REPORT TO THE
SUBCOMMITTEE ON HEALTH
SENATE COMMITTEE ON FINANCE

BY THE COMPTROLLER GENERAL
OF THE UNITED STATES

North Carolina's Medicaid Insurance Agreement: Contracting Procedures Need Improvement

Department of Health, Education, and Welfare

North Carolina's approach to controlling increasing Medicaid costs by negotiating an insurance agreement with a private contractor could be improved by encouraging maximum competition and by more meaningfully evaluating proposed contract prices. This project has been the subject of premature and overstated claims of benefits, which have been attributed to the agreement and related contract negotiations.

HRD-76-139

JULY 1, 1976

COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D.C. 20548

B-164031(3)

The Honorable Herman E. Talmadge
Chairman, Subcommittee on Health
Committee on Finance
United States Senate

Dear Mr. Chairman:

This report discusses a contract between North Carolina and Health Application Systems, Inc., which provides for an insuring agreement covering all health services, except prescription drugs, provided under the State's Medicaid program. An analysis of North Carolina's contracting procedures and the extent of the Department of Health, Education, and Welfare's involvement in the solicitation for and award of the contract is included. The State expected to derive several benefits from the contract, but our analysis shows that these benefits probably will either not materialize or not directly result from the insuring agreement.

The report is in response to your letter of May 22, 1975, requesting information on the North Carolina contract. We are reviewing the other Medicaid insuring agreements that were in effect at that time and will report to you later on them.

Comments of the Department of Health, Education, and Welfare; North Carolina; and Health Application Systems, Inc., on the matters discussed in the report are included.

Sincerely yours,

Comptroller General
of the United States

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ABBREVIATIONS

GAO	General Accounting Office
HAS	Health Application Systems, Inc.
HEW	Department of Health, Education, and Welfare
ICF	intermediate care facility
MMIS	Medicaid Management Information System
PAID	Paid Prescriptions, Inc.
SMI	Supplemental Medical Insurance
SNF	skilled nursing facility
SRS	Social and Rehabilitation Service
SSA	Social Security Administration
SSI	Supplemental Security Income

COMPTROLLER GENERAL'S
REPORT TO THE
SUBCOMMITTEE ON HEALTH
SENATE COMMITTEE ON FINANCE

NORTH CAROLINA'S MEDICAID INSURANCE AGREEMENT: CONTRACTING PROCEDURES NEED IMPROVEMENT

Department of Health, Education, and Welfare

D I G E S T

In April 1975 North Carolina entered into a 2-year, $376 million insurance agreement with Health Application Systems, Inc., which made it responsible for paying for claims and assuming all of the administrative duties for the State's Medicaid program except for

--determining a person's eligibility for Medicaid,

--inspecting and certifying providers,

--setting overall program policy,

--paying drug claims which had been contracted under a separate agreement several years before, and

--paying the costs of yearend settlements with providers, which were paid initially on an interim basis. (See pp. 4 to 6.)

WEAKNESSES IN CONTRACTING PROCEDURES

Out of 33 firms solicited, only Health Application Systems submitted a proposal for an insurance agreement. Competition was limited as a result of the innovative nature of and risks involved in the procurement. Competition was further limited because:

--Many firms could not do the required work. (See p. 10.)

--Data in the request for proposals was insufficient for developing valid premium rates. (See p. 11.)

--Some firms believed the request for proposals was biased toward a preselected contractor. (See p. 12.)

--At the time of the request, the legality of a Medicaid insurance contract under State laws was questionable. (See p. 14.)

--The State insurance laws placed bona fide insurance companies at a competitive disadvantage because of requirements that money be kept in a contingency reserve. (See p. 15.)

In evaluating the Health Application Systems' proposal, North Carolina compared the proposed contract price to its Medicaid budget. (See p. 17.)

The State evaluated the savings possible from its program to review the appropriateness of hospital and nursing home care provided to recipients. These savings would have been realized whether or not an insurance agreement was entered. Savings estimates of $3.5 million, $4 million, $6.4 million, $7.4 million, and $9.4 million were developed. Only under the $3.5 million and $4 million estimates would the State analysis show that the insurance agreement cost less than a State-administered program. The $3.5 million estimate was used to justify the contract. (See pp. 18 and 19.)

The State's final contract negotiations were aimed at adding to Health Application Systems' responsibilities or increasing the State's participation in the reserve money or profits under the contract. The value placed by the State on these negotiations was about $22.3 million. However, the Health Application Systems' proposals already included most of the negotiated items. (See p. 20.)

The Medicaid budget estimates used to evaluate the proposed price had certain problems:

--The State Medicaid program pays a monthly Medicare premium for people eligible for part B of Medicare. The Department of Health, Education, and Welfare (HEW) established the premiums nationally. The budgeted costs for these premiums were overstated by about $3.7 million. (See p. 23.)

--Projected increases for inflation, utilization, and the number of eligible people could not be validated. (See p. 25.)

The Medicare premiums should not have been included in an insurance arrangement because, if it were underpriced, the insurer would incur losses over which it had no control. On the other hand, if the buy-in program were overpriced--as was the case with this contract--the insurer would receive a windfall profit. (See p. 23.)

Although the profit sharing arrangement under the contract (75 percent to the State and 25 percent to Health Application Systems) could reduce the effect of any overpricing, such an arrangement is not an adequate substitute for sound contract pricing at the time of award.

SOME BENEFITS EXPECTED FROM THE CONTRACT NOT ASSURED

The State expected its costs to be reduced by about $3.2 million as a result of increases in costs borne by Federal and local governments. The principal element of the expected increase in Federal participation was the inclusion in the contract of monthly premiums paid to the Social Security Administration to cover, under part B of Medicare, medically needy Medicaid recipients who do not receive cash assistance under the public assistance programs.

Federal law prohibits sharing in these medically needy premium costs under Medicaid. When GAO brought this to HEW's attention, HEW said Federal sharing for the medically needy would not be allowed under the insurance agreement. Thus, the State will not receive the about $2.6 million in Federal funds it expected. (See pp. 28 to 32.)

The insurance agreement was expected to place a ceiling on Medicaid expenditures. However, the State has already renegotiated the contract price because the maximum daily payment rate for nursing homes was increased by the State legislature. This change also increased the maximum

rates for intermediate care facilities. These changes increased the original contract price by about $6.7 million. Because of two conflicting renegotiation clauses in the contract, prices could increase further. (See pp. 32 to 37.)

The insurance agreement was supposed to provide for better and more comprehensive program data and improved medical and utilization review. However, the expected improvements related to programs either in effect or planned when the agreement was signed. An insurance agreement was not necessary to obtain these benefits--a State-administered program or a fiscal agent agreement could result in the same benefits. (See pp. 37 and 38.)

The maximum monthly premium included in the contract protects the State against the costs that could result if the number of recipients increased. However, a 15-percent decrease in recipients--to the April 1971 level--would be required to reduce the total monthly premium. (See p. 39.)

HEW INVOLVEMENT IN CONTRACT

HEW had not participated extensively in the State's activities preceding the development and negotiation of the final contract. Social and Rehabilitation Service regional office and headquarters officials reviewed a draft of the contract and assisted the State in contract negotiations, but the proposed contract was not specifically approved by them because HEW regulations then in effect did not require prior HEW approval.

HEW, however, did approve the insurance arrangement for Federal financial participation. HEW has amended its regulations--effective August 9, 1975--to require prior HEW approval for State Medicaid contracts over $100,000.

CONTRACT MONITORING

GAO could not determine whether the contract was sufficiently monitored. At the time of GAO's fieldwork, HEW had not formalized its monitoring

procedures and the State had not fully implemented its plan for monitoring contract performance. However, the State plan should provide for sufficient program and fiscal monitoring and review if fully implemented.

AGENCY COMMENTS

HEW, the State, and Health Application Systems, in commenting on GAO's draft report, said it served no useful purpose since it did not analyze Health Application Systems' performance under the contract or the results of the contract and was not a fair evaluation of the contract. GAO did not attempt to evaluate contract performance or results because it was too early in the contract period to do so.

The State presented data which it believed demonstrated that money was being saved under the contract. However, because the data used by the State was not comparable between the two periods analyzed, and because of several other reasons, GAO believes the State analysis is not valid. In fact, in May 1976 the contractor notified the State that it was contemplating termination of the contract because of possible losses. (See Ch. 6.)

This report comments on the State's contracting procedures, the basis on which the State expected to derive benefits from the contract, and whether or not these benefits will be realized. This information will be useful to any other States which consider entering into a Medicaid insurance agreement and to HEW in its efforts to assist such States.

The State's, Health Application Systems', and HEW's written comments and GAO's response to them are presented in appendixes II-IV.

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Because this report covers the first stage of a broader review of several State Medicaid insurance arrangements, GAO is making no recommendations at this time.

CHAPTER 1

INTRODUCTION

On April 28, 1975, North Carolina entered into a 2-year insurance agreement with Health Application Systems, Inc. (HAS), to undertake all aspects of the State's Medicaid program except for determining program policy and recipient eligibility, inspecting and certifying providers, and processing and paying drug claims. Determining recipient eligibility remained a State function. The State had previously contracted the Medicaid drug program under an insurance arrangement to Paid Prescriptions, Inc. (PAID), which had in turn subcontracted with HAS for processing Medicaid drug claims.

By letter dated May 22, 1975 (see app. I), the Chairman, Subcommittee on Health, Senate Committee on Finance, requested that we review the North Carolina insurance contract as the first stage of a broader review of the Department of Health, Education, and Welfare's (HEW's) and various States' policies and procedures for awarding insurance-type contracts.

The Chairman also expressed concern about

--the extent of HEW's involvement in the award of the North Carolina contract and

--HEW's capability to monitor such contracts and to assess the contractor's performance.

In September 1975 the Legislative Services Commission of the General Assembly of North Carolina by resolution called upon the congressional delegation of that State to request that we evaluate the effectiveness of the North Carolina insuring agreement. In response to the request, we indicated that it was too early to fairly or objectively evaluate the overall effectiveness of the contract; nevertheless, we considered the concerns of the Commission during our review.

THE MEDICAID PROGRAM AND ITS ADMINISTRATION

Title XIX of the Social Security Act (42 U.S.C. 1396) authorizes Federal participation in the costs of State medical assistance (Medicaid) programs which conform to the provisions of the act. The Federal Government pays for 50 to 78 percent (depending on the State's per capita income) of the costs of providing medical services under Medicaid.

Medicaid recipients include persons or families receiving or entitled to receive cash assistance payments under the

Supplemental Security Income (SSI) or Aid to Families with Dependent Children programs. These recipients are referred to as the categorically needy.

In addition, States may elect to pay for medical care to medically needy persons and their families (individuals whose income exceeds the State's standard under the appropriate financial assistance plan, but is insufficient to meet their medical costs). As of July 1975, 32 States and jurisdictions, including North Carolina, had elected to pay for care to the medically needy.

The Social Security Act requires that a participating State submit to the Secretary of HEW a plan for medical assistance which meets the conditions specified in the act and that the Secretary approve any State plan which meets those conditions.

The act specifies (42 U.S.C. 1396a(a)(4)) that the State plan must provide for "such methods of administration * * * as are found by the Secretary to be necessary for the proper and efficient operation of the plan * * *" but does not otherwise refer to methods by which a State might administer its plan.

The Secretary of HEW has delegated the responsibility for administering Medicaid at the Federal level to the Administrator of the Social and Rehabilitation Service (SRS). Authority to approve State Medicaid plans has been delegated to the SRS regional commissioners who administer the field activities of the program through HEW's 10 regional offices. The commissioners are responsible for determining whether State programs comply with Federal requirements and approved State plans.

RELATIONSHIP BETWEEN MEDICAID AND PART B OF MEDICARE--THE BUY-IN PROGRAM

Medicare, administered by HEW's Social Security Administration (SSA), provides two forms of health insurance to eligible aged or disabled persons. One (part A) primarily covers inpatient hospital services and is principally financed by a designated portion of the social security tax. The other (part B) covers physician services, outpatient hospital services, and several other medical services. Eligible elderly and disabled persons may enroll in part B, which is financed by premiums paid by the enrollees and by contributions by the Federal Government. In 1974 and 1975 the monthly premiums payable by enrollees was $6.70. Beginning in July 1976 the premium will increase to $7.20.

Section 1843 of the Social Security Act authorizes States, under agreements with HEW, to enroll in part B of Medicare eligible aged and disabled Medicaid beneficiaries. Under this provision--commonly called the buy-in program--the State pays the premiums, deductibles, and coinsurance and Medicare pays all other costs for the medical services covered by that program. The Federal Government helps to pay the cost of premiums paid to Medicare for persons receiving cash assistance--the so-called categorically needy--but Federal sharing is not available for buying-in the medically needy. If a person eligible for both Medicaid and Medicare is not bought-in to part B of Medicare, the State must pay--without Federal participation--the medical expenses that would have been covered by part B. Thus, a State has a strong financial incentive for participating in the buy-in program because (1) for all Medicaid eligibles, bought-in to part B, it receives the benefit of the Federal contribution under Medicare, which finances over half of part B, and (2) for categorically needy enrollees it also receives the benefit of Federal Medicaid participation in the buy-in premium.

As of July 1, 1975, 49 States and jurisdictions, including North Carolina, had buy-in agreements to enroll eligible aged and disabled Medicaid beneficiaries in part B of Medicare and about 2.7 million persons were enrolled.

HEW POLICIES AND PROCEDURES APPLICABLE TO MEDICAID INSURANCE CONTRACTS

HEW Medicaid regulations (45 CFR 249.82) provide for Federal financial participation in costs paid by a State to health insuring organizations, fiscal agents, or private nonmedical institutions under contracts for administration of a State's program.

At the time the North Carolina contract was being proposed and negotiated, the regulations did not require prior HEW approval of insurance contracts. The regulations were amended effective August 9, 1975, to require such approval of all contracts for more than $100,000.

The regulations governing contracts with health insuring organizations are discussed in greater detail later in this report.

NORTH CAROLINA'S MEDICAID PROGRAM

North Carolina's Medicaid program was initiated in January 1970. The following table shows the growth in total program costs, excluding State administration costs, since then.

Fiscal year	Costs
	(millions)
1970 (6 months)	$ 26.3
1971	93.9
1972	104.0
1973	124.9
1974	128.1
1975	180.7
Total	$657.9

The Federal Government's share of this cost over the 5-1/2-year period was about $476 million (70 percent). State budget projections as of October 14, 1974, for fiscal years 1976 and 1977 showed anticipated cost increases to $211.1 million and $241.4 million, respectively.

The average number of eligible recipients for medical assistance in North Carolina grew from about 222,000 in fiscal year 1970 to about 291,000 in fiscal year 1975.

From January 1970 through December 1972, Blue Cross-Blue Shield administered the North Carolina program as a fiscal agent. From January 1973 through April 1975, the program was administered directly by the State agency (North Carolina Department of Human Resources).

DESCRIPTION OF CONTRACT

The HAS contract covers the period May 1, 1975, through June 30, 1977. During May and June 1975, HAS functioned as a fiscal agent of the State. 1/ For the remainder of the contract period, HAS is to function as a health insuring organization.

For the first year of the insuring arrangement, the State is to pay HAS a prepaid monthly fee of $54.30 for each person eligible to participate in the Medicaid program, not to exceed $14,660,000 a month ($175,920,000 for the year).

1/HAS is also required to pay, as a fiscal agent, claims received after July 1, 1975, for services provided before that date. Under the contract, the State is not liable to reimburse HAS for these payments until after contract termination. See p. 52 for a complete explanation of this arrangement.

During the second year, the prepaid monthly fee is to be increased to $61.70 for each eligible recipient, not to exceed $16,660,000 a month ($199,920,000 for the year). However, payment of the maximum amount each month is virtually assured. (See p. 35.)

In return for these payments, the contractor agreed to process and pay all valid claims--based on services and payments authorized in the State plan--received during the contract period. The contractor further agreed to process and pay 90 percent of all valid and properly submitted claims within 30 days of their receipt. The only claims-related aspect of the program for which the State remains directly responsible is yearend cost settlements with providers who are paid during the year at interim rates.

Other responsibilities of the contractor include

--implementing and operating an electronic data processing system to meet the specifications of HEW's Medicaid Management Information System (MMIS),

--establishing and maintaining a Medicaid eligibility file based upon information to be supplied by the State,

--paying the Medicare buy-in premiums for Medicaid recipients eligible for Medicare,

--subcontracting with Medicare intermediaries for the common audit of certain institutional providers, and

--assuring compliance with the utilization control and utilization review requirements of title XIX.

In addition to paying the monthly fees, the State must

--establish and certify the eligibility of enrolled recipients and notify the contractor of changes in the eligibility status of enrolled recipients,

--set overall program policy,

--identify for the contractor those providers who have been lawfully terminated or suspended from further participation in the program, and

--notify the contractor of any changes in the program.

The contractor is required to establish two bank accounts--a "Title XIX Trust Account," which must be kept under

an investment agreement with a depository bank in North Carolina, and an "H.A.S. Disbursing Account." The monthly fees paid by the State and net recoveries from third parties are required to be deposited in the Title XIX Trust Account. Funds are to be transferred from the Title XIX Trust Account to the H.A.S. Disbursing Account as necessary to cover administrative costs and payments to vendors. (An agreement between HAS and a bank provides that (1) the balance in the Title XIX Trust Account will be invested in U.S. Treasury bills unless HAS specifically authorizes investment in the bank's Short Term Common Trust Fund and (2) funds will be transferred from the Title XIX Trust Account to the H.A.S. Disbursing Account daily as required to cover checks presented for payment.)

The contract provides that any interest earned on funds in the Title XIX Trust Account will be available to pay the costs of the contract, but that any unused interest at completion of the contract will be paid to the State. Any other funds remaining in the account at completion of the contract will be divided between the State and the contractor, with the State receiving 75 percent.

The contractor is required to maintain in its Raleigh offices commercially acceptable accounting records of all income and all costs or expenditures related to the contract, and to make those records available for review by authorized representatives of the State or Federal Governments.

RELATIONSHIPS BETWEEN CONTRACTOR AND OTHER CORPORATIONS IN THE DRUG AND HEALTH PRODUCTS INDUSTRIES

HAS is a wholly owned subsidiary of the Bergin-Brunswig Corporation, a manufacturer of health products and a leading distributor of pharmaceutical products.

PAID is a California not-for-profit corporation which either has, or until recently had, insurance-type contracts with Arkansas, California, Florida, Maine, North Carolina, and Pennsylvania to administer the Medicaid drug program on a prepaid, capitation basis. HAS and PAID, and their predecessor organizations, have been affiliated since 1969 in a series of agreements which have given HAS increasing control over PAID.

The present agreement between HAS and PAID covers the period September 1, 1974, through December 31, 1993, and is renewable for two additional 10-year periods at HAS' option. Under this agreement, HAS has an exclusive right to promote, market, and use PAID's data service programs. All PAID contracts must be approved by a committee consisting of three

PAID representatives and three HAS representatives, with the president of PAID casting the deciding vote in case of a tie. The agreement provides for PAID to pay HAS for claims processing a percentage of all the premiums PAID receives, except for the North Carolina drug contract, under which HAS is paid $135,000 per month.

The North Carolina Medicaid contract requires that HAS must provide a $6 million performance bond and $6 million of reinsurance or an equivalent guarantee to assure payment of Medicaid claims. The performance bond was obtained from a major insurance company. On May 9, 1975, HAS made an agreement with a large multinational pharmaceutical manufacturer and distributor. The agreement called for the manufacturer to arrange for issuance of a letter of credit to satisfy HAS' obligation to insure claims payment. The letter of credit was issued on June 1, 1975, by a Newark, New Jersey, bank. In exchange for the letter of credit, HAS agreed to pay the drug manufacturer 25 percent of its profits on the North Carolina contract, and Bergin-Brunswig Corporation gave the firm an option, exercisable at any time before August 29, 1976, to purchase a 25-percent interest in HAS for $10,000,000.

In May 1976 the drug manufacturer notified HAS that it was terminating the reinsurance arrangement effective September 30, 1976.

SCOPE OF REVIEW

Our review was directed toward (1) evaluating North Carolina's contracting procedures for insuring agreements, (2) evaluating the State's capability to administer this type of arrangement and to assess HAS' performance under the contract, and (3) ascertaining the extent of HEW's involvement in contract development and award.

We reviewed pertinent records and files and interviewed appropriate HEW, North Carolina, and HAS officials. We also reviewed HEW regulations pertaining to insuring agreements and to contracting procedures and the policies and practices of the State's contract procurement agency. We also reviewed reports of the North Carolina Auditor's Office and Department of Human Resources' medical services section pertaining to the State's procurement policies and practices and to the Medicaid insuring agreement.

