LEGISLATIVE BUDGET BOARD

Managed Care Organization Contract Reporting and Oversight

PRESENTED TO HOUSE COMMITTEE ON APPROPRIATIONS

SUBCOMMITTEE ON ARTICE II

LEGISLATIVE BUDGET BOARD STAFF

MARCH 2018

Overview

Related to House Appropriations Committee Interim Charge 4, including when reviewing the Health and Human Services Commission's (HHSC) managed care contracts, determine if HHSC has adequate data, staff, and processes to provide appropriately rigorous contract oversight, including but not limited to the use of outcome metrics. Consider whether HHSC properly enforces contractual sanctions when managed care organizations (MCOs) are out of compliance, as well as how HHSC uses Medicaid participants' complaints regarding access to care to improve quality:

1. Managed Care Organization (MCO) Contract Reporting Requirements
2. 2018-19 General Appropriations Act (GAA) - HHSC
3. Agency Requested Funding
4. HHSC MCO Contract Oversight
5. Other MCO Contract Oversight

Attestation Letters

Art IX, Sec. 7.12 of the GAA requires a letter, signed by the executive commissioner or designee, for each procurement over $10.0 million and non-competitive procurement over $1.0 million attesting that:

1. The procurement complied with all applicable statutes, rules, and policies;
2. The agency has an effective process to verify vendor performance and deliverables;
3. The good or services being procured are necessary; and
4. There is a continuing duty to report any changes to the information provided.

HHSC has submitted the required attestation letters for all managed care contracts.

Managed Care Contracts

HHSC has reported 48 active managed care contracts worth $91.7 billion. All have the required attestation letter. The term of each contract varies.

10 Largest MCOs	Total Value of Contracts	Number of Contracts
Superior	$20,119,112,559	7
Amerigroup	$16,016,142,963	5
United Healthcare	$10,297,770,360	3
Molina	$9,372,199,193	4
Texas Children's Health	$5,656,397,948	2
Community Health Choice	$4,440,883,072	1
Dentaquest	$4,133,571,752	1
MCNA Insurance	$3,185,126,414	1
Healthspring	$3,055,979,119	3
Parkland Community Health	$3,019,141,048	1
Total of Top Ten MCOs	**$79,296,324,428**	**28**

LBB Contract Oversight

LBB Staff Contract Reviews
2018–19 GAA, Article IX, Sections 7.04(f) and 7.12(f)

- LBB staff are authorized to conduct reviews of contracts to ensure compliance with best practices and any applicable statues, rules, policies, and procedures.
- The Director of LBB may provide confidential written notification to the Comptroller, the Governor, and/or the Legislative Budget Board of any unresolved violations identified.
- Starting September 1, 2017, the written notification may include enforcement mechanisms based on existing legislative authorities.

2018-19 General Appropriations Act

Health and Human Services Commission (HHSC) Medicaid and CHIP Contracts and Administration (2018-19 biennium) (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.

2018-19 General Appropriations Act
Continued

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 has not submitted any requests for transfers into or out of these strategies for the 2018-19 biennium.

2018-19 General Appropriations Act
Continued

- **Other Riders:**
  - Rider 26, Evaluation of Medicaid Data (added in the 2016-17 GAA)
    - Requires HHSC to annually evaluate data submitted by MCOs to determine whether the data continues to be useful or if additional data is needed to oversee contracts or evaluate the effectiveness of Medicaid.
  - Rider 38, Data Analysis Unit Reporting (added in the 2018-19 GAA)
    - Government Code, §531.0082 (added by Senate Bill 8, Eighty-third Legislature, Regular Session, 2013) requires HHSC to report quarterly on the activities and findings of the Data Analysis Unit, and any anomalies related to service utilization, providers, payment methodologies, and compliance with requirements in Medicaid and CHIP to the OIG.
    - HHSC submitted the first quarterly report for FY 2018 pursuant to the rider on January 12, 2018. LBB did not receive written reports on the Data Analysis Unit prior to fiscal year 2018.

2018-19 General Appropriations Act
Continued

- **Other Riders, Continued:**
  - Rider 61, Evaluation of Medicaid Managed Care (added in the 2018-19 GAA)
    - Subsection (b), Contract Review and Oversight, requires HHSC to submit a report on the agency’s contract management and oversight function for Medicaid and CHIP managed care contracts to the LBB and the standing committees with jurisdiction over health and human services no later than September 1, 2018.

Agency Requested Funding

2016-17 General Appropriations Act, Regular Session, 2015
(dollar amounts in millions)

Strategy	General Revenue	All Funds	FTEs
B.3.1, Medicaid Contracts and Administration	$0.5	$3.0	17.3

- HHSC was appropriated the amounts above in the 2016-17 biennium to improve Medicaid staffing and support. The agency requested this funding in the Legislative Appropriations Request (LAR) for the 2016-17 biennium.
- The request included 5.0 FTEs to support health plan management for new managed care program expansions; 10.0 FTEs to expand utilization review functions to support managed care expansion and Medicaid Management Information System claims administrator contract management; and 2.0 FTEs to support Medicaid/CHIP program data analytics.

Agency Requested Funding

Continued

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.

- All agencies were provided the opportunity to revise their exceptional item requests after the General Appropriations Bills (Senate Bill 1 and House Bill 1) were Introduced, and HHSC did not include the request in their revised exceptional item list.

HHSC MCO Contract Oversight

Responsibility for managed care contract oversight and audit of MCO contracts at the agency level is shared among HHSC Medicaid and CHIP Services Department, HHSC Internal Audit, and the Office of the Inspector General. Audit coverage and contract oversight functions at HHSC generally address particular, focused aspects of MCO contracts and operations.

- **Medicaid and CHIP Services Department (MCSD):**
  - Included in Strategy B.1.1, Medicaid Contracts and Administration (FY 2018) (dollar amounts in millions):

Function	General Revenue	All Funds	FTEs
Contract compliance and performance management	$2.5	$6.5	79.0
Health plan management	$1.3	$2.6	33.0
Total	**$3.8**	**$9.1**	**112.0**

  - MCSD conducts financial and operational oversight and monitoring activities of the MCOs, and is also responsible for financial audits (Agreed Upon Procedures), risk assessment engagements, and performance audits to be conducted by outside contractors.

HHSC MCO Contract Oversight
Continued

- **HHSC Internal Audit:**
  - Included in Goal L, System Oversight and Program Support (FY 2018) (dollar amounts in millions):

Function	General Revenue	All Funds	FTEs
Internal audit	$2.3	$5.7	59.0

  - Provides assessments of programs, processes, and systems under oversight of HHSC in accordance with the HHSC Internal Audit Charter or at the request of executive management, which could include audits of MCOs.
  - There are no managed care related internal audits on the Fiscal Year 2018 Audit Plan as of March 8, 2018.

HHSC MCO Contract Oversight
Continued

- **The Office of the Inspector General (OIG):**
  - Included in Strategy K.1.1, Client and Provider Accountability (FY 2018) (dollar amounts in millions):

Function	General Revenue	All Funds	FTEs
Audit	$2.9	$5.6	81.7

  - Responsible for planning and conducting regular performance audits of MCOs in coordination with MCSD and HHSC Internal Audit.
  - Performance audits determined by a collaborative risk-assessment process or at the request of HHSC management.

Agreed Upon Procedures

- Each MCO is subject to an annual Agreed Upon Procedures engagement (AUP) conducted by an audit contractor to verify the accuracy of the annual financial statistical report (FSR) for each MCO.
- FSRs are required by contract on an annual basis and serve as the primary statement of financial results for the MCOs.
    - The FSR serves as the basis for the calculation of Experience Rebate payments to the state.
    - The Uniform Managed Care Manual provides cost principles for determining allowable and unallowable administrative and other expenses for the FSR.
- AUPs may result in updated Experience Rebates, Liquidated Damages, or a corrective action plan.

Utilization Review

- HHSC added the Acute Care Utilization Review (UR) Section to the Medicaid and CHIP Services Office of the Medical Director following a directive from Senate Bill 8, Eighty-third Legislature, Regular Session, 2013.
- The UR Section is managed by a registered nurse and reviews the prior authorization and utilization management practices in managed care programs with the intention of ensuring not only that MCOs are correctly enrolling members in STAR+PLUS Home and Community Based Services (pursuant to Government Code, Section 533.00281) but also MCOs are providing services according to their assessment of service needs.
- The OIG also conducts retrospective utilization reviews of hospitals and nursing facilities to assess the medical necessity for care, appropriateness of diagnosis coding, and quality of care. The OIG selects claims for review based on an assessment of risk.
- UR activities can inform contract policy and operational changes including policy and contract clarifications, MCO training, internal process improvements, or other remedies.

External Quality Review

- The federal Balanced Budget Act of 1997 requires state Medicaid programs to contract with an external quality review organization (EQRO) to ensure state programs and contracted MCOs are compliant with established standards.
  - The Institute for Child Health Policy has been the EQRO for Texas since 2002.
- The EQRO produces reports to support efforts to ensure timely and quality care in managed care programs, allow comparisons across MCOs in each program, and to develop goals and other quality improvement activities.
- The EQRO conducts ongoing evaluations of quality of care primarily using MCO administrative data, including claims and encounter 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.

Other Contract Oversight

- **Federal**
  - Department of Health and Human Services/Centers for Medicare and Medicaid Services
  - HHS Office of Inspector General
- **State**
  - State Auditor's Office
  - Sunset Commission
  - Comptroller of Public Accounts/Contract Advisory Team

LEGISLATIVE BUDGET BOARD

Contact the LBB

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