Key Points of Report

An Audit Report on Medicaid Managed Care at the Texas Department of Health

February 1998

Overall Conclusion

The Bureau of Managed Care (Bureau) of the Texas Department of Health has worked diligently to develop a successful managed care system of delivering health care services to Texas Medicaid clients. With limited staff, the Bureau has successfully rolled out managed care in five major areas in the State and is working aggressively to expand managed care to the entire State.

The Bureau, however, does not have adequate systems or controls in place to sufficiently monitor the managed care program. Not all cost effectiveness and program outcome information is collected or fully analyzed. The Bureau is not fully staffed to adequately manage this labor-intensive program.

Overall, the Bureau agrees with our assessment and is quickly moving to strengthen systems and controls over this new and rapidly expanding program.

Key Facts and Findings

- The Medicaid program is the single largest assistance program in Texas, serving approximately 1.9 million Texans at a cost of more than $10.4 billion in fiscal year 1997. Managed care was developed as a cost-effective alternative of providing health care to our Medicaid clients. Currently 15 percent of Medicaid recipients receive their health care through a managed care delivery system. It is expected that by the end of fiscal year 1998, 25 percent of all Medicaid recipients will receive their health care through this new delivery method.

- The Bureau is not adequately staffed to sufficiently monitor or oversee the Managed Care Program. One half of all positions within the Bureau are vacant. Additionally, not all third-party managed care information can be directly or easily accessed by Bureau staff for complete analysis of the costs and types of services provided.

- The Bureau cannot fully evaluate the cost effectiveness of managed care or ensure program outcomes are achieved because (1) written policies and procedures for updating capitation rates in future contract periods have not been developed, and (2) outcome information is not routinely collected and analyzed.

- We compliment the Department for quickly responding to provider complaints, including language in the health maintenance organization's (HMO) contracts that allows the State to share in realized profits, reevaluating information requirements to reduce the reporting burden of the managed care organizations, and coordinating and communicating with the Texas Department of Insurance on HMO complaints and solvency issues.

Contact:

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Office of the State Auditor

Lawrence F. Alwin, CPA

This audit was conducted in accordance with Government Code, Section 321.0133

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Executive Summary

The Bureau of Managed Care (Bureau) of the Texas Department of Health has worked diligently to develop a successful managed care system of delivering health care services to Texas Medicaid clients. With limited staff, the Bureau has successfully rolled out managed care in five major areas in the State and is working aggressively to expand managed care to the entire State.

The Bureau, however, does not have adequate systems or controls in place to sufficiently monitor the managed care program. Not all cost effectiveness and program outcome information is collected or fully analyzed. Additionally the Bureau is not fully staffed to adequately manage this labor-intensive program.

The Bureau of Managed Care Does Not Have Sufficient Controls in Place to Effectively Monitor and Oversee the Managed Care Program

Inadequate staffing, nonexistent and undocumented procedures, unauthorized modifications to data, limited access to data, and undocumented contract revisions negatively impact the Bureau of Managed Care's ability to effectively monitor and oversee the managed care program.

The Bureau of Managed Care is responsible for monitoring the managed care program to ensure that Medicaid clients are satisfied with the services provided and that program goals are met. A lack of sufficient staff limits the Bureau's ability to adequately track and monitor information and verify the accuracy of data submitted. In addition, a lack of formalized and documented procedures results in inconsistent and possibly incomplete monitoring and analysis of program data.

Monitoring is also difficult because managed care data cannot be directly or easily accessed by staff within the Bureau of Managed Care, and contract revisions between the Bureau and the managed care organizations (MCOs) are not always formalized and documented.

Cost Effectiveness Cannot Be Ensured Without the Development of Written Policies and Procedures for Updating Capitation Rates

One of the primary goals of providing Medicaid services through a managed care system is to operate a health care delivery system that is more cost effective than the traditional fee-for-service system. The Bureau of Managed Care is responsible for ensuring the cost effectiveness of the managed care system. A key component of ensuring cost effectiveness is paying the lowest reasonable price for the services provided while maintaining a quality system of health care. For future contract periods, the Bureau cannot be assured that it is paying the lowest reasonable price for the services provided if the capitation rates paid to the MCOs are not updated using data that is reflective of the actual services being provided.

The Bureau of Managed Care Cannot Ensure Program Outcomes Are Met When Outcome Information Is Not Routinely Collected and Analyzed

Outcome information that is included in the standard contract with MCOs is not always collected as required. When information is collected, it is not consistently and thoroughly verified or analyzed to ensure program outcomes are met. Information from the managed care organizations and system contractor, National Heritage Insurance Corporation (NHIC), is sometimes not submitted or, when it is submitted, it is often late and upon review is found to be incorrect.