Our review was conducted at HEW headquarters in Washington, D.C.; SSA headquarters in Baltimore; the HEW regional office in Atlanta; the North Carolina Department of Human Resources and other State agencies in Raleigh; and HAS facilities in Raleigh and in Burlingame, California. We also

visited the offices of the North Carolina Medical Peer Review Foundation, an HAS subcontractor, and held discussions with appropriate Foundation officials. In addition, we visited and telephoned several firms that were sent the request for proposals to obtain their reasons for not submitting a proposal.

We also analyzed certain State calculations of the cost reductions reportedly realized under the contract for September 1975 through February 1976.

CHAPTER 2

THE STATE'S PROCUREMENT PRACTICES DID NOT INSURE MAXIMUM COMPETITION OR ADEQUATE PROPOSAL EVALUATION

The State's request for proposals was sent to 33 firms, but only HAS submitted a proposal. 1/

Essentially, the State's evaluation consisted of comparing the proposed contract price with its Medicaid budget estimate. The fact that a price proposed by a contractor is within the limits of available funds is no assurance that it represents what an efficiently managed program should cost.

The supporting data for HAS' proposal showed that about 96 percent of the value of the items the State said it had negotiated into the contract were already included in HAS' proposals.

LACK OF COMPETITION

The procurement standards applicable to HEW grantees, including State and local governments (45 CFR 74.150 et. seq.), provide that all procurement transactions, negotiated or advertised, without regard to dollar value, shall be conducted to provide maximum open and free competition.

The apparent lack of interest in competing for the North Carolina Medicaid insuring contract seems to have been the result of several factors--(1) questionable selection of firms to receive the request for proposals, (2) the view of some prospective offerors that the venture was too risky, primarily because of the unavailability of data necessary for computation of valid premium rates, (3) an unwarranted perception on the part of some prospective offerors that the requirements were biased in favor of a particular offeror, and (4) an uncertain legal climate.

From our review of correspondence and discussions with representatives of firms that did not submit proposals, we identified the following reasons for 21 firms not responding.

1/The State sent out 35 copies of the request for proposals but 2 were duplicates to the same firms.

Primary reason proposal not submitted	Number of firms
Firm had inadequate resources and capability	8
Venture too risky because of inadequate data	4
Requirements too restrictive	4
Firm did not receive request for proposals	2
State laws placed company at competitive disadvantage	1
Firm not advised of deadline for submission of proposal	1
Firm had other commitments	1
	21

Questionable selection of firms to receive request for proposals

The 33 firms to which the request for proposals was sent included 6 certified public accounting firms, an automatic data processing equipment manufacturer, several management consulting firms, a small local bank in Georgia, but only 3 insurance companies (one of which reported to us that it did not receive a request for proposals). We believe the fact that many solicited firms did not respond because they did not have the capability to perform the contract could have been anticipated from the nature of the firms to which the State sent the request for proposals.

The former State Chief of Medical Services told us that the list of prospective offerors was developed from

--a list, furnished by HEW in 1972, of firms supposedly capable of operating an MMIS;

--a list of firms that had expressed an interest in operating an MMIS or had previously contracted with the State agency; and

--firms suggested by the regional HEW medical services representatives.

The regional HEW representative said he had suggested that the request for proposals be mailed to certain large insurance companies and to the Bank of Forest Park, Georgia. He said that the executive vice president of that bank had previously processed Medicaid payments for Alabama when he was an employee of a bank in that State.

Although over 300 companies were licensed to write health insurance in the State, the North Carolina Insurance Commissioner was not asked to provide a list of insurance companies to which the request for proposals might have been sent.

Unavailability of data led some firms to believe the venture was too risky

The request for proposals was issued on October 23, 1974, calling for submission of proposals by November 25, 1974. On November 6 Blue Cross-Blue Shield wrote to the State agency stating that it could not submit "a thoughtfully prepared and fiscally responsible bid" and still meet the November 25 deadline and asked for a 2-month extension. In an addendum dated November 12, 1974, the State agency notified prospective offerors that the proposal submission deadline would be extended to an "early date in January 1975." In the last addendum, dated December 16, 1974, the State agency notified prospective offerors that the deadline for submission of proposals was January 14, 1975.

The request for proposals required that prospective offerors quote a monthly per capita premium rate for each aid category (i.e., Aid to Families with Dependent Children, Aid to the Aged, Aid to the Blind, and Aid to the Disabled). Development of valid premium rates on this basis would require accurate data concerning the number of persons in each aid category (eligibles), the number of persons in each aid category who actually received medical care (users), and the cost of providing such medical care--all over a period long enough to permit identification and projection of trends. The request for proposals showed the number of eligibles in each aid category as of September 1974 and projected numbers of eligibles by aid category for fiscal years 1975-77; but it had no information on the number of users or the costs by aid category.

The data in the request for proposals was also inadequate because of the basis on which it was accumulated. Prospective offerors were required to submit proposals containing monthly per capita premiums which would cover the cost of services provided to eligibles during the month irrespective of when the services were paid for. However, the data in the request for proposals was based on when the services were paid for, not when they were provided. It is difficult to convert date-of-payment data into the date-of-service data which is necessary to determine reliable monthly per capita premiums.

One of the insurance companies (North Carolina Blue Cross-Blue Shield) to which the request for proposals was

sent requested the State to furnish data on the amount and number of claims paid and the number of eligibles by aid category for each month beginning with January 1973 so that its actuary could compute reliable premium rates. The State agency supplied the requested information, but only for 5 months--July-November 1974.

The lack of information on which to base premium rates was the primary factor in four prospective offerors'--including the Nation's largest life insurance company (Prudential Insurance Companies of America)--declining to submit a proposal because they felt the venture was too risky.

Some firms believed the requirements were biased

Representatives of three prospective offerors told us that their firms did not respond because the request for proposals was too restrictive because (1) it required the selected contractor to have certain specific talents or to have prior experience in the prepaid Medicaid area and (2) it dictated where and how the work would be done. Representatives of three firms said that they had received information from State officials and other sources which caused them to believe that the State agency had preselected a contractor and had tailored the request for proposals to that contractor.

In our opinion, the request for proposals, with one possible exception, was not written to favor HAS. Other matters related to the contract solicitation, however, seem to lend support to the assertion that HAS was in a more favorable position than its potential competitors.

The one aspect of the request for proposals which we think might have favored HAS was in the criteria to be used in evaluating proposals. The request stated:

> "Proposals received under this solicitation will be evaluated and a selection made using at least the following primary criteria (not limited to this listing):
>
> "1. Adequacy and completeness of the contractor's technical proposal.
>
> "2. Price and pricing data.
>
> "3. Capability of the offeror to perform the anticipated task within the time required.

"4. Prior experience in development and installation of systems similar to the Medicaid Management Information System.

"5. Experience in administering pre-paid Medicaid Programs."

The request for proposals did not state the weight to be given the various criteria, but to the extent that prior experience in administering prepaid Medicaid programs might have determined the winning offeror, the evaluation criteria favored HAS because at that time only HAS/PAID and possibly Texas Blue Cross-Blue Shield and the Equitable Assurance Society had such experience.

We mentioned earlier that North Carolina Blue Cross-Blue Shield had requested certain detailed program information for each month beginning with January 1973 and that the State had furnished information for only the 5-month period July-November 1974. The information for the 5-month period was furnished to all prospective offerors on November 23, 1974, as an addendum to the request for proposals. In a letter attached only to the addendum mailed to North Carolina Blue Cross-Blue Shield, the former Chief of Medical Services stated that the information furnished was the best available. In our discussion of this matter with him, he acknowledged that the requested information was available but said that it was not readily available. However, according to other employees of the State agency, the requested information could have been made available to all prospective offerors within a few days.

Certain conditions also tended to put HAS in a favorable position vis-a-vis its potential competitors.

1. HAS had been involved with PAID in administering the prescription drug portion of North Carolina's Medicaid program since 1972. This involvement gave HAS access to such data as historical information on the number of Medicaid eligibles which HAS used in preparing its proposal. This is part of the data which the State told Blue Cross-Blue Shield was not readily available.

2. In July 1974 the State agency contracted with HAS for assistance in developing a request for proposals for implementing MMIS. HAS stated in its proposal that this experience gave it a detailed understanding of the North Carolina Medicaid program.

3. During August and September 1974, State officials discussed Medicaid program management problems with the president of HAS and during these discussions

the concept of a prepaid Medicaid program, similar to the drug contract, was discussed. The president of HAS, in a letter dated September 16, 1974, advised the State that HAS was in a position to expand the prepayment method of administering Medicaid beyond the drug program and that his company would welcome the opportunity to initiate such a program in North Carolina. He said that he believed that implementing a prepaid program would place a ceiling on the State's Medicaid expenditures and would reduce direct program, personnel, and facility costs. He added that within 5 months HAS could implement a program that could save the State about $668,000 in fiscal year 1975 and $3,972,000 in fiscal year 1976. He assured State officials that "in no case" would payments exceed the State's budget and suggested that, because the State was already planning to implement MMIS, HAS could tie the MMIS into a total prepaid program.

State officials ordered development of a request for proposals for a prepaid program in October 1974.

Uncertain legal climate

When the request for proposals was written, North Carolina law permitted paying medical assistance funds only to providers of medical services--a provision which precluded contracting for an insuring agreement. There was also a question concerning application of the State's insurance laws to such a contract if one could be awarded.

A reason given for extending the deadline for submission of proposals from November 25, 1974, to early January 1975 was to permit the North Carolina Attorney General to determine the effect of a provision of the general statutes which might prevent contracting for an insuring agreement under the Medicaid program. The addendum which extended the submission date stated that the general assembly might have to amend the law before the proposed contract could be awarded.

The State Attorney General concluded in an advisory opinion dated November 25, 1974, that the proposed contract would violate State law. However, at the request of the State agency, the State legislature amended the law in April 1975 to permit payments of medical assistance funds to prepaid health service contractors.

Considering the substantial cost which would have been incurred in developing a response to the request for proposals, it seems reasonable to expect that the uncertainty

with respect to the legality of the proposed contract could have deterred some firms from submitting a proposal. By letter dated December 24, 1974, Blue Cross-Blue Shield advised the State that it would not submit a proposal in light of the Attorney General's November 25, 1974, opinion.

In addition to this uncertainty, another possible legal problem existed. The North Carolina insurance laws require that a hospital, medical, or dental service corporation maintain a contingency reserve in excess of three times its average monthly payments for hospital, medical, and dental claims. 1/

Representatives of North Carolina Blue Cross-Blue Shield and Prudential told us that another reason their firms did not submit a proposal was because of the insurance reserve requirement.

To determine whether the reserve requirement was applicable to these firms, we talked to an assistant State attorney general. He said that, if any insurance company had obtained the prepaid Medicaid contract, the reserve requirement probably would have been applicable because other subscribers or policyholders with the company would have been adversely affected if the contract proved unsuccessful. However, the State Attorney General issued an advisory opinion on April 4, 1975, which concluded that HAS--which is not an insurance company--was not subject to the laws regulating hospital, medical, and dental service corporations and that therefore HAS was not required to accumulate the contingency reserve.

State and HAS comments

In commenting on the lack of competition, the State (see p. 63) and HAS (see p. 99) emphasized that the uniqueness of the innovative prepaid arrangement in North Carolina, including the total Medicaid program and the substantial risks involved, was, in their opinion, the reason for the lack of competition for the contract. The relative newness of the State's insuring concept undoubtedly did make obtaining competition more difficult. However, according to potential offerors, the factors discussed in this chapter also contributed to the lack of competition.

1/Based on the fiscal year 1976 monthly premium under the HAS contract, the contingency reserve would have had to have been about $44 million.

MINIMAL EVALUATION OF PROPOSED CONTRACT PRICE

The State did not use or adequately analyze available data as to the basis for HAS' proposed contract price. The State contends that it had negotiated additional values of $22,342,200 into the contract, but the data available to us showed that most of these values were already in HAS' proposed price or in its revised proposal submitted about 6 weeks before formal negotiation started. Essentially, the State's formal evaluation consisted of comparing the proposed price to the Medicaid budget.

HAS' proposal

HAS' initial proposal, delivered to the State on January 14, 1975, provided for payment of a monthly premium for each certified eligible in each of the four aid categories, as follows:

Aid category	Monthly premium
Aid to Families with Dependent Children	$20.28
Aid to the Aged	82.70
Aid to the Blind	76.12
Aid to the Disabled	94.49

The total proposed contract price was therefore contingent on the number of certified eligibles in each aid category; however, based on eligibility data presented in the request for proposals, HAS estimated that during fiscal year 1976 the State could anticipate total payments of about $175.9 million. This was about $6.1 million less than the State's then current fiscal year 1976 Medicaid budget estimate--excluding drugs but including administrative costs--of about $182 million. HAS proposed to operate the program for 13 months from June 1, 1975, to July 1, 1976. In addition, HAS' proposal provided for a 3-month implementation phase--March 1 through May 31, 1975--during which HAS would acquire the hardware and facilities; develop, evaluate, and test data systems; and hire and train personnel.

The January 1975 proposal also provided that, if payments to HAS exceeded the cost of services provided and related HAS administration costs, the State and HAS would share in the excess as follows:

Amount of excess	Percent to State	Percent to HAS
Below $1 million	80	20
$1 million to $2 million	70	30
$2 million to $3 million	60	40
Above $3 million	50	50

Although this proposal was responsive to the requirements of the request for proposals, the State agency rejected it because

--it did not place a ceiling on program costs,

--the amount of projected savings was too low, and

--the proposed contract duration of 13 months was too short.

On February 13, 1975, HAS submitted a revised proposal for a 2-year contract at a fixed monthly group premium of $14.66 million, or $175.9 for fiscal year 1976, and of $16.66 million, or $199.9 million for fiscal year 1977--independent of either inflationary effects or increases in the rates of utilization or in the number of certified eligibles. In the revised proposal, HAS also changed the proposed ratio for sharing the excess of premium payments over its costs from the sliding scale previously proposed to a fixed ratio of 75 percent for the State and 25 percent for the contractor.

State agency's evaluation of HAS' proposal

The State agency appointed a fiscal review committee consisting of the Comptroller of Social Services, the Chief of the Medicaid Accounting Branch, and two budget analysts from the State Department of Administration to evaluate HAS' original proposal. According to members of the committee, they did not attempt to determine whether the proposed price was reasonable but merely whether the State's budget could finance the arrangement.

In its evaluation, the committee followed the suggestion of a consultant who had been employed by the State to develop a method for the State to use in evaluating proposals for a prepaid insurance contract. The consultant suggested that the State develop a capitation rate based on the Medicaid budget and compare that rate with the proposed rate. The committee's comparison of January 15, 1975, was as follows, based on the 1976 budgeted amounts excluding yearend settlement costs.

	State	HAS
	(000 omitted)	
Medical services payments		
Total	$205,035	
Drugs	(27,202)	
Net of drugs	$177,833	
State administrative cost	4,188	
Estimated budget net of drugs	$182,021	
Deduct:		
Savings applicable to implementation of long-term care and hospital admissions review programs	(6,400)	
Cost for residual administrative organization	(788)	
Annual premium	$174,833	$175,900
Monthly premium (annual premium divided by 12 months)	$ 14,569	$ 14,658
Monthly capitation rate (based on 312,612 eligibles shown in the request for proposals)	$46.61	$46.89

Thus, the committee's comparison of HAS' original proposal and the State budget showed that the contract would cost slightly over $1 million more than a State-administered program.

Probably the most critical figure in the comparison is the amount of savings attributed to implementation of the long-term care and hospital admission review programs. For that reason we attempted to evaluate the basis for that figure but did not attempt to evaluate the rest of the comparison except to verify it to the budget and to HAS' proposal.

The fiscal review committee's estimate of a $6.4 million savings from implementing the two admission review programs was based on a consultant's estimate of $7.4 million, from which the committee deducted $1 million for administering the programs.

The consultant's estimate of $7.4 million, however, was qualified in that it acknowledged that many variables which affect a State's program cost were not considered in computing the estimated savings.

During our review, State agency officials provided us with other estimates of annual savings to be realized from implementation of the utilization review programs--one for $3.5 million, one for $4 million, and one for $9.4 million (dated October 1973 and for hospital admission review program savings only), none of which could be substantiated. At a meeting in April 1975 at which approval of the contract was obtained, the State agency and the State Advisory Budget Commission agreed to use the $3.5 million estimate, which showed that the contract would lower State costs for fiscal year 1976.

On the basis of the $3.5 million estimate, the State agency in April 1975 proposed a biannual budget reduction of $7 million for savings attributed to improved utilization review programs which was distributed as follows.

State	$1,902,000
Federal	4,762,000
Local	336,000
Total	$7,000,000

It is interesting to note that the use of the fiscal review committee's $6.4 million estimate or the consultant's $7.4 million estimate for utilization review savings would not have shown any savings in total Medicaid costs directly attributable to the proposed contract.

Contract negotiators' evaluation of HAS' proposal

We asked the State to show us the record of negotiations for the procurement. We were informed that no record of negotiations had been prepared. The State later provided us with information which it said reflected the results of the negotiations.

Based on the information the State provided, we concluded that the negotiators for the State--the principal negotiator was the Chief of Contractual Services in the State Department of Administration--did not determine the basis for HAS' proposed price. According to the information, provided to us, however, they did prepare a comparative analysis of HAS' proposal and the State Medicaid budget which showed projections of possible breakeven points and potential accumulated reserves under the contract.

For the first year of the contract, the State negotiator estimated that, based on the number of eligibles included in the request for proposals, reserves of about $13 million

would be accumulated. The average number of eligibles would have to increase to about 339,000 before the contract would fail to accumulate reserves. For the 2-year period of the contract, the State's negotiator estimated, based on the number of eligibles in the request for proposals, that reserves would be about $30 million at the end of the contract period and that the average number of eligibles would have to increase to about 348,000 before the contract would fail to accumulate reserves.

According to the principal negotiator, these estimates of the potential reserves were considered during negotiations, but they were not used to negotiate a reduction in HAS' proposal. Instead, he said, as a result of the negotiations other changes were made, either to add to HAS' liabilities or to increase the State's participation in the accumulated reserves and any income therefrom.

By memorandum to us dated November 19, 1975, the principal negotiator listed these changes as follows:

	Monetary benefit to the State
HAS to pay Medicare buy-in premiums	$ 9,600,000
HAS to pay Medicaid share of common audit cost	960,000
HAS to process Medicare crossover claims (note a)	79,200
State to retain all interest income	1,440,000
Accumulated reserves sharing ratio changes	10,263,000
	$22,342,200

a/These are claims applicable to people eligible for both Medicare and Medicaid (dual beneficiaries) when Medicaid pays the deductible and coinsurance amounts not paid by Medicare.

However, the supporting data behind HAS' proposed price (which HAS had provided us during our review and which the State advised us in April 1976 that it had obtained on February 13, 1975) showed that that price already included the costs of the Medicare buy-in premiums. The information we obtained from HAS showed that the processing of Medicare crossover claims was also included. The change in sharing ratios for accumulated reserves and interest income could have resulted from informal discussions in the period between submission of the initial proposal on January 14, 1975, and

submission of the revised proposal on February 13, 1975--almost 6 weeks before formal negotiations were started--but these changes were included in the revised proposal. 1/

The requirement for HAS to pay the State's share of common audit costs could have resulted from the final contract negotiations.

State and HAS comments

The State and HAS, in commenting on a draft of this report, objected to our description of the State's evaluation of the HAS proposal.

The State commented that "no Government agency routinely receives an analysis of the bidders proposed contract price." (See p. 66.) In our view, this comment fails to recognize HEW Procurement Standards pertaining to records for negotiated procurements by State and local governments (45 CFR 74.157), which state that:

> "The procurement records or files of State or local government grantees for negotiated purchases in amounts in excess of $2,500 shall include the following pertinent information: * * * the basis for the cost or price negotiated."

Further, the "Truth in Negotiation Act" (P.L. 87-653) and the Federal Procurement Regulations (41 CFR 1-3.807-3), which are applicable to Federal agencies, require such agencies to obtain and analyze cost and pricing data for their negotiated procurements over $100,000. Firms making proposals for Federal contracts must also certify that their cost and pricing data is current, complete, and accurate. Had the State required HAS to submit its cost and pricing data and certify its currency, completeness, and accuracy, many of the problems that the State and we have had in reconstructing the negotiation proceedings could have been avoided.

HAS stated that, in the negotiating sessions which were open to the public, HAS spelled out how it arrived at its totals.

1/The sharing ratios for accumulated interest were changed slightly during negotiations. The revised proposal said the State would get all unused interest up to an interest rate of 5 percent and 75 percent of the interest earned above 5 percent. The contract provides that the State gets all unused interest.

