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C O M M I T T E E S   O N  
A P P R O P R I A T I O N S   S U B C O M M I T T E E   O N   A R T I C L E   I I  
A N D  
G E N E R A L   I N V E S T I G A T I N G   &   E T H I C S

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TEXAS HOUSE OF REPRESENTATIVES  
P.O. BOX 2910 • AUSTIN, TEXAS 78768-2910  
CAPITOL ROOM GW.4 • 512-463-0389

SARAH DAVIS  
CHAIRMAN  
APPROPRIATIONS S/C ON ART. II  
GENERAL INVESTIGATING & ETHICS

GREG BONNEN, M.D.  
VICE CHAIRMAN  
APPROPRIATIONS S/C ON ART. II

JOE MOODY  
VICE CHAIRMAN  
GENERAL INVESTIGATING & ETHICS



**JOINT HEARING AGENDA**  
HOUSE COMMITTEES ON  
APPROPRIATIONS SUBCOMMITTEE ON ART. II  
GENERAL INVESTIGATING AND ETHICS  
REPRESENTATIVE SARAH DAVIS, CHAIR  
WEDNESDAY, JUNE 27, 2018, 8:30 AM  
AUSTIN, TX  
CAPITOL ROOM E1.030

*Appropriations Interim Charge 18/General Investigating & Ethics Interim Charge 10: Monitor the agencies and programs under the Committees' jurisdictions and oversee the implementation of relevant legislation passed by the 85th Legislature*

- I. Call to Order**
- II. Roll Call**
- III. Chairman's Opening Remarks**
- IV. Committee Business: Oversight of Medicaid Managed Care Contracts**

*1. Panel 1: Patients & Impacted Individuals*

- Ms. Linda Badawo
- Ms. Heather Powell
- Ms. Marta Whitworth
- Ms. Nancy Toll
- Ms. Caroline Cheevers

*2. Panel 2: Managed Care Organizations*

- Mr. Mark Sanders, Chief Executive Officer, Superior HealthPlan
- Mr. David Harmon, Chief Medical Officer, Superior HealthPlan
- Ms. LeAnn Behrens, President for Medicaid, West Region, Amerigroup
- Mr. Daniel Chambers, Medicaid Executive Director, Cigna Health Spring
- Ms. Anne Rote, President, Molina Healthcare of Texas
- Mr. Don Langer, Chief Executive Officer, United Healthcare Community Plan of Texas

*3. Panel 3: State Agencies*

- Ms. Leora Rodell, Manager - Health & Human Services Data Analysis Team, Legislative Budget Board
- Mr. Mike Diehl, Analyst, Legislative Budget Board

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- Mr. John Young, Audit Manager, State Auditor's Office

APPROPRIATIONS S/C ON ART. II MEMBERS:  
DAWNNA DUKES • SERGIO MUÑOZ, JR. • KEVIN ROBERTS • J.D. SHEFFIELD • GENE WU

GENERAL INVESTIGATING & ETHICS MEMBERS:  
GIOVANNI CAPRIGLIONE • PONCHO NEVÁREZ • FOUR PRICE • HUGH D. SHINE • CHRIS TURNER

- Mr. Willie Hicks, Project Manager, State Auditor's Office
- Mr. Arby Gonzalez, Project Manager, State Auditor's Office
- Ms. Olga Rodriguez, Chief Strategy Officer, Health and Human Services Commission - Office of the Inspector General

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- Mr. Henry "Hank" Whitman, Commissioner, Department of Family & Protective Services
- Ms. Elizabeth "Liz" Kromrei, Director of Medical Services & Accountability Division, Department of Family & Protective Services
- Ms. Stephanie Muth, State Medicaid Director, Health & Human Services Commission
- Mr. Enrique Marquez, Deputy Executive Commissioner for Medical & Social Services, Health & Human Services Commission

#### 4. *Panel 4: Interested Parties and Stakeholders*

- Mr. Ken Janda, President & Chief Executive Officer, Community Health Choice
- Ms. Kabby Thomas, Director of Managed Care, Texas Children's Hospital
- Dr. Ray Tsai, Senior Vice President, Children's Medical Center of Dallas
- Dr. Ruchi Kaushik, Medical Director, Comprehensive Peds for Complex Needs, The Children's Hospital of San Antonio

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- Ms. Hannah Mehta, Protect Texas Fragile Kids
- Ms. Pamela McPeters, Vice President of Public Affairs, TexProtects

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- Mr. Bob Kafka, Organizer, ADAPT/PACT of Texas
- Mr. Terry Anstee, Healthcare Staff Attorney, Disability Rights Texas
- Mr. Dennis Borel, Executive Director, Coalition of Texans with Disabilities

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- Ms. Rachel Hammon, Executive Director, Texas Association of Home Care & Hospice
- Ms. Julie Ross, Board Member, The Arc of Texas
- Dr. Andrew "Andy" Keller, President, Meadows Mental Health Policy Institute

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- Dr. M. Ray Perryman, President & Chief Executive Officer, The Perryman Group
- Dr. Deane Waldman, Director, Center for Healthcare Policy, Texas Public Policy Foundation
- Ms. Anne Dunkelberg, Associate Director, Center for Public Policy Priorities

#### 5. *Public Testimony*

### V. **Recess/Adjourn**

# CIGNA-HEALTHSPRING TEXAS MEDICAID

June 27, 2018

**Together, all the way.®**



# Cigna-HealthSpring Texas Medicaid

## We serve Texas Medicaid STAR+PLUS Adults

- We have experience serving Texas Medicaid since 2011
- People who have disabilities or are age 65 or older
- We cover ~51,000 STAR+PLUS Medicaid only and dual eligible members as well as operate a Medicare and Medicaid (MMP) plan
- We operate in three Medicaid Service Areas (Northeast, Hidalgo and Tarrant) spanning 50 counties ranging from major metropolitan areas to rural areas of Texas





# Opportunities to improve Medicaid service delivery



**1**

## **Streamline the service coordination assessment requirements**

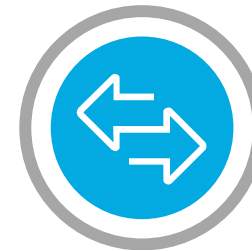
- Multiple required forms result in complex/redundant processes that reduce quality face-to-face time
- Create an MCO/HHSC workgroup to review required forms and design a more efficient process
- HHSC has begun addressing one such form (H1700-3 Nursing Service Plan)



**2**

## **Improve the complaint monitoring and reporting process**

- Ensure accurate and consistent data reporting across all MCOs
- Partner with HHSC to develop solutions for standardizing and improving complaint data collection to better identify policy issues and other areas for improvement



**3**

## **Improve continuity of services for members with providers and MCOs**

- Continuity of care is a critical component to ensuring the best health outcomes
  - Improves medical history retention and the reduction of duplicate services,
  - Allows time for chronic care programs to impact member health, and
  - Enhances the provider's ability to advocate for their patient
- Develop a process that encourages members to remain with the same providers (PCP, Attendant Agencies, etc.) and MCOs
- Member protections in place in order to support choice of provider

# APPENDIX

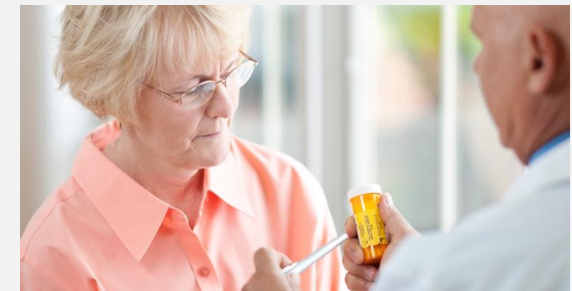
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# Caring for the most vulnerable

## Personalized Intensive Outreach for both Behavioral and Physical Health

### IMPROVING CARE FOR MEMBERS – 2016 VS. 2017:

- Emergency Room (ER) utilization:
  - Physical health visits decreased by 38%
  - Behavioral health visits decreased by 56%
- Readmission within 30 days (all cause)
  - Physical health readmissions decreased by 56%
  - Behavioral health readmissions decreased by 50%
- Inpatient per member per month costs
  - Physical health costs decreased by 26%
  - Behavioral health costs decreased by 18%



# Caring for the most vulnerable

## Chronic Respiratory Program

### IMPROVING CARE FOR MEMBERS – 2016 VS. 2017:

- 97% completed baseline spirometry testing
- Long acting medication use (standard of care)
  - 30% at time of enrollment vs. 83% post enrollment
- Short acting medication use (standard of care)
  - 47% at time of enrollment vs. 87% post enrollment
- For members who also had diabetes
  - 36% tested blood sugar at time of enrollment vs. 73% post enrollment



# Caring for the most vulnerable

## Comprehensive Diabetes Management

### IMPROVING CARE FOR MEMBERS – 2016 VS. 2017:

- Hospital readmission rates (all cause) decreased by 39%
- Members testing their blood sugar daily increased to 96%
- Members with a HbA1c value less than 8% increased to 75%
- The standard of care for individuals with diabetes to be treated with an ACE or ARB increased to 58%
- Members getting retinal eye exams increased to 53%
- Members getting tested for diabetic damage to their kidneys increased to 74%



# Tackling the opioid epidemic

Cigna Corporate-wide initiative:

Achieved a **25% reduction** in member prescriptions in two years by taking a holistic approach to care and collaborating with 1.1M prescribing clinicians.



- More than **9,000 provider groups** representing more than 130,000 prescribing clinicians have signed the Cigna opioid pledge, which aligns with the former U.S. Surgeon General's "Turn the Tide" pledge and the CDC's opioid prescribing guidelines.
- **National Veteran Support Line** free for all veterans, their families and caregivers – whether or not the veteran is a Cigna member that connects to services and resources for pain management, substance use counseling and treatment, and more.
- **Help with Pain consumer education campaign** and online resource hub to encourage patients and physicians to have conversations about pain management and the safe use of opioids.
- New commitment to achieve **25% reduction in opioid overdoses** among members in targeted U.S. communities by year-end 2021 through collaborative, community-approach to improve access to pain management and addiction care.





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## LEGISLATIVE BUDGET BOARD

# Medicaid Managed Care in Texas

**PRESENTED TO HOUSE COMMITTEES ON GENERAL INVESTIGATIONS AND  
ETHICS AND APPROPRIATIONS SUBCOMMITTEE ON ARTICLE II  
LEGISLATIVE BUDGET BOARD STAFF**

**JUNE 2018**



# Statement of Interim Charge

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Related to House Appropriations Committee Interim Charge 18 / General Investigating and Ethics Interim Charge 10: monitor the agencies and programs under the Committees' jurisdiction and oversee the implementation of relevant legislation passed by the 85<sup>th</sup> Legislature, including oversight of the Texas Health and Human Services Commission's management of Medicaid managed care contracts.

1. Overview and History of Medicaid Managed Care in Texas
2. Managed Care Costs and Capitation Rates
3. Medicaid Experience Rebates
4. HHSC Managed Care Contract Oversight
5. Managed Care Organization Procurement Process

# Medicaid Overview

**Medicaid** is a jointly-funded State/Federal program providing health insurance primarily to low-income parents, non-disabled children, pregnant women, the elderly, and people with disabilities. As a requirement of participation, states must cover certain groups and have the option to cover additional groups; Texas does not provide significant coverage of optional groups.

The Health and Human Services Commission (HHSC) is the single state agency responsible for Texas's Medicaid program, but services are administered by a variety of state agencies.

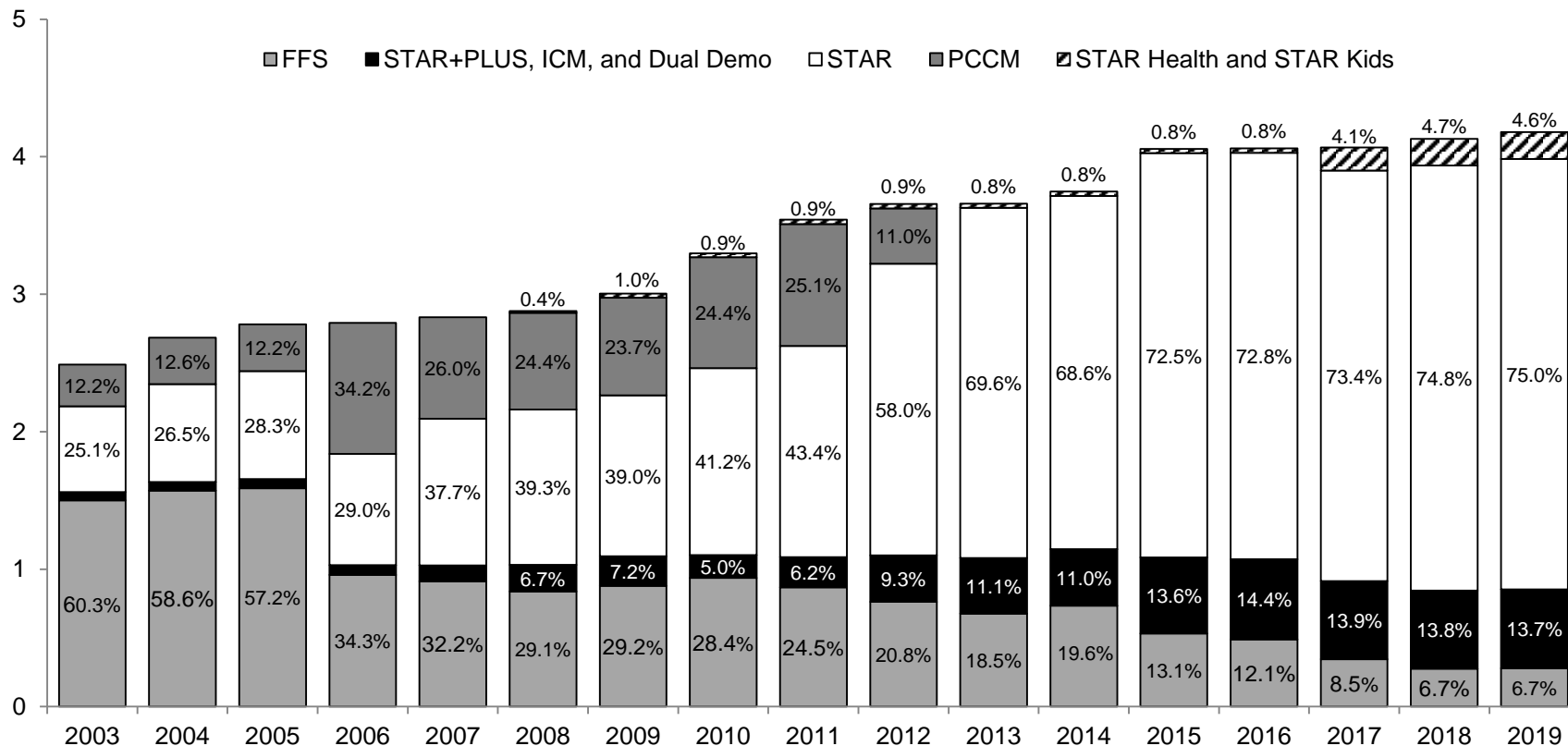
**Managed care** is a system of delivering health care in which the state contracts with managed care organizations (MCOs) to provide services to Medicaid members and pays the MCOs a per member per month amount (premium or capitation payment).

HHSC is responsible for monitoring MCO contract compliance, service utilization, and quality of care, as well as developing and maintaining Uniform Managed Care Contracts (UMCC) and the Uniform Managed Care Manual (UMCM).

# Medicaid Average Monthly Full-Benefit Caseload by Delivery Model

## Fiscal Year 2003 to 2019

IN MILLIONS



### NOTES:

(1) Represents average monthly number of clients receiving full-benefit Medicaid health insurance services. Managed Care delivery models include all but Fee-for-Service. The percent of clients receiving STAR+PLUS and ICM from 2003 to 2007 was between 2.4 and 4.1 percent.

(2) Fiscal years 2018 through 2019 are based on Legislative Budget Board projections prepared for the 2018-19 General Appropriations Act.

(3) Integrated Care Management (ICM) was an alternative to STAR+PLUS operating in Dallas from February 2008 through May 2009.

(4) Primary Care Case Management (PCCM) was a non-capitated model implemented in September 2005 and discontinued in March 2012.

SOURCES: Legislative Budget Board; Health and Human Services Commission.

# Current Managed Care Programs

## STAR

Serves eligible non-disabled children, pregnant women, and certain other adults.

Provides acute care, behavioral health care, and pharmacy services.

- August/December 1993: LoneSTAR managed care pilot programs implemented in Travis county and Chambers, Jefferson, and Galveston counties.
- December 1995: Expanded to three additional counties, renamed STAR (State of Texas Access Reform).
- September 1996: Expanded to Bexar, Lubbock, and Tarrant service areas and Travis area was expanded to include additional counties.
- December 1997: Expanded to Harris service area.
- 1999: Expanded to Dallas and El Paso service areas.
- 2006: Expanded to Nueces service area.
- September 2011: Expanded to counties contiguous to existing service areas and to Jefferson service area.
- March 2012: Expanded to Medicaid Rural Service Areas (MRSA) and Hidalgo service area.
- March 2012: Pharmacy benefits carved in. Children's dental services provided through a managed care model.
- September 2017: Expanded to include children for whom an adoption subsidy or permanency care assistance payment is made.

# Current Managed Care Programs (cont.)

## STAR+PLUS

Serves eligible adults with disabilities, adults over the age of 65, and women enrolled in Medicaid for Breast and Cervical Cancer.

Provides the same services as STAR but incorporates long-term-care services.

Includes waiver-like services for certain qualifying persons similar to the former Community-based Alternatives (CBA) waiver.

- December 1997: Implemented in Harris service area.
- February 2007: Expanded to Bexar, Travis, Nueces, and Harris contiguous service areas.
- February 2011: Expanded to Dallas and Tarrant service areas.
- March 2012: Expanded to El Paso, Lubbock, and Hidalgo service areas.
- March 2012: Pharmacy and inpatient hospital benefits carved in.
- September 2014: Expanded statewide.
- September 2014: Non-dual-eligible clients in waivers for individuals with intellectual and developmental disabilities and nursing-facility benefits carved in.
- September 2017: Expanded to include women enrolled in Medicaid for Breast and Cervical Cancer.

# Current Managed Care Programs (cont.)

## STAR Health

Serves foster children and certain former foster children.  
Provides a service array similar to STAR+PLUS but includes dental services.

- April 2008: Implemented statewide.
- March 2012: Pharmacy benefits carved in.

## Dual Demonstration

Serves persons dually eligible for Medicare and Medicaid who were previously enrolled in separate coverage for each program.  
Provides the full array of Medicaid and Medicare services.

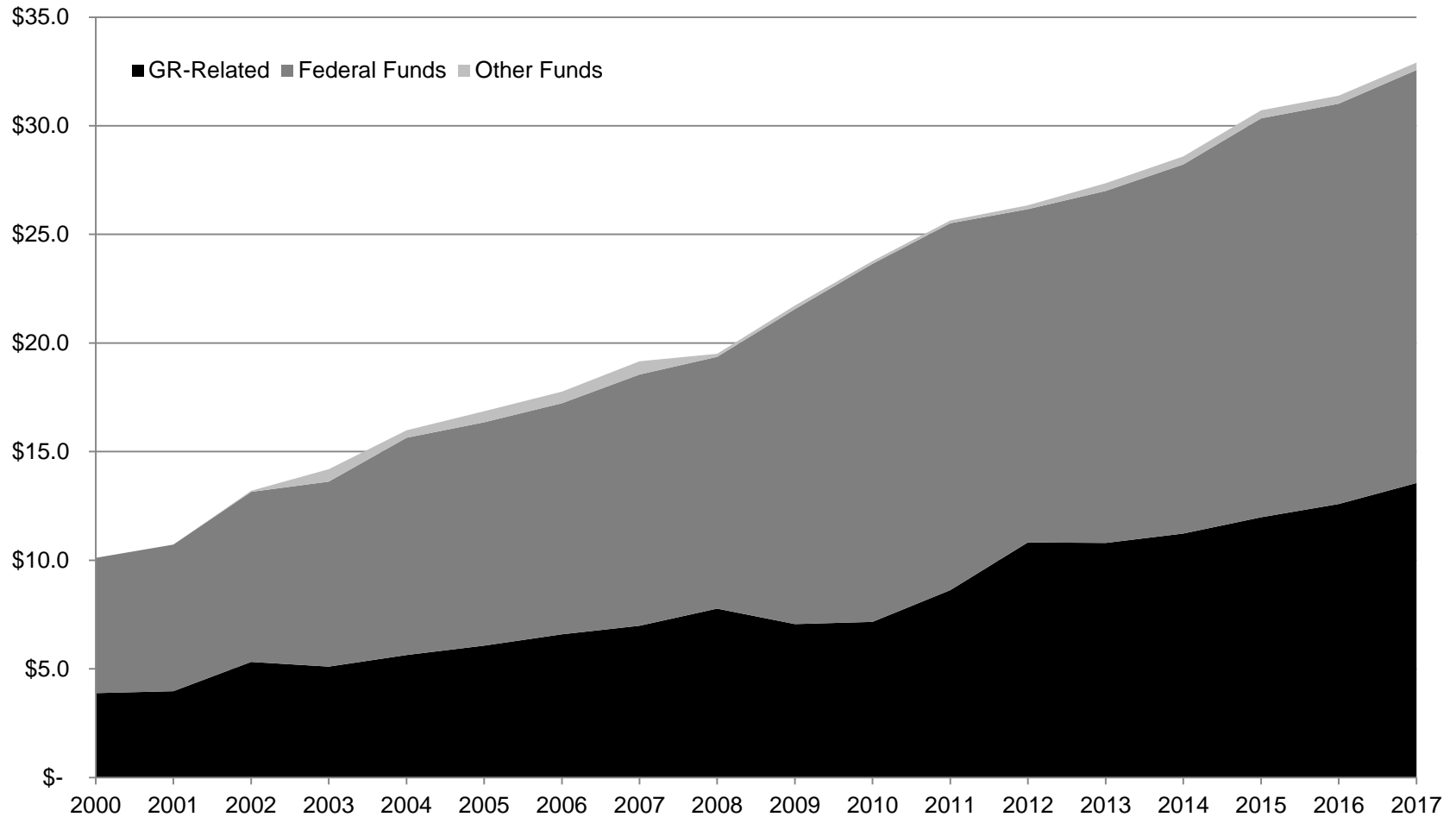
- September 2014: Implemented in Bexar, Dallas, El Paso, Harris, Hidalgo, and Tarrant counties.

## STAR Kids

Serves eligible children with disabilities.  
Provides a service array similar to STAR+PLUS.  
Includes children enrolled in the Medically Dependent Children Program (MDCP waiver).

- November 2016: Implemented statewide.

# Medicaid Funding by Method of Finance Fiscal Years 2000 to 2017



NOTES:

(1) Fiscal year 2017 is estimated.

SOURCE: Legislative Budget Board.

# Managed Care Capitation Rates

The state pays MCOs a set amount for each enrolled person, whether or not that person seeks care (capitation rate).

Capitation rates are set primarily on the basis of base year experience data, adjusted for cost, inflation, and utilization trends (trend factors). Capitation rates include the following components:

- (1) An amount for health care services performed (including adjustments for service-specific rate changes or the addition of new benefits);
- (2) An amount for administration (including both fixed and variable administrative components); and
- (3) An amount for the risk margin (reflecting the level of uncertainty regarding the costs of providing coverage).
  - Risk margin percentages were reduced beginning in fiscal year 2018 pursuant to Health and Human Services Commission Rider 37 in the 2018-19 General Appropriations Act.
    - From 2.0 to 1.5 percent for STAR and STAR Health
    - From 2.0 to 1.75 percent for STAR+PLUS and STAR Kids
- (4) An amount for premium tax.



# Experience Rebates

Texas Government Code, §533.104, requires HHSC to adopt rules to ensure MCOs share profits earned through the Medicaid managed care program. 1 TAC §353.3 states that each MCO must pay an experience rebate according to a tiered rebate method described in the MCOs contract with HHSC.

By contract, MCOs must submit a Financial Statistical Report (FSR) including revenue and cost data to HHSC every 12 months. At the end of each FSR Reporting Period, the MCO must pay an Experience Rebate to the state if the percentage of the MCO's Net Income Before Taxes is more than three percent of the total Revenue for the period. The amount of the rebate varies based on the percentages in the table below.

Revenue from experience rebates is appropriated to HHSC to fund Medicaid client services.

Pre-tax Income as a % of Revenues	MCO Share	State Share
> 3% and ≤ 5%	80%	20%
> 5% and ≤ 7%	60%	40%
> 7% and ≤ 9%	40%	60%
> 9% and ≤ 12%	20%	80%
> 12%	0%	100%

Source: Uniform Managed Care Contract

# Administrative Cap

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Under contract with HHSC, MCOs are required to assemble and pay a network of providers to provide covered services to members enrolled with the MCO. MCOs have flexibility to organize business practices and discretion over how to spend capitation payments, provided that the MCO meets all the requirements of the contract.

The Uniform Managed Care Contract provides for a cap on administrative expenses that an MCO may deduct from Revenue for the purposes of determining income subject to an Experience Rebate. The administrative cap:

- 1) Does not affect FSR reporting;
- 2) Does not prohibit the MCO from incurring administrative expenses above the cap; but
- 3) Requires that administrative expenses above the limit must be counted as Net Income for the purposes of calculating an Experience Rebate.

# Managed Care Contract Oversight

	Planning	Solicitation	Contract Award & Formation	Post Award
Internal Oversight	<ul style="list-style-type: none"> <li>• Medicaid/CHIP Staff</li> <li>• HHSC Management</li> </ul>	<ul style="list-style-type: none"> <li>• Medicaid/CHIP Staff</li> <li>• HHSC Management</li> </ul>	<ul style="list-style-type: none"> <li>• Medicaid/CHIP Staff</li> <li>• HHSC Management</li> </ul>	<ul style="list-style-type: none"> <li>• Medicaid/CHIP Staff</li> <li>• HHSC Management</li> <li>• Inspector General</li> <li>• Internal Audit</li> </ul>
External Oversight	<ul style="list-style-type: none"> <li>• Centers for Medicare &amp; Medicaid Services (CMS)</li> </ul>	<ul style="list-style-type: none"> <li>• Contract Advisory Team</li> </ul>	<ul style="list-style-type: none"> <li>• Attorney General (over \$250M)</li> </ul>	<ul style="list-style-type: none"> <li>• LBB</li> <li>• State Auditor</li> <li>• Federal HHS OIG</li> <li>• CMS</li> </ul>

# HHSC Managed Care Contract Oversight

Components of HHSC's contractual requirements on MCOs include:

- Specifying member's benefit packages;
- Setting service accessibility standards;
- Mandating provider network adequacy;
- Mandating a process for resolving member and provider complaints and appeals; and
- Establishing measures of quality.

HHSC is responsible for monitoring contract compliance and determining contractual remedies (including corrective action plans, assessment of liquidated damages, or contract termination) for non-compliance. Monitoring activities include:

- Agreed Upon Procedures engagements conducted by an audit contractor to verify accuracy of the FSR.
- Utilization Review of utilization management practices in managed care programs.
- Contracting with an external quality review organization to ensure state programs and contracted MCOs are compliant with established standards.

# HHSC MCO Contract Oversight

## 2018-19 General Appropriations Act

### Medicaid and CHIP Contracts and Administration (dollar amounts in millions)

Strategy	General Revenue	All Funds	FTEs
B.1.1, Medicaid Contracts and Administration	\$387.6	\$1,258.5	806.1
B.1.2, CHIP Contracts and Administration	\$2.1	\$30.3	60.0
Total	\$389.7	\$1,288.8	866.1

These strategies include costs for administering the Texas Medicaid and CHIP programs. Expenditures include staffing costs as well as contracted costs for the claims administrator, managed care quality monitoring support, enrollment broker services, informal dispute resolution, and MCO contract oversight.

# HHSC MCO Contract Oversight

## 2018-19 General Appropriations Act (cont.)

HHSC has broad authority to allocate funding and FTEs that are not otherwise restricted by a rider in the 2018-19 GAA between functions and activities within the Medicaid and CHIP Contracts and Administration strategies.

- **Transfer Authority**

- Provided by Rider 195, Limitations on Transfer Authority – Medicaid & CHIP Contracts and Administration
  - Requires HHSC to obtain written approval from the LBB and the Governor before making any transfers of funding, FTEs, or capital budget authority into or out of Strategy B.1.1, Medicaid Contracts and Administration or B.1.2, CHIP Contracts and Administration.
  - HHSC requested and received approval from the LBB on June 1, 2018 to transfer an additional \$4.5 million and 98.0 FTEs for the biennium from Strategy I.1.1, Integrated Eligibility and Enrollment, to Strategy B.1.1, to increase contract oversight and utilization review of the Medicaid program.

# Agency Requested Funding

## Eighty-fifth Legislature, Regular Session, 2017

- HHSC's LAR for the 2018-19 biennium included a request for \$13.7 million in All Funds (\$6.8 million in General Revenue Funds) and 79.0 FTEs for contract management, oversight, system improvements, and to extend the Quality Monitoring Program for Intermediate Care Facilities for Individuals with Intellectual Disabilities.
- Agency exceptional item requests are typically not funded in the Introduced General Appropriations Bills. Agencies were asked to revise their exceptional item requests after the General Appropriations Bills (Senate Bill 1 and House Bill 1) were Introduced.
- HHSC did not include the request in their revised exceptional item list after the General Appropriations Bills (Senate Bill 1 and House Bill 1) were Introduced.

# MCO Procurement Process

## Planning Phase

- Solicitation development and determination of evaluation criteria
- Solicitation review by the Contract Advisory Team

## Solicitation Phase

- Solicitation posted to Electronic State Business Daily website
- Pre-proposal conference and vendor questions

## Evaluation and Negotiation Phase

- Respondents evaluated against best value criteria
- Preliminary negotiation with vendors in competitive range
- Vendor selection and HHSC internal approval



# MCO Procurement Process (cont.)

## Contract Award

- Final negotiations with selected vendors
- Contract review by OAG and CMS
- Final review and approval by HHSC Executive management

## Contract Management and Oversight

- Internal
- External

# MCO Procurement Concerns

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- Staffing shortages
  - Procurement and Contracting Services (PCS) had 109 vacancies out of 256 total FTEs as of May 2018
- Evaluation Tools and Process
  - Lack of quality control in vendor scoring and evaluation
- Corrective Actions
  - Audits and management review of procurement processes
  - Procurement consultant RFP released in May 2018
  - In June, HHSC received approval to transfer \$0.6 million in All Funds (\$0.5 million in General Revenue) and 4.0 FTEs for the biennium into Strategy L.1.1, HHS System Supports, to increase salaries and provide for a quality control team in PCS



## LEGISLATIVE BUDGET BOARD

### **Contact the LBB**

Legislative Budget Board

[www.lbb.state.tx.us](http://www.lbb.state.tx.us)

512.463.1200



# A Summary of Audits Conducted by the State Auditor's Office Related to the Health and Human Services Commission and Managed Care Organizations

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## Background

- The State Auditor's Office (SAO) conducted three audits related to Texas Medicaid managed care organizations. They are:
  - *An Audit Report on Medicaid Managed Care Contract Processes at the Health and Human Services Commission* (Report No. 17-007, October 2016)
  - *An Audit Report on HealthSpring Life and Health Insurance Company, Inc., a Medicaid STAR+PLUS Managed Care Organization* (Report No. 17-025, February 2017)
  - *An Audit Report on the Health and Human Services Commission's Management of Its Medicaid Managed Care Contract with Superior HealthPlan, Inc. and Superior HealthPlan Network, and Superior's Compliance with Reporting Requirements* (Report No. 18-015, January 2018)



# **A Summary of Audits Conducted by the State Auditor's Office Related to the Health and Human Services Commission and Managed Care Organizations**

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## **Background**

- Texas Government Code, Section 321.013, requires the SAO to consider the performance of audits on contracts entered into by the Health and Human Services Commission (Commission) that exceed \$100 million in annual value, including a contract between the Commission and a managed care organization.
- Texas Government Code, Section 321.014, requires each audited department or entity to report on the manner in which the department or entity has addressed the findings and recommendations that are included in a report prepared by the State Auditor.



# **A Summary of Audits Conducted by the State Auditor's Office Related to the Health and Human Services Commission and Managed Care Organizations**

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*An Audit Report on Medicaid Managed Care Contract Processes at the Health and Human Services Commission (SAO Report No. 17-007, October 2016)*

## **Overall Conclusion**

**The Commission should develop and implement an overall strategy for planning, managing, and coordinating audit resources that it uses to verify the accuracy and reliability of program and financial information that managed care organizations (MCOs) report to it. The lack of an overall strategy has resulted in gaps in audit coverage of MCOs, lack of consistent follow-up on audit findings, inconsistent application of procedures, and duplication of effort.**

*The Commission self-reported on December 8, 2017, that it had implemented 7 of 17 recommendations in the report. The Commission reported the implementation status of the remaining 10 recommendations as incomplete or ongoing as of that date.*



# A Summary of Audits Conducted by the State Auditor's Office Related to the Health and Human Services Commission and Managed Care Organizations

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## Findings

- Chapter 1-A: The Commission Should Improve Its Processes for Performance Audits of MCOs
  - The Commission lacks a documented process to show how it determines which MCOs to audit.
  - For performance audits covering fiscal year 2011 through May 2016, the Commission did not verify or track whether MCOs corrected findings for 11 (92 percent) of 12 performance audits conducted.

*As of December 8, 2017, the Commission's reported that its target date for implementing SAO recommendations for the findings associated with this subchapter is July 30, 2018.*

- Chapter 1-B: The Commission Should Enhance Its Use of Agreed-upon Procedures (AUP) Engagements to Ensure That Financial Risks Are Consistently Addressed and Identified Issues Are Corrected
  - The Commission did not consistently require each audit firm to expand audit tests to determine whether identified errors were systemic within an MCO's operations and could materially affect the accuracy of financial statistical reports.



# A Summary of Audits Conducted by the State Auditor's Office Related to the Health and Human Services Commission and Managed Care Organizations

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## Findings (continued)

- The Commission does not have a process to issue corrective action plans to correct performance or noncompliance issues identified in AUP engagements.

*As of December 8, 2017, the Commission reported that the SAO recommendations for this subchapter were fully implemented.*

- Chapter 1-C: The Commission Should Obtain Greater Assurance About the Effectiveness of MCOs' Pharmacy Benefit Managers' Internal Controls and Compliance with State Requirements

- Since fiscal year 2012, the Commission has not conducted performance audits of the services that MCOs' pharmacy benefit manager contractors provide.

*As of December 8, 2017, the Commission reported that the Office of Inspector General was conducting an audit of one MCO with an expected completion date of January 31, 2018, and that third party performance audits were underway for all MCOs with an expected completion date of January 31, 2018.*





# A Summary of Audits Conducted by the State Auditor's Office Related to the Health and Human Services Commission and Managed Care Organizations

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## Findings (continued)

- Chapter 1-D: The Commission Should Improve Coordination of Audit Activities
  - The Office of Inspector General conducted performance audits on the financial statistical reports of 6 of the 8 MCOs that had been previously evaluated by contracted audit firms during AUP engagements.

*As of December 8, 2017, the Commission reported that the SAO recommendations for this subchapter were fully implemented*

- Chapter 2-A: The Commission Did Not Collect All Costs for Audit-related Services

*As of December 8, 2017, the Commission reported that the SAO recommendations for this subchapter were fully implemented.*

- Chapter 2-B: The Commission Collected Experience Rebates in a Timely Manner; However, It Should Improve Certain Collection Activities

*As of December 8, 2017, the Commission's reported target for implementing SAO recommendations for the findings associated with this subchapter was March 31, 2018.*



# A Summary of Audits Conducted by the State Auditor's Office Related to the Health and Human Services Commission and Managed Care Organizations

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## Findings (continued)

- Chapter 3: The Commission Should Use Information That Its External Quality Review Organization Contractor Provides to Strengthen Its Monitoring of MCO Performance

*As of December 8, 2017, the Commission's reported target for implementing SAO recommendations for the findings associated with this subchapter is July 31, 2018.*

- Chapter 4: The Commission Should Strengthen Its Security and Processing Controls Over Certain Information Technology Systems

*As of December 8, 2017, the Commission reported that the SAO recommendations for this subchapter were fully implemented.*



# A Summary of Audits Conducted by the State Auditor's Office Related to the Health and Human Services Commission and Managed Care Organizations

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## Audits of Managed Care Organizations

- *An Audit Report on HealthSpring Life and Health Insurance Company, Inc., a Medicaid STAR+PLUS Managed Care Organization (Report No. 17-025, February 2017)*
- *An Audit Report on the Health and Human Services Commission's Management of Its Medicaid Managed Care Contract with Superior HealthPlan, Inc. and Superior HealthPlan Network, and Superior's Compliance with Reporting Requirements (Report No. 18-015, January 2018)*

## Overall Conclusion

The overall conclusion for both the Healthspring and Superior audits was that each MCO accurately reported expenditures for medical and prescription drug claims to the Commission. Healthspring reported \$601.3 million in medical and prescription expenses in fiscal year 2015. Superior reported \$1.9 billion in medical and prescription expenses in fiscal year 2016. However:

- Both MCOs reported unallowable costs on their financial statistical reports.



# A Summary of Audits Conducted by the State Auditor's Office Related to the Health and Human Services Commission and Managed Care Organizations

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## Findings

### For the Healthspring audit:

- The SAO identified a total of \$3.8 million unallowable costs.
  - \$2.4 million of the \$3.8 million in unallowable costs were for bonuses and stock options for employees of affiliate organizations.

### For the Superior audit:

- The SAO expanded the scope of the Superior audit to include the business practices of the Commission. Auditors identified three areas in which the Commission's business practices did not align with the written terms of the cost principles in its contract with Superior. Specifically:
  - The Commission allowed Superior to report \$29.6 million in unallowable bonus and incentive payments to affiliate employees.



# A Summary of Audits Conducted by the State Auditor's Office Related to the Health and Human Services Commission and Managed Care Organizations

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## Findings (continued)

- The SAO recommended that:
  - ♦ The Commission should enforce the written terms of its contract with Superior or change the contract to align with its business practice of allowing MCOs to report affiliate employee bonus and incentive payments.
  - ♦ If the Commission amended its cost principles to allow MCOs to report bonus and incentive payments to affiliates, the Commission should require MCOs to report bonuses paid to affiliates separately from the corporate allocation line item in financial statistical reports to increase transparency.
- The Commission did not require Superior to obtain the Commission's prior written approval to report affiliate profits as costs.
  - The SAO recommended that the Commission:
    - ♦ Follow the approval process in its contract before allowing affiliate profits to be reported as costs.
    - ♦ Include a separate section in its template for financial statistical reports to separately identify and report affiliate profits.



# A Summary of Audits Conducted by the State Auditor's Office Related to the Health and Human Services Commission and Managed Care Organizations

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## Findings (continued)

- The Commission cited a federal regulation that was not applicable to its Medicaid contracts related to a limitation on reporting executive compensation. As a result, the Commission's limitation on reporting executive compensation may not be enforceable.
  - The SAO recommended that the Commission review and adjust if necessary the cost principle related to limitations on executive compensation.

*After the SAO audit of the Commission and Superior, the Commission amended its cost principles on May 15, 2018.*



# **A Summary of Audits Conducted by the State Auditor's Office Related to the Health and Human Services Commission and Managed Care Organizations**

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## **Changes in Cost Principles Made in Response to SAO Audits**

- Bonuses and incentive payments paid to employees of MCO affiliates:
  - The Commission's revised cost principles allow MCOs to make bonus and incentive payments to individuals whose activities support Texas Medicaid, including affiliate employees.
  - The Commission's revised cost principles do not address the SAO recommendation to report bonuses paid to affiliate employees separately from the corporate allocation line item.
- Reporting Affiliate Profits
  - The Commission's revised cost principles removed the requirement for MCOs to obtain prior approval for reporting affiliate profits as costs.
  - The Commission's revised cost principles require MCOs to report medical claims and services at fair market value. In addition, the revised cost principles require allocated and outsourced administrative costs to be reported at cost.
  - The Commission's revised cost principles remove the requirement that MCOs separately identify and report affiliate profits.



# **A Summary of Audits Conducted by the State Auditor's Office Related to the Health and Human Services Commission and Managed Care Organizations**

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## **Changes Made in Response to SAO Audits (continued)**

- Limitation on Executive Compensation
  - The Commission's revised cost principles modified the language regarding the limitation on executive compensation.





# A Summary of Audits Conducted by the State Auditor's Office Related to the Health and Human Services Commission and Managed Care Organizations

## Issue Ratings

- *An Audit Report on Medicaid Managed Care Contract Processes at the Health and Human Services Commission* (Report No. 17-007, October 2016)

Summary of Chapters/Subchapters and Related Issue Ratings		
Chapter/ Subchapter	Title	Issue Rating <sup>a</sup>
1-A	The Commission Should Improve Its Processes for Performance Audits of MCOs	Priority
1-B	The Commission Should Enhance Its Use of Agreed-upon Procedures Engagements to Ensure That Financial Risks Are Consistently Addressed and Identified Issues Are Corrected	High
1-C	The Commission Should Obtain Greater Assurance About the Effectiveness of MCOs' Pharmacy Benefit Managers' Internal Controls and Compliance with State Requirements	Priority
1-D	The Commission Should Improve Coordination of Audit Activities	High
2-A	The Commission Did Not Collect All Costs for Audit-related Services	Medium
2-B	The Commission Collected Experience Rebates in a Timely Manner; However, It Should Improve Certain Collection Activities	Low
3	The Commission Should Use Information That Its External Quality Review Organization Contractor Provides to Strengthen Its Monitoring of MCO Performance	Low
4	The Commission Should Strengthen Its Security and Processing Controls Over Certain Information Technology Systems	Medium



# A Summary of Audits Conducted by the State Auditor's Office Related to the Health and Human Services Commission and Managed Care Organizations

- *An Audit Report on HealthSpring Life and Health Insurance Company, Inc., a Medicaid STAR+PLUS Managed Care Organization (Report No. 17-025, February 2017)*

Summary of Subchapters and Related Issue Ratings		
Subchapter	Title	Issue Rating <sup>a</sup>
1-A	HealthSpring Accurately Reported the Medical Claims and Prescription Drug Claims That It Paid in Fiscal Year 2015	Low
1-B	HealthSpring Included Unallowable Costs in the Bonuses It Reported on Its Financial Statistical Reports, and It Did Not Prepare Required Certifications and Personnel Activity Reports	High
1-C	HealthSpring Did Not Develop a Written Allocation Methodology as Required, and It Overstated Its Reported Allocated Corporate Costs on Its Financial Statistical Reports	High
1-D	HealthSpring Did Not Consistently Maintain Documentation to Show That Certain Legal and Professional Services Costs Were Applicable to STAR+PLUS and Incurred During the Reporting Period	Medium
1-E	HealthSpring Did Not Report Accurate and Complete Information About Its Affiliate Companies	Medium
2-A	HealthSpring Did Not Consistently Document the Reasons for Post-payment Adjustments That It Made to Paid Medical Claims	High
2-B	HealthSpring Did Not Ensure That It Paid All Medical Claims Within 30 Days of Receipt of a Clean Claim as Required	Medium



# A Summary of Audits Conducted by the State Auditor's Office Related to the Health and Human Services Commission and Managed Care Organizations

- *An Audit Report on the Health and Human Services Commission's Management of Its Medicaid Managed Care Contract with Superior HealthPlan, Inc. and Superior HealthPlan Network, and Superior's Compliance with Reporting Requirements (Report No. 18-015, January 2018)*

Summary of Subchapters and Related Issue Ratings		
Chapter/ Subchapter	Title	Issue Rating <sup>a</sup>
1-A	The Commission Allowed Superior to Report Bonus and Incentive Payments to Affiliate Employees in Fiscal Year 2016	Priority
1-B	The Commission Did Not Enforce Its Cost Principles Related to Reporting Affiliate Profits	Priority
1-C	The Commission Cited a Federal Regulation That Was Not Applicable to Its Medicaid Contracts Related to a Limitation for Reporting MCO Executive Compensation, and That Limitation May Not Be Enforceable	Priority
2-A	Superior Accurately Reported Medical and Prescription Claims in Its Financial Statistical Report for Fiscal Year 2016	Low
2-B	Superior Did Not Consistently Report Accurate Expenditures In Its Fiscal Year 2016 Financial Statistical Report	Medium
3-A	Superior Paid Claims for Drugs Covered by the Commission's Vendor Drug Program and Adjudicated Medical and Pharmacy Claims Within the Required Time Frames	Low
3-B	Superior Denied Medical Claims in Accordance with Its Contract; However, It Should Ensure That it Consistently Responds to Appeals and Notifies Providers About Appeals as Required	Medium



# A Summary of Audits Conducted by the State Auditor's Office Related to the Health and Human Services Commission and Managed Care Organizations

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- A chapter or subchapter is rated **Priority** if the issues identified present risks or effects that if not addressed could critically affect the audited entity's ability to effectively administer the program(s)/function(s) audited. Immediate action is required to address the noted concern and reduce risks to the audited entity.
- A chapter or subchapter is rated **High** if the issues identified present risks or effects that if not addressed could substantially affect the audited entity's ability to effectively administer the program(s)/function(s) audited. Prompt action is essential to address the noted concern and reduce risks to the audited entity.
- A chapter or subchapter is rated **Medium** if the issues identified present risks or effects that if not addressed could moderately affect the audited entity's ability to effectively administer program(s)/function(s) audited. Action is needed to address the noted concern and reduce risks to a more desirable level.
- A chapter or subchapter is rated **Low** if the audit identified strengths that support the audited entity's ability to administer the program(s)/functions(s) audited or the issues identified do not present significant risks or effects that would negatively affect the audited entity's ability to effectively administer the program(s)/function(s) audited.



An Audit Report on

# **Medicaid Managed Care Contract Processes at the Health and Human Services Commission**

October 2016  
Report No. 17-007



An Audit Report on

# Medicaid Managed Care Contract Processes at the Health and Human Services Commission

SAO Report No. 17-007  
October 2016

## Overall Conclusion

The Health and Human Services Commission (Commission) should develop and implement an overall strategy for planning, managing, and coordinating audit resources that it uses to verify the accuracy and reliability of program and financial information that managed care organizations (MCOs) report to it. The lack of an overall strategy has resulted in gaps in audit coverage of MCOs, lack of consistent follow-up on audit findings, inconsistent application of procedures, and duplication of effort.

The Commission paid a total of \$35.7 billion to MCOs for Medicaid managed care between **fiscal years 2013 and 2015**. **The Commission's** need for a well-defined strategy for managing audit resources in an effective and efficient manner is increasingly important due to the continued expansion of Medicaid managed care programs in areas such as behavioral health services, prescription drug benefits, and nursing facilities.

The Commission contracts with two audit firms for periodic performance audits and annual agreed-upon procedures (AUP) engagements of MCOs. The Commission uses those audit activities as a key component to verify the accuracy and reliability of information that it uses to monitor MCO compliance with Medicaid managed care contract requirements (see text box for definitions of AUP engagements and performance audits). The Office of Inspector General also conducts performance audits of MCOs.

The audit activities performed by contracted audit firms and the Office of Inspector General

### Background Information

The 72nd Legislature established a Medicaid managed care pilot program. In a managed care program, a managed care organization (MCO) is paid for each client enrolled. In managed care, clients receive health care services through a network of doctors, hospitals, and other health care providers that have contracted with the MCO. The Health and Human Services Commission (Commission) continues to expand Medicaid managed care. In fiscal year 2013, 80 percent of the **State's** Medicaid population was enrolled in managed care.

As of February 2015, Texas Medicaid managed care programs included State of Texas Access Reform (STAR), STAR+PLUS, NorthSTAR, STAR Health, and **Children's Medicaid Dental Services**.

Sources: *Texas Medicaid and CHIP in Perspective*, Tenth Edition, Health and Human Services Commission, February 2015, and data from the Uniform Statewide Accounting System.

### Audit-related Activities for MCOs

Agreed-upon Procedures (AUP) Engagements - The Commission uses AUP engagements to verify financial statistical reports that MCOs submit to validate whether MCOs owe the Commission money under the **State's Medicaid rebate requirements**. In an AUP engagement, the auditor reports only on the findings related to the procedures that the Commission approved.

Performance Audits - Performance audits are greater in scope than AUP engagements. They provide **assurance regarding the effectiveness of MCOs'** internal controls and should address fraud, waste, and abuse as part of the audit scope. The objectives of those audits are based on the risks identified at each MCO. The Commission approves the scope and objectives for each performance audit. Examples of performance audits that the Commission had its contracted audit firms conduct in fiscal years 2011 **through 2015 included coverage of MCOs'** subcontractor monitoring, claims processing, and complaints tracking. Those performance audit reports included reviews of internal controls, and some audits had findings related to subcontractor monitoring, claims processing, and complaints tracking.

Sources: The Commission and generally accepted governmental auditing standards.

This audit was conducted in accordance with Texas Government Code, Sections 321.0131 and 321.0132.

For more information regarding this report, please contact John Young, Audit Manager, or Lisa Collier, First Assistant State Auditor, at (512) 936-9500.

varied in frequency and methodology. The Commission has not comprehensively defined how those different audit approaches address the risks associated with Medicaid managed care, and it does not use results of those audit activities to **monitor MCOs' performance**.

The weaknesses in the Commission's **use of audit resources are discussed in more detail below**.

The Commission lacks a documented audit selection process, and there are gaps in **the Commission's** performance audit coverage.

The Commission lacks a documented process to show how it determines which MCOs to audit. Although the Commission paid contracted audit firms a total of \$1,337,525 to assess the risks of each MCO in fiscal years 2011, 2013, and 2015, it did not document how those risk assessments were used to select which MCOs to audit. The risk assessments identified risk areas for all of the MCOs reviewed. However, the Commission did not audit 12 (52 percent) of the 23 MCOs that provided Medicaid services from fiscal year 2011 through fiscal year 2015.

In addition, since fiscal year 2012 the Commission has not conducted performance **audits of the services that MCOs' pharmacy benefit manager contractors** provide. Pharmacy benefit manager contractors administer the prescription drug benefits of MCOs. From March 2012 to August 2015, MCOs reported they paid \$235,199,287 to pharmacy benefit manager contractors to administer \$7.4 billion in prescription benefits.

The Commission did not sufficiently follow up on issues identified from performance audits and AUP engagements.

The Commission did not follow up on issues identified in 11 of 12 performance audits conducted, and it did not issue any corrective action plans related to issues identified in the AUP engagements.

The Commission did not ensure that procedures for identifying issues at MCOs were consistent between the two contracted audit firms.

When performing AUP engagements for the Commission, both contracted audit firms have the same objective of validating **MCOs' financial statistical reports that** the Commission uses to verify the amount of "experience rebates"<sup>1</sup> that MCOs owe. **However, the Commission's requirements for the audit firms to expand** certain tests were different for each of the two firms. The Commission did not require each audit firm to expand those tests to determine whether identified errors were systemic within an **MCO's operations and could materially affect the** accuracy of financial statistical reports.

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<sup>1</sup> "Experience rebates" are a portion of an MCO's net income before taxes that is returned to the State in accordance with statute and the uniform managed care contract terms.

The Commission's **Medicaid** CHIP division and the Office of Inspector General did not coordinate audit coverage to minimize duplication of effort.

The Office of Inspector General conducted performance audits on the financial statistical reports of 6 of the 8 MCOs that had been previously evaluated by contracted audit firms during AUP engagements. The Commission paid those contracted audit firms a total of \$236,415 to evaluate those financial statistical reports.

The Commission did not collect all costs for audit-related services.

The Commission did not collect \$2,022,025 (41 percent) of the \$4,950,664 in costs that it incurred for fiscal years 2011 through 2015 for audit-related services for which MCOs were required to reimburse the Commission.

The Commission generally collected rebates from MCOs as required.