MCOs are generally aware of the information requirements and due dates for submission

because this information is laid out in their contracts. However, one reason information may not be submitted as required is that some information requirements are not formally documented. Additionally, some reviews of information are not completed because the Bureau does not have sufficient staffing resources to conduct the reviews.

We Commend the Bureau of Managed Care for Its Dedication to Making Medicaid Managed Care a Successful Program in Texas

After two successful pilots and recent expansions into three additional areas, 15 percent of current Medicaid recipients now receive health care through a managed care delivery system. As previously indicated, the Bureau of Managed Care of the Texas Department of Health has worked diligently to develop a successful managed care system of delivering Medicaid services to Texas clients. With limited staff, it has successfully rolled out managed care in five major areas in the State and is working aggressively to expand managed care to the entire State. It is expected that by the end of fiscal year 1998, 25 percent of all Medicaid recipients will receive health care through this new delivery method.

While we identified several opportunities for improvement, we commend the Department for quickly responding to provider complaints, including language in the health maintenance organization's (HMO) contracts that allows the State to share in realized profits, reevaluating information requirements to reduce the reporting burden of the managed care organizations, and coordinating and communicating with the Texas Department of Insurance on HMO complaints and solvency issues.

Summary of Management's Response

We appreciate that this audit report, while noting certain opportunities for improvement, also acknowledges the great effort put forth by the department to administer this program in a responsible manner.

Full text of management's responses can be found on page 11.

Summary of Objective and Scope

The primary objectives of this project were to determine if the Texas Department of Health has sufficient management controls in place to:

- Manage and monitor Medicaid managed care.
- Evaluate and ensure that the program is cost effective.
- Evaluate and ensure that program outcomes are met.

The scope of our audit included:

- Review of the overall management systems of Medicaid managed care
- Review of the relationships between the Department and their managed care providers
- Review of the appropriations of the managed care strategy
- Review of the expenditures and cost allocation systems related to managed care.

Section 1: MONITORING

The Bureau of Managed Care Does Not Have Sufficient Controls in Place to Effectively Monitor and Oversee the Managed Care Program

Inadequate staffing, nonexistent and undocumented procedures, unauthorized modifications to data, limited access to data, and undocumented contract revisions negatively impact the Bureau of Managed Care's (Bureau) ability to effectively monitor and oversee the managed care program.

The Bureau is responsible for monitoring the managed care program to ensure that Medicaid clients are satisfied with the services provided and that program goals are met. A lack of sufficient staff limits the Bureau's ability to adequately track and monitor information and verify the accuracy of data submitted. In addition, a lack of formalized and documented procedures results in inconsistent and possibly incomplete monitoring and analysis of program data. Furthermore, monitoring is difficult because managed care data cannot be directly or easily accessed by staff within the Bureau, and contract revisions between the Bureau and the managed care organizations (MCOs) are not always formalized and documented.

Section 1-A:

The Bureau of Managed Care Is Not Adequately Staffed to Appropriately Monitor and Oversee the Managed Care Program

Routine monitoring and oversight of the managed care program is impeded by vacancies within the Bureau. Approximately one-half of all positions within the Program Operations, Program Quality Health Services, and Client-Provider Services divisions are currently vacant. These vacancies are new positions that were created with the restructuring of the Bureau, but they have never been filled. The Bureau of Managed Care is responsible for monitoring the managed care program to ensure that clients and providers are satisfied with the services provided. However, a lack of staff limits the Bureau's ability to track and monitor information and verify the accuracy of data submitted.

Inadequate staffing has also contributed to a lack of documented procedures for information gathering and monitoring. Policies and procedures to be followed by staff within the Bureau of Managed Care have not been formalized and documented. The lack of formalized and documented procedures results in inconsistent and possibly incomplete monitoring and analysis of program data. Additionally, new staff members are not afforded the formal guidelines needed to quickly master the responsibilities of their positions.

Recommendation:

We recommend the Bureau of Managed Care work aggressively to fill each of the vacant positions within the Bureau. Policies and procedures to be followed by staff should be formalized and documented, and new staff members should be trained in the policies and procedures so that they fully understand the responsibilities of their positions.

Management's Response:

The Bureau of Managed Care fully realizes that to best manage program responsibilities, the Bureau must have adequate human resources, properly trained. In an attempt to correct this, an additional fourteen positions were requested at the close of the fiscal year process. During the time of the audit review process, twenty-three vacancies appeared on the organizational chart. Approval to fill these positions was received by the Bureau during the first week of November, 1997. Seven of these positions have been filled to date and five others are currently advertised. Aggressive steps to advertise and fill the remaining eleven vacancies is underway. Expectation for completion of hirings is April 1, 1998.

When positions are filled, managers are responsible for providing on-the-job training for their new staff so that they understand the responsibilities of their positions.