The State commented that it did receive a complete disclosure from HAS on December 11. (See p. 66.) When asked what year the State was referring to, we were informed that the date of disclosure was December 11, 1975. When we pointed out that this was more than 7 months after the contract was awarded, the State said the date was December 11, 1974. When we pointed out that this was more than 1 month before HAS submitted its initial proposal, the State said the date was February 13, 1975--the day HAS submitted its revised proposal.

On April 12, 1976, the State sent us copies of the material it said it had received from HAS on February 13, 1975. 1/ This information was essentially the same as some we had obtained from HAS earlier in our review.

In its comments, the State also contends that "This yardstick was obviously used by the State of North Carolina to negotiate a value change in the amount of twenty-two million, three hundred forty-two thousand two hundred dollars."

The State cannot take both sides of the same argument. The data reportedly used by the State during negotiations to negotiate value changes of $22,342,200 clearly showed that the cost of the buy-in--as noted above--was already included in HAS' proposed price.

The State also commented that we had falsely assumed that the State's evaluation consisted of comparing the proposed contract price to the State's Medicaid budget. The State's evaluation of HAS' initial proposal, conducted by a fiscal review committee (presented on p. 18), clearly shows that the evaluation was based on a comparison of the Medicaid budget and the proposed price. Also the State's evaluation of April 21, 1975, presented to the Advisory Budget Commission to justify the contract, compared the contract price to the Medicaid budget.

BUDGET ESTIMATES WERE NOT A SOUND BASIS FOR EVALUATING CONTRACTOR'S PROPOSED PRICES

The State's fiscal years 1976 and 1977 Medicaid budget estimates were not a sound basis for determining the acceptability of the contractor's proposed prices because the estimates were based in part on inaccurate data and unsupported anticipated cost increases for program eligibles. The use of

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1/We had requested the State to provide us this information on many occasions during October and November 1975.

inaccurate cost data to project Medicare buy-in premiums may result in a $3.7 million windfall for HAS, which it could use to cover any losses it might have in other program areas or to increase its reserves which would be ultimately shared with the State.

Inflated Medicare buy-in premiums

The North Carolina Medicaid program pays a monthly Medicare buy-in premium for each Medicaid eligible that is also eligible for part B of Medicare. (See p. 2.) The State's decision to include this segment of the Medicaid program under the contract could provide HAS with a $3.7 million windfall because the base year cost data and the anticipated monthly buy-in premium rates, from which the budget projections were made, were overstated.

The projected buy-in premiums were overstated by about $1.4 million because the fiscal year 1974 cost data on which the budget was based erroneously included one month of fiscal year 1975 premium payments. Thus, data for 13 months was used to project the amount of funds needed for the buy-in program in fiscal years 1976 and 1977. The budget was overstated by $2.3 million more because the State anticipated monthly buy-in premium rates for fiscal years 1976 and 1977 that were higher than the rates established for those years.

The State budget was based on monthly buy-in premium rates of $7.57 and $8.48 for fiscal years 1976 and 1977, respectively. However, because of a technical error in the Medicare law, the premium rate for part B of Medicare was frozen at $6.70. This situation was known before contract negotiations began. The Congress amended the Medicare law in December 1975 to correct the technical error, and the monthly premium rate for fiscal year 1977 will now be $7.20. Because the Medicare buy-in premium rates were overstated, the State Medicaid budget was overstated by about $2.3 million.

In our opinion, including the cost of the Medicare buy-in program in a Medicaid insuring agreement is not appropriate. In addition to unnecessarily complicating the calculation of Federal participation by including the cost of the premium for the medically needy (as discussed in ch. 3), including the buy-in program in an insuring agreement (unless accurately priced) can be expected to produce inequities. Neither a State nor its potential contractor has any control over the amount of the Medicare premium--which is promulgated by HEW on a national basis--and the contractor has little or no

control over the number of eligibles--a significant factor under the North Carolina contract. 1/ If the budgeted buy-in premium is underpriced, the insurer would incur losses due to circumstances over which he has no control. On the other hand, if the estimated cost of the buy-in premium is overpriced, as was the case with the North Carolina contract, the insurer can receive a windfall profit not earned by program efficiencies.

State and HAS comments

In commenting on a draft of this report, the State and HAS also strongly objected to our discussion of the inflated budget estimates for the Medicare buy-in premiums.

Both the State and HAS stated that the Medicare buy-in premiums were "negotiated" into the contract at a rate of $400,000 per month. The State said actual buy-in premiums have exceeded $525,000 per month and HAS said they averaged over $540,000 per month. However, as we discussed on page 20, the Medicare buy-in premiums were not negotiated into the contract but were, in fact, included in HAS' initial and revised proposed prices. The average monthly amounts in the State budget for buy-in premiums were about $718,000 for fiscal year 1976 and $826,000 for fiscal year 1977. The average monthly amount included in the information the State said it received from HAS on February 13, 1975, was $725,000 for fiscal year 1976 and $837,000 for fiscal year 1977.

The State also pointed out that a letter it received from the Social Security Administration in February 1975 informing the State that the Medicare part B premium was frozen had led the State to believe that HEW would request congressional action to correct the error and that the premium would be raised to $7.50 as of July 1, 1975. However, we noted that the letter stated that the premium rate would remain at the existing level of $6.70 a month beginning July 1975 and that corrective legislation was planned to be requested.

The letter also stated, "The Secretary's announcement [of the $6.70 premium beginning July 1975] indicated that if he could promulgate a higher premium, it would be $7.50

1/As discussed in ch. 3, because of the way the monthly capitation rates were calculated and the limitation on total monthly premiums, the total premiums can be expected to be the same unless there is a significant decrease in the number of eligibles.

a month effective July 1975." (Emphasis added.) We do not believe this statement warranted assuming for the purpose of pricing a 2-year contract that legislation would be introduced, passed, and acted upon by July 1, 1975.

Under the Medicare law (section 1839), as amended by the Social Security Amendments of 1972, the Secretary is required during each December beginning in 1972 to promulgate the monthly premium for the 12 months commencing July 1 in the succeeding year. The premium increase cannot exceed the percentage by which Social Security cash benefits have been increased since the premium was last increased.

Because of a change in the law in December 1973 (Public Law 93-233) governing the determination of social security cash benefits, it was impossible for the Secretary to determine in December 1974 what Social Security cash benefits would be for the following June. Thus, the $6.70 premium rate for fiscal year 1975 could not be increased without a change in the law.

On January 7, 1975, the Secretary's notice, dated December 30, 1974, of the $6.70 part B premium rate for fiscal year 1976 was published in the Federal Register. Therefore, the fact that the premium would not increase in July 1975 and the reason therefore was a matter of public record months before the contract with HAS was negotiated.

Furthermore, as previously discussed, we do not believe that the buy-in program should have been included in the insuring contract.

Unsupported projected budget increases

The projected payments for fiscal years 1976 and 1977 to providers of medical services were calculated by adding to prior year payments anticipated increases for inflation, the rate of program utilization, and the number of eligibles. Some of the projections for anticipated increases, however, were unsupported estimates.

The base data was increased by 13 percent in fiscal year 1976 and 12 percent in fiscal year 1977 for inflation and an additional 3 percent in each of the two fiscal years for increases in the number of program eligibles. An additional 1 percent for an increase in the rate of program utilization was included in the fiscal year 1976 projections. It was assumed that all Medicaid eligibles would know about the program by the end of fiscal year 1976 and that there would be no further increase in the rate of utilization.

State officials said that the inflation factors used were based on the latest published annual increase in the consumer price index for medical care at the time the budget was initially prepared. The officials added that the projected increases in the rate of utilization and in the number of eligibles were management judgments and were not statistically derived. Attempts by State officials, and by us, during our review to validate the source and basis of these estimated increases were unsuccessful.

CONCLUSIONS

The State's procurement practices did not insure either maximum competition or adequate evaluation of HAS' proposal.

Competition was limited as a result of the innovative nature of and risks involved in the procurement. Competition was further limited because:

- --The request for proposals did not include all the data necessary to determine capitation rates and to respond to the request for proposals. This led some firms to conclude that the venture was too risky.

- --Of the uncertain legal climate surrounding the State's ability to award such a contract at the time the request for proposals was issued and responses were required.

- --Insurance companies were placed at a competitive disadvantage because the State's insurance laws required them to have contingency reserves while noninsurance companies did not have to meet this requirement.

- --Some firms believed that the State had preselected a contractor.

- --The State made a questionable selection of firms to which the request for proposals was sent.

In our view, procurement practices could be improved and greater competition fostered by assuring that (1) the request for proposals included the data necessary to respond to it and (2) all potential offerors have access to and are provided with the same data with which to prepare proposals. Also, legal questions concerning a State's ability to enter into a particular contract and the applicability of laws to certain classes of potential offerors should be resolved before proposals are requested.

The State's evaluation of HAS' proposal essentially consisted of comparing it to the State's Medicaid budget. In our opinion, the Medicaid budget was not a sound basis on which to determine the reasonableness of the proposed prices because the budget estimates were based, in part, on inaccurate and unsupported cost and eligibility data. Further, the State's final negotiation efforts appeared to be directed toward matters already in the original and/or revised proposal.

Although the profit-sharing arrangement under the contract (75 percent to the State and 25 percent to HAS) might mitigate the impact of any overpricing, we believe that such an arrangement is not an adequate substitute for sound contract pricing at the time of award.

CHAPTER 3

SOME CLAIMED BENEFITS OF INSURING AGREEMENT ARE NOT ASSURED

In seeking approval for the contract from the State Advisory Budget Commission on April 25, 1975, State officials claimed that the insuring agreement with HAS would

--reduce the State's biannual Medicaid budget for fiscal years 1976 and 1977 by $4.4 million,

--place a $376 million ceiling on Medicaid expenditures (excluding drug and State administration costs) for fiscal years 1976 and 1977, 1/ and

--provide better and more comprehensive program data and improve medical and utilization review, resulting in more effective program management and additional program savings.

Our analysis of the claimed benefits showed that (1) about half of the reduction in the State's Medicaid budget will probably not materialize because the State erroneously assumed that under an insuring agreement the Federal Government would participate in the Medicare buy-in premiums for the medically needy, (2) the "ceiling" on Medicaid expenditures has been modified upwards under the terms of the contract, and (3) whatever improved controls may come about will result more from programs that were either in effect or planned when the insuring agreement was signed rather than from the underwriting feature of the agreement itself.

REDUCTION IN THE STATE'S MEDICAID BUDGET

In addition to the budget reduction for savings attributed to improved utilization review programs discussed in the previous chapter, the State reduced its Medicaid budget for fiscal years 1976 and 1977 by about $4.4 million, concurrent with the award of the contract to HAS. The net reductions in the State budget directly attributed to the contract by the State are summarized in the following table.

1/The total contract amount was $405 million, which included estimated costs of $29 million for May and June 1975, during which HAS acted as a fiscal agent for the State.

Budget subprograms	Source of funds State	Federal	Local	Total
	(000 omitted)			
General administration and support:				
Reduction in administrative expenses (note a)	$(1,084)	$(1,688)	$ -	$(2,772)
Medical services payments:				
Increases in participation in medical services payments by Federal or local governments (note b)	(3,218)	3,450	265	497
Reserves and transfers	(91)	(91)	-	(182)
Net	$(4,393)	$ 1,671	$265	$(2,457)

a/The Department of Human Resources planned to reduce its Medicaid administrative and training staff from 179 to 32. This planned reduction enabled the State to reduce its budgeted administrative costs by about $2.8 million.

b/The medical services payment portion of the State budget includes payments directly to providers, Medicare part B buy-in premiums, and health insurance premiums.

As indicated by the table, the major item of expected savings ($3.2 million) involved a reduction in the State's medical services payments. Although the State could not provide us with the details of this adjustment, 1/ State agency officials advised us that it principally consisted of

--changing the rate of Federal financial participation for family planning services and

--including as one of the items covered by the contract the cost of Medicare "buy-in" premiums for the medically needy Medicaid eligibles.

A discussion of these changes and our evaluation of the impact are summarized below.

1/In February 1976 we reconstructed the State's computations using its original assumptions. The reconstructed net reduction in the State's budget was about $5.4 million instead of the $4.4 million presented to the State Advisory Budget Commission. (See p. 75.)

Changing the rate of Federal financial participation for family planning

The percentage of Federal financial participation in a State's Medicaid expenditures is established by the Social Security Act. Federal financial participation in payments for Medicaid services is determined by comparing the State's per capita income with per capita income nationwide. The Federal medical assistance percentage for North Carolina during fiscal year 1976 is 68.03 percent. The act establishes specific rates for Federal financial participation in certain other allowable Medicaid costs. For example, general administrative costs are reimbursed at 50 percent, some training costs at 75 percent, and family planning costs at 90 percent.

HEW regulations allow Federal cost sharing at the medical assistance percentage for total premiums paid to a health insuring organization for carrying out all the provisions of the contract, including administration, training, and family planning. Therefore, under the contract with HAS, the Federal Government reimburses the State at the medical assistance percentage for the premiums paid to HAS even though the contract covers services that would be reimbursed at different rates under a State-administered program.

Based on the State budget estimates for fiscal years 1976 and 1977 and on the change in the Federal participation in family planning services, State costs would be increased by about $1.7 million.

Medicare buy-in premiums

Under the Medicare buy-in program, States may enroll certain needy aged or disabled people under the Supplemental Medical Insurance (SMI) program (part B of Medicare) and pay their premiums to SSA. The monthly premiums paid on behalf of recipients of SSI or State supplemental SSI payments or money payments under the Aid to Families with Dependent Children program (referred to as categorically needy individuals) are considered medical services payments and are subject to the Federal matching formula applicable under the Social Security Act. However, Medicare premium payments made on behalf of individuals who are not eligible

for welfare payments (the medically needy individuals) are generally not subject to matching Federal payments. 1/

The contract with HAS includes payments to SSA for Medicare buy-in premiums for both categorically needy individuals and medically needy individuals.

As discussed on page 23 the original State budget amounts for the medically needy buy-in premiums were grossly overstated. Nevertheless, on the basis of the initial State budget, the estimated cost of the premiums of the medically needy for fiscal years 1976 and 1977 was about $8.5 million, of which the State expected to receive a Federal share--at the fiscal year 1976 medical services payment rate of 68.03 percent--of about $5.8 million. Thus, including such premiums in the cost of the insuring agreement was apparently intended to transfer about $5.8 million in budgeted costs from the State to the Federal Government.

At December 31, 1975, HEW had reimbursed the State for the contract premiums paid to HAS during July, August, and September 1975. During those 3 months, HAS had paid SSA about $466,000 in buy-in premiums for the medically needy. Thus, Federal funds of about $317,000 had been paid out for the medically needy buy-in costs not subject to Federal participation.

1/The Congress' rationale for not making the buy-in premiums for the medically needy eligible for Federal participation under Medicaid was contained in the reports of the House Committee on Ways and Means and of the Senate Committee on Finance on the Social Security Amendments of 1967 (P.L. 90-248), which initially extended the buy-in coverage to the aged, non-cash-assistance Medicaid eligibles. (H.R. Rep. No. 544 and S. Rep. No. 744, 90th Cong. 1st Sess.). The House report stated:

> "Your Committee believes that it is very much to the advantage of States to cover their medically needy aged under the SMI program, under which one-half of the cost is met from general revenues. It accordingly does not believe that it is appropriate for States to receive also Federal financed participation on the $3 monthly premium they pay on behalf of medically needy persons and the bill so provides."

The Senate report contained similar language.

We brought this matter to the attention of the SRS Associate Regional Commissioner for Mangement Services in December 1975. He agreed to collect the $317,000 overpayment from the State and to disallow future claims by the State for Medicare buy-in premiums for medically needy individuals.

Over the life of the HAS contract, we estimate that the premiums for the medically needy should total about $3.8 million, of which the Federal share would have been about $2.6 million. Assuming that HEW disallows such amounts for Federal participation as it has stated it will, a substantial portion of the benefits expected to accrue to the State from including the medically needy buy-in premiums in the insuring agreement will not materialize.

CEILING ON EXPENDITURES

In seeking approval of the State Advisory Budget Commission, the State agency told the Commission on April 25, 1975, that the insuring agreement with HAS would place a $376 million ceiling on the State's obligation for Medicaid expenditures under the contract, irrespective of the effects of inflation, increased utilization, or increased number of eligibles. Although the maximum monthly payment feature of the contract does provide some control over expenditures, we believe that the claimed benefit of a "ceiling" on expenditures should be qualified because the contract provides for the renegotiation of the maximum payment. In this regard, the contract price has already been increased by an estimated $6.7 million (Federal share $4.5 million) because of two contract modifications. Also, conflicting clauses dealing with contract renegotiation could result in further increases in program costs. Further, because the capitation rates specified in the contract were set in such a manner that payment of the maximum premium is virtually assured, only a substantial reduction in the number of eligibles would reduce the total contract price.

In addition, after we informed the State that an intended contract provision designed to minimize the State's yearend settlement costs was omitted from the final negotiated contract, the State included the provision in the contract.

Contract modifications increase costs

In North Carolina the maximum daily payment that Medicaid can make to skilled nursing facilities (SNFs) is set

by State law. 1/ Effective July 1, 1975, the North Carolina General Assembly amended the State law to increase the maximum daily payment from $25 to $28. The act granting this increase cited as the reason for the increase "pressure created by an inflationary economy."

Because of the increased maximum daily payment rate, the State and HAS negotiated a contract modification which requires the State to reimburse HAS for all interim payments to SNFs exceeding the old $25 a day maximum. HAS estimated that these State reimbursements which are in addition to the monthly premiums would total about $3.2 million over the life of the contract.

In addition, because the maximum daily payment rate for intermediate care facilities (ICFs) is established as a percentage of the maximum SNF rate, the State and HAS negotiated a contract modification under which the State is obligated to reimburse HAS for interim payments to ICFs exceeding the maximum amount allowed before the ceiling on SNF payments was raised. HAS estimated that these additional reimbursements above the premium payment would amount to about $3.5 million during the contract period.

Thus, the two contract modifications negotiated after the law setting maximum daily payment rates was amended have increased State Medicaid liabilities by an estimated $6.7 million. The Federal share of the increase would be about $4.5 million. 2/

Conflicting contract renegotiation clauses

The contract changes covering additional costs for increased payments to SNFs and ICFs were negotiated under article V, section 2, item 16, of the contract, which states:

1/SNFs are reimbursed by Medicaid on the basis of their actual reasonable costs, subject to the ceiling contained in State law. These facilities are paid on an estimated cost basis--called interim payments--during the year with retroactive adjustments made at the end of the year based on actual allowable costs. Under the insuring agreement the State is liable for the costs of these retroactive adjustments.

2/As of April 1976, no payments had been made under these modifications. However, HAS had submitted a bill totaling about $367,000 which had not been paid.

"It is understood that the monthly capitation rates and the limitations on total monthly payments stipulated in Article VI hereof are based on the [Social Security] Act, [Federal] Regulations, North Carolina law and the State Plan, all as effective January 14, 1975. If there should be a proposed change in any of the foregoing which is likely to increase or decrease the cost of this program, either party shall have the right to renegotiate the capitation rates and limitations on total monthly payments subject to the change becoming effective."

This contract clause apparently intends to allow renegotiation of the contract price for any change, affecting program costs, in title XIX, Federal regulations, State law, or the State Medicaid plan. However, another contract clause dealing with renegotiations (article V, section 2, item 19) appears to limit price renegotiation to cases where the amount, duration, or scope of services under Medicaid change or where additional administrative services are added to the contract. This clause states:

"Increases in the capitation rates and limitations on total monthly payments provided for in Article VI, during the contract period shall only be to cover increased cost resulting from increases in amount, duration, scope of services or administrative services added to the Contract and not heretofore covered." (Emphasis added.)

Because the change in maximum daily payment rates to SNFs did not affect the amount, duration, or scope of services or administrative duties, we believe that this clause would not have permitted renegotiation.

Thus, while one contract clause provided for renegotiation under certain circumstances, another appears to preclude renegotiation under those circumstances. The contract was, in fact, renegotiated upward because of the pressures of inflation and resulting changes in State law. It seems to us that unless the amounts payable under an insurance contract can be insulated from the effects of inflation in the cost of medical care, there can be no firm ceiling on program costs.

State and HAS comments

Regarding our discussion of these two renegotiation clauses, the State and HAS commented that it is appropriate to include in an insurance contract a renegotiation clause which applies when changes are made to the program which

affect program costs. We agree that it was appropriate to include a renegotiation clause to cover situations in which program changes materially affect program costs. However, we do not believe it appropriate to include two renegotiation clauses with conflicting criteria for situations under which renegotiations could be undertaken.