The Commission collected \$787,077,260 (99.6 percent) of the \$789,862,545 in experience rebates that MCOs were contractually required to pay the Commission for fiscal years 2011 through 2014. However, it did not resolve in a timely manner the experience rebates that certain MCOs disputed. Specifically, the Commission did not collect \$3,458,395 in required rebates from 3 MCOs for fiscal years 2011, 2012, and 2013 as a result of unresolved disputes.

The Commission should use information from its External Quality Review Organization to strengthen its monitoring of **MCOs' performance**.

**The Commission's Health Plan Management unit indicated that it did not receive detailed information available from the Commission's External Quality Review Organization.** The Health Plan Management unit could use that detailed information to strengthen its monitoring efforts. Specifically, the detailed information includes performance information on MCOs from Medicaid client surveys, such as ratings on **access to urgent care or Medicaid clients' ratings of** their health plans.

The Commission should strengthen controls over certain information technology systems.

The Commission did not establish adequate information technology controls to ensure that its reconciliations of daily deposits were documented, access to its systems was appropriate, and changes to the systems were documented.



Table 1 presents a summary of the findings in this report and the related issue rating. (See Appendix 2 for more information about the issue rating classifications and descriptions.)

Table 1

Summary of Chapters/Subchapters and Related Issue Ratings		
Chapter/ Subchapter	Title	Issue Rating <sup>a</sup>
1-A	The Commission Should Improve Its Processes for Performance Audits of MCOs	Priority
1-B	The Commission Should Enhance Its Use of Agreed-upon Procedures Engagements to Ensure That Financial Risks Are Consistently Addressed and Identified Issues Are Corrected	High
1-C	The Commission Should Obtain Greater Assurance About the Effectiveness of <b>MCOs' Pharmacy Benefit Managers'</b> Internal Controls and Compliance with State Requirements	Priority
1-D	The Commission Should Improve Coordination of Audit Activities	High
2-A	The Commission Did Not Collect All Costs for Audit-related Services	Medium
2-B	The Commission Collected Experience Rebates in a Timely Manner; However, It Should Improve Certain Collection Activities	Low
3	The Commission Should Use Information That Its External Quality Review Organization Contractor Provides to Strengthen Its Monitoring of MCO Performance	Low
4	The Commission Should Strengthen Its Security and Processing Controls Over Certain Information Technology Systems	Medium
<sup>a</sup> A chapter or subchapter is rated Priority if the issues identified present risks or effects that if not addressed could critically affect the <b>audited entity's ability to effectively administer the program(s)/function(s) audited. Immediate action is required</b> to address the noted concern and reduce risks to the audited entity. A chapter or subchapter is rated High if the issues identified present risks or effects that if not addressed could substantially affect the <b>audited entity's ability to effectively administer the program(s)/function(s) audited. Prompt action is essential to address</b> the noted concern and reduce risks to the audited entity. A chapter or subchapter is rated Medium if the issues identified present risks or effects that if not addressed could moderately affect the <b>audited entity's ability to effectively administer program(s)/function(s) audited. Action is needed to address the noted concern</b> and reduce risks to a more desirable level. A chapter or subchapter is rated Low if the <b>audit identified strengths that support the audited entity's ability to administer the program(s)/functions(s) audited</b> or the issues identified do not present significant risks or effects that would negatively affect the <b>audited entity's ability to effectively administer the program(s)/function(s) audited.</b>		

Auditors communicated other, less significant issues in writing to Commission management.

## *Summary of **Management's Response***

At the end of each chapter in this report, auditors made recommendations to address the issues identified during this audit. The Commission generally agreed **with the recommendations in this report. The Commission's management's** responses are presented in Appendix 6.

## *Audit Objective and Scope*

The objective of this audit was to determine whether the Commission and the Office of Inspector General administer selected Medicaid managed care contract management processes and related controls in accordance with contract terms, applicable laws, regulations, and agency policies and procedures.

**The scope of this audit covered the Commission's Medicaid managed care** contracted audit activities from fiscal year 2011 through fiscal year 2015, performance audits conducted by the Office of Inspector General from fiscal year 2011 through fiscal year **2015, and the Commission's External Quality Review** Organization contract for fiscal years 2014 and 2015.

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# Detailed Results

## Chapter 1

### *The Commission Should Improve Its Use of Audit Activities to Monitor MCOs*

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The Health and Human Services Commission (Commission) contracts with external auditors to perform periodic performance audits and annual agreed-upon procedures (AUP) engagements of Medicaid managed care organizations (MCOs). In addition, the Office of Inspector General conducts performance audits of MCOs. However, the Commission should develop and implement an overall strategy for planning, managing, and coordinating its audit-related resources for verifying information that MCOs report to it. The lack of an overall strategy for auditing MCOs has resulted in gaps in audit coverage, lack of consistent follow-up on audit findings, inconsistent application of procedures, and duplication of effort.

#### Chapter 1-A

#### The Commission Should Improve Its Processes for Performance Audits of MCOs

Chapter 1-A  
Rating:  
Priority<sup>2</sup>

The Commission uses performance audits to obtain assurance about MCOs' internal controls and compliance. However, the Commission lacks a documented process to determine which MCOs should receive a performance audit and what the scope and objectives of each performance audit should be. While the Commission's contracted audit firms conducted performance audits of 11 MCOs covering fiscal years 2011 and 2015, the Commission did not document why it selected those MCOs to be audited.

The Commission paid contracted audit firms \$1,337,525 to perform risk assessments of MCOs in fiscal years 2011, 2013, and 2015. According to the Commission, it discussed those risk assessments, which identified risk areas for all of the MCOs reviewed, with the contracted audits firms. However, the Commission did not document how it used those risk assessments to determine which MCOs to audit. For example, the Commission did not have documentation showing why it had not audited the MCO that one contracted audit firm identified as the highest risk and recommended be audited.

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<sup>2</sup> The risks related to the issues discussed in Chapter 1-A are rated as Priority because they present risks or results that if not addressed could critically affect the audited entity's ability to effectively administer the program(s)/function(s) audited. Immediate action is required to address the noted concern(s) and reduce risks to the audited entity.

Without a documented process to determine which MCOs pose the highest risk, the Commission cannot ensure that MCOs that present the greatest risks to Medicaid managed care receive audit coverage. Of the 23 MCOs with active contracts with the Commission from fiscal year 2011 through fiscal year 2015, 12 (52 percent) had not received a performance audit during that time. According to Texas Government Code, Section 531.02412 (a), “the Commission shall make every effort to ensure the integrity of Medicaid. To ensure that integrity, the Commission shall perform risk assessments of every element of the program and audit those elements of the program that are determined to present the greatest risks.” Performance audits are used to provide the Commission with assurance about whether a MCO’s internal controls are operating effectively.

The Commission did not verify that MCOs corrected performance audit findings.

The Commission does not have a documented process for how it should follow up on performance audit findings. For performance audits covering fiscal year 2011 through May 2016, the Commission did not verify or track whether MCOs corrected findings for 11 (92 percent) of 12 performance audits conducted.<sup>3</sup> The Commission asserted that it follows up verbally on the status of performance audit findings and recommendations. However, it did not document any follow up, and it also did not require its contracted audit firms to perform follow-up on performance audits.

In addition, the Commission does not have a documented process for determining when a corrective action plan should be issued in response to performance audit findings. For the 12 performance audits discussed above, only 1 MCO received a corrective action plan from the Commission that required the MCO to address the audit findings. For the one performance audit for which the Commission issued a corrective action plan, the findings included issues with subcontractor monitoring. However, three other performance audits for which the Commission did not issue corrective action plans also included findings with subcontractor monitoring. The Commission did not have documentation showing why corrective action plans were not issued for those other audits. Examples of other findings in the 11 performance audits for which the Commission did not issue corrective action plans included problems with MCOs’ claims processing and complaints procedures.

If the Commission does not adequately document its follow-up activities or if it does not consistently issue corrective action plans, it cannot fully ensure the integrity of Medicaid, as required by Texas Government Code, and

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<sup>3</sup> Eleven of 23 MCOs active from fiscal year 2011 through fiscal year 2015 received performance audits during that time. However, 12 individual performance audits were conducted; and one MCO (Seton Health Plan) received two separate performance audits.

findings at MCOs may not be resolved, which may present greater risks to Medicaid patients and to the State.

Performance audits met certain requirements.

All 12 performance audits conducted by the Commission's contracted audit firms indicated that internal controls and fraud, waste, and abuse at MCOs were considered, as required by generally accepted governmental auditing standards.

#### Recommendations

##### The Commission should:

- Document the process it uses to select MCOs to audit.
- Prioritize the highest risk MCOs to audit.
- Include previous audit coverage as a risk factor in selecting MCOs to audit.
- Establish a process to document its follow-up on performance audit findings and verify the implementation of audit recommendations.
- Establish and implement policies and procedures to (1) determine when a corrective action plan should be issued and (2) follow up on MCO implementation of corrective action plans.

## The Commission Should Enhance Its Use of Agreed-upon Procedures Engagements to Ensure That Financial Risks Are Consistently Addressed and Identified Issues Are Corrected

Chapter 1-B  
Rating:  
High<sup>4</sup>

For fiscal years 2011 through 2013, the Commission used agreed-upon procedures (AUP) engagements to ensure that the annual financial statistical reports MCOs submitted to the Commission complied with contractual reporting requirements (see text box for more information on financial statistical reports). The Commission used those reports to determine the amount of experience rebates that MCOs were required to pay to the Commission (see text box for information about experience rebates). However, opportunities exist for the Commission to enhance its use of AUP engagements to identify MCOs' performance and compliance issues and to ensure that the issues identified in AUP engagements are corrected.

To identify systemic issues, the Commission should ensure that certain procedures are performed in a consistent manner by each contracted audit firm.

AUP engagements include procedure steps to verify that certain financial items such as medical claims, pharmacy claims, and administrative expenses are appropriate, accurate, and reported in compliance with applicable requirements. When performing AUP engagements for the Commission during fiscal years 2011 through 2013, both contracted audit firms had the same objective of validating MCOs' financial statistical reports that the Commission uses to verify the amount of experience rebates that MCOs owed. However, the Commission approved different procedures for each contracted audit firm. For example, of the AUP engagements that the State Auditor's Office reviewed:

- The Commission approved different procedures to identify possible systemic errors in the MCOs' financial reports for the two audit firms with which the Commission contracted to perform AUP engagements in fiscal year 2013. The procedures the Commission approved for one contracted audit firm, which evaluated 11 MCOs, required the audit firm to discuss

### Financial Statistical Reports

The Commission receives financial statistical reports from MCOs on a quarterly and annual basis as required by the Commission's contracts with the MCOs. Those reports are the primary statements of financial results submitted by MCOs to the Commission. The Commission uses the reports to analyze the MCO's membership, revenues, expenses, and net income by service area and program.

Source: The Commission.

### Experience Rebates

Texas Government Code, Section 533.014, requires the Commission to adopt rules that ensure MCOs share profits they earn through the Medicaid managed care program. The Commission has incorporated profit-sharing provisions into its contracts with MCOs that require MCOs to share certain percentages of their net income before taxes with the Commission (see Appendix 4 for more information on how experience rebates are calculated.)

The General Appropriations Act (83rd Legislature), Rider 13, page II-91, requires that experience rebates the Commission receives from MCOs be spent on funding services for Medicaid.

<sup>4</sup> The risks related to the issues discussed in Chapter 1-B are rated as High because they present risks or effects that if not addressed could substantially affect the audited entity's ability to effectively administer the program(s)/function(s) audited. Prompt action is essential to address the noted concern(s) and reduce risks to the audited entity.

with the Commission whether to perform additional tests to determine whether testing errors identified in medical claims, pharmacy claims, and administrative expenses were systemic. For the other contracted audit firm, which evaluated 10 MCOs, the Commission directed the audit firm to expand its testing if identified errors indicated potential systemic problems. However, those expanded testing procedures applied only to issues associated with unallowable administrative expenses. In addition, that audit firm was not required to discuss with the Commission the decision to expand its testing to determine whether issues were systemic.

- The Commission did not require one contracted audit firm to expand its testing to determine the materiality of the total unallowable expenses that audit firm identified. Based on that audit firm's testing of a sample of 75 administrative expenses for fiscal year 2012, that audit firm reported concerns that an MCO reported unallowable expenses that could materially affect the accuracy of its financial statistical report. The audit firm calculated that the identified errors represented \$18,351 of the MCO's reported administrative expenses, which totaled \$6,242,240.

The Commission did not issue any corrective action plans related to AUP engagements.

The Commission does not have a process to issue corrective action plans to correct performance or noncompliance issues identified in AUP engagements. In the AUP engagements, the contracted audit firms identified payment inaccuracies with medical claims, pharmacy claims, and administrative expenses reported on MCOs' financial statistical reports. In addition, some AUP engagements also identified performance and noncompliance issues with Medicaid program requirements and other contract requirements, such as processing errors with medical claims (for example, late payments and failure to pay interest charges) or inappropriately charging processing fees to pharmacies.

The Commission's use of AUP engagement findings was limited to recalculating experience rebates based on the identified errors. The Commission asserted that, if a finding results in additional experience rebates, it also will assess the MCO an interest charge on the additional amount owed.



## Recommendations

### The Commission should:

- Ensure that financial risks identified in AUP engagements are adequately and consistently addressed.
- Establish policies and procedures for determining when a corrective action plan should be issued for AUP engagements.

## The Commission Should Obtain Greater Assurance About the Effectiveness of MCOs' Pharmacy Benefit Managers' Internal Controls and Compliance with State Requirements

Chapter 1-C  
Rating:  
Priority<sup>5</sup>

### Transfer of Managing Managed Care Pharmacy Benefits from the Commission to MCOs

Effective March 2012, most Medicaid clients and all **Children's Health Insurance Program (CHIP)** clients began obtaining their prescription drug benefits through an MCO, as required by Senate Bill 7 (82nd Legislature, First Called Session). Outpatient prescription drugs are a benefit of each of the following Medicaid managed care programs: State of Texas Access Reform (STAR), STAR+PLUS, and STAR Health.

Each MCO has its own participating pharmacy network comprising pharmacies contracted with the Commission to allow local pharmacies to dispense medications to managed care members. The MCO contracts with a pharmacy benefit manager (PBM) to process prescription claims, and the PBM contracts and works with pharmacies that dispense medications to Medicaid managed care members.

MCOs and PBMs are required by state law to adhere to the Commission's Vendor Drug Program's list of preferred and non-preferred prescription medications for Medicaid formularies until August 31, 2018.

Source: *Texas Medicaid and CHIP in Perspective*, Tenth Edition, Health and Human Services Commission, February 2015.

The Commission's oversight of the MCOs' pharmacy benefit managers (PBMs) relies on a combination of monitoring self-reported information from MCOs and limited verification of selected portions of that self-reported

information through annual AUP engagements performed by contracted audit firms. The Commission has not conducted a performance audit of PBM contractors since fiscal year 2012. As a result, it has limited assurance about the effectiveness of PBMs' internal controls and compliance with Commission requirements. In addition, the Commission has not verified whether PBMs have corrected findings from the one performance audit conducted on MCO's PBMs since MCOs became responsible for managing pharmacy benefits in 2012 (see text box for more information). The Commission also relies on MCOs' management assertions that the findings identified in AUP engagements have been addressed. MCOs paid \$235,199,287 to PBMs from March 2012 through August 2015 to administer \$7.4 billion in prescription benefits (see Appendix 5 for more information).

The Commission receives self-reported information from MCOs each quarter, and the Commission asserted that it relies on that information and the results from AUP engagements to determine whether PBMs comply with pharmacy benefit requirements. However, as discussed in Chapter 1-B, the Commission's use of AUP engagements primarily focuses on validating financial statistical reports that the Commission uses to verify the amount of experience rebates that MCOs owed.

The AUP engagement procedures that covered PBM activity during fiscal year 2013<sup>6</sup> did not include PBM compliance with requirements in areas such as pharmacy network adequacy or drug utilization.

The limited procedures that the Commission has approved for AUP engagements related to PBMs indicate the need for greater assurance about

<sup>5</sup> The risks related to the issues discussed in Chapter 1-C are rated as Priority because they present risks or results that if not addressed could critically affect the audited entity's ability to effectively administer the program(s)/function(s) audited. Immediate action is required to address the noted concern(s) and reduce risks to the audited entity.

<sup>6</sup> The AUP engagements covering fiscal year 2013 financial statistical reports were the most recently completed AUP engagements as of February 2016.

PBM internal controls and compliance with state requirements. For example:

- The contracted audit firms identified seven MCOs whose PBMs charged pharmacy transactions fees for processing pharmacy claims, which is not allowed by the Commission's contract with the MCOs.
- AUP engagements completed on 11 MCOs during fiscal year 2013 determined that there was not a complete audit trail of claims the PBM paid to pharmacies and the contracted auditor was unable to verify the accuracy of pharmacy expenses.

The Commission did not issue any corrective action plans to MCOs to require them to correct performance or noncompliance issues related to PBMs identified in AUP engagements.

The Commission has **performed only one performance audit of MCOs' PBMs**, and the scope of that audit was limited to two months.

Since MCOs became responsible for managing pharmacy benefits in March 2012, the Commission has performed only one performance audit of MCOs' PBMs (the cost for that audit was \$120,785). While that performance audit included three PBMs that subcontracted with five MCOs, the scope was March 2012 through April 2012, which were the first two months after MCOs became responsible for managing Medicaid pharmacy benefits.

That 2012 performance audit concluded that PBMs were complying with certain transparency standards and that a test sample of pharmacy claims payments were accurate. However, that audit also determined that PBMs were not complying with the Commission's preferred drug list and prior authorization requirements. The Commission did not perform any follow-up audits or independently verify that those PBMs had taken corrective action to ensure compliance with the requirements identified.

#### Recommendations

The Commission should:

- Conduct periodic audits of MCOs' PBM contractors or require MCOs to conduct periodic audits of their PBM contractors.
- Develop, document, and implement a monitoring process to ensure that MCOs satisfactorily correct and resolve findings reported in performance audits and AUP engagements of PBM contractors.

## The Commission Should Improve Coordination of Audit Activities

Chapter 1-D  
Rating:  
High<sup>7</sup>

Texas Government Code,  
Sections 531.102(w) and  
531.1025

Effective September 1, 2015, Texas Government Code, Sections 531.102(w) and 531.1025, required that the Office of Inspector General coordinate all audit and oversight activities relating to providers, including the development of audit plans, risk assessments, and findings, with the Commission to minimize the duplication of activities.

The Commission should ensure that its Medicaid Children's Health Insurance Program (CHIP) Division and its Office of Inspector General coordinate audit activities involving MCOs to minimize duplication of effort. Specifically, 6 (75 percent) of the 8 MCO performance audits that the Office of Inspector

General performed between fiscal years 2011 and 2015 included reviews of an MCO's financial statistical reports that had been previously reviewed in an AUP engagement contracted by the Commission's Medicaid CHIP Division. Texas Government Code, Sections 531.102(w) and 531.1025, require the Commission to coordinate all audit activities to minimize duplication of effort (see text box). The Commission paid the contracted audit firms \$236,415 for those six AUP engagements.

For those six audits, the Office of Inspector General reviewed the same financial statistical reports for the same time periods as the contracted audit firms. The Office of Inspector General reported inaccuracies in the MCOs' financial reports, including experience rebate adjustments for three MCOs that totaled \$303,895. While the Office of Inspector General and the contracted audit firms identified similar types of findings, the financial effects identified by each report were different. In addition, the Office of Inspector General's audit reports were released after the AUP engagements were completed.

Table 2 on the next page shows the six audits for which the Commission's contracted audit firms and the Office of Inspector General reviewed the same financial statistical reports for the same time periods.

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<sup>7</sup> The risks related to the issues discussed in Chapter 1-D are rated as High because they present risks or effects that if not addressed could substantially affect the audited entity's ability to effectively administer the program(s)/function(s) audited. Prompt action is essential to address the noted concern(s) and reduce risks to the audited entity.

Table 2

Six MCO Audits the Office of Inspector General Performed That Also Had a Contracted AUP Engagement				
MCO Audited	Office of Inspector General Report Release Date	Contracted Audit Firm Report Release Date	Time Between Reports Released	Audit Scope
Amerigroup Texas, Inc.	August 28, 2015	March 31, 2015	150 days	March 1, 2012, through August 31, 2013
Community Health Choice	December 21, 2015	December 2, 2014	384 days	March 1, 2012, through August 31, 2013
<b>Cook Children's Health Plan</b>	August 3, 2015	January 11, 2013	934 days	September 1, 2010, through August 31, 2011
Driscoll Health Plan	November 25, 2013	November 27, 2012	363 days	September 1, 2010, through August 31, 2011
Molina Healthcare of Texas, Inc.	March 4, 2015	February 5, 2013	757 days	September 1, 2010, through August 31, 2011
Parkland Community Health Plan	November 17, 2014	January 4, 2013	682 days	September 1, 2010, through August 31, 2011

Source: Office of Inspector General.

Improved coordination between the Office of Inspector General and the Medicaid CHIP Division could help to ensure the efficient use of the Commission's resources.

#### Recommendation

The Commission should improve the coordination of audit activities between its Medicaid CHIP Division and the Office of Inspector General to minimize duplication of audit coverage of MCOs.

## *The Commission Should Improve Its Processes for Collecting Reimbursements of Costs Related to Its Contracted Audit Services and Collecting Experience Rebates*

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The Commission should improve its process for collecting reimbursements from MCOs for contracted audit services. Those services are performed to determine MCOs' compliance with certain state and contract requirements for the Medicaid managed care program, including certain financial reporting requirements that help ensure the accuracy and completeness of experience rebates MCOs may owe the Commission.

In addition, the Commission should improve its processes for collecting experience rebates. The Commission collected \$787,077,260 in experience rebates that MCOs owed to it. However, opportunities exist for the Commission to improve its collection process to ensure that all experience rebates that MCOs owe are collected and deposited in the Commission's Medicaid program accounts in a timely manner.

### Chapter 2-A

#### The Commission Did Not Collect All Costs for Audit-related Services

Chapter 2-A  
Rating:  
Medium <sup>8</sup>

The Commission did not consistently collect reimbursements for all of its costs from MCOs for contracted audit firms' audit-related services conducted on MCOs' operations and financial reports. Specifically, the Commission did not collect \$2,022,025 (41 percent) of the \$4,950,664 in costs that MCOs were required to reimburse to the Commission for fiscal years 2011 through 2015. In addition, the Commission did not request reimbursement from MCOs for \$1,176,428 (58 percent) of the \$2,022,025 uncollected amount (see Table 3 on the next page).

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<sup>8</sup> The risks related to the issues discussed in Chapter 2-A are rated as Medium because they present risks or effects that if not addressed could moderately affect the audited entity's ability to effectively administer the program(s)/function(s) audited. Action is needed to address the noted concern and reduce risks to a more desirable level.

Table 3

Reimbursements for Audit-related Costs as of May 2016 <sup>a</sup>					
Contracted Service	The Commission's Total Cost	Amount the Commission Collected	Amount Outstanding as of May 2016		Outstanding Amount (Percent of the Commission's Total Cost)
			Billed	Not Billed	
Risk Assessment	\$ 1,337,525	\$ 328,280	\$114,334	\$ 894,911 <sup>b</sup>	75%
Performance Audit	1,401,652	711,209	427,901	262,542 <sup>c</sup>	49%
AUP Engagement	2,211,487	1,889,150	303,362	18,975 <sup>d</sup>	15%
Totals	\$4,950,664	\$2,928,639	\$845,597	\$1,176,428	41%
<sup>a</sup> Amounts presented for risk assessments and performance audits include amounts due for contracted audit firms' services on both Medicaid and CHIP programs. The audit services for those contracted audits cannot be separated by Medicaid- and CHIP-related programs. However, AUP engagement totals in Table 3 represent amounts only for Medicaid-related engagements.					
<sup>b</sup> Amount includes \$441,490 for 16 risk assessments covering fiscal years 2010 and 2011 for which the contracted audit firms invoiced the Commission in May 2011 and August 2011; \$237,567 for 10 risk assessments covering fiscal year 2013 for which one contracted audit firm invoiced the Commission in December 2013; and \$215,854 for 11 risk assessments covering fiscal year 2015 for which one contracted audit firm invoiced the Commission in October and November 2015.					
<sup>c</sup> Amount includes \$147,538 for one performance audit covering fiscal years 2011 and 2012 for which one contracted audit firm invoiced the Commission in March 2013, and one performance audit for \$115,004 covering fiscal years 2012 and 2013 for which one contracted audit firm invoiced the Commission in May 2013.					
<sup>d</sup> Amount is for one AUP engagement covering fiscal year 2013 for which the contracted audit firm invoiced the Commission in June 2015.					

Source: Invoices and payment documentation provided by the Commission.

The Commission's contract with MCOs specifies that each MCO agrees to pay for all reasonable costs the Commission incurs to perform an examination, review, or audit of the MCO's books relating to the contract.

#### Recommendation

The Commission should develop, document, and implement billing processes within its Medicaid/CHIP Division to ensure that MCOs reimburse the Commission for audit-related services as required.

## The Commission Collected Experience Rebates in a Timely Manner; However, It Should Improve Certain Collection Activities

Chapter 2-B  
Rating:  
Low <sup>9</sup>

The Commission collected \$787,077,260 (99.6 percent) of the \$789,862,545 in experience rebates that MCOs owed the Commission for fiscal years 2011 through 2014. Opportunities exist for the Commission to strengthen its collection process to ensure that:

- All experience rebates that the Commission collects are deposited in Medicaid and CHIP program accounts<sup>10</sup> in a timely manner.
- All MCOs' disputes of experience rebates owed to the Commission are followed up on and resolved in a timely manner.

The Commission should ensure that it consistently transfers experience rebates that were deposited into its suspense fund to Medicaid and CHIP program accounts in a timely manner.

### Suspense Fund

A suspense fund is established to separately account for certain receipts pending their distribution or disposal.

Source: Office of the Comptroller of Public Accounts.

The Commission did not ensure that it accurately and completely transferred all experience rebates deposited in its suspense fund to Medicaid and CHIP program accounts in a timely manner (see text box for more information about a suspense fund). As of February 29, 2016, the Commission had 30 experience rebates that totaled \$153,057,379 deposited in its suspense fund. Eight of those 30 experience rebates had been held in the suspense fund for at least 179 days. Those eight experience rebates totaled \$27,617,250; one of those rebates, totaling \$273,681<sup>11</sup>, had been in suspense for 420 days.

The Commission does not have a documented process to follow up on and resolve experience rebates disputed by MCOs.

The Commission does not have a documented process to follow up on and resolve experience rebates disputed by MCOs. For example, the Commission did not resolve or collect \$3,458,395<sup>12</sup> in experience rebates from 3 MCOs during fiscal years 2011 through 2013.

<sup>9</sup> The risks related to the issues discussed in Chapter 2-B are rated as Low because the audit identified strengths that support the audited entity's ability to administer the program(s)/function(s) audited or the issues identified do not present significant risks or effects that would negatively affect the audited entity's ability to effectively administer the program(s)/function(s) audited.

<sup>10</sup> For MCOs that provide services under CHIP, payments for experience rebates included amounts for the Medicaid and CHIP programs. Auditors determined that payments for experience rebates in the suspense fund are approximately 90 percent for the Medicaid program and 10 percent for the CHIP program.

<sup>11</sup> The \$273,681 amount in suspense was a partial amount of an experience rebate payment that totaled \$45,310,794. The Commission was unable to explain why the full amount of the experience rebate had not been transferred from its suspense fund to the appropriate Medicaid and CHIP accounts.

<sup>12</sup> This amount is not the difference between the total amount assessed and the total amount collected because it does not include refunds that the Commission may pay MCOs pending the completion of financial examinations. As of May 2016, the refunds paid for fiscal years 2011 through 2014 totaled \$111,529.



## Recommendations

The Commission should develop, document, and implement monitoring processes within its Medicaid/CHIP Division to ensure that:

- It identifies experience rebates deposited in the Commission's suspense account and transfers those rebates to the appropriate Medicaid and CHIP program accounts in a timely manner.
- It follows up on and resolves in a timely manner experience rebates disputed by MCOs.

## *The Commission Should Use Information That Its External Quality Review Organization Contractor Provides to Strengthen Its Monitoring of MCO Performance*

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Chapter 3  
Rating:  
Low<sup>13</sup>

### External Quality Review Organization (EQRO)

**The Commission's EQRO contractor** is the Institute for Child Health Policy with the University of Florida. Federal law requires state Medicaid programs to contract with an EQRO to help evaluate Medicaid managed care programs.

The EQRO assesses care provided by MCOs by conducting ongoing evaluations of the quality of care provided primarily using MCO administrative data, including claims data. The EQRO also reviews MCO documents and provider medical records; conducts interviews with MCO administrators; and conducts surveys of Texas Medicaid and CHIP members, caregivers of members, and providers.

Sources: *Texas Medicaid and CHIP in Perspective*, Tenth Edition, February 2015; and the Commission.

The Commission's Health Plan Management unit is responsible for monitoring activities of MCOs. The Health Plan Management unit asserted that it receives and reviews a summary report of member surveys from the Commission's External Quality Review Organization (EQRO) contractor (see text box for more information about the EQRO). The Commission reviewed and approved all invoices, totaling \$2.6 million, that auditors tested for certain deliverables provided by the EQRO contractor during fiscal years 2014 and 2015.

However, the Health Plan Management unit did not document how it used reports from the EQRO in monitoring MCOs. In addition, the Health Plan Management unit indicated that it did not receive more detailed information about member surveys that the contractor provides to the Commission. That Health Plan Management unit could use that detailed information to strengthen its monitoring efforts. Specifically, the detailed information includes performance information on MCOs from Medicaid client surveys, such as ratings on access to urgent care or Medicaid clients' ratings of their health plans. The Commission does not have a process to track summary performance information the Health Plan Management unit receives, and it does not have a process to communicate the detailed performance information to the Health Plan Management unit.

The Commission's request for proposals for the EQRO contract stated that part of the Commission's desired mission was to improve the health of Texans by monitoring consumer satisfaction, monitoring the quality of care provided to consumers, and measuring the performance of MCOs participating in Texas Medicaid programs. If the Commission does not use the results from the member surveys that its EQRO contractor provides and document the results of its monitoring, there is an increased risk that MCOs will not address Medicaid clients' concerns.

The Commission also does not use the validation results of paid claims data from the EQRO contractor to monitor MCO performance. In the validation process, the EQRO contractor matches paid claims data with medical records

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<sup>13</sup> The risks related to the issues discussed in Chapter 3 are rated as Low because the audit identified strengths that support the audited entity's ability to administer the program(s)/functions(s) audited or the issues identified do not present significant risks or effects that would negatively affect the audited entity's ability to effectively administer the program(s)/function(s) audited.

it obtains from providers and reports on discrepancies in the data. The Commission could use the validation results to help monitor MCO performance by considering the amount of discrepancies as a risk factor in its monitoring of MCOs. The *State of Texas Contract Management Guide* states that monitoring a contractor's performance to ensure that the contractor is performing all duties required and that all developing problems are addressed is a key function of proper contract administration.

#### Recommendation

The Commission should use member survey results, including detailed data, and the validation results of paid claims data, to enhance its monitoring of MCOs and document how it uses that information in its monitoring efforts.

## *The Commission Should Strengthen Its Security and Processing Controls Over Certain Information Technology Systems*

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Chapter 4  
Rating:  
Medium<sup>14</sup>

Auditors reviewed the Commission's Accounts Receivable Tracking System (ARTS), which the Commission uses to track experience rebates and payments collected from MCOs. Auditors reviewed controls over user access, password security, change management, and data processing for ARTS. The Commission did not establish controls to ensure that data recorded in ARTS matches data in the Health and Human Services Accounting System (HHSAS) and the Uniform Statewide Accounting System (USAS). Auditors also identified weaknesses in the Commission's change management process for ARTS.

In addition, the Commission should strengthen its user access controls for ARTS and certain network folders that the Commission uses to manage experience rebate collections. To minimize security risks, auditors communicated details about the user access weaknesses for ARTS and network folders directly to Commission management.

The Commission should ensure that it documents its reconciliations of deposits recorded in ARTS to deposit records in HHSAS and USAS.

The Commission did not document its reconciliations to show that it verified that daily deposits recorded in ARTS were processed accurately and completely in HHSAS and USAS. The Commission asserted that its accounts receivable staff (1) generated daily reports showing the previous day's transactions processed in ARTS, HHSAS, and USAS and (2) performed a reconciliation. However, it did not have a process to document those reconciliations. As a result, the Commission could not provide documentation to support its assertion that reconciliations were performed. Without documenting the daily reconciliations among ARTS, HHSAS, and USAS, the Commission cannot ensure that reconciliations are performed consistently and that errors detected during reconciliations are corrected.

The Commission should ensure that its information technology contractor documents programming changes made to ARTS and that Commission management authorizes those changes.

The Commission did not maintain proper documentation of programming changes to ARTS. The Commission did not maintain a comprehensive list of requested, reviewed, and approved changes to ARTS. Specifically, when the information technology contractor made programming changes to ARTS, the

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<sup>14</sup> The risks related to the issues discussed in Chapter 4 are rated as Medium because they present risks or effects that if not addressed could moderately affect the audited entity's ability to effectively administer program(s)/function(s) audited. Action is needed to address the noted concern(s) and reduce risks to a more desirable level.

Commission did not ensure that the information technology contractor (1) documented a description of the user testing of the changes, including the results of that testing, and (2) obtained the Commission's documented authorization to make the changes. Without maintaining a complete list of changes, there is an increased risk that unauthorized changes may be made in the system.

#### Recommendations

##### The Commission should:

- Strengthen user access controls for ARTS and certain network folders that the Commission uses to manage experience rebate collections.
- Require its accounts receivable staff to document daily reconciliations of deposits recorded in ARTS to the transactions processed in HHSAS and USAS.
- Develop, document, and implement a process to ensure that all programming changes to ARTS and the authorization and testing of those changes are formally documented.

# Appendices

## Appendix 1

### *Objective, Scope, and Methodology*

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#### Objective

The objective of this audit was to determine whether the Health and Human Services Commission (Commission) and the Office of Inspector General administer selected Medicaid managed care contract management processes and related controls in accordance with contract terms, applicable laws, regulations, and agency policies and procedures.

#### Scope

The scope of this audit covered the Commission's Medicaid managed care contracted audit activities from fiscal year 2011 through fiscal year 2015, performance audits conducted by the Office of Inspector General from fiscal year 2011 through fiscal year 2015, and the Commission's External Quality Review Organization (EQRO) contract for fiscal years 2014 and 2015.

#### Methodology

The audit methodology included reviewing results of contracted audit activities of managed care organizations (MCO), as well as performance information from the Commission's EQRO contractor.

Audit work included collecting and reviewing the Commission's agreed-upon procedures (AUP) engagements and performance audits related to MCOs, the Commission's payments to the contracted audit firms for audit services, the Commission's reimbursements from MCOs for audit services, and support for certain deliverables from the EQRO contract.

#### Data Reliability and Completeness

Accounts Receivable Tracking System (ARTS). Auditors tested receipt of experience rebates in ARTS. Auditors also tested general controls, including access, change management, and password settings. Auditors determined that ARTS data was of undetermined reliability because of weaknesses in user access and change management controls.

The Commission's spreadsheets for calculating and tracking experience rebates. Auditors tested calculations in the experience rebate spreadsheet templates. Auditors also tested general controls such as password configuration and user access. Auditors determined that the spreadsheets were of undetermined reliability due to issues identified related to user access.

#### Sampling Methodology

Auditors selected a nonstatistical random sample of 16 reimbursements to test the accuracy and completeness of reimbursements for contracted audit-related services recorded in ARTS. The sampled items were generally not representative of the population and, therefore, it would not be appropriate to project those test results to the population.

Information collected and reviewed included the following:

- The Commission's AUP reports related to MCOs.
- The Commission's engagement letters with contracted audit firms.
- Reports from the Commission's performance audits of MCOs.
- Risk assessments prepared by external audit firms.
- Invoices from audit firms for contracted audit services.
- Proof of payment to the Commission for contracted audit services.
- Experience rebate calculations and payments.
- The Commission's contract with the EQRO.
- MCO report cards and member surveys.
- Invoices and proof of payment to the EQRO.
- The EQRO's methodology for validation of paid claims data.
- Office of Inspector General performance audit reports.
- User access lists to the ARTS database.
- User access lists to network folders for experience rebate spreadsheets.

Procedures and tests conducted included the following:

- Interviewed Commission and Office of Inspector General staff.
- Interviewed staff at the Commission's contracted audit firms.
- Reviewed Commission policies and procedures.
- Reviewed results of the Commission's performance audits of MCOs.
- Reviewed results of the AUP engagements of MCOs.
- Reviewed audit procedures and risk assessments for the Commission's performance audits of MCOs.
- Reviewed reimbursements from MCOs to the Commission for contracted audit services.
- Verified experience rebate and recovery calculations and reviewed payment information the Commission received from MCOs.
- Performed analysis of AUP engagement procedures and verified whether the Commission approved the procedures.
- Reviewed the Commission's performance audit of its pharmacy benefit manager.
- Reviewed the Commission's contract with the EQRO and deliverables related to claims data verification, member surveys, and MCO report cards.
- Reviewed invoices and proof of payment to the EQRO.
- Tested user access to the ARTS database.
- Tested user access to network folders for experience rebate spreadsheets.
- Tested change management and password security in the ARTS database.
- Reviewed data processing controls in ARTS.



Criteria used included the following:

- Texas Government Code, Sections 531.02412 and 531.102.
- Title 1, Texas Administrative Code, Chapter 202.
- The Office of the Comptroller of Public Accounts' *Reporting Requirements for Fiscal 2016 Annual Financial Reports of State Agencies and Universities, Agency Funds*.
- The Commission's *Uniform Managed Care Terms and Conditions*.
- *State of Texas Contract Management Guide*, version 1.10.
- *Government Auditing Standards*, 2011 Revision, U.S. Government Accountability Office.

#### Project Information

Audit fieldwork was conducted from December 2015 through August 2016. We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

The following members of the State Auditor's staff performed the audit:

- Kristyn Hirsch Scoggins, CGAP (Project Manager)
- Willie J. Hicks, MBA, CGAP (Assistant Project Manager)
- Salem Chuah, CPA
- Katherine M. Curtsinger
- Allison Fries
- Steven M. Summers, CPA, CISA, CFE
- Dennis Ray Bushnell, CPA (Quality Control Reviewer)
- John Young, MPAff (Audit Manager)

## Issue Rating Classifications and Descriptions

Auditors used professional judgement and rated the audit findings identified in this report. Those issue ratings are summarized in the report chapters/sub-chapters. The issue ratings were determined based on the degree of risk or effect of the findings in relation to the audit objective(s).

In determining the ratings of audit findings, auditors considered factors such as financial impact; potential failure to meet program/function objectives; noncompliance with state statute(s), rules, regulations, and other requirements or criteria; and the inadequacy of the design and/or operating effectiveness of internal controls. In addition, evidence of potential fraud, waste, or abuse; significant control environment issues; and little to no corrective action for issues previously identified could increase the ratings for audit findings. Auditors also identified and considered other factors when appropriate.

Table 4 provides a description of the issue ratings presented in this report.

Table 4

Summary of Issue Ratings	
Issue Rating	Description of Rating
Low	The audit identified strengths that support the audited entity's ability to administer the program(s)/functions(s) audited <u>or</u> the issues identified do not present significant risks or effects that would negatively affect the audited entity's ability to effectively administer the program(s)/function(s) audited.
Medium	Issues identified present risks or effects that if not addressed could <u>moderately affect</u> the audited entity's ability to effectively administer program(s)/function(s) audited. Action is needed to address the noted concern(s) and reduce risks to a more desirable level.
High	Issues identified present risks or effects that if not addressed could <u>substantially affect</u> the audited entity's ability to effectively administer the program(s)/function(s) audited. Prompt action is essential to address the noted concern(s) and reduce risks to the audited entity.
Priority	Issues identified present risks or effects that if not addressed could <u>critically affect</u> the audited entity's ability to effectively administer the program(s)/function(s) audited. Immediate action is required to address the noted concern(s) and reduce risks to the audited entity.

## The Commission's Payments to MCOs

The Health and Human Services Commission (Commission) paid a total of \$35,723,212,549 to managed care organizations (MCOs) from fiscal year 2013 through fiscal year 2015 for Medicaid expenses. Table 5 lists the MCOs, including dental maintenance organizations, that received payment during that time period.

Table 5

Amounts the Commission Paid to MCOs Fiscal Year 2013 through Fiscal Year 2015	
Aetna Health, Inc.	\$ 635,458,500
Amerigroup Insurance Company	2,552,115,297
Health Care Service Corporation (doing business as Blue Cross Blue Shield of Texas)	162,857,308
CHRISTUS Health Plan	73,048,721
Community First Health Plans, Inc.	749,846,561
Community Health Choice	1,913,732,756
Cook Children's Health Plan	725,096,743
DentaQuest USA Insurance Company	1,937,303,895
Driscoll Health Plan	1,078,466,054
El Paso First Health Plans, Inc.	404,027,241
CignaHealthSpring	1,178,919,816
MCNA Dental Insurance Company (doing business as MCNA Dental)	1,540,821,212
Molina Healthcare of Texas	3,973,096,009
Parkland Community Health Plan, Inc.	1,406,110,463
Scott & White Health Plan	359,384,365
Sendero Health Plans, Inc.	101,011,319
Seton Health Plan	105,022,017
SHA, LLC (doing business as FirstCare)	869,706,793
Superior HealthPlan <sup>a</sup>	12,025,719,599
<b>Texas Children's Health Plan, Inc.</b>	<b>2,144,891,875</b>
UnitedHealthcare	1,786,576,005
<b>Total</b>	<b>\$ 35,723,212,549</b>
<sup>a</sup> Includes payments to Bankers Life Insurance of Wisconsin and Superior Health Plan, Inc. According to the Centene Corporation Web site and the U.S. Securities and Exchange Commission Web site, Bankers Reserve Life Insurance Company of Wisconsin and Superior HealthPlan are subsidiaries of Centene Corporation.	

Sources: Uniform Statewide Accounting System and MCO or company Web sites.

## Calculating Experience Rebates

The Health and Human Services Commission (Commission) included in its contracts with managed care organizations (MCOs) the requirements for calculating experience rebates in Texas Government Code, Section 533.014. (See Chapter 1-B for more information on that statute.)

According to the Commission's contracts with MCOs, an MCO must pay an experience rebate to the Commission if the MCO's net income before taxes exceeds a certain percentage, as defined by the Commission, of the total revenue a MCO receives each fiscal period. The experience rebate is calculated in accordance with a tiered rebate method that the Commission defines (see Table 6). The tiers are based on the consolidated net income before taxes for all of the MCO's Medicaid program and Children's Health Insurance Program service areas that are included in the scope of the contract, as reported on the MCO's financial statistical reports (which the Commission should review and confirm).

Table 6

Tiers for Experience Rebates		
Pre-tax Income as a Percent of Revenues	MCO Share	The Commission's Share
Less than or equal to 3 percent	100 percent	0 percent
Greater than 3 percent and less than or equal to 5 percent	80 percent	20 percent
Greater than 5 percent and less than or equal to 7 percent	60 percent	40 percent
Greater than 7 percent and less than or equal to 9 percent	40 percent	60 percent
Greater than 9 percent and less than or equal to 12 percent	20 percent	80 percent
Greater than 12 percent	0 percent	100 percent

Source: The Commission's *Uniform Managed Care Terms and Conditions*.

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*Pharmacy Benefit Managers' Financial Information*

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Table 7 shows the financial activity that all managed care organizations (MCOs) reported to the Health and Human Services Commission (Commission) for managing pharmacy benefit managers from March 2012 through August 2015.

Table 7

Financial Information for Pharmacy Benefit Managers Reported by All MCOs March 2012 through August 2015	
Type of Financial Activity	Total
Pharmacy premiums that MCOs received from the Commission	\$8,102,949,089
Prescription expenses	\$7,413,793,743
Administrative expense - pharmacy benefit manager contractors	\$235,199,287

Source: The Commission.

## **The Commission's Management's Response**

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STATE AUDITOR'S OFFICE (SAO)  
Audit of Medicaid Managed Care Contract Processes at the Health and Human Services Commission  
HHSC Management Responses

### **Overall Conclusion**

The Health and Human Services Commission (Commission) should develop and implement an overall strategy for planning, managing, and coordinating audit resources that it uses to verify the accuracy and reliability of program and financial information that managed care organizations (MCOs) report to it. The lack of an overall strategy has resulted in gaps in audit coverage of MCOs, lack of consistent follow-up on audit findings, inconsistent application of procedures, and duplication of effort.

### **Overall Management Comments**

The Commission operates under a collaborative approach in which several areas within the Medicaid and CHIP Services Department as well as the HHSC Inspector General, oversee specified Medicaid managed care contract requirements.

The Commission has designated resources for major contract monitoring requirements such as: Health Plan Management who is responsible for overall operations; Financial Reporting and Audit Coordination for financial reporting; Operations Coordination for encounter data; Program Support and Utilization Management for long term care utilization; Vendor Drug for prescription benefits; Contract Compliance and Support for assessment of actual remedies; as well as the Inspector General for special investigation units of the MCOS.

While Health Plan Management serves as the centralized unit responsible for managing the MCO day-to-day operational aspects of the Medicaid and CHIP managed care programs, the knowledge and expertise of subject matter experts within the Health and Human Services System (HHS System) are essential for successful operation of the Medicaid and CHIP programs.

A holistic assessment of performance monitoring takes place on a routine basis. Specific contractual requirements are assigned to the various units based on area of expertise. The responsible area monitors MCO performance, conducts analysis, and recommends remedies, including liquidated damages and corrective action. On a quarterly basis, the appropriate areas conduct an overall assessment of each MCO based on performance for the specified timeframe and information is presented to Medicaid/CHIP executive management before execution of recommendations.

### **Chapter 1 - Audit Activities used to Monitor MCOs**

#### **Chapter 1-A - Performance Audits of MCOs**

##### **Recommendations**

The Commission should:

- Document the process it uses to select MCOs to audit.
- Prioritize the highest risk MCOs to audit.
- Include previous audit coverage as a risk factor.

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- Establish a process to document its follow-up on performance audit findings and verify the implementation of audit recommendations.
- Establish and implement policies and procedures to (1) determine when a corrective action plan should be issued and (2) follow-up on MCO implementation of corrective action plans.

**HHSC Management Response**

*The Commission is in agreement with the finding and associated recommendations and offer the following response.*

*Health Plan Management developed a desk manual with established standard operating procedures to provide defined processes and to ensure consistency across MCOs. Since the implementation of the revised desk manual in 2015, Health Plan Management continues to add new standard operating procedures in an effort to proactively provide consistent documented guidance while maintaining existing processes. Health Plan Management initiated the development of a process to guide the prioritization of MCO risk and audit activity as well as a documented process for follow-up on performance audit findings from initiation of remedies through implementation of audit recommendations.*

*Health Plan Management established procedures to routinely review data reported by the MCO, data produced by the Commission, and audit findings in order to provide cross-analysis of information for determining and prioritizing risk. Quarterly Reporting elements are reviewed quarterly to identify non-compliance with defined performance standards and corrective action. HPM will develop procedures to utilize risk assessments conducted to identify MCO(s) with the highest risk in order to prioritize performance audits.*

*Health Plan Management operates a robust process for managing complaints and/or inquiries received from Medicaid contracted providers, other state agencies, government officials, and the Medicaid and CHIP Department. This process provides direct insight of trends and possible non-compliance which could require prompt corrective action throughout the Medicaid managed care programs*

*MCO claims processing performance is monitored and assessed quarterly for non-compliance requiring corrective action and helps identify risks by service type (i.e. acute care, behavioral health, dental, long term care, pharmacy, and vision). This separation of claims by types of service allows for identification of specific potential areas of concern that might be obscured if all claims were monitored together.*

*The Medicaid managed care contracts specifically provide the Commission the ability to conduct additional readiness reviews and monitoring efforts on MCOs as determined necessary. To enhance the process the Commission plans to complete the following:*

- Document processes utilized for the performance audit selection of MCOs.
- Establish a process to include prioritization by MCO risk level using data and information gathered through agency monitoring of MCOs.

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- *Establish a process to include consideration of risks from previous audit findings.*
- *Develop standard operating procedures to document follow-up monitoring efforts for performance audit findings to include verification of implementation of audit recommendations.*
- *Develop standard operating procedures to include Corrective Action Plan (CAP) issuance determination and monitoring efforts.*

**Implementation Date:**

*July 2017*

**Responsible Person:**

*Director of MCD Health Plan Management*

**Chapter 1-B - Agreed Upon Procedure Engagements**

**Recommendations**

The Commission should:

- Ensure that financial risks identified in AUP engagements are adequately and consistently addressed.
- Establish policies and procedures for determining when a corrective action plan should be issued for AUP engagements.

**HHSC Management Response - Consistency**

*The Commission is in agreement with the finding and associated recommendations and offer the following response.*

*HHSC is committed to achieving effective and consistent identification of any financial risks which may exist within the MCOs participating in the Medicaid and CHIP programs. HHSC has required the audit firms to align the Agreed Upon Procedures (AUPs) between firms to provide a more consistent evaluation of the MCOs (completed for FY 2014 AUPs and planned for FY 2015 AUPs). The Commission has discussed with the audit firms planned actions when errors are identified in either the claims or administrative sample selections (expanding testing, noting the availability of MCO data, and/or administrative penalties and possible termination of the contract, etc.).*

*HHSC plans to implement a consolidated Financial Statistical Report for SFY 2016 to allow the audit firms to efficiently test expense captions using a statistically valid sample so that error rates can be extrapolated to the entire population, thus eliminating the need to perform expanded testing in most circumstances. This process will completely align sampling procedures for all MCOs and among the audit firms.*



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**Implementation Date:**

*December 2016*

**Responsible Person:**

*Director of MCD Financial Reporting and Audit Coordination*

**HHSC Management Response- Corrective Action Plans**

*HHSC agrees that formal CAPs can be effective in improving contractor performance. However they are not necessarily required to address all findings identified by the audit firms through the AUP engagements. HHSC's contractor monitoring includes a two-step follow-up process in the existing engagements that is intended to ensure findings are addressed by the MCOs. This process starts with requiring each MCO to provide management responses to the findings detailed in the AUP reports. These management responses become part of the reports and are intended to outline the MCOs' agreement or disagreement with the findings, and how the MCO will correct any deficiencies in controls and processes to address the issue. The audit firms are responsible for providing auditor follow-up comments to these management responses if the MCO does not sufficiently address the finding to ensure the proper action is taken to resolve the issue. The second step in the follow-up process is an AUP procedure, which states "Obtain copies of the MCOs 2013 FSR attestation reports and review the MCO management responses to identify the corrective actions that were to be implemented. Through inquiry of the MCO management, determine the nature, timing, and extent of efforts to remediate the cause of prior year recommendations. Document whether such efforts were consistent with the management response provided in the prior year report." This procedure step is applied at the start of the next year's AUP engagement and is intended to follow-up on the MCOs actions to fully address the prior year's AUP findings.*

*MCOs might have repeat findings over multiple fiscal years, and while this is reasonable for a second year since the AUP reports are not issued until close to or after the next year's 334-day FSRs are submitted, many findings are repeated beyond the second year. Going forward, HHSC will issue CAPs to ensure that repeat findings do not occur.*

*In order to ensure that findings are fully addressed and corrected HHSC will issue CAPs when appropriate.*

*HHSC will collaborate with its audit contractors and MCD Contract Compliance and Support at the end of each audit cycle and will pay special attention to findings which are repetitive in nature or are demonstrative of a pattern of non-compliance. HHSC will also evaluate findings with respect to recent MCO Risk Assessments that have been conducted to determine if the finding falls into a category or function that has been identified as high risk. HHSC will also consider the MCO's demonstrated performance in preparing and submitting quarterly financial deliverables.*

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*HHSC will develop a plan for monitoring ongoing MCO progress in implementing each CAP. In addition AUP procedure step #1 will be revised to require the audit firm to follow-up and report on the progress the MCO has made on implementing the formal CAP submitted in response to the prior year's report.*

**Implementation Date:**

*September 2017 for FY 2015 AUP assignments*

**Responsible Person:**

*Director of MCD Financial Reporting and Audit Coordination  
Deputy Director of MCD Contract and Performance Management*

**Chapter 1-C - MCO Pharmacy Benefits Manager Internal Control and Compliance**

**Recommendations**

The Commission should:

- Conduct periodic audits of MCOs' pharmacy benefit manager contractors or require MCOs to conduct periodic audits of their pharmacy benefit manager contractors.
- Develop, document, and implement a monitoring process to ensure that MCOs satisfactorily correct and resolve findings reported in performance audits and AUPs of pharmacy benefit manager contractors.

