North Carolina Department of Health and Human Services
Division of Medical Assistance
2501 Mail Service Center • Raleigh, N. C. 27699-2501 • Tel 919-855-4100 • Fax 919-733-6608

Beverly Eaves Perdue, Governor
Albert A. Delia, Acting Secretary

Michael Watson, Director

August 1, 2012

Charles Schoenheit
Western Highlands Network
356 Biltmore Avenue
Asheville, NC 28801

Dear Mr. Schoenheit:

During your first quarterly performance review, The NC Division of Medical Assistance (DMA) identified several areas of concern based on your financial statements. On July 10-12, 2012, a team from Mercer Human Services Consulting and DMA performed a financial and related area review of your managed care operations pursuant to your contract with the Division of Medical Assistance. The following findings and corrective action steps are based on the Mercer Report, dated July 23, 2012.

As a fundamental step in addressing the findings in the Mercer report, we highly recommend that WHN secure the services of a managed care consultant. As part of this corrective action, DMA will approve your choice of consultant. We expect that WHN will contract with a consultant by September 3, 2012. We will schedule a meeting with you in Raleigh during the week of August 6, 2012 to review these action steps. Thereafter, you will be expected to meet with DMA weekly to monitor adherence to this corrective action plan.

1. Management Reporting

1a. Finding: The management reporting outputs of WHN do not provide WHN the ability to effectively manage care and finances as an efficient organization for Medicaid operations.

CORRECTIVE ACTION: WHN needs to develop a management reporting package that allows the organization to identify potential risk factors and areas of opportunity. The following reports, at a minim, must be developed for review on a monthly basis:

- Reporting by category of service (category of service should be consistent with rate development):
  - Number of unduplicated users
  - Cost per unduplicated user
  - Number of units per unduplicated user
  - Cost per unit
- Per member per month and per unduplicated user per month income statement by category of service

- Inpatient and residential statistics:
  - Number of discharges/admissions
  - Average length of stay
  - Average cost per discharge
  - Readmission within 30/60/90 days
  - Number of members in inpatient/residential
- Actual to budgeted statistics for the above categories

DUE DATE:

The first reports will be due September 3, 2012, to include data through July 31st of 2012.

1b. Finding: The management team at WHN does not meet to discuss key management reports.

CORRECTIVE ACTION: WHN needs to conduct weekly meetings across its key management team to discuss management reports and overall Medicaid operations. These meetings should result in action items to direct change within the organization. For example, if it is identified through review of management reports that there is an increase in the number of recipients in emergency departments, the management team would identify this issue and meet to discuss opportunities to shift members to less costly levels of care while maintaining appropriate services.

DUE DATE:

These meetings should begin immediately. Minutes from these minutes will be required by DMA at the first of every month, beginning September 3, 2012.

1c. Finding: Operational units do not have power users to analyze data on a timely basis.

CORRECTIVE ACTION: WHN needs to develop power users to analyze data on a timely basis within operational units. Even though the development of system-generated reports should remain within the information technology area, operational units must have access to the data warehouse (SQL server) to run queries and provide ad-hoc analysis on a timely basis. For managers that have Microsoft Access experience, this would be minimal training to query and analyze data for internal monitoring. For those without specific experience, staff would need additional training in SQL software tools. Since the SQL server is a read-only copy of the data in Netsmart, the users cannot change data.

At the end of every checkwrite cycle , the claims and reconciliation staff should, at a minimum, have the capability to review claims data to correctly deny or recoup inappropriate payments for the following reasons:

- Claims still pending after 30 days
- Claims without any status (e.g., pend, deny, accept) in the system
- Discrepancy in units processed. This could be various issues, not limited to the following:
  - Provider billing issues, including direct data entry errors when the provider is entering claims directly into the WHN front-end system