The State also commented that the first clause identifies existing Federal and State laws in effect at the time of contract award, while the second clause allows for changes resulting from changes in State law. Therefore, the State concluded that no conflict existed between the clauses. However, the first clause not only identified exising Federal and State laws (and Federal regulations and the State Medicaid plan), but also provided for renegotiation for any change in the laws, regulations, or State plan which would increase or decrease the cost of the State's Medicaid program. The second clause permits renegotiation to increase payments to HAS only in cases in which the amount, duration, or scope of services provided under the State's Medicaid program are increased or where additional administrative duties are placed on HAS. Thus, we believe there is a conflict between the two clauses with regard to renegotiations to increase payments to HAS. The first clause permits renegotiations for any change in the cited laws, regulations, or State plan which increase program costs, while the second clause allows renegotiations only if the changes made also increased the amount, duration, or scope of services or placed additional administrative duties on HAS.

Payment of maximum monthly premium is virtually assured

The contract calls for the State to pay in fiscal year 1976 a monthly premium of $54.30 for each eligible individual, not to exceed a monthly total of $14.66 million. In fiscal year 1977, the monthly premium and maximum are $61.70 and $16.66 million, respectively. The monthly premium rates were established so as to virtually assure that HAS would receive the maximum amount each month.

HAS had initially proposed a 13-month contract with different per capita payment rates for each of the several categories of persons covered by the Medicaid program, but had not proposed a maximum contract amount--the total contract amount being dependent upon the number of persons eligible for the program. However, based upon the estimated number of eligible persons shown in the request for proposals for each of the aid categories--a total of 312,612 for fiscal year 1976--the estimated total monthly payments under the proposed per capita rates would have been about $14.66 million.

Because the State agency wanted to contract for 2 fiscal years and to place a ceiling on the monthly premium payment, HAS revised its proposal to provide for a 2-year contract with fixed monthly group premiums of $14.66 million in fiscal year 1976 and $16.66 million in fiscal year 1977. (HAS' proposals are discussed further on pp. 16 to 22.)

The HEW regional office staff questioned whether paying a fixed group premium as proposed by HAS would satisfy the Federal regulations applicable to insuring arrangements, which specified that in such arrangements a State must pay a monthly premium "for each eligible individual." Apparently to satisfy the HEW regulations, HAS developed the monthly capitation rates specified in the contract.

In developing these rates, however, HAS did not use the estimated numbers of eligible persons which had been shown in the request for proposals for fiscal years 1976 and 1977--312,612 and 321,991, respectively. Instead, HAS used a 270,000 estimate which HAS officials said was derived from information for July through October 1974 contained in the request for proposals. The capitation rate specified in the contract for fiscal year 1976 was derived by dividing the estimated monthly cost of $14.66 million--which had been derived based upon 312,612 eligible persons--by 270,000 eligible persons ($14,660,000 ÷ 270,000 = $54.30). The capitation rate for fiscal year 1977 was also based on 270,000 eligible persons.

Thus, HAS will be paid the maximum monthly premium provided for in the contract unless the number of persons eligible for Medicaid falls below 270,000. Information furnished by State agency officials shows that the number of eligible persons has not been below 270,000 since April 1971. We think it reasonable to expect that the number will stay above that limit for the life of the contract.

Contract clause omitted

An intended contract provision which would have required that the interim rates to be paid by HAS to ICFs be partly based on the latest published annual increase in the "all items" consumer price index was inadvertently left out of the final version of the contract. As a result, the interim rates were established using a 5-percent inflationary factor, while the applicable consumer price index averaged about 8.4 percent between May and November 1975.

Since the State is liable under the contract for year-end cost settlements to ICFs and other providers paid on an interim rate basis, it is to the State's advantage to have

interim rates set as close to actual costs as possible. To the extent that omitting the inflation clause resulted in payments to ICFs below their actual costs, the State would become liable for increased yearend settlement costs subject to the State's maximum daily payment rate.

The State had not assessed the financial effect of omitting the clause from the contract. Our estimates showed that the omission could have increased the costs of final settlements with ICFs by as much as $1.1 million (Federal share $770,000) over the life of the contract.

State officials were aware in December 1975 that this provision had been omitted from the contract but had not acted to correct the situation. When we brought the matter to the attention of top mangement of the State agency on January 29, 1976, the State requested--and HAS agreed--that the clause be included in the contract retroactively effective to July 1, 1975.

MORE EFFECTIVE PROGRAM MANAGEMENT

The State agency expects the insuring agreement to provide better and more comprehensive program data and improved medical and utilization review, which will result in both improved medical service to program recipients and reduced costs to government. We agree that the potential is present for such benefits over the life of the contract; but the benefits will come from programs which existed or were planned and which are quite unrelated to the underwriting or risk feature of the insuring agreement.

These benefits are expected to accrue from implementation of (1) MMIS, which should provide better management data necessary for more effective program control, and (2) an expanded utilization review program, which should provide opportunities for improving the quality of health care and for reducing overall program costs.

Medicaid Management Information System

MMIS is a sophisticated computer system designed by HEW for processing and controlling Medicaid payments and for providing the management data necessary for program planning and control. North Carolina began in July 1972 to develop a request for proposals for a contract to implement MMIS. This attempt was terminated by the then secretary of the State agency. In July 1974 the State agency again began to develop a request for proposals for MMIS implementation and awarded a contract to HAS to prepare the request. This project was

canceled when the State agency decided to combine MMIS implementation into the request for proposals for an insuring agreement.

MMIS provides programs for use in claims processing which should facilitate identification and elimination of duplicate payments, payments on behalf of ineligible recipients, payments for noncovered services, and payments at excessive rates. It also includes programs for analysis of provider and recipient patterns of use which, in conjunction with the work of the North Carolina Medical Peer Review Foundation (discussed below), should identify and correct instances of overutilization or improper utilization of the program.

The MMIS installed by HAS for use during the insuring agreement is the general MMIS developed by HEW modified to suit conditions in North Carolina.

Medical and utilization review

The basic purpose of medical and utilization review is to monitor the quality and appropriateness of health care provided to Medicaid recipients. Such reviews in North Carolina are carried out by the North Carolina Medical Peer Review Foundation, a private, not-for-profit corporation with over 1,500 physician members.

The State agency contracted with the Foundation in March 1974 to develop, implement, and operate a long-term care review program for monitoring the quality and the utilization of services in SNFs and in psychiatric and tuberculosis hospitals. The contract was amended in Janaury 1975 to provide for a hospital admissions review program.

The State estimated that these two programs would reduce Medicaid costs for fiscal years 1976 and 1977 by about $7 million. A State agency document dated April 25, 1975, which summarized the recommended Medicaid budget reductions, separated this $7 million savings attributed to utilization review from those attributed to entering into the contract with HAS.

HAS is responsible under the insuring agreement for conducting the long-term care and hospital admissions review programs. In accordance with the contract, HAS has subcontracted this activity to the Foundation.

CONCLUSIONS

Although the insuring agreement has not been in operation long enough to assess its overall effectiveness, apparently, except for the estimated reduction in State administrative costs resulting from the planned 147-person reduction in State staff, the cost savings expected by the State through increased Federal participation will not materialize. Also, the contract modifications have resulted in cost increases and the provisons in the contract dealing with renegotiation are sufficiently conflicting to make further increases possible.

The maximum monthly premium provides the State with protection against the costs that could result if the number of recipients increases. However, a 15-percent decrease in the number of recipients--to the April 1971 level--would be needed to result in a decrease in the monthly premium.

The improvements in program management and control claimed by the State are not a direct result of having an insuring agreement because theoretically they could also be derived under a State-administered program or fiscal agent arrangement.

The State agency, in commenting on a draft of this report, said that it believed that the contract had already resulted in a significant cost reduction. Although we did not attempt to evaluate the effectiveness of the contract during our fieldwork because it had not been in effect long enough, we did obtain data on which to analyze the State's claim. The State's comments and our analysis are presented in chapter 6.

CHAPTER 4

HEW'S INVOLVEMENT IN CONTRACT DEVELOPMENT AND AWARD

For all practical purposes, HEW did not participate in the State's activities until after HAS submitted its proposal. Social and Rehabilitation Service regional officials reviewed the proposed contract and were instrumental in getting some changes made. When the contract was awarded, Federal regulations did not require HEW approval of contracts of this kind. Accordingly, the State did not submit the contract for HEW's approval. The Regional Commissioner of SRS did write to the State agency, however, to advise that the contract met Federal requirements and to support the concept of an insuring agreement for administration of a State's Medicaid program.

INVOLVEMENT IN PRESELECTION ACTIVITIES

Both HEW and State officials told us that the State did not seek HEW's assistance in preparing the request for proposals. According to the State officials, they had not consciously excluded HEW, but just had not thought about it.

As stated on page 10, the State asked the regional SRS medical services representative to suggest firms to which the request for proposals might be sent, and the HEW representative made some suggestions.

The State sent a copy of HAS' proposal to the SRS Regional Commissioner on January 29, 1975, and asked the Commissioner to "provide any representation you feel is appropriate in the deliberations for contracting."

Regional SRS management services personnel said they made a limited review of HAS' proposal, but they had no records of the review. They said the review was not carried to the point of reaching conclusions concerning reasonableness of the proposed premium rates.

Rather than concentrating on a review of HAS' proposal, they had concentrated their effort on reviewing a consultant's January 2, 1975, report, on which they thought the State was going to rely in deciding whether to enter into an insurance contract.

On February 11, 1975, the SRS Regional Commissioner wrote to the State agency about the consultant's report and HAS' proposal, stating that

--some of the conclusions in the consultant's report appeared to be erroneous and that it would be premature for the State to act on them before the questions were resolved and

--in many areas the language of HAS' proposal was too general (for example, stating that the contract could be terminated for good cause but not specifying what would constitute good cause or who would make the final determination as to whether good cause existed).

The Regional Commissioner suggested that the State thoroughly analyze adoption of the prepaid contract approach, determine those general provisions of the proposal which would have to be more specifically stated in the contract, and develop appropriate provisions to protect both the State and Federal interests. In this regard, she stated that SRS could not accept a possible financial loss by the contractor as constituting good cause for termination.

A State agency official said that he believed that SRS officials were overly concerned with the accuracy of information contained in the consultant's report and had misinterpreted the purpose of the consultant's study. He said the study was intended to provide guidance and assistance in obtaining a prepaid insuring arrangement and not to form the basis for a decision about whether or not to enter into such an arrangement--a decision that he said was made in October 1974 subject to the State's ability to obtain an acceptable contract.

INVOLVEMENT IN CONTRACT NEGOTIATIONS

HEW's involvement in developing and negotiating the final contract was greater than its involvement in preselection activities. Numerous meetings were held involving the regional SRS staff and State personnel during preparation of several drafts of a contract. State and SRS correspondence and records of several meetings during February and March 1975 show that SRS raised several questions about the contract. Probably the most important policy question raised by the HEW regional staff concerned the acceptability of the group premium provided for in HAS' revised proposal. Indicative of other concerns expressed are those stated in a March 12, 1975, letter from the Regional Commissioner of SRS to the State agency. Areas discussed included:

--The difficulties in closely estimating the cost of a prepaid plan before the specific functions and duties of the State and of the contractor have been fully identified and assigned.

--The need for the State to maintain an adequate contract monitoring staff.

--The need for the State to determine whether the selected contractor was to be considered an insuror or a fiscal agent.

--The need for the State to look closely at the amount of anticipated savings, since most of those savings were based on a large reduction in the State staff and the cost of performing the functions of the State staff would become a part of the contractor's administrative costs.

--The need for the State to be prepared for a time to pay both the premium to the contractor and the cost of claims for services provided before the effective date of the contract.

According to the State's chief negotiator, the regional SRS medical services representative had been instrumental in assuring that the contract contain terms and provisions to protect the interests of both the Federal and State governments (for example, provisions for audit of the contractor by both Federal and State agencies, termination clauses, and a requirement for a performance bond). The SRS representative was present during negotiations between the State and HAS as an observer and as an advisor to the State, but he did not actually participate.

In April 1975 HEW headquarters representatives also reviewed the proposed contract. Probably the most serious question considered in their review was whether the provision for the State to be responsible for making yearend cost settlements with institutional providers violated the HEW regulations pertaining to insuring agreements.

HEW regulations provided that, for an insuring agreement to exist, the premium payment must constitute "full dischange of all responsibility by the State for costs of covered medical care and services." The SRS region believed that the contract satisfied this regulation because the premium covered the cost of all services covered by the contract because yearend cost settlements were not a covered service. However, the HEW General Counsel's office believed that the contract did not meet the requirement since the State responsibility for yearend settlements meant the premium did not discharge the State of all responsibility for the cost of covered services provided to institutionalized recipients.

However, because of changes to the applicable regulations (published in the Federal Register on May 9, 1975, and effective Aug. 9, 1975), the point became moot and the General Counsel's office dropped its objection.

The SRS Regional Commissioner wrote to the State agency advising it that HEW had determined that the contract, for the period beginning July 1, 1975, met the requirements of Federal regulations for a health insuring arrangement. This had the effect of approving the contract for Federal participation. In this letter she stated,

> "* * * We appreciated the opportunity to participate with you and provide technical assistance in the preparation of the proposed contract between your Agency and Health Application Systems, Inc. We view this contract as an innovative approach to the administration of the Medicaid Program and support the concept of a pre-paid capitation arrangement which is one of several options available to the State * * *."

CONCLUSIONS

HEW had not participated extensively in the State's activities before the development and negotiation of the final contract. SRS regional office and headquarters officials did review a draft of the contract and assist the State in contract negotiations, but the proposed contract was not specifically approved by them because HEW regulations then in effect did not require prior HEW approval. However, HEW did approve the insurance arrangement for Federal financial participation. HEW amended its regulations, effective August 9, 1975, to require prior HEW approval for State Medicaid contracts exceeding $100,000.

CHAPTER 5

PROVISIONS FOR MONITORING THE CONTRACT

Through November 1975 the State's monitoring had been limited, but its provisions and preparations for monitoring should result in adequate oversight of the contractor's performance. The SRS regional staff did not plan any special monitoring of the contract. HEW headquarters issued a request for proposals on April 2, 1976, for a contract to have a private consultant evaluate the efficiency and effectiveness of the contractual operation.

STATE MONITORING ACTIVITIES

At the time the contract was awarded, the State Department of Human Resources reorganized its Medical Services Section and the Medical Assistance Accounting Branch of the Comptroller's Section to function as contract monitors and reviewers rather than as program administrators. The Medical Services Section was made responsible for monitoring and reviewing the programmatic aspects of the contract, and the Medical Assistance Accounting Branch was made responsible for monitoring and reviewing the fiscal aspects.

Monitoring both aspects of the contract will depend heavily on reports produced by the MMIS. State officials said, however, that through November 1975 the reports submitted by HAS had been of little value because they had been untimely, inaccurate, inconsistent, and incomplete.

Through November 1975 the Medical Services Section had devoted most of its time to learning how the MMIS operates and to rearranging and correcting information in reports produced by the system. The section had not developed a formal plan for program oversight. However, selected individuals within the section had been assigned areas of responsibility corresponding to specific reports produced by the MMIS, and an overall program surveillance plan was being developed. Also, to insure monitoring proficiency, the section planned to provide an ongoing training program.

The staff assigned to fiscal audits had spent most of its time reviewing and analyzing general and administrative expenses claimed by HAS for the fiscal agent period of the contract, evaluating and determining interim reimbursement rates to institutional providers, and reviewing yearend cost settlements with institutional providers.

In November 1975 the staff completed a detailed evaluation of all HAS' general and administrative expenses charged through

August 1975 to the fiscal agent period of the contract. They questioned more than $420,000 of the $1.33 million claimed by HAS and recommended that these expenses be disallowed. HAS believes it has adequate documentation to support these expenses.

The staff also questioned whether HAS was complying with the contractual requirement that the contractor maintain commercially acceptable accounting records in its Raleigh office. Their evaluation of general and administrative expenses did not include a test of cash disbursement because the checks, cash disbursement journals, and related records were in California. Payments for these expenses are made through a central disbursement system at Bergin-Brunswig Corporation in California. The staff further questioned the adequacy of HAS' North Carolina accounting system because

--the accounting records for the Medicaid program were maintained in a set of books with other HAS-administered programs,

--HAS provided the State only photocopies of California-originated invoices, and

--the records were not sufficient to permit adequate evaluation of the allocation of some general and administrative expenses.

These questions had not been resolved at completion of our fieldwork in February 1976.

In commenting on our draft report, the State said that HAS has agreed to finance visits to its headquarters in California by State employees to audit the disbursement records. HAS said that it believes the use of its central disbursement system in California represents an efficiency of operation and reduces program costs.

For August 19 through October 15, 1975, the staff found that HAS had underpaid 58 ICF providers by $168,207. The underpayments resulted primarily from HAS' failure to adequately update its reimbursement records. As discussed on page 36, if HAS is allowed to pay providers at less than the established interim rates, the State's Medicaid costs will be increased to the extent of such underpayments because the contract requires the State to make final yearend cost settlements. HAS commented that the underpayments to the 58 ICFs have been entered into the adjustment system and that proper payments and adjustments will be made. HAS also said that it had not purposely tried to undercompensate any providers.

HEW'S MONITORING ACTIVITIES

HEW headquarters issued a request for proposals on April 2, 1976, for a contract to have a private consultant evaluate the efficiency and effectiveness of the contract. The SRS regional office had provided a draft request for proposals for headquarters' use in soliciting proposals from consultants.

According to the regional SRS medical services representative to North Carolina, he plans to make two trips a month to North Carolina, instead of his usual one, to determine whether the State's Medicaid program is in compliance with the State plan and to provide technical assistance.

SRS regional financial management services had not formulated special plans for reviewing North Carolina's program.

CONCLUSIONS

We were unable to determine the sufficiency of overall contract monitoring because, at the time of our fieldwork, HEW had not formalized its oversight procedures and the State had not fully implemented its plan for monitoring contract performance. However, the State plan appears to provide for sufficient program and fiscal oversight and review if it is fully implemented.

CHAPTER 6

ANALYSIS OF FINANCIAL PERFORMANCE UNDER THE CONTRACT

The State agency claimed in its March 31, 1976, comments on a draft of our report that Medicaid program costs on a cash basis had been reduced by $8.2 million during the September 1975-February 1976 period compared to fiscal year 1975 costs under the State-administered program. We analyzed the data the State used to estimate this cost reduction and obtained additional data from HAS to determine the validity of the State's claim. Our analysis showed that the State estimate was not valid and that, in fact, HAS' Medicaid program costs on an adjusted cash basis were higher by about $8 million under the contract than at the State-administered program average cost in fiscal year 1975. In addition, our analysis showed that HAS was having serious cash flow problems under the contract. Also, in May 1976 the contractor notified the State it was contemplating termination because of possible losses under the contract.

BASIS FOR STATE'S ESTIMATE OF COST REDUCTIONS

In commenting on a draft of our report, the State said that it had analyzed data for fiscal year 1975 and determined that the cost per eligible per month had been $46.25. For a 6-month contract period, September 1975 through February 1976, the State said the cost under the contract had been $42.21 per eligible per month. According to the State, the lower cost per eligible under the contract resulted in a cost reduction of $8,241,600.

During our fieldwork, we did not attempt to evaluate the financial performance under the contract because the contract had not been in effect long enough to permit a fair evaluation. However, because the State raised the issue of financial performance, we analyzed the available data to determine the validity of the State's estimate of cost reductions.

We obtained from the State agency the data on which it based its estimate. The State's analysis, which was on a cash or benefits paid basis, was as follows.

State's Estimate of Cost Reduction During the September 1975-February 1976 Contract Period

	Fiscal Year 1975		September 1975-February 1976	
	Total cost	Cost per eligible per month	Total cost	Cost per eligible per month
Payments to providers (including Medicare buy-in premiums)	$151,851,000	$42.68	$79,814,000	$39.12
Yearend settlements with providers	7,356,000	2.07	-	-
State administration costs	5,337,000	1.50	1,331,000	.66
HAS administration costs	-	-	4,965,000	2.43
Total costs included	$164,544,000	$46.25	$86,110,000	$42.21

The State included yearend settlement costs in its fiscal year 1975 analysis, but not in its contract period analysis. Also, the State administration costs were not on the same basis for the two periods. To make the cost per eligible per month comparable, we deleted the yearend settlement costs from the fiscal year 1975 data and adjusted the State administration costs to reflect total State and local administration costs during the two periods. These adjustments resulted in cost per eligible per month estimates of $45.60 for fiscal year 1975 and $43.61 for the 6-month period as follows.