**HHSC Management Response - AUPs**

*The Commission is in agreement with the finding and associated recommendations and offer the following response.*

*On a quarterly basis, Health Plan Management reviews reports with the health plans regarding compliance with requirements. These reviews include separate pharmacy items such as changes in pharmacy network, pharmacy member appeals and complaints made both to the MCO and HHSC, pharmacy claims adjudication timeliness, and reconciliation of pharmacy encounters to the Financial Statistical Reports (FSRs). In addition, pharmacy is included in the overall analysis of member and provider hotline compliance with requirements. However, we agree with the SAO's observation that the Pharmacy Benefit Manager (PBM) data reviewed by HPM is self-reported and not currently validated.*

*FSR AUPs include testing for the sampled claims' adherence to the Preferred Drug List requirements and prior authorizations, as well as proper reporting of paid claims on the FSR. Testing procedures also include pharmacy claim payments pricing term's adherence to executed pharmacy contracts. We agree that the audit firms' FSR work doesn't address other areas of operational compliance.*

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*HHSC does not consider the audit firms finding relating to the transaction fees in SFY 2013 to be an issue of noncompliance. HHSC disallowed the practice in SFY 2014 and requested the audit firms to determine whether transaction fees were utilized by the PBMs prior to the disallowance of the practice. The audit firms did not find any cases in SFY 2014 where PBM transaction fees were paid.*

*To address the risk of inaccurate reporting, the audit firms have been engaged to perform data validation of 12 quarterly self-prepared reports for all MCOs. These reports include pharmacy self-reported data. The data validation work will coincide with the SFY 2015 FSR AUP work.*

**Implementation Date:**

*AUP assignment for FY 2015 commences November 2017  
Performance audit of MCO self-reported data issued August 2017*

**Responsible Person:**

*Director of MCD Financial Reporting and Audit Coordination  
Director of MCD Health Plan Management*

**HHSC Management Response – Performance Audits**

**HHSC Management Response-1**

*The IG has included an audit of Managed Care Pharmacy Benefit Manager Compliance in its Fiscal Year 2017 Audit Plan. The IG plans to initiate the audit within the next six months, and will coordinate the timing, selection of one or more pharmacy benefit managers to audit, and preliminary scope and objectives of the audit with MCD before the audit is initiated.*

**Implementation Date:**

*March 2017*

**Responsible Person:**

*Deputy Inspector General for Audit*

**HHSC Management Response-2**

*Medicaid and CHIP Services Department will consider the overall risk to the Medicaid Program of PBM performance in determining the frequency of Performance Audits. In making this determination they will use: results of internal monitoring efforts; PBM performance as indicated by member complaint logs; results of annual MCO AUPs and results of IG audits.*

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**Implementation Date:**

August 2017

**Responsible Person:**

Director of MCD Health Plan Management

**HHSC Management Response – Monitoring**

Currently, the Commission utilizes encounter data and self-reported information from MCOs to conduct quarterly reviews in order to determine compliance with pharmacy benefit contract requirements. This includes the reviewing of quarterly reports to monitor compliance with the Preferred Drug List, changes in pharmacy networks, pharmacy member appeals and complaints, pharmacy claims adjudication timeliness, and reconciliation of pharmacy encounters to Financial Status Reports.

To strengthen the oversight process HHSC will:

- Conduct periodic onsite reviews of MCOs' PBM.
- Develop, document, and implement a monitoring process to ensure MCOs perform audits on the PBMs and that reported findings are corrected and resolved.
- Develop, document, and implement a monitoring process to ensure that MCOs satisfactorily correct and resolve findings reported in performance audits and agreed upon procedure engagements of PBM contractors.

**Implementation Date:**

March 2017

**Responsible Person:**

Deputy Director of MCD Operations

**Chapter 1-D - Coordination of Audit Activities**

**Recommendation**

The Commission should improve the coordination of audit activities between its Medicaid CHIP Division and the Office of Inspector General to eliminate duplication of audit coverage of MCOs.

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**HHSC Management Response**

*The Commission is in agreement with the finding and associated recommendation and offer the following response.*

*HHSC is completing a series of steps planned to establish policy and guidelines to ensure appropriate communication and collaboration on the planning and performance of managed care organization audits.*

*Texas Administrative Code Sections 371.37 and 353.6 were adopted on July 14, 2016. These rules assigned authority to the HHSC Executive Commissioner to establish policy outlining the roles and responsibilities of divisions, departments, and offices of HHSC in coordinating and performing audits of participating managed care organizations.*

*HHSC has prepared a draft circular titled "Coordination of Managed Care Organization Audits." The circular establishes the Executive Commissioner's policies for coordination of audits of managed care organizations, and defines roles in, jurisdiction over, and frequency of audits of managed care organizations participating in Medicaid conducted by various divisions of HHSC, including the Medicaid and CHIP Services Department (MCD) and the Inspector General (IG). The draft circular is currently in the review and approval process.*

*In addition, processes and practices are fully established and performed that ensure coordination between MCD and the IG occurs frequently and regularly. These processes and practices include:*

- Coordination between IG and MCD in the development and periodic revision of proposed managed care organization audits included in the IG Audit Plan.*
- Quarterly briefings by the IG Audit Division to the Medicaid and CHIP Director and applicable MCD senior staff on the status of active managed care organization audits.*
- Participation by MCD in the planning process of IG managed care organization audits, including providing input to IG on the timing of audits, applicable risks, and proposed audit scope and objectives.*
- Participation by MCD in key managed care organization audit meetings, including entrance conferences, status updates, and exit conferences.*
- MCD review of proposed IG audit findings and recommendations, and draft audit reports.*

**Implementation Date:**

*January 2017 - Approval of Managed Care Organization Audit Coordination Circular*

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**Responsible Person:**

*Deputy Inspector General for Audit  
Director of MCD Financial Reporting and Audit Coordination*

**Chapter 2 - Collecting Contracted Audit Services Costs and Experience Rebates**

**Chapter 2-A - Ensure MCOs reimburse for all Audit Related Services**

**Recommendation**

The Commission should develop, document, and implement billing processes within its Medicaid and CHIP Services Department to ensure that MCOs reimburse the Commission for audit-related services as required.

**HHSC Management Response**

*HHSC has initiated billing MCOs for risk assessments, reviews, and audits conducted by external auditors including assessments, reviews and audits utilized for broader compliance and performance testing.*

*HHSC will review the language in the managed care contracts and clarify the requirement that MCOs will pay for costs incurred by HHSC for external audits necessary for oversight of participating MCOs, if clarification is necessary.*

**Implementation Date:**

*September 2017*

**Responsible Person:**

*Deputy Director of MCD Contract and Performance Management  
Director of MCD Financial Reporting and Audit Coordination*

**Chapter 2-B - Improve Certain Experience Rebate Collection Activities**

**Recommendations**

The Commission should develop, document, and implement monitoring processes within its Medicaid and CHIP Services Department to ensure that:

- It identifies Experience Rebates deposited in the Commission's suspense account and transfers those rebates to the appropriate Medicaid and CHIP program accounts in a timely manner.
- It follows-up on and resolves Experience Rebates disputed by MCOs in a timely manner.

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**HHSC Management Response -1**

*The Commission is in agreement with the finding and associated recommendations and offer the following response.*

*Experience Rebates are calculated at least three times before they are finalized. MCOs submit 90-day FSRs on December 31<sup>st</sup> for the prior fiscal year. At the same time the MCOs submit a check for any Experience Rebate that might be due. They submit the 334-day FSR on August 31<sup>st</sup> of the following year. This delayed submission allows for claims runout. The Experience Rebate is recalculated using the 334-day FSR and MCOs will submit a check for any additional Experience Rebate that might be due. In addition MCOs are assessed 12% interest compounded daily beginning on the due date of the 90-day FSR on any additional Experience Rebate due. Findings from HHSC's contract auditor's AUP engagements might affect an MCO's net income and, therefore, the amount of Experience Rebate due from the MCO. The MCOs are assessed an interest penalty on any adjusted Experience Rebate amounts. This can occur up to two years after the close of the fiscal year.*

*Some MCOs attempt to minimize their exposure to the amount of interest charged. There have been cases where MCOs have submitted checks after the close of the fiscal year, but prior to the completion of the AUPs, for any potential findings that would increase Experience Rebate due. In some cases, some or all of these amounts are ultimately refunded to the MCOs as overpayments of the Experience Rebate. Since these amounts represent estimates by the MCOs and are subject to potential refund they are not allocated to a Program by HHSC. Therefore, they remain in a suspense account until the final AUPs are completed.*

*In general the Accounts Receivable (AR) department receives the check for processing and after initial entry, the check is deposited into AR's suspense account. The check is recorded on an internal form and sent to Medicaid and CHIP Services Department (MCD) Finance to await coding instructions to process and allocate the funds appropriately. Once MCD Finance validates the MCO's self-reported Financial Statistical Reports (FSRs) against known data, such as HHSC's membership and capitation reports, the experience rebate calculation is completed using the UMCC methodology. The calculation is then reviewed and approved by the Director Financial Reporting and Audit Coordination for MCD. Once approved, the allocation is sent to AR's Accounts Receivable Tracking System (ARTS), usually based on the Document Locator Number (DLN) or check number provided via the internal form sent originally.*

*AR will implement a process whereby MCD Finance is contacted monthly via email inquiring about any and all outstanding funds related to Medicaid and Chip Programs. This will provide a paper trail and an account of proactively trying to clear the AR suspense account.*

**Implementation Date:**

*Implemented September 1, 2016*

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**Responsible Person:**

*Accounts Receivable Supervisor  
Accounts Receivable Detail/Initial Team Lead*

**HHSC Management Response-2**

*In a very few cases MCOs have used the Experience Rebate as a method to offset amounts they believe are owed to them by HHSC.*

*Demand letters will be issued for all outstanding Experience Rebates due.*

**Implementation Date:**

*October 2016*

**Responsible Person:**

*Director of MCD Financial Reporting and Audit Coordination  
Deputy Director of MCD Contract and Performance Management*

**Chapter 3 - Better Utilize External Quality Review Organization Contractor Information**

**Recommendation**

The Commission should use member survey results, including detailed data, and the validation results of paid claims data to enhance its monitoring of MCOs and document how it uses that information in its monitoring efforts.

**HHSC Management Response**

*The Commission will revise its policies and processes to enhance its monitoring of MCO performance. In its assessment of MCO performance, the Commission will consider information from its external quality review organization (EQRO), including member survey results and validation of paid claims.*

**Implementation Date:**

*July 2017*

**Responsible Person:**

*Deputy Medicaid Director for Quality and Program Improvement  
Director of MCD Health Plan Management*

**Chapter 4 - Strengthen IT Security and Processing Controls**



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**Recommendations**

The Commission should:

- Strengthen user access controls for ARTS and certain network folders the Commission uses to manage experience rebate collections.
- Require its accounts receivable staff to document daily reconciliations of deposits recorded in ARTS to the transactions processed in HHSAS and USAS.
- Develop, document, and implement a process to ensure that all programming changes to ARTS and the authorization and testing of those changes are formally documented.

**HHSC Management Response**

*The Commission is currently in the process of migrating to a single platform with full functionality available. This will allow security classes to be simplified (including keyword feature, manager approvals, etc.) and user authorization to be handled in one place. This will also allow the system to make use of user identification. Upon completion of maintenance changes (estimated to be effective September 1, 2017) ARTS will no longer require password management through itself and changes to HHSC security policies will be handled outside of the ARTS department.*

*Effective July 2016 all daily reconciliations are now being initialed and dated upon completion. The reconciliation process and segregation of duties occurs from the initial entry. Warrants/checks are entered into ARTS (which interfaces with HHSAS) via the scan process and initial entry whereby a DLN (Document Locator Number) is assigned. The detail entry area determines where the funds should be allocated via the service codes and groups them accordingly by receipt category. Upon completion of the checks being allocated to the appropriate service codes, the checks are surrendered to the voucher processing area where comptroller document numbers are assigned to keep track of deposits. Reconciliation between HHSAS and USAS are performed the following day after the overnight batch processes have occurred.*

*Change management process currently in place that requires the approval of either the AR Supervisor or AR Manager, before any maintenance, and/or system enhancements are performed. The current process consist of approvals via email, however a more formal automated change management process is planned for implementation by December 15, 2016.*

**Implementation Date:**

*September 1, 2017*

**Responsible Person:**

*Accounts Receivable Manager  
HHSC IT Enterprise Contract Manager*

Copies of this report have been distributed to the following:

### Legislative Audit Committee

The Honorable Dan Patrick, Lieutenant Governor, Joint Chair

The Honorable Joe Straus III, Speaker of the House, Joint Chair

The Honorable Jane Nelson, Senate Finance Committee

The Honorable Robert Nichols, Member, Texas Senate

The Honorable John Otto, House Appropriations Committee

The Honorable Dennis Bonnen, House Ways and Means Committee

### Office of the Governor

The Honorable Greg Abbott, Governor

### Health and Human Services Commission

Mr. Charles Smith, Executive Commissioner



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An Audit Report on

**HealthSpring Life and Health Insurance  
Company, Inc., a Medicaid STAR+PLUS  
Managed Care Organization**

February 2017  
Report No. 17-025



An Audit Report on

# **HealthSpring Life and Health Insurance Company, Inc., a Medicaid STAR+PLUS Managed Care Organization**

SAO Report No. 17-025  
February 2017

## **Overall Conclusion**

HealthSpring Life and Health Insurance Company, Inc.'s (HealthSpring) controls over its financial reporting process provided reasonable assurance that the \$601.3 million in medical claims and prescription drug claims that HealthSpring paid in fiscal year 2015 for the Medicaid STAR+PLUS managed care program (STAR+PLUS) were accurately reported on its financial statistical reports to the Health and Human Services Commission (Commission).

However, the salaries, other medical expenses, bonuses, allocated corporate costs, and professional services costs that HealthSpring reported on its financial statistical reports for fiscal year 2015 were not compliant with the Commission's contract requirements. Those costs were approximately \$53.8 million. Specifically:

- **Unallowable Costs** - Auditors identified approximately \$3.8 million in unallowable costs. HealthSpring (1) reported bonuses paid by its affiliate companies and (2) included advertising costs, charitable donations, non-STAR+PLUS affiliate company expenses, employee events expense, gifts, and stock options in its reported allocated corporate costs on its financial statistical reports. The Commission's Medicaid program requirements specify that those costs are unallowable and, therefore, should not be reported on the financial statistical reports. In addition, \$163,977 in reported professional services costs were for costs incurred in fiscal year 2014.
- **Questioned Costs** - Auditors identified approximately \$34.0 million in questioned salaries, other medical expenses (service coordinator salaries), and professional services costs. HealthSpring did not prepare certifications or personnel activity reports that the Commission requires to show that its reported salaries, approximately \$33.7 million, were for services that supported STAR+PLUS. In addition, HealthSpring could not provide

### **Background Information**

HealthSpring Life and Health Insurance Company, Inc. (HealthSpring) provides acute care services plus long-term care services and support (LTSS) by integrating primary care, pharmacy services, and LTSS for individuals who are age 65 or older or have a disability through services delivered through Medicaid STAR+PLUS managed care program (STAR+PLUS) in three service delivery areas in Texas. Those service delivery areas are: Tarrant service delivery area, Hidalgo service delivery area, and Northeast Medicaid rural service areas (see Appendix 3 for additional information on those service delivery areas).

From September 1, 2014, through August 31, 2015, HealthSpring received payments from the Health and Human Services Commission (Commission) that totaled \$713.7 million. Approximately \$601.3 million of that amount paid for medical claims and prescription drug claims for 62,828 people enrolled in STAR+PLUS.

Source: The Commission.

*This audit was conducted in accordance with Texas Government Code, Sections 321.0131, 321.0132, and 321.013(k)(2).*

*For more information regarding this report, please contact John Young, Audit Manager, or Lisa Collier, First Assistant State Auditor, at (512) 936-9500.*

documentation to show that \$359,912 in professional service costs tested were for STAR+PLUS.

The unallowable and questioned costs identified affect the accuracy of HealthSpring’s calculation of net income, which the Commission uses to calculate the experience rebate<sup>1</sup> amounts that HealthSpring is required to pay the Commission. For fiscal year 2015, HealthSpring paid the Commission an experience rebate of approximately \$12.5 million.

In addition, HealthSpring had weaknesses in the controls over its process for documenting the reasons for post-payment adjustments to medical claims and for ensuring that medical claims are paid within 30 days of receipt of a “clean claim”<sup>2</sup> as required. The weaknesses identified in the claims payment process could affect the continued participation of HealthSpring’s medical providers in STAR+PLUS.

Auditors communicated other, less significant issues to HealthSpring management and Commission management separately in writing.

Table 1 presents a summary of the findings in this report and the related issue ratings. (See Appendix 2 for more information about the issue rating classifications and descriptions.)

Table 1

Summary of Subchapters and Related Issue Ratings		
Subchapter	Title	Issue Rating <sup>a</sup>
1-A	HealthSpring Accurately Reported the Medical Claims and Prescription Drug Claims That It Paid in Fiscal Year 2015	Low
1-B	HealthSpring Included Unallowable Costs in the Bonuses It Reported on Its Financial Statistical Reports, and It Did Not Prepare Required Certifications and Personnel Activity Reports	High
1-C	HealthSpring Did Not Develop a Written Allocation Methodology as Required, and It Overstated Its Reported Allocated Corporate Costs on Its Financial Statistical Reports	High
1-D	HealthSpring Did Not Consistently Maintain Documentation to Show That Certain Legal and Professional Services Costs Were Applicable to STAR+PLUS and Incurred During the Reporting Period	Medium

<sup>1</sup> “Experience rebates” are a portion of a managed care organization’s net income before taxes that is returned to the State in accordance with statute and the uniform managed care contract terms.

<sup>2</sup> Title 28, Texas Administrative Code, Section 21.802 (6), defines a clean claim as follows:

- For nonelectronic claims, a claim submitted by a physician or a provider for medical care or health care services rendered to an enrollee under a health care plan or to an insured person under a health insurance policy that includes required data elements and the amount paid by a health plan.
- For electronic claims, a claim submitted by a physician or a provider for medical care or health care services rendered to an enrollee under a health care plan or to an insured person under a health insurance policy using the ASC X12N 837 format and in compliance with all applicable federal laws related to electronic health care claims, including applicable implementation guides, companion guides, and trading partner agreements.

Summary of Subchapters and Related Issue Ratings		
Subchapter	Title	Issue Rating <sup>a</sup>
1-E	HealthSpring Did Not Report Accurate and Complete Information About Its Affiliate Companies	Medium
2-A	HealthSpring Did Not Consistently Document the Reasons for Post-payment Adjustments That It Made to Paid Medical Claims	High
2-B	HealthSpring Did Not Ensure That It Paid All Medical Claims Within 30 Days of Receipt of a Clean Claim as Required	Medium
<p><sup>a</sup> A subchapter is rated <b>Priority</b> if the issues identified present risks or effects that if not addressed could critically affect the audited entity's ability to effectively administer the program(s)/function(s) audited. Immediate action is required to address the noted concern and reduce risks to the audited entity.</p> <p>A subchapter is rated <b>High</b> if the issues identified present risks or effects that if not addressed could substantially affect the audited entity's ability to effectively administer the program(s)/function(s) audited. Prompt action is essential to address the noted concern and reduce risks to the audited entity.</p> <p>A subchapter is rated <b>Medium</b> if the issues identified present risks or effects that if not addressed could moderately affect the audited entity's ability to effectively administer program(s)/function(s) audited. Action is needed to address the noted concern and reduce risks to a more desirable level.</p> <p>A subchapter is rated <b>Low</b> if the audit identified strengths that support the audited entity's ability to administer the program(s)/functions(s) audited or the issues identified do not present significant risks or effects that would negatively affect the audited entity's ability to effectively administer the program(s)/function(s) audited.</p>		

## ***Summary of Management's Response***

At the end of each chapter in this report, auditors made recommendations to address the issues identified during this audit. HealthSpring generally agreed with the recommendations in this report, and management's response is presented in Appendix 7.

## ***Audit Objective and Scope***

The objective of this audit was to determine whether selected financial processes and related controls at a Medicaid managed care organization (MCO) are designed and operating to help ensure (1) the accuracy and completeness of data that the MCO reports to the Commission and (2) compliance with applicable requirements.

The scope of this audit covered HealthSpring's contracts with the Commission for STAR+PLUS. It covered HealthSpring's financial statistical reports and its reported medical claims and pharmacy claims for fiscal year 2015. It also included the Commission's management of the MCO's subcontractor agreements and readiness review records for fiscal year 2015.

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## ***Detailed Results***

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# Detailed Results

## Chapter 1

### ***HealthSpring Accurately Reported State Payments, Medical Claims, and Prescription Drug Claims on Its Financial Statistical Reports for Fiscal Year 2015; However, It Had Significant Weaknesses for Reporting Its Administrative Expenses***

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#### **Unallowable Cost**

The Commission's *Uniform Managed Care Manual* defines the cost principles that establish the allowability of various administrative expenses that an MCO can report on the financial statistical reports. A designation of "allowable" or "unallowable" does not generally govern whether the MCO can incur a cost or make a payment; allowability reflects only what is reportable on the financial statistical reports. To be allowable, expenses must conform to the requirements of the Commission's cost principles, which include being reasonable and allocable.

#### **Questioned Cost**

According to the Code of Federal Regulations, a "questioned cost" is a cost charged to MCO funds that MCO management, federal oversight entities, an independent auditor, or other audit organization authorized to conduct an audit of an MCO has questioned because of an audit or other finding. Costs may be questioned because:

- There may have been a violation of a provision of a law, regulation, contract, grant, or other agreement or document governing the use of MCO funds;
- The cost is not supported by adequate documentation; or
- The cost incurred appears unnecessary or unreasonable and does not reflect the actions a prudent person would take in the circumstances.

Sources: The Commission's *Uniform Managed Care Manual* and Title 45, Code of Federal Regulations, Section 1630.2(g).

HealthSpring Life and Health Insurance Company, Inc.'s (HealthSpring) financial reporting process provided reasonable assurance that it accurately reported certain costs on its financial statistical reports to the Health and Human Services Commission (Commission). Specifically, HealthSpring accurately reported the Medicaid STAR+PLUS (STAR+PLUS) program medical claims and the prescription drug claims that it paid for fiscal year 2015, totaling \$601,313,929, as required by its contracts with the Commission.

However, the salaries, other medical expenses, bonuses, allocated corporate costs, and professional services costs that HealthSpring reported on its financial statistical reports for fiscal year 2015, totaling \$53,808,621, may be overstated. Auditors identified weaknesses in HealthSpring's controls for reporting those costs that resulted in \$3,831,812 in unallowable costs to be reported. In addition, auditors identified \$34,039,615 in questioned costs because HealthSpring did not maintain documentation to show that the reported costs were attributable to STAR+PLUS (see text box for information about unallowable and questioned costs).

HealthSpring's overstatement of the costs listed above would affect the accuracy of HealthSpring's calculation of net income. The Commission uses the reported net income to calculate the amount of "experience rebates"<sup>3</sup> that managed care organizations (MCOs), such as HealthSpring, are statutorily required to pay the Commission. As of August 2016, HealthSpring paid the Commission a total of \$12,478,448 in experience rebates for fiscal year 2015. (See Appendix 6 for more information about calculating the experience rebate that HealthSpring owed for fiscal year 2015.)

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<sup>3</sup> "Experience rebates" are a portion of an MCO's net income before taxes that is returned to the State in accordance with statute and the uniform managed care contract terms. (See Appendix 5 for more information about experience rebates.)

Table 2 summarizes the identified unallowable and questioned costs.

Table 2

Unallowable and Questioned Costs That HealthSpring Reported on Its Financial Statistical Reports for Fiscal Year 2015			
Type of Administrative Expense	Reported Costs for Fiscal Year 2015	Total Unallowable Costs Identified	Total Questioned Costs Identified
Salaries	\$ 22,848,767	\$ 0	\$ 22,848,767
Bonuses	786,457	786,457	0
Other Medical Expenses <sup>a</sup>	11,137,962	0	10,830,936 <sup>b</sup>
Allocated Corporate Costs	15,355,392	2,881,358	0
Legal and Professional Services Costs	3,680,042	163,997	359,912
<b>Totals</b>	<b>\$53,808,621</b>	<b>\$3,831,812</b>	<b>\$34,039,615</b>
<sup>a</sup> Other Medical Expenses represent salary and miscellaneous expenses related to service coordinators. A service coordinator is an employee who works with a STAR+PLUS member, the member's family, and the member's doctors and other providers to help the member get the medical and long-term care services and support they need. The coordinator must identify the member's needs and develop a plan of care. <sup>b</sup> The questioned costs for Other Medical Expenses represent only the salary costs portion of HealthSpring's reported Other Medical Expenses. See Chapter 1-B for information about Other Medical Expenses that auditors tested.			

Source: HealthSpring and the Commission.

HealthSpring also reported inaccurate and incomplete information to the Commission about its affiliate companies that provide services supporting its administration of STAR+PLUS. The Commission uses the information that HealthSpring reports as part of its monitoring efforts to ensure the transparency and reasonableness of HealthSpring's related-party transactions.

## HealthSpring Accurately Reported the Medical Claims and Prescription Drug Claims That It Paid in Fiscal Year 2015

### Chapter 1-A Rating:

Low <sup>4</sup>

#### Financial Statistical Reports

The Commission receives financial statistical reports from MCOs on a quarterly and annual basis as required by the Commission's contracts with the MCOs. Those reports are the primary statements of financial results the MCOs submit to the Commission. The Commission uses the reports to analyze the MCOs' membership, revenues, expenses, and net income by service area and program.

Source: The Commission.

#### Medical Claims and Pharmacy Claims Tested

The samples auditors tested were selected as follows:

- **Medical Claims.** Auditors selected a random sample of 60 paid medical claims and used professional judgment to select a risk-based sample of 17 additional medical claims to test.
- **Pharmacy Claims.** Auditors selected a random sample of eight vendor payments to HealthSpring's pharmacy benefit manager and used professional judgment to select a risk-based sample of three additional vendor payments to test.

HealthSpring's financial reporting processes and controls provided reasonable assurance that the \$601,313,929 in medical claims and prescription drug claims it paid in fiscal year 2015 were accurately calculated and reported on its financial statistical reports to the Commission (see text box for information about the required financial statistical reports).

Auditors tested samples of HealthSpring's medical claims and vendor payments to its pharmacy benefit manager<sup>5</sup> that were reported as paid during fiscal year 2015 (see text box for additional details on the medical claims and pharmacy claims tested). The tested medical claims and pharmacy claims were accurate, supported by documentation, and submitted for eligible STAR+PLUS members.

**Paid medical claims tested were accurate, supported by documentation, and submitted by eligible providers for eligible STAR+PLUS members.**

The medical claim payments tested that HealthSpring reported on its financial statistical reports for fiscal year 2015 were allowable, supported by documentation, and documented accurately in HealthSpring's claims processing system. HealthSpring reported a total of \$510,400,761 in medical claim payments for fiscal year 2015. Auditors tested a sample of 77 medical claim payments, totaling \$786,899, and verified that:

- The medical claim payment amounts matched the payment amounts shown in (1) HealthSpring's claims processing system, (2) the medical claims data that HealthSpring reported to the Commission, and (3) copies of the explanation of payment (EOP) statements that HealthSpring sent to medical providers.

<sup>4</sup> The risks related to the issues discussed in Chapter 1-A are rated as Low because the audit identified strengths that support the audited entity's ability to administer the program(s)/functions(s) audited or the issues identified do not present significant risks or effects that would negatively affect the audited entity's ability to effectively administer the program(s)/function(s) audited.

<sup>5</sup> HealthSpring contracts with a pharmacy benefit manager to manage and pay pharmacy drug claims purchased through its STAR+PLUS contract. HealthSpring reimburses its pharmacy benefit manager for the pharmacy drug claims paid, and it pays a monthly management fee to the pharmacy benefit manager for the services provided. For fiscal year 2015, HealthSpring reported that it paid \$538,000 to its pharmacy benefit manager.

- Eligible providers submitted the medical claims, and those claims were for eligible STAR+PLUS members.

However, auditors identified weaknesses in HealthSpring's controls over post-payment adjustments to medical claims and for ensuring the timeliness of medical claims payments (see Chapter 2).

**HealthSpring's vendor payments to its pharmacy benefit manager were accurate, supported by documentation, and for pharmacy claims for eligible STAR+PLUS members.**

The pharmacy claims payments tested were accurate and supported by documentation. HealthSpring reported that it paid its pharmacy benefit manager a total of \$90,913,168 in fiscal year 2015. Auditors tested a sample of 11 payments to the pharmacy benefit manager, totaling \$18,960,236, and verified that the payment amounts matched the weekly invoices that HealthSpring received from its pharmacy benefit manager.

In addition, auditors verified that the payments for a sample of 81 pharmacy claims from HealthSpring (1) matched the payment amounts reported to the Commission and (2) were for pharmacy claims for eligible STAR+PLUS members.

#### Chapter 1-B

### **HealthSpring Included Unallowable Costs in the Bonuses It Reported on Its Financial Statistical Reports, and It Did Not Prepare Required Certifications and Personnel Activity Reports**

**Chapter 1-B  
Rating:  
High <sup>6</sup>**

HealthSpring included unallowable costs and questioned costs on its financial statistical reports for fiscal year 2015. Auditors identified \$786,457 in bonuses that HealthSpring should not have reported on its financial statistical reports for fiscal year 2015. The amount that HealthSpring reported was for bonuses that were paid to staff employed by its affiliate companies. The Commission's reporting requirements specify that bonuses paid to affiliates are unallowable costs.

In addition, auditors identified \$33,679,703 in questioned salaries and other medical expenses<sup>7</sup> (see Table 3). HealthSpring did not prepare certifications

<sup>6</sup> The risks related to the issues discussed in Chapter 1-B are rated as High because they present risks or results that if not addressed could substantially affect the audited entity's ability to effectively administer the program(s)/function(s) audited. Prompt action is essential to address the noted concern(s) and reduce risks to the audited entity.

<sup>7</sup> Other medical expenses represent the salaries and other costs associated with service coordinator positions. A service coordinator is an employee who works with a STAR+PLUS member, the member's family, and the member's doctors and other providers to help the member get the medical and long-term care services and support needed. The coordinator must

and personnel activity reports to show that the amounts reported for salaries and other medical expenses were for staff who worked on STAR+PLUS as required by the Commission.

Table 3

Fiscal Year 2015 Salaries, Bonuses, and Other Medical Expenses <sup>a</sup>		
Total Reported Costs for Fiscal Year 2015	Total Unallowable Costs Identified	Total Questioned Costs Identified <sup>b</sup>
\$34,773,186	\$786,457	\$33,679,703
<sup>a</sup> Other Medical Expenses represent salary and miscellaneous expenses related to service coordinators. <sup>b</sup> The questioned costs include only the salary costs and the salary portion of the Other Medical Expenses HealthSpring reported.		

Source: HealthSpring and the Commission.

The unallowable costs and questioned costs that auditors identified affect the Commission's calculation of the experience rebate amount that HealthSpring may owe the Commission for fiscal year 2015. (See Appendix 5 for more information about how the Commission calculates the experience rebate amounts that an MCO may owe it.)

**HealthSpring erroneously reported bonuses that were paid to an affiliate company's staff on its financial statistical reports.**

HealthSpring reported bonuses totaling \$786,457 on its financial statistical reports that were paid to staff employed by HealthSpring's affiliate companies (see Chapter 1-E for more information about HealthSpring's affiliate companies and Appendix 4 for information on HealthSpring's corporate structure, including its affiliate companies). While salaries for affiliate companies should be reported, the Commission's *Uniform Managed Care Manual* states that bonuses paid or payable to an affiliate are unallowable. The bonuses paid to staff employed by HealthSpring's affiliate companies should not be reported on HealthSpring's financial statistical reports.

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identify the member's needs and develop a plan of care. Auditors tested only the salary costs included in the other medical expense amount that HealthSpring reported on its financial statistical reports for fiscal year 2015.

### Reporting Requirements for Affiliate Salaries

The Commission's *Uniform Managed Care Manual* specifies the following reporting requirements for affiliate salaries:

- Where employees are expected to work solely on a single contract, charges for their salaries and wages will be supported by periodic certifications that the employees worked solely on that contract for the period covered by the certification. These certifications will be prepared at least semi-annually and will be signed by the employee or supervisory official having firsthand knowledge of the work performed by the employee.
- Where employees work on multiple activities, a distribution of their salaries or wages will be supported by personnel activity reports or equivalent documentation that meets the standards in Section VI(14)(h)(5) unless a substitute system has been reviewed in advance by the Commission and will be subject to audit. Documentary support will be required where employees work on more than one activity within the MCO.

HealthSpring did not perform required certifications and prepare personnel activity reports to support the salary amounts reported on its financial statistical reports.

Auditors identified \$33,679,703 in questioned costs for salaries (totaling \$22,848,767) and for other medical expenses (totaling \$10,830,936) that HealthSpring reported on its financial statistical reports for fiscal year 2015. HealthSpring's management asserted to auditors that it did not have any staff that worked on the STAR+PLUS contracts, and that the staff who worked on the STAR+PLUS contracts were employed by its affiliate company, GulfQuest, L.P. (GulfQuest). The salary amount that HealthSpring reported on its financial statistical reports were the salary costs for staff employed by its affiliate companies. While HealthSpring correctly reported actual salary costs for staff employed by its affiliate companies on its financial statistical reports, as required, it did not perform required certifications and prepare personnel activity reports to show that affiliate companies' salaries that it used to calculate the reported amounts on its financial statistical reports were for staff who worked on STAR+PLUS-related activities (see text box for reporting requirements for affiliate company salaries).

Preparing certifications and personnel activity reports is important to help ensure that HealthSpring does not include the salary amounts or allocated salary amounts for affiliate companies' staff who may work on HealthSpring's other lines of Medicaid and Medicare health care programs located outside Texas.

### Recommendations

HealthSpring should:

- Adjust applicable amounts on its financial statistical reports for fiscal year 2015 by the unallowable amounts that auditors identified.
- Discuss with the Commission how to resolve the identified questioned costs, including what adjustments should be made to the financial statistical reports for fiscal year 2015.
- Comply with the Commission's requirements that it not include bonuses paid by its affiliate companies on its financial statistical reports.
- Perform periodic certifications and prepare personnel activity reports that support the amount of time its staff or its affiliate companies' staff spend working on STAR+PLUS as required.

## HealthSpring Did Not Develop a Written Allocation Methodology as Required and It Overstated Its Reported Allocated Corporate Costs on Its Financial Statistical Reports

Chapter 1-C  
Rating:  
High <sup>8</sup>

HealthSpring's methodology for calculating allocated corporate costs, totaling \$15,355,392, reported on its financial statistical reports for fiscal year 2015 was not in compliance with the Commission's requirements. The Commission's *Uniform Managed Care Manual* requires an MCO to ensure that:

- It develops a written allocation methodology policy.
- Costs clearly represent specifically identified operating services provided.
- Services directly benefit the Commission or its clients/customers.

However, HealthSpring did not have a written allocation methodology policy in place for fiscal year 2015 as required. In addition, its methodology for calculating allocated corporate costs included certain costs that were not allowable by the Commission. As a result, HealthSpring included \$2,881,358 in unallowable costs in the allocated corporate cost it reported (see Table 4).

Table 4

Fiscal Year 2015 Allocated Corporate Costs		
Total Reported Costs on the Financial Statistical Reports	Total Unallowable Costs Identified	Total Questioned Costs Identified
\$15,355,392	\$2,881,358	\$0

Source: HealthSpring and the Commission.

### HealthSpring did not have a written policy for calculating the allocated corporate costs reported on its financial statistical reports to the Commission.

HealthSpring's methodology for calculating its allocated corporate costs was based on spreadsheets created to calculate the allocated corporate costs that it reported on its financial statistical reports for STAR+PLUS. However, HealthSpring did not have a written policy, as required by the Commission, to help ensure that allocated corporate costs it reported were calculated correctly and that those costs were properly reviewed and approved. Having a written policy is important because HealthSpring's corporate operations manage other Medicaid and Medicare health programs throughout the

<sup>8</sup> The risks related to the issues discussed in Chapter 1-C are rated as High because they present risks or results that if not addressed could substantially affect the audited entity's ability to effectively administer the program(s)/function(s) audited. Prompt action is essential to address the noted concern(s) and reduce risks to the audited entity.

United States, including a separate contract with the Commission for the Medicaid-Medicare Plan.<sup>9</sup> HealthSpring uses the costs from those programs when determining the basis for allocating costs to its STAR+PLUS contracts. Without a written allocation methodology, there is an increased risk that HealthSpring may use inconsistent methods to calculate and allocate its corporate costs among STAR+PLUS and its other health care programs. Those inconsistencies could affect the accuracy of its reported net income amount, which the Commission uses to calculate HealthSpring's experience rebates.

**The allocated corporate costs that HealthSpring reported for fiscal year 2015 included unallowable costs.**

The costs that HealthSpring included in its calculation for determining the allocated corporate costs to report on its financial statistical reports for fiscal year 2015 included \$2,881,358 in unallowable costs. Specifically, the reported amount included the following unallowable costs:

- Allocated corporate costs for advertising, charitable donations, non-STAR+PLUS affiliate expenses, employee events, gifts, bonuses, and stock options, totaling \$2,736,870, were indirect costs that did not provide a direct benefit to STAR+PLUS. The Commission's *Uniform Managed Care Manual* states that the expenses identified are unallowable.
- Allocated corporate costs for severance pay, totaling \$144,488, were accrual amounts and not actual expenses that HealthSpring incurred. The Commission's *Uniform Managed Care Manual* states that severance payments, but not accruals, associated with normal turnover are allowable.

**HealthSpring did not maintain documentation to support the reasonableness and accuracy of internally generated financial reports and services that its corporate divisions provided.**

HealthSpring did not have documentation to show the following:

- Email confirmations from managers of its corporate divisions whose staff salaries were included in the allocated corporate costs reported on the financial statistical reports for fiscal year 2015. HealthSpring stated that

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<sup>9</sup> According to the Commission, on May 23, 2014, the U.S. Centers for Medicare and Medicaid Services (CMS) announced that the State of Texas would partner with CMS to test a new model for providing Medicare and Medicaid enrollees with a coordinated, person-centered care experience. Texas and CMS would contract with Medicare and Medicaid plans to coordinate the delivery of and be accountable for covered Medicare and Medicaid services for participating Medicare and Medicaid enrollees. Under the demonstration, Medicare and Medicaid Plans would cover Medicare benefits in addition to the existing set of Medicaid benefits currently offered under STAR+PLUS, allowing for an integrated set of benefits for enrollees.



the email confirmations could show when staff were assigned to work on STAR+PLUS activities.

- How HealthSpring identified all of its Medicaid and Medicare health care programs for which it set the rate of allocating its corporate costs among its Medicaid and Medicare health care programs based on those programs' number of members and applicable financial information.

The Commission's *Uniform Managed Care Manual* states that for costs to be allowable, they must be adequately documented. Without adequate documentation, HealthSpring cannot show that the salaries and other information used to create the rate it used to allocate its corporate costs to STAR+PLUS is reasonable and accurate.

## Recommendations

HealthSpring should:

- Adjust applicable amounts on its financial statistical reports for fiscal year 2015 by the unallowable amounts that auditors identified.
- Document its methodology for calculating allocated corporate costs for STAR+PLUS as required.
- Ensure that its methodology for calculating corporate allocation amounts align with the Commission's requirements.
- Maintain copies of emails and other documentation to support management assertions used for determining allocated corporate costs.

## HealthSpring Did Not Consistently Maintain Documentation to Show That Certain Legal and Professional Services Costs Were Applicable to STAR+PLUS and Incurred During the Reporting Period

**Chapter 1-D  
Rating:**  
Medium <sup>10</sup>

HealthSpring did not consistently maintain documentation to support the reasonableness and appropriateness of the vendor payment amounts that it used to calculate and report its legal and professional services costs, totaling \$3,680,042, on its financial statistical reports for fiscal year 2015. Auditors tested a sample of 26 vendor payments that totaled \$934,227 and identified unallowable costs and questioned costs (see Table 5).

Table 5

Fiscal Year 2015 Legal and Professional Services		
Total Reported Costs on the Financial Statistical Reports	Total Unallowable Costs Identified	Total Questioned Costs Identified
\$3,680,042	\$163,997	\$359,912

Source: HealthSpring and the Commission.

### Legal and Professional Services Costs Tested

Auditors used professional judgment to select a risk-based sample of 26 expenditures from the general ledger of one of HealthSpring's affiliate companies, GulfQuest, which manages HealthSpring's operations for STAR+PLUS. (See Chapter 1-E for more information.)

Specifically, 10 (38.5 percent) of those 26 vendor payments tested were for services provided in fiscal year 2014 but paid for in fiscal year 2015. Those 10 payment totaled \$163,997. The Commission's *Uniform Managed Care Manual* requires administrative expenses to be reported based on the date incurred rather than the date paid. It also requires prior quarters' data to be updated as needed.

In addition, 6 (23.1 percent) of the 26 vendor payments tested did not have documentation to show that the vendor payment was related to STAR+PLUS (see text box for information about the sample tested). Those 6 payments totaled \$359,912. The Commission's *Uniform Managed Care Manual* specifies that a cost is allowable only to the extent of the benefits the Commission received under the contract.

Without consistent documentation to show the appropriateness and reasonableness of the legal and professional services costs, there is an increased risk that the legal and professional services costs that HealthSpring reported on its financial statistical reports for fiscal year 2015 may be

<sup>10</sup> The risks related to the issues discussed in Chapter 1-D are rated as Medium because they present risks or results that if not addressed could moderately affect the audited entity's ability to effectively administer program(s)/function(s) audited. Action is needed to address the noted concern(s) and reduce risks to a more desirable level.

overstated. This may affect the experience rebate amount HealthSpring may owe the Commission. (See Appendix 5 for more information for how the Commission calculates the experience rebate amount an MCO may owe.)

## Recommendations

HealthSpring should:

- Adjust applicable amounts on its financial statistical reports for fiscal year 2015 by the unallowable amounts that auditors identified.
- Discuss with the Commission how to resolve the questioned costs that auditors identified, including what adjustments should be made to the financial statistical reports for fiscal year 2015.
- Maintain supporting documentation to show that a vendor payment is for services related to STAR+PLUS and that the reported amounts are accurate.
- Report vendor payments based on the dates on which the costs were incurred.

Chapter 1-E

### HealthSpring Did Not Report Accurate and Complete Information About Its Affiliate Companies

**Chapter 1-E  
Rating:**  
Medium <sup>11</sup>

HealthSpring reported inaccurate information about its affiliate companies involved with the services provided for its STAR+PLUS contracts with the Commission. The Commission's contract requires that an MCO submit an annual affiliate report that provides organizational and financial information on affiliate companies involved with the services provided under managed care contracts.

In addition, HealthSpring did not provide the Commission with copies of its contracts with its affiliate companies that provide administrative services under its STAR+PLUS contracts with the Commission. The Commission's

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<sup>11</sup> The risks related to the issues discussed in Chapter 1-E are rated as Medium because they present risks or results that if not addressed could moderately affect the audited entity's ability to effectively administer program(s)/function(s) audited. Action is needed to address the noted concern(s) and reduce risks to a more desirable level.

contract specifies that an MCO must submit to the Commission a copy of its contract agreements with affiliate companies.<sup>12</sup>

Auditors also identified payments to affiliate companies that did not have documentation to support amounts paid or were not calculated according to contract requirements.

The Commission uses the affiliate information and copies of affiliate company contracts with MCOs to support its monitoring efforts to ensure the transparency and reasonableness of an MCO's related-party transactions.

**HealthSpring provided the Commission inaccurate and incomplete information on its affiliate companies involved with its STAR+PLUS contracts.**

While HealthSpring submitted an affiliate report for fiscal year 2015 as required, that report included inaccurate and incomplete information on the services provided by and management fees paid to its affiliate companies. Specifically, HealthSpring's affiliate report included the following inaccurate and incomplete information:

- HealthSpring identified only one affiliate company on its affiliate report, GulfQuest. However, HealthSpring contracts with a different affiliate company, HealthSpring Management of America (HMA), for the professional services that HealthSpring described on its affiliate report. HMA has a subcontract agreement with GulfQuest to provide the actual professional services to HealthSpring. (HealthSpring's contract with HMA and HMA's subcontract with GulfQuest is discussed in more detail later in this chapter.)
- HealthSpring inaccurately reported that it paid management fees to GulfQuest that totaled \$342,000,000 in fiscal year 2015 for the professional services provided; however, auditors determined that for STAR+PLUS HealthSpring's payments totaled \$104,668,705 and those payments were paid to HMA.
- HealthSpring did not include four additional affiliate companies—Bravo Health MidAtlantic, HealthSpring USA, Newquest LLC, and Newquest of Illinois—on its affiliate report. On its financial statistical reports for fiscal year 2015, HealthSpring reported allocated corporate costs from Newquest LLC totaling \$10,878,506 and salaries and bonuses totaling \$681,531 that were related to those four companies. The Commission's contracts with HealthSpring specify that an MCO must submit a list of all

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<sup>12</sup> Under the Commission's contract with HealthSpring for STAR+PLUS, all material subcontracts should be reported. A material subcontract is any contract, subcontract, or agreement between an MCO and another entity that meets certain criteria, including whether the other entity is an affiliate of the MCO.

affiliates and a schedule of all transactions with affiliates that will be allowable for reporting purposes. Those transactions should describe the financial terms, provide a detailed description of the services to be provided, and include an estimated amount that will be incurred by the MCO for such services.

**HealthSpring did not provide the Commission a copy of its contracts with the affiliate companies that provide administrative services on its STAR+PLUS contracts.**

HealthSpring did not provide the Commission a copy of the contracts that it had with its affiliate companies for STAR+PLUS. Specifically, HealthSpring did not provide the Commission copies of the following contracts:

- **HMA.** HealthSpring's contract with HMA, effective January 1, 2012, specifies that it will provide management and administrative services to HealthSpring. For STAR+PLUS, HealthSpring will pay HMA a monthly management fee based on a percentage of HealthSpring's operating revenue for the calendar year.
- **GulfQuest.** HMA subcontracted its contracted services with HealthSpring to GulfQuest. HMA's subcontract agreement with GulfQuest, executed on July 15, 2010, assigned to GulfQuest the management and administrative services that HMA was contracted to provide to HealthSpring.

Having copies of the contracts between MCOs and their affiliate companies, including applicable subcontract agreements, helps the Commission to ensure the transparency of the financial terms for the services that affiliate companies provide to MCOs.

See Appendix 4 for more information about HealthSpring's affiliate companies.

**HealthSpring did not have documentation to support the accuracy and appropriateness of payments to HMA for service coordinator-related costs.**

HealthSpring's payments to HMA included an amount intended to reimburse GulfQuest for service coordinator-related expenses. HealthSpring's contract with HMA specified that HealthSpring would be invoiced by HMA on a monthly basis for service coordinator-related costs and that the invoice would have sufficient detail supporting the costs. However, HealthSpring did not receive invoices as required. HealthSpring asserted that it based its reimbursement to HMA on a monthly financial report that shows the amount it owes HMA. The financial report does not show any specific information related to the reimbursement amount. It only shows the total amount owed HMA for the STAR+PLUS program and other healthcare programs HMA manages for HealthSpring. For fiscal year 2015, HealthSpring asserted that it

reimbursed HMA for service coordinator-related costs that totaled \$10,669,435. (See Chapter 1-B for more information about the service coordinator-related salaries that HealthSpring reported.)

**HMA's payments to GulfQuest were calculated using a methodology that differed from the methodology required by its contract.**

HMA's payments to GulfQuest were not calculated according to the payment requirements in its contract with GulfQuest. While HMA's contract with GulfQuest stated that it would pay a certain percentage of its operating revenues to GulfQuest, HMA actually paid to GulfQuest all the management fees that it received from HealthSpring for STAR+PLUS.

## **Recommendations**

HealthSpring should:

- Report all of its affiliate companies involved in STAR+PLUS, and report accurate and complete information about those companies and costs to the Commission as required.
- Ensure that it provides the Commission copies of all of its contracts with affiliate companies, including subcontract agreements, that provide services on its STAR+PLUS contracts as required.
- Obtain and maintain documentation to support its payments to HMA for service coordinator-related expenses.
- Ensure that HMA's payments to GulfQuest are calculated and paid in accordance with contract requirements.

## ***HealthSpring Did Not Consistently Document the Reasons for Post-payment Adjustments to Medical Claims and Pay Medical Claims Within the Required Timeframe***

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Because of weaknesses in HealthSpring's controls over post-payment adjustments to medical claims, it did not consistently document the reasons for its post-payment adjustments that it made to medical claims. In addition, weaknesses in HealthSpring's controls resulted in some medical claims tested not being paid within 30 days of receipt of a "clean claim" as required by HealthSpring's contracts with the Commission. (See Chapter 2-B for additional information on clean claims.)

The weaknesses identified in HealthSpring's claims payment process could affect the continued participation of HealthSpring's medical providers in STAR+PLUS.

Chapter 2-A

### **HealthSpring Did Not Consistently Document the Reasons for Post-payment Adjustments That It Made to Paid Medical Claims**

**Chapter 2-A  
Rating:  
High <sup>13</sup>**

#### **Post-payment Adjustments Tested**

Auditors selected a random sample of 60 post-payment adjusted medical claims and used professional judgment to select 1 additional post-payment adjusted medical claim to determine whether the post-payment adjustment matched the medical service information shown in (1) HealthSpring's claims processing system and (2) copies of the EOP statements that HealthSpring submitted to medical providers. Auditors also determined whether HealthSpring documented its reasons for the adjustments.

Auditors tested a sample of 61 post-payment adjustments to medical claims, totaling \$52,209 that HealthSpring reported to the Commission (see text box for more information about the claims tested). The post-payment adjustments tested resulted in HealthSpring reversing the original payment amount to a provider. For 27 (44 percent) of 61 medical claims tested, totaling \$32,067, HealthSpring did not record the reason it made the post-payment adjustment in its claims processing system. The Commission's *Uniform Managed Care Claims Manual* requires an MCO's claims system to maintain adequate audit trails and report accurate medical provider service data on paid medical claims to the Commission.

In addition, HealthSpring did not document the reason it adjusted a claim on the Explanation of Payment (EOP) for 9 (33 percent) of those 27 medical claims. An EOP notifies a medical provider about the processing status of a medical claim that HealthSpring has received. Those 9 medical claims totaled \$12,780. For the other 18 medical claims tested, the EOP included a code that indicated only that the medical claim was adjusted. The code did not provide any details about the reason the medical claim was adjusted.

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<sup>13</sup> The risks related to the issues discussed in Chapter 2-A are rated as High because they present risks or results that not addressed could substantially affect the audited entity's ability to effectively administer the program(s)/function(s) audited. Prompt action is essential to address the noted concern and reduce risks to the audited entity.

The post-payment adjustments that auditors tested were reversals of medical claim payments by HealthSpring to medical providers. In some cases a new payment may have been issued to the provider. However, due to the lack of documentation describing the reasons for post-payment adjustments, auditors were unable to always determine whether a post-payment adjustment was reasonable and whether a new payment had been paid to a medical provider. As a result, there is an increased risk that HealthSpring may have inappropriately recouped its payments to medical providers.