  - Units exceeding the maximum units per 24-hour day (e.g., 96 fifteen-minute units per day)
  - Units exceeding procedure code maximum units per day (e.g., one room and board charge per day, etc.)
  - Payments for units less than one (e.g., partial units or zero)
  - Therapeutic leave (e.g., revenue code 0183) exceeding 15 days/quarter or 45 days/year)
- Missing primary diagnosis information in the data (at least 800 service lines are missing a primary diagnosis in the system)
- Validation of payment, including correct payment of emergency room services
- Accuracy of error codes used (e.g., benefits not in the plan versus included as part of a contractual arrangement)
- Validation of system edit accuracy (e.g., duplicate claims)
- Payments made for emergency room service without a primary diagnosis of 290–319

DUE DATE:

The first set of reports for the areas noted above will be due to DMA by September 3, 2012. At that time, WHN will also be expected to provide a detailed plan for recoupment of funds for claims identified as having been paid incorrectly in the reporting areas identified above.

Again, WHN may wish to consider reports in addition to these required elements, including high cost providers versus outcomes and high dollar or high length of stay outcomes over a period of time if paying per diem.

2. Financial Operations

2a. Finding: The incurred but not reported claims expense calculation does not provide an accurate estimation of Medicaid medical expenses on an accrual basis.

CORRECTIVE ACTION: WHN must develop a methodology that correctly estimates incurred but not reported (IBNR) accrual and expenses. Given the technical nature of developing an accurate methodology, WHN must determine if it needs to subcontract with an actuarial consulting or other management consulting firm to develop this methodology. In addition, WHN should submit a restated first quarter financial reporting package based upon the misstatement of its estimated Medicaid IBNR liability and medical expenses.

DUE DATE:

Specifications will be given to WHN by DMA by September 3, 2012. WHN will be expected to provide the first report on the noted specifications by October 1, 2012, to include data through August 31, 2012.

2b. Finding: WHN is operating at a projected loss and has identified action items to reverse this projected loss.

CORRECTIVE ACTION: WHN should be placed on a financial corrective action plan that allows for weekly and monthly monitoring of its financial position by DMA. In addition, based upon weekly/monthly reporting submissions to DMA , there should be a

monitoring call with WHN to discuss the current progress of the operations. The following information should be submitted:

Balance sheet – (Medicaid Only (Monthly)

- Income statement by funding source (Medicaid Only) (monthly)
- Paid claims summary (weekly after each claim system check fun) – illustrates claims paid by month of service and month of payment
- IBNR claims liability by month of service (Medicaid Only) (weekly after each claims system check run)
- Update and status of WHN plan for estimated savings monthly) – also include any new initiatives implemented by WHN
- Additional reports as identified in 1a (monthly after development)
- Received but not paid/pending adjudication

DUE DATE:

Specifications will be given to WHN by DMA by September 3, 2012. WHN will be expected to provide the first report on the noted specifications by October 1, 2012, to include data through August 31, 2012.

2c. Finding: WHN submitted reports to DMA that contained combined information for Medicaid and integrated payment and reporting system (IPRS) (state funded) dollars and utilization.

CORRECTIVE ACTION: WHN should always treat the Medicaid data and IPRS information as separate due to the different funding sources. If reporting totals for both, there should also be separate information that indicates the Medicaid dollars and utilization separately. In many cases, it would also be helpful to understand the utilization patterns of 1915(b) versus 1915(c) waiver services – please see recommendation 1a (Management Reporting).

DUE DATE:

Specifications will be given to WHN by DMA by September 3, 2012. WHN will be expected to provide the first report on the noted specifications by October 1, 2012, to include data through August 31, 2012.

3. Information Technology and Claims

3a. Finding: System edits are still in the process of being developed. Some were implemented at different times in 2012.

CORRECTIVE ACTION: Since WHN implemented the waiver program on January 1, 2012, the system should have all edits in place. However, as new edits are introduced, validation of the data should be performed to see if there are missed opportunities during the months prior to the edit being implemented.