Adjusted Cost per Eligible per Month

	Fiscal Year 1975		September 1975-February 1976	
	Total cost	Cost per eligible per month	Total cost	Cost per eligible per month
Payments to providers (including Medicare buy-in premiums)	$151,851,000	$42.68	$79,814,000	$39.12
State and local administration costs	10,373,000	2.92	4,197,000	2.06
HAS administration costs	-	-	4,965,000	2.43
Total costs included	$162,224,000	$45.60	$88,976,000	$43.61

ADDITIONAL INFORMATION REFLECTING ON THE STATE'S ESTIMATE OF COST REDUCTIONS

We obtained additional information from HAS which affects the validity of the State's estimate of cost reductions. Because of problems in implementing the MMIS, HAS accumulated a large backlog of unprocessed claims between September 1, 1975, and February 29, 1976. Because of this backlog, HAS advanced certain providers funds against their unprocessed claims. The advances were not recorded as expenditures in HAS' accounting records or reported to HEW, but were shown as accounts receivable from the providers.

Providers' accounts receivable balances were reduced when backlogged claims were eventually processed. Between August 31, 1975, and February 29, 1976, accounts receivable from providers increased from about $1.2 million to $8.6 million, which had the effect of deferring the reporting of $7.4 million in Medicaid payments to the period beyond February 1976. This resulted in HAS underreporting its costs for the September-February period. Thus, the cost per eligible per month used by the State in its analysis of cost reductions was understated.

During March 1976, HAS paid $28.9 million in Medicaid claims, and this large payout supposedly cleared up most of the backlogged claims. The accounts receivable balance

at March 31, 1976, was $3.6 million, indicating that $5 million of the backlog that existed at the end of February had been liquidated.

Another factor which affects the cost per eligible per month used by the State in its analysis of cost reductions is the claims held in suspense by HAS. Suspended claims are those on which payment is being withheld pending determination of recipient eligibility or of whether the claim is a duplicate or for other reasons. The balance in the suspended claims account on February 29, 1976, for the period September 1975-February 1976 was $9.5 million. The balance on March 31, 1976, was $9.7 million. HAS estimates that 65 percent of the value of these suspended claims will eventually be paid.

The following table shows the effect of including the advance payments for unprocessed claims backlog and the suspended claims on the cost per eligible per month.

Computation of Average Cost Per Eligible Per Month (Adjusted Cash Basis)

	September 1975-February 1976		September 1975-March 1976	
	Total cost	Cost per eligible per month	Total cost	Cost per eligible per month
Payments to providers (including Medicare buy-in premiums)	$ 79,814,000	$39.12	$108,881,000	$45.75
State and local administration costs	4,197,000	2.06	4,977,000	2.09
HAS administration costs	4,965,000	2.43	5,508,000	2.31
Net increase in advance payments to providers	7,360,000	3.61	2,288,000	.96
65 percent of the value of suspended claims	4,645,000	2.28	6,360,000	2.67
Total	$100,981,000	$49.50	$128,014,000	$53.78

Thus, the cost per eligible per month used by the State in its analysis of cost reductions did not accurately reflect what was paid or due providers during the period. The cost

per eligible amounts we derived above indicate that costs under the contract for the September-February period exceeded the cost per eligible amount during fiscal year 1975 and that Medicaid program costs have increased by about $8 million. Over the September-March period, the indicated increase is about $19.5 million.

Although we believe our analysis of Medicaid costs under the contract more accurately reflects the actual experience than does the State's analysis, neither fully reflects State costs under the contract. During the 6-month period, the State paid HAS a monthly premium of $14,660,000, or a total of $87,960,000, and the State and local governments had administrative costs of $4,197,000. To these costs, an allowance should be added for payments to SNFs and ICFs resulting from the contract modifications discussed on pages 32 and 33. Since the State had not yet reimbursed HAS for these payments, we prorated the total estimated costs over the life of the contract, resulting in an estimated State liability of $1,650,000. Thus, the State had incurred costs and liabilities for the 6-month period which equal about $46 per eligible per month, as compared to $45.60 under the State-administered program in fiscal year 1975. 1/ HAS' actual costs under the contract will not be known until after the contract is completed. Therefore, it is not possible to now determine whether HAS' costs will be less than its premiums, in which case the State will receive 75 percent of the reserve, or whether HAS' costs will be greater than its premiums, in which case HAS will lose money under the contract.

CONTRACTOR CASH FLOW PROBLEMS

As discussed above, payments by HAS to providers were higher during the September-March period than the premiums HAS received from the State. HAS' administrative costs have also been higher than expected. In addition, HAS has paid about $24 million for claims for services provided to eligibles before the effective date of the insuring agreement for which it has not, under the terms of the contract, been paid by the State. These three factors caused HAS to have a serious cash flow problem.

1/Neither figure includes yearend settlement costs with providers paid initially on an interim payment basis. These costs were excluded because they are not covered by the insuring agreement.

Costs for preinsuring contract claims

The contract called for HAS to function as a fiscal agent for processing and paying claims for services provided before July 1, 1975. In essence, the contract provided that HAS would be reimbursed for all claims paid and administrative costs incurred relative to the fiscal agent claims. However, the contract provided for two separate reimbursement arrangements depending on whether the claim was received by June 30, 1975 (fiscal agent claims), or after June 30, 1975 ("preeffective" claims).

Concerning reimbursement for the fiscal agent claims, the contract provided that:

> "During the months of May and June 1975 the State Agency shall pay Contractor funds as required by the Contractor to pay provider claims received by the Contractor and administrative costs incurred by the Contractor as provided by the Contract in the amount of $14,660,000 per month, it being clearly understood that Contractor's responsibility during May and June 1975 is solely that of a fiscal agent for State Agency."
>
> * * * * *
>
> "If claims paid and administrative costs incurred by Contractor during the months of May and June 1975 should exceed monthly fees received by the Contractor for those two months, the State Agency will pay 100 percent of the difference to the Contractor as follows: 70% by July 10, 1975 and the balance by July 10, 1976. * * *"

According to HAS' financial records and State agency and HAS officials' comments, HAS paid provider claims and incurred administrative costs totaling about $38.9 million ($9.6 million more than the $29.3 million estimated in the contract) applicable to claims received by the contractor before July 3, 1975, and postmarked on or before June 30, 1975. The State agency reimbursed HAS for all of these costs. The reimbursements were made in three increments, one for each of three provider payouts made as follows:

Reimbursements by State		HAS' payments to providers	
Date	Amount	Date	Amount
5/75	$11,500,000	5/75	$10,117,347
6/75	15,507,064	6/75	15,635,379
7/75	11,923,923	7/75	11,923,923
Total (note a)	$38,930,987		$37,676,649

a/Difference between reimbursements by the State and payments to providers represent the contractors' administrative costs and other miscellaneous adjustments.

Concerning reimbursement of the preeffective claims, the contract stated that:

> "If the claims received by Contractor after July 1, 1975, with respect to periods of service prior to that date ("pre-effective claims") should exceed claims received by State Agency after June 30, 1977 or any earlier termination of this contract with respect to periods of service prior to such effective termination date ("post-effective claims"), State Agency shall reimburse contractor for 100% of the difference. Conversely, if post-effective claims should exceed pre-effective claims, Contractor shall reimburse State Agency for 100% of the difference deducted from the Medicaid reserve."

According to State agency and HAS officials, the anticipated dollar value of preeffective claims was discussed during contract negotiations and it was the general consensus that the total value would probably be between $14 and $17 million. Agreement, therefore, was reached whereby HAS would pay for preeffective claims from premiums received during the risk period, 1/ and these payments would be offset against payments that the State agency would have to make after the end of the contract period.

Financial records showed that as of March 31, 1976, HAS had paid about $24.2 million in preeffective claims, or about $7.2 million more than the $17 million that State agency and HAS officials believed would be the maximum payout for these

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1/Premiums under the risk period began in July 1975, whereas substantial payments to providers for services provided during the risk period did not begin until late August.

claims. In addition, about $2.4 million worth of preeffective claims were in suspense on March 31, 1976, and according to an HAS official, an estimated 65 percent of this amount will eventually be paid.

Status of contract cash flow

The contractor, as required by the contract, established two bank accounts--a "Title XIX Trust Account," which must be kept under an investment agreement with a depository bank in North Carolina, and an "H.A.S. Disbursing Account." The monthly fees paid by the State, net recoveries from third parties, and interest income earned on excess funds in the trust account are credited to the Title XIX Trust Account. Funds are transferred from the Title XIX Trust Account to the H.A.S. Disbursing Account as necessary to cover administrative costs and payments to providers. Theoretically, a zero balance is maintained in the disbursing account.

An agreement between HAS and the bank provides that the balance in the trust account will be invested in U.S. Treasury bills unless HAS specifically authorizes investment in the bank's Short Term Common Trust Fund. Records show that the depository bank did not invest the funds in the account directly in U.S. Treasury bills. Instead, according to the vice president of the bank's trust department, an arrangement was reached with a large bank in New York whereby funds are placed with the New York bank, which pledges U.S. Treasury bills as security for the funds. The New York bank pays the depository bank interest at a rate less than the rate which could be earned on direct investment in U.S. treasury bills. The vice president of the depository bank said that to invest the funds directly in U.S. Treasury bills would not permit sufficient liquidity of the trust account funds, which must be available on short notice for transfer to the disbursing account.

As of February 29, 1976, interest income of $494,859 had been credited to the trust account from investments with the New York bank. Also, $1,085,943 had been recovered and deposited in the trust account from third parties who were liable to pay for medical services received by Medicaid eligibles.

The ending monthly cash balance in the trust account averaged $11.2 million between July 1975 and February 1976, and it did not drop below $6.3 million. However, the payment of $29.1 million in Medicaid expenditures during March 1976 reduced the trust account cash balance to $1.8 million at March 31. This amount was not sufficient to cover the $5.6 million April 5 provider check run; therefore, the

checks were not mailed until April 8, the date the State agency paid HAS the April premium due by April 10. HAS paid the April 15 provider check run, which totaled $8.6 million, on schedule. However, as of April 29, HAS had mailed only $1.5 million of the $5.2 million in provider checks from the April 25 check run. HAS borrowed funds from its parent corporation, Bergin-Brunswig, to enable payment of the remaining checks. On May 12, 1976, Bergin-Brunswig notified the State that it was considering terminating the contract effective September 30, 1976, because of possible losses.

CONCLUSIONS

The State's conclusion that the performance under the contract during the September 1975-February 1976 period showed a cost reduction of $8.2 million compared to the State's experience in fiscal year 1975 is not supported. The State failed to take into account two factors which materially affected program costs: (1) HAS' use of advance payments to providers because of a large backlog of unprocessed claims which deferred reporting of expenditures until after the 6-month period and (2) suspended claims for the period (an estimated 65 percent of the value of which will eventually be paid) were not included in the analysis. Taking these factors into account, we found that, compared to the State's experience during fiscal year 1975, HAS' costs under the contract had increased by about $8 million for the September-February period and by about $19.5 million for the September-March period. However, the State made payments or incurred liability for payments which averaged about $46 per eligible per month during the September-February period which compares favorably with State experience during fiscal year 1975. Whether the contractor will accumulate reserves or incur a loss will not be known until the contract has ended.

Because of higher than expected costs under the insuring agreement and higher than expected costs for claims for services provided before the effective date of the insuring agreement, HAS had a serious cash flow problem in April 1976. In May 1976 the contractor notified the State it was considering termination because of possible losses.

APPENDIX I

United States Senate
COMMITTEE ON FINANCE
WASHINGTON, D.C. 20510

May 22, 1975

B-164031(3)

The Honorable Elmer B. Staats
Comptroller General of
The United States
Washington, D. C.

Dear Mr. Staats:

I understand that the State of North Carolina awarded a twenty-sixth month, $405 million insurance-type contract to the Bergin Brunswig Corporation to underwrite and operate the State's Medicaid program. It is my understanding that there was only minimal involvement by the Department of Health, Education and Welfare (HEW) in the award of this contract. Since the Federal Government will be committed to paying 70 percent of the contract costs, I am concerned about the lack of HEW participation in the contract award.

Accordingly, I would like the General Accounting Office (GAO) to make a two-part review. First, to review and report on HEW's policies and procedures relating to Medicaid insurance contract awards and the extent of HEW's involvement in the award of this particular contract.

Second, to undertake a broader review of HEW and State policies and procedures for awarding insurance-type contracts. This would include the capability of HEW to monitor these contracts and assess the contractor's performance. States with Medicaid insurance-type contracts for all or part of their Medicaid program include Arkansas, California, Florida, Massachusetts, Pennsylvania, and Texas.

Other States may decide to enter into insurance-type contracts for all or a portion of their Medicaid program. I am concerned that HEW may not have the appropriate controls and capabilities to either provide the States with necessary guidance or to protect the Federal Government's interest. Most importantly, this attempt by a State to totally contract with a private firm for Medicaid underwriting and administration is wholly inconsistent with the legislative history of title XIX as a Federal-State program. Seemingly, a policy

APPENDIX I

change of this magnitude and significance should be embodied in specific statutory authorization rather than handled as a matter of administrative discretion.

Sincerely,

Herman E. Talmadge

Herman E. Talmadge
Chairman,
Subcommittee on Health

APPENDIX II

STATE OF NORTH CAROLINA
DEPARTMENT OF HUMAN RESOURCES
325 NORTH SALISBURY STREET
RALEIGH 27611

JAMES E. HOLSHOUSER, JR.
GOVERNOR

DAVID T. FLAHERTY
SECRETARY

TELEPHONE
919/829-4534

March 31, 1976

Mr. Gregory J. Ahart
Director
United States General Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

Please find enclosed three draft copies of the Department's response to the GAO draft on North Carolina's Title XIX contract.

As you know, we kept our date for the scheduled exit interview with your representatives at the hour of 11 a.m. this date. We, of course, were disappointed that your office chose not to participate because of the presence of the news media. But, frankly, as I mentioned in our phone conversation Tuesday, the most open and objective manner for the Department of Human Resources to make its position known short of releasing the GAO draft, was to invite the media to hear both sides. I made that decision and in retrospect it was the only one I could make.

Please be assured, that while the news media were given copies of our response, we did not release or have reprinted the GAO draft document.

Let me assure you that our position in this whole matter is to be responsive and responsible to the people of North Carolina who in the final analysis will reap the benefits provided by this contract.

In closing, should further questions arise the State of North Carolina is ready, willing and able to provide answers. We have nothing to hide, as your investigators should already have told you.

With best regards.

Sincerely,

David T. Flaherty
Secretary

cc: Senators: Jesse Helms
Robert B. Morgan
Representatives:

Walter B. Jones	Ike F. Andrews	Charles Rose	James Broyhill
L.H. Fountain	Stephen L.Neal	William G. Heffner	Roy A. Taylor
David N. Henderson	Richardson Preyer	James G. Martin	

RESPONSE TO GAO REPORT ON THE N. C. TITLE XIX CONTRACT

INTRODUCTION:

We have looked forward for some time to an objective GAO study of North Carolina's Medicaid contract. But frankly, after reviewing the contents of this document, we can come to only one conclusion. This draft report does not reflect a true evaluation of what we have done here in this state with the Medicaid program, but it is merely an accumulation of half-facts and inaccuracies which misrepresent what the contract is all about.

In no way does it evaluate the concept that the state of North Carolina has pioneered in the pre-paid health care programs that guaranteed a ceiling on Medicaid expenditures for the benefit of taxpayers.

North Carolina is the only state in the southeast with a viable and working Medicaid program, at the same time other states are struggling to find an answer to the skyrocketing cost of administering the same program while reducing services to indigent citizens.

And secondly, this report fails to make one vitally important observation. No model or manual exists for what this state has done in developing the Medicaid pre-paid concept.

The following specific comments on the draft should be considered in assessing the validity of this report.

GAO note: The following is a verbatim et literatim (word for word and letter for letter) copy of the State's comments except that the page references have been changed to reflect the page numbers in this report. Because of the length of the State exhibits to its comments, the exhibits are not included.

State Comment:

Reference Page iii of the Digest. GAO draft report quotes: "Benefits expected to be derived from the contract are not assured." In analyzing the 1974/75 fiscal year, the cost per eligible recipient per month under the State operation was $46.25. Under the present prepaid contractual arrangement, the cost per eligible per month utilizing the new management techniques and sub-contract agreements is $42.21. This reflects a cost reduction effect of $1,373,600.00 per month and shows a cost differential of $8,241,600.00 from September 1, 1975 thru February 29, 1976. The contract provides for a Bond in the amount of $6,000,000.00 and a letter of credit in the amount of $6,000,000.00 factors which demonstrate assurance and guarantee contract success.

GAO Response:

As discussed on pages 47 through 51, although the State's experience under the contract appears to compare favorably with its fiscal year 1975 experience, its estimated cost savings are grossly overstated. On May 12, 1976, the contractor advised the State that its letter of credit arrangement had been canceled effective September 30, 1976, and that, unless increases in the contract price could be negotiated, the contract would be terminated.

State Comment:

Reference Page iii, paragraph 5, and page 32, paragraph 5, all standard risk contracts with government and industry contain renegotiation clauses resulting from the change in State and Federal laws. These are basic ground rules for risk contracting. These rules are utilized for the protection of both the Contractor and government. The effects of the legislative change in maximum allowable rate for Skilled Nursing Care and Intermediate Care cannot be measured for some time to come. The reference to ambiguous renegotiation clauses is simply erroneous. Clause number one (1) simply identifies existing Federal and State laws in effect at the time of the Contract signing and number two (2) allows for changes resulting from changes in State law.

GAO Response:

The two renegotiation clauses are separate and distinct. Renegotiations are allowed under either clause, and the two clauses can apply to different things. See discussion on pages 34 and 35.

State Comment:

Reference Page iv, paragraph 1, contrary to the GAO draft report, other benefits claims for the insuring agreement do involve better and more comprehensive program data and improved Medicaid and Utilization Review. Without the prepaid contract, these plans would not have materialized because of inadequate funding.

GAO Response:

We did not say that the expected benefits would not be realized, only that an insuring agreement was not necessary to obtain these benefits which, theoretically, could also be achieved under a State-administered program or a fiscal agent agreement. Since the State legislature had not been requested to fund an MMIS, we do not know whether adequate funding would have been available. However, since the Federal Government pays 90 percent of MMIS installation costs, the State would have had to pay only 10 percent of the costs of installing an MMIS. Also, as we pointed out, the State had a contract under which the North Carolina Medical Peer Review Foundation would have administered basically the same long-term care and hospital admissions review programs as it does for HAS.

State Comment:

Reference Page iv, paragraph 2 ... maximum capitation on expenditures as a part of the prepaid contract does protect the State Agency against rises in eligibility. During the first six months of the contractual agreement, the number of recipients covered by the N.C. Medicaid Program increased by approximately ten percent.

GAO Response:

We said that the maximum monthly payment rate provided the State with protection against increases in the number of Medicaid eligibles. The average monthly number of eligibles increased from 291,132 during fiscal year 1975 to 311,895 during the first 8 months of the insuring agreement. This represents an increase in the number of eligibles of about 7 percent. The projected average number of eligibles for fiscal year 1976 which was included in the request for proposals was 312,612.

State Comment:

Reference Page iv, paragraph 1: "Other benefits claimed for the insuring agreement involved better and more comprehensive program data and improved medical and utilization review. GAO stated, however, that the expected improvements related to programs which were either in effect or planned when the insuring agreement was signed and were not a direct result of the insuring agreement itself, (see pages 37 and 38)." Health Application Systems was required to subcontract to the North Carolina Medical Peer Review Foundation to complete all medical determinations pertinent to the program. Natually, the Medicaid Management Information System will make information more readily available to the Foundation to do better quality review. The State will take this conversion from manual to computer factor under advisement in computing program savings.

GAO Response:

HAS was required by the contract to subcontract the utilization review determination portion of its administration

to the North Carolina Medical Peer Review Foundation, and the MMIS was expected to make utilization information more readily available to the Foundation. However, in March 1976 Foundation officials informed us that they had been able to do relatively little medical and utilization review because HAS had not provided the volume of information expected. The officials also said they could perform their functions equally well under a State-administered program, a fiscal agent agreement, or an insuring agreement.

State Comment:

Reference Page i "Reasonableness of Contract Price not Assured" In view of the fact that no other total prepaid arrangement has ever existed in this country for Title XIX, it is obvious that competition was not readily available prior to issuance of the request for proposals. This is not a rare occurance (sic) with the onset of any new service contract. These requests for proposals were mailed to a total of thirty-five firms in an attempt to insure competiveness (sic). Although the Federal government had derived the guideline under which a prepaid concept was to operate in 1972, the State Agency was unable to obtain a list of qualified bidders. No government agency is able to substantiate competition for providing a service prior to opening bids for that service.

