tracked against actual caseload growth to evaluate the accuracy of the forecasting methodology.

DHHS Response: The Department agrees with the recommendation. DMA provides a multiyear caseload projection utilizing the Statistical Analysis System (SAS) statistical forecasting tool. We will enhance the caseload forecasting to support multiyear expenditures. Should it be determined that the Department, OSBM and the Legislature require forecasts beyond the 2 year biennium cycle, DMA will implement an extension of the forecast to accommodate whatever time period is requested.

2. DMA should perform a study to evaluate reimbursement methodology reform which should have a goal of establishing stable reimbursement methodologies that do not increase automatically, but are only increased by actions approved by the General Assembly.

DHHS Response: The Department agrees with this recommendation. Payment reform is a critical long term issue for the NC Medicaid program. The reform should include the design of a Medicaid program that defines the health outcomes and objectives of the state, including a payment system that supports the achievement of those goals.

3. The State of North Carolina should engage medical researchers to perform a scientifically valid study based on actual data to determine whether the CCNC model saves money and improves health outcomes.

DHHS Response: The Department agrees with this recommendation. As we work to control costs and improve the quality within the Medicaid program, it is critically important that the data available is analyzed by a reputable research organization.

4. Actions should occur, probably from outside the agency, to enforce a change in Division organizational culture to provide a focus on a health insurance perspective that encourages cost containment in an environment of increasing medical services and expanding payments to providers.

***DHHS Response:** The Department agrees with this recommendation. The Secretary and Medicaid Director are committed to providing the leadership and tools necessary to ensure the proper staffing and focus for this health insurance program.*

Finding #4: DMA failed to comply with a legislative mandate to eliminate inflationary increases for nursing facilities.

***General Response:** The Department agrees with the finding. The Division will ensure compliance with any and all state and federal mandates.*

Recommendations:

DMA should give complete and accurate information to the General Assembly when seeking approval to violate legislative mandates. Approval by the General Assembly should occur in a recognized forum with authority to provide this approval, rather than in informal discussions with individual legislators.

***DHHS Response:** As stated above, the Division will ensure compliance with any and all state and federal mandates. In addition, we will maintain complete transparency with the General Assembly regarding issues and financing of the Medicaid program.*

STATE PLAN AMENDMENTS

Finding: The cost savings incorporated into the budget for specific State Plan Amendments (SPAs) are not always realized due to varying factors - some within DMA's control.

***General Response:** The Department agrees with the finding.*

Recommendation:

1. The savings incorporated into the state budget need to be more realistically calculated by the DMA and DHHS with consideration of costs of implementation and realistic implementation dates given current system constraints.

***DHHS Response:** The Department agrees with the recommendation and will review ways to improve calculations of cost savings.*

REPORTING

Finding: Medicaid reports do not provide easily understood and timely data.

***General Response:** The Department agrees with the finding and will attempt to make reports more reader friendly. We will work with OSBM and Fiscal Research to ensure more user friendly report(s)*

Recommendations:

1. DMA should consult with the DHHS Secretary, Office of the Governor, OSBM, and Fiscal Research Division of the North Carolina General Assembly to determine the informational needs of those charged with governance over the State's Medicaid program. Medicaid reporting requirements, including report formats and timeframes, should be formally established and followed.

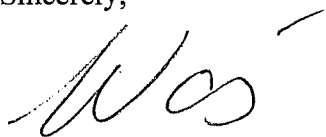
DHHS Response: *The Department agrees with the recommendation.*

2. Once reporting formats and timeframes have been established, the DHHS Secretary should ensure DMA is held accountable for providing accurate and timely reports to stakeholders.

DHHS Response: *The Department agrees with the recommendation.*

If you need any additional information, please contact Monica Hughes at (919) 855-3720.

Sincerely,



Aldona Wos, M.D.
Secretary

AW:mh

cc: Beth Melcher, Chief Deputy Secretary for Health Services
Dan Stewart, Assistant Secretary for Finance and Business Operations
Carol H. Steckel, Director of Medical Assistance
Tara Larson, Chief Clinical Operations Officer
Steve Owen, Chief Business Operating Officer
Laketha Miller, Director, Office of Controller
Thomas Edward Berryman, Director of Internal Audit

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