## Recommendation

HealthSpring should develop, document, and implement a process to ensure that it records the reason for all post-payment adjustments to medical claims in its claims processing system and on the EOPs sent to medical providers.

Chapter 2-B

### HealthSpring Did Not Ensure That It Paid All Medical Claims Within 30 Days of Receipt of a Clean Claim as Required

**Chapter 2-B  
Rating:**  
Medium <sup>14</sup>

Auditors tested a sample of 77 paid medical claims that totaled \$786,889 (see text box for more information about the claims tested). HealthSpring did not process 15 (20 percent) of the 77 paid medical claims tested within 30 days of receipt of a clean claim as required (see Table 6). Those 15 claims totaled \$386,779.

Table 6

Medical Claims Tested That HealthSpring Processed Late		
Number of Days Past Due	Number of Claims	Amount
1-10 Days	6	\$148,478
11-30 Days	6	237,471
More than 30 Days	3	830
<b>Totals</b>	<b>15</b>	<b>\$386,779</b>

Source: HealthSpring.

#### Medical Claims Tested

Auditors selected a random sample of 60 paid medical claims and used professional judgment to select a risk-based sample of 17 additional paid medical claims to test. Auditors verified whether the payment amounts matched the payment amounts shown in (1) HealthSpring's claims processing system, (2) the medical claims data that HealthSpring reported to the Commission, and (3) copies of the EOP statements that HealthSpring submitted to medical providers. Auditors also determined whether the medical claims were processed in a timely manner and in compliance with the Commission's requirements.

<sup>14</sup> The risks related to the issues discussed in Chapter 2-B are rated as Medium because they present risks or results that if not addressed could moderately affect the audited entity's ability to effectively administer program(s)/function(s) audited. Action is needed to address the noted concern(s) and reduce risks to a more desirable level.



### Clean Claims

Title 28, Texas Administrative Code, Section 21.802(6), defines a **clean claim** as follows:

- For nonelectronic claims, a claim submitted by a physician or a provider for medical care or health care services rendered to an enrollee under a health care plan or to an insured person under a health insurance policy that includes required data elements and the amount paid by a health plan.
- For electronic claims, a claim submitted by a physician or a provider for medical care or health care services rendered to an enrollee under a health care plan or to an insured person under a health insurance policy using the ASC X12N 837 format and in compliance with all applicable federal laws related to electronic health care claims, including applicable implementation guides, companion guides, and trading partner agreements.

The Commission's *Uniform Managed Care Manual* requires that, once an MCO receives a "clean claim" (see text box for explanation of a clean claim), it is required to pay the total amount of the claim, or part of the claim, in accordance with the contract within the 30-day claim payment period. HealthSpring reported to auditors that the 15 medical claims tested were not processed within 30 days of receipt of the clean claims as a result of a staffing shortage it experienced during fiscal year 2015. However, HealthSpring paid the interest penalties on 13 (86.7 percent) of the 15 medical claims tested that were not processed within 30 days of receipt of a clean claim. HealthSpring did not pay interest for two medical claims that it processed within 3 days after the 30-day requirement.

### Recommendations

HealthSpring should:

- Ensure that all medical claims are paid within the Commission's required timeframe.
- Pay interest penalties on all medical claims that are not processed within the Commission's required time frame.

# Appendices

## Appendix 1

### **Objective, Scope, and Methodology**

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#### **Objective**

The objective of this audit was to determine whether selected financial processes and related controls at a Medicaid managed care organization (MCO) are designed and operating to help ensure (1) the accuracy and completeness of data that the MCO reports to the Commission and (2) compliance with applicable requirements.

#### **Scope**

The scope of this audit covered HealthSpring Life and Health Insurance Company, Inc.'s (HealthSpring) contracts with the Health and Human Services Commission (Commission) for the Medicaid STAR+PLUS managed care program (STAR+PLUS). It covered HealthSpring's financial statistical reports and its reported medical claims and pharmacy claims for fiscal year 2015. It also included the Commission's management of the MCO's subcontractor agreements and readiness review records for fiscal year 2015.

#### **Methodology**

The audit methodology included selecting an MCO based on the State Auditor's Office's risk assessment of MCOs that included obtaining information and data from the Commission concerning the risks associated with MCOs.

Additionally, the audit methodology included collecting information and documentation, performing selected tests and other procedures, analyzing and evaluating results of the tests, and interviewing management and staff at HealthSpring and the Commission.

#### **Data Reliability and Completeness**

Auditors assessed the reliability of data used in the audit and determined the following:

- For medical claims and pharmacy claims data managed by HealthSpring's claims processing system, auditors reconciled claims data to claim payment totals reported on HealthSpring's financial statistical reports and to medical claims and pharmacy claims data reported to the Commission. Auditors also assessed HealthSpring's reconciliation of medical claims payment data among its claims processing system,

accounting system, and direct deposit system. Auditors determined that the data was sufficiently reliable for the purposes of this audit.

- Auditors relied on HealthSpring's external auditors' prior work on general and application controls for HealthSpring's (1) claims processing system, (2) financial accounting system, and (3) third-party vendor systems and determined that data from those three information systems was sufficiently reliable for the purposes of this audit.

#### **Sampling Methodology**

For the samples discussed below, auditors applied a nonstatistical sampling methodology primarily through random selection. In some cases, auditors used professional judgment to select sample items for testing. The sample items were not generally representative of the population; therefore, it would not be appropriate to project the test results to the population. Auditors selected the following samples:

- To test the validity, accuracy, and completeness of medical claims data and medical claims payments, auditors selected a nonstatistical, random sample of 60 medical claims and used professional judgment to select a risk-based sample of 17 additional medical claims processed during fiscal year 2015.
- To test the validity, accuracy, and completeness of pharmacy claims payments, auditors selected a nonstatistical, random sample of eight vendor payments paid to HealthSpring's pharmacy benefit manager by date and used professional judgment to select a risk-based sample of three additional vendor payments paid to HealthSpring's pharmacy benefit manager that were processed during fiscal year 2015.
- To test the validity, accuracy, and allowability of salary and bonuses reported on HealthSpring's administrative financial statistical reports for fiscal year 2015, auditors selected a nonstatistical, random sample of 90 full-time staff (excluding service coordinator positions) employed during fiscal year 2015.
- To test the validity, accuracy, and allowability of other medical expenses that HealthSpring reported on the financial statistical reports for fiscal year 2015, auditors selected a nonstatistical, random sample of 90 full-time service coordinators employed during fiscal year 2015.
- To test the validity, accuracy, and allowability of professional services that HealthSpring reported on the financial statistical reports for fiscal year 2015, auditors used professional judgment to select a risk-based sample of 26 expenditures processed during fiscal year 2015.

- To test the accuracy and allowability of allocated corporate costs that HealthSpring reported on the financial statistical reports for fiscal year 2015, auditors used professional judgment to select a risk-based sample of (1) the corporate costs for 8 health insurance markets managed by HealthSpring from September 2014 through December 2014, (2) the corporate costs for 10 health insurance markets managed by HealthSpring from January 2015 through August 2015, and (3) the allocated corporate costs related to 12 full-time employees during fiscal year 2015.
- To test the validity, accuracy, and completeness of post-payment adjustments to medical claims data, auditors selected a nonstatistical, random sample of 60 adjusted medical claims that were processed during fiscal year 2015 and used professional judgment to select a risk-based sample of 5 additional adjusted medical claims processed during fiscal year 2015.
- To test the validity and completeness of medical claims data in HealthSpring's claims processing system, auditors used professional judgment to select a risk-based sample of 60 medical claims processed during fiscal year 2015.

Information collected and reviewed included the following:

- The Commission's STAR+PLUS contracts with HealthSpring.
- The Commission's STAR+PLUS member eligibility records for HealthSpring.
- The Commission's and HealthSpring's medical claims and pharmacy claims data.
- HealthSpring's policies and procedures.
- HealthSpring's financial statistical reports for fiscal year 2015.
- HealthSpring's payroll and human resources records.
- HealthSpring's supporting documentation for calculating reported allocated corporate costs for fiscal year 2015.
- External audit reports and consultant reports on HealthSpring's claims processing system, financial accounting system, and select third-party vendor systems.
- The general ledger of GulfQuest, an affiliate company of HealthSpring, of STAR+PLUS administrative expenses for fiscal year 2015.

- HealthSpring's subcontractor agreements with its pharmacy benefit manager and affiliate companies.
- The Commission's MCO contract monitoring policies, procedures, and manuals.
- The Commission's readiness review records of HealthSpring.

Procedures and tests conducted included the following:

- Interviewed employees at HealthSpring and the Commission.
- Reconciled revenue payments reported on HealthSpring's financial statistical reports for fiscal year 2015.
- Reviewed and recalculated HealthSpring's reported allocated corporate costs on the financial statistical reports for fiscal year 2015.
- Tested to determine whether reported salaries and bonuses were accurate and supported by documentation.
- Tested to determine whether reported legal and professional costs on the financial statistical reports for fiscal year 2015 were incurred in fiscal year 2015 and applicable to STAR+PLUS.
- Tested medical claims and pharmacy claims to determine whether they were accurate, valid, supported by documentation, and submitted for eligible STAR+PLUS members.
- Reviewed the Commission's records of HealthSpring's readiness reviews and subcontractor agreements.

Criteria used included the following:

- Title 45, Code of Federal Regulations, Section 1630.2.
- Texas Government Code, Chapters 321, 531, 533, and 536.
- Title 1, Texas Administrative Code, Chapters 353 and 370.
- Title 28, Texas Administrative Code, Chapter 21.
- The General Appropriations Act (83rd Legislature).
- The Commission's Uniform Managed Care Contract for STAR+PLUS.
- The Commission's *Uniform Managed Care Manual*.

## Project Information

Audit fieldwork was conducted from July 2016 and December 2016. We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

The following members of the State Auditor's staff performed the audit:

- Willie J. Hicks, MBA, CGAP (Project Manager)
- Anca Pinchas, CPA, CIDA, CISA (Assistant Project Manager)
- Mary Anderson
- Salem Chuah, CPA
- Rachel Lynne Goldman, CPA
- Joseph A. Kozak, CPA, CISA
- Sarah Rajiah
- Fred Ramirez, CISA
- Michelle Rodriguez
- Dennis Ray Bushnell, CPA (Quality Control Reviewer)
- John Young, MPAff (Audit Manager)

## Issue Rating Classifications and Descriptions

Auditors used professional judgement and rated the audit findings identified in this report. Those issue ratings are summarized in the report chapters/sub-chapters. The issue ratings were determined based on the degree of risk or effect of the findings in relation to the audit objective(s).

In determining the ratings of audit findings, auditors considered factors such as financial impact; potential failure to meet program/function objectives; noncompliance with state statute(s), rules, regulations, and other requirements or criteria; and the inadequacy of the design and/or operating effectiveness of internal controls. In addition, evidence of potential fraud, waste, or abuse; significant control environment issues; and little to no corrective action for issues previously identified could increase the ratings for audit findings. Auditors also identified and considered other factors when appropriate.

Table 7 provides a description of the issue ratings presented in this report.

Table 7

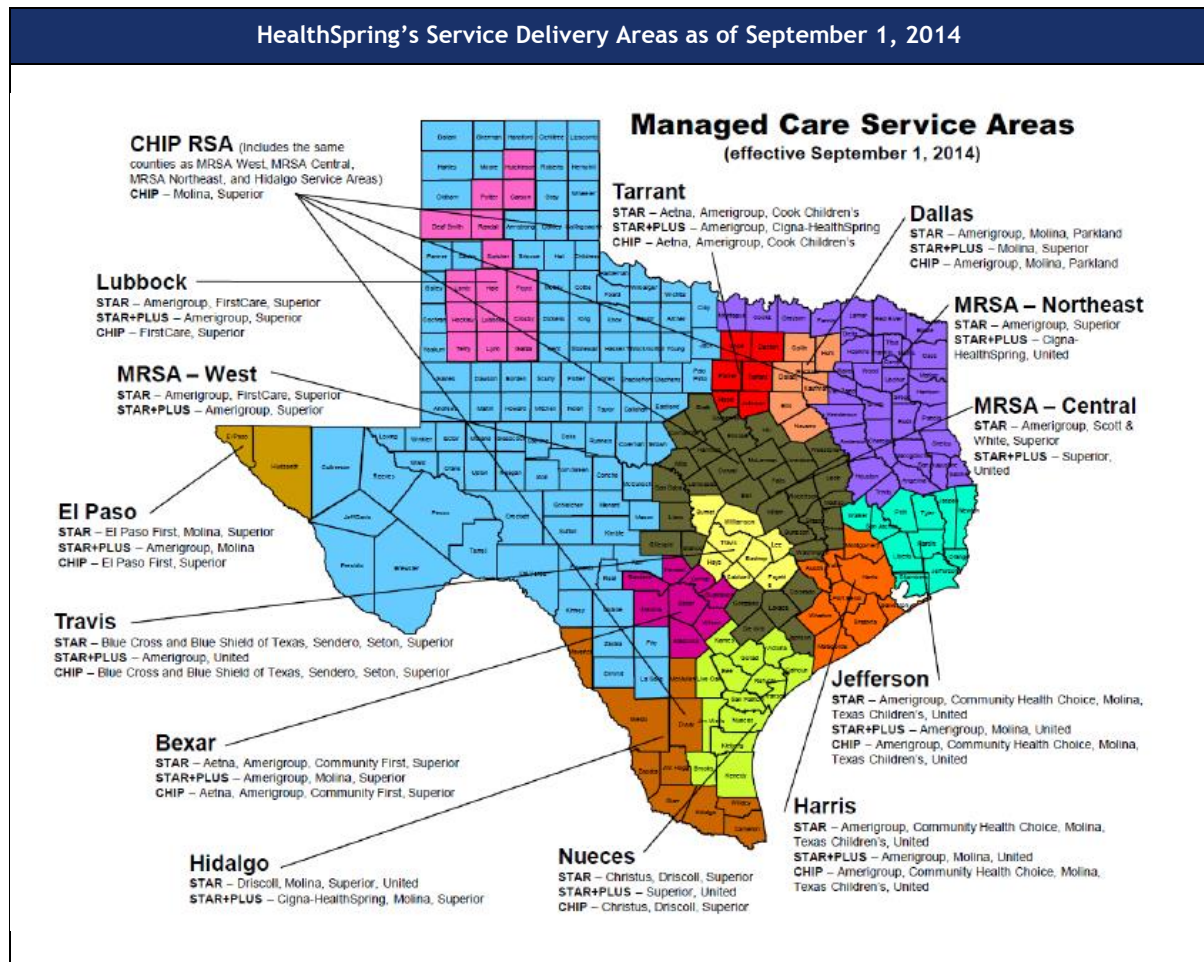
Summary of Issue Ratings	
Issue Rating	Description of Rating
Low	The audit identified strengths that support the audited entity's ability to administer the program(s)/functions(s) audited <u>or</u> the issues identified do not present significant risks or effects that would negatively affect the audited entity's ability to effectively administer the program(s)/function(s) audited.
Medium	Issues identified present risks or effects that if not addressed could <u>moderately affect</u> the audited entity's ability to effectively administer program(s)/function(s) audited. Action is needed to address the noted concern(s) and reduce risks to a more desirable level.
High	Issues identified present risks or effects that if not addressed could <u>substantially affect</u> the audited entity's ability to effectively administer the program(s)/function(s) audited. Prompt action is essential to address the noted concern(s) and reduce risks to the audited entity.
Priority	Issues identified present risks or effects that if not addressed could <u>critically affect</u> the audited entity's ability to effectively administer the program(s)/function(s) audited. Immediate action is required to address the noted concern(s) and reduce risks to the audited entity.

## HealthSpring Life and Health Insurance Company, Inc. Service Delivery Areas

HealthSpring Life and Health Insurance Company, Inc. (HealthSpring) provides Medicaid STAR+PLUS managed care program services to three service delivery areas in Texas through its contracts with the Health and Human Services Commission. Those three service delivery areas are: (1) Tarrant (effective February 1, 2011); (2) Hidalgo (effective March 1, 2012); and (3) Northeast Medicaid Rural Service Areas (effective September 1, 2014).

Figure 1 is a regional map that shows the location of all the managed care service delivery areas, including HealthSpring's service delivery areas as of September 1, 2014.

Figure 1



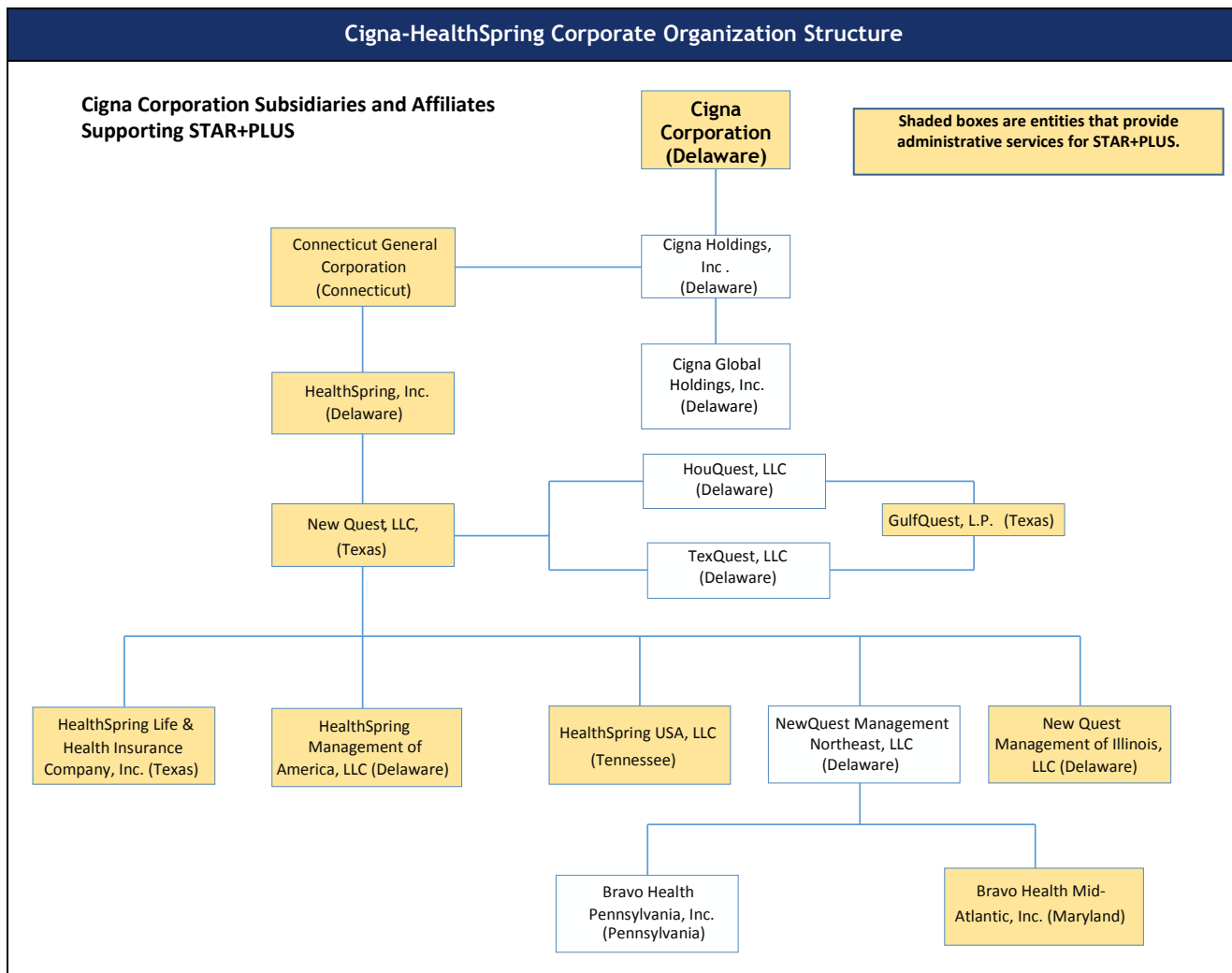
Source: *Texas Medicaid and CHIP in Perspective*, Health and Human Services Commission, February 2015.



## Cigna-HealthSpring Corporate Organization Structure

HealthSpring Life and Health Insurance Company, Inc. (HealthSpring) is a company within the Cigna Corporation. Figure 2 shows Cigna Corporation's organization chart, which includes HealthSpring and other affiliate companies that provided services during fiscal year 2015 for HealthSpring's Medicaid STAR+PLUS managed care program (STAR+PLUS) contract with the Health and Human Services Commission.

Figure 2



Source: HealthSpring.

## Calculating Experience Rebates

Texas Government Code, Section 533.014, requires the Health and Human Services Commission (Commission) to adopt rules that ensure that managed care organizations (MCOs) share profits they earn through the Medicaid managed care program. Title 1, Texas Administrative Code, Section 353.3, states that each MCO participating in Medicaid managed care must pay to the State an experience rebate calculated according to the graduated rebate method described in the MCO's contract with the Commission. The Commission has incorporated profit-sharing provisions into its contracts with MCOs that require MCOs to share certain percentages of their net income before taxes with the Commission. The General Appropriations Act (83rd Legislature), Rider 13, page II-91, requires that experience rebates the Commission receives from MCOs be spent on funding services for Medicaid.

According to the Commission's contracts with MCOs, an MCO must pay an experience rebate to the Commission if the MCO's net income before taxes exceeds a certain percentage, as defined by the Commission, of the total revenue the MCO receives each fiscal period. The experience rebate is calculated in accordance with a tiered rebate method that the Commission defines (see Table 8). The tiers are based on the consolidated net income before taxes for all of the MCO's Medicaid program and Children's Health Insurance Program service areas that are included in the scope of the contract, as reported on the MCO's financial statistical reports (which the Commission reviews and confirms through annual agreed-upon procedures engagements performed by its contracted audit firms).

Table 8

Tiers for Experience Rebates		
Pre-tax Income as a Percent of Revenues	MCO's Share	Commission's Share
Less than or equal to 3 percent	100 percent	0 percent
More than 3 percent and less than or equal to 5 percent	80 percent	20 percent
More than 5 percent and less than or equal to 7 percent	60 percent	40 percent
More than 7 percent and less than or equal to 9 percent	40 percent	60 percent
More than 9 percent and less than or equal to 12 percent	20 percent	80 percent
More than 12 percent	0 percent	100 percent

Source: *Texas Health and Human Services Commission Uniform Managed Care Terms and Conditions.*

## Calculating the Experience Rebate HealthSpring Owed for Fiscal Year 2015

Based on HealthSpring Life and Health Insurance Company, Inc.'s (HealthSpring) unaudited financial statistical reports for fiscal year 2015, the Health and Human Services Commission (Commission) calculated the experience rebate amount that HealthSpring owed the Commission for that fiscal period. Table 9 shows the Commission's calculation of the pre-tax net income that is subject to the tiered rebate methodology described in Appendix 5.

Table 9

Commission's Calculation of HealthSpring's Income Subject to Experience Rebate for Fiscal Year 2015	
Unaudited Pre-Tax Net Income	\$52,709,294
Admin Cap impact: Expenses reduced <sup>a</sup>	\$7,363,317
Cap-adjusted Pre-tax Net Income	\$60,072,611
Pre-implementation Costs <sup>b</sup>	(\$3,397,931)
Adjusted Income Subject to Experience Rebate	\$56,674,680
<sup>a</sup> The admin cap is a calculated maximum amount of administrative expense dollars that can be deducted from revenues for the purposes of determining income subject to the experience rebate. While administrative expenses may be limited by the admin cap to determine experience rebates, all valid allowable expenses will continue to be reported on the financial statistical reports. The admin cap does not affect financial statistical reporting, but it may affect any associated experience rebate calculation. For fiscal year 2015, the \$7,363,317 amount was the difference between HealthSpring's admin cap of \$40,899,830 and its reported administrative expenses of \$48,263,147.	
<sup>b</sup> The pre-implementation costs in this table are related to the Commission's contract with HealthSpring for the Northeast Medicaid Rural Service Area that was effective September 1, 2014. An MCO incurs pre-implementation costs on or after the effective date of its contract but prior to the operational start date of the contract. Pre-implementation costs must be reported for each month in which the expenses were incurred and must be reported separately in financial statistical reports.	

Source: The Commission.

Table 10 shows the Commission's calculation of the total experience rebate that HealthSpring owed the State for fiscal year 2015 as of November 2016.

Table 10

The Commission's Calculation of HealthSpring's Experience Rebate for Fiscal Year 2015					
Tiers - Percent of Revenue	Upper Revenue Limit	Net Income	HealthSpring's Share	The State's Share	State's Share Percentage
Less than or equal to 3 percent	\$21,522,528	\$21,522,528	\$21,522,528	\$ 0	0 percent
More than 3 percent and less than or equal to 5 percent	\$35,870,880	14,348,352	11,478,681	2,869,670	20 percent
More than 5 percent and less than or equal to 7 percent	\$50,219,231	14,348,352	8,609,011	5,739,341	40 percent
More than 7 percent and less than or equal to 9 percent	\$64,567,583	6,455,449	2,582,180	3,873,270	60 percent
More than 9 percent and less than or equal to 12 percent	\$86,090,111	0	0	0	80 percent
More than 12 percent	No Limit	0	0	0	100 percent
<b>Totals</b>		<b>\$56,674,681</b>	<b>\$44,192,400</b>	<b>\$12,482,281</b>	

Source: The Commission.

## **HealthSpring's Management Responses**

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**Jay Hurt**  
**President/Chief Executive Officer**  
2900 North Loop West, Suite 1300  
Houston, TX 77092  
Tel: 832-553-3311  
Fax: 832-553-3412

February 9, 2017

**Via Electronic Mail and Overnight Delivery**

Willie J. Hicks, MBA, CGAP  
Project Manager  
State Auditor's Office  
1501 N. Congress Avenue  
Austin, Texas 78701

RE: Management Responses to Recommendations in Draft Audit Report

Dear Mr. Hicks,

On behalf of HealthSpring Life and Health Insurance Company, Inc. ("HealthSpring"), I am writing to respond to the recommendations set forth in the draft audit report issued on January 26, 2017 by the State Auditor's Office.

We are pleased with the recognition that HealthSpring's financial reporting processes adequately demonstrate accurate reporting of fiscal year 2015 medical claim and prescription drug claim payments. We also appreciate the opportunity to respond in accordance with Texas Government Code § 321.014(g) to certain findings and recommendations relating to other reported costs.

**Chapter 1 – Financial Statistical Reports for Fiscal Year 2015**

**Chapter 1-A – Accurate Reporting of Medical and Prescription Drug Claims Paid**

**Recommendations**

None.

**HealthSpring Management Response**

HealthSpring is in agreement with the findings.

## **Chapter 1-B – Reporting of Bonus Costs and Personnel Certifications**

### **Recommendations**

HealthSpring should:

- Adjust applicable amounts on its financial statistical reports for fiscal year 2015 by the unallowable amounts that auditors identified.
- Discuss with the Commission how to resolve the identified questioned costs, including what adjustments should be made to the financial statistical reports for fiscal year 2015.
- Comply with the Commission's requirements that it not include bonuses paid by its affiliate companies on its financial statistical reports.
- Perform periodic certifications and prepare personnel activity reports that support the amount of time its staff or its affiliate companies' staff spend working on STAR+PLUS as required.

### **HealthSpring Management Response**

HealthSpring acknowledges the rationale for questioning the bonus payments. However, HealthSpring maintains that the payments are more appropriately classified as questioned costs than disallowed costs, and that such payments should be resolved during discussions with the Commission.

HealthSpring employs all of its administrative personnel through an affiliate organization, and this relationship was known to the Commission at the time the contract was awarded. Consequently, bonuses for affiliated employees are not excessive or duplicative of normal allowable employee bonuses. Rather, the affiliated employee bonuses are in lieu of any other allowable bonus costs. HealthSpring proposes to discuss the bonus payments further with the Commission and to make any adjustments that may be required after final resolution.

HealthSpring also agrees to discuss the remaining questioned costs with the Commission. HealthSpring acknowledges that it was unable to produce the requisite employee certifications. Instead of using an employee certification process, HealthSpring used an alternate allocation method to achieve the same goal. HealthSpring's process reflected an after-the-fact distribution of the actual activity of each employee and accounted for the total activity for which each employee is compensated, as the Uniform Managed Care Manual requires. HealthSpring maintains that its methodology resulted in a fair, accurate representation of the amount of time each employee spent on STAR+PLUS contracts and that the questioned costs are allowable.

In recognition of the Commission's expectation that the sponsor fulfill the aims of the Uniform Managed Care Manual through employee certifications, HealthSpring is augmenting its process for accounting for employee activity and costs on a per-contract basis by implementing a semi-

annual attestation process that will define clearly the percentage of time that each employee dedicates to a particular contract. The bi-annual employee certifications will be populated into automated compensation allocation reports, which will be reviewed and verified by managers.

*Responsible Persons:*

Human Resources Director  
Medicaid Finance Director Unit Managers

*Implementation Date:*

July 31, 2017

## **Chapter 1-C – Allocation Methodology and Costs**

### **Recommendations**

HealthSpring should:

- Adjust applicable amounts on its financial statistical reports for fiscal year 2015 by the unallowable amounts that auditors identified.
- Document its methodology for calculating allocated corporate costs for STAR+PLUS as required.
- Ensure that its methodology for calculating corporate allocation amounts align with the Commission's requirements.
- Maintain copies of emails and other documentation to support management assertions used for determining allocated corporate costs.

### **HealthSpring Management Response**

HealthSpring agrees with the findings and recommendations and offers the following responses.

The unallowable costs identified by the auditors were expenses incurred during the limited period of September through December 2014. While the corporate allocations were correctly reported for the remainder of the year, HealthSpring acknowledges this isolated error.

HealthSpring will adopt formal written standards describing its methodology for calculating allocated corporate costs in accordance with the Commission's requirements. The standards also will require adequate documentation and improve internal controls to ensure proper verification of corporate cost computation and allocation prior to reporting.

*Responsible Persons:*

Willie J. Hicks  
February 9, 2017  
Page 4

Financial Analysis Manager  
Medicaid Finance Director

*Implementation Date:*

June 1, 2017

#### **Chapter 1-D – Documentation of Legal and Professional Services Costs**

##### **Recommendations**

HealthSpring should:

- Adjust applicable amounts on its financial statistical reports for fiscal year 2015 by the unallowable amounts that auditors identified.
- Discuss with the Commission on how to resolve the questioned costs that auditors identified, including what adjustments should be made to the financial statistical reports for fiscal year 2015.
- Maintain supporting documentation to show that a vendor payment is for services related to STAR+PLUS and that the reported amounts are accurate.
- Report vendor payments based on the dates on which the costs were incurred.

##### **HealthSpring Management Response -1**

HealthSpring generally agrees with the findings and recommendations and offers the following responses.

HealthSpring will consult with the Commission to ensure that it is reconciling properly the requirement to avoid reporting accrual cost amounts, in accordance with the Chapter 1-C findings, while still appropriately report administrative expenses based on the date incurred rather than the date paid as described in Chapter 1-D. Upon clarification, HealthSpring will adjust any costs determined by the Commission to be unallowable and adopt written standards necessary to prevent recurrence of this concern.

*Responsible Person:*

Medicaid Finance Director

*Implementation Date:*

March 31, 2017



### **HealthSpring Management Response – 2**

HealthSpring anticipates discussions with the Commission will resolve successfully concerns with the questioned costs. Although the invoices at issue do not expressly reference the STAR+PLUS program, they were all mailed to the Bedford office, which is a center of operations that supports the STAR+PLUS program. HealthSpring is confident that the documentation is sufficient to resolve these questioned costs favorably.

Additionally, HealthSpring is working with vendors to enhance its automated documentation capabilities. HealthSpring anticipates that the revised documents will identify adequately the programs for which legal and professional services were rendered.

*Responsible Person:*

Medicaid Finance Director

*Implementation Date:*

June 1, 2017

### **Chapter 1-E – Affiliated Company Reporting**

#### **Recommendations**

HealthSpring should:

- Report all its affiliated companies involved in its STAR+PLUS program and report accurate and complete information about those companies and costs to the Commission as required.
- Ensure that it provides the Commission copies of all its contracts with affiliate companies, including subcontract agreements, that provide services on its STAR+PLUS contract as required.
- Ensure that its contracts with affiliate companies clearly define all services that will be paid.
- Obtain and maintain documentation to support its payments to HMA for service coordinator-related expenses.

#### **HealthSpring Management Response**

HealthSpring generally agrees with the findings and recommendations and offers the following responses.

HealthSpring traditionally has not reported affiliated companies that do not retain funds originating from STAR+PLUS contracts, either because they do not receive such funds or because they are solely pass-through entities. These companies include HealthSpring Management of America, LLC, and NewQuest, LLC. Additionally, HealthSpring has not reported affiliations with Bravo Health Mid-Atlantic, Inc., HealthSpring USA, LLC, and NewQuest Management of Illinois, LLC, because it has no affiliate agreements or financial relationships with any of these entities.

HealthSpring provided a copy of the Amended and Restated Management Agreement with HealthSpring Management of America, LLC in each of its responses to STAR+PLUS Requests for Proposal.

HealthSpring agrees to report all requested information relating to HealthSpring Management of America, LLC, beginning with the Affiliate Report due on August 31, 2017. HealthSpring also will provide a copy of the downstream management agreement between HealthSpring Management of America, LLC and GulfQuest, LP on a going forward basis beginning with that report. HealthSpring will break out the management fees attributable to STAR+PLUS contracts in disclosures going forward.

HealthSpring further agrees to submit an informational copy of its expense sharing agreement with its immediate parent organization, NewQuest, LLC, in which the parties agreed to the allocation of actual costs throughout the Cigna-HealthSpring organization. HealthSpring will also report a disclaimer to indicate that it pays no administrative fees to NewQuest, LLC under this agreement.

Finally, HealthSpring is amending the downstream management agreement between HealthSpring Management of America, LLC and GulfQuest, LP to clarify the payment of downstream management fees arising from the STAR+PLUS contracts. Once the amendment is finalized, HealthSpring will provide a copy to the Commission.

*Responsible Persons:*

Managing Counsel  
Senior Compliance Specialist

*Implementation Date:*

August 31, 2017

**Chapter 2 – Medical Claim Payments and Adjustments**

**Chapter 2-A – Documentation of Payment Adjustments**

**Recommendations**

HealthSpring should develop, document, and implement a process to ensure that it records the reason for all post payment adjustments to medical claims in its claims processing system and on the EOPs sent to medical providers.

#### **HealthSpring Management Response**

HealthSpring agrees with the recommendation. HealthSpring has completed a root cause analysis and determined that its post-payment memoranda were not consistently entered into the claims processing system. HealthSpring is revising its procedures to prevent a recurrence. Additionally, HealthSpring will train staff members on the revised procedures and will employ strategies to monitor their compliance with the new processes.

*Responsible Persons:*

Service Operation Director

*Implementation Date:*

March 1, 2017

#### **Chapter 2-B – Timely Medical Claim Payment**

##### **Recommendations**

HealthSpring should:

- Ensure that all medical claims are paid within the Commission's required timeframe.
- Pay interest penalties on all medical claims that are not processed within the Commission's required timeframe.

#### **HealthSpring Management Response**

HealthSpring is generally in agreement with the recommendations. Because the audit tested claims from fiscal year 2015, the findings do not reflect more recent changes to HealthSpring's controls, which enhanced the timely payment of medical claims. HealthSpring currently pays medical claims within the Commission's timeliness guidelines and interest does not normally accrue.

\*\*\*

HealthSpring recognizes the importance of developing and maintaining a robust program to ensure appropriate payment, allocation, and reporting of costs. To that end, HealthSpring strives

Willie J. Hicks  
February 9, 2017  
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continually to strengthen its processes and procedures. We welcome the opportunity to collaborate with you and the Commission, as we fulfill our internal commitment to those guiding principles.

Very truly yours,



Jay Hurt

cc: Charles Smith  
Executive Commissioner  
Texas Health and Human Services Commission

Gary Jessee  
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**Related State Auditor's Office Work**

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Related State Auditor's Office Work		
Number	Product Name	Release Date
17-007	An Audit Report on Medicaid Managed Care Contract Processes at the Health and Human Services Commission	October 2016

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An Audit Report on

**The Health and Human Services  
Commission's Management of Its  
Medicaid Managed Care Contract with  
Superior HealthPlan, Inc. and Superior  
HealthPlan Network, and Superior's  
Compliance with Reporting  
Requirements**

January 2018

Report No. 18-015





An Audit Report on

# *The Health and Human Services **Commission's** Management of Its Medicaid Managed Care Contract with Superior HealthPlan, Inc. and Superior HealthPlan Network, and Superior's Compliance with Reporting Requirements*

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SAO Report No. 18-015  
January 2018

## *Overall Conclusion*

Superior HealthPlan, Inc. and Superior HealthPlan Network (Superior) accurately reported the approximately \$1.9 billion in medical (fee-for-service) claims and prescription drug claims it paid for the Medicaid STAR+PLUS managed care program in its financial statistical reports for fiscal year 2016. It should improve its compliance with reporting requirements to ensure that it reports only allowable costs.

However, the Health and Human Services Commission (Commission) did not ensure that its business practices aligned with its managed care contract requirements. For example, the Commission allowed Superior to report bonus and incentive payments paid to affiliate employees in its financial statistical report, which are unallowable costs under its contract with Superior. The disparities between the **Commission's** actual business practices and the written contract requirements weakens **the Commission's ability** to consistently oversee all of the contracts the Commission has with its other Medicaid Managed Care Organizations (MCOs).

The Commission did not ensure that its business practices aligned with its managed care contract.

The Commission did not ensure that its business practices related to its uniform managed care contract with Superior aligned with the written requirements in the contract and its *Uniform Managed Care Manual*. Specifically, **in Superior's financial** statistical report for fiscal year 2016, the Commission:

- Allowed Superior to report approximately \$29.6 million in bonus and incentive payments paid to affiliates' employees that were unallowable under the contract with Superior.

### Background Information

Superior HealthPlan, Inc. and Superior HealthPlan Network (Superior) provides the Medicaid STAR, STAR+PLUS, STAR Health, and STAR Kids programs to seven service delivery areas in Texas: Bexar, Dallas, Lubbock, Nueces, Medicaid Rural Service Area (MRSA) - Central, MRSA - West, and Hidalgo (see Appendix 3 for additional information on those service delivery areas).

From September 1, 2015, through August 31, 2016, Superior received payments from the Health and Human Services Commission (Commission) that totaled \$2.4 billion for the STAR+PLUS program. Approximately \$2.2 billion of that funding paid for medical claims and prescription drug claims for 1,735,028 people enrolled in the STAR+PLUS program.

Sources: The Commission.

- **Approved Superior's request to report affiliate profits as costs without** following the approval process outlined in its contract with Superior.

By not following the written requirements in its contract with Superior, the Commission weakens its ability to consistently oversee the contract and creates a lack of transparency in its administration of Medicaid managed care programs.

The Commission also included in its contract with Superior a limitation on reporting the cost of executive compensation that may not be enforceable.

Superior reported medical and prescription claims accurately. However, it should improve its compliance with reporting requirements.

**Superior's controls** over its financial reporting process provided reasonable assurance that it accurately reported to the Commission the approximately \$1.9 billion in medical claims and prescription drug claims that Superior paid in fiscal year 2016 for the Medicaid STAR+PLUS managed care program (STAR+PLUS).

While Superior reported medical and prescription claims accurately, it did not comply with certain reporting requirements outlined in the **Commission's** Uniform Managed Care Contract and *Uniform Managed Care Manual*, resulting in unallowable and questioned costs in its financial statistical report for fiscal year 2016. Superior included approximately \$31.2 million in unallowable costs (including the approximately \$29.6 million in bonus and incentive payments that the Commission allowed Superior to report). Superior also included \$443,909 in questioned costs. Including unallowable and questioned costs in the financial statistical report affects **the calculation of Superior's net** profit, which the Commission uses to determine whether Superior owes money to the State under the experience rebate profit-sharing requirement. Table 1 on the next page shows the unallowable and questioned costs that Superior reported on its financial statistical report for fiscal year 2016.

#### Financial Statistical Reports

The Commission receives financial statistical reports from managed care organizations (MCOs) on a quarterly and annual basis as required by the **Commission's contracts with** the MCOs. Those reports are the primary statements of financial results the MCOs submit to the Commission. The Commission **uses the reports to analyze the MCOs'** membership, revenues, expenses, and net income by service area and program. The reports provide a basis for calculating the amount a MCO may owe the State through the experience rebate profit-sharing requirement (see Appendix 6 for information on the experience rebate).

Source: The Commission.

Table 1

Unallowable and Questioned Costs, Per the <i>Uniform Managed Care Manual</i> , That Superior Reported on Its Financial Statistical Report (FSR) for Fiscal Year 2016				
Type of Expense/ FSR Line Item	Reported Costs for Fiscal Year 2016	Total Unallowable Costs Identified	Total Questioned Costs Identified	Report Subchapter Discussing the Costs
Costs That Were Unallowable and Questioned per the <i>Uniform Managed Care Manual</i> , But That the Commission Allowed Superior to Include in Reported Costs				
Corporate Allocations <sup>a</sup>	\$ 119,132,444	\$ 28,846,721	\$ 0	Chapter 1-A
Bonuses	727,733	727,733	0	Chapter 1-A
Subtotals	\$ 119,860,177	\$ 29,574,454	\$ 0	
Costs That Were Unallowable and Questioned Per the <i>Uniform Managed Care Manual</i>				
STAR+PLUS Medical Fee-for-Service <sup>b</sup>	\$ 1,578,551,710	\$ 1,311,841	\$ 0	Chapter 2-A
Salaries	98,343,968	2,309	0	Chapter 2-B
STAR+PLUS Total Other Medical Expenses <sup>b</sup>	58,897,764	44	1,975	Chapters 2-B
Other Administrative Expenses	13,388,215	127,149	35,872	Chapter 2-B
Legal and Professional Services	8,184,061	98,751	139,658	Chapter 2-B
Travel Expenses	2,636,561	71	0	Chapter 2-B
Rent, Lease, or Mortgage Payment for Office Space	4,712,133	0	266,404	Chapter 2-B
Corporate Allocations <sup>c</sup>	(see above)	102,799	0	Chapter 2-B
Subtotals	\$1,764,714,412	\$ 1,642,964	\$443,909	
Totals	\$1,884,574,589	\$ 31,217,418	\$443,909	
<sup>a</sup> Of the \$119,132,444 reported in the Corporate Allocations line item, \$28,846,721 was bonus and incentive payments to affiliates' employees. <sup>b</sup> These line items show expenses reported for only the Medicaid STAR+PLUS program. All other line items show expenses reported as administrative costs that Superior had for the STAR, STAR+PLUS, CHIP, STAR Health, STAR Kids, and the Dental Program. <sup>c</sup> The \$102,799 of unallowable costs was due to overreporting administrative expenditures.				

Source: Superior's financial statistical report for fiscal year 2016.

In addition, Superior should improve processes related to processing medical and prescription claims. Specifically, Superior did not consistently respond to appeals **and notify providers about appeals as required by the Commission's *Uniform Managed Care Manual***.

Auditors communicated other, less significant issues to the Commission and Superior separately in writing.

Table 2 presents a summary of the findings in this report and the related issue ratings. (See Appendix 2 for more information about the issue rating classifications and descriptions.)

Table 2

Summary of Subchapters and Related Issue Ratings		
Chapter/ Subchapter	Title	Issue Rating <sup>a</sup>
1-A	The Commission Allowed Superior to Report Bonus and Incentive Payments to Affiliate Employees in Fiscal Year 2016	Priority
1-B	The Commission Did Not Enforce Its Cost Principles Related to Reporting Affiliate Profits	Priority
1-C	The Commission Cited a Federal Regulation That Was Not Applicable to Its Medicaid Contracts Related to a Limitation for Reporting MCO Executive Compensation, and That Limitation May Not Be Enforceable	Priority
2-A	Superior Accurately Reported Medical and Prescription Claims in Its Financial Statistical Report for Fiscal Year 2016	Low
2-B	Superior Did Not Consistently Report Accurate Expenditures In Its Fiscal Year 2016 Financial Statistical Report	Medium
3-A	<b>Superior Paid Claims for Drugs Covered by the Commission's Vendor Drug Program and Adjudicated Medical and Pharmacy Claims Within the Required Time Frames</b>	Low
3-B	Superior Denied Medical Claims in Accordance with Its Contract; However, It Should Ensure That it Consistently Responds to Appeals and Notifies Providers About Appeals as Required	Medium
<sup>a</sup> A subchapter is rated Priority if the issues identified present risks or effects that if not addressed could critically affect the audited entity's ability to effectively administer the program(s)/function(s) audited. Immediate action is required to address the noted concern and reduce risks to the audited entity. A subchapter is rated High if the issues identified present risks or effects that if not addressed could substantially affect the audited entity's ability to effectively administer the program(s)/function(s) audited. Prompt action is essential to address the noted concern and reduce risks to the audited entity. A subchapter is rated Medium if the issues identified present risks or effects that if not addressed could moderately affect the audited entity's ability to effectively administer program(s)/function(s) audited. Action is needed to address the noted concern and reduce risks to a more desirable level. A subchapter is rated Low if the audit identified strengths that support the audited entity's ability to administer the program(s)/functions(s) audited or the issues identified do not present significant risks or effects that would negatively affect the audited entity's ability to effectively administer the program(s)/function(s) audited.		

## Summary of Management's Response

At the end of each chapter in this report, auditors made recommendations to address the issues identified during this audit. The Commission agreed with the findings and recommendations in Chapter 1 that address its oversight of the Superior contract. The **Commission's detailed management responses** are presented immediately following the recommendations in Chapter 1.

Superior provided management responses to the findings and recommendations in Chapter 1 that were addressed to the Commission. Superior disagreed with the

findings related to employee bonuses and incentive payments and affiliate profits. Superior provided a summary **of its management's response**. That summary and **Superior's responses to the issues discussed in Chapter 1** are presented in Appendix 8.

Superior agreed with the recommendations addressed to it in Chapter 2 and 3. **However, it disagreed with certain findings in those chapters related to Superior's reported expenditures and auditors' data analysis of paid medical and prescription claims. Superior's detailed management responses are presented immediately following the recommendations in Chapters 2 and 3.**

**After review and consideration of Superior's management's responses, the State Auditor's Office stands by its conclusions** based on evidence presented and compiled during this audit.

## *Audit Objective and Scope*

The objective of this audit was to determine whether selected financial processes and related controls at a Medicaid managed care organization are designed and operating to help ensure (1) the accuracy and completeness of data that the Medicaid managed care organization reports to the Commission and (2) compliance with applicable requirements.

**The scope of this audit covered Superior's contracts with the Commission to deliver the Texas Medicaid program. It covered Superior's financial statistical reports and its reported medical claims and pharmacy claims for fiscal year 2016. It also included the Commission's management of its contract with Superior, including the two most recent agreed-upon procedures engagements for which it contracted with an external audit firm.**

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# Detailed Results

Chapter 1

## ***The Commission's Business Practices Did Not Align with Its Contract with Superior to Deliver the Texas Medicaid Program, and Its Limit on Reporting MCO Executive Compensation May Not Be Enforceable***

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### Cost Principles

The Commission's cost principles are part of its *Uniform Managed Care Manual*, which contains policies and procedures that all Managed Care Organizations (MCOs) participating in Medicaid programs are required to follow. The *Uniform Managed Care Manual* is incorporated by reference into the contract between the Commission and MCOs.

Source: The Commission.

The Health and Human Services Commission's (Commission) business practices did not align with its contract with Superior HealthPlan, Inc. and Superior HealthPlan Network (Superior). Specifically, the Commission did not adhere to certain provisions within the cost principles, which is part of its contract with Superior, related to reporting affiliate employee bonus and incentive payments and affiliate profits as costs in Superior's financial statistical report for fiscal year 2016 (see text box for information about the contract and the cost principles).

In addition, the Commission's limitation on reporting the cost of executive compensation in financial statistical reports may not be enforceable because the Commission cited a federal regulation that is not applicable to its contracts with Medicaid managed care organizations (MCOs).

Chapter 1-A

The Commission Allowed Superior to Report Bonus and Incentive Payments to Affiliate Employees in Fiscal Year 2016

Chapter 1-A  
Rating:  
Priority <sup>1</sup>

The cost principles in the Commission's contract with Superior state that "bonuses paid or payable to affiliates are unallowable." However, the Commission allowed Superior to report bonus and incentive payments paid to its affiliates' employees as costs to deliver Texas Medicaid programs (see Appendix 4 for contract language related to bonus and incentive payments).

In its financial statistical report for fiscal year 2016, Superior reported \$29,574,454 of bonus and incentive payments<sup>2</sup> paid to employees of affiliate companies. It reported \$28,846,721 (98 percent) of those bonus and incentive payments within the single corporate allocation line item (that line

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<sup>1</sup> The risk related to the issues discussed in Chapter 1-A is rated as Priority because the issues identified present risks or effects that if not addressed could critically affect the audited entity's ability to effectively administer the program(s)/function(s) audited. Immediate action is required to address the noted concern and reduce risks to the audited entity.

<sup>2</sup> The reported bonus and incentive payments included cash bonuses and incentive plan payments, such as stock options.



item totaled \$119,132,444<sup>3</sup>). Reporting bonus and incentive payments paid to employees of affiliate companies within the corporate allocation line item decreases transparency over the expenditure of Medicaid managed care funds. For example, auditors identified the bonus and incentive payments to affiliate employees while reviewing the supporting documentation for the expenses reported in the corporate allocation line item. Superior reported the remaining \$727,733 of bonus and incentive payments in the financial statistical report's bonus line item.

Reporting affiliate bonus and incentive payments as costs in the financial statistical report is a business practice known to the Commission. Superior does not have employees; all staff working for Superior are employees of affiliate companies (Centene Company of Texas, LP or Centene Management, LLC). (See Appendix 5 for an organizational chart with bonus and incentive payments for Superior's affiliates.)

#### Experience Rebates

Texas Government Code, Section 533.014, requires the Commission to adopt rules that ensure MCOs share profits they earn through the Medicaid managed care program. The Commission has incorporated profit-sharing provisions into its contracts with MCOs that require MCOs to share certain percentages of their net income before taxes with the Commission (see Appendix 6 for more information on how experience rebates are calculated).

The General Appropriations Act (84th Legislature), Rider 13, page II-88, requires that experience rebates the Commission receives from MCOs be spent on funding services for Medicaid.

Allowing Superior to report bonus and incentive payments, which are unallowable costs under the Commission's cost principles, results in Superior understating its net profit in its financial statistical report. That affects the calculation that determines whether Superior owes money to the Commission under the experience rebate profit-sharing requirements (see text box and Appendix 6 for more information on experience rebates).

By not requiring MCOs to follow the written requirements in its contract related to reporting bonus and incentive payments to affiliates, the Commission weakens its ability to oversee its contracts consistently and creates a lack of transparency in its administration of Texas Medicaid managed care programs.

## Recommendations

### The Commission should:

- Adhere to its cost principle that states bonus and incentive payments are unallowable costs for financial statistical reports, or amend the cost principles to allow bonus and incentive payments to reflect current business practices.

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<sup>3</sup> The corporate allocation line item consisted of compensation expenses (\$42,331,022), non-compensation expenses (\$47,954,701), incentive plan expenses such as stock options (\$16,621,142), and annual bonus expenses (\$12,225,579) that Superior made to its parent company or affiliates.

- If it amends its cost principle to allow MCOs to report bonus and incentive payments to affiliates, require MCOs to report bonus and incentive payments paid to affiliates separately from the corporate allocation line item in financial statistical reports to increase transparency.