GAO Response:

Although it is true that obtaining competition for a new type of program is often more difficult, we believe that the State's selection of potential bidders did not help insure that whatever competition was available was obtained. Also, we noted that Texas recently received three proposals for a Medicaid insuring agreement similar in scope to the North Carolina contract.

State Comment:

Reference the sentence on Page i, "Data provided potential offerors in the request for proposals was insufficient for developing valid premium rates" (See page 11 GAO report). Since data for developing a request for proposal for a total Medicaid concept are not on file elsewhere in the country, and since North Carolina (sic) request for proposal did result in a viable contract with Health Application Systems, we must conclude that the data was adequate.

GAO Response:

A number of States have extensive data bases which they could use to develop an adequate request for proposals for a Medicaid insuring agreement. Also, the contract as negotiated is materially different from that which was asked for in the request for proposals. Texas recently issued a request for proposals which included extensive data on the number of eligibles and the utilization of services and three proposals were submitted in response.

State Comment:

Reference the sentence on Page i, "Some firms believed the request for proposals was biased in favor of a preselected contractor." (See p. 12 of GAO Report). Firms which do not receive award of a contract often indicate they feel that the request for proposal was biased in favor of a preselected contractor. This is a widely known fact throughout the nation.

GAO Response:

We believe that potential offerors' perception of the fairness of the procurement process is an important factor in their willingness to participate and can thus assure maximum competition. In this connection, a June 1974 report to the Secretary of HEW from the Advisory Committee on

Medicare Administration, Contracting and Subcontracting cited potential offerors' low confidence in the procurement process as an important factor which deterred competition for electronic data processing subcontracts.

State Comment:

Reference Page ii, sentence stating, "At the time of the request, etc...." The change in State law in no way affected the ability of any contractor to bid on supplying the service. Thirty-five prospective bidders were so informed. The balance of the names of firms to whom request for proposals were mailed was developed by the Division of Purchase and Contract, Department of Administration prior to mailing.

GAO Response:

The State did inform prospective offerors that a change in the State law would be required before a contract could be awarded. Therefore, any firm could have submitted a proposal if it were willing to incur the costs of preparing a proposal without some assurance that a contract could be awarded.

State Comment:

Reference to Page ii, sentence, "The State insurance laws placed bona fide insurance companies at a competitive disadvantage because of certain reserve requirements." (See page 15.) No opinion from the Attorney General's office was requested or obtained relative to the effect the change in State law had on insurance companies bidding for supplying the service. The State Agency did obtain a ruling from the Attorney General's office indicating that a prepaid Medicaid contract does not fall within insurance law requirments. (See Exhibit 1) This was previously supplied to the GAO investigators.

GAO Response:

The State Agency had not requested an opinion on the applicability of contingency reserve requirements of State

insurance laws to an insurance company if one had been awarded the Medicaid insuring agreement. After several potential offerors raised the issue, we discussed this matter with an Assistant State Attorney General who said he believed the contingency reserve requirements would have had to be met had an insurance company been awarded the Medicaid contract. His rationale was that the State could not allow an insurance company to place its private policies in jeopardy because of risks assumed under a State contract.

The State Attorney General's ruling does not say that a prepaid Medicaid contract does not fall within insurance law requirements. Instead, it says that, since HAS is not an insurance company, the State does not have to apply its insurance laws to HAS.

State Comment:

Reference Page ii, paragraph 5, "Although competition was absent, the State did not request or obtain the data on which HAS based its proposed contract price." No government agency routinely receives an analysis of the bidders proposed contract price. Although on December 11, the State of North Carolina did receive a complete disclosure from Health Application Systems. This yardstick was obviously used by the State of North Carolina to negotiate a value change in the amount of twenty-two million, three hundred forty-two thousand two hundred dollars. This is substantiated by correspondence supplied to GAO Representatives by memo of November 19, 1975; and reflected in an analysis prepared for the State Purchase and Contract Officers on April 24, 1975 (Exhibit No. 2). The document was headed Advantages Gained as a result of Negotiations on Title XIX Contract.

GAO Response:

This comment is discussed on page 22.

State Comment:

Reference Page ii, paragraph 3, "The State's evaluation consisted of comparing the proposed price to its Medicaid budget. "The GAO draft contains a false assumption that the State's evaluation consisted of [comparing] the proposed contract price to its Medicaid budget. (See p. 27.)

GAO Response:

This comment is discussed on page 22.

State Comment:

Reference Page iv, paragraph 1, Health Application Systems was required to subcontract to the North Carolina Medical Peer Review Foundation to complete all medical determinations pertinent to this program. Naturally, the Medicaid Management Information System sub-system will make information more readily available for the Foundation to do better quality review. The State did take this conversion from manual to computer factor under advisement in computing program savings (to be continued later).

GAO Response:

This comment is identical to one addressed on page 62.

State Comment:

Reference Page ii, paragraph 5, first sentence. All contracts are negotiated on relative values. This particular contract was negotiated for an advantage of $22,342,200.00 to government.

GAO Response:

As discussed on page 22, if the State knew what was included in HAS' proposed price, it cannot reasonably contend that it negotiated increases in HAS' liabilities or in State participation in accumulated reserves and interest on them worth $22,342,200. All the items "negotiated" by the State had already been included in HAS' proposal, except possibly $960,000 for common audit costs. For example, one of the

documents the State said it received from HAS on February 13, 1975, gave the following breakdown of HAS costs:

	Fiscal Year 1976	Fiscal year 1977
Expenditures:		
Costs [of medical services]	$161,199,000	$186,822,000
Savings [from utilization review]	(8,062,000)	(10,044,000)
Buy-in	8,700,000	9,341,000
Administration	5,070,000	5,412,000
Total	$166,907,000	$191,531,000

Clearly, the cost of the buy-in program, which the State said it negotiated into the contract, was already included in HAS' proposal price.

State Comment:

Reference Page ii, paragraph 6, first sentence. On the strength of the operation data at the conclusion of fiscal year 1975, the budget estimates used for evaluating the Medicaid Program were in error by $6,000. The total program cost for Fiscal year 1975 was more than $180,000,000. We conclude that the estimates were most appropriate.

GAO Response:

The State claim that its fiscal year 1975 budget was in error by only $6,000 was based on the State's comparison of the sum of four quarterly expenditure reports with a report that listed total fiscal year 1975 expenditures. However, if the State's certified budget is compared to actual expenditures, the budget was overstated by about $2.1 million. Also, the State budget was based on date-of-payment data, whereas potential offerors were asked to submit proposals on a date-of-service basis.

State Comment:

Reference Page ii, paragraph 7, "The State Medicaid Program pays a monthly Medicare "buy-in" premium for Medicaid eligibles that are eligible for Part B of Medicare." Buy-In premiums estimated in October, 1974, were based on the increase presumably to be allowed by law. The technical error in the law was brought to the State's attention in February, 1975. A letter dated January 22, 1975, (Exhibit 3) from the Social Security Administration was received on February 18, 1975. The letter leads the reader to believe that congressional action would be requested; and if legislation occurred the premium would be $7.50 per month. The Division of Social Services had estimated $7.57 in October, 1974. During the pre-contract period, the possibility of no increase in the $6.70 premium was discussed. However, the general interpretation was that legislation would correct the law and allow the $7.50 premium as of July 1, 1975. The buy-in was negotiated into the contract on the basis of an allowance of $400,000.00 per month. Actual expenditures have exceeded $525,000.00 per month resulting in an added cost to the Contractor. This is to the advantage of the State and the taxpayer. Although not referenced in the GAO report, States do have the option in Medicare Part A benefit packages for their recipients. In keeping with Federal and State procurement laws, sound contracting procedures were adhered to throughout these negotiations and the award of this contractual arrangement. (Exhibit 4).

GAO Response:

This comment is discussed on pages 24 and 25.

State Comment:

Reference Page iv, paragraph 3, "HEW Involvement in Contract". The State Agency during a meeting with Region IV, Department of Health, Education, and Welfare in February 1975, did request HEW's involvement in participation of development and negotiation of the final contract. The Department of Health, Education, and Welfare graciously supplied such assistance. (Exhibit 5).

GAO Response:

Our report already discussed this information at page 41.

State Comment:

Reference Page iv, paragraph 4, sentence, "HEW did approve the insurance arrangement for Federal financial participation." The inclusion of the buy-in premium was

discussed with Department of Health, Education, and Welfare and agreeably inserted through contract negotiations.

GAO Response:

We could not corroborate that HEW had agreed to share in the buy-in premiums for the medically needy.

State Comment:

Reference Page iv, paragraph 5, "Contract Monitoring". The Medical Services Section does issue a monthly activities report. (Exhibit 6). Copies of these reports and other monitoring documents were utilized for GAO review; copies have been furnished to the Department of Health, Education, and Welfare, Region IV.

GAO Response:

The Medical Services Section does issue such a report. However, we do not see that this comment has any relevance to the matters discussed.

State Comment:

Reference Page v, paragraph 5 - Since North Carolina (sic) Medicaid Contract is the only one of its type in the nation, we anticipate a favorable GAO response in the future.

GAO Response:

The State was commenting on the statement in the draft report that this report represents the first stage of our broader review of various State Medicaid insuring agreements and, therefore, we are making no recommendations at this time. We have no comment on this.

State Comment:

Reference Page 1, paragraph 3; Although Federal law and State legal requirements at the time of the contract signing did not dictate Federal participation in any of the activities, the State of North Carolina did involve and invite HEW participation. This concept is verified in Mrs. Virginia Smyth's

letter of March 12, 1975, in which she states, "...it has become apparent that this concept is quite complex and there are few precedents to guidance..." (Exhibit 7)

GAO Response:

This information was included in the draft report.

State Comment:

Reference Page 3 - The second sentence incorrectly states that "the State pays the (Buy-In) premium and Medicare pays for the medical services covered by that (Medicare Program)." Medicare does not pay deductible and co-insurance amounts for Part B services; these costs are paid by Medicaid in addition to the Buy-In premium. This misinterpretation of one aspect of the Medicaid Program may indicate that the GAO review was completed with its representatives not fully understanding some aspects of the programs.

GAO Response:

This sentence has been revised to state that Medicare does not pay the deductible and coinsurance amounts for part B and that Medicaid does pay them for individuals covered under both programs.

State Comment:

Reference Page 3 - No reference is made by the report of the requirements of Federal Act 92-603.

GAO Response:

When we inquired about which requirements of P.L. 92-603 it was referring to, the State said it was referring to sections which included eligibility of persons receiving payments under the Supplemental Security Income program for Federal participation in the Medicare buy-in program. The provisions the State is concerned about were not part of

P.L. 92-603, but rather part of P.L. 93-233. Also, these provisions have no effect on our discussion of the buy-in program not previously considered.

State Comment:

Reference Page 4 - "Description of Contract" - This contract was consumated with Health Application Systems as a prepaid capitation rate contract. Health Application Systems is not a health insuring organization. Increases and decreases in eligibility resulting in eligibility capitation rate changes are part of the risk arrangement assumed by the Contractor. Accordingly, the capitation fee changes monthly with increases or decreases in the number of eligible recipients may not (sic), however, exceed $14,660,000 monthly premium payments.

GAO Response:

The State is, in effect, saying here that the per capita rates included in the contract ($54.30 for fiscal year 1976 and $61.70 for fiscal year 1977) are meaningless and that the monthly maximums ($14,660,000 and $16,660,000 for the 2 years) are the real premium rates. Thus, since the number of eligibles fluctuates from month to month, the actual amount the State pays per eligible also fluctuates. We agree.

State Comment:

Reference Page 5, "Identifying for the contract those providers who have been lawfully terminated or suspended from further participation in the program". The State retained the responsibility and the authority for enrolling providers. This includes the suspension or termination of providers.

GAO Response:

This information was included in the draft report.

State Comment:

Reference Page 6, "Relationships between Contractor and Other Corporations in the Drug and Health Products

Industries" - Health Application Systems is a wholly owned subsidiary of Bergin Brunswig Corporation.

GAO Response:

This statement is correct and was included in the draft report.

State Comment:

Reference Page 7, first paragraph. The PAID contract is not related to the contract between the State and Health Application Systems. The agreement provides for PAID to pay Health Application Systems a fixed administrative fee of $135,000.00 per month. (Exhibit No. 8.)

GAO Response:

This statement is correct and the report has been modified to indicate the $135,000 per month limit on HAS' administrative fee under the State's drug insuring agreement.

State Comment:

Reference "Scope of Review", Page 7 - In the opinion of the State of North Carolina, the GAO review as stated in this draft does not constitute an evaluation of the contract or contracting procedures.

GAO Response:

As we stated, the report does not attempt to evaluate contract performance or results, but it does evaluate the State's contracting procedures.

State Comment:

Reference Chapter 3, Page 28, last paragraph - State reduced its Medicaid budget for fiscal years 1976 and 1977 by more than 4.4 million (sic).

GAO Response:

As stated in the draft report, the State reduced the total Medicaid budget by $7 million (including the State share

of $1.9 million) because of savings it expected to derive from its utilization review contract with the North Carolina Medical Peer Review Foundation. Since the contract with the Foundation was in force before the insuring agreement, the related savings did not depend on the State entering an insuring agreement. The State also reduced its Medicaid budget by $4.4 million because of savings it expected to realize from the insuring agreement.

State Comment:

Reference Page 29, paragraph 1, "Although the State could not provide us with the details of this adjustment....." This subject was discussed thoroughly and GAO's worksheets were reviewed by DSS [Division of Social Services] fiscal staff with the GAO auditor to clarify the adjustment. Exception is taken to GAO's statement because of the extraordinary amount of time spent with the GAO auditor on this matter. GAO worksheets were in error due to misapplication of Federal Financial Participation on several services. (comparing cost under a State operation versus a contract operation) These differences were explained by pointing out the errors on worksheets. A very insignificant difference was not reconciled but the auditor said he was satisfied with the explanation given. This is another indication of GAO representatives leaving a problem without understanding the explanation offered by the State.

GAO Response:

Because the details of the budget changes made in April 1975 were not available, we reconstructed the computation in February 1976 with the assistance of State agency personnel. A comparison of the amounts used by the State in April 1975 and reconstructed by us using the State's original assumptions are summarized in the following table.

Budget subprograms	Source of funds State	Federal	Local	Total
General administration and support:				
As submitted by State agency	(1,084)	(1,688)	-	(2,772)
As reconstructed	(1,045)	(1,732)	5	(2,772)
Medical services payments:				
As submitted by State agency	(3,218)	3,450	265	497
As reconstructed	(4,252)	4,676	73	497
Reserves and transfers:				
As submitted by State agency	(91)	(91)	-	(182)
As reconstructed	(59)	(123)	-	(182)
Net:				
As submitted by State agency	(4,393)	1,671	265	(2,457)
As reconstructed	(5,356)	2,821	78	(2,457)

The purpose of reconstructing the computation of the budget change was to verify the general accuracy of what State agency officials had told us were the principal reasons for the changes.

State Comment:

Reference Page 30, Sentence 5 states "....some training costs are reimbursed at 75 percent,....." Survey and training costs for personnel inspecting SNF's and ICF's are subject to 100 percent Federal Financial Participation; costs for skilled professional medical personnel and supporting staff are subject to 75 percent Federal Financial Participation. No training costs are reimbursed at 75 percent Federal Financial Participation; indicates GAO review did not obtain all facts concerning various Federal Financial Participation rates.

GAO Response:

Our lead in, "for example," indicates that we were not attempting to list all the various Federal sharing rates.

Also, training costs for professional medical personnel are reimbursed at the 75-percent level.

State Comment:

Reference Page 30: Including the Buy-In premium for the Medically Needy in the contract was not purposely intended to gain the Federal Financial Participation. The State did not assume the premium would be subject to Federal Financial Participation until it received a letter dated April 22, 1975 (Exhibit 9) from the SRS Regional Commissioner to the Secretary of DHR [Department of Human Resources]. Since SRS did not exclude any part of the contract from Federal Financial Participation at the medical assistance percentage (except the fiscal agent portion of the contract in May and June, 1975) the State assumed it was allowable to claim the total HAS premium at 68.03 percent. This was discussed in at least one of the fiscal meetings between SRS and DHR officials. The State was given the impression that no breakdown of Federal Financial Participation for the several percentages available was to be allowed, i.e., 90 percent for family planning, 75 percent for cost of services performed by skilled professional medical personnel, and 50 percent for other HAS administrative costs (except during the May and June fiscal agent period). Federal law and regulations do not allow Federal Financial Participation in the Buy-In premium paid for Medicaid eligibles who do not receive a cash assistance payment. Page 30 of the GAO report, last sentence states "...individuals who are not eligible for welfare payments..." The statement is incorrect because the law excludes non-money payment recipients, not just those ineligible for a payment. The excluded recipients are called Categorically Needly No-Money Payment and Medically Needy in North Carolina, not Medically Needy only. Exception should be taken to this portion of the report since the State is paying an overall prepaid premium to HAS which covers Buy-In premium (sic) and all other Medicaid costs, except drugs. Since the State is not paying the premium to Social Security Administration, it appears that 45 CFR 249.82(d)(2)(ii) allows Federal Financial Participation to be claimed at the medical assistance percentage on the total HAS premium.

GAO Response:

In the State's analysis of the savings it expected to realize from the insuring agreement, it included savings expected to result from obtaining Federal participation in the

buy-in program for the medically needy. Federal law does not allow participation in buy-in premiums for the medically needy, and when we brought this to HEW's attention, HEW agreed not to provide Federal sharing in these premiums. In regard to the State's contention that Federal regulations (45 CFR 249.82(d)(2)(ii)) allow Federal participation under an insuring agreement for medically needy buy-in premiums, we note that only allowable costs can be shared in by the Federal Government. Since medically needy buy-in premiums are not an allowable cost, they cannot be shared in.

State Comment:

Reference Page 33: Paragraph 3 - Is this referring to the CPI [Consumer Price Index] factor excluded from Exhibit 1, No. 8? (See Page 36, "contract clause omitted").

GAO Response:

No. This paragraph refers to the contract modification negotiated to cover increases in payments to ICFs because of the change in State law raising the maximum daily payment rate.

State Comment:

Reference Page 33 and Page 34: "Conflicting Contract Renegotiation Clauses" - Amendment No. 1 to the contract covers the increased maximum payment to ICF's due to the State Statute which raised SNF's to $28 per day. Since both type facilities are covered by the same statute, there is no conflict.

GAO Response:

We are not referring to a conflict in the State law but rather to a conflict between the two renegotiation clauses in the contract.

State Comment:

Reference Page 35 - The actual per eligible capitation rate fluctuates monthly in keeping with the monthly fluctuation in eligible number of recipiencts.

GAO Response:

This comment is similar to the one presented on page 72.

State Comment:

Reference Page 36, concerning the "CPI" clause omission: A DSS memo to HAS on January 29, 1976, was responded to by HAS on February 2, 1976, who agreed to insert the omitted sentence in Exhibit I, No. 8 of the contract. The sentence states the effective date as July 1, 1975; GAO states the effective date as January 1, 1976. DSS fiscal staff is currently computing the financial impact created by not implementing the CPI factor at July 1, 1975, instead of February 23, 1976, when final notification of agreement was received by Fiscal Management from Medical Services.

GAO Response:

The date has been changed to conform to the State comment.

State Comment:

Reference Page 36, paragraph 6: Since the [ICF payment escalation] clause was typographically omitted in the initial contract, there is no cost differential. Although one sentence was omitted in the retyping of this contract from Exhibit No. 8 referenced on Page 36 and 37 of the GAO report, the sentence was restored retroactively to July 1, 1975. Although this does reflect a typographical omission, it is one omission in a document that is 12 inches thick.

GAO Response:

Because the State retroactively included the clause to July 1, 1975, there should now be no additional costs to the State.

State Comment:

Reference Page 37, last paragraph: The request for proposal for development and implementation of the North Carolian Medicaid Management Information System was begun in July, 1972; not July, 1974 as referenced in the GAO report.

GAO Response:

We were referring to the most recent project to develop an MMIS request for proposal. However, we have revised our discussion on page 37 to reflect the State comment.

State Comment:

Reference Page 38, fifth paragraph: The Foundation in turn subcontracted to Health Application Systems for administrative support of these review programs. Under the prepaid agreement, this effort was consolidated.

GAO Response:

This information was included in the draft report.

State Comment:

Reference last paragraph, Page 38: Health Application Systems is required contractually to subcontract for conduct of the long-term care review and hospital admissions review programs with the North Carolina Medical Peer Review Foundation. This was not an optional decision of Health Application Systems.

GAO Response:

This statement is correct.

State Comment:

Reference Page 39, "Conclusions" - See Exhibit No. 1.

GAO Response:

Exhibit I to the State's comments is the State Attorney General's opinion that, since HAS is not an insurance company, it does not have to meet the State's insurance company

contingency reserve requirement. We see no relevance in this comment to the conclusions on page 39.