Section 1-B:

Medicaid Managed Care Data Cannot Be Directly or Easily Accessed by Staff Within the Bureau of Managed Care

Medicaid managed care data cannot be directly or easily accessed by staff within the Bureau of Managed Care. Although much of the information currently needed by the Bureau can be obtained through ad hoc reports, this is time consuming and does not guarantee that all information requested is included.

Medicaid managed care data is edited, processed, and maintained by the system contractor, the National Heritage Insurance Corporation (NHIC). To extract the necessary data, the Bureau must request ad hoc reports from NHIC programmers assigned to write, modify, and maintain the programs. The average turnaround time for ad hoc repots is about two days and does not include any additional time that may be necessary for an incorrect request or completion of other priorities.

Additionally, there is no mechanism available for the Bureau to verify the report sample against the total population. The Bureau already maintains several analytical tools that could be used to analyze and further verify the accuracy of the automated claim data, but the Bureau has minimal confidence in data it is unable to query itself. Without quick and direct access to this information, the Texas Department of Health

(Department) cannot be assured that it is evaluating timely, complete, and appropriate information from the managed care organizations.

Recommendation:

We recommend the Bureau of Managed Care thoroughly evaluate what its Medicaid managed care information needs are and what barriers to those information needs exist. The Bureau should then develop several alternatives to obtaining the information and evaluate the cost effectiveness of each. We recommend the Department complete as soon as possible its current evaluation of using a data warehouse to provide a central location to store and access data.

Management's Response:

TDH has signed a systems development contract with NHIC to provide a state of-the-art claims processing and encounter reporting system called Compass21. Query and extensive ad hoc reporting capabilities are scheduled to be implemented by April of 1999. In addition, TDH has also signed a contract with the Texas Health Quality Alliance for data analysis and other related functions.

Section 1-C:

Contract Revisions Between the Department and the Managed Care Organizations Are Not Always Formalized

Revisions to the contracts between the Department of Health and the managed care organizations are not always formalized in writing. The revisions are typically announced verbally during the routine work group meeting between the Department and the managed care organizations. The lack of documented contract revisions increases the risk that contract amendments will not be adhered to consistently by managed care organizations or will be inappropriately monitored by the Bureau of Managed Care.

Recommendation:

We recommend all revisions to contracts be formalized and documented as amendments to the contract. Memoranda of understanding between the Department and managed care organizations may serve as an alternative to formal contract amendments. However, such memoranda should be distributed to all contract signatories and key stakeholders and be included in the master contract files.

Management's Response:

The Department agrees that all revisions to contracts should be formalized and documented as amendments to the contract. This is currently underway for revisions

to the 1997 TDH-HMO contract. In addition, work group discussions sometimes result in written clarifications to existing contract language. These written clarifications are distributed to all plan CEOs and others as appropriate. A Bureau Policy and Procedure manual, well under development, is a compilation of existing policies and the platform for tracking future contract clarifications and/or changes.

Section 1-D:

The System Contractor Performs Unauthorized Modifications to Data Submitted by the Managed Care Organizations

The National Heritage Insurance Corporation, which processes all Medicaid claims, often modifies data submitted by the managed care organizations without consulting or notifying them. Edits have been incorporated into the processing of submitted data at various levels, which can cause files to be rejected during the initial editing process. This rejected data is returned to the submitting managed care organization for correction. However, errors identified in later editing processes may be evaluated and modified by NHIC without consulting or notifying the submitting managed care organization. Data correction is not only an additional task for NHIC staff, but also requires additional research to resolve the discrepancy during the reconciliation process. Although these discrepancies are eventually identified, placement of all edits in the initial process would preclude the need for system contractor intervention and ensure integrity of the data by its originator.

Recommendation:

We recommend the Bureau of Managed Care reevaluate the various levels of edits to determine location appropriateness. Editing should be performed as early in processing as possible to allow correction by the creator of the data.

Management's Response:

Management agrees with the issue and recommendation. The appropriateness of NHIC edits and placement of the front end process have been incorporated into the Encounter Process Action Plan to be completed by August 31, 1998.

Section 1-E:

The Automated System Maintained by the System Contractor Has Not Been Independently Reviewed to Ensure Adequacy of Controls in Over Four Years

The automated system maintained by NHIC has not been independently reviewed to ensure adequacy of controls in over four years. Although the Department's Internal Audit group has maintained a staff position to ensure review of the automated system,

problems have been encountered with keeping this position filled. Contract compliance, financial reviews, and other audits performed by the Department's Internal Audit group have identified errors in the automated system, but the Department continues to rely heavily on the edits that have been incorporated into the automated system. Unauthorized modifications, inappropriate location of edit checks, and inadequate edits as mentioned previously are just a few of the issues that could be identified with a periodic, comprehensive review of the automated system.

Recommendation:

We recommend the Department conduct or arrange for an independent review of the automated controls of the system contractor, NHIC. This review should include a comprehensive analysis of controls over contract compliance, fiscal management, and the automated system.