Additional edits should be placed in the system to validate data, including:

- Service codes should contain only valid revenue codes (four digits) and Health Care Financing Administration common procedure coding system (HCPCS) codes or HCPCS/modifier combinations. Three-digit revenue codes, codes of PR, HC or codes containing special characters should not be present as a payable valid service code
- Primary diagnosis code should be within the range of 290–319xx or be automatically denied for certain services
- The form type should only be a C (professional) or U (UB)
- WHN needs to review all DMA publication bulletins to keep up with any changes in policy. For example, WHN has been allowing providers to bill H codes when providers should bill the appropriate CPT code
- Edits should enforce all current Medicaid policy (benefit) limitations
- Claims should be linked to prior authorization, not only provider-specific contracts

DUE DATE:

System edits should be in place by no later than December 1, 2012. DMA will require documentation of successful User Acceptance Testing to complete this item. At that time, WHN will also be expected to provide a detailed plan for recoupment of funds for claims identified as having been paid incorrectly in the reporting areas identified above.

3b. Finding: Currently, there is no claims audit process in place to validate the accuracy of claims processed. WHN has recently started to perform focused audits based on potential issues.

CORRECTIVE ACTION: WHN must develop and perform a claims audit process. Mercer recommends that 3% of all claims processed are audited for each processor, including the system auto adjudicated claims where no manual intervention is performed. Audits are intended to validate accuracy of claims payment, provide opportunities for claim processor training and find any system issues that need resolution.

DUE DATE:

An audit report of 3% of all claims processed will be required by DMA by September 3, 2012.

3c. Finding: The claim adjustment process can be performed by voiding a partial payment. The system indicates the status as void instead of as an adjustment.

CORRECTIVE ACTION: WHN should be able to adjust a claim, but the status should indicate an adjustment. This will be needed to distinguish what the original payment was and what the actual payment is after the adjustment. A distinct status code should be made to correctly identify pended, accepted and denied services, but also the initial claim, adjustment or void. This will also be needed for accurate encounter reporting to the State Medicaid Management Information Systems.

DUE DATE:

User Acceptance Testing of this process will be required by DMA by September 3, 2012.

3d. Finding: Multiple claims were manually processed with two check payments outside of the claim system in February 2012, totaling $63,471.96. The claims associated with these payments still have not been entered into the system. Without entering the claims into the system, there could be duplicates paid, and these dollars are not reflected in system reports.

CORRECTIVE ACTION: WHN should process the claims associated with these payments to the hospital in the system. Verification should be made to ensure correct payment was made, that patients were actually eligible for services, that authorizations were correctly matched, that the claims do not have duplicate payments with those processed in the system and that additional system checks are not produced for these services.

DUE DATE:

No claims should be paid outside of the system, effectively immediately. By September 3, 2012, DMA requires evidence that all claims processed outside of the system have been entered into the system. WHN must demonstrate that the ledger amount for claims equals the amount processed in the claims system.

3e. Finding: The system does not capture the complete date of service. WHN collects the statement header dates on institutional (UB and 837I) types of claims, but only one service date on the detail lines and professional claims.

CORRECTIVE ACTION: Claim systems should be set up to capture header dates of service that encompass the "from" and "to" dates of service for all service lines within a claim. At a detail level, the "from" and "to" date of service should also be included. In many instances, the "from" and "to" date of service will be the same. This provides validation of the number of units to the service dates paid on the line, such as for inpatient details where multiple days are paid on one service line, or multiple detail lines are utilized for payment due to changes in room types (private to semi-private room).

DUE DATE:

A claims audit in addition to the 3% noted in item 3b will be required by DMA by September 3, 2012, demonstrating compliance with this item. At that time, WHN will also be expected to provide a detailed account of any recoupment for overpayment or any provider payment for any underpayment.

3f. Finding: Authorizations in the system are not made based on the provider's location where the services will be rendered. This allows the possibility that a provider with multiple sites could receive an authorization for a site that is not part of the contract. The claims system will deny services at the site that is not within the contract.