State Comment:

Reference Page 39, "Conclusions" second sentence. All Federal and State contracts have standard negotiation clauses. These clauses are not ambiguous and without them a private contractor would liberally (sic) assume all liabilities for underwriting the Federal Government of the United States.

GAO Response:

One clause limits increases in the capitation rates and in the limitations on total monthly payment to cover increased costs resulting only from increases in the amount, duration, or scope of services or from administrative services added to the contract. However, the State liability under the contract was increased under the other renegotitation clause for cost increases which had nothing to do with increases in the amount, duration, or scope of services or with increased administrative services.

State Comment:

Reference Page 39, paragraph 3: It may be possible that State administered programs could achieve the same program management and contractual results as those being achieved under this prepaid insured (sic) arrangement. It is interesting to note that no such program accomplishment exist in the country today.

GAO Response:

We are not in a position to discuss program accomplishments throughout the Nation.

State Comment:

Reference Page 9, Chapeter (sic) 2, "The State's Procurement Practices Did Not Insure that Contract Price was

Reasonable" - The State of North Carolina's evaluation of the Health Application Systems proposal was conducted to the same degree that applies for all valid Federal, State contractual agreements. The present evaluation of the program demonstrates that indeed the figures as utilized were valid.

GAO Response:

This is a broad statement relating to the matters discussed in chapter 2. Our position relating to the State's evaluation of HAS' proposal is fully discussed in that chapter. The State's evaluation of program results, which the State claims shows large savings, is discussed in chapter 6.

State Comment:

Reference "Lack of Competition", Page 9: It is routinely customary that any new service being made available to either private industry or government does not display ultimate competitiveness during the pioneer stage of the pilot project.

GAO Response:

This comment is similar to the one addressed on page 63.

State Comment:

Reference Page 10, "Questionable selection of firms to which request for proposals was furnished" - Since the State of North Carolina utilized its own best resources and those resources of Department of Health, Education and Welfare, it would seem appropriate for GAO to furnish the State of North Carolina names of additional prospective bidders. This could be useful in not only updating the North Carolina bid files, but could be utilized as a reference tool for other states who are anticipating this kind of arrangement.

GAO Response:

We furnished the State with a list of the health insurance companies licensed by the State Insurance Commissioner to do business in North Carolina.

State Comment:

Reference Page 11, first paragraph: The State of North Carolina's Insurance Commissioner does not normally provide a list of prospective bidders for prepaid Medicaid contracts. Since Medicaid has been deemed a non-insurance program, it is doubtful as to whether his input would be valid.

GAO Response:

Although Medicaid is not strictly an insurance program, the State's contract with HAS is an insuring agreement. The State sought, and received from HEW, approval for Federal participation in contract costs at the sharing rate applicable to prepaid insuring arrangements under 45 CFR 249.82.

State Comment:

Reference Page 12, paragraph 5: The basis for evaluation of the bid selection of a contractor in the request for proposal parameters was approved by the State of North Carolina prior to the issuance of the request for bids. These parameters are not unique.

GAO Response:

This statement is correct.

State Comment:

Reference Page 13, second paragraph, sentence stating, "...In a letter attached only to the addendum mailed from North Carolina Blue Cross-Blue Shield..." This statement should either be substantiated or omitted.

GAO Response:

The letter referred to was the one transmitting certain information for the period July-November 1974 to North Carolina Blue Cross-Blue Shield and was different from the letters transmitting the same data to the other prospective offerors because Blue Cross-Blue Shield was the potential offeror requesting the information.

State Comment:

Reference Page 15, paragraph 3, See Exhibit 10. [Letter from Blue Cross-Blue Shield stating it would not submit a proposal because of the uncertain legality of contract award.]

GAO Response:

The State comment indicates that Blue Cross-Blue Shield did not inform the State that it believed the State's insurance laws placed it at a competitive disadvantage. Blue Cross-Blue Shield told us this.

State Comment:

Reference Page 15, fourth paragraph: As referenced in the introductory remarks, the State of North Carolina does not have an Attorney General's opinion.

GAO Response:

This comment is the same as one addressed on pages 65 and 66.

State Comment:

Reference Page 15: The letter of April 4, 1975, does not reference Health Application Systems.

GAO Response:

The State Attorney General's letter of April 4, 1975, does specifically refer to HAS.

State Comment:

Reference Page 17, paragraph 3: The Department of Administration, Purchase and Contract Division did complete this financial analysis.

GAO Response:

As indicated in the draft report, this statement is correct.

State Comment:

[Related to matters discussed in the draft report but not included in this report.]

State Comment:

Reference Page 19, paragraph 3: This would not result in a more costly program to the State, but would result in more or less savings resulting to the State of North Carolina.

GAO Response:

We were commenting on what the State analysis would show. Obviously, if using the $6.4 million estimate of utilization review savings which the State would realize if it continued to administer the program showed the insuring agreement to be more costly than a State-administered program, using any higher estimate of savings would produce the same result.

State Comment:

Reference Page 19 "Contract negotiators' evaluation of HAS' proposal" - The State of North Carolina Department of Administration, did indeed determine the basis for the Health Application Systems' proposed price. This can best be attested to by reference to Exhibit No. 2 outlining the values of negotiation. Without the analysis, the State would have been unable to determine the appropriate level of negotiation to still assure the success of the contractual arrangement.

GAO Response:

This comment is discussed on pages 21 and 22.

State Comment:

Reference Paragraph 3, Page 20: All contract negotiations are negotiations of values and not only dollars, and the value attached to this negotiation is $22,342,200.00.

GAO Response:

This comment is discussed on pages 21 and 22.

State Comment:

Reference Page 22, last paragraph: ($6,000 off)

GAO Response:

The State is commenting that its fiscal year 1975 Medicaid budget was only $6,000 different than its expenditures. This is incorrect and the reasons for the error are discussed on p. 68.

State Comment:

Reference Page 23 - (This was discussed earlier in this response)

GAO Response:

The State is referring to our discussion of the Medicare buy-in program being included in the budget at erroneously high amounts.

State Comment:

Reference Page 23: The inclusion of the Buy-In premium was a part of this contractual arrangement as debated by Department of Health, Education, and Welfare in Washington, and the Regional Office in Atlanta prior to incorporating it into the contractual arrangement. It is appropriate that a risk contract should clearly denote risk.

GAO Response:

We were not able to corroborate the statement that HEW specifically took a position one way or the other on including the Medicare buy-in premiums in the insuring agreement.

State Comment:

Reference Page 26, "Conclusions" Item I - The State's procurement practice did insure the only competition available in the marketplace. It did guarantee the reasonable price of the contract for the services to be performed. (see Exhibit 2) Medical Cost Analysis.

GAO Response:

This comment is discussed in Chapter 2.

State Comment:

Reference Item 2, Page 26: There was not an uncertain legal climate surrounding the State's ability to award this contract.

GAO Response:

The State knew that its Medicaid law would have to be amended to enable it to award an insuring agreement. The State issued the request for proposals in October 1974, and proposals had to be submitted by January 1975. The State law was not amended until April 1975. We believe this constitutes an uncertain legal climate at the time the request for proposals was issued and responses to it required.

State Comment:

Reference Item 3, Page 26: Insurance companies were not placed at a competitive disadvantage because Medicaid is not an insurance coverage.

GAO Response:

Insurance companies were at a competitive disadvantage because the contract that was awarded was judged to be an insurance contract and, in the view of several potential offerors and a State Assistant Attorney General, had an insurance company been awarded the contract, it would have been required to meet the State's reserve requirements. Because HAS is not an insurance company, it did not have to meet the reserve requirements and thus had a competitive advantage over insurance companies.

State Comment:

Reference Item 4, Page 26: The State of North Carolina does not engage in the practice of preselecting contractors.

GAO Responses:

We did not say that North Carolina engaged in this practice.

State Comment:

Reference Page 27: Exception is taken to the statement that "In our opinion, however, the Medicaid budget was not a sound basis.....because.....estimates were based on inaccurate and unsupported cost and eligibility data." The budget was developed in August and September, 1974, from the data and other resources available and within the amount DHR management approved as a maximum budget request for Medicaid. The Statement that GAO considered the State's budget estimates for Medicaid to be based on "inaccurate and unsupported cost and eligibility data" is not based on factual information. On the contrary, the DSS fiscal staff was asked by GAO personnel during the course of their review how the State had budgeted so close to actual expenditures for Medicaid payments in the past years. Budget estimates and actual expenditures have closely correlated in each of the budget years since North Carolina began its Medicaid Program in January 1, 1970, with the possible exception of its first year.

GAO was told: (1) Budget estimates had been based on historical cost by type of service and historical utilization (Occasions of service) data; (2) Inflationary trend projections from provider associations, both State and national, consultation with regional and central DHEW staff, and inflationary trends in medical costs according to the Consumer Price Index; (3) State management staff's judgement as to impact on costs due to the Supplemental Security Income (SSI) program effect and the full implementation of the many new services added to the N.C. Medicaid program effective July 1, 1973. These estimates were reviewed and modified where appropriate by experienced management staff at all levels of State government - first by the Division of Social Services, then at Department of Human Resources, then by budget staff in the State Budget Office, then by the Advisory Budget Division before being submitted to the General Assembly. During legislative appropriations committee hearings, the estimates were thoroughly analyzed by key legislators and their staff before the appropriations were enacted.

DSS fiscal staff spent a great deal of time providing all the data, files, and supporting documentation requested by GAO personnel. In addition, many hours of staff time was spent explaining our budgetary process to one or more of the GAO staff of (sic) several different occasions. There was never any indication given during these discussions that GAO questioned our budgetary process. The Medicaid budgetary process is one of the most thorough in State government; in our opinion, the GAO staff lack the necessary experience to make such a judgement.

GAO Response:

We were not questioning the adequacy of the State's budget processes, but rather the appropriateness of using a budget developed in August and September 1974 as a basis for evaluating proposed prices several months later.

--The State budget for the Medicare buy-in program was overstated based on information that was publicly available on Janaury 7, 1975.

--The percentage factors added to prior years' medical service payments to provide for cost increases due to inflation and increases in the number of eligibles were unsupported.

--The budget costs were developed on a cash or date-of-payment basis, whereas the contract prices were to be based on a cost incurred or date-of-service basis. As discussed in chapter 6, this change from one accounting basis to another has contributed to HAS' cash flow problems.

Also, although the State contends that budget estimates and actual expenditures have been closely correlated in prior years, historically the State has periodically revised its budget amounts during a year to recognize actual cost experience. Similar periodic revisions, based on actual cost experience, were not provided for in the HAS contract.

State Comment:

Reference Page 40, "Involvement in Pre-Selection Activities" - Neither State or Federal law required the State of North Carolina to involve the Department of Health, Education, and Welfare's assistance in developing the request for proposal on the Medicaid Program.

GAO Response:

This information was included in the draft report.

State Comment:

Reference Page 45, second paragraph: The State Agency and Health Application Systems have reached an agreement whereby Health Application Systems will finance visits to California by members of the State staff on an as requested basis.

GAO Response:

Such an agreement has been reached.

State Comment:

CONCLUSION:

If Congress were to act on the type of misleading information as contained in this report, it would poorly serve the taxpayer. We cannot accept the draft as written and we insist that all of our comments and corrections of fact be entered as part of the permanent GAO document.

Health Application Systems, Inc. 1633 Bayshore Highway, Burlingame, California 94010 (415) 692-3960

ROBERT E ABRAMS
President

April 20, 1976

Mr. Robert Iffert, Assistant Director
United States General Accounting Office
Manpower and Welfare Division
Washington, D.C. 20548

Dear Mr. Iffert:

This will serve to formally convey our comments which were presented to you and your associates at our meeting on Tuesday, April 6, 1976. As I indicated at the meeting, we are deeply concerned over the tone of the report, and sincerely question whether the draft truly responds to the task which the report was to cover.

My concern covers both the errors of content in the report, but of even greater significance are the errors of omission. Although we would be the last to indicate that the North Carolina program represents perfection, we strongly believe that its innovative approach to the serious problems facing Medicaid programs today warrants a full and objective evaluation. There is no question in my mind that the very existence of the contract represents specific fiscal advantages to both the State and Federal governments.

Sincerely yours,

Robert E. Abrams

REA:hbm

GAO note: The following is a verbatim et literatim copy of HAS' comments except that page references have been changed to reflect the page numbers in this report.

HAS Comment:

Overview

In reading the draft of the report, it is extremely disturbing to find that in light of the extensive time and effort that was spent by GAO in reviewing and the various HAS facilities in providing extensive information the report totally ignores the philosophy and basis for the entire approach to the administration of North Carolina's Medicaid program. The discussion of most, if not all of the items presented, appears to be directed to present solely negative implications without providing any of the positive elements which are involved with each of the respective matters. It would seem that a conscientious effort was made or directed to report only the areas that might be open for criticism without attempting to produce information which will allow a truly objective evaluation and an assessment for future direction.

The title itself seems to reflect this attitude. This statement is made because of the fact that at the time the audit was made data was available to reveal that under the "insurance agreement" the expenditures by the State on a per capita basis were significantly less than the State has incurred during the previous year. This was true in spite of the fact that a significant degree of inflation is taking place. This, coupled with the increase in the number of eligible recipients, made the contract beneficial to the State and the Federal Governments from the day of its inception.

The following comments will discuss each of the areas as perceived by those in HAS who are assuming responsibility for responding to the report and its significant lack of validity. It would also seem that in light of the stated objective of the report, namely "to review HEW's and the State's policies and procedures in . . . . awards," that any reference to BBC [Bergin-Brunswig Corporation], HAS, PAID relationship and background is totally irrelevant. This would also apply to the identification of the Guarantor of the $6 million pledge which HAS for competitive reasons requested to remain confidential.

GAO Response:

See responses to detailed HAS comments.

HAS Comment:

Digest

In discussing the State's responsibility under the contract, the important fact that the State retains the responsibility of establishing policies of the program which includes

determination of program parameters, benefit structures, and overall governing policy is not mentioned. Yet it would seem that the retention of this responsibility and the control of the program parameters by the State is an important factor.

GAO Response:

The responsibility cited by HAS is important and has been added to the list of State responsibilities.

HAS Comment:

The conclusion expressed in the Digest on Federal Participation is incorrect under prepayment arrangement. We would assume that the State will address this issue.

GAO Response:

The conclusion that Federal participation is not available for the costs of Medicare part B buy-in premiums for the medically needy is correct. For a more complete discussion of this issue, see the State comment addressed on pages 76 and 77.

HAS Comment:

[Related to matters discussed in the draft report but not included in the final report.]

HAS Comment:

Chapter 2

Significance is raised by the issue of the fact that the State expected that its costs would be reduced as a result of shared costs for the Medically Needy. Nowhere in HAS' recollection of the discussion of this contract was an issue raised by the State concerning this factor.

GAO Response:

No comment.

HAS Comment:

All of the savings which were projected for the State were based on an eligibility count that was significantly less than what the eligibility count turned out to be from

the time HAS initiated the contract. In the 11 months since contract signing, average reported monthly eligibility has been over 335,000. This information was available to GAO.

GAO Response:

The 335,000 eligibility number HAS is referring to is the number of eligible months. This is a different count than the number of certified eligibles because, when an individual becomes eligible for Medicaid, he or she is entitled to coverage for up to 3 months before application for eligibility. The number of certified eligibles was used in the request for proposals. The estimated number of certified eligibles in the request for proposals was 312,612 per month. The actual number of certified eligibles during the July 1975-April 1976 insuring agreement period averaged 311,044 per month, which was slightly less than was estimated.

HAS Comment:

In addition, there were indications of savings due to other aspects of the program that were to be introduced. As far as the State is concerned, it would appear from the current data and information, some of which at least was available to GAO, and based on the increased eligibility, that the original savings projected by the State will not only be achieved but will be exceeded.

GAO Response:

See chapter 6 for a discussion of HAS' financial performance under the contract.

HAS Comment:

The contract properly contained a clause which indicates that should the benefit structure (which is totally under the control of the State) change, then the premium rates would be renegotiated based on that change. The fact that the State controls this factor of the program content makes this provision of the contract sound, plus the fact that the original

rates were predicated on a certain standard set of benefits as defined in the RFP [request for proposals]. If this clause were not in the contract, then the State could simply open up many kinds of additional benefits for which the "insurer" would be liable and for which he had no way of predicting any type of evaluation in quoting his rates. It is like bidding on a five-story building and suddenly finding that the contracting party says it should be seven stories at the same price.

GAO Response:

We were not discussing the circumstances or conditions under which a Medicaid insuring arrangement should or should not provide for the renegotiation of premium rates. We were merely pointing out that the State's oft-repeated claim that this insurance arrangement "guaranteed a ceiling on Medicaid expenditures," should be qualified to recognize the existence of such renegotiation clauses and that two such modifications having the effect of increasing the ceiling were renegotiated the same month the insuring arrangement went into effect.

HAS Comment:

SNF and ICF Maximums

The changes made by the legislature in raising the maximum rates for SNF and ICF were subsequent to the contract, and rather than adjust the premium on a per capita basis, the report neglects to indicate that the modification of the contract provides that the State will reimburse HAS only for the additional amount that the legislative change requires HAS to reimburse these providers. Also, there does not seem to be any mention, at least in the summarization of the issues, of the fact that if the State were to change the benefit structure by reducing certain benefits there would be a corresponding reduction in the amount that the State would pay HAS.

Ths issue is addressed in the discussion on page 32 of the draft report, but it is essential in evaluating future "insurance contracts" that limitations that are existing in the program must be the basis on which any contracting party can develop a premium figure. The normal rates of inflation,

since a significant number of the ICF and the SNFs were well below the limit, are covered in the contractual relationship and there is this "insulation" which the report speaks to. However, the situation where limits are changed by the legislature which were beyond any information that the contractor had available cannot be included equitably in that concept. The report implies that the setting of a maximum was a new principle. In actuality the legislature raised the maximum in effect from $25 to $28.

GAO Response:

The draft report stated that HAS would only be paid for its payments exceeding the old maximum payment rates.

The draft report did not imply that the maximum daily rate was a new principle, but stated that the contract modifications represented increases to the so-called guaranteed maximum costs which resulted from a change in the State law which was in turn attributable to inflation. The question of whether such modification should have been permitted was the subject of some debate within the State because of the existence of another renegotiation clause limiting price increases to changes in the amount, duration, or scope of services or administrative duties.

HAS Comment:

Loss of Matching Funds

On page 30 implication is made that the State may be losing certain matching funds, while in other areas of the report it implies the opposite. These inconsistencies in the GAO conclusions which emphasize the negatives in each case represent an area for introspection.

GAO Response:

There is no inconsistency. The State is receiving lower Federal sharing under the insuring agreement in some areas

(for example, family planning costs) than it would under a State or fiscal agent administered program. In other areas, (for example, certain administration costs which were assumed by HAS) the State is receiving higher Federal sharing under the insuring agreement than it would under a State or fiscal agent administered program. Both situations are discussed in the report.

HAS Comment:

Eligibility Counts

Eligible counts on pages 35 and 36 and the manner in which the capitation rate was derived were properly reported. However, GAO states an opinion that they can reasonably expect that the number of eligibles will remain above 270,000 for the life of the contract. No effort is made to also make a statement with respect to the probability of fiscal year 1976 averaging above the 312,612, and for 1977, above 321,991, which was the number given in the RFP. The data that is already available for 1976 indicates reported average monthly eligibility in excess of 335,000. This indicates again that the State in negotiating the fixed contract price saved funds by this method.

GAO, in stating a figure on page 35 on costs per eligibles, uses a number based on the projected eligibles in the RFP rather than the higher number of actual eligibles. This more current information was available to GAO. This again indicates, as offered in our earlier statement, the lack of fair balance of presentation of issues which permeates this report.

GAO Response:

All the data included in the request for proposals was based on the number of certified eligibles, and HAS has stated that it used the request for proposals data to derive its contract price.

As we previously discussed, the 335,000 figure presented here by HAS is the number of eligible months. During the July 1975-April 1976 insuring agreement period, the number of certified eligibles has averaged 311,044, slightly below the estimate in the request for proposals. Although eligible months is one valid method for measuring eligibility, we believe it is unfair to introduce this basis for measuring eligibility to support a charge of lack of balance in the report.

HAS Comment:

Contract Omission

The inclusion in the report on pages 36, 37 of information concerning the contract clause omission makes improper implications. This clause was part of our original negotiations, and when this clerical omission was pointed out, HAS and the State quickly made the appropriate adjustment. Therefore, the statement on page 37 is misleading.

GAO Response:

We noted in the report that, once we brought the matter to the attention of top State officials, HAS and the State took prompt corrective action.