Management's Response:

The Internal Audit group dedicated to continuously review NHIC performance has recently employed an EDP auditor that will perform this function for the Department.

Section 2: COST EFFECTIVENESS

Cost Effectiveness Cannot Be Ensured Without the Development of Written Policies and Procedures for Updating Capitation Rates

One of the primary goals of providing Medicaid services through a managed care system is to operate a health care delivery system that is more cost effective than the traditional fee-for-service system. The Bureau of Managed Care is responsible for ensuring the cost effectiveness of the managed care system. A key component of ensuring cost effectiveness is paying the lowest reasonable price for the services provided while maintaining a quality system of health care. For future contract periods, the Bureau cannot be assured that it is paying the lowest reasonable price for the services provided if the capitation rates paid to the managed care organizations (MCOs) are not updated using data that is reflective of the actual services provided.

Policies and procedures for updating capitation rates have not been established. The Bureau of Statistics and Analysis (BSA) has not developed written policies and procedures for updating capitation rates in years subsequent to the initial roll out of the MCOs' contracts. Capitation rates for the initial rollouts were established by obtaining historical fee-for-services costs for the service delivery area and then applying a discount. This method of establishing initial rates is an acceptable industry practice. However, because costs and use of services vary throughout the State and are likely to change from year to year, it is important that capitation rates be routinely reviewed and updated. This helps ensure that the rates the Department is paying each year are fair and reasonable for the services provided.

Encounter data should be used to analyze the reasonableness of the capitation rates. Ideally, the BSA would use encounter data in its analysis of the reasonableness of capitation rates. However, it is not receiving the encounter data necessary to do this. Encounter data is the information received from the MCOs about the number of visits and types of services provided to each client. A report from the Lewin Group emphasized the need for valid encounter data in evaluating cost trends across different categories of beneficiaries and services. The use of encounter data helps to ensure that the established rate is reasonable in light of the services provided.

Capitation Verses Fee-For-Service

Under a **capitated system** of service delivery, the State contracts with a health maintenance organization to provide comprehensive quality health care to Medicaid enrollees at a fixed monthly payment (capitation rate) per enrollee. This method of providing care generally is the more cost-effective alternative because the providers of services are paid a fixed amount regardless of the actual number or nature of the services provided. Under this method, managed care organizations assume the financial risk for the care of their clients so there is incentive for them to limit the use of the services by keeping their patients as healthy as possible.

Fee-for-service is the traditional method of paying for medical services whereby a physician or other practitioner bills for each service provided. Under this method, providers do not assume financial risk for the medical care of their clients. Unlike managed care, there is no incentive for providers to limit utilization because each visit and service is reimbursed by the State.

Recommendation:

We recommend the Bureau of Statistics and Analysis develop and implement written policies and procedures for evaluating and updating capitated rates in the periods subsequent to initial roll out. We also recommend encounter data be obtained, verified, and used in the analysis of the capitation rates to ensure that the rates established are a reasonable reflection of the actual services provided.

Management's Response:

Management agrees with this recommendation.

Section 3: OUTCOMES

The Bureau of Managed Care Cannot Ensure Program Outcomes Are Met When Outcome Information Is not Routinely Collected and Analyzed

Outcome information that is included in the standard contract with MCOs is not always collected as required. When information is collected, it is not consistently and thoroughly verified or analyzed to ensure program outcomes are met. Information from the MCOs and system contractor, National Heritage Insurance Corporation (NHIC), is sometimes not submitted or, when it is submitted, it is often late and upon review is found to be incorrect.

MCOs are generally aware of the information requirements and due dates for submission because this information is laid out in their contracts. However, one reason information may not be submitted as required is that some information requirements are not formally documented. As indicated in Section 1, some information requirements are communicated verbally without formalizing them in contract amendments or memoranda of understanding. Additionally, some reviews of information are not completed because the Bureau does not have sufficient staffing resources to conduct the reviews.

Outcome data requirements must be clearly communicated in writing to MCOs, and Department staff members must ensure they collect and thoroughly review the data if they are to ensure that program outcomes are met. When MCOs do not supply the necessary information, sanctions should be imposed to ensure that the outcome data is submitted as required.

Recommendation:

We recommend the Department evaluate its current process of collecting, analyzing, and reviewing data from the MCOs. Controls should be established to ensure that all required information is documented and communicated consistently to MCOs and Department staff. Additionally, work loads should be analyzed to determine that critical reviews are adequately covered and conducted in a timely manner.

Management's Response:

The Department agrees that ongoing evaluation of the process of collecting, analyzing, and reviewing data from the managed care organization is necessary. Requirements for reports are documented within the TDH-HMO contract and the related contract deliverables matrix. The newly-contracted Quality Monitor (December 1997) will perform analysis of reports submitted by the MCOs and other critical reviews of MCOs. In addition, newly hired Bureau MCO Coordinators are key to the process of collecting, analyzing and reviewing data from the MCOs.