CORRECTIVE ACTION: WHN's system needs to contain the site where the service is being rendered in the authorization data so that claims payment can properly pay authorized services for Medicaid members with the provider contract.

DUE DATE:

A claims audit in addition to the 3% noted in item 3b will be required by DMA by September 3, 2012, demonstrating compliance with this item. At that time, WHN will also be expected to provide a detailed account of any recoupment for overpayment or any provider payment for any underpayment.

3g. Finding: WHN process to identify a clean claim is a claim that was entered into the system without hitting any system edits. This does not match the expected definition by DMA.

CORRECTIVE ACTION: Reports need to correctly identify clean claims as any claim that does not require providers to submit additional information in order for the claim to be processed as an accepted or denied claim.

DUE DATE:

DMA's expectation is that only clean claims will be paid, after all edits/audits and supporting documentation have been received and cleared. WHN's definition of a clean claim is to be submitted to DMA by September 3, 2012. A claims audit in addition to the 3% noted in item 3b will be required by DMA by September 3, 2012, demonstrating compliance with this item. At that time, WHN will also be expected to provide a detailed account of any recoupment for overpayment or any provider payment for any underpayment.

3h. Finding: Coordination of benefits handling is being done; however, WHN is not collecting data properly in their system. The actual payment made by Medicare was not captured, therefore, it could not be validated that the coordination was accurately performed.

CORRECTIVE ACTION: WHN needs to capture the Medicare (and other insurance) payment information to ensure that the correct payment is being made on the claim, with Medicaid paying their allowable minus the primary carrier payment.

DUE DATE:

DMA requires evidence of lower of logic, demonstrating that the total payments cannot exceed MCO reimbursement. A claims audit in addition to the 3% noted in item 3b will be required by DMA by September 3, 2012, demonstrating compliance with this item. At that time, WHN will also be expected to provide a detailed account of any recoupment for overpayment or any provider payment for any underpayment.

4. Clinical Operations

4a. Finding: While active care management is ongoing, clinical managers require routine utilization reports and access to the data sources for queries in order to manage care effectively and efficiently.

CORRECTIVE ACTION: The following reports, at a minim, must be developed for review on a routine basis as indicated below:

1. Daily census reports:
   A. Adult and Child Inpatient (mental health/substance abuse (MH/SA) and intellectual disability/developmental disabilities (I/DD))
   B. Child Psychiatric Residential Treatment Facility (PRTF)
   C. Intermediate Care Facility for the Mentally Retarded
   D. Emergency Room (ER) - Adult and Child (MH/SA and I/DD)

2. Treatment authorization requests (weekly):
   A. Total number of treatment authorization requests (TARS) reviewed by care manager
   B. Total TARS approved by care manager
   C. Number of TARS reviewed in 14 days by care manager
   D. Percent of TARS reviewed within 14 days by care manager
   E. Average number of days to review a TAR by care manager
   F. Caseload size by care manager and care coordinator (MH/SA & I/DD)
   G. Number/percent of service denials by level of care

3. Consumer and Family Grievances (Adult/Child, MH/SA, I/DD by county)

4. Top 20% Cost by Consumer Report (#75)

5. Continuity of Care – Follow up After Discharge from a Community Crisis Service (#305)

6. Continuity of Care – Follow up After Discharge from a Community Psychiatric Hospital Bed (#307)

7. Average Length of Stay in ER Setting

8. ER Setting Dispositions (inpatient, home, homeless shelter, etc.)

9. Inpatient Recidivism Report by consumer, by facility

10. Service utilization reports (by level of care, consumer, county)

DUE DATE:

DMA requires WHN to submit the reports above by September 3, 2012. Report dates should cover January through July of 2012.

4b. Finding: Transitional authorizations by ValueOptions (VO) for PRTF and other high cost intensive services do not appear to be consistent with DMA policy, resulting in PRTF authorizations beyond 30 days and more, typically for six months to one year for PRTF and other services, such as assertive community treatment (ACT) and community support team (CST). WHN believed they had to honor these authorizations per the transition plan.