HAS Comment:

Benefit Claims for Administrative Savings

The discussions on pages 37 and 38 do not reflect a true evaluation of the situation involving the possible implementation of the MMIS program nor of the utilization review mechanism. Although the installation by the State of the MMIS system was planned, nowhere in the discussion is it indicated how much time it would have taken for this implementation and the cost involved for the implementation. It would seem that the GAO might want to investigate these costs in other States to place some perspective on the value that North Carolina received by the fact that HAS was willing, as part of the "insuring agreement" to install the MMIS program. On page 38 a correction of fact is required. In actuality,

HAS was required by the State to contract with the Foundation for the enumerated functions.

For though it is true the utilization effort had been started by the State, the extension of this effort and the provision of the kind of information that is necessary for this review could not have been available under the prior existing State system. The estimated savings would not have been achieved without the impact of being able to assist in the development of the Foundation function and acceleration of its activities as provided by HAS' involvement. The report gives no indication of these contributions by HAS.

In addition, in its conclusion for this section, based on no evidenced data, a statement is made that "the improvement of program management and control claimed by the State are not a direct result of having an 'insuring agreement' because they could also be derived under a state-administered program or fiscal arrangement." Although the latter statement may be theoretically true, it should be evident to anyone examining the prior performance of the State under the program and the problems that this State and other States have had in administering the Medicaid program that a state administered program could not have achieved the improvements in program management that were achieved by HAS and in the time frame involved. This (sic) is also solid evidence to indicate that during the two months in which HAS simply acted as the fiscal agent, the total costs per eligible to the State were less than the cost per eligible for prior periods.

GAO Response:

Although our initial review was not aimed at assessing performance under the contract, State and Foundation officials have informed us that they believe the MMIS had not been fully implemented as of February 1976 and that they were not receiving all the information they needed and were supposed to get from the MMIS.

Regarding improved utilization review procedures, Foundation officials said they are not receiving all the data necessary or all the data they are supposed to receive. In

addition, Foundation officials said they could perform utilization review equally well under an insuring agreement, a fiscal agent agreement, or a State-administered program.

On the other hand, whatever HAS is able to accomplish in the area of management information systems would be an improvement over the prior State system. Our basic point was that such improvements are not necessarily the result of the underwriting or risk features of an insuring arrangement.

HAS was not able to provide us with information to substantiate that for the 2 months HAS acted as the State's fiscal agent the total costs per eligible were less than these costs for prior periods.

HAS Comment:

Chapter 3

The discussion leading up to the solicitation and contract award are in the main correct, although there are certain items on pages 9 through 15 which must be disputed. In HAS' efforts to obtain reinsurance, it discussed the contract with a number of major insurance companies in the country and presented the figures and basis for the agreed-upon rate: none of these major insurance concerns were prepared to become involved, even in reinsuring a portion of the risk which would have to be assumed by HAS. The fact that the North Carolina approach was new and innovative is totally ignored in the discussions concerning the reasonableness of the basis of the contract. Other than as indicated, Texas Blue Cross-Blue Shield which had a contract that did not assume anywhere near the risk that the North Carolina Program assumed and the Equitable Assurance Company which had insured medical services in several states, the idea of a total prepaid state contract had never been previously proposed. Therefore, the willingness to innovate and take risks, which had not been evidenced in the health insurance field since its inception, was accepted by HAS as a new approach. The failure to include recognition of this innovation is a major failing of the Draft Report. The contract, which provides a different approach to a situation which the Congress and the States have pointed

out to be a serious administrative and fiscal problem should have at least been identified by the GAO in its report.

It is disturbing to review the inconsistencies in the section on competition. Significant carriers were provided opportunity to bid and refused. To imply that the RFP favored HAS is untrue, and this was indicated in the response received from some of the others who received RFPs.

GAO Response:

The request for proposals was sent only to three insurance companies. One informed us that it did not receive the request. Another did not submit a proposal because the State did not provide it with adequate data on which to determine premium rates and because, at the time of the request, there was a question as to whether the State could legally enter into such an insurance arrangement. The third did not submit a proposal principally because it believed that, because of its lack of experience with Medicaid, the contract would be too risky.

HAS Comment:

[Related to matters discussed in the draft report but not included in this report.]

HAS Comment:

Also on page 13 an innuendo is made that because of HAS' involvement in the Drug program they had information which was not available to other bidders. This is not true, and all of this information was available as a matter of public record.

GAO Response:

Because of HAS' prior involvement in the State's Medicaid drug program, it had available to it the actual number of eligibles (both certified eligibles and eligible months) in

the program since January 1973. Although it is true that other prospective offerors could have obtained this data from PAID, when North Carolina Blue Cross-Blue Shield requested this information from the State, it was told this data was not readily available.

HAS Comment:

A statement was made in the digest ii and page 20 about the State not requesting data on which HAS based its proposed contract price. This is not so. In the negotiation sessions, which were open to the public and even attended by a reporter from one of the local newspapers, HAS did spell out how it arrived at its totals and indicated the amount that [it] had put into its rate determination for utilization control.

GAO Response:

See page 22 for a discussion of the cost and pricing data obtained by the State. Because of the lack of a record of negotiation, we could not determine what information HAS presented at the negotiation sessions.

HAS Comment:

HAS, in its collaborative efforts in drug utilization efforts, has achieved savings with the support of systems programming and report design which no other state has achieved in the drug programs when they have operated their own drug utilization review. The attempt to indicate that the State would have achieved the same savings in utilization control is without any sound understanding of the manner in which current programs are operated nor is it supported by any available data.

GAO Response:

We are not now in the position to respond to this comment.

HAS Comment:

Medicare Buy-in

Through pages 23, 24 a discussion of the Medicare "buy-in" is described with the term "windfall." In developing its rates, HAS did consider the Medicare buy-in for, and predicated its number on, eligible counts provided by the State and on the anticipated increase in rate that had been proposed for the fiscal years 76 and 77. The fact that the increase did not take place is true. However, what the report neglects to indicate is that in place of an increase, the law was changed so that the deductibles and copayment were increased. This produced additional costs for HAS and increased its exposure under the contract which will require an adjustment. It would seem that this factor should have been indicated in the discussion of this section.

GAO Response:

Since the request for proposals, the law has not been changed to increase Medicare part B deductibles and coinsurance. When we inquired about what HAS was referring to as an increase in the rate, we learned that it was the inpatient hospital deductible under Medicare part A, which is not involved in the buy-in. This increase was not related to a change in law but has been part of the Medicare program since its inception. The hospital deductible has changed every year since 1969. The amount of the deductible depends on the increases in hospital costs that have occurred during the previous year. The part A hospital deductible cost had already been increased for an inflation factor by the State in the data HAS used to compute its price.

HAS Comment:

In addition, the number of persons eligible for the buy-in exceeds those that were indicated in the preliminary data on which HAS based it figures. In negotiating the contract

the State utilized a figure of $400,000 per month as the estimated cost of Medicare buy-in. Based on actual expenditures, the monthly cost to HAS has exceeded $540,000. The use of the term "windfall profit" is obviously a prejudicial term and not substantiated by the facts which were available to GAO. The unanticipated increase in eligibles in the program is nowhere described as a "windfall loss" as far as HAS is concerned or a "windfall profit" as far as the State and Federal Governments.

GAO Response:

As stated on page 24, the Medicare buy-in program was included at a price substantially higher than $400,000.

HAS Comment:

Again the conclusions as stated on pages 26 and 27 are open to question. There seems to be no indication of the fact that prior information or the lack of comparative data might be a factor and that, based on the state of the art information and the innovative approach of the contract, both HAS and the State provided an effort that was reasonable to both parties at the time that the contract was negotiated. It will only be after the comparative expenditures for other States are available for the fiscal year 1976, that the benefit to the State will be evident. However, based on all of the information which is currently being made available, including the number of states that are reducing their benefits in this current fiscal year, results might prove that the North Carolina program will produce significant savings and will provide a more effective administrative mechanism to control program costs.

GAO Response:

The conclusions referred to have been modified to take note of the newness of the concept. We hope that HAS' predictions for beneficial results under the contract will be correct; however, because of differences in the methods of accounting between the State-administered and the HAS programs for reporting costs discussed in chapter 6, the comparisons contemplated by HAS may be difficult to make.

HAS Comment:

Nowhere in the draft report is there any indication of the slightest possibility that the program will turn out to be advantageous to the State or to the Federal Government. Yet it is HAS' firm belief that already significant savings and improvements are evident if only a cursory subjective evaluation is made. It is not our feeling that competition was limited. It is our belief that there are a lot of people sitting on the bank watching how well HAS does in the water and who may be willing to through (sic) some rocks to assure that they do not do well. However, once the concept inherent in the HAS approach does show signs of potential success there will be at first a few more swimmers and then, undoubtedly, a significant number. This competition, we believe, will be good for Medicaid and may be worthy of investigation for the administration of Medicare.

GAO Response:

We believe it is neither fair nor accurate to characterize the report as providing no indication of the slightest possibility that the program will turn out be advantageous to the State or to the Federal Government.

Although we have criticized some of the circumstances surrounding the award of the contract and pointed out that some of the expected benefits may not be fully realized, we have also mentioned our perceptions of the advantages to be realized from the arrangement. Specifically:

--The profit sharing arrangement does tend to mitigate the impact of any overpricing. (See p. 27.)

--Assuming the same eligibility criteria and benefit structure, the maximum monthly payment features do provide the State protection against the costs of unanticipated increases in eligibles and utilization. (See p. 39.)

--The expected reduction in the State's administrative costs resulting from fewer State personnel seemed a legitimate and reasonable benefit to be claimed for the contract. (See p. 39.)

HAS Comment:

An effort to introduce competition into Medicare's administration could be a very desirable activity that should be stimulated by both the Congress and GAO. it seems somewhat peculiar that since its inception there has been no competitive bidding available nor any type of administrative incentive contract initiated for the administration of all or portions of the Medicare program--a program which exceeds in dollar value the Medicaid effort.

GAO Response:

We agree, although there has been competitive bidding for Medicare data processing subcontracts. How to encourage more competition in this area has been the focus of much study and effort.

HAS Comment:

Monitoring Activities

On page 44 an allegation is made that State Officials have stated that the reports provided are of little value. HAS has worked with the state to train them to properly utilize the reports and to make adjustments for normal implementation problems and to provide additional reports beyond the MMIS requirements. During the same period Federal reporting requirements have also changed.

GAO Response:

State officials did tell us that the reports provided as of February 1976 were of little value.

HAS Comment:

On page 45 there are certain areas of discussion which involve disagreement between HAS and the North Carolina Accounting staff involving $420,000 of administrative expense. There is adequate backup and documentation for these funds. We feel that they will not be disallowed.

As far as the disbursement records are concerned, the use of the Corporate Central Disbursement system for payment of expenses represents an efficiency of operation and the elimination of an additional cost which avoids charges to the

program. There are adequate copies of backup for all of the expenses that are being disbursed under the program; and a complete set of satisfactory accounting records, as determined by the HAS public auditing firm, are available to anyone making any audits at the North Carolina facility. It goes without saying that this program has been probably the most audited program to date which includes both internal auditors as well as state, GAO and HEW representatives.

The underpayment of the 58 ICF providers has been entered into the adjustment system, and all proper payments and adjustments will be made. No effort has been made to purposefully undercompensate any provider. To offer the statement on page 45 without indicating that this error has been found and is being corrected is an improper implication.

GAO Response:

See page 45.

HAS Comment:

As previously indicated it is with real concern that we view the approach and manner utilized in this GAO draft. We would expect that there will be a reevaluation of the manner in which the information will be presented. The North Carolina approach may not be the ultimate, but it does provide a mechanism which is reducing costs to the State and Federal Governments. It combines the efforts of government, professional responsibility and involvement, and free enterprise to address a serious social, professional, and economic problem. It deserves objective evaluation and encouragement for improvement. It could well prove to be the only viable approach to the dilemma that faces the country today in providing health services to the elderly and poor at a cost that the taxpayers can reasonably afford.

If anything, the approach to North Carolina should be encouraged; and although the procedures can always be improved, it is HAS' belief that the imaginative approach adopted by the State and the risks assumed by HAS can only provide for a stimulation toward the improvement of the administration of Medicaid programs.

GAO Response:

We have considered HAS' views in finalizing this report.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
OFFICE OF THE SECRETARY
WASHINGTON, D.C. 20201

April 22, 1976

Mr. Gregory J. Ahart
Director, Manpower and
Welfare Division
United States General
Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

As requested in your letter of March 22, Department officials met with your staff to discuss your draft report, "North Carolina's Medicaid Insuring Agreement: Expected Benefits and Reasonable Cost Are Not Assured." I have enclosed a letter from Acting Administrator Social and Rehabilitation Service, Don Wortman, which confirms prior oral comments given at this meeting.

We appreciate the opportunity to comment on this draft report before its publication.

Sincerely yours,

John D. Young
Assistant Secretary, Comptroller

Enclosure

GAO note: The following is a verbatim et literatim copy of HEW's comments.

HEW Comment:

At the request of the General Accounting Office, members of the Medical Services Administration staff met with GAO representatives on Tuesday, March 30, 1976, to discuss the attached GAO report on Health Applications Systems (HAS) North Carolina Insuring agreement. The meeting ended without an understanding that GAO would make any changes in the report discussed. In addition, GAO did not request a written reply from the Department of Health, Education, and Welfare. I would like to give you our assessment of the GAO report so that you might ensure that HEW's views are adequately considered in the final report. We believe that no useful purpose will be served by publishing the report as it is now written.

We believe the report provides very little substantive or productive information. The dollar findings were communicated to Regional and State officials who agreed to take corrective actions. What remains in the report beyond these findings are inconclusive findings and other narrative on the basis of which GAO has made no recommendations. Thus, there is little that can be used to make decisions regarding the application of insuring arrangements to the Medicaid program.

Following is a brief discussion of the six findings of this report:

(1) The first finding was that part of the savings anticipated by the State from the contract would not be realized. In its computation of anticipated savings to accrue from the contract, the State erroneously included savings to the State due to the expectation of Federal sharing in Medicare part B payments for medically needy recipients. The GAO auditors communicated this fact to the SRS Associate Regional Commissioner for Management at the time of the audit and he agreed to collect from the State $317,000 in excess Federal funds already reimbursed for the first quarter of FY 1976. We do not see the value in GAO's interpretation of this finding as an indication that the State overestimated the savings to be realized from the contract, because there is no further corrective action that can be taken. This was an apparent oversight by the State.

GAO Response:

When the contract was approved in April 1975, the only reduction to the State budget the State agency attributed

directly to the insurance agreement was $4.4 million. This reduction was based principally on the erroneous assumption that the Federal Government could legally participate in the Medicare part B buy-in premiums on behalf of the medically needy. HEW had in fact participated in these ineligible payments until we brought the matter to its attention.

Federal participation in the Medicare buy-in premium for the medically needy was the principal quantified monetary benefit directly attributed to the insurance agreement at the time it was approved.

HEW Comment:

(2) The second finding was that the insuring contract would not place a ceiling on Medicaid expenditures as was expected because the contract allows for increased reimbursement to HAS if the State Legislature increases the maximum perdiem reimbursement rate for SNFs (and consequently for ICFs). The auditors note that this legislative action has occurred and the contract has been renegotiated. Such renegotiations were, of course, expected since the contract included provisions for them.

The auditors state further that there are two conflicting sections of the contract, one that allows for such renegotiations and one that does not. We do not agree with the auditors. We believe the two sections are in concert. The first says the contract can be renegotiated if there is a proposed change to North Carolina law or the State Medicaid Plan. The second section, which the auditors say contradicts the first, states that increased rates are allowed only to cover increased cost resulting from "increases in amount, duration or scope of services". We believe these words in the contract are applicable only when the proposed change is to the State Medicaid Plan and do not apply to legislative actions intended to account for inflationary pressures. Thus, we believe the terms of the contract are consistent.

Finally, the auditors stated it would be easy for HAS to receive the maximum monthly reimbursement because the

number of eligibles would probably never fall below 270,000. We believe the terms of the contract in this regard are appropriate to this insuring arrangement in which the State retains responsibility for eligibility determinations. If the capitation rate was based on more eligibles, as the auditors would apparently prefer, the reimbursement to the contractor would surely fluctuate and the arrangement would not be a true insurance type arrangement.

GAO Response:

In seeking approval of the contract from the State's Social Services Advisory Commission and the State's Legislative Advisory Budget Commission, the State agency emphasized that the contract provided a ceiling on Federal, State, and local funding requirements for the State Medicaid program. Also, the State agency comments on our draft report stated that "* * * the State of North Carolina has pioneered in the pre-paid health care programs that guaranteed a ceiling on Medicaid expenditures for the benefit of taxpayers." (Emphasis added.) Because the State has and continues to emphasize the "ceiling on expenditures" aspect of the contract, we believe it is appropriate for us to discuss it.

The differences between the two renegotiation clauses are discussed on pages 34 and 35. In addition, the second clause states that the only basis for renegotiation is a change in the amount, duration, or scope of services or administrative duties. No reference is made to the State Medicaid plan or any other document in the second clause.

HEW regulations state that, for a contract to be considered an insurance arrangement, the contractor must be

paid on the basis of a per capita amount for each eligible recipient enrolled under the contract. As pointed out in the report, the contract as initially negotiated by the State did not include a per capita amount. At HEW's urging, the State included a per capita amount in order to meet the requirements of an insuring arrangement. The per capita amount was set at an artifically high level, which virtually assures the contractor of receiving the maximum monthly payment included in the contract. Thus, if the contract contained a per capita rate which reflected the expected costs per eligible instead of the artificial per capita rate included in the contract, the contract would be, by HEW's definition, a true insurance agreement.

HEW Comment:

(3) The third finding was that certain program benefits the state agency expected to result from the insuring agreement (more comprehensive program data through the MMIS and improved medical and utilization review) were not a direct result of the insuring aspect of the contract. We agree that the insuring aspect of the contract was not the cause for more comprehensive program data and improved reviews. These improvements could have been attained through a State administered program or other type of contract. What the ensuring aspect did, in our opinion, was to help control the costs of the North Carolina Medicaid program.

GAO Response:

HEW agrees with our conclusion that improvements in management data and utilization review are not derived from the insuring aspect of the contract.

HEW Comment:

(4) The fourth finding was that the State's contracting procedures used for this procurement were not sound. According to GAO the procedures did not ensure adequate competition for the award and they did not ensure a reasonable contract price relative to the cost of performing the contract. The General Accounting Office believes that comparisons to budget do not constitute adequate methodology to ensure reasonableness of contract cost. In response, we believe that competition was ensured because more than adequate steps were taken by the State to encourage responses from other companies besides HAS. Furthermore, since GAO does not provide in the report its estimate of the cost of performing the contract or propose a better overall methodology for determining the reasonable cost, no decision can be made that the contract price in unreasonable.

GAO Response:

The factors inhibiting competition on this procurement are discussed on pages 9 to 14. Because of the types of firms solicited, the inadequacy of the data included in the request for proposals, the uncertain legal climate surrounding the procurement, and the doubts of some of the potential offerors about the impartiality of the request for proposals, we do not believe that the State took more than adequate steps to insure competition.

As stated in the report, it is too early in the contract period to evaluate contract performance. However, the State did in its comments present some data which it believed demonstrated that the contract was saving the State funds. Our analysis of the data submitted by the State and the reasons we believe that the State's comparisons are not valid are presented on pages 47 to 51.

We also stated in the report that, if the State had used available cost and pricing data, it would have had a better basis on which to conduct negotiations. (See pp. 19 to 22.

HEW Comment:

(5) The fifth finding was that there had not been enough HEW involvement in the contract negotiations. We agree with that assessment, but we re-emphasize the auditors' point that regulations in effect at that time did not require such involvement. Subsequently, regulations have been changed so that contracting procedures require more HEW staff involvement in future contracts of this type entered into by States.

GAO Response:

We stated that there was little HEW involvement before contract negotiations but that HEW did assist the State during negotiations.

HEW comment:

(6) The sixth finding was that GAO was unable to determine the sufficiency of contract monitoring because "HEW had not formalized its oversight procedures and the State had not fully implemented its State Plan for monitoring contract performance." The auditors said they thought the State Plan had adequate provisions if fully implemented.

GAO Response:

This statement is correct.

HEW Comment:

In conclusion, the report does not give us sufficient useful data to assess the value to us of participating in future insuring arrangements for Medicaid. We think the final report should give more consideration to that fact and we feel that publication of the present report would serve no useful purpose.

GAO Response:

This report comments on (1) the State's contracting procedures, (2) the basis on which the State expected to derive benefits from the contract, and (3) whether or not these benefits will be realized. We believe this information will be useful to any other States that might consider entering into a Medicaid insuring agreement and to HEW in its efforts to assist such States.

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