### **The Commission's Management's Response**

*The Health and Human Services Commission (HHSC) is in agreement with the findings and associated recommendations and offer the following responses.*

*HHSC will amend the contracts with the MCOs to clarify the definition of affiliates to be consistent with business practices which have evolved over the last several years. FSR reporting will also be amended to show affiliate bonuses as a separate line item.*

#### **Implementation Date:**

*HHSC will issue a contract amendment effective September 1, 2018 which will clarify the definition of affiliates and the treatment of affiliate bonuses.*

#### **Responsible Person:**

*Director of Financial Reporting and Audit Coordination*

Chapter 1-B

The Commission Did Not Enforce Its Cost Principles Related to Reporting Affiliate Profits

Chapter 1-B  
Rating:  
Priority <sup>4</sup>

The Commission did not require Superior to follow the approval process outlined in its cost principles for reporting affiliate profits even though it was aware that Superior included affiliate profits in its financial statistical reports. Specifically, for a MCO to report an affiliate's profit as a cost, it must obtain the Commission's prior written approval, which is called a "comparable unaffiliated sales exception." To obtain the exception, the cost principles require a MCO to submit documentation prior to receiving an exception that demonstrates that the prices charged to the MCO are comparable to the prices that the affiliate charges to unrelated third parties. However, the Commission approved an exception for Superior without obtaining or reviewing documentation on affiliate pricing.

<sup>4</sup> The risk related to the issues discussed in Chapter 1-B is rated as Priority because the issues identified present risks or effects that if not addressed could critically affect the audited entity's ability to effectively administer the program(s)/function(s) audited. Immediate action is required to address the noted concern and reduce risks to the audited entity.

In addition, although the Commission's cost principles require MCOs to report and separately identify affiliate profits, the Commission did not include a section in the template for the financial statistical report for MCOs to separately identify and report affiliate profits.

By not enforcing the written requirements related to reporting affiliate profits, the Commission weakens its ability to effectively oversee its managed care contracts. In addition, not including a section in the financial statistical report template for MCOs to separately identify and report affiliate profits creates a lack of transparency in the Commission's administration of the Texas Medicaid programs.

#### Recommendations

The Commission should:

- Obtain and review MCO documentation on affiliate pricing before providing written approval for a comparable unaffiliated sales exception.
- Include a section in its template for financial statistical reports to separately identify and report affiliate profits.

#### The Commission's Management's Response

*The Health and Human Services Commission (HHSC) is in agreement with the findings and associated recommendations and offer the following responses.*

*The Medicaid and CHIP Services Department within HHSC currently collaborates with Actuarial Analysis and contract auditors in analyzing affiliate pricing arrangements. That process uses data that is collected from MCOs through various channels. HHSC will clarify the MCOs' responsibilities in conforming to the requirements of that process in an amendment to the MCO contracts.*

*HHSC will evaluate reporting methodologies that would give the appropriate level of transparency to affiliate transactions without exposing MCO proprietary data.*

#### **Implementation Date:**

*HHSC will issue a contract amendment effective September 1, 2018. The amendment will define the process that MCOs will follow to justify pricing in affiliate arrangements.*

*Affiliate data reporting will commence with 1<sup>st</sup> quarter FY 2019.*

**Responsible Person:**

*Director of Financial Reporting and Audit Coordination*

Chapter 1-C

The Commission Cited a Federal Regulation That Was Not Applicable to Its Medicaid Contracts Related to a Limitation for Reporting MCO Executive Compensation, and That Limitation May Not Be Enforceable

Chapter 1-C  
Rating:  
Priority <sup>5</sup>

The Commission's *Uniform Managed Care Manual* incorporates a federal acquisition regulation that includes a limitation on executive compensation. However, that federal acquisition regulation (Title 48, Code of Federal Regulations, Part 31) related to the executive compensation limitation is applicable only to cost-based contracts. In its cost principles, which are part of its contract with Superior, the Commission explicitly defined its contract with Superior as a fixed-price contract. As a result, the Commission's limitation for reporting the cost of executive compensation may not be enforceable.

The Commission contracts with external audit firms to perform limited reviews related to the executive compensation limitation as part of agreed-upon procedures (AUP) engagements. However, those AUPs, for which the Commission approves the procedures, may not be sufficient to identify all instances in which the contractor exceeds the limitation on executive compensation. For example, an AUP report for fiscal year 2014 evaluated whether Superior's bonus and incentive payments for the top five highest compensated individuals exceeded the Commission's limitation on executive compensation. That report concluded that Superior had exceeded the limitation on executive compensation by \$6.9 million for those five individuals. However, pursuant to the approved procedures, testing was not expanded to determine whether the reported compensation costs for other employees exceeded the limitation. In its management response to the AUP report, Superior disagreed that the executive compensation limitation was applicable to its contract with the Commission.

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<sup>5</sup> The risk related to the issues discussed in Chapter 1-C is rated as Priority because the issues identified present risks or effects that if not addressed could critically affect the audited entity's ability to effectively administer the program(s)/function(s) audited. Immediate action is required to address the noted concern and reduce risks to the audited entity.

## Recommendation

The Commission should:

- Review and adjust, if necessary, its cost principle regarding the executive compensation limitation to ensure that it is enforceable.
- Ensure that AUPs include sufficient procedures to identify all employees whose compensation exceeds the limitation on executive compensation.

## The Commission's Management's Response

*The Health and Human Services Commission (HHSC) is in agreement with the findings and associated recommendations and offer the following responses.*

*HHSC will develop language related to allowable executive compensation which specifically defines a cap.*

*HHSC will ensure that Agreed-Upon-Procedures include a procedure which identifies instances where MCO compensation exceeds the contract limit.*

*HHSC will also review and modify, if necessary, specific contract language that invokes the Federal Acquisition Regulations (FAR). The objective is to ensure that the FAR does not diminish HHSC's ability to establish firm contract requirements.*

### **Implementation Date:**

*HHSC will issue a contract amendment effective September 1, 2018.*

*AUPs for the next cycle will have sufficient procedures to identify MCO employees who exceed the compensation cap.*

### **Responsible Person:**

*Director of Financial Reporting and Audit Coordination*

## ***Superior Reported Medical and Prescription Claims Accurately in Its Financial Statistical Report for Fiscal Year 2016; However, It Did Not Comply With Certain Reporting Requirements***

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Superior's financial reporting process provided reasonable assurance that it accurately reported certain costs in its financial statistical report for fiscal year 2016. Specifically, Superior accurately reported STAR+PLUS medical (fee-for-service) and prescription expenses totaling approximately \$1.9 billion. However, Superior did not report some of its expenses accurately in its 2016 financial statistical report. The issues discussed in Chapter 2 address the accuracy of Superior's financial statistical report for fiscal year 2016.

### Chapter 2-A

#### Superior Accurately Reported Medical and Prescription Claims in Its Financial Statistical Report for Fiscal Year 2016

Chapter 2-A  
Rating:  
Low <sup>6</sup>

Auditors reconciled the reported \$1.6 billion in paid medical expenses to Superior's claims processing system and matched the amount to within less than 1 percent. Auditors also reconciled the \$362.7 million in paid prescription expenses to Superior's pharmacy claims data and matched the amount to within less than 1 percent.

In addition, auditors compared medical and prescription claims for the STAR+PLUS program that Superior paid in fiscal year 2016 to eligibility data from the Commission and determined that Superior paid medical and prescription claims to eligible members.

The Commission's *Uniform Managed Care Manual* requires a MCO to process and pay Medicaid provider claims in accordance with the benefits limits and exclusions as listed in the *Texas Medicaid Provider Procedures Manual*. Auditors reviewed 11.4 million paid medical claims that Superior paid during fiscal year 2016 (reported at \$1.6 billion) and determined that Superior paid claims for medical procedures covered by Texas Medicaid as part of its STAR+PLUS program. However, auditors identified 1,635 paid claims for procedure codes that were not covered by Texas Medicaid. The total cost of those uncovered claims was \$1.3 million in Superior's financial statistical report for fiscal year 2016, which was less than 1 percent of Superior's total paid medical claims for that time period.

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<sup>6</sup> Chapter 2-A is rated Low because the audit identified strengths that support the audited entity's ability to administer the program(s)/functions(s) audited or the issues identified do not present significant risks or effects that would negatively affect the audited entity's ability to effectively administer the program(s)/function(s) audited.

## Recommendations

Superior should improve its processes to ensure that it:

- Pays only for covered medical claims.
- Reports only covered medical claims in its financial statistical reports.

## Superior's Management's Response

*The errors identified were a very low percentage of the 11.4 million claims processed by Superior during fiscal year 2016. Superior will review and improve its processes.*

## Superior Did Not Consistently Report Accurate Expenditures in Its Fiscal Year 2016 Financial Statistical Report

Chapter 2-B  
Rating:  
Medium <sup>7</sup>

Auditors tested random samples of expenditures<sup>8</sup> that Superior reported in its fiscal year 2016 financial statistical report. That expenditure testing identified \$331,123 in unallowable costs and \$433,909 in questioned costs (see text box for information about those types of costs). The inaccuracies identified may affect the calculation of Superior's net income, which the Commission uses to determine whether Superior owes money to the Commission under the experience rebate profit-sharing requirement. (See Table 3 on the next page for detailed results of the expenditure testing.)

### Costs were identified as unallowable because:

- Superior reported \$226,015 in expenditures in its fiscal year 2016 financial statistical report that it did not incur during that time period. **The Commission's *Uniform Managed Care Manual* states that a MCO should report expenditures in its financial statistical report based on the dates it incurred a service. Superior's policies and procedures did not address the requirement that it report only expenditures incurred within the reporting period of its financial statistical report.**

- Superior overreported \$2,309 in salary expenditures. **Auditors identified eight expenditures for employees that Superior either incorrectly included in or excluded from its financial statistical report for fiscal year 2016. Superior's review process did not identify the inaccuracies.**
- Superior overstated administrative expenditures by \$102,799. **Superior reported expenditures related to outsourced services in both the outsourced**

### Unallowable Cost

The **Commission's *Uniform Managed Care Manual*** defines the cost principles that establish allowability of expenses related to selected Medicaid programs that a MCO can report on its financial statistical report (FSR). A designation of "allowable" or "unallowable" does not generally govern whether the MCO can incur a cost or make a payment; allowability reflects only what is reportable on the FSR. To be allowable, expenses must conform to the **requirements of the Commission's cost principles**, which include being reasonable and allocable.

### Questioned Cost

According to the Code of Federal Regulations, a "questioned cost," is a cost charged that MCO management, federal oversight entities, an independent auditor, or other audit organization authorized to conduct an audit of a MCO has questioned because of an audit or other finding. A cost may be questioned because:

- There may have been a violation of a provision of a law, regulation, contract, grant, or other agreement or document governing the use of MCO funds.
- The cost is not supported by adequate documentation.
- The cost incurred appears unnecessary or unreasonable and does not reflect the actions that a prudent person would take in the circumstances.

Sources: **The Commission's *Uniform Managed Care Manual***, and Title 45, Code of Federal Regulations, Section 1630.2(g).

<sup>7</sup> The risk related to the issues discussed in Chapter 2-B is rated as Medium because the issues identified present risks or effects that if not addressed could moderately affect the audited entity's ability to effectively administer program(s)/function(s) audited. Action is needed to address the noted concern and reduce risks to a more desirable level.

<sup>8</sup> Except for third-party recovery expenditures, which auditors selected a risk-based sample of expenditures due to the quantity of line items for each payment related to that expense.



services and corporate allocation line items. Superior's review process did not identify the overstatement.

Table 3 shows the detailed results for the unallowable costs that auditors identified through expenditure testing of Superior's financial statistical report for fiscal year 2016.

Table 3

Testing Results for Unallowable Costs					
Line Item	Number of Expenditures Tested	Number of Unallowable Expenditures	Percent of Tested Expenditures in Error	Dollar Amount Tested	Dollar Amount of Unallowable Costs
Other Medical Expenses <sup>a</sup>	50	2	4%	\$ 36,812	\$ 44
Legal and Professional Services	30	8	27%	488,251	98,751
Other Administrative Expenses	49	17	35%	281,471	127,149
Travel	50	5	10%	3,588	71
Salaries	75	8	11%	110,084	2,309
Totals	254	40	16%	\$920,206	\$228,324 <sup>b</sup>
<sup>a</sup> Line item reported for the STAR+PLUS program only. <sup>b</sup> The total amount does not include the \$102,799 in overstated administrative expenditures described in the previous page.					

Source: Auditor testing of expenditures reported in Superior's financial statistical report for fiscal year 2016.

In addition to the unallowable costs discussed above, auditors identified questioned costs. Specifically:

- Superior did not consistently ensure that it had sufficient supporting documentation for \$443,909 of reported expenses. **The Commission's uniform managed care contract requires a MCO to maintain records for administrative services or functions and provide to auditors detailed records and supporting documentation for all costs it reported. Superior's policies and procedures did not specify the documentation that it was required to maintain to support expenditures included in its financial statistical report.**

Table 4 on the next page shows the detailed results for the questioned costs that auditors identified during the testing of expenditures that Superior reported in its financial statistical report for fiscal year 2016.

Table 4

Testing Results for Questioned Costs					
Line Item	Number of Expenditures Tested	Number of Questioned Expenditures	Percent of Tested Expenditures in Error	Dollar Amount Tested	Dollar Amount of Questioned Costs
Other Medical Expenses <sup>a</sup>	50	1	2%	\$ 36,812	\$ 1,975
Legal and Professional Services	30	5	17%	488,251	139,658
Other Administrative Expenses	52	5	10%	430,955	35,872
Rent, Lease, or Mortgage	30	30	100%	266,404	266,404
Totals	162	41	25%	\$1,222,422	\$443,909
<sup>a</sup> Line item reported for the STAR+PLUS program only.					

Source: Auditor testing of expenditures reported in Superior's financial statistical report for fiscal year 2016.

## Recommendations

### Superior should:

- Update its policies and procedures to ensure that it reports only items incurred within the reporting period for financial statistical reports.
- Improve its reporting and review process for calculating and reporting expenditures in its financial statistical reports so that it (1) can identify any overstatements and (2) ensure that staff salaries are correctly reported.
- Update its policies and procedures to ensure that it retains adequate detailed documentation to support all expenses included in its financial statistical reports.

### Superior's Management's Response

*The majority of the \$443,909 of questioned costs relates to the auditor's questioning of Superior's rent expenses. It is disappointing that the technical accounting procedure for three (3) months of rent expenses that were offered as "rent-free" months has been labeled as a medium risk to the Texas Medicaid program. The disagreement here is nothing more than whether Superior should be allowed to use GAAP (Generally Accepted Accounting Principles) in considering the cost of the entire life of the lease and then finding a monthly expense by dividing the entire cost by the number of leased months. The first bullet in Chapter 2-B does not provide this context. Considering the context, the auditor appears to assert that, for those months*

*in which no rent payment was required, Superior should not be allowed to state a rent expense per understood GAAP requirements that reflect an overall monthly cost of the entirety of the lease.*

*Superior incurs, records and reports rent expenses on a straight line basis, as prescribed by GAAP. As the auditor has referenced within this report, MCOs are instructed to report expenditures in the period incurred rather than on a cash basis. Superior has provided its lease contracts and ledger activity that agree with and support the amounts reported as expenses (Note: Superior's lessors do not provide invoices for monthly payments). Superior considers this adequate documentation.*

*Additionally, the auditor's statement regarding "adequate...documentation," does not mean documentation did not exist for the financial statistical reports. Superior will review its systems to ensure the level of detail the auditors require will be available. This has no financial impact on the cost of the program.*

#### Auditor Follow-up Comment

The *Uniform Managed Care Manual*, which is incorporated into Superior's contract with the Commission, states that the financial statistical report should include only paid expenses that support the Texas Medicaid program. Superior provided documentation regarding the Rent, Lease, or Mortgage line item. However, the documentation provided did not support the actual amounts paid, resulting in questioned costs.

## ***Superior Should Improve Certain Processes Related to Processing Medical and Prescription Claims***

Overall, Superior paid only for drugs covered by the Commission's vendor drug program and adjudicated and paid or denied the medical and pharmacy claims it received within the time frames required by its contract with the Commission. However, Superior did not consistently respond to appeals and notify providers as required by its contract. The issues discussed in Chapter 3 address Superior's processes and compliance with requirements related to delivering the Medicaid STAR+PLUS program.

### Chapter 3-A

#### **Superior Paid Claims for Drugs Covered by the Commission's Vendor Drug Program and Adjudicated Medical and Pharmacy Claims Within the Required Time Frames**

Chapter 3-A  
Rating:  
Low <sup>9</sup>

Superior paid prescription claims for the STAR+PLUS program for drugs covered by the Commission's Vendor Drug Program's drug formulary. Of the approximately 3.3 million prescription claims for \$362.7 million paid during fiscal year 2016 that auditors reviewed, more than 99 percent were for drugs covered by the drug formulary.<sup>10</sup>

In addition, Superior ensured that medical claims for the STAR+PLUS program were adjudicated within the required time frames. The Commission's *Uniform Managed Care Manual* requires that once a MCO receives a "clean claim" (see text box for explanation of a clean claim), it is required within the 30-day claim payment period to: (1) pay the total amount of the claim, or part of the claim, in accordance with the contract or (2) deny the entire claim, or part of the claim, and notify the provider why the claim will not be paid.

The Commission's *Uniform Managed Care Manual* also states that a MCO is subject to remedies, including liquidated damages, if it does not pay providers interest

#### Clean Claims

Title 28, Texas Administrative Code, Section 21.802(6), defines a clean claim as follows:

- For nonelectronic claims, a claim submitted by a physician or a provider for medical care or health care services rendered to an enrollee under a health care plan or to an insured person under a health insurance policy that includes required data elements and the amount paid by a health plan.
- For electronic claims, a claim submitted by a physician or a provider for medical care or health care services rendered to an enrollee under a health care plan or to an insured person under a health insurance policy using the ASC X12N 837 format and in compliance with all applicable federal laws related to electronic health care claims, including applicable implementation guides, companion guides, and trading partner agreements.

<sup>9</sup> Chapter 3-A is rated Low because the audit identified strengths that support the audited entity's ability to administer the program(s)/functions(s) audited or the issues identified do not present significant risks or effects that would negatively affect the audited entity's ability to effectively administer the program(s)/function(s) audited.

<sup>10</sup> Superior did not include the paid claims for drugs not covered by the drug formulary in its financial statistical report for fiscal year 2016 or as part of the encounter data reported to the Commission.

for the full period in which the clean claim or a portion of the clean claim remains unadjudicated beyond the 30-day claims processing time period.

Of the approximately 11.4 million paid medical claims (reported at \$1.6 billion) that auditors reviewed, approximately 11.3 million (99 percent) were adjudicated within the required time frames. Auditors identified 132,140 claims that were adjudicated from 1 day to 623 days after the required time frame. Superior did not pay the required interest for 10,285 (8 percent) of those late claims.

In addition, Superior ensured that it adjudicated all 3.5 million paid prescription claims that auditors reviewed within 18 days as required during fiscal year 2016.

#### Recommendations

Superior should improve its processes to ensure that it:

- Adjudicates all claims within required time frames.
- Pays interest on the claims that were not adjudicated within the required time frames.

#### Superior's Management's Response

*Auditors selected "non-statistical, random samples" which should be considered in reviewing the results regarding the percent of error. However, Superior will review its adjudicated claims processes and implement any necessary improvements. Superior will pay interest when required.*

#### Auditor Follow-up Comment

Auditors did not conduct sampling of paid medical claims. Data analysis was conducted on the entire population to test the timeliness of the adjudication of the approximately 11.4 million paid medical claims, and whether the required interest was paid for claims that were not processed within required timeframes.

Superior Denied Medical Claims in Accordance with Its Contract;  
However, It Should Ensure That it Consistently Responds to  
Appeals and Notifies Providers About Appeals as Required

Chapter 3-B  
Rating:  
Medium <sup>11</sup>

Of the approximately 11.4 million paid medical claims that auditors reviewed, 958,347 were denied claims. Auditors reviewed a random sample of 25 of those denied medical claims and determined that Superior included an explanation for the denial and adjudicated the denial within 30 days, as required by the Commission's *Uniform Managed Care Manual*.

Auditors received a separate file of 1,243 appealed claims for fiscal year 2016. Auditors reviewed a random sample of 25 of those appealed medical claims and determined that:

- For 1 (4 percent) claim, Superior did not respond to the appeal within 30 days as required.
- For 2 (8 percent) claims, Superior did not retain any evidence that it notified the provider regarding the disposition of the appeal as required.

Recommendations

Superior should improve its processes to ensure that it:

- Responds to all appealed medical claims within required time frames.
- Communicates the disposition of all appealed medical claims to its providers as required.

**Superior's Management's Response**

*The auditors selected "non-statistical, random samples" which invalidates the accuracy of these results regarding the percent of error. Also, and by way of example, in many cases, errors in filing the claims prevented Superior from responding within the 30 days. Nevertheless, Superior will give the results consideration and review its appeals and notification process, implement any necessary improvements, and communicate the disposition of all appeals to its providers.*

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<sup>11</sup> The risk related to the issues discussed in Chapter 3-C is rated as Medium because the issues identified present risks or effects that if not addressed could moderately affect the audited entity's ability to effectively administer program(s)/function(s) audited. Action is needed to address the noted concern and reduce risks to a more desirable level.

#### Auditor Follow-Up Comment

The samples were designed to be representative of the population. The error rates may be projected to the population. However, the accuracy of the projection cannot be measured. Please see Appendix 1 for more information about auditors' sampling methodology.

# Appendices

## Appendix 1

### **Objective, Scope, and Methodology**

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#### Objective

The objective of this audit was to determine whether selected financial processes and related controls at a Medicaid managed care organization (MCO) are designed and operating to help ensure (1) the accuracy and completeness of data that the Medicaid managed care organization reports to the Health and Human Services Commission (Commission) and (2) compliance with applicable requirements.

#### Scope

The scope of this audit covered Superior HealthPlan, Inc. and Superior HealthPlan Network's (Superior) contracts with the Commission to deliver the Texas Medicaid program. It covered Superior's financial statistical reports and its reported medical claims and pharmacy claims for fiscal year 2016. It also included the Commission's management of its contract with Superior, including the two most recent agreed-upon procedures (AUP) engagements for which it contracted with an external audit firm.

#### Methodology

The audit methodology included selecting a MCO based on risk by obtaining and reviewing information from the Commission. Additionally, the audit methodology included collecting information and documentation, performing selected tests and other procedures, analyzing and evaluating results of the tests, and interviewing management and staff at Superior and the Commission.

#### Data Reliability and Completeness

Auditors assessed the reliability of data used in the audit and determined the following:

- For medical claims data managed by Superior's claims processing system and pharmacy claims data from Superior's subcontractor's pharmacy benefits system, auditors reconciled claims data to claim payment totals reported on Superior's financial statistical reports and to medical claims and pharmacy claims reported to the Commission. In addition, auditors reconciled payroll data to Superior's general ledger. Auditors determined that the medical claims data and pharmacy claims data, payroll data, and



Superior's general ledger was sufficiently reliable for the purposes of this audit.

- Auditors relied on Superior's external auditors' prior work on general and application controls for Superior's (1) claims processing system, (2) financial accounting system, and (3) third-party vendor systems and determined that data from those three information systems was sufficiently reliable for the purposes of this audit.

#### Sampling Methodology

For the samples discussed below, auditors applied a nonstatistical sampling methodology primarily through random selection. Auditors selected the following samples:

- To test for allowability, appropriateness, and adequate support, auditors selected nonstatistical, random samples through random selection designed to be representative of the population. Specifically, auditors selected :
  - ♦ Twenty-five service coordinator salary, wages, and overtime expenditures from Superior's payroll system.
  - ♦ Twenty-five service coordinator travel expenditures from Superior's accounting system.
  - ♦ Twenty-five related party transactions from Superior's accounting system.
  - ♦ Thirty rent, lease, and mortgage payments related to the rent, lease, and mortgage line item from Superior's accounting system.
  - ♦ Thirty legal and professional services expenditures from Superior's accounting system.
  - ♦ Fifty travel expenses from Superior's accounting system.
  - ♦ Twenty-five expenditures related to the other administrative expenses line item from Superior's accounting system.
  - ♦ Twenty-five denied claims and 25 appealed claims from Superior's claims system.

Test results for the samples listed above may be projected to the population, but the accuracy of the projection cannot be measured.

To test for proper classification, appropriateness, and adequate support, auditors selected nonstatistical, random samples designed to be

representative of the population from Superior's payroll system of salary, wages, and overtime expenditures for 75 employees. Test results may be projected to the population, but the accuracy of the projection cannot be measured.

To test for allowability, appropriateness, and adequate support, auditors selected a nonstatistical, risk-based sample of 27 third-party recovery transactions from Superior's accounting system. The sample items were not generally representative of the population; therefore, it would not be appropriate to project the test results to the population.

Information collected and reviewed included the following:

- The Commission's STAR+PLUS contracts with Superior.
- The Commission's STAR+PLUS member eligibility records for Superior.
- Superior's medical claims and pharmacy claims data.
- Superior's policies and procedures.
- Superior's 90-day and 210-day financial statistical report for fiscal year 2016.
- Superior's payroll and human resources records for fiscal year 2016.
- Superior's supporting documentation for calculating reported allocated corporate costs for fiscal year 2016.
- External audit reports and consultant reports on Superior's claims processing system, financial accounting system, and select third-party vendor systems.
- The Commission's required MCO reports, manuals, and AUP reports.
- Superior's subcontractor agreements with its pharmacy benefit manager and affiliate companies.

Procedures and tests conducted included the following:

- Reviewed required reports, bonus and incentive payment plans, and encounter data that Superior submitted to the Commission.
- Reviewed the fiscal years 2013 and 2014 AUPs prepared by the Commission's external auditors to determine whether the AUP identified or addressed significant weaknesses or areas of concern related to selected line items in Superior's financial statistical reports for fiscal years 2013 and 2014.

- Recalculated and reconciled selected medical expenses and administrative expenses line items in Superior's financial statistical report for fiscal year 2016 to the Superior's general ledger.
- Tested to determine whether service coordinator salaries, wages, overtime, and travel expenditures reported in the other medical line item of Superior's financial statistical report for fiscal year 2016 were allowable, appropriate, and adequately supported.
- Tested to determine whether Superior's reported payroll expenditures were appropriately classified and allocated, incurred in fiscal year 2016, and adequately supported.
- Tested to determine whether transactions reported in the related party expenses line item of Superior's fiscal year 2016 financial statistical report were allowable, appropriate, and adequately supported.
- Tested to determine whether payments reported in the rent, lease, and mortgage line item of Superior's fiscal year 2016 financial statistical report were allowable, appropriate, and adequately supported.
- Tested to determine whether expenditures reported in the legal and professional services line item of Superior's fiscal year 2016 financial statistical report were allowable, appropriate, and adequately supported.
- Tested to determine whether expenditures reported in the travel expenses line item of Superior's fiscal year 2016 financial statistical report were allowable, appropriate, and adequately supported.
- Tested to determine whether administrative expenditures and third-party recovery transactions reported in the other administrative expenses line item of Superior's fiscal year 2016 financial statistical report were allowable, appropriate, and adequately supported.
- Tested to determine whether denied and appealed claims were adjudicated according to the Commission's contract requirements and whether interest was paid if needed.
- Reviewed Superior's corporate allocation methodology to determine reasonableness and allowability.
- Analyzed and tested all STAR+PLUS medical and pharmacy claims for fiscal year 2016 to determine whether they were paid in accordance with the Commission's contract requirements, and submitted for STAR+PLUS eligible members.

Criteria used included the following:

- The General Appropriations Act (84th Legislature).
- Title 48, Code of Federal Regulations, Part 31.
- Title 41, United States Code, Sections 1127 and 4304.
- Texas Government Code, Chapters 531, 533, and 536.
- Title 1, Texas Administrative Code, Chapters 353 and 370.
- The Commission's uniform managed care contract for STAR+PLUS with Superior.
- The Commission's *Uniform Managed Care Manual*.
- The Commission's *Uniform Managed Care Pharmacy Claims Manual*.
- The Commission's Vendor Drug Program drug formulary.
- The Commission's *Texas Medicaid Provider Procedures Manual*.
- The Commission's *Texas Medicaid Pharmacy Provider Procedures Manual*.
- The Commission's Texas Medicaid fee schedule.

#### Project Information

Audit fieldwork was conducted from March 2017 through December 2017 year. We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

The following members of the State Auditor's staff performed the audit:

- Arby James Gonzales, CPA, CFE (Project Manager)
- Serra Tamur, MPAff, CISA, CIA (Assistant Project Manager)
- Katherine Curtsinger
- Scott Labbe, CPA

- Anca Pinchas, CPA, CISA, CIDA
- Sarah Rajiah
- Adam K. Ryan
- Cameron Scanlon, CFE
- Felicia Villela
- Dennis Bushnell, CPA (Quality Control Reviewer)
- Brianna C. Pierce, CPA (Quality Control Reviewer)
- John Young, MPAff (Audit Manager)

## Issue Rating Classifications and Descriptions

Auditors used professional judgement and rated the audit findings identified in this report. Those issue ratings are summarized in the report chapters/sub-chapters. The issue ratings were determined based on the degree of risk or effect of the findings in relation to the audit objective(s).

In determining the ratings of audit findings, auditors considered factors such as financial impact; potential failure to meet program/function objectives; noncompliance with state statute(s), rules, regulations, and other requirements or criteria; and the inadequacy of the design and/or operating effectiveness of internal controls. In addition, evidence of potential fraud, waste, or abuse; significant control environment issues; and little to no corrective action for issues previously identified could increase the ratings for audit findings. Auditors also identified and considered other factors when appropriate.

Table 5 provides a description of the issue ratings presented in this report.

Table 5

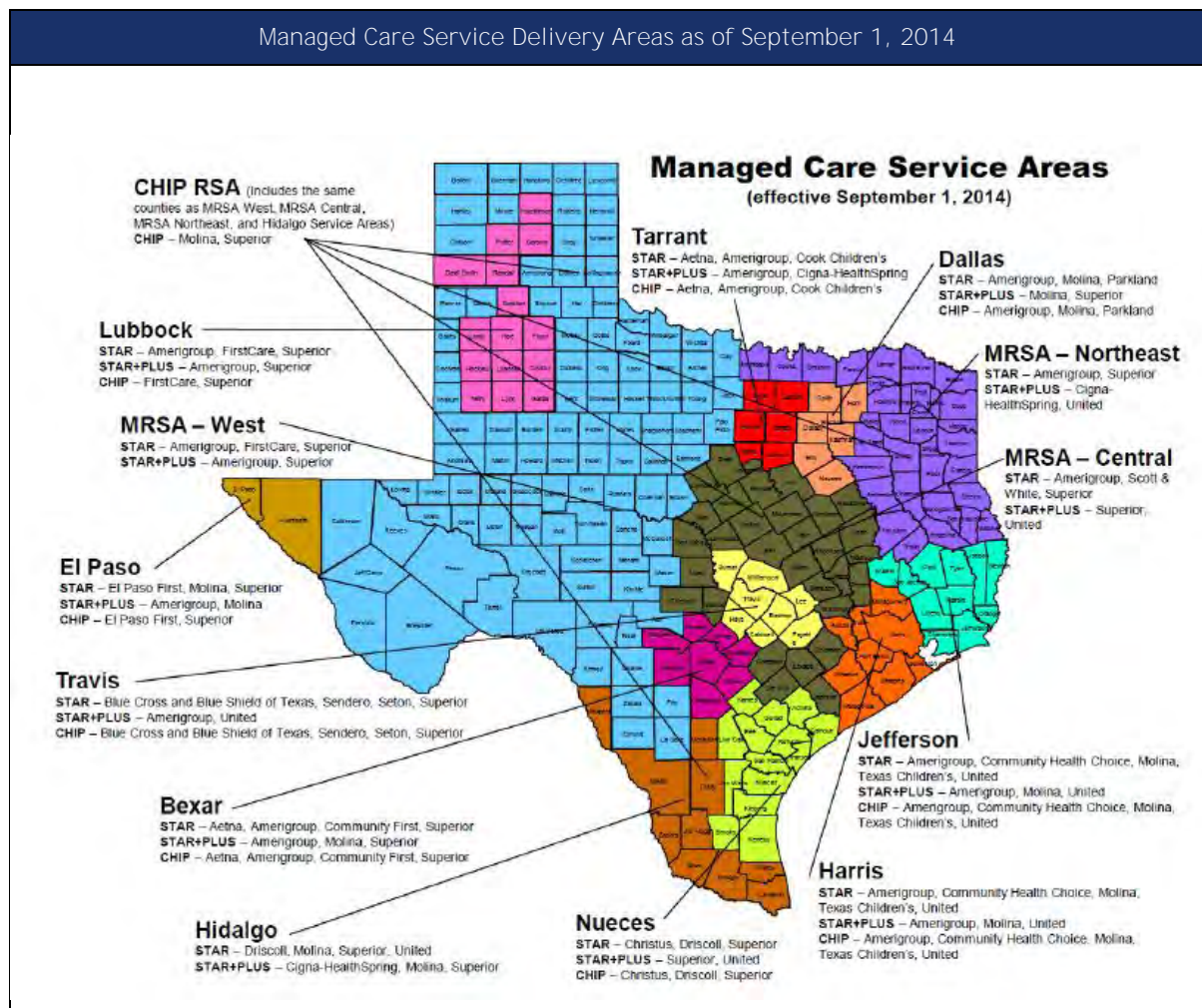
Summary of Issue Ratings	
Issue Rating	Description of Rating
Low	The audit identified strengths that support the audited entity's ability to administer the program(s)/functions(s) audited <u>or</u> the issues identified do not present significant risks or effects that would negatively affect the audited entity's ability to effectively administer the program(s)/function(s) audited.
Medium	Issues identified present risks or effects that if not addressed could <u>moderately affect</u> the audited entity's ability to effectively administer program(s)/function(s) audited. Action is needed to address the noted concern(s) and reduce risks to a more desirable level.
High	Issues identified present risks or effects that if not addressed could <u>substantially affect</u> the audited entity's ability to effectively administer the program(s)/function(s) audited. Prompt action is essential to address the noted concern(s) and reduce risks to the audited entity.
Priority	Issues identified present risks or effects that if not addressed could <u>critically affect</u> the audited entity's ability to effectively administer the program(s)/function(s) audited. Immediate action is required to address the noted concern(s) and reduce risks to the audited entity.

## Superior's Service Delivery Areas for STAR+PLUS

Superior HealthPlan, Inc. and Superior HealthPlan Network (Superior) provides Medicaid STAR+PLUS services to seven service delivery areas in Texas through its contracts with the Health and Human Services Commission. Those seven service delivery areas are: Bexar, Dallas, Lubbock, Nueces, Medicaid Rural Service Area (MRSA) - Central, MRSA - West, and Hidalgo (for Superior HealthPlan Network).

Figure 1 is a regional map that shows the location of all the managed care service delivery areas, including Superior's service delivery areas as of September 1, 2014.

Figure 1



Source: The Commission.

## ***Excerpts from Superior's Uniform Managed Care Contract and the Commission's Uniform Managed Care Manual Related to Bonus and Incentive Payment Plans***

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Below is an excerpt from Section 7.2.4.1 of uniform managed care contract between Superior HealthPlan, Inc. and Superior HealthPlan Network and the Health and Human Services Commission (Commission).

### **Employee Bonus and/or Incentive Payment Plan**

If the MCO intends to include Employee Bonus or Incentive Payments as allowable administrative expenses, the MCO must furnish a written Employee Bonus and/or Incentive Payments Plan to HHSC. The written plan must include a description of the MCO's criteria for establishing bonus and/or incentive payments, the methodology to calculate bonus and/or incentive payments, and the timing of bonus and/or incentive payments. The Bonus and/or Incentive Payment Plan and description must be submitted during the Transition Phase, no later than 30 days after the Effective Date of the Contract. If the MCO substantively revises the Employee Bonus and/or Incentive Payment Plan during the Operations Phase, the MCO must submit the revised plan to HHSC at least 30 days in advance of its effective date.

HHSC reserves the right to disallow all or part of a plan that it deems inappropriate. Any such payments are subject to audit, **and must conform within the Uniform Managed Care Manual, Chapter 6.1, "Cost Principles for Expenses"** [emphasis added].



Below is an excerpt from the Commission's *Uniform Managed Care Manual*, Chapter 6.1, "Cost Principles for Expenses" Section VI(14)(i) related to bonus and incentive payment plans.

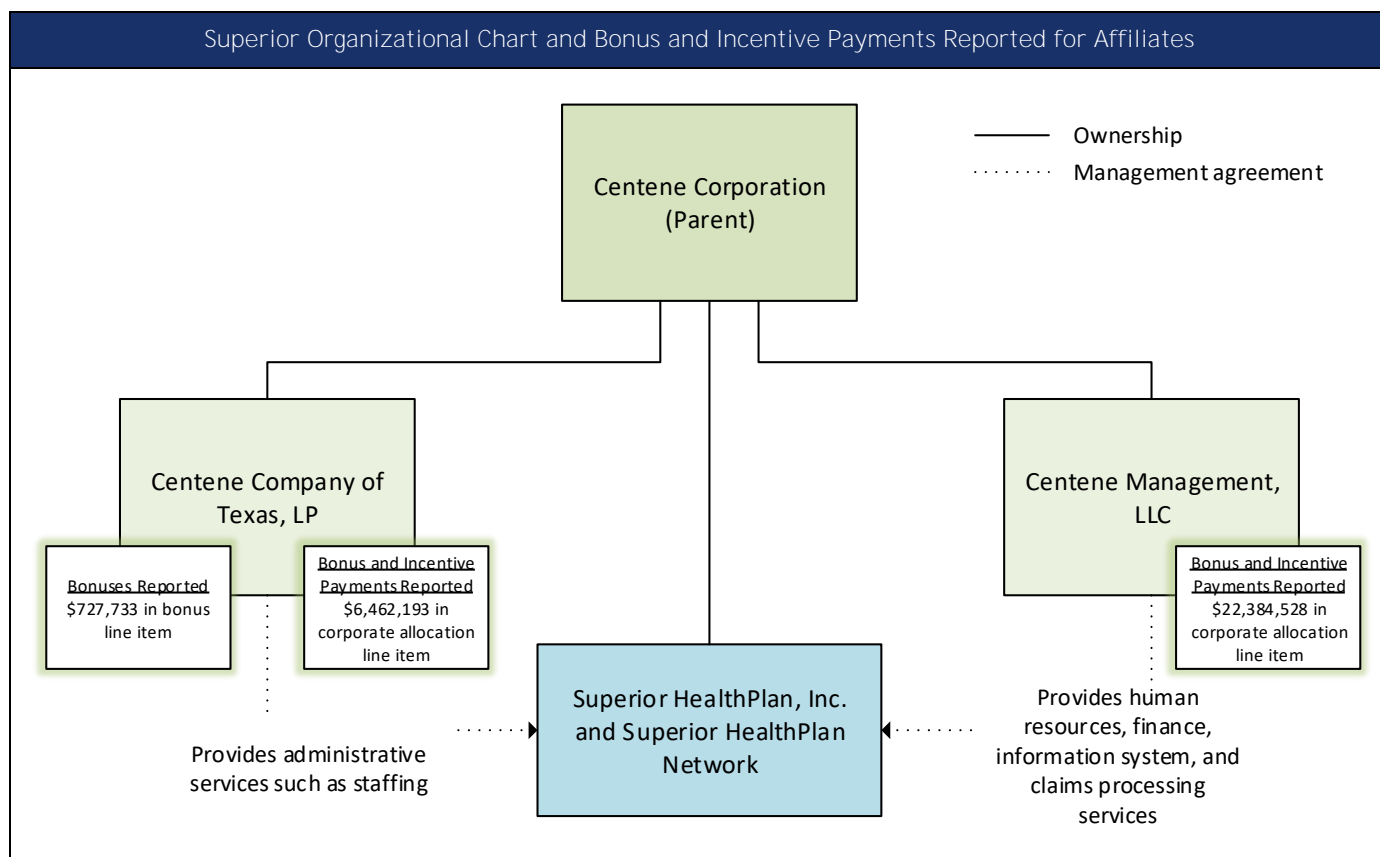
Employee Bonuses or Incentive Payments.

1. Employee bonuses are allowable if they are:
  - (a) Part of and in conformance with an existing plan that has been submitted at least nine months in advance to HHSC, and which is in compliance with any relevant specific terms of the Contract, such as those describing the criteria required for an employee bonus or incentive payment plan;
  - (b) Based on individual or group performance with respect to clearly-stated goals within a defined period (generally either the MCO's fiscal year, the MCO Parent's fiscal year, the calendar year, or the FSR reporting period); and
  - (c) Paid after the end of and within 90 days of the defined period, and is not contingent upon future services any recipient would provide.
2. **Bonuses paid or payable to an Affiliate are unallowable.** [emphasis added].

## Superior's Organizational Chart with Bonus and Incentive Payments for Affiliates

Figure 2 shows an organizational chart for Superior HealthPlan, Inc. and Superior HealthPlan Network (Superior) with bonus and incentive payments for affiliates.

Figure 2



Source: Auditors created the figure based on information Superior reported to the Commission.

## Calculating Experience Rebates

Texas Government Code, Section 533.014, requires the Health and Human Services Commission (Commission) to adopt rules that ensure that managed care organizations (MCOs) share profits they earn through the Medicaid managed care program. Title 1, Texas Administrative Code, Section 353.3, states that each MCO participating in Medicaid managed care must pay to the State an experience rebate calculated according to the graduated rebate method described in the MCO's contract with the Commission. The Commission has incorporated profit-sharing provisions into its contracts with MCOs that require MCOs to share certain percentages of their net income before taxes with the Commission. The General Appropriations Act (84th Legislature), Rider 13, page II-88, requires that experience rebates the Commission receives from MCOs be spent on funding services for Medicaid.

According to the Commission's contracts with MCOs, a MCO must pay an experience rebate to the Commission if the MCO's net income before taxes exceeds a certain percentage, as defined by the Commission, of the total revenue the MCO receives each fiscal period. The experience rebate is calculated in accordance with a tiered rebate method that the Commission defines (see Table 6). The tiers are based on the consolidated net income before taxes for all of the MCO's Medicaid program and Children's Health Insurance Program service areas that are included in the scope of the contract, as reported on the MCO's financial statistical reports (which the Commission reviews and confirms through annual agreed-upon procedures engagements performed by its contracted audit firms).

Table 6

Tiers for Experience Rebates		
Pre-tax Income as a Percent of Revenues	MCO Share	The Commission's Share
Less than or Equal to 3 percent	100 percent	0 percent
Greater than 3 percent and Less than or Equal to 5 percent	80 percent	20 percent
Greater than 5 percent and Less than or Equal to 7 percent	60 percent	40 percent
Greater than 7 percent and Less than or Equal to 9 percent	40 percent	60 percent
Greater than 9 percent and Less than or Equal to 12 percent	20 percent	80 percent
Greater than 12 percent	0 percent	100 percent

Source: The Commission's *Uniform Managed Care Terms and Conditions*.

## Calculation of the Experience Rebate Superior Owed for Fiscal Year 2016

Based on Superior HealthPlan, Inc. and Superior HealthPlan Network's (Superior) unaudited financial statistical report for fiscal year 2016, the Health and Human Services Commission (Commission) calculated the experience rebate amount that Superior owed the Commission for that fiscal period. Table 7 shows the Commission's calculation of the income that is subject to the tiered rebate methodology described in Appendix 6.

Table 7

The Commission's Calculation of Superior's Income Subject to Experience Rebate for Fiscal Year 2016	
Unaudited Pre-tax Net Income	\$94,651,680
Admin Cap impact: Expenses reduced <sup>a</sup>	\$10,805,292
Cap-adjusted Pre-tax Net Income	\$105,456,972
Pre-implementation Costs	\$0
Adjusted Income Subject to Experience Rebate	\$105,456,972
<sup>a</sup> The Admin Cap is a calculated maximum amount of administrative expenses that can be deducted from revenues for purposes of determining income subject to the experience rebate. While administrative expenses may be limited by the Admin Cap to determine experience rebates, all valid allowable expenses will continue to be reported on the financial statistical reports. The Admin Cap does not affect financial statistical reporting, but it may affect any associated experience rebate calculation. For fiscal year 2016, the \$10,805,292 amount is the difference between Superior's Admin Cap of \$337,743,981 and its reported administrative expenses of \$348,549,273.	

Source: The Commission.

Table 8 shows the Commission's calculation of the experience rebate that Superior owed the State for fiscal year 2016.

Table 8

The Commission's Calculation of Superior's Experience Rebate for Fiscal Year 2016					
Tiers - Percent of Revenue	Upper Rev Limit	Net Income	Superior's Share	State's Share	State's Share Percentage
0 percent to 3 percent	\$148,799,961	\$105,456,972	\$105,456,972	\$ 0	0 percent
3 percent to 5 percent	\$247,999,935	0	0	0	20 percent
5 percent to 7 percent	\$347,199,908	0	0	0	40 percent
7 percent to 9 percent	\$446,399,882	0	0	0	60 percent
9 percent to 12 percent	\$595,199,843	0	0	0	80 percent
Over 12 percent	No Limit	0	0	0	100 percent
Totals		\$105,456,972	\$105,456,972	\$0	

Source: The Commission.

## ***Additional Management's Responses from Superior***

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In addition to its management's responses to the recommendations directed to it in Chapters 2 and 3 of this report, Superior HealthPlan, Inc. and Superior HealthPlan Network (Superior) submitted (1) a summary of its management's response and (2) detailed responses to the recommendations in Chapter 1 directed to the Health and Human Services Commission. That summary and those additional responses are presented below.

### ***Summary***

*Superior disagrees with the auditors on two key issues, performance based incentive payments to employees and the reporting of affiliate cost. Superior disagrees with the auditor's interpretations of the cost principles and contract requirements. Further, Superior is concerned that the auditor chose to ignore: (1) the documentation of the long-standing course of performance by the parties; and (2) the manner in which both the Texas Health and Human Services Commission (HHSC) and Superior interpreted their own agreement in applying the Uniform Managed Care Manual's cost principles to the specific structure of Superior's participation in the Texas Medicaid program. Superior has consistently worked with HHSC to transparently disclose the employee incentive payments and the technicalities associated with a holding company staffing structure. HHSC has permitted the employee incentives (after receiving the required filings and request from Superior) consistent with allowances that would be available for a company not using Superior's structure. Superior believes this approach to be well within the letter, spirit, and intent of the cost principles. Similarly, Superior has made HHSC aware of its affiliate cost structure and both Superior and HHSC have arrived at an approach for the application of the cost principles to Superior's specific structure. The inconsistency between the auditor's findings and the well-established history of the course of performance between the parties to the agreement is further evidenced by more recent proposed changes to the referenced provisions by HHSC that would allow the parties to maintain the current approach.*

*Unfortunately, the auditor gave neither the history nor the proposed language changes any weight or context in the report and instead relied upon its own interpretation of a contractual and regulatory structure in which it does not have day-to-day experience. Incentive payments and affiliate cost could be considered by the auditor to be questionable costs,*

*rather than unallowable, due to the technical language issues raised by the auditor. However, the auditor should not ignore the documented decisions, planning, reporting and auditing of the costs for multiple years by the actual parties to the contract when communicating these issues in this report.*

#### *Chapter I-A*

*Superior does not agree with the auditor's interpretation of the cost principles regarding performance based compensation and incentive payments and is disappointed that the auditor chose to omit the fundamental contextual issues related to this issue, which include a technical inter-company staffing arrangement the auditor is not properly considering or explaining in presenting the interpretation, and a filing by Superior to HHSC seeking the approval of this compensation and incentive payment structure. The auditors have misinterpreted the cost principles relating to payments to employees in contrast to payment to an affiliate. The performance incentive payments identified are paid directly to employees providing contract services directly to Superior and not paid to an entity such as an affiliate for discretionary distribution to actual employees. Many of the employees in question are the only employees that can properly be attributed to Superior and they function as the day-to-day employees of Superior through a staffing agreement. The staffing agreement between Superior and Centene of Texas, Inc. (CTX), an affiliate of Superior, provides a level of simplicity for the holding company system in which Superior is a wholly owned subsidiary. CTX provides employees to Superior and does so for only Superior.*

*The cost principles are complex and the provision related to employee bonus and incentive payments unfortunately includes language regarding bonus payments to affiliates that does not make any reference to employees. This results in some ambiguity. Superior has long understood this language to prohibit bonus payments directly to affiliated entities for reaching certain performance targets and to not apply to employees who are technically employed through an affiliate but providing services specifically to Superior. HHSC's approval of Superior's filed employee bonus and incentive plans is consistent with that understanding and with the allowable employee bonus and incentive expenses for MCOs not utilizing this staffing structure. However, the auditor determined that this language should be interpreted to completely disallow the employee bonus and incentive payments. The ambiguity in the cost principle language should be resolved consistent with usual contract construction principles, which would properly consider the course of performance of*

*the parties to the agreement. This well understood contractual interpretation principle is expressed in numerous sources, including judicial decisions, the Restatement (Second) of Contracts, and in state statute at TEX. BUS. & COM. CODE sec. 1.303.*

*The HHSC cost principles allow MCOs to structure compensation arrangements to employees such that those employees are paid bonus or incentive payments. This is consistent with general practices in employment arrangements. The cost principles indicate that an MCO is not allowed to take the employee incentive payment allowance and use it to pay a bonus to an affiliate. To ensure that an MCO's planned employee incentive structure is consistent with the intent of the allowance, MCOs are required to file the details of the employee bonus and incentive structure with HHSC.*

*Incentive payments to Superior employees have been authorized by the Health and Human Services during the years that Superior has been a contractor. The payments are based on meeting established employee goals during the year. This issue is well known and understood by HHSC due to the filing process. Superior has been reviewed by HHSC's contracted third party auditors on multiple occasions through annual AUP reviews and the issue has not been raised as a finding in those reviews. The application of the cost principles in this audit report without a transparent effort to provide context, history, or reference to the pattern and practice of the parties subject to the cost principles agreement has provided an opportunity to issue a notable finding by the SAO, but the finding does not reflect the situation accurately.*

*Finally, Superior understands that the placement of the cost principle language regarding bonuses and incentives can be confusing in the context of an audit and can raise questions like those identified in the report. HHSC has recently proposed changes to the cost principles that Superior believes further clarify the intent of the language and eliminate opportunities for confusion in future reviews or audits.*

#### *Chapter I-B*

*Superior has worked cooperatively and transparently with HHSC for many years regarding the methodology for reporting the appropriate pricing of the services Superior receives from its affiliated entities. The annual Agreed Upon Procedures (AUP) reviews by a third party auditor contracted through HHSC also test this specific issue. Superior understands that the State Auditor's Office would raise the issue as being potentially inconsistent with a technical reading of the cost principles and*

*associated requirements. However, the issue is easily identified by an auditor's review because it is being handled by both HHSC and Superior in a transparent manner that includes Superior's requests to HHSC and HHSC's instructions regarding testing in the AUP reviews. The State Auditor's Office appears to have identified an opportunity to enforce the contract in a more stringent manner. Superior's position is that HHSC was aware of that opportunity and made a more fact-specific determination that is backed up by post-reporting third-party review. This context was also known to the State Auditor's Office but was not effectively communicated or referenced in the audit report.*

#### *Chapter 1-C*

*Superior's contract with HHSC is a risk-based contract. The Executive Compensation limitation (cited above) per federal requirements applies to cost reimbursement or solely cost-based contracts and thus does not affect this agreement. The recommendations in the report are not, in Superior's view, well-considered. The application of the Federal Acquisition Regulation (FAR) to the HHSC-MCO contracts is a much larger issue than the identified executive compensation matter. The complexity related to hundreds of pages of FAR regulatory requirements and decisions is not expertise routinely maintained by either the MCOs or HHSC. Recommending any changes to the method for referencing FAR is far more complicated than an effort at addressing a singular issue identified in this report.*



**Related State Auditor's Office Work**

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Related State Auditor's Office Work		
Number	Product Name	Release Date
18-006	A Report on Health and Human Services Contracts	December 2017
17-025	An Audit Report on HealthSpring Life and Health Insurance Company, Inc., a Medicaid STAR+PLUS Managed Care Organization	February 2017
17-007	An Audit Report on Medicaid Managed Care Contract Processes at the Health and Human Services Commission	October 2016

Copies of this report have been distributed to the following:

### Legislative Audit Committee

**The Honorable Dan Patrick, Lieutenant Governor, Joint Chair**

**The Honorable Joe Straus III, Speaker of the House, Joint Chair**

**The Honorable Jane Nelson, Senate Finance Committee**

**The Honorable Robert Nichols, Member, Texas Senate**

**The Honorable John Zerwas, House Appropriations Committee**

**The Honorable Dennis Bonnen, House Ways and Means Committee**

### Office of the Governor

**The Honorable Greg Abbott, Governor**

### Health and Human Services Commission

**Mr. Charles Smith, Executive Commissioner**

### Superior HealthPlan, Inc. and Superior HealthPlan Network

**Mr. Mark Sanders, Plan President and Chief Executive Officer**



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**Joint Hearing: House Committees on Appropriations, Subcommittee on Art. II  
and General Investigating and Ethics  
June 27, 2018**

*Testimony of Olga Rodriguez, Chief Strategy Officer*

Good morning Chairwoman Davis, members. Thank you for inviting me to speak this morning. I am Olga Rodriguez, Chief Strategy Officer for the HHSC Office of Inspector General.

Unfortunately, our Inspector General Sylvia Hernandez Kauffman couldn't be here this morning, however she is willing to follow-up with each of you on an individual basis. We also have an additional resource witness available.

You invited us to speak about the status of the STAR Kids/STAR Health audit. Before I provide that update, I would like to briefly discuss the OIG tools used to detect fraud, waste, and abuse in the HHS System.

The OIG is responsible for the prevention, detection, and deterrence of fraud, waste, and abuse through the audit, investigation, inspection, and medical review of federal and state taxpayer dollars used to deliver health and human services in Texas.

We have four tools available for oversight: audits, reviews, inspections, and investigations. Each of these remains applicable in managed care, but the focus can be different. For example, instead of a provider investigation focusing on one provider in FFS, OIG investigations can look across all the MCOs that contract with that provider. If the issue being investigated is prevalent across multiple MCOs, the OIG can go a step further to see if there is a systemic issue across MCOs that is allowing the fraud, waste, or abuse to happen.

In addition to our primary tools, the OIG works on program integrity in other ways, like data analytics. Data analytics is an important detection tool for identifying outliers to help focus investigative actions and areas of interest that may warrant further review.

To advance the OIG mission, the Audit Division conducts risk-based audits of HHS and DFPS contractors, providers, and agency programs.

There are three stages to an audit: planning, fieldwork, and reporting. I will mention this in more detail in a moment, but the STAR Kids/STAR Health Audit is in the planning stage.

Part of the OIG's role is to constantly assess risk throughout the HHS System. We develop audit and inspection work plans to assist us in planning and prioritizing to better serve the state and its taxpayers.

In January of this year, the OIG published its two-year rolling audit plan, which included provider audits on STAR Kids and STAR Health. The OIG coordinates managed care audits with Medicaid and CHIP to assist us in prioritizing and to avoid duplication. An additional audit in the plan, which will examine potential duplicate payments for services covered by STAR Health procured under DFPS child-specific contracts, will be initiated in July.

The scope of the STAR Kids/STAR Health audits is to evaluate whether MCOs are delivering needed services to the children who are enrolled in the Medically Dependent Children Program, known as MDCP, who are also receiving private duty nursing, referred to as PDN. By extension, in March HHSC asked us to examine additional issues like utilization in our STAR Kids/STAR Health audits.

Our audit is still in the planning phase. We are conducting interviews, gathering information, and requesting and evaluating data. As we complete planning, we will be selecting an MCO for the first of what will be a series of audits.

The next phase, which begins in July, is field work. Auditors, with the assistance of OIG nurses, will examine records. We anticipate examining processes that lead to service delivery, including initial and periodic assessments, development of individual service plans, and MCO prior authorization. Then we will look at medical records, and possibly conduct interviews, to determine whether needed services were delivered.

We expect this audit in its entirety to take about nine months. Now, we realize nine months is too long a wait for many of you to start reviewing information on utilization while it continues to impact our most vulnerable Texans. As a result, we are trying to identify and prioritize areas where we can provide more information, sooner, while still maintaining the integrity of the process. Our office will work to keep each of your offices updated and provide that information as it becomes available.



# **Managed Care: Contract Oversight and Monitoring**

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**Enrique Marquez**

**Chief Program & Services Officer**

**Stephanie Muth**

**State Medicaid Director**



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**June 27, 2018**



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# **Provider Access Landscape**

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**Network adequacy is influenced by many factors:**

- **Provider density,**
- **Provider capacity,**
- **Program administrative complexity, and**
- **Payment rates.**

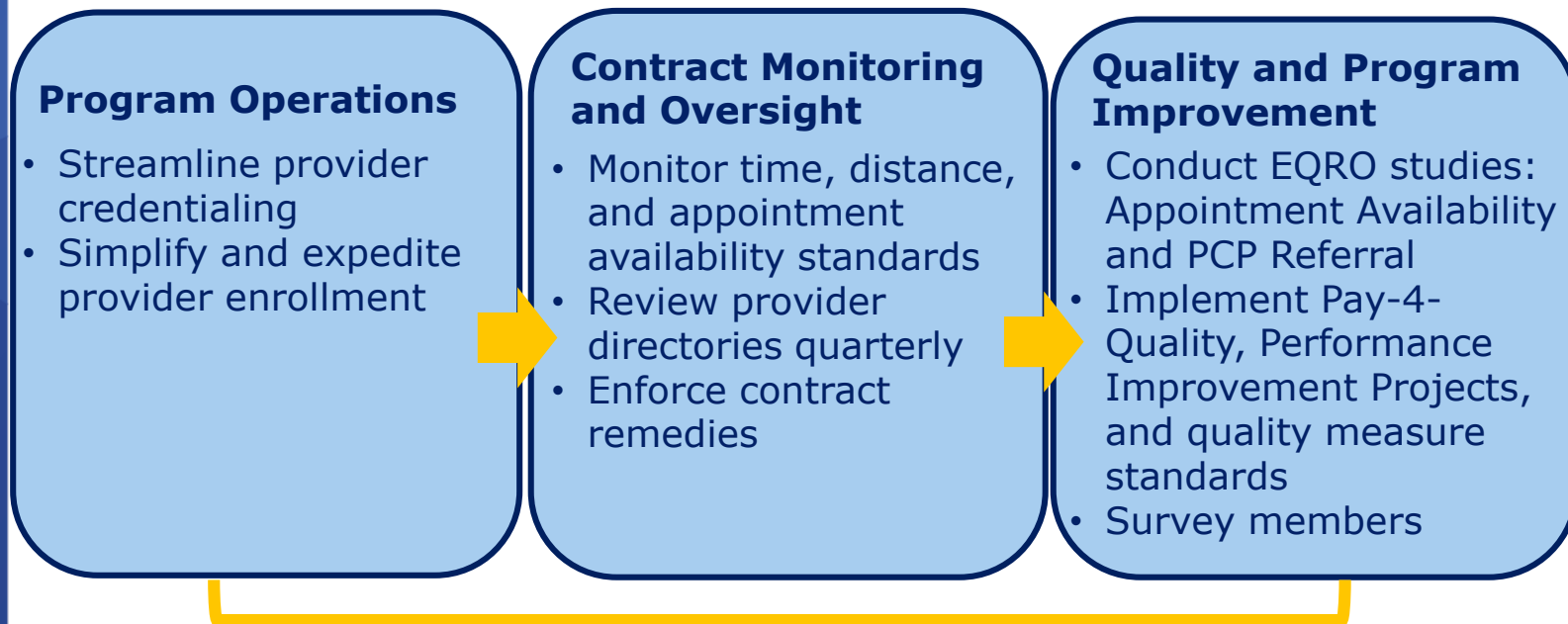
**These same issues are common to commercial insurance plans and Medicaid programs nationally.**



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# Network Adequacy Oversight Approach

**Cross-functional approach to monitoring and improving network adequacy.**



*Routine and targeted data analytics support activities.*

*Care coordination helps members access the services they need.*

PCP: Primary Care Physician  
EQRO: External Quality Review Organization





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# Network Adequacy Standards

## Distance and Travel Time Standards

Provider Type	Distance in Miles			Travel Time in Minutes		
	Metro	Micro	Rural	Metro	Micro	Rural
Behavioral Health-outpatient	30	30	75	45	45	90
Cardiovascular Disease	20	35	60	30	50	75
ENT (otolaryngology)	30	60	75	45	80	90
General Surgeon	20	35	60	30	50	75
Hospital - Acute Care	30	30	30	45	45	45
Nursing Facility	75	75	75	-	-	-
OB/GYN	30	60	75	45	80	90
Occupational, Physical, or Speech Therapy	30	60	60	45	80	75
Ophthalmologist	20	35	60	30	50	75
Orthopedist	20	35	60	30	50	75
Prenatal	10	20	30	15	30	40
Primary Care Provider	10	20	30	15	30	40
Psychiatrist	30	45	60	45	60	75
Urologist	30	45	60	45	60	75

Long Term Services and Supports (LTSS) and Pharmacy standards proposed to be implemented in the September 2018 managed care contracts.  
Metro = county with a pop. of 200,000 or greater, Micro = county with a pop. between 50,000-199,999, Rural = county with a pop. of 49,999 or less.



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# Network Adequacy Appointment Availability Study

**“Secret shoppers” call enrolled providers to see how long it takes to get an appointment.**

Level/Type of Care	Time to Treatment Requirements
Urgent Care (child and adult)	Within 24 hours
Routine Primary Care (child and adult)	Within 14 calendar days
Preventive Health Services for New Child Members	No later than 90 calendar days of enrollment
Initial Outpatient Behavioral Health Visits (child and adult)	Within 14 calendar days
Preventive Health Services for Adults	Within 90 calendar days
Prenatal Care (not high-risk)	Within 14 calendar days
Prenatal Care (high-risk)	Within 5 calendar days
Prenatal Care (new member in 3rd trimester)	Within 5 calendar days

## Actions

- Corrective Action Plans (CAPs) have been imposed on all the managed care organizations (MCOs) in at least one service area for not meeting appointment availability standards.
- EQRO will repeat the studies over 2018 and 2019.



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# Network Adequacy Oversight

## Oversight Requirements

- Quarterly monitoring process using provider reconciliation files and member eligibility files.
  - No longer using MCO self-reported data.
- MCOs who do not meet 75 percent compliance with standards are issued a CAP.
- In January 2019, this requirement will increase to 90 percent compliance and issuance of both CAPs and liquidated damages (LDs).
- Implemented Provider Directory requirements in 2016.



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# Network Adequacy

## Next Steps

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- Ramp up standards and remedies for time, distance, and appointment availability requirements.
- Perform targeted analysis of access to specialty services, including STAR Health psychiatry services and PCP referral study.
- Strengthen linkages between data analytics and program oversight and operations.
- Identify opportunities, in collaboration with stakeholders, to expand alternative service delivery models, such as telemedicine, telehealth, and remote monitoring.
- Promote quality and access through the Pay-for-Quality program, Performance Improvement Projects, and quality measure standards.
- Examine provider directory data issues.
- Analyze claims data to identify and address inactive providers that are not delivering services.
- Lead cross-functional workgroup to identify network adequacy issues and solutions.

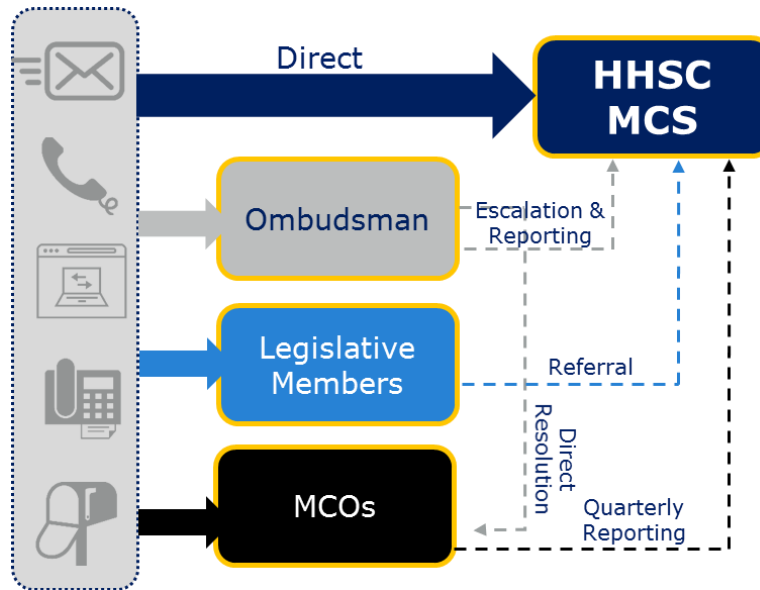


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# MCO Member Complaints

## Two Areas of Focus

### #1 is resolution



- No wrong point of entry
- HHSC resolution specialist assigned until case is closed
- Resolution timelines in contract requirements

### #2 is oversight

- Analysis of MCO member complaints to pinpoint trends that indicate:
  - Operational issues
  - Needed policy clarifications
- Adding additional resources to strengthen analytics and focus on real time data



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# Complaints

## Trending and Analysis

---

### Future Improvements

- Cross-divisional workgroup to standardize and improve on data collection.
- Contract oversight escalation team.
  - Analyze complaints to determine root cause of issues presented and identify needed actions
- Flexible data portal.
  - Support data visualization
  - Faster extraction of complaints analysis
  - Facilitate strategic oversight of health plans
- Improvements will allow HHSC to use complaints data to identify risks, increase program transparency, and inform areas for improvement.



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# Operational Reviews

## Current Activities / Next Steps

---

- HHSC strengthened contract oversight by adding onsite operational reviews of MCOs in September 2017.
  - Team of 20-25 subject matter experts conduct onsite monitoring of one MCO per month.
- Onsite comprehensive review of MCO performance across a series of critical indicators, including:
  - Claims processing,
  - Prior authorization,
  - Utilization management, and
  - Encounter submissions.
- Continue to refine the process and add modules
  - Additional staffing resources will support this effort
- Results of operational reviews inform contractual enforcement and training and technical assistance needs.



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# **Long-term Services and Supports Utilization Reviews**

## **Current Activities / Next Steps**

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- Created by S.B. 348, 83<sup>rd</sup> Legislature, Regular Session, 2015.
- Provides oversight of STAR+PLUS Home and Community Based Services (HCBS) program in order to ensure:
  - MCOs are correctly enrolling members in HCBS through assessment and justification of service need; and
  - MCOs are providing services according to their assessment of service needs.
- Additional resources allocated to provide oversight of STAR Kids and STAR Health Medically Dependent Children's Program (MDCP).





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# MCO Oversight

## Next Steps

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### **Rider 61(b) Recommendations**

In July 2018, Deloitte will complete their independent assessment of contract review and oversight for Medicaid and CHIP managed care contracts, including:

- Effectiveness and frequency of audits;
- Data necessary to evaluate existing contract requirements and enforcement including penalties; and
- Need for additional training and resources for effective contract management.



# Appendix

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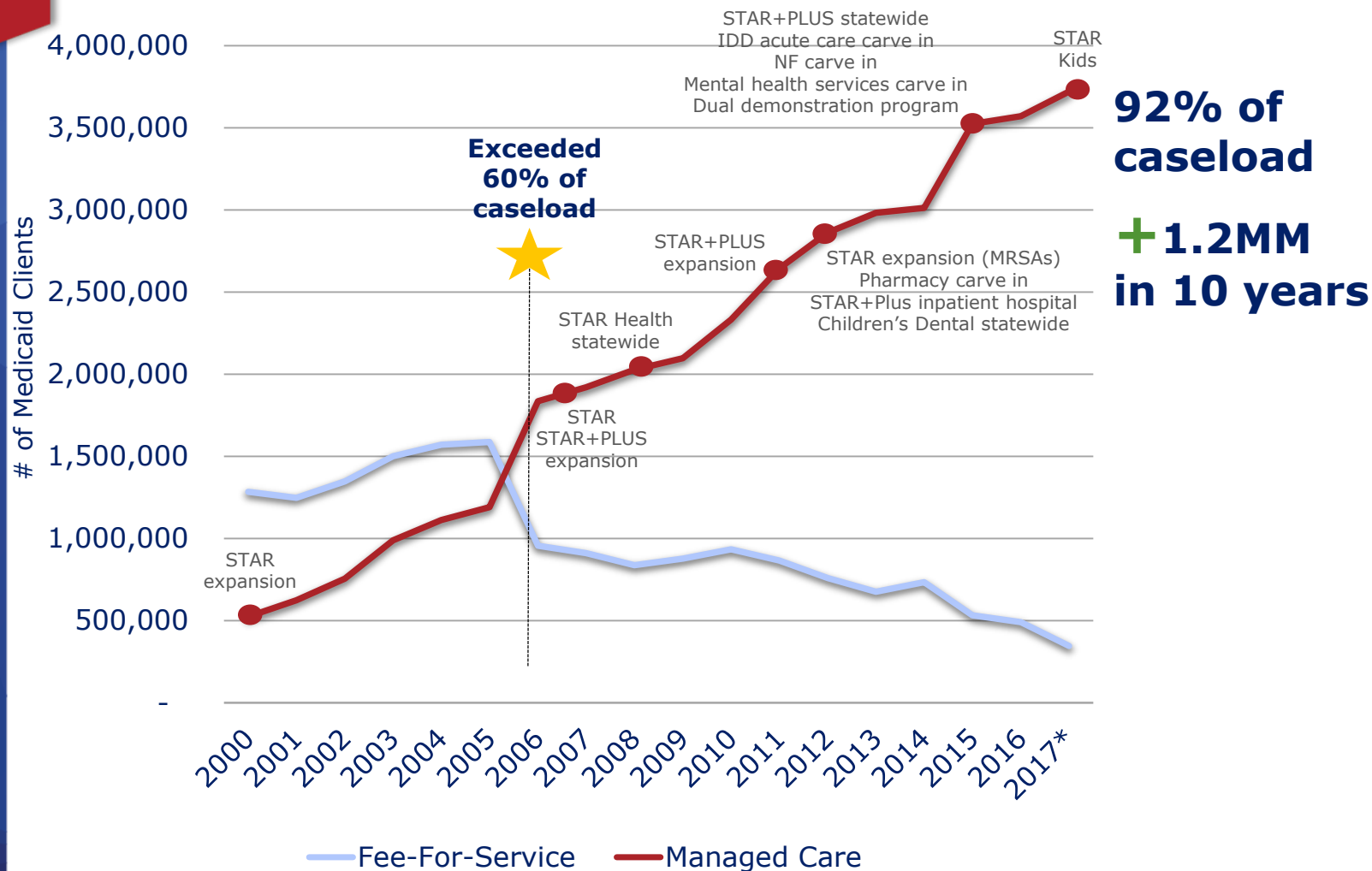


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# An Evolving Landscape

## Rapid Growth of Managed Care Model

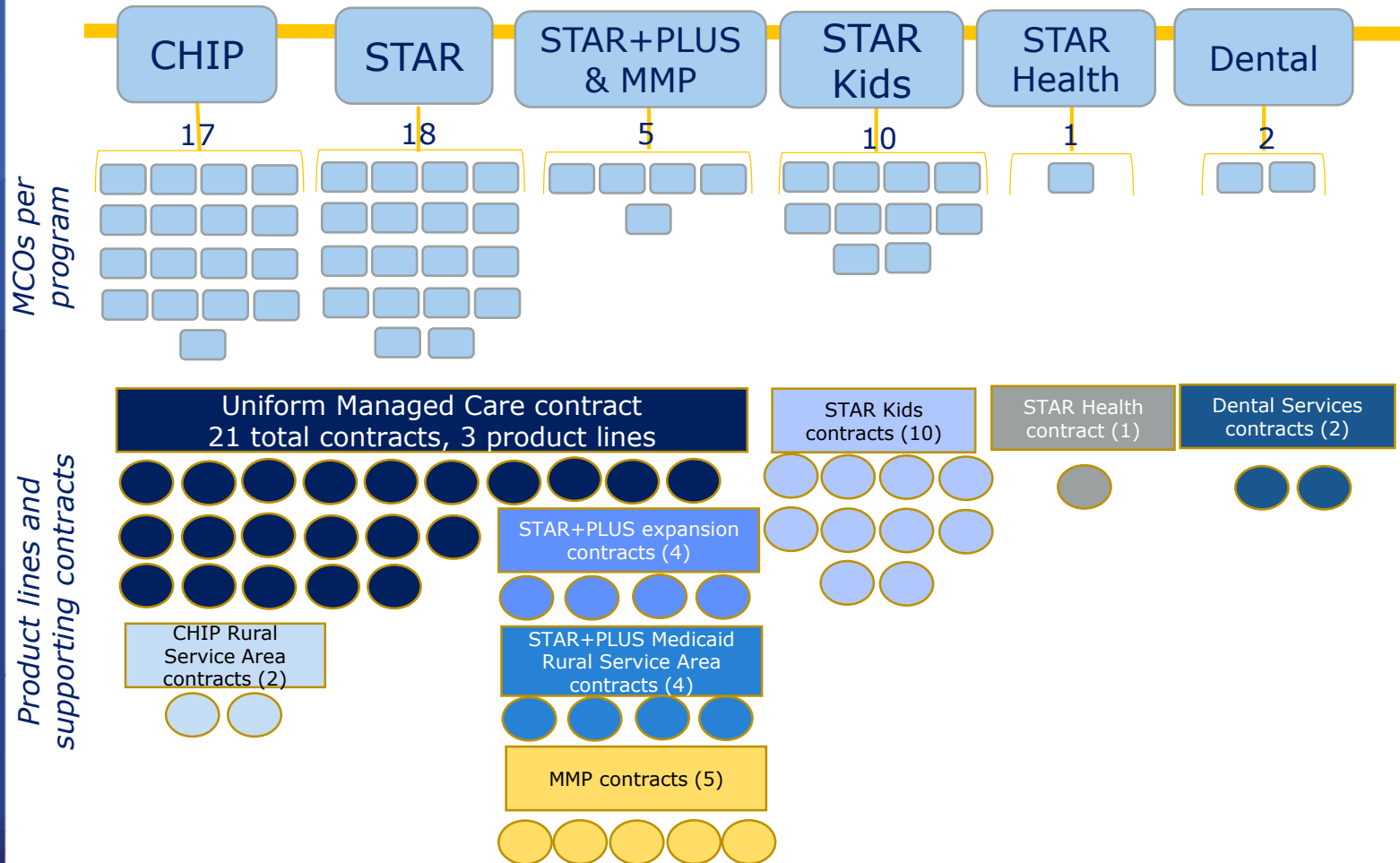




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# An Evolving Infrastructure Supporting Managed Care

## Managed Care Programs





# Strength in Oversight Starts with Contract Formation

## Example: Financial Oversight



*Non-compliance discoveries enforced as established in the contract, including liquidated damages or recovery of the Experience Rebate (i.e. recovery of "excess profit").*

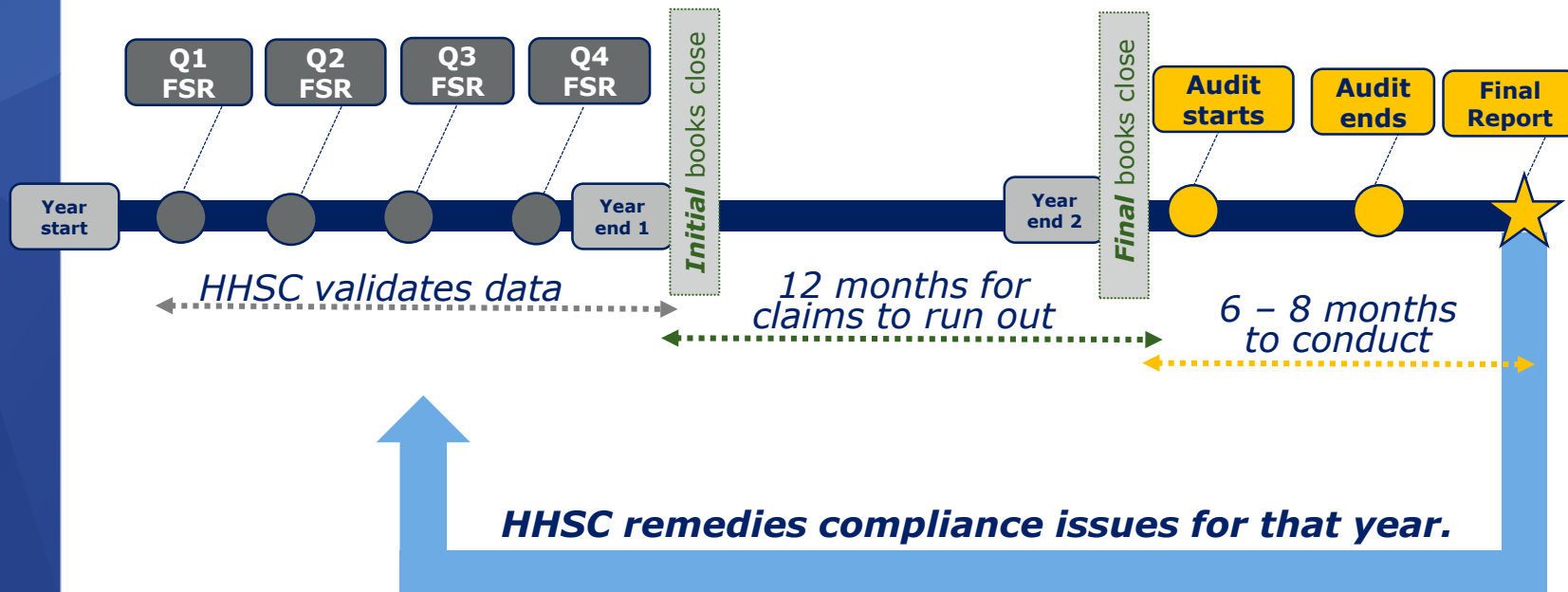


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# Financial Oversight

## Timeline for Managing Compliance

An 18-20 month audit process post-year end.



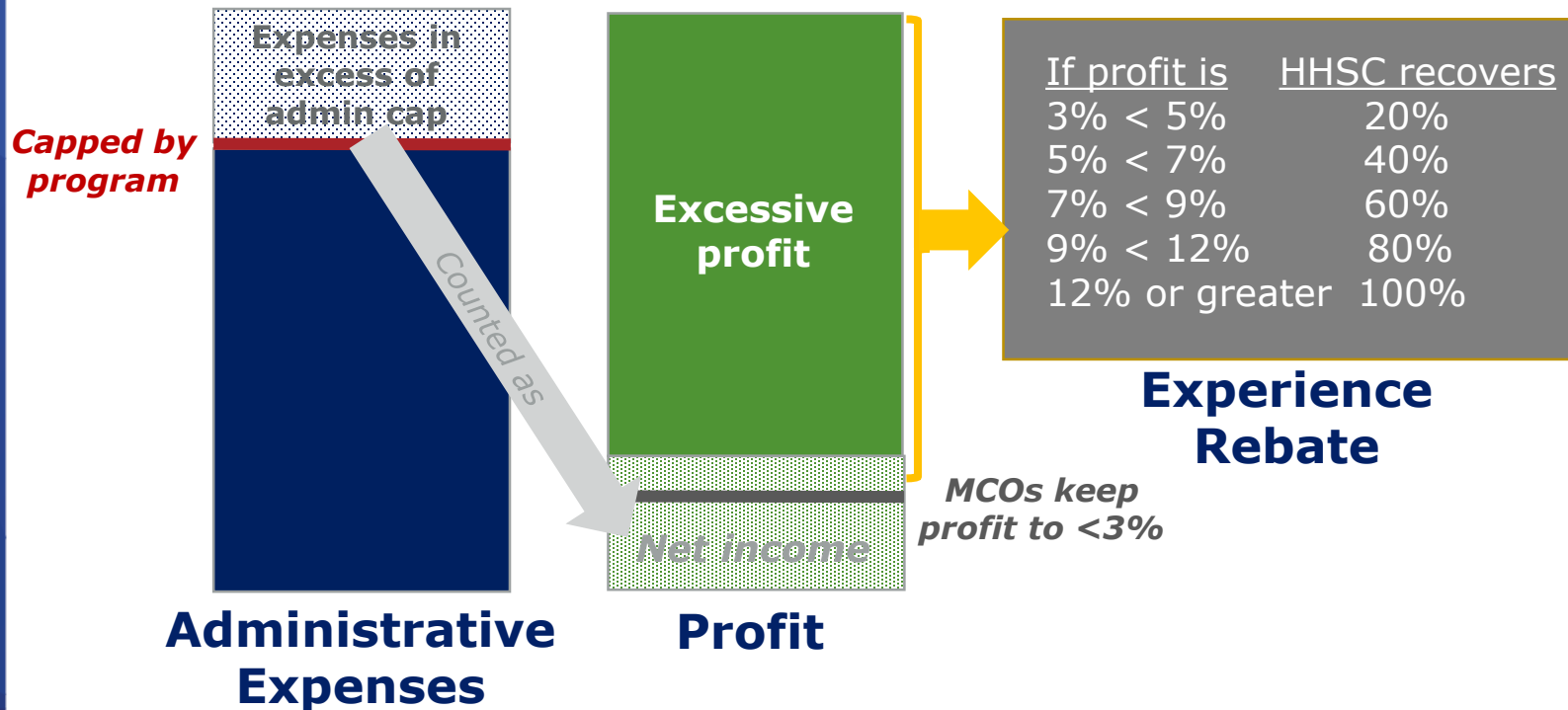


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# Contract Financial Structure

## Safeguards to Ensure Fiscal Responsibility

Major components are caps on administrative expenses, conversions to income, and rebates on excessive profit.





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# Operations Oversight Tools

## HHSC and External Auditors

Like financial oversight, operations has multiple monitoring perspectives.

HHSC onsite biennial  
operational reviews

### ***Critical indicator focus***

Claims  
Processing

Encounter  
Data

Provider  
Relations

Prior  
Authorization  
Process

Complaints/  
Appeals

Utilization  
Management

Call Center  
Functioning

Website  
Critical  
Elements

+ Additional modules  
under development

3rd party biennial performance audits  
(or more frequently as determined by risk)

### ***Two areas of focus***

MCO self-  
reported data

Operational  
processes

Targeted area(s) may vary.  
Examples include:

- MCO Hotlines
- Complaints and Appeals
- Claims processing
- Subcontractor monitoring (including PBMs)

Can inform the focus of the 3<sup>rd</sup> party audit or  
the need for an incremental one.



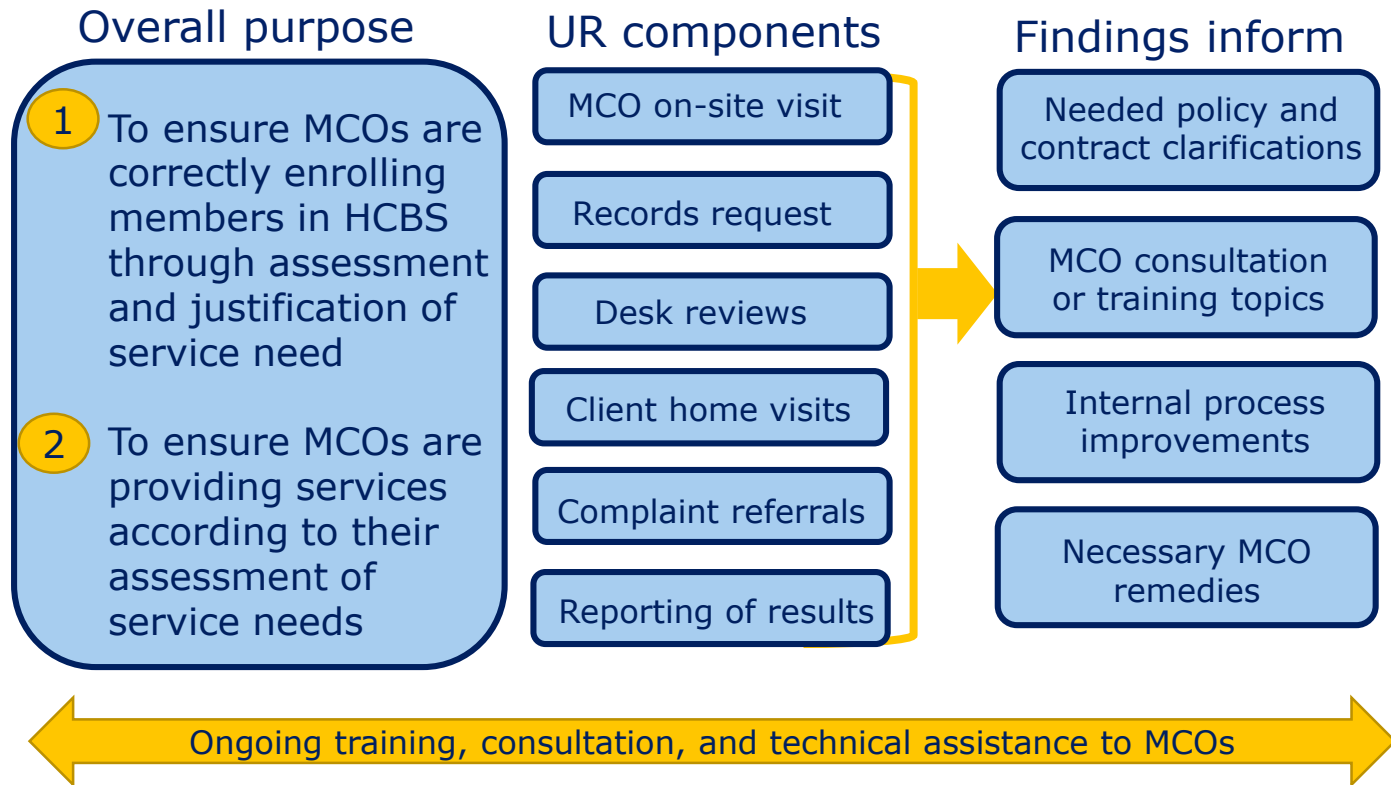


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# Services Oversight Tool

## Utilization Reviews

Utilization Reviews (UR) are conducted by nurses and overseen by the Office of the Medical Director.





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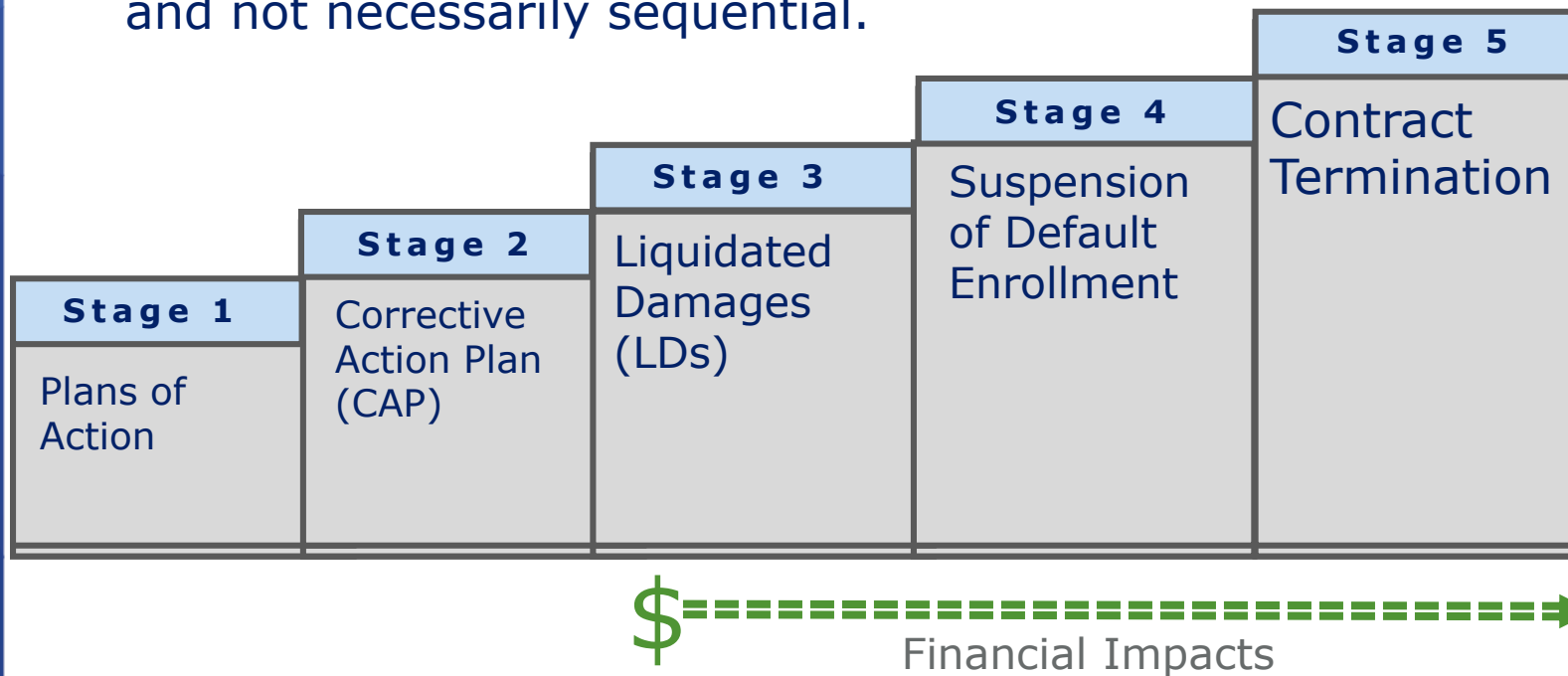
# Addressing Non-Compliance

## Graduated Remedy Process

Multiple stages to address non-compliance discovered via oversight and monitoring.

Increased levels of impact for MCOs.

Remedy issued is contingent on type of non-compliance and not necessarily sequential.



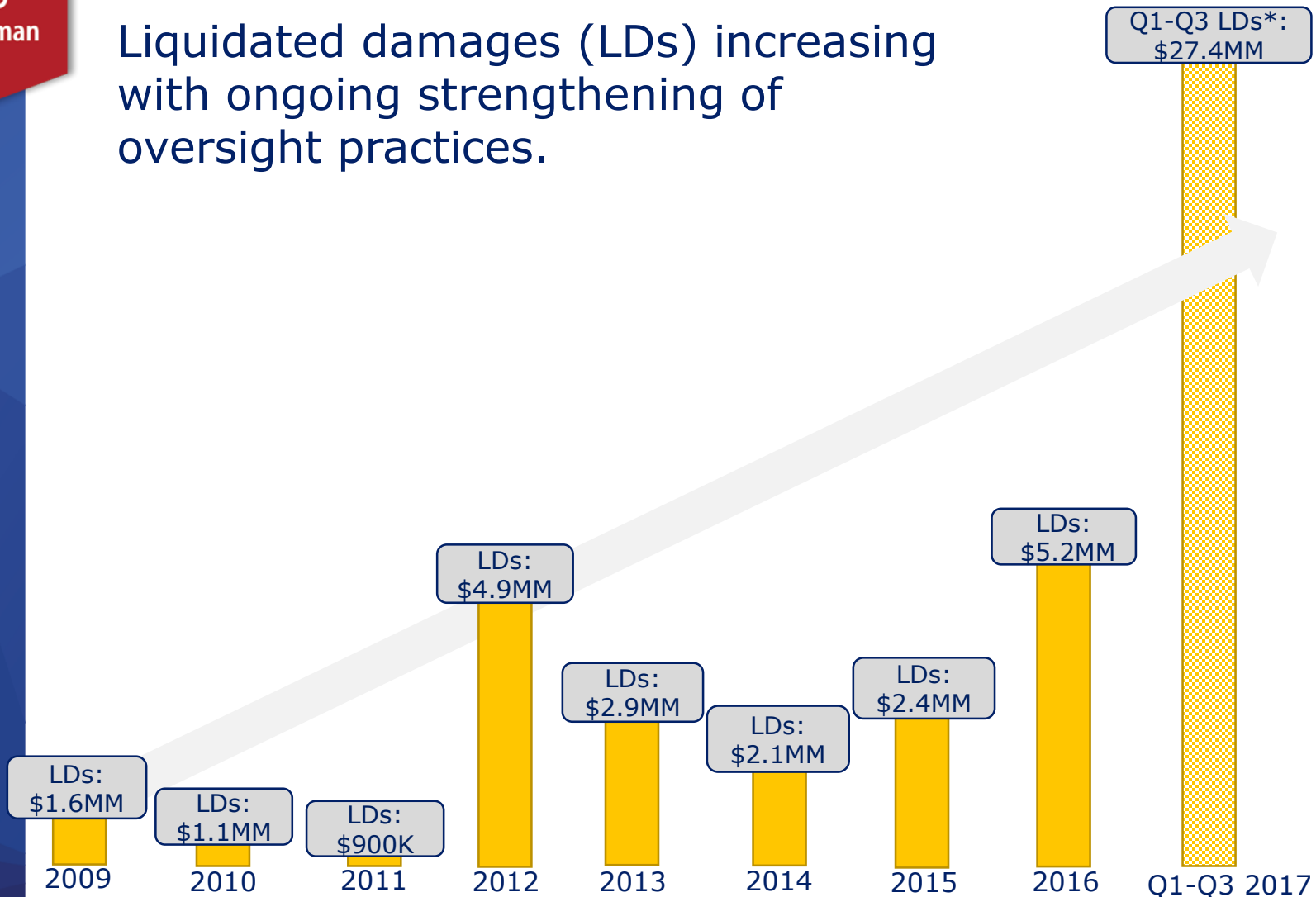


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# Financial Impact Stage

## Liquidated Damages Issued

Liquidated damages (LDs) increasing with ongoing strengthening of oversight practices.



\*Q3 2017 LD dollar amount of \$17.7MM is not final.  
All dollars are based on state fiscal year. All numbers are rounded.



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# Utilization Review Liquidated Damages Matrix

## Managed Care Utilization Review Liquidated Damages (per day) Matrix

<i>Risk of Harm Impact Tiers</i>	Covered Service		Administrative Service	
	Isolated	Systemic	Isolated	Systemic
4 - significant harm	\$ 5,000	\$ 7,500	\$ 3,000	\$ 5,000
3 - actual harm	\$ 3,500	\$ 5,000	\$ 1,750	\$ 3,500
2 - no actual harm, imminent risk for more than minimal harm to member	\$ 1,500	\$ 2,500	\$ 750	\$ 1,500
1 - no actual harm, imminent risk for minimal harm to member	\$ 500	\$ 1,000	\$ 250	\$ 500

# A Vision for Texas Medicaid 2020

## Appropriations Sub-Committee on Article II

Ken Janda  
President and CEO  
June 27, 2018

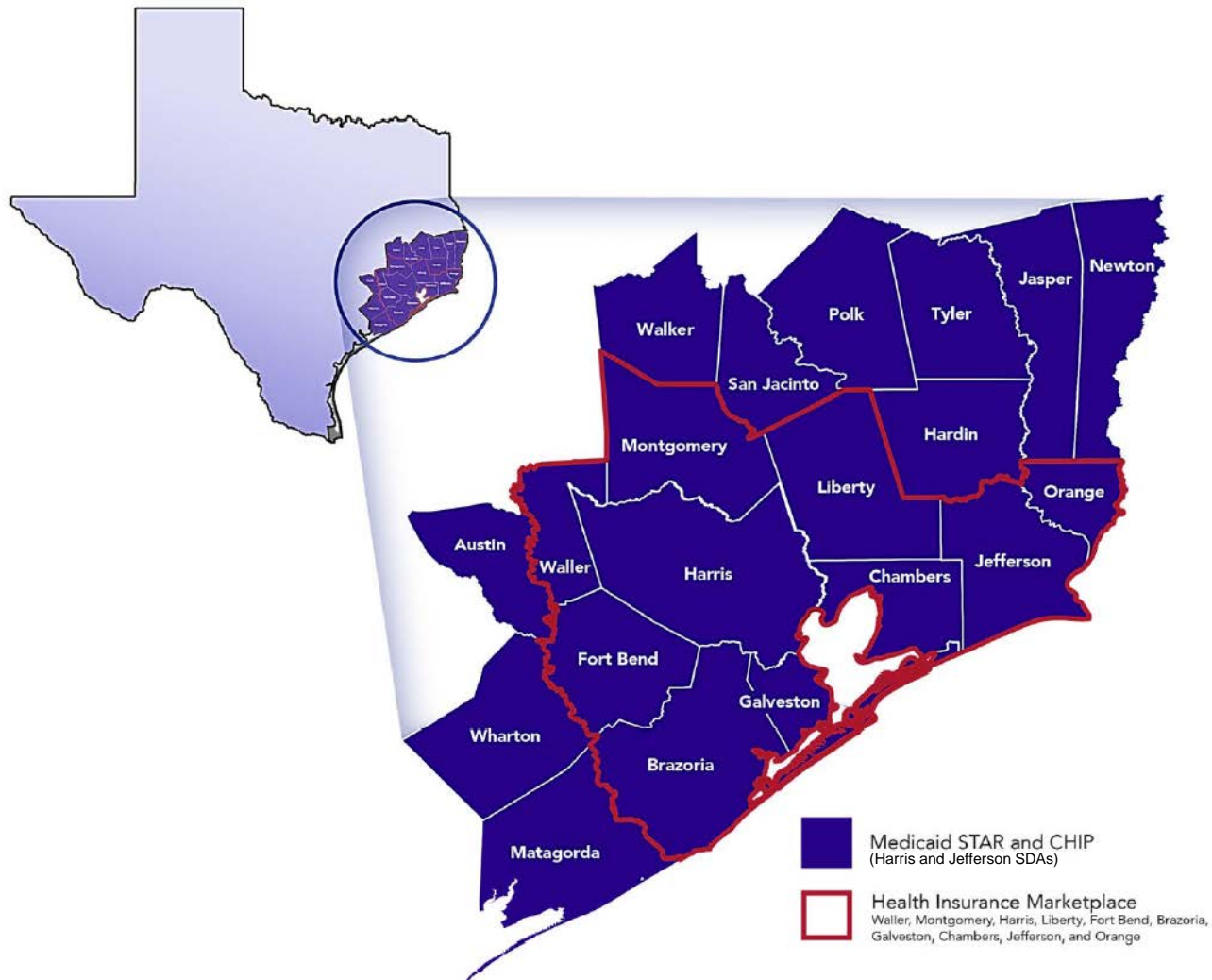


# About Community



- A Texas non-profit corporation (IRC 501(c)4), organized for the promotion of social welfare and community benefit
- Licensed and regulated by the Texas Department of Insurance as a Health Maintenance Organization (HMO)
- A Safety Net Health Plan as defined by the ACA, focused on serving low-income populations, exempt from ACA excise tax
- Affiliate of the Harris County Hospital District (Harris Health System).
- Community serves more than 425,000 Members:
  - Medicaid STAR and Children's Health Insurance Program (CHIP)
  - Health Insurance Marketplace Plans offered to individuals under the ACA
  - Regional HMO coverage for State of Texas employees (ERS)
  - Administrator for collaborative safety net projects including DSRIP & NAIP

# Service Area Map



# Medicaid Managed Care Success Story



- Over the last 20 years, Texas has become a national leader in the use of managed care to reform its Medicaid program...a huge success overall.
- The shift from fee-for-service (FFS) to managed care rooted in private sector incentives and free market innovation has:
  - Increased access, better care
  - Saved money and reduced financial risk (\$4 billion saved 2010-2015)
  - Increased accountability and reduced fraud, waste and abuse
  - Facilitated the state's focus on patient outcomes
  - Allowed greater innovation



# Medicaid Managed Care Success Story

Enrollee choices drive MCO competition (2-5 MCOs per service area, per program):

- Breadth of network
- Key providers
- Provider satisfaction
- Quality stars
- Member satisfaction/customer service
- Value added services



- ***Enrollees can and should vote with their feet, choose the plan that works best for them, HHSC need only set a floor.***
- ***MCO competition makes us all better.***

# Challenges and Opportunities

- 92% of Medicaid recipients are now in managed care
- New round of MCO contracts to be awarded for 2020
- The legislature, HHSC and MCOs must collaborate to resolve problems, evolve contractual oversight and continue success
- Opportunity to outline the key goals for the Medicaid program
- Texas has achieved many original goals: let's build on that success for 2020 and beyond



- ***Define what should be achieved rather than adding additional administrative and regulatory requirements...what, not how.***

# A Vision for Texas Medicaid 2020

## Overarching Goals



For Medicaid 2020 and beyond, we should implement updated milestones and success measures, enhancing transparency and accountability:

1. Improve access to care and service provided to Medicaid beneficiaries;
2. Improve the health of low income and vulnerable populations served by Medicaid; and
3. Control the costs of the Medicaid program at or below consumer inflations levels, as adjusted for population growth.

# Goal #1: Improve Access

## Improve access to care and service provided to Medicaid beneficiaries:

- Ensure all Medicaid recipients have geographic access to care at same levels as required by TDI for commercial insurance and/or the expectations for ERS and TRS health programs
- Ensure timely appointment availability, at same levels as required by TDI for commercial insurance and/or the expectations for ERS and TRS health programs
- Maintain Medicaid member satisfaction scores (CAHPS surveys) at same levels as that provided via ERS and TRS health programs, and above the 75<sup>th</sup> percentile of all state Medicaid programs
- Consistently measure and improve provider satisfaction
- Reduce member and provider appeals and complaints utilizing consistent standards



- ***Reduce administrative burden, duplication and inconsistencies.***
- ***Common standards and improvements in access, availability, provider directories and authorizations across all health insurance programs.***

# Goal #2:

## Improve Health Outcomes

Improve the health of low income and vulnerable populations served by Medicaid.