Our Compliments

The Bureau of Managed Care of the Texas Department of Health has worked diligently to develop a successful managed care system of delivering Medicaid services to Texas clients. With limited staff, the Bureau has successfully rolled out managed care in five major areas in the State and is working aggressively to expand managed care to the entire State.

Currently 15 percent of Medicaid recipients receive health care through a managed care delivery system. It is expected that by the end of fiscal year 1998, 25 percent of all Medicaid recipients will receive health care through this new delivery method.

While we identified several opportunities for improvement in Sections 1 through 3 of this report, we also noted the following:

- When physicians complained about payment of claims by one of the large health maintenance organizations (HMO), the Bureau performed a claims audit of the entity, identified significant problems, and imposed sanctions on the entity until corrective action was taken.
- The Bureau included specific language in the managed care contracts with health maintenance organizations that allows the State to share in any profits resulting from the state contracts.
- The Bureau reviews its information requirements of the managed care organizations to ensure that the requirements are reasonable and that only necessary information is requested.
- The Department of Health is actively coordinating and communicating with the Texas Department of Insurance on solvency issues and complaints against HMOs.
- The Bureau has begun the process of formalizing many of its policies and procedures.

Management's Responses

Texas Department of Health

William R. Archer III, M.D.
Commissioner of Health

Patti J. Patterson, M.D., M.P.H.
Executive Deputy Commissioner

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February 13, 1998

Mr. Lawrence F. Alwin, CPA
State Auditor
Post Office Box 12067
Austin, Texas 78701

Dear Mr. Alwin:

On February 11, 1998, your office provided us a draft report entitled "An Audit Report on Medicaid Managed Care" and requested that we review and provide our management responses on the report.

We appreciate that this audit report, while noting certain opportunities for improvement, also acknowledges the great effort put forth by the department to administer this program in a responsible manner.

Our management responses to your recommendations are enclosed. We appreciate the opportunity to work with your staff on these issues. If we can be of further assistance, please contact Randy P. Washington, Deputy Commissioner, Health Care Financing at (512) 338-6500.

Sincerely,

William R. Archer, III, M.D.
Commissioner of Health

Enclosure

Texas State Auditors Report To The Texas Department of Health

SECTION 1: MONITORING
The Bureau Of Managed Care Does Not Have Sufficient Controls In Place To Effectively Monitor and Oversee The Managed Care Program.

SECTION 1-A:
The Bureau Of Managed Care Is Not Adequately Staffed To Appropriately Monitor And Oversee The Managed Care Programs.

Recommendation: We recommend the Bureau of Managed Care work aggressively to fill each of the vacant positions within the Bureau. Policies and procedures to be followed by staff should be formalized and documented, and new staff members should be trained in the policies and procedures so that they fully understand the responsibilities of their positions.

Management Response: The Bureau of Managed Care fully realizes that to best manage program responsibilities, the Bureau must have adequate human resources, properly trained. In an attempt to correct this, an additional fourteen positions were requested at the close of the fiscal year process. During the time of the audit review process, twenty-three vacancies appeared on the organizational chart. Approval to fill these positions was received by the Bureau during the first week of November, 1997. Seven of these positions have been filled to date and five others are currently advertised. Aggressive steps to advertise and fill the remaining eleven vacancies is underway. Expectation for completion of hirings is April 1, 1998.

When positions are filled, managers are responsible for providing on-the-job training for their new staff so that they understand the responsibilities of their positions.

SECTION 1-B
Medicaid Managed Care Data Cannot Be Directly Or Easily Accessed By Staff Within The Bureau of Managed Care.

Recommendation: We recommend the Bureau of Managed Care thoroughly evaluate what its Medicaid managed care information needs are and what barriers to those information needs exist. The Bureau should then develop several alternatives to obtaining the information and evaluate the cost effectiveness of each. We recommend the Department complete as soon as possible its current evaluation of using a data warehouse to provide a central location to store and access data.

Management Response: TDH has signed systems development contract with NHIC to provide a state-of-the-art claims processing and encounter reporting system called Compass21. Query and extensive ad hoc reporting capabilities are scheduled to be implemented by April of 1999. In addition, TDH has also signed a contract with the Texas Health Quality Alliance for data analysis and other related functions.

SECTION 1-C:
Contract Revisions Between The Department and the Managed Care Organizations are not Formalized.

Recommendation: We recommend all revisions to contracts be formalized and documented as amendments to the contract. Memoranda of understanding between the Department and managed care organizations may serve as an alternative to formal contract amendments. However, such memoranda should be distributed to all contract signatories and key stakeholders and be included in the master contract files.