CORRECTIVE ACTION: Clarification by DMA of authorization timeframes and length of current transitional authorizations. WHN plans to review placements of all children and youth in

PRTFs and other high-cost services. Continue positive efforts resulting from WHN study to transition children and youth with conduct disorders into more appropriate settings. Continue efforts to review appropriate utilization of ACT and CST services for adults.

DUE DATE:

WHN is required to submit a report of current authorizations to include units and authorization end dates for recipients in the following levels of care: PRTF, ACTT, TFC, Level III, and CST. This report will be due September 3, 2012.

4c. Findings: Care management/utilization management (CM/UM) and care coordination staff rely on paper processes to manage care and workflow. For example, care coordinators must go through each record to determine if person-centered plans were completed and timely. CM/UM maintains TARs in hard copy in a locked file due to lack of confidence in the validity of the data in the system. The information system does not have prompts or flags for clinical management staff to notify them of pending items.

CORRECTIVE ACTION: Assess the capability of the information system and electronic medical record to support care management/coordination functions. For example, the system should provide staff with an automatic daily task list of key required activities, such as dates for re-reviews of inpatient stays, due dates for submission of requested information and completion of person-center plans, etc.

DUE DATE:

A procedure noting all system flow, including flags and queuing logic, is required by DMA by September 3, 2012. The procedure should include a sample dashboard for a care manager.

4d. Finding: The process for report development is cumbersome. Quality management staff meets with clinical managers to develop reports and then the reports are prioritized by senior management. Historically, clinical management reports are low priority, resulting from claims management and financial reporting challenges and the need to focus resources on provider payments. However, this has left clinical management staff with gaps in information necessary to manage care effectively and efficiently.

CORRECTIVE ACTION: Elevate priority for clinical management reports recommended in this report for completion within 30 to 60 days and allow senior clinical staff access to database for data queries as indicated in 1c above.

DUE DATE:

DMA will review the reports indicated throughout this report in the timeframes indicated during weekly monitoring.

4e. Finding: The outpatient therapies authorization guidelines may result in over-utilization of outpatient individual, group and family therapies. WHN utilizes their experience with management of state-funded services for authorizing a Medicaid package of outpatient services (individual, family and group therapy) based on LOCUS or CALOCUS scores, American Society of Addiction Medicines criteria and other clinical information. While the

WHN care managers review 100% of all treatment requests, the authorization of a "package of services" that includes up to 312 events/services per year may result in the routine authorization of an excessive number of services.

CORRECTIVE ACTION: WHN should suspend the authorization of Medicaid packages for outpatient services until the care management system is fully functional, and clinical staff has access to accurate, timely CM/UM reports to support the management of care. As a new managed care organization, care mangers will then have more opportunities to engage providers, requesting additional services to ensure appropriate alternative services, such as dialectical behavioral therapy or intensive outpatient programs based on the individual's clinical presentation. A policy focusing on use of the outpatient authorization guidelines should be developed to orient new staff on their use and to prevent automatic authorization of the maximum number of services.

DUE DATE:

WHN is required to produce the benefit package and policy for outpatient therapies as well as a spreadsheet of all open authorizations for outpatient services to DMA by September 3, 2012.

If you have any initial questions about this report, please feel free to contact me. As mentioned, you will be expected to participate in weekly monitoring meetings. The first meeting with DHHS staff will be face to face at the Dorothea Dix Campus in Raleigh during the week of August 6, 2012. Details regarding exact location and times will be forwarded to you shortly. At that time, we will discuss this action plan in detail.

Sincerely,

Kelly Crosbie, LCSW
Chief, Behavioral Health Policy Section

CC: Michael Watson, DMA
Tara Larson, DMA
Steve Owen, DMA
Roger Barnes, DMA
Beth Melcher, DHHS
Jim Jarrard, DMHDDSAS
Don Herring, WHN