### For Pregnant Women:

- Increase the number of Prenatal and Postpartum Care visits
- Reduce the number of low birth-weight births
- Reduce maternal mortality
- Increase inter-conception care including post-partum depression



- ***Integration of the Healthy Texas Women Program with the STAR Program/MCOs.***

# Goal #2:

## Improve Health Outcomes

Improve the health of low income and vulnerable populations served by Medicaid

### For Children:

- Increase the number of children who have received all necessary vaccinations by their second birthday
- Improve well-child checkup rates
- Follow-up care after hospitalization



- ***Support for immunization measures.***
- ***A streamlined appeals/fair hearing process.***
- ***New processes for STAR Kids families with private insurance.***

# Goal #2:

## Improve Health Outcomes

Improve the health of low income and vulnerable populations served by Medicaid

For Adults:

- Increase the percentage of enrollees who had a diagnosis of hypertension and whose blood pressure was adequately controlled
- Increase the percentage of members who had a 7-day and 30-day follow-up visit after hospitalization for mental illness
- Reduce the number of diabetics with uncontrolled Hgb A1c
- Reduce rate of adults without cancer who receive high dosages of opioids for 90 consecutive days or longer
- Increase follow-up after ED visit for mental illness or alcohol and other drug dependence
- Reduce potentially preventable hospital complications and readmissions (PPCs and PPRs)



- ***Improve long-term care coordination: home and community services to hospital to nursing home.***
- ***Integration of mental and physical health services.***
- ***Look for opportunities to expand coverage for those paid by supplemental programs.***

# Goal #3: Controlling Costs

Control the costs of the Medicaid program at or below consumer inflations levels, as adjusted for population growth:

- Maintain per capita cost trends below rates of increase for CPI and/or ERS and TRS health plans
- Achieve 50% of payments to providers under value-based programs by 2023
- Maintain administrative expenses at less than the national average for Medicaid programs
- Increase overall funding for community support services and other services addressing the social influencers of health, the cost of which will be more than offset with health care cost savings
- Develop programs creating more opportunities for low-income Texans to move out of poverty – this will reduce the case load burden and therefore Medicaid expenditures



- ***Modernizing rate setting and financial evaluation processes.***





# Modernizing Rate Setting and Financial Evaluation Processes

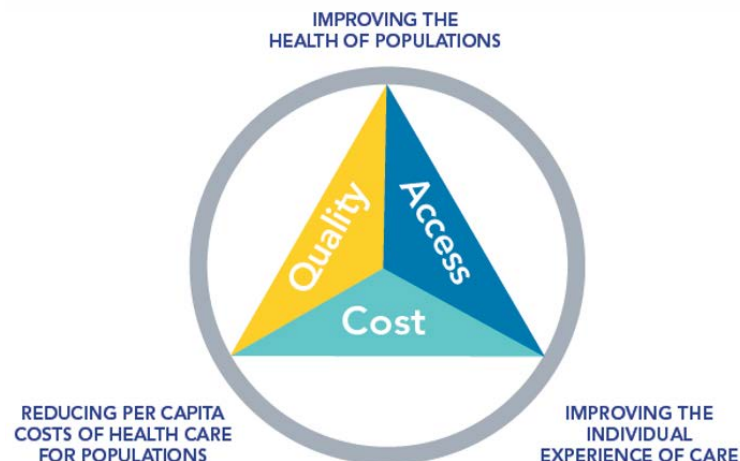
- Replace usual “cost containment” rider with specific long-term per capita cost targets (growth in MCO capitation rates)
- Increase transparency of state actuarial rate setting calculations and MCO financial results, medical and administrative expenses
- Modify the experience rebate methodology preserving 3% margin, reducing earnings potential above 10%
- Avoid carving out services or ability of MCOs to manage both unit costs and utilization (e.g., allow MCOs control of formulary as in all other health insurance segments)
- Provide incentives to MCOs for education and job training programs to reduce caseloads
- Better, smarter contract oversight by HHSC and OIG, including enhanced data analytics capabilities...replacing hundreds of administrative requirements with reports on achievement of goals



# Better, Smarter Oversight

Legislature, HHSC, TDI, MCOs and the provider community must collaborate to create a better, smarter Medicaid program for Texas

- Clearly communicated specific, measurable and relevant goals
- Efficient smart bureaucracy → HHSC tells MCOs what to achieve, not micro-managing specific tasks and how to do them
- Streamlined HHSC staff with different skillsets
- Working together to achieve the health care triple aim



## Contact Information:

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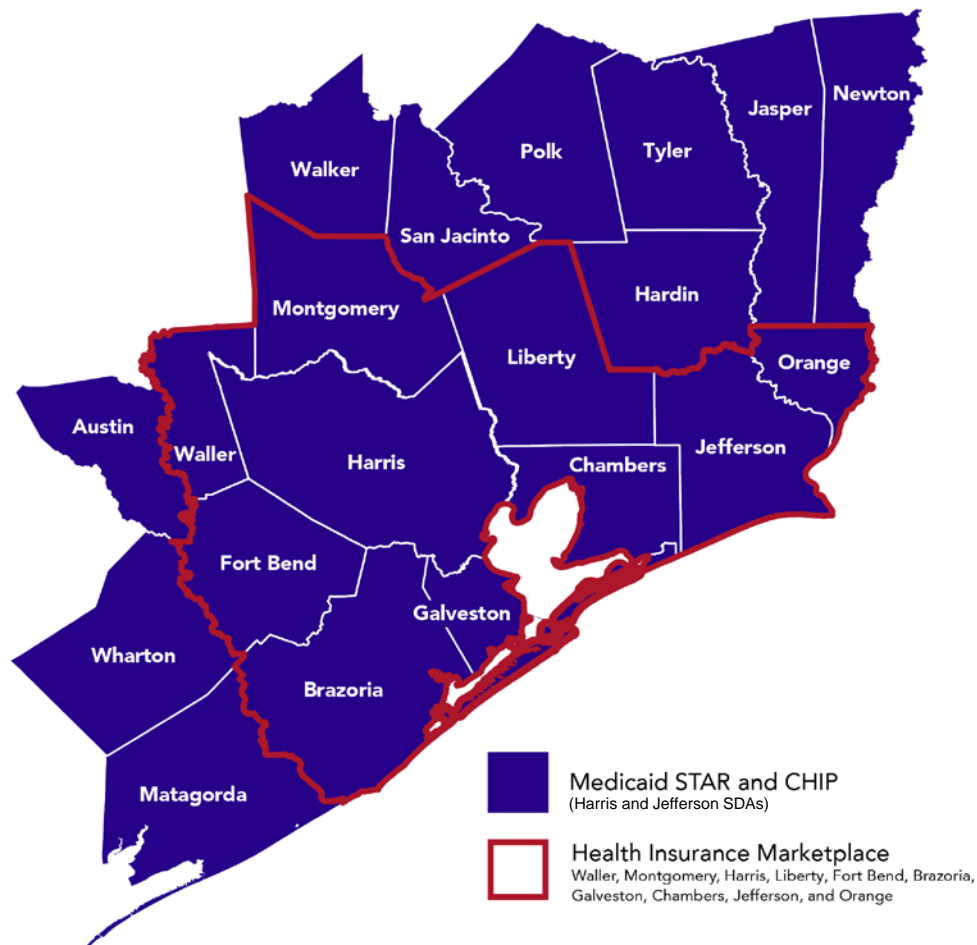
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# Appendix

# Network Adequacy Standards: Medicaid vs. Commercial

Provider Type	Maximum Distance in Miles				
	Medicaid			TDI - HMO (PPO)	
	Metro (county >200,000)	Micro (county 50,000-199,999)	Rural (county <49,999)	Non-Rural (county >49,999)	Rural (county <49,999)
Behavioral Health- Outpatient	30	30	75	75	75
Cardiovascular	20	35	60	75	75
ENT (otolaryngology)	30	60	75	75	75
General Surgeon	20	35	60	75	75
Hospital – Acute Care	30	30	30	30	30 (60)
Nursing Facility	75	75	75	75	75
OBGYN	30	60	75	75	75
Occupational, Physical, or Speech Therapy	30	60	60	75	75
Ophthalmologist	20	35	60	75	75
Orthopedist	20	35	60	75	75
Prenatal	10	20	30	75	75
Primary Care Provider	10	20	30	30	30 (60)
Psychiatrist	30	45	60	75	75
Urologist	30	45	60	75	75

# Network Adequacy Standards: Metro, Micro, Rural Counties



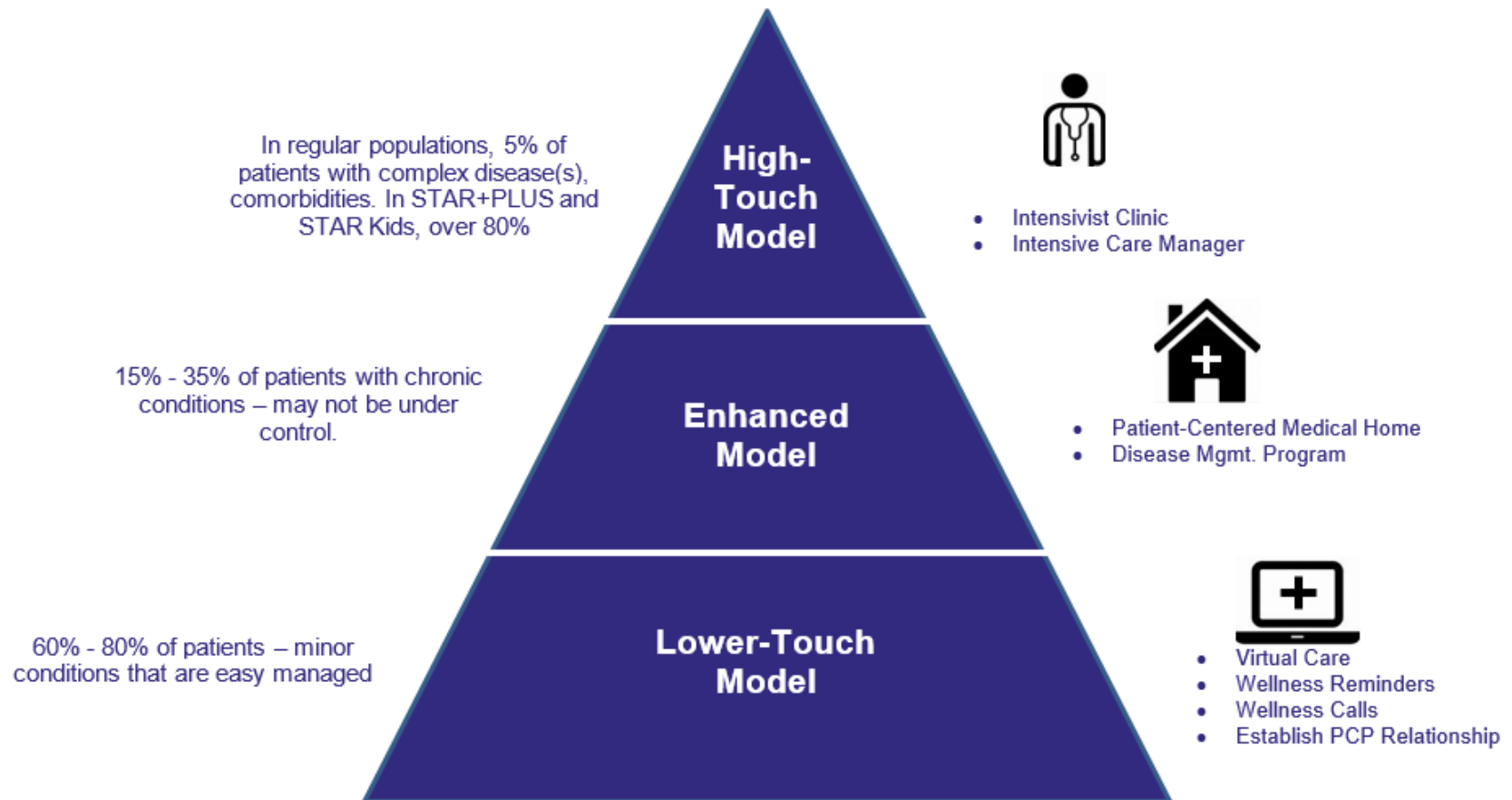
County	HHSC Designation
Brazoria	Metro
Fort Bend	Metro
Galveston	Metro
Harris	Metro
Jefferson	Metro
Montgomery	Metro
Orange	Metro
Chambers	Micro
Hardin	Micro
Liberty	Micro
Walker	Micro
Waller	Micro
Austin	Rural
Jasper	Rural
Matagorda	Rural
Newton	Rural
Polk	Rural
San Jacinto	Rural
Tyler	Rural
Wharton	Rural

# Appointment Availability

Level of Care	Medicaid Appointment Availability/Time to Treatment Requirements	
	Medicaid	TDI
Urgent Care	Within 24 hours	Within 24 hours
Routine Primary Care	Within 14 days	Within 3 weeks
Preventive Health Service for New Child Members	No later than 90 calendar days of enrollment (varies with periodicity schedules)	Within 2 months
Preventive Health Services for Adults	Within 90 days	Within 3 months
Initial Outpatient Behavioral Health Visits	Within 14 days	Within 2 weeks
Prenatal Care (not high-risk)	Within 14 days	Within 2 weeks
Prenatal Care (high-risk)	Within 5 days	-

# Population Health

In Population Health, Providers and Payers Segment by Risk Level, Health Need





# Report Card for STAR Children (Harris Service Area)

	Amerigroup	Community Health Choice	Molina Healthcare	Texas Children's Health Plan	United Healthcare
<b>Overall Health Plan Quality</b>	★	★★★★	★	★★★★	★★★★
<b>Experience with Doctors and the Health Plan</b>	★	★★	★	★★★★	★★
Children get appointments soon and emergency care right away	★	★★★★	★★★★	★★★★	★★★★
Doctors listen carefully, explain clearly and spend enough time with people	★★★★	★	★★★★	★★★★	★★★★
Parents give high ratings to their child's personal doctor	★★★★	★★	★★★★	★★★★	★★★★
Parents give high ratings to the health plan	★	★★★★	★	★★★★	★★★★
<b>Staying Healthy</b>	★★	★★★★★	★★	★★★★	★★★★
Babies get regular yearly checkups	★★★★	★★★★★	★★★★★	★★★★	★★★★★
Children and teens get regular checkups	★★	★★★★★	★★	★★★★	★★★★
Children and teens get their vaccines	★★★★	★★★★	★★	★★★★★	★★★★
<b>Controlling Chronic Diseases</b>	★★★★	★★★★★	★★	★★★★★	★★★★★
Children get medicine for asthma	★★★★	★★★★★	★★	★★★★★	★★★★★
Children see the doctor for ADHD (Attention Deficit Hyperactivity Disorder)	★★★★	★★★★★	★	★★★★	★★★★★

# MCO Financial Results

## SFY 2017



Plan	Average Membership	Premium Revenue (Millions \$)	Margin* (Millions \$)	Profit Margin*		MLR
				Before experience rebate	After experience rebate	
Superior	1,013,527	\$5,455.7	\$178.1	3.3%	3.2%	88%
Amerigroup	800,190	\$4,114.7	\$315.9	7.7%	6.1%	86%
United Health Care	279,878	\$2,871.3	-\$5.3	-0.2%	-0.2%	91%
Molina	219,977	\$1,793.9	\$13.9	0.8%	0.8%	89%
Texas Children's Health Plan	432,542	\$1,436.8	-\$33.2	-2.3%	-2.3%	94%
<b>Community Health Choice</b>	<b>279,809</b>	<b>\$910.2</b>	<b>\$13.7</b>	<b>1.5%</b>	<b>1.5%</b>	<b>90%</b>
Cigna-Health Spring	50,239	\$855.9	\$5.9	0.7%	0.7%	92%
Driscoll Children's Health Plan	167,232	\$652.7	\$50.1	7.7%	6.1%	85%
Parkland	196,129	\$539.6	-\$2.4	-0.4%	-0.4%	91%
Community First Health Plans	132,088	\$466.2	\$14.5	3.1%	3.1%	89%
Cook Children's Health Plan	133,327	\$466.0	-\$0.4	-0.1%	-0.1%	93%
Aetna	88,150	\$307.2	\$42.4	13.8%	7.2%	76%
First Care	98,084	\$296.5	\$3.7	1.2%	1.2%	86%
BCBS	38,540	\$216.1	-\$28.5	-13.2%	-13.2%	94%
El Paso First	77,526	\$194.7	\$11.7	6.0%	5.2%	85%
Children's Medical Center Health Plan	8,029	\$194.5	-\$44.4	-22.8%	-22.8%	114%
Scott & White	45,296	\$122.0	-\$0.3	-0.3%	-0.3%	88%
Seton	25,927	\$60.4	\$5.8	9.6%	6.7%	79%
Sendero	15,542	\$40.1	\$0.1	0.4%	0.4%	82%
Christus	5,957	\$19.2	-\$0.5	-2.8%	-2.8%	87%
<b>Totals</b>	<b>4,107,989</b>	<b>\$21,014</b>	<b>\$540.8</b>	<b>2.6%</b>	<b>2.25%</b>	<b>89%</b>

Community Health Choice	SFY 15	SFY 16	SFY 17	SFY 18 Q2
Margin*	\$13,325,027	\$15,823,411	\$13,685,332	\$(19,621,491)
Profit Margin*	1.8%	1.8%	1.5%	-4.3%

\* Before value added services and other excluded costs

# Illustrative Experience Rebate Modification



Current		Future Example	
If profit is:	HHSC Recovers	If profit is:	HHSC Recovers
0-3%	0%	0-3%	0%
3% < 5%	20%	3% < 5%	25%
5% < 7%	40%	5% < 7.5%	50%
7% < 9%	60%	7.5% < 10%	75%
9% < 12%	80%	10% or greater	100%
12% or greater	100%	-	-



June 27, 2018

TO: Members of the House Appropriations Subcommittee on Article II and House General Investigating & Ethics Committee

FROM: Ruchi Kaushik, MD, MPH, FAAP, Medical Director, Comprehensive Peds for Complex Needs, Children's Hospital of San Antonio, Assistant Professor, Pediatrics, Baylor College of Medicine

Re: Appropriations Interim Charge 18/General Investigating & Ethics Interim Charge 10: Monitor the agencies and programs under the Committees' jurisdiction and oversee the implementation of relevant legislation passed by the 85th Legislature.

Chairwoman Davis and members of the committees:

My name is Ruchi Kaushik, and I am the Medical Director for the Comprehensive Peds for Complex Needs clinic at the Children's Hospital of San Antonio. I am also an Assistant Professor of Pediatrics at Baylor College of Medicine. Thank you for the opportunity to testify and offer the following written testimony on the interim charges before the committees regarding Texas' Medicaid managed care program.

While hospitals and patients have benefitted in some ways from the transition to managed care from fee-for-service care, there are ongoing issues, particularly related to administrative burdens imposed by managed care plans. There seems to be an emphasis by some insurance companies on making a profit rather than ensuring patients receive the care they need and that is prescribed by their health care providers. In some instances, the Medicaid managed care organizations (MCOs) override the medical opinions of specialists who treat children with medical fragility in what seems to be an effort to save dollars. These policies by the MCOs that are charged with ensuring the most vulnerable Texans (including those in the foster care system) receive needed specialized care often result in harm to patients and increased health care costs in the long run.

**Denials for lack of patient progress:** In my experience with caring for medically fragile children, services are often denied because of what is perceived to be the patient's lack of progress. This is a determination made by the MCO and their staff who are not actually treating these children, and such determinations are contrary to the medical opinions of specialists and therapists who are intimately involved and treating the patient. These denials can result in the abrupt cessation of therapies altogether in a child who had been receiving twice-weekly therapy for several months. Such a drastic and medically inappropriate reduction in therapy results in developmental regression in the child, and in some cases, complications necessitating additional medical procedures to address the sequelae. Ultimately, the child suffers and the cost of providing care rises because the MCO, in an effort to save dollars, overrode the medical opinion of a specialist personally involved in the care of a child with medical complexity.

**Obstacles to obtaining durable medical equipment (DME):** Further, providers now face overwhelming burden in terms of the ever-increasing length of forms to obtain durable medical equipment. For example, to obtain feeding supplies, which are necessary for children who depend upon tube feedings to sustain life, MCOs require multiple forms that ask the exact same questions about calorie intake, in addition to the typical, necessary Title XIX forms required to request DME. There is no plausible explanation for such duplicative, administratively-burdensome requirements. To exacerbate the burden, there are also requests for letters of medical necessity to accompany these duplicative forms. Even after receiving multiple letters of medical necessity from specialists and treating physicians, MCOs may still deny authorization and prevent patients from receiving care, which is medically necessary in the expert opinion of the treating doctors. Practices similar to my own are not reimbursed for the administrative costs to complete this paperwork and do not have time or resources to complete these requests; some providers often give up, understandably, and the child suffers by not receiving the necessary services. Rather than completing redundant paperwork, we should be focusing on providing medical care for children with medical fragility.

Additionally, Superior Health Plan has imposed a restriction that prevents children in San Antonio who receive Superior Medicaid coverage from receiving physician-ordered DME prior to 48 hours before discharge. This results in a delay of receiving prescribed equipment and, hence, a delay in the opportunity to train families and caregivers on how to safely and appropriately use the equipment prior to discharge. MCOs are placing children with medical fragility in a potentially harmful environment by arbitrarily imposing such requirements. Though this 48 hour rule may exist in Medicare it is not included in Medicaid and conflicts with what is medically in the best interest of pediatric patients.

**Requirement for primary care physician (PCP) to write a prescription for a specialist:** In some cases where a PCP refers a child to a specialist to order DME including orthotics, MCOs require the PCP to write the prescription for the DME being prescribed by the specialist. Not only does this stipulation require a doctor to prescribe equipment for which he or she lack expertise, but it also results in delays in the patients getting the equipment they need and potentially having to make multiple office visits. Furthermore, prescriptions for DME are often initially denied and sent to an appeals process, which go back to the PCP who lacks the expertise to handle these appeals. Consequently, these prescriptions are often lost in the appeal and the process must start over causing further delay for the patient. It would make sense for the specialist, to whom the patient was referred by the PCP, to write these prescriptions and for the MCO to honor the specialist's request.

**Administrative burdens for peer-to-peer reviews:** Another example of administrative burden imposed by MCOs is that peer-to-peer offerings are most often communicated by facsimile. With the advent of electronic health records (EHRs) live fax machines are now rare and the letters often fall into some EHR void and are not seen until the requisite 8 or 16 business hours have expired. Then, if the MCO does call they almost always call after 4:50 pm to offer a peer-to-peer review. If a peer-to-peer is not performed (either because of time constraints or because the provider assumes she will never win), the MCO sends a letter to families that their service was


denied because their physician did not call. This misrepresents the fact that the process seems to be designed to be so administratively burdensome so as to make it impractical for the physician to reach the MCO to perform a peer-to-peer.

**Requests that are not congruent with medical pathology:** The MCOs have begun to request studies or procedures to approve therapies that are not aligned with the specific therapy requested. For example, hearing screens are often required for feeding therapy and swallow studies are often required for language therapy. As normal hearing is not necessary to teach a child to swallow and a safe swallow is not necessary to teach a child to communicate, this not only delays the initiation of medically necessary therapy but also results in the waste of health care dollars. Additionally, MCOs are also requiring that hearing screens be obtained every 6 months when speech therapy is being reauthorized. Waiting lists for audiology can often be 3 to 6 months long, and, moreover, unless some incident has occurred to result in hearing loss in a child, if the child has passed one hearing screen, it is unlikely the child will fail another one in 6 months. This requirement is contrary to the medical standard of care and creates an unnecessary obstacle for the patient.

**Inpatient to Outpatient transition before discharge:** One specific issue that managed care and care coordination can address is the challenging transition from inpatient to outpatient care. Gaps in this transition often result in readmission or poor health outcomes. MCOs have delayed access to much-needed outpatient services by not allowing the application of these services prior to discharge. For example, children who qualify for the Money Follows the Person program cannot apply until after discharge from inpatient status. This means that children who depend upon ventilators are sent home with one or two caregivers and no private duty nursing, requiring parents to remain awake for 24 hours of the day to care for their children due to this disconnect between inpatient and outpatient care.

**The standard set by for-profit MCOs affects nonprofit community MCOs:** When for-profit MCOs deny services for children with disabilities in an effort to save dollars, not-for-profit, community-based MCOs are held to a similar standard and often cannot remain in the marketplace. This is especially true for smaller provider-owned MCOs as we have seen many of these entities exit the market. This not only limits options for families, but also eliminates organizations that are often identifying and approving medically necessary services and are often involved in population health initiatives to improve the community's health outcomes.

**Potential Solutions:** The overwhelming burden placed on physicians trying to procure medically necessary services for patients with disabilities may be lessened with the standardization of approved services. Individual MCOs often arbitrarily write their own policies and then decide if services are approved or denied based on these policies. These policies are inconsistent across MCOs and do not always align with the state Medicaid program. Policies should be more standardized across the state and adhered to statewide so that children with disabilities across Texas receive equal and appropriate care. The Health and Human Services Commission (HHSC) should play a more active role in regulating MCOs than simply determining whether an MCO followed a policy it created for itself. Further compounding this problem is the leverage that MCOs have in the contract negotiation process, which often forces providers to acquiesce in order to avoid being kicked out-of-network and receiving unsustainably, low levels of



reimbursement for services that should be covered for Medicaid enrollees. Uniform policies at the state –level would help balance the negotiations. Additionally, requiring that out-of-network services that are covered by Medicaid be reimbursed at Medicaid rates would improve the contracting process and alleviate burdens on providers currently having to navigate inconsistent policies. This would not only address network inadequacy issues but would also ensure that medically complex children receive the care they need in the most appropriate setting. Finally, MCOs should not be allowed to impose requirements that go beyond state and federal law and that create unnecessary burdens on health care providers.



## **Top 11 Most Impactful STAR Kids Legislative Protections & Safeguards: Minimum Immediate Changes Required for the Medically Fragile Population**

GOAL: Empower families of medically fragile children to work with their existing care teams and choose which service delivery method best meets their child's needs. Ensure that medically fragile Texas children are able to access the care and resources necessary to remain in the community by ensuring access to the most appropriate care in the least restrictive environment without disruption to existing care teams, life-threatening delays or harmful changes.

- 1) **Allow families to select the delivery method most appropriate for their child's needs.** Reduce limitations on families' access to providers and services: Excise artificial regional geographic boundaries dividing the state into small county-based service areas. Allow families to select the delivery method most appropriate for their child's needs. Delivery method for medically fragile children should default to traditional fee-for-service (FFS). If families elect to opt-in to managed care, they should be able to choose from all 10 MCOs.
  - a. In as far as eliminating boundaries may be in violation of TDI network adequacy regulations, the MCO structure still must reflect that the highly specialized and urgent needs of fragile kids are obstructed by geographical limitations. SCAs are not guaranteed to provide access to specialists throughout the state and country, and obtaining these further delays access to care.
  - b. No restrictions (referrals, pre-auths, etc.) on access to specialty care. Families need immediate access to specialty care, and should not have to obtain referrals or pre-authorizations from a primary care physician who does not know how to treat their complex child.
- 2) **Implement a pilot program examining alternative delivery methods** (other than managed care) specifically designed for the medically fragile population (*see draft Amendment, SB1947*).
  - a. As part of this process, set up a high-level panel / blue ribbon commission appointed outside of HHSC with legislative authority. This panel should be comprised of knowledgeable parents, providers, advocates and HHSC representation with ability to provide guidance, oversight and direction in piloting, developing and implementing alternative delivery models more appropriate to a medically fragile population.
- 3) **Ensure transparency & clarity:** Develop and implement simplified, standardized, transparent processes and procedures across all 10 MCOs.
  - a. Without standardized processes and procedures for each MCO, children essentially face discrimination in coverage based on where they live and which plans are available to them.
  - b. The burden on providers in dealing with different procedures for each MCO is ultimately born by the children, as providers are much less likely to contract with plans and provide services if payment is not guaranteed.
  - c. Setting standards (such as minimum time periods for authorizations, etc.) will significantly reduce administrative complexity.
- 4) **Determination of Medical Necessity:** determination and standard of "medical necessity" should automatically default to patient's treating physician.



**5) Address MDCP Eligibility Denials:**

- a. Offer children who have lost eligibility for Medicaid due to their loss of MDCP eligibility, access to another 1915(c) waiver such as Community Living Assistance and Support Services (CLASS) or Home and Community-based Services (HCS). Not only have children lost eligibility for waiver services, some have lost access to their critical health care and long-term services and supports such as Personal Care Services. *Without these services children are at risk of unnecessary institutionalization in Intermediate Care Facilities and Nursing Facilities at a higher cost to the children, their families and Texas Medicaid.*
- b. Place the names of all the children who have lost MDCP eligibility on the HCS and CLASS waiting lists using the same date the children's names were originally added to the MDCP list.
- c. Retest those children who lost eligibility or place the names of children who have lost MDCP eligibility back at the top of the MDCP waiver waiting list. Many of the children waited up to five+ years to get into services and should not have to start over.
- d. Examine and compare the MN assessment tool being used to determine nursing facility eligibility for children in MDCP with the MN assessment being used to determine nursing facility eligibility for the approximately 60,000 children and adults in Texas nursing facilities adults in the STAR Plus waiver. Ensure that a higher level of MN as defined in the Texas Administrative Code (TAC) is not being required for admission to MDCP than is being required for the STAR Plus waiver or for children and adults being admitted to nursing facilities. If a more accurate assessment process is going to be used to determine MN for MDCP then, the same process should be applied to all individuals in nursing facilities and adults in the STAR Plus waiver. Using a different tool to determine MDCP eligibility from what is being used for individuals in nursing facilities and applying a more stringent review and eligibility requirement could be institutionally biased making community services harder to access than services in a nursing facility.
- e. Develop checklists, talking points and handouts for families and service coordinators about the MDCP evaluation process, and specifically what families can do to prepare for and expect during an appeal.

**6) Mandate MCO oversight & accountability measures,** including individual & consumer-based quality metrics and audits.

**7) Address Blatant Conflict of Interests** –Neutral, third-party coordinators/caseworkers should determine access & eligibility for services and oversee coordination of services. There is an inherent conflict of interests in having agents of the insurance company acting as the gatekeepers to determine eligibility and medical necessity for all services.

**8) Implement High-level regional review panel(s)** outside of HHSC comprised of knowledgeable parents, providers, advocates and HHSC representation with ability to override/mediate/weigh-in on MCO denials.

**9) Provision for continued access to medications** already prescribed for children even if not on the plan/PBM formulary. Plan/PBM formularies should reflect the Medicaid formulary, without requiring multiple onerous layers of prior authorization & certification that multiple medications have been trialed/failed within a certain period of time, etc.

- 10) **Make provision for primary private insurance to allow maximum usage:** remove in-network requirement for all providers without limitations or end date. Allow those with private commercial coverage to select fee-for-service delivery method. Allowing families the ability to utilize primary private insurance to the maximum extent provides the state with maximum savings. Under the current STAR Kids program, Medicaid coverage for those with primary private insurance is paramount to having two commercial plans irrespective of each other, as opposed to true secondary coverage.
- a. Expand the HIPP Program to increase cost savings to the state.
  - b. Address the issues that have developed with the HIPP Program since the transition to managed care.
- 11) **Reasonable provider protections**, including (but not limited to):
- a. Compel/oblige MCOs to contract with significant traditional providers for indefinite time period throughout the life of the MCO's contract with the State. (Currently, MCOs are only contractually obligated to attempt to contract with significant service providers for the first 3 yrs of contract.)
  - b. As part of network adequacy requirements, MCOs must contract with more than one provider offering specific credentials/capabilities/services, and cannot change or select a provider without express permission from the parents or legal guardian.
  - c. A protected complaints process.
  - d. Mandated threshold/floor at a minimum (no less than XX%) of Medicaid rates;  
*While we understand the concept of reasonable value-based purchasing, there must be a balance. If MCOs are to receive a capitated rate per head for delivery of specific services based on a set Medicaid rate, then it is fraudulent for them to then force providers into unreasonable contracts which cause significant delivery and access to care issues for patients, who are then unable to access those services which the MCO is being paid to deliver.*
  - e. Restore therapy rates.
- 12) **Incentivize physicians and other providers to treat medically complex children proactively** by providing and managing the level of care required to maintain medical baseline.

**TexPROTECTS**

*ADAPT OF TEXAS  
PERSONAL ATTENDANT COALITION OF TEXAS  
TESTIMONY  
HOUSE COMMITTEE ON APPROPRIATIONS  
SUBCOMMITTEE ON ARTICLE II  
WEDNESDAY, JUNE 27, 2018*



## **ADAPT OF TEXAS**

### **STARPLUS and Other Home and Community Based Service Reforms**

**Wednesday, June 27, 2018**

**Good morning! My name is Bob Kafka. I am an Organizer for ADAPT of Texas/Personal Attendant Coalition of Texas. We are a not for profit statewide disability rights organization advocating for the community integration of people with disabilities and older Texans including for their services and supports, access to community as well as accessible, affordable integrated housing. We also advocate for increased wages and benefits for Community Attendants.**

**The recent expose on Medicaid Managed Care highlighted in the 5 day Dallas Morning News brought to light some of the issues that the Legislature, HHSC and the Managed Care industry must address to improve the delivery system of acute and long term services and supports in Texas.**

**It is essential that the RIGHT SERVICES and SUPPORTS to the RIGHT PERSON in the RIGHT LOCATION be at the foundation of the delivery system.**

**ADAPT's advocacy in regard to managed care has been, from its beginning, to build an ACCOUNTABLE health care delivery system including community long term services and supports, that are built around INDEPENDENT LIVING PRINCIPLES. These services should be PERSON CENTERED, CONSUMER DRIVEN, built on the FUNCTIONAL NEEDS of the individual NOT by medical or outdated government labels based on age of onset of your disability.**

**We recognize the importance of the medical needs of the individuals in StarPlus however our medical needs do not totally define our lives. The services delivered in StarPlus are a means to an end. Not an end in of**

themselves. I have a Primary doctor, a Spinal Cord Injury doctor, a Urologist, a Gastrologist and a Wound doctor. I occasionally see a Physical Therapist and a Speech Therapist

Including all those I just mentioned, I see these medical professionals less than 20 times a year. My Community Attendant, on the other hand, I see 730 times a year. After hearing what I just said you actually know nothing about Bob Kafka, the person. I won't bore you with any details. You can wait for the movie!

My comments and written testimony today will cover 5 topics:

## **1. FUNDING FOR SERVICES**

Lack of sufficient Medicaid funding must be addressed by the Legislature as part of the problem with our delivery system. Yes we must have more efficiencies. Yes we must assure there is not undue corporate profits. Yes waste and fraud must be addressed.

However the old Midas Muffler commercial should be a guide.

*"YOU CAN PAY US NOW OR YOU CAN PAY US LATER!"*

Another adage: *"A Penny Wise and a Pound Foolish"*

All of our recommendations must be seen in the light of the need for adequate funding.

- 1. FUNDING FOR SERVICES**
- 2. ACCOUNTABILITY AND TRANSPARENCY**
- 3. INTEGRATION OF MEDICAID WAIVERS**
- 4. RECRUITMENT-RETENTION OF COMMUNITY ATTENDANTS**
- 5. CONSUMER DIRECTED SERVICES**

**2. ACCOUNTABILITY and TRANSPARENCY can be improved by:**

**Community Integration Performance Indicators (RIDER 51)**

**Increase and Enforce Network Adequacy Requirements (RIDER 218)**

**Increase Who Receives and # of in person Service Coordinator Visits**

**Regional Consumer Input System as well as State Advisory Cmtte**

**Review of Disparity in Provider Rates for Similar Services**

**Link lack of MCO compliance to penalties**

**3. INTEGRATION OF MEDICAID WAIVERS/STATE INSTITUTIONS**

**Integrate Texas Home Living into StarPlus**

**Delay Integration of Medically Fragile Children**

**Review # of people (brain injury, stroke, Alzheimer's) currently in**

**StarPlus who have needs similar to those receiving HCS or CLASS**

**Community First Choice eligible folks (on SSI) come off waiting list and integrated into StarPlus**

**Increase funding for the transition of people from Nursing Facilities and Private/Public ICF-DD to HCBS (Replacement of MFP Funding)**

**Consolidate State Supported Living Centers**

**4. RECRUITMENT AND RETENTION OF COMMUNITY ATTENDANTS**

**Track turnover rate and how it relates to secondary medical conditions**

**Improve wages, health benefits, sick leave and vacation**

**Monitor implementation of RIDER 218**

**Improve administrative costs to community agency providers**

**Implement innovative ways to R&R Community Attendants**

**Work with Texas Workforce Commission**

**Health Care Student Internship**

**Legal Immigrants as Community Attendants**

**HHSC should develop a Communication Strategy to promote  
recruiting Community Attendants**

## **5. CONSUMER DIRECTED SERVICES (RIDER 48)**

**Identify how CDS are presented and why CDS are not selected**

**Develop Back Up Services program (Possible Pilot)**

**Eliminate unnecessary bureaucracy/paperwork in getting services**

**Delay implementing EVV in CDS till January 2020**

**Increase funding for non Medicaid funded programs like Consumer  
Managed Person Attendant Services**

**Thank you for the opportunity to speak.**

**Bob Kafka, Organizer**

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**Written Testimony from Terry Anstee, Staff Attorney with Disability Rights Texas**

**General Investigating and Ethics and Appropriations, Subcommittee on Art. II  
General Investigating & Ethics Charge 10/Appropriations Charge 18**

**June 27, 2018**

**Introduction**

Thank you for the opportunity to provide testimony on the oversight of the Texas Health & Human Services Commission's management of Medicaid managed care contracts, particularly on issues related to the Medically Dependent Children Program and issues raised in the recent Dallas Morning News reporting on Medicaid managed care.

Disability Rights Texas is the congressionally-mandated protection and advocacy organization for Texans with disabilities. I am Terry Anstee, a staff attorney with Disability Rights Texas on the Community Integration/Healthcare team. I am also a registered nurse with 11 years of experience caring for adult and neonatal patients. For almost 6 years I have represented children and adults with disabilities in a variety of Medicaid cases, including administrative hearings to advocate for denied or reduced Medicaid services.

**The Medically Dependent Children Program and the STAR Kids Screening and Assessment Instrument**

In Texas the Texas Health and Human Services Commission (HHSC) operates a federally approved home and community-based waiver program for Texas children with disabilities called the Medically Dependent Children Program (MDCP). The purpose of MDCP is to provide supports to families and caregivers of children who desire to move from a nursing facility to the community or remain in the community. Services available through MDCP include respite, flexible family support services, minor home modifications, adaptive aids, transition assistance services, supported employment, and employment assistance. Many children also become eligible for Medicaid as a result of meeting medical necessity criteria for MDCP.

Before November 1, 2016, MDCP was primarily administered by the Department of Aging and Disability Services (DADS). Nurses with DADS would perform an annual MDCP assessment using the Medical Necessity and Level of Care Assessment (MN/LOC). Children in MDCP before November 1, 2016 received their Medicaid services through fee-for-service Medicaid (aka traditional Medicaid).

On November 1, 2016 MDCP moved into STAR Kids, a new Medicaid managed care program for children and adults age 20 and younger with disabilities. Individuals in MDCP had to move to managed care from fee-for-service Medicaid. The new annual assessment form is the

STAR Kids Screening and Assessment Instrument (SK-SAI). The process for eligibility for MDCP, in short, is as follows: the SK-SAI is filled in by a managed care organization (MCO) nurse; the completed SK-SAI is sent by the MCO to the Texas Medicaid & Healthcare Partnership (TMHP); and TMHP nurse reviewers and its medical directors use portions of the SK-SAI—primarily the NCAM (Nursing Care Assessment Module)—to determine eligibility for MDCP.

As more children were assessed in 2017 by MCOs with the new SK-SAI, we began to see a large spike in MDCP medical necessity denials. One of the issues we identified is that the assessment process used by MCOs results in errors and omissions in the SK-SAI. While the MCO assessor typically asks questions and gathers information from the beneficiary's parent or guardian, the assessor often completes the SK-SAI at a later time in a separate place. In other words, the parent or guardian is not directly involved in actually completing and reviewing the SK-SAI prior to its submission to TMHP, and therefore does not typically see the completed SK-SAI until eligibility is denied, and a Medicaid fair hearing is requested. To ensure that the information captured on the SK-SAI is both accurate and complete, we recommended to individuals at HHSC, the Governor's Committee on People with Disabilities, and the Legislative Budget Board as recently as April and May 2018 that the beneficiary and his or her parents or guardians should be involved in completing and reviewing the assessment instrument together with the MCOs *before* it is submitted to TMHP. On June 22, 2018 Stephanie Stephens and Michelle Irwin from HHSC spoke at the Texas Parent to Parent Conference and stated that parents will soon have the choice to review the SK-SAI before it is sent to TMHP. However, the solution that will be more effective and consistent in preventing errors and omissions in the SK-SAI is making it *mandatory* that the MCO review the SK-SAI with the parent before it is sent to TMHP.

### **MDCP and inadequate provider networks in managed care**

Another common issue we hear from parents of children in MDCP are difficulties finding doctors for their medically complex children within the MCO provider networks. As mentioned above, children in MDCP before November 1, 2016 received their Medicaid services in a fee-for-service model. That means that a child in fee-for-service Medicaid could see any Medicaid provider in Texas regardless of location. For example, since there was no constrictive provider network to contend with in the fee-for-service model, a medically complex child living in Dallas could see a specialist in Houston, and not have to worry about whether Medicaid would pay for the visit. However, in the managed care model, it is unlikely that the specialist the child from Dallas saw in Houston would be in the provider network, and that child's parents may have trouble finding an equivalent specialist in Dallas. It is not uncommon for children in MDCP to have rare genetic disorders or diseases, and it is not an easy task to find the right doctors for those children. In some cases parents of children in MDCP have spent years finding the right doctors for complex or difficult to treat disorders.

HHSC heard from many stakeholders about the issue of network adequacy before and after the November 1, 2016 rollout of STAR Kids. HHSC did extend the time children in MDCP could see out-of-network doctors, and MCOs did offer the opportunity for single-case agreements with out-of-network providers, but those were only short-term or tenuous solutions.

STAR Kids was legislatively mandated by Senate Bill 7 in 2013. STAR Kids was supposed to have rolled out in November 2015, but was delayed a year. In HHSC information sessions about STAR Kids in 2016 prior to roll out, Brian Dees, formally with HHSC, acknowledged that the STAR Kids MCOs were still trying to build up the provider networks just two to three months prior to roll out. Earlier this month the Dallas Morning News reported on the ongoing issues with provider network adequacy at Superior Healthplan. The point is that this issue has been going on for far too long.

On June 20, 2018 HHSC presented a PowerPoint on the issue at the House Human Services Committee meeting. One slide entitled 'Next Steps' has eight points, but, tellingly, none of the points from HHSC mention improving provider rates or dealing with MCO payment delays to providers. Tackling those two points would be a good start. Fair, competitive payment rates and timely payment for services provided could go a long way in incentivizing providers to contract with Medicaid MCOs.

Another approach to the issue of network adequacy is to give children the choice in MDCP to opt out of Medicaid managed care. There are a number of ways opting out of managed care might work. Texas could recreate an MDCP state-managed unit much like DADS, the agency that administered MDCP before STAR Kids. This agency would do everything that DADS did in the past pertaining to management of MDCP, like case management and the annual MDCP assessment, among other duties. Alternatively, Texas can avoid recreating an MDCP state-managed unit like DADS by allowing individuals in MDCP to transfer to the Home and Community-based Services (HCS) waiver, a Medicaid waiver that uses fee-for-service for acute care and HCS providers for waiver services.

### **Adverse determination letters from MCOs and HHSC to Medicaid recipients frequently do not comply with fundamental due process**

Due process at its most basic means fundamental fairness and justice. In the Medicaid context due process means advance notice and the right to a hearing before services are denied or reduced. Federal law requires a "fair hearing" before benefits may be denied, 42 C.F.R. § 1396a(a)(3), and prior to such a denial, written notice must be given setting forth "the reasons for the intended action," including "the specific regulations that support...the action." 42 C.F.R. § 431.210(b) and (c). In other words, a Medicaid recipient is supposed to be able to review a denial notice and understand why they are being denied. If a Medicaid recipient cannot do that then the denial notice is inadequate and cannot serve as a basis to deny or reduce Medicaid services.

Medicaid recipients frequently receive denial or reduction letters from MCOs or HHSC that do not comply with state and federal Medicaid law. Many denial letters cite to regulations with little specificity. For example, a letter denying or reducing private duty nursing services may cite to a section of the Texas Medicaid Provider Procedures Manual (TMPPM) that is 40 pages long. The lack of specificity impermissibly forces a Medicaid recipient to comb through pages and pages of regulations and attempt to guess what regulations the MCO or HHSC specifically used to justify their determination, and makes it virtually impossible to adequately prepare for a Medicaid fair hearing.

Further, many denial notices from MCOs or HHSC do not provide personalized factual explanation or reasoning for the denial or reduction of services. Simply stating something is “not medically necessary” without an individualized explanation is not enough. The lack of clear, personalized reasoning in the denial letter forces a Medicaid recipient to speculate what the specific, individualized reasons are for the MCO or HHSC action. This is another impediment to a Medicaid recipient determining the accuracy of Texas Medicaid’s determination, and preparing for a Medicaid fair hearing.

Moreover, the denial notice is the foundation of a Medicaid fair hearing, the administrative hearing a Medicaid recipient is entitled to after services are formally denied or reduced. A denial notice that complies with state and federal Medicaid assists the hearings officer in understanding what reasons and specific regulations are the focus of the fair hearing, and what to apply when reviewing the evidence presented at the hearing. Without the legal confines of an adequate denial notice, an MCO or other Medicaid agency is impermissibly free to use whatever denial reason or regulation they want at a Medicaid fair hearing, and no Medicaid recipient could ever be prepared to deal with such a scenario at a fair hearing. DRTx has made multiple complaints to HHSC, hearings officers, and Managed Care Compliance & Operations (formerly Health Plan Management (HPM)) on the issue of inadequate denial notices.

Specific to MDCP, the denial letter/form sent by HHSC Program Support Unit (PSU) to Medicaid recipients does not provide enough specificity in the cited regulations, or any reasoning as to why the recipient allegedly does not meet the criteria for medical necessity for MDCP. DRTx has complained to HHSC and hearings about the MDCP denial notices, and we have addressed the issue before and during Medicaid fair hearings. Many hearings officers have correctly postponed hearings and ordered HHSC PSU to revise and reissue the MDCP denial notices. However, a complete overhaul of the MDCP denial notices by HHSC is required so that the denial notices comply with state and federal Medicaid law. On June 22, 2018 Stephanie Stephens and Michelle Irwin from HHSC spoke at the Texas Parent to Parent Conference and stated that denial notices are being reworked, but there was no specificity as to what denial notices they were speaking about.

### **No choice of MCO for children in foster care in Texas**

Unlike other children in Medicaid in Texas, there is currently no choice of MCO for children in Texas Department of Family and Protective Services (DFPS) care. Prior to 2005 children in DFPS care received medical care in the Medicaid fee-for-service model. In 2005 HHSC moved Medicaid for children in DFPS care into a managed care model with STAR Health. Since at least 2008 Superior Healthplan has been the sole MCO contracted to provide Medicaid services in STAR Health for most children in DFPS care.

The absence of competition in STAR Health does not incentivize an MCO like Superior Healthplan to improve services to children in foster care in Texas. If two MCOs had the STAR Health contract, competition between the MCOs could potentially elevate the quality of services, especially if an MCO knew dissatisfaction could drive a member to another MCO in STAR Health.

**Superior Healthplan STAR Health requires prior authorizations for therapy evaluations, which prevents many children in foster care from even accessing the doorway to services**

Pursuant to HHSC's own Texas Medicaid Provider Procedures Manual: Physical Therapy, Occupational Therapy, and Speech Therapy Services Handbook (January 2018), Section 5.2.1, "Initial evaluations *do not* require prior authorization." (Emphasis added.) In contrast, Superior Healthplan STAR Health requires prior authorizations for initial evaluations for therapy for children in foster care. The extensive paperwork Superior Healthplan requires just for an evaluation for therapy services is not required of children not in the foster care system. This additional paperwork includes an evaluation order, Texas Health Steps Periodicity exam or office exam note, a specialist office exam note if applicable, and evidence of a developmental screen performed by the primary care physician within the last ninety days if the member is under 6 years of age and applicable.

These additional bureaucratic steps just to get an evaluation to see if therapy is recommended make it practically impossible for children in foster care to even get in the door for therapy. Even if a caregiver can accumulate all of the requirements and secure an order from the primary care physician for the requisite evaluations, Superior Healthplan often denies the request for a therapy evaluation because they do not believe it is medically necessary, despite the opinion of the child's treating physician. This systemic problem effectively precludes physical, occupational, and speech therapies from children who need it most. These therapy services are frequently required to ameliorate and stabilize other issues in a child's life, like history of trauma and foster care placement instability.

**Superior Healthplan staff will not speak directly with attorneys ad litem appointed by the court, in direct violation of Texas Family Code § 107.006.**

Attorneys ad litem for children in foster care are frequently unable to communicate directly with Superior Healthplan staff to address scheduling issues, service authorization issues, or availability of service providers in the community. Superior Healthplan staff consistently insist they can only talk to the medical consentor, a person entered into a system by DFPS. Superior Healthplan staff must be trained that the court appointed attorney ad litem for a child in foster care is entitled access to all the child's health records pursuant to Texas Family Code § 107.006.

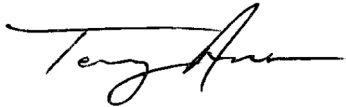
**Superior Healthplan STAR Health fails to provide adequate behavioral services and supports, resulting in disruption in placements and instability for children with disabilities in foster care**

Many children in foster care present with behavioral, attachment, and interpersonal problems due to experiencing complex trauma. To identify medically necessary behavioral health services, youth in foster care receive psychological evaluations conducted by Superior Healthplan's providers. These psychological evaluations often contain outdated screening tools that have questionable validity and generalized recommendations that provide little to no guidance on behavioral supports and services that are medically necessary to heal these children from trauma. The evaluations usually recommend individual therapy and psychiatric services. Consequently, the only behavioral health service that children in foster care frequently receive are

psychiatric services and a form of cognitive behavioral therapy that is not appropriate for traumatized children. We rarely see recommendations for more appropriate behavioral services and supports covered by Medicaid such as skills training and development for children and their caregivers, psychosocial rehabilitative services, crisis intervention, personal care services, and medication training and support services. Without necessary behavioral treatment, children in foster care frequently experience repeated disruption in placements or placement in residential treatment centers because children and their caregivers are not equipped to manage the challenging behaviors.

Thank you for the opportunity to provide written testimony. For more information, I can be contacted via phone (832-681-8214) or email ([tanstee@disabilityrightstx.org](mailto:tanstee@disabilityrightstx.org)).

Respectfully,

A handwritten signature in black ink, appearing to read "Terry Anstee", with a stylized, flowing script.

Terry Anstee  
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## Medicaid As It Should Be:

### Recommendations to the House Appropriations Article 2 Subcommittee and the House General Investigating and Ethics Committee

June 27, 2018

Medicaid should:

1. be a shared responsibility among the Health & Human Services Commission (HHSC), the Texas Legislature and the Managed Care Organizations (MCOs)
2. be responsive to changes in individual beneficiaries
3. have accountability
4. be sustainable and more humanitarian
5. have a plan to accomplish # 1-4

#### 1. Shared responsibility

Too often, the three main actors— the Legislature, HHSC, and the MCOs—seem to be arguing about who's responsible rather than accepting that outcomes accrue to all.

#### 2. Responding to changes individual beneficiaries

The conditions of people change and demand a response.

Recommendation: Strengthen the role of HHSC in ensuring quality of care. As Medicaid has transitioned from a fee-for-service model to managed care, structures have been installed for contract oversight and back-end utilization reviews. **HHSC needs to develop the space between those two, the surveying and ensuring that beneficiaries get the acute care and long term services and supports they need.**

Recommendation: The D'ashon Morris case exposed a flaw in the appeals process; it was too slow. **HHSC should install a flag system in cases of urgency that require appeals, including Fair Hearings, to be conducted in 48 hours.**

Recommendation: D'ashon's case revealed a second gap in the system. The majority of appeals are made when services are proposed to be cut. To protect the consumer during such procedures, the existing level of services is maintained. However, D'ashon's appeal was based on the amount of increase in services: he had 12 hours per day of nursing, his doctor requested 24 hours and the MCO approved 17 hours. During the appeals process, his services were kept at the existing 12 hours per day. **In cases where appeals are for an increase, the services should be increased to the full amount requested during the procedure.** Since such cases will likely fall under the flag system, there should be little time between appeal and resolution.

### 3. Accountability

Accountability is an HHSC role.

Recommendation: In addition to its role in ensuring quality of care as cited above, HHSC staff need to have the right skill sets to oversee complicated contracts. **Evaluate the capacity of HHSC contract management; identify and fund improvements.**

Recommendation: **Fines and liquidated damages must be consistent** and objective to be an accountability tool. **Fines, liquidated damages and shared MCO profits should be considered as program revenue and dedicated for improving program outcomes.**

### 4. Towards a sustainable Medicaid system

There is chronic underfunding in Medicaid and, particularly when it comes to people with more complex needs, Texas focuses on expensive, avoidable care rather than cost-effective up-front health maintenance.

Recommendation: **Address the lack of reliable community attendant care due to low wages.** People who need assistance with daily living and don't get it have adverse health results, leading to ER visits, unnecessary hospitalizations and institutionalization. **Promote consumer directed services,** proven to result in more reliable attendant care.

Recommendation: **Add a dental benefit for adults.** Currently, there are little or no dental services for adults in Medicaid, resulting in poor oral health, poor nutrition and complications including heart disease, diabetes and hypertension. Severe dental pain is among the most common reasons for ER visits by adults in Medicaid and is a source for opioid prescriptions.

Recommendation: **Increase provider rates for therapies to increase access.** Without needed therapies, kids fail to maximize or lose function, leading to less success in education and less chance of future participation in the workforce.



Recommendation: **Right-size the network of state supported living centers (SSLCs).** SSLCs are by far the most unsustainable cost center in Medicaid. With a 25-year decline in residents and skyrocketing costs, Texas no longer can support 13 SSLCs. Through closure and consolidation to a more affordable six SSLCs, the State can actually better guarantee an institutional placement for all who want it.

**5. Develop a real plan to accomplish #1-4**

Recommendation: Appoint an independent commission to make specific recommendations to the 2019 Legislature with strong stakeholder input.

Submitted by Dennis Borel, Executive Director, Coalition of Texans with Disabilities

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*CTD is a 501(c)3 nonprofit organization with Federal Tax ID #74-2071160. CTD is a social and economic impact organization benefitting Texans with all disabilities of all ages. CTD is a membership organization controlled by people with disabilities. Your contributions are tax deductible to the full extent of the law.*

# **Texas Association for Home Care and Hospice**

# APPROPRIATIONS ARTICLE TWO AND GENERAL INVESTIGATING AND ETHICS : IDD LTSS MANAGED CARE CARVE-IN

The Arc of Texas

Julie Ross, Board Member and Government Affairs  
Committee Chair

The Arc of Texas

06/27/2018





THE ARC OF TEXAS  
PROMOTES, PROTECTS  
AND ADVOCATES FOR  
THE HUMAN RIGHTS AND  
SELF-DETERMINATION OF  
TEXANS WITH  
INTELLECTUAL AND  
DEVELOPMENTAL  
DISABILITIES (IDD).

31 Local Chapters of The Arc of  
Texas Statewide.

Intellectual disability is a disability characterized by significant limitations both in intellectual functioning (reasoning, learning, problem solving) and in adaptive behavior, which covers a range of everyday social and practical skills. This disability originates before the age of 18.

Developmental disabilities are severe chronic disabilities that can be cognitive or physical or both. The disabilities appear before the age of 22 and are likely to be lifelong. Some developmental disabilities are largely physical issues, such as cerebral palsy or epilepsy. Some individuals may have a condition that includes a physical and intellectual disability, for example Down syndrome or fetal alcohol syndrome.



# TESTIMONY OVERVIEW: IDD LTSS CARVE-IN

- ▶ History of SB 07
- ▶ The Arc of Texas Opposition and Negotiations
- ▶ Implementation of SB 07 Safeguards
- ▶ Evaluation of Managed Care
- ▶ Recommendations

# SENATE BILL 07

Where did we start and where are we now?



- ▶ Became law on June 14<sup>th</sup>, 2013
- ▶ Sweeping changes to IDD services delivery system
- ▶ Changed how Texas manages and pays for services for people with IDD in TxHmL, HCS, CLASS, and DBMD
- ▶ Pleased to be “at the table” for SB 7 negotiations
- ▶ Established safeguards for people with IDD in the redesigned systems based on The Arc of Texas’ values and principles

## SENATE BILL 07

“Simply stated, we have yet to be convinced that the diverse needs of Texans with IDD are truly understood or accounted for in managed care as it exists in our state today. Any system redesign must remove any doubt we have about that.” – The Arc of Texas, 2013





## The Arc of Texas initially opposed Senate Bill 07 due to significant concerns around:

- ▶ Lack of adequate notice and information to individuals with IDD and their families about the transition to STAR+PLUS.
- ▶ Network Adequacy Issues: the current readiness review process; lack of an adequate number of medical professionals with expertise in the unique services needed by persons with developmental disabilities; and the lack of process to evaluate MCOs ability to adequately meet the needs of individuals with IDD.
- ▶ History of “Glitches” relating to STAR+PLUS carve-ins and the real fear that due to DADS computer system issues and other eligibility issues, individuals with I/DD will lose services.
- ▶ The IDD population has traditionally been left out of managed care. This population requires a specialized, targeted service array of community supports.

# THE ARC OF TEXAS OPPOSITION TO SENATE BILL 07

## The Arc of Texas initially opposed Senate Bill 07 due to significant concerns from our members around:

- ▶ Family members and individuals with disabilities did not know about the transition far enough in advance and/or still do not understand.
- ▶ People have been misinformed by MAXIMUS.
- ▶ Individuals have received letters in error (some more than once).
- ▶ Network Adequacy Issues: Individuals are having trouble keeping doctors they have a relationship with, and keeping or locating a specialist in their area.
- ▶ Concerns about medication changes.
- ▶ Concerns about private insurance and HIPP.

# THE ARC OF TEXAS OPPOSITION TO SENATE BILL 07

# SENATE BILL 07

Negotiated Safeguards and Protections?

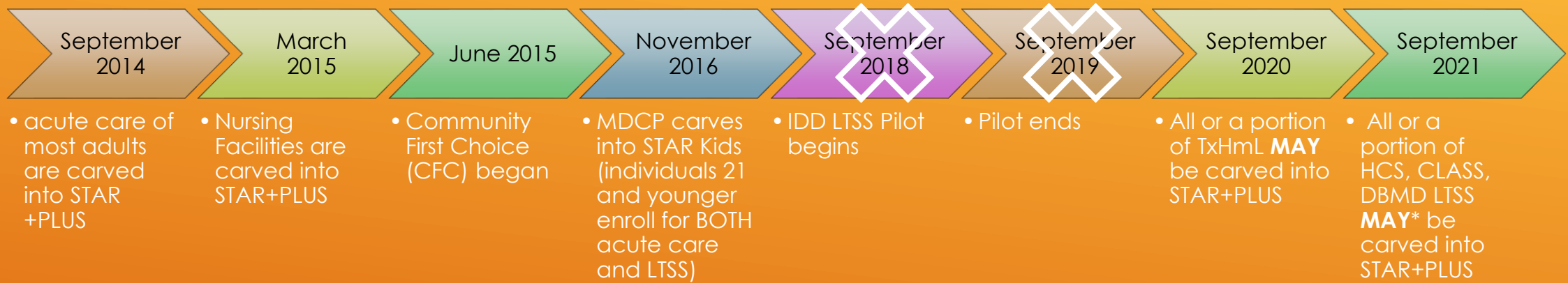


- ▶ Expanded timeframe (3 legislative sessions) for continued evaluation and improvements
- ▶ Definitions for key terms
- ▶ IDD System Redesign Advisory Committee
- ▶ Voluntary STAR+PLUS enrollment for DBMD, HCS, and CLASS waiver participants
- ▶ Waivers can stay in place to provide supplemental services STAR+PLUS doesn't offer
- ▶ New and continuous reporting

## THE ARC OF TEXAS SAFEGUARDS AND NEGOTIATIONS

- ▶ Independent functional needs assessments
- ▶ Contracts with traditional providers and others already in the strong LTSS network
- ▶ DADS can use an existing nationally recognized assessment tool to evaluate functional need
- ▶ Emphasis on values related to self-direction and community inclusion
- ▶ No premiums to get medical or LTSS

## THE ARC OF TEXAS SAFEGUARDS AND NEGOTIATIONS



## SENATE BILL 07

# SENATE BILL 07

Implementation of Safeguards



- ▶ Voluntary STAR+PLUS enrollment for DBMD, HCS, and CLASS waiver participants (protective provision or grandfather clause)
- ▶ Waivers can stay in place to provide supplemental services STAR+PLUS doesn't offer (continuation of 1915c waivers)
- ▶ New and continuous reporting

## HHSC IMPLEMENTATION OF SAFEGUARDS



- ▶ One of the most significant safeguards built into Senate Bill 07 through the negotiation process
- ▶ Allows individuals with IDD to continue services in their current waiver structure if IDD LTSS is carved into managed care
- ▶ HHSC is interpreting this language as discretionary
- ▶ The Arc of Texas cannot support any IDD LTSS carve-in that does not have a protective supervision as negotiated in Senate Bill 07

## HHSC IMPLEMENTATION OF SAFEGUARDS: PROTECTIVE PROVISION

- ▶ Unclear if HHSC intends to continue and/or maintain the 1915c waivers (especially with their new interpretation of the protective provision)
- ▶ A super majority of states who have a managed care system maintain their 1915c waiver structure
- ▶ It is critical that Texas maintain their 1915c waivers so we are not forced into a position where we have no other place to go if Medicaid managed care is not the right fit
- ▶ There are lessons to be learned from other states

## HHSC IMPLEMENTATION OF SAFEGUARDS: CONTINUATION OF 1915C WAIVERS

- ▶ The current fee-for-service system allows for robust reporting and data collection
- ▶ LBB reports concerns with HHSC's ability to validate service delivery
- ▶ Extremely difficult to receive data from HHSC about managed care services

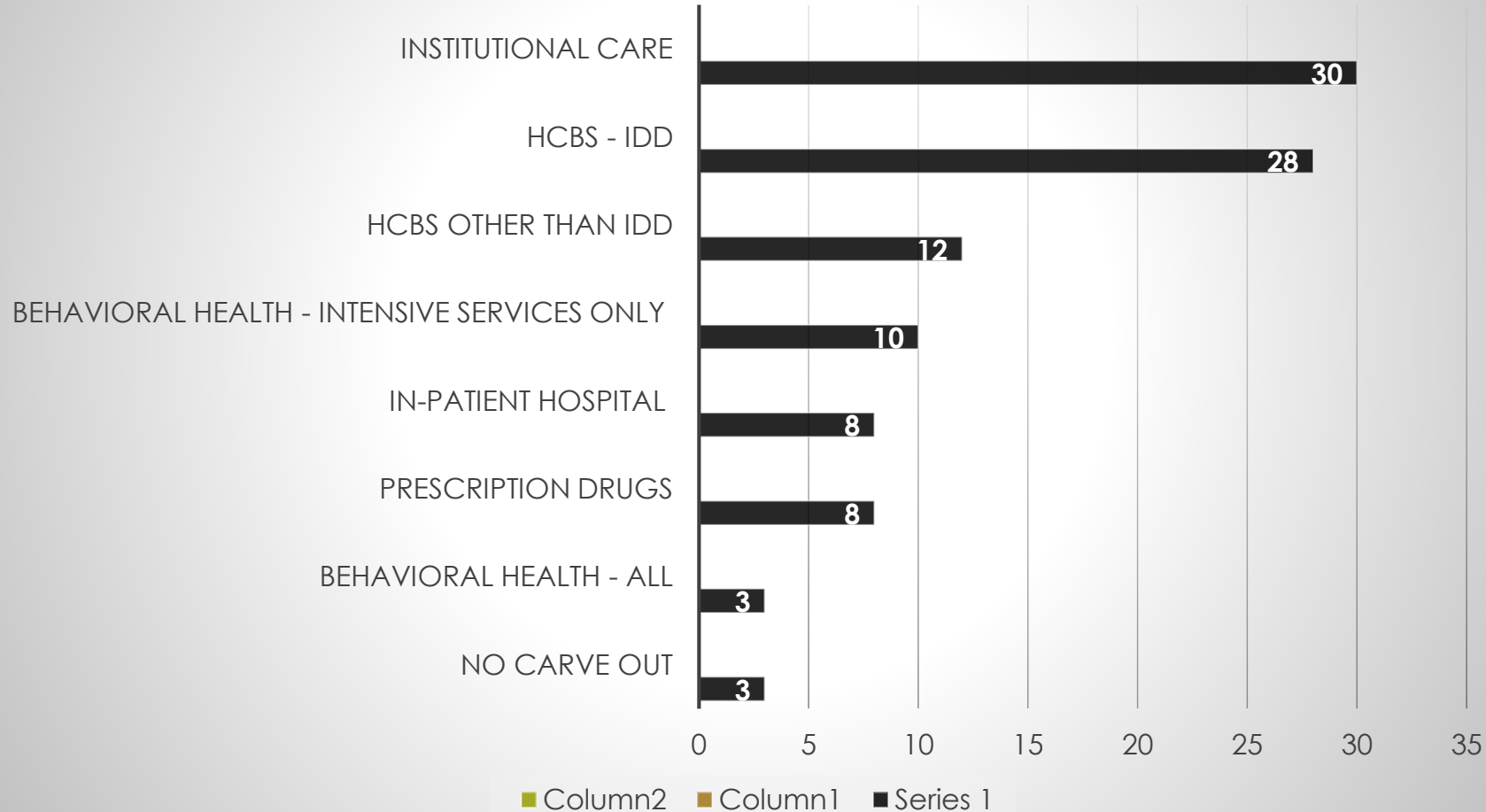
## HHSC IMPLEMENTATION OF SAFEGUARDS: NEW AND CONTINUOUS REPORTING

# TXHML CARVE-IN

Is Texas Ready?



## Benefits Carved Out of Managed Care Capitation Rates, 2017



\* There are 25 states that have 41 managed LTSS programs

\* Some states have pulled out of managed IDD LTSS

\* According to a report by CMS and Mathematica, only 5 states resemble the goals of SB 07; programs are still very different.

\* Significant majority of states do not carve in IDD LTSS.

# WHERE DOES THE COUNTRY STAND?

- ▶ HB 3295
- ▶ Managed Care Pilot Cancellation
- ▶ STAR+PLUS RFP
- ▶ Evaluation

## TXHML CARVE-IN

- ▶ HB 3295 extended the IDD Managed Care Pilot deadline to give Texas enough time to implement and evaluate the pilot. Additionally, it pushed the TxHmL carve-in to September 2020.
- ▶ There has been consistent recognition by the Legislature that Texas needs more time.
- ▶ HHSC made the decision to cancel the IDD Managed Care Pilot.
- ▶ HHSC identified many risks to moving people with IDD into the managed care pilot. One of those risks was time.

## TXHML CARVE-IN: HB 3295 AND IDD MANAGED CARE PILOT CANCELATION

- ▶ In reaction to HHSC's decision to cancel the IDD Managed Care Pilot, Jami Snyder (previous Medicaid Director) convened stakeholders to talk about evaluations and the STAR+PLUS RFP.
- ▶ Stakeholders pushed for a comprehensive evaluation outside of the STAR+PLUS RFP.
- ▶ The Arc of Texas expressed to HHSC that the STAR+PLUS RFP was an inappropriate place to evaluate whether or not MCOs were able to provide IDD LTSS.
  - ▶ RFP not designed for LTSS
  - ▶ Only a few questions
  - ▶ How will HHSC procure MCOs for LTSS if a portion or all of TxHmL is carved-in?

## TXHML CARVE-IN: STAR+PLUS RFP



- ▶ Thankfully, HHSC heard our concerns and have decided to move forward with an evaluation, as required by SB 07.
- ▶ HHSC has contracted with Deloitte and University of Texas Health Science Center at Houston, School of Public Health to conduct the evaluation.
- ▶ HHSC has indicated that the evaluation will, among other things, evaluate:
  - ▶ CFC
  - ▶ Previous carve-ins (STAR+PLUS, STAR KIDS, STAR)
  - ▶ Member satisfaction with managed care
  - ▶ State-by-state analysis of managed care
  - ▶ Cost effectiveness of managed care

## TXHML CARVE-IN: EVALUATION

- ▶ HHSC must gauge member satisfaction with managed care and interview individuals with IDD and family members who receive services through STAR+PLUS, STAR KIDS and CFC through managed care.
- ▶ Provide a comprehensive evaluation of IDD LTSS managed care in other states. A simple overview will not provide enough information to make educated decisions. It must evaluate the differing factors between states including rates, which states carve-in all IDD LTSS and not just a portion, and how those managed services are delivered.
- ▶ The Legislature directed HHSC to conduct a cost effectiveness review. HMA determined that managed care was not cost effective for Texas in 2010. How will this evaluation consider this report?
- ▶ Give the evaluators enough time.

## TXHML CARVE-IN: EVALUATION RECOMMENDATIONS

# RECOMMENDATIONS

- ▶ Give Texas more time to evaluate and make educated decisions around future carve-ins so Texans with IDD are not harmed. We must have a comprehensive conversation about how long Texas needs so we are not in this same position again for the 87<sup>th</sup> Legislative Session.
- ▶ Direct HHSC to go through another RFP process prior to any IDD LTSS Waiver services getting carved-in to determine if MCOs are able to provide IDD LTSS (the STAR+PLUS RFP is inadequate).
- ▶ Require HHSC to develop verifiable utilization data for every service delivered in managed care for Texans with IDD.

## RECOMMENDATIONS

- ▶ Direct HHSC to implement a prior authorization portal where MCOs have to upload prior authorization requests and their approval/denials. This portal should be accessible to both the member and HHSC. This will ensure prior authorization data is immediately accessible and accurate to HHSC.
- ▶ Direct the Managed Care Utilization and Review Department to specifically monitor and review service hours/units that have been requested, the amount approved and amount delivered/billed. They have expanded their staff and this would be a timely addition.
- ▶ Create a streamlined, easy-to-use and single access complaint system that tracks all managed care complaints with data available to the public. Track IDD and disability specific members and services.

## RECOMMENDATIONS

# QUESTIONS?

The Arc of Texas

Julie Ross

Kyle Piccola, Chief Government and Community  
Relations Officer

[Kpiccola@thearcoftexas.org](mailto:Kpiccola@thearcoftexas.org)

05.09.2018





THE MEADOWS MENTAL HEALTH POLICY INSTITUTE

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**House Committees on Appropriations, Subcommittee on Article II  
and General Investigating and Ethics**

**- Improving Managed Care for People with Mental Illness -**

Andy Keller, PhD | June 27, 2018

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# Meadows Mental Health Policy Institute

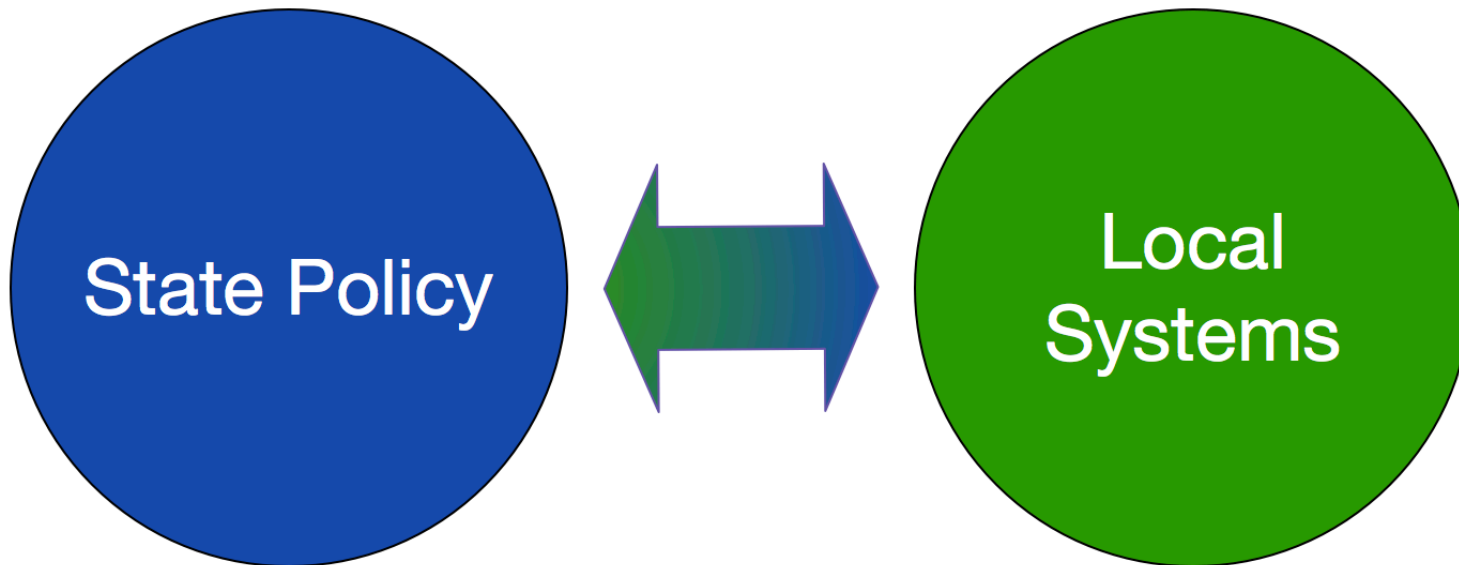
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## Vision

We envision Texas to be the national leader in treating people with mental health needs.

## Mission Statement

To provide independent, non-partisan, and trusted policy and program guidance that creates systemic changes so all Texans can obtain effective, efficient behavioral health care when and where they need it.





# 85(R) SB 1 - HHSC Rider 45a

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- Requires HHSC to *improve efforts to better serve* individuals with serious mental illness.
- Requires HHSC to *develop performance metrics to better hold managed care companies accountable* for care of enrollees with serious mental illness.
  - Metrics include industry standard performance measures for integrated care, chronic illness, inpatient and emergency department diversion, post-discharge linkage to care, and medication adherence.
- Report to the Legislative Budget Board and Governor is due no later than **November 1, 2018**.

# MMHPI Performance Measures Review

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In response to Rider 45a, MMHPI reviewed **performance measures** for individuals with serious mental illness (SMI).

- Reviewed the **STAR+PLUS Medicaid program** in Texas.
- Reviewed **leading states' Medicaid managed care programs**.
- Focused on data typically collected, particularly **Healthcare Effectiveness Data and Information Set (HEDIS) measures**.
  - HEDIS consists of **81 measures across five domains** of care and are used by more than **90 percent of America's health plans** to measure performance, including Texas.

Our recommended performance measures address ***both physical and behavioral health status***, given that most morbidity and costs involve co-morbid and preventable chronic diseases.

# Recommended Performance Measures

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MMHPI recommended ten performance measures for the SMI population in **STAR+PLUS**, based on national best practices.

- HHSC currently collects data for seven of the **ten** measures.

HHSC could monitor the remaining three performance measures if **Adult Needs and Strengths Assessment (ANSA)** data *are shared with MCOs*.

- The ANSA is an **assessment tool** used by local mental health authorities and other providers to **support decision making**, including **level of care and service planning**. The ANSA can also be used to facilitate **quality improvement initiatives** and allow for the **monitoring of outcomes**.

# Recommendation – Share ANSA Data

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## Share ANSA data with MCOs.

- Currently, a provider **completes the ANSA and enters data** into the state's Clinical Management for Behavioral Health Services (CMBHS) web-based system.
- CMBHS assigns a **level of care (LOC) recommendation**.
- The provider then **sends a service request** to the MCO that includes the **LOC recommendation**, based on the ANSA.
- However, the **results of the ANSA** are NOT shared with MCOs.

Today, the state only collects the ANSA information for **local mental health authorities (LMHAs)** and only reports back to LMHAs.

# 10 Recommended Measures

Performance Indicator	
1.	Number of members with SMI and ANSA determination of Level of Care (LOC) 4 that receive Assertive Community Treatment (ACT) services (ANSA)
2.	Percentage of members with SMI and ANSA determination of Level of Care 4 who receive a face-to-face ACT service within 48 hours of discharge (ANSA)
3.	Percentage of members with SMI in competitive employment or in school/GED program (ANSA)
4.	<b>Metabolic Screening:</b> Percentage of members with SMI screened in previous 12 months; Metabolic screening includes BMI, <b>blood pressure (BP)</b> , HDL cholesterol, triglycerides, and HbA1c or FBG
5.	<b>Follow-Up After Hospitalization for Mental Illness (FUH) – at 7 and 30 days</b>
6.	<b>Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)</b>
7.	<b>Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)</b>
8.	<b>Follow-Up After Emergency Department Visit for Mental Illness (FUM)</b>
9.	<b>Adherence to Medications:</b> Antipsychotic Medications for Individuals with Schizophrenia (SAA), Mood stabilizer Medications for Individuals with Bi-polar Disorders, <b>and Antidepressants for Individuals with Depressive Disorders</b>
10.	<b>Cardiovascular Monitoring for People With Cardiovascular Disease &amp; Schizophrenia (SMC)</b>

# Recommendation – Add Value-Based Contracts

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## Add value-based purchasing requirements for members with SMI.

- Current contract language requires MCOs to use **value-based payments** for at least 25% of their purchases, of which at least 10% must share financial risk and rewards with providers.
- MMHPI has *not been able to identify* any current value-based purchasing approaches in use by MCOs **for members with SMI.**

HHSC should designate a percentage of value-based purchasing for providers delivering care to the SMI population.

# Recommendation – Add to Pay for Quality

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## Add SMI measures to the Pay for Quality (P4Q) program.

- HHSC utilizes a Pay for Quality program that creates *incentives* and *disincentives* for MCOs based on performance.
- MCOs that excel at meeting the at-risk measures and bonus measures may be **eligible for additional funds**, while MCOs that do not meet their at-risk measures can **lose up to three percent (3%)** of their capitation rate.
- Currently, only one at-risk measure focuses on **SMI** and no bonus measures focus on **SMI**.

HHSC should expand the number of measures relating to SMI.

# **Recommendation – Enforce Network Adequacy**

- Throughout Texas (and nationally), there is a **shortage of psychiatrists** (especially for children and in rural areas).
- HHSC's monitoring strategies for *provider network adequacy* are consistent with CMS rules and other states' approaches.
- To ensure that members have timely access to care, HHSC should continue implementation and increase enforcement of:
  - 84(R) SB 760 network adequacy standards; and
  - New CMS Medicaid managed care rules.

Contract standards without enforcement are meaningless, and MCOs will have to pay more in some cases. Therefore, rate-setting must incorporate these higher rates by amounts that may exceed the fee-for-service schedule.



# Recommendation – Leave FFS Behind

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The state must move away from FFS requirements for MCOs.

- Fee-for-service (FFS) utilization management requirements (such as those specified in the Texas Resilience and Recovery Utilization Management Guidelines) *make no sense in managed care and are often barriers to care.*
- These guidelines were created under FFS for LMHAs and are *outdated and inconsistent with person-centered practices.*

Provide financial incentives for MCOs to support Health Homes and integrated service coordination for members with SMI (including use of value-based purchasing).

Allow provider rates to follow the market, not the old FFS schedule.

# Addressing Gaps in Pediatric Networks

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75% of children with mental health issues who receive care, receive it in a primary care setting (family doctor, pediatrician).

- With the right early support, *most would not need a specialist.*
- In addition to routine care for most (including victims), it is **key to early identification, referral, & coordination** for higher risks.
- Over a decade of research demonstrates that primary care providers can treat behavioral health issues as they would any other health issue – **treating mild and moderate cases** and **detecting the more complex or severe cases** for specialists.

## Current Barriers

- limited time during each visit
- minimal training and a lack of confidence in knowledge of behavioral health disorders
- limited capacity to link cases to needed specialists and behavioral health consultation

# Leveraging Primary Care: Child Psychiatry Access Programs (CPAP)

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- Nearly 30 states have implemented CPAP programs.
- The Massachusetts Child Psychiatry Access Program, established in 2004, is the longest-running program.

A statewide system of regional children's behavioral health consultation and referral hubs.

Each hub is located at an academic medical center.

Each hub can build over a few years to support the primary care needs of 900,000 children and youth.

Once fully operating, the cost is \$2 a year per child.

# Recommendation – Expand CPAP

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Expand the Child Psychiatry Access Program (CPAP) across the entire state using Texas medical schools.

- In response to Hurricane Harvey, local philanthropy developed a CPAP model in Harris County and the region through Baylor College of Medicine, UTHealth Houston, Texas Children's Hospital, and Harris Health.
- Dallas Children's Medical Center, in partnership with UTSW, has a DSRIP-funded project.

Expanding CPAP will expand access to needed behavioral health services, improve detection, and increase early intervention.

Maximizing use of primary care capacity is essential to solving our behavioral health workforce shortages.

TEXAS STATE  
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THE MEADOWS MENTAL HEALTH POLICY INSTITUTE

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*The truth is: mental illness affects more people than you may think, and we need to talk about it. It's Okay to say..."* [okaytosay.org](http://okaytosay.org)

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Invited Testimony of M. Ray Perryman before the  
Texas House Committee on General Investigations and Ethics and the  
Appropriations Subcommittee on Article II  
Regarding Medicaid Managed Care Contracts

June 27, 2018

Madam Chair and Distinguished Members:

My name is M. Ray Perryman. I am President of The Perryman Group, an economic research and analysis firm based in Waco. I hold a BS degree in Mathematics from Baylor University and a PhD in Economics from Rice University. I have more than 40 years of professional experience and have built and continue to maintain an extensive set of models for the Texas economy. I am extremely involved in a wide variety of public policy issues, and have worked on numerous economic development initiatives throughout the world. I have frequently testified before the Texas Legislature on a wide range of issues related to the Texas economy, including Medicaid and other health-related matters. I greatly appreciate the opportunity to provide this testimony and hope that it will be useful to your deliberations.

***Synopsis of Testimony***

Many of the more than four million individuals who rely on Medicaid to pay for their health care needs are among the most vulnerable in our society such as indigent children, expectant mothers, and individuals who are disabled or chronically ill. It is crucial that the Managed Care Organizations (MCOs) serving Texas Medicaid patients function in an environment that both protects the affected recipients and makes use of public resources in a prudent and responsible manner. It is also important that MCOs have sufficient resources to adequately meet the needs of the people they serve.

My review of the situation indicates that the MCOs serving Texas Medicaid patients face a difficult environment which compromises the ability to align incentives to encourage desired outcomes for patients, the system of healthcare provision, and society as a whole.

Insurers in Texas face, relative to other states, sicker populations with less benefit from wellness initiatives, greater risk with no downside protection, lower opportunities for profit, and more uncertainty regarding the status and timing of payments. This pattern, taken as a whole, largely undermines the basic incentive structure on which the capitated model functions and achieves positive results in a competitive market.

Adequate funding, reasonable capitation rates, and balanced oversight are essential to improving outcomes.

### ***Background and Experience***

I have studied many aspects of health and wellness and insurance, including indigent health care, Medicaid and Children's Health Insurance Program (CHIP) funding, benefits of health insurance coverage for State employees, and scope of practice. I have performed economic analysis of issues related to obesity, diabetes, cancer, and mental health, as well as public policy studies related to numerous health issue. In particular, I performed several large-scale studies related to the proposed expansion of Medicaid in Texas following the enactment of the Affordable Care Act, including multiple potential structures and the effects by county and region. I also performed comprehensive analyses of the effects of hunger and child maltreatment in the US, both of which involve substantial health care components. I have testified before the Texas Legislature on health policy issues on multiple occasions.

I have also conducted a variety of studies of economic and fiscal effects of major hospital systems such as Parkland Memorial Hospital, University Health System, Texas Medical Center, Menninger Clinic, Baylor Scott & White, and Methodist Hospital. Assessments have also been performed for medical schools including UT Southwestern, The University of Texas Medical Branch, M.D. Anderson, the University of Kansas Medical School, The University of Texas Health Science Center at San Antonio, Baylor College of Medicine, Texas Tech University Health Sciences Center, The University of Texas Dell Medical School, the Temple Medical and Educational District, and multiple institutions and initiatives within Texas A&M University's Research Valley Biocorridor. I have also analyzed numerous emerging technologies in the health care arena, including wound care treatment advances, genomic medicine, nanomedicine, and vaccine incubation.

I have also served on the board of directors of a large health insurance company (though not one of the top five Medicaid providers in Texas) since 1990 and previously served briefly on the board of an insurer specializing in government programs.

I have fully examined the interplay of the economy, healthcare, and issues related to insufficient insurance coverage on many occasions. I am pleased to offer this perspective on Medicaid and managed care in Texas.

At the outset, I should point out that (1) the testimony that I am offering reflects my own views and not those of any organization with which I am affiliated and (2) my expertise and ability to potentially assist these Committees lies in the area of economics rather than the nuts and bolts of contract administration. Thus, I will focus my comments on the economic framework surrounding Medicaid managed care and the resulting implications for legislative and regulatory action.

### ***Overview of Incentives***

The fundamental economic principle of relevance to this process is that of incentives and their role in determining outcomes. The effects of incentives on decisions and behavior, whether by individuals or groups, have been well understood for millennia, dating back at least to ancient Greece. In the current context, it is essential to examine the incentives MCOs are facing in order to understand and potentially improve their behavior and outcomes. Proper incentives can encourage behaviors which both benefit Medicaid patients and encourage efficient resource allocation. Similarly, inappropriate incentives can foster actions which harm patients, the system of healthcare provision, and society as a whole. Such harmful patterns also have negative economic and fiscal implications.

MCOs serving Texas Medicaid patients work with a managed care or “capitation” reimbursement structure rather than the traditional “fee for service” model. Both can be subject to positive and negative influences and evidence indicates that either system can be effective or ineffective<sup>1</sup>. The incentives confronting the MCOs are one of the key deciding factors in ultimate outcomes.

With a capitation system, MCOs are paid a pre-determined amount to manage the health of a group of recipients. Thus, they are incentivized to increase their profits through at least three primary beneficial channels: (1) innovation to improve the overall health of the relevant population, (2) enhanced efficiency in health care delivery and administration, and (3) greater emphasis on overall wellness. All of these strategies can bring positive results ranging from better health and wellness to lower costs for taxpayers. On the other hand, MCOs are also

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<sup>1</sup> “Managed Care’s Effect on Outcomes.” *Medicaid and CHIP Payment and Access Commission*, n.d., accessed 22 June 2018, <https://www.macpac.gov/subtopic/managed-cares-effect-on-outcomes/>.



incentivized to provide less service than needed in order to control short-term costs,<sup>2</sup> which can clearly cause problems such as adverse patient outcomes or situations such as those recently described in a series of high-profile articles in the *Dallas Morning News*. (Note that I recognize that some of the information in this series is being disputed and that I have not investigated their veracity in any way. I am not expressing any opinions on the accuracy of the reports.)

It should be noted that adverse incentives are quite common and certainly not unique to capitation programs. For example, the “fee for service” model can at times encourage the provision of excessive or unnecessary services as a mechanism to increase revenues and profits. Nonetheless, a structure can be created to minimize these risks and improve outcomes. This process must also be informed by the fact that Texas health care functions within a national market in which many large insurers (and the capital sources for smaller ones) evaluate opportunities within the state relative to those in other parts of the country. With this framework as a backdrop, the situation confronting Texas MCOs is briefly explored.

### ***Texas MCOs***

The MCOs serving Texas Medicaid patients face a **difficult environment** in many respects which compromises the ability to properly align incentives. Profitability is low, and recent Legislative actions such as reducing the **risk margin** have increased pressure on MCOs. The risk margin is an amount that provides protection against unexpected cost increases, which can occur as a result of factors such as unexpected costs increases (zika or flu outbreaks or natural disasters with health consequences are examples of pertinent recent concerns, as is the introduction of new and expensive drugs or treatment options). Increases in required benefits that are imposed without associated funding being provided, which at times occur due to governmental mandates, also pose potential risks. Moreover, at times, higher reimbursements rates are required in order to maintain appropriate access to providers for the covered populations. The lower risk margins are further exacerbated by the fact that Texas, unlike most other states, provides no downside risk protection to counter these effects. The result is a situation in which basic actuarial principles would require additional reserves, thus discouraging investments that might achieve better outcomes and lower costs over time.

A similar issue arises from the fact that Texas has to date chosen not to expand Medicaid coverage under the Affordable Care Act. As a result, the individuals covered by Medicaid in the state are **among the most vulnerable** such as children, chronically ill persons, the disabled, the elderly, and expectant mothers. This population has the potential to involve unexpectedly high

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<sup>2</sup> “Managed Care’s Effect on Outcomes.” *Medicaid and CHIP Payment and Access Commission*, n.d., accessed 22 June 2018, <https://www.macpac.gov/subtopic/managed-cares-effect-on-outcomes/>.

healthcare costs. A report by Billy Hamilton Consulting concluded during the expansion decision period that “federal funding for the adult expansion far exceeds current local expenses for unreimbursed health care costs.”<sup>3</sup> Analysis by our firm also demonstrated that the State would profit from the expansion as a result of both the high level of federal offset and the benefits derived from avoiding excessive emergency room visits, greater preventive care, and higher levels of worker productivity.<sup>4</sup> While I recognize that this issue is not explicitly before the Committee at this time, one consequence of this decision is that a very large portion of the Medicaid population has or is vulnerable to severe health issues, thus reducing the opportunity to provide contracts for diverse groups of patients with varying needs over which actuarial risks can be spread. Moreover, one of the primary methods of increasing profits used by MCOs in other settings, encouraging wellness in order to reduce costs, is less effective in that the covered populations are beyond the point for significant benefit from such investments. As a result, the efficacy of the normal incentive structure is again compromised.

Texas also has the most **stringent profit sharing** requirements for Medicaid contractors in the United States. Current requirements mandate that MCOs must begin sharing profits with the State on a graduated basis beginning after the first 3% of income as a percentage of revenue generated. This formula suppresses profit potential, which further reduces the incentive to innovate. In addition, many large publicly-traded providers, which must make allocations of resources across multiple states, will find greater opportunities for profitability in other areas, thus further eroding the incentives that should drive the system toward better care and greater efficiency. It is certainly appropriate to have a mechanism in which some of the benefits from greater efficiency flow to the State and its taxpayers, but it must be designed in a manner that is cognizant of external market conditions.

The situation has been further exacerbated by the fact that payments to Texas MCOs have been deferred into future budget years as part of the biennial accounting chicanery that typically characterizes the State budget. Such **payment deferrals** modestly reduce the present value of payments and introduce another element of risk from the perspective of the companies involved. While there is certainly a strong expectation that the obligations will be met, companies are influenced by the relatively recent situation regarding the federal risk corridor transition payments associated with Affordable Care Act, most of which have not yet been (and may never be) paid. The result is an increased concern among companies and institutional investors regarding payment deferrals from governmental entities.

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<sup>3</sup> “Expanding Medicaid in Texas: Smart, Affordable, and Fair.” *Billy Hamilton Consulting*. January 2013, [http://www.mhm.org/images/stories/advocacy\\_and\\_public\\_policy/Smart%20Affordable%20and%20Fair\\_FNL\\_FUL.pdf](http://www.mhm.org/images/stories/advocacy_and_public_policy/Smart%20Affordable%20and%20Fair_FNL_FUL.pdf).

<sup>4</sup> “Only One Rational Choice: Texas Should Participate in Medicaid Expansion Under the Affordable Care Act.” *The Perryman Group*. October 2012.

**The end result of this combination of factors is that insurers in Texas face, relative to other states, sicker populations with less benefit from wellness initiatives, greater risk with no downside protection, lower opportunities for profit, and more uncertainty regarding the status and timing of payments. This pattern, taken as a whole, largely undermines the basic incentive structure on which the capitated model functions and achieves positive results in a competitive market.**

### ***Economic Returns on Medicaid Resources: A Brief Digression***

While the primary purpose of any insurance program is human health and wellness for the relevant population, providing adequate resources for Medicaid also makes economic sense. Without adequate care, health issues can escalate into bigger and more expensive problems.

When Medicaid expansion was considered in 2012, a number of studies demonstrated that taxpayer resources used to fund Medicaid are more than returned when dynamic effects are considered. For example, in 2012, my firm studied the issue and found that for every \$1 spent by the State returns \$1.29 in dynamic State government revenue over the first 10 years of the expansion. In other words, the State actually makes money by participating in the Medicaid expansion.<sup>5</sup> Although I recognize expanding Medicaid coverage is difficult to contemplate in the current budget environment, it is an investment that improves the quality of life of many Texans, while simultaneously enhancing the economy, and providing a positive return to the State government on the dollars expended. Within the current context, these results take on greater significance in that (1) such expansion would allow more diverse populations to be included in contracts, thus restoring key incentives for prevention and wellness investments by the contracted MCOs, and (2) broader coverage would reduce the risk of more Texans entering the system already chronically ill or disabled, thus providing the opportunity to substantially reduce the costs per participant.

Other assessments have demonstrated similar results. A report by Billy Hamilton Consulting concluded that “State and local government and the state’s hospitals collectively spend far more on piecemeal health care for low-income Texans than the state’s expected match for the expansion. Expanding Medicaid would move thousands of people into managed care from these programs and significantly reduce the use of expensive emergency room treatment for routine care.”<sup>6</sup> Kaiser states that, “The prospects for proposals that would affect Medicare’s

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<sup>5</sup> “Only One Rational Choice: Texas Should Participate in Medicaid Expansion Under the Affordable Care Act.” *The Perryman Group*. October 2012.

<sup>6</sup> “Expanding Medicaid in Texas: Smart, Affordable, and Fair.” *Billy Hamilton Consulting*. January 2013, [http://www.mhm.org/images/stories/advocacy\\_and\\_public\\_policy/Smart%20Affordable%20and%20Fair\\_FNL\\_FUL.pdf](http://www.mhm.org/images/stories/advocacy_and_public_policy/Smart%20Affordable%20and%20Fair_FNL_FUL.pdf).

financial outlook are unknown, but few would question the importance of carefully deliberating ways to bolster the Medicare program for today's beneficiaries and for the growing number of people who will depend on Medicare in the future."<sup>7</sup>

### ***Potential Structural Changes***

In any situation where a company is granted what is essentially monopoly power (such as with an MCO with a contract to provide service to a particular population segment or geographic region), effective oversight is essential. In the days when the electric power and telecommunications industries in Texas were regulated, for example, state agencies oversaw much of operations among the companies granted exclusive territories. Similarly, **oversight is needed** for MCOs serving the Medicaid population in order to guard against potential abuses. As mentioned above, I have no particular knowledge or expertise in the mechanics of this process, but economics can offer some reasonable guidelines.

First, oversight should seek to strike an appropriate balance. It certainly needs to involve measures to minimize the possibility of the types of situations recently chronicled in which the health of the served populations are placed at significant risk. On the other hand, it must not be so stringent as to preclude or unduly complicate innovations that can improve outcomes and reduce costs. This premise is fundamental to all optimal oversight and regulatory models. The idea is much like the bumpers that are put in bowling lanes so that young kids can enjoy the sport without excessive frustration and crying (a lesson learned well when my kids were younger). You want enough freedom (width in the bowling lane) to allow different approaches, but still safeguard against ending up in the gutter.

Second, as noted, managed care models have been shown to work well in some instances and, if structured properly, to save money. The key is to ensure that companies are incentivized in ways that lead to desirable outcomes, and **reasonable capitation rates are crucial**. If the capitation rate is too low, companies will face mounting pressure to "cheat" and not provide needed care. With few options to lower costs given the population they serve and little room to reasonably expect that future profits can make up for current excessive needs (due to restrictive profit sharing, limited capacity to deal with risk, and uncertainty regarding payments), some firms will fail to provide needed care. There must be enough cushion for MCOs to achieve profitability while providing needed services. Many insurers will face pressure

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<sup>7</sup> Cubanski, Juliette and Tricia Neuman. "The Facts on Medicare Spending and Financing." *Henry J Kaiser Family Foundation*. 22 June 2018, <https://www.kff.org/medicare/issue-brief/the-facts-on-medicare-spending-and-financing/>.

to meet the earnings expectations of public or private investors, which further complicates the situation.

**Adequate funding is essential** to improving the situation. Failing to provide sufficient resources not only puts pressure on MCOs which can contribute to undesirable outcomes, but also increases the likelihood of escalating health problems and higher long-term costs. Robust competition to obtain the managed care contracts can help alleviate issues with the system, but without sufficient incentives to enter the market, the ability to attract and retain market participants will be severely constrained.

The arena of basic bargaining and game theory is also useful with regard to designing a proper framework for maintaining competition. Specifically, this type of analysis strongly suggests that a decentralized regional contracting strategy would be optimal. Specifically, the use of **multiple contractors across the state** would provide greater relative bargaining power to the State as compared to a situation in which the program becomes highly dependent on one or a few providers. All major bargaining models and a substantial body of empirical analysis demonstrate that the party with the greater relative bargaining strength will achieve more desirable outcomes (in this case, better patient outcomes and lower costs). While there is the possibility of economies of scale bringing savings in some contexts, it is not likely to be effective in the current context in that (1) various parts of the state are diverse with regard to affected populations and other relevant characteristics (some areas have greater levels of obesity and, thus, more heart disease and diabetes; some have younger populations with more pregnancies and indigent children; some have aging populations with greater probability of becoming eligible; some have broad network opportunities while others are very limited) and (2) regional firms with specific local advantages can at times better respond to relevant needs. In any case, the adverse bargaining power effects associated with large contracts would more than offset any economies of scale that might exist.

### ***Concluding Comments***

As noted, companies providing managed care to Texas Medicaid patients are faced with difficult circumstances. The incentives that they currently face are not consistent with desirable outcomes, but instead tend to encourage denial of needed care and other adverse consequences. However, higher capitation rates and a more reasonable sharing of potential profits and risks between the State and MCOs can help improve the situation. Effective, but not overly aggressive, oversight is also needed, as is the strategic use of the bargaining strength inherently conveyed upon the State.

The human costs when individuals do not receive needed care can be tragic. As a society, we have determined that allowing people to go without necessary care is unacceptable. However, you and your colleagues in the House and Senate have a solemn duty to manage the public resources that are entrusted to you in a prudent and responsible manner, and our growing state has many pressing needs. Within that framework, **it is counterproductive to underfund Medicaid**. Moreover, such an approach is not consistent with prudent long-term fiscal responsibility. It's what my late and wonderful Welsh mother-in-law would have called being "penny wise and pound foolish." We may save some pennies today, but it will end up costing us much more later. (As an aside, she would have been quite distressed to learn that this distinctly British axiom was, in its original form, not from her beloved homeland, but sprang from the pen of Louis of Granada, a Dominican friar, and scholar in the mid-1500s.) Short-term savings will, over time, lead to higher costs and worse outcomes.

Many studies by my firm and others have found that when measured over time, strategic investments in key areas such as Medicaid (and, for that matter, public education, higher education, and infrastructure) will more than pay for themselves. Although I fully recognize the extreme pressure posed by the need to create biennial budgets, a short-term mentality is inconsistent with optimizing long-term results, including tax receipts and required fiscal outlays for the State.

Again, I am grateful for the opportunity to offer this perspective, and I hope that you find it beneficial. I sincerely appreciate all that each of you do for Texas and Texans and would be happy to answer any questions that you may have. If I can assist your efforts in any other way, please let me know. As always, I can be directly reached at [ray@perrymangroup.com](mailto:ray@perrymangroup.com).

Respectfully submitted,

A handwritten signature in black ink that reads "M. Ray Perryman". The signature is written in a cursive, flowing style.

M. Ray Perryman, PhD, President

The Perryman Group

# **Texas Public Policy Foundation**

**Testimony of Center for Public Policy Priorities**  
**Joint hearing of The House Committees on Appropriations, Subcommittee on Art. II and**  
**General Investigating and Ethics**

*Submitted June 25, 2018*

The Center for Public Policy Priorities appreciates the opportunity to testify on Appropriations Interim Charge 18/General Investigating & Ethics Interim Charge 10: *Monitor the agencies and programs under the Committees' jurisdiction and oversee the implementation of relevant legislation passed by the 85th Legislature, Oversight of the Texas Health & Human Services Commission's management of Medicaid managed care contracts.*

The Benedictine Sisters of Boerne, Texas, founded CPPP in 1985 to advance public policy solutions for expanding access to health care. We became an independent, tax-exempt organization in 1999, and over time our focus has expanded to include economic opportunity and fiscal policy. We are based in Austin, Texas, and work statewide. At CPPP, we believe in a Texas that offers everyone the chance to compete and succeed in life.

CPPP has joined in a letter from 14 Texas organizations to The Governor, Lt. Governor, members of the Texas Legislature, and the Texas Health and Human Services Commission (HHSC) regarding the Dallas Morning News' reporting series on Medicaid Managed Care, and the key issues it has raised. My testimony will not cover all of that entire letter, but each of your offices has received a copy and I am available for questions about the letter, along with representatives from the other signatories.

My testimony focuses on the final paragraph from the letter:

***Proactive agency oversight must be backed by Legislative openness to bad news:*** *The recent reports include stories of dangerous MCO policies that should have been stopped before ever taking effect, and of agency findings of threats to health and safety that never became public. If this is to change, our Texas Legislative culture must welcome hard truths about problems and challenges state agencies face, including those that will require appropriations as part of their solutions. A culture of transparency and high performance—one that does not encourage agencies to obscure problems but rewards them for confronting them—could have identified and prevented many of the issues raised in the Dallas Morning News series.*

I worked for the Texas Medicaid director in 1993 when Medicaid Managed Care was brand new to our state. We knew then that Fee-for-Service Medicaid in Texas had done a lousy job of guaranteeing care – remember the *Frew* lawsuit was first filed that year, and at its heart was the failure of Texas Medicaid to guarantee children access to medical and dental. Still, the main pressure we were facing was, as ever, fiscal, and Lt. Governor Bullock was insisting on a magic bullet to slow Medicaid spending growth, and Medicaid Managed Care was it.

Gov. Bullock was so intimidating that when the first Pink Book ([Texas Medicaid in Perspective](#)) was published by our office, we included two near-identical bar charts on the same page, just to avoid any impression that an earlier similar chart which his staff had provided him was in error.

This anecdote tees up the two topics I want to address:

1. First, that an inordinate amount of energy goes into obscuring critical realities in the name of shielding elected officials and agencies from criticism; and
2. Second, that was also the same year Texas froze physician and other health care professionals' Medicaid fees, and ended regular updates in those fees to address inflation.

**1) Needed: transparency and public exposure of complaints.** Protecting Medicaid Managed Care plans, agency, lawmakers from embarrassment has for many years (to varying degrees depending on leadership of moment and their culture) consistently taken precedence over the competing values of patient safety, pursuit of excellence via



continuous quality improvement, care in the least restrictive setting, and the right of Texas taxpayers to have full knowledge of how their money is being spent. That said, many instances in the DMN reports (and in my experience) portray great agency work that uncovered serious shortcomings, and that demonstrate the willingness and capacity of agency to put clients before vendors. Unfortunately, we see too many instances where problems ferreted out by the agency were actively repressed or simply left to die from inaction.

While the attitudes of agency Commissioners have a great impact on the degree of transparency about revealing when policies fall short, it would be a mistake to say the buck stops there. The Governor, Lt. Governor and state Legislature—not the agency alone—also strongly shape the culture that determines whether hiding flaws is prioritized over correcting them and improving program quality.

If we want to really pursue excellence in Medicaid Managed Care—not just to stay out of the newspapers—adopting a culture that no longer seeks to hide problems but only to resolve and learn from them is our best cure. If we open the windows, and expose the truth about all taxpayer-supported work despite risk of potential embarrassment, we could achieve ongoing quality improvements and a transparency that makes whistleblowers unnecessary.

**2) Needed: evaluation of the fact that we allow substantial retained profits – well beyond costs of care—to Medicaid Managed Care plans, while physicians and other practitioners including mental health and therapy providers have not had regular updates or any cost basis for their fees for about 25 years.**

In 2016, retained profits (after “experience rebates”) of Texas Medicaid Managed Care plans ranged from a high of \$168 million for one plan, to a loss of \$31 million for another. The highest profit percentage (of gross revenues) was 7.2%, and the lowest a loss of 6%.

This is not to suggest that no profits are allowable, or that Medicaid Managed Care plans are the only Texas Medicaid providers making a profit. But we may be shooting ourselves in the foot by over-rewarding MCOs who stand to profit from limiting care access, while starving access to the providers who could keep their Medicaid patients out of hospitals, support optimal developmental supports for kids of all kinds, prevent worsening of disabilities, support optimal birth outcomes, and perhaps even prevent newspaper articles.

**HHSC does not require a minimum Medical Loss Ratio.**

**HHSC does require an “Experience Rebate”**

Pre-Tax Incomes as a % of Revenue	HMO Share	HHSC Share
≤ 3%	100%	0%
> 3% and ≤ 5%	80%	20%
> 5% and ≤ 7%	60%	40%
> 7% and ≤ 9%	40%	60%
> 9% and ≤ 12%	20%	80%
>12%	0%	100%

There has long been confusion over the degree to which the Texas Medicaid MCO methodology limits retained profits, see chart.

The Legislature should sponsor an independent review of the imbalance in Texas Medicaid reimbursements across classes of providers, and the implications for access to care that result. The study would have to be done by an entity free of concern about impact on future business with HHSC, the Legislature, or state elected officials.

Thank you for the opportunity to testify. Any questions may be directed to Anne Dunkelberg, Associate Director, CPPP; [dunkelberg@cppp.org](mailto:dunkelberg@cppp.org).

The **Center for Public Policy Priorities** is an independent public policy organization that uses research, analysis and advocacy to promote solutions that enable Texans of all backgrounds to reach their full potential.

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