Management Response: The Department agrees that all revisions to contracts should be formalized and documented as amendments to contract. This is currently underway for revisions to the 1997 TDH-HMO contract. In addition, work group discussions sometimes result in written clarifications to existing contract language. These written clarifications are distributed to all plan CEOs, and others as appropriate. A Bureau Policy and Procedure manual, well under

development, is a compilation of existing policies and the platform for tracking future contract clarifications and/or changes.

SECTION 1-D:
The System Contractor Performs Unauthorized Modifications To Data Submitted By The Managed Care Organization.

Recommendation: We recommend the Bureau of Managed Care reevaluate the various levels of edits to determine location appropriateness. Editing should be performed as early in processing as possible to allow correction by the creator of the data.

Management Response: Management agrees with the issue and recommendation. The appropriateness of NHIC edits and placement of the front end process have been incorporated into the Encounter Process Action Plan to be completed by August 31, 1998.

SECTION 1-E:
The Automated System Maintained By The System Contractor Has Not Been Reviewed By An Independent Firm To Ensure Adequacy Of Controls In Over Four Years.

Recommendation: We recommend the Department arrange for an independent review of the automated controls of the system contractor, NHIC. This review should include a comprehensive analysis of controls over contract compliance, fiscal management, and the automated system.

Management Response: The Internal Audit group dedicated to continuously review NHIC performance has recently employed an EDP auditor that will perform this function for the Department.

SECTION 2: COST EFFECTIVENESS
Cost Effectiveness cannot be Assured Without Written Policies and Procedures that Include the Analysis of Encounter and Cost Data.

Recommendation: We recommend the Bureau of Statistics and Analysis develop and implement written policies and procedures for evaluating and updating

capitated rates in the periods subsequent to initial roll out. We also recommend encounter data be obtained, verified, and used in the analysis of the capitation rates to ensure that the rates being established are a reasonable reflection of the actual services being provided.

Management Response: Management agrees with this recommendation.

SECTION 3: OUTCOMES

The Bureau of Managed Care cannot Ensure Program Outcomes are being met when Outcome Information is not Routinely Collected and Analyzed.

Recommendation: We recommend the Department evaluate its current process of collecting, analyzing, and reviewing data from the managed care organizations. Controls should be established to ensure that all required information is documented and communicated consistently to MCOs and Department staff. Additionally, work loads should be analyzed to determine that critical reviews are adequately covered and being conducted in a timely manner.

Management Response: The Department agrees that ongoing evaluation of the process of collecting, analyzing, and reviewing data from the managed care organization is necessary. Requirements for reports are documented within the TDH-HMO contract and the related contract deliverables matrix. The newly-contracted Quality Monitor (December 1997) will perform analysis of reports submitted by the MCOs and other critical reviews of MCOs. In addition, newly hired Bureau MCO Coordinators are key to the process of collecting, analyzing and reviewing data from MCOs.

Appendix 1:

Objectives, Scope and Methodology

Objectives

The primary objectives of this project were to determine if the Texas Department of Health has sufficient management controls in place to:

- Manage and monitor Medicaid managed care
- Evaluate and ensure the cost effectiveness of Medicaid managed care
- Evaluate and ensure that program outcomes of Medicaid managed care are achieved

Management controls are the policies, procedures, and processes used to carry out an organization's objectives. They should provide reasonable assurance that:

- Goals are met.
- Assets are safeguarded and efficiently used.
- Reliable data is reported.
- Laws and regulations are complied with.

Management controls, no matter how well designed and operated, can only provide reasonable assurance that the organization's objectives will be achieved. However, monitoring established controls can assist in detecting and correcting weaknesses in a timely manner.

Scope

The scope of this audit included the review of:

- Overall management systems of Medicaid managed care: policy management, information management, performance management, and resource management
- Relationships between the Department and its managed care providers
- Appropriations of the managed care strategy
- Expenditures and cost allocation systems related to managed care

Methodology

Information collected:

- Interviews with members of the Legislature and staff
- Interviews with Department executive management and staff
- Interviews with management and staff of the Legislative Budget Board
- Medicaid legislation
- Managed care contracts
- Various management reports
- Audit reports from the State Auditor's Office and the Department's Internal Audit Division relation to Medicaid managed care
- The *Texas Medicaid in Perspective Report* issued in January of 1997 by the Texas Health and Human Services Commission
- Recommendations of the Texas Performance Review relating to Medicaid Managed Care
- Various managed care and Medicaid managed care industry reports
- Various consultant reports on Texas Medicaid managed care

Procedures and tests conducted:

- Review of the Medicaid managed care-related legislation
- Review of the sufficiency of contract provisions
- Analysis of costs related to managed health care
- Review of cost data
- Review of performance monitoring and evaluation processes
- Review of various studies and consultants reports of Texas Medicaid managed care

Criteria used:

- State Auditor's Office Accountability Model
- State Auditor's Office Contract Administration Model
- Department of Health's policies and procedures related to Medicaid managed care
- Senate Bill 10, 74th Legislature
- Other standards and criteria established during fieldwork

Other Information

Fieldwork was conducted from July 1997 to November 1997. The audit was conducted in accordance with applicable professional standards, including:

- Generally Accepted Government Auditing Standards
- Generally Accepted Auditing Standards

There were no significant instances of noncompliance with these standards.

The audit work was performed by the following members of the State Auditor's Office:

- Kathryn A. Schwerdtfeger, CPA, CGFM (Project Manager, Report)
- Chris Munn, CPA (Project Manger, Planning and Fieldwork)
- Patricia Perry-Williams, CISA, CGFM
- Yomi Owolabi, MBA
- Steven Summers
- Laura Reyes
- Ashaer Khawaja Hamid, MBA
- Pat Keith, CQA (Audit Manager)
- Craig D. Kinton, CPA (Audit Director)

Appendix 2:

The Shift to Managed Care

The 74th Legislature passed Senate Bill 10, which authorized the Texas Health and Human Services Commission to implement a managed care program for Texas Medicaid clients. This legislation expanded the previous two pilot programs instituted in Travis County (Austin) and an area along the Gulf Coast comprised of Galveston, Jefferson, and Chambers counties. The expansion of managed care has included roll outs in the San Antonio, Lubbock, Fort Worth, and the Houston metropolitan areas.

Estimates for fiscal year 1997 set the Texas managed care population at 328,000 of the total 1.9 million medicaid clients and capitation payments at $505 million of the total $10.4 billion Medicaid expenditures. Currently 15 percent of Medicaid recipients receive health care through a managed care delivery system. It is expected that by the end of fiscal year 1998, 25 percent of all Medicaid recipients will receive health care through this new delivery method.

Nationally, the trend to managed care has grown precipitously in the first half of this decade. By the end of 1994, 43 states and the District of Columbia had a Medicaid managed care initiative. Managed care originated in the 1970s but growth was slow throughout the 70s and early 80s. Then, due to the double-digit inflation in Medicaid spending, managed care rapidly expanded in the late 80s and early 90s.

Supporters of a managed care delivery system contend that the following benefits can be realized:

- Coordination of medical services by one provider will eliminate fragmentation as experienced in the traditional fee-for-service delivery system.

- Better access to primary health care providers, increased preventative care, early intervention, and a diversion from using emergency rooms for non-emergency conditions.

- A capitated payment system that shifts part of the risk to contractors and providers as a means to accurately budget for health care costs under a managed care system.

Detractors maintain that (1) a managed care system will provide an incentive to under serve clients, (2) clients with complex medical needs may be forced to choose new providers, and (3) existing health maintenance organizations are not familiar with a client population with a significant number of aged and disabled persons.

A drawback to managed care is that historically it has been more costly to establish, monitor, and administer than traditional fee-for-service systems. Administering a managed care system is likely to require additional staff and development of new

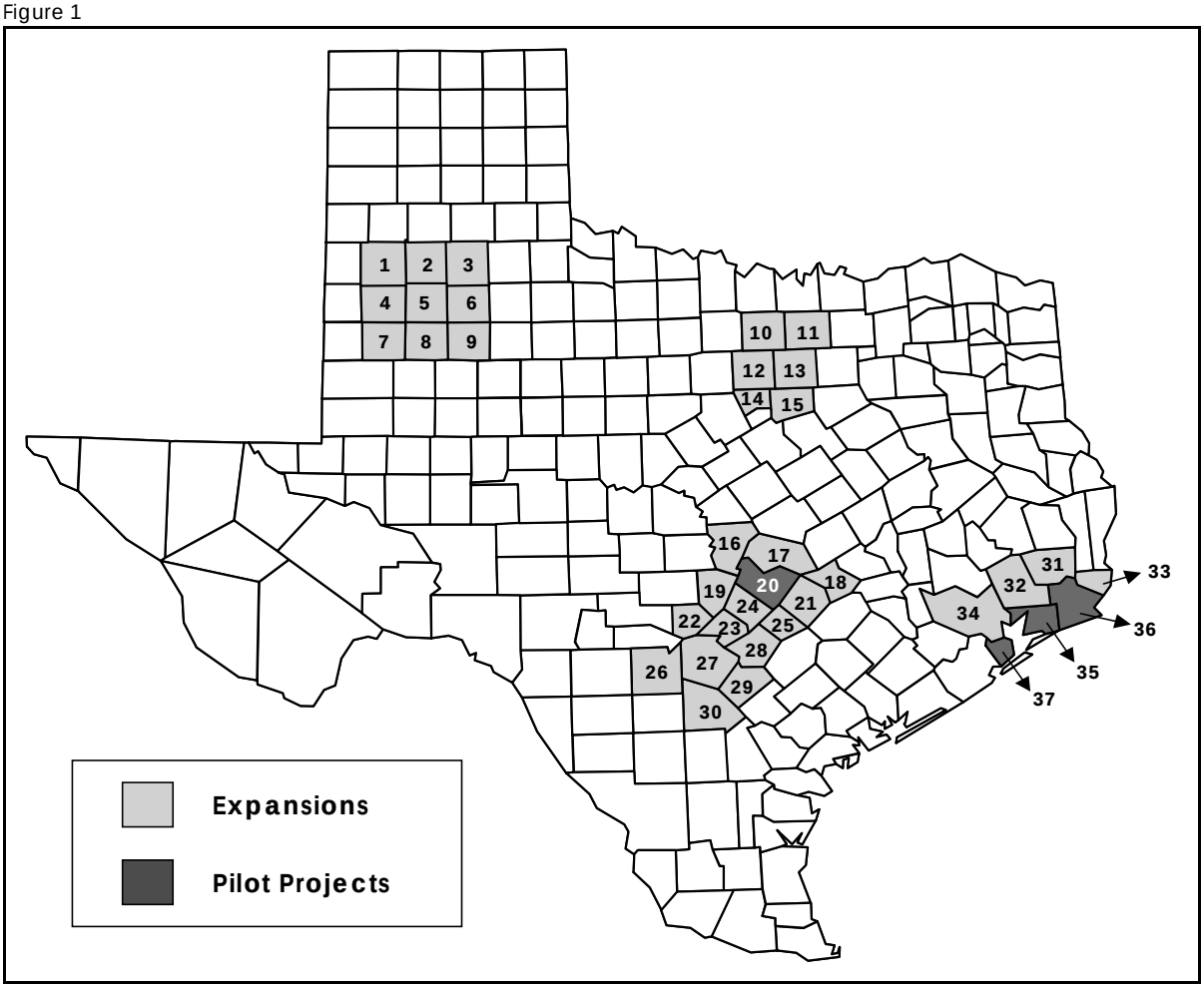
administrative expertise, rate-setting mechanisms, and most likely, a new organizational structure.

There is a belief that managed care can help keep costs of Medicaid services under control. A Kaiser Commission report in 1996 found that successful managed care programs have saved somewhere between 5 and 15 percent over fee-for-service programs and the quality of care remained about the same. In the *Texas Medicaid in Perspective Report* issued by the Health and Human Services Commission in January 1997, it was estimated that managed care in Texas would save approximately 3.7 percent over what costs for those areas would have been under a fee-for-service environment.

Appendix 3:

Service Delivery Areas

Figure 1



Pilot Project Counties

Chambers - 35
Galveston - 37
Jefferson - 36
Travis - 20

Expansion Counties

Atascosa - 30
Bastrop - 21
Bexar - 27
Blanco - 19
Burnet - 16
Caldwell - 25
Comal - 23
Crosby - 6
Denton - 11
Floyd - 3
Garza - 9
Guadalupe - 28
Hale - 2
Hardin - 31
Harris - 34
Hays - 24
Hockley - 4
Hood - 14
Johnson - 15
Kendall - 22
Lamb - 1
Lee - 18
Liberty - 32
Lubbock - 5
Lynn - 8
Medina - 26
Orange - 33
Parker - 12
Tarrant - 13
Terry - 7
Williamson - 17
Wilson - 29
Wise - 10

Appendix 4:

Legislation

In 1991, the Texas Legislature adopted House Bill 7 authorizing a two-year pilot program for providing Medicaid services through a managed care delivery system. These pilots were launched in Travis County and in the Gulf Coast area of Galveston, Jefferson, and Chambers counties.

With Medicaid costs on the rise and two successful managed care programs operating in the State, the Texas Legislature adopted Senate Bill 10 in May of 1995. Senate Bill 10 authorized the Health and Human Services Commission to restructure the Texas Medicaid program to incorporate managed care delivery systems across the State. Specifically Senate Bill 10 required the Commission to:

- Design a Medicaid system to control costs.
- Include methods for ensuring accountability, incorporating financial reporting, quality assurance, and utilization review.
- Provide a single point of accountability for the collection of uniform data to assess, compile, and analyze outcome quality and cost efficiency.
- Perform comparative analyses of compiled data to assess the relative value of alternative health care delivery systems. Report the results of the analyses to the Governor, Lieutenant Governor, and the Speaker of the House of Representatives.
- Oversee the methodology for setting capitation and provider payment rate to ensure the cost-effective provision of quality health care.
- Design the system to enable the State to review and implement any changes in the Medicaid prescription drug program determined to be cost-effective.
- Establish geographic health care service regions and emphasize regional coordination in the provision of indigent health care.
- Adopt rules regarding the health care delivery plan agreement and requiring an intergovernmental initiative to seek public input. The minimum requirements in the health care plan agreement with the intergovernmental initiative must include provisions relating to:
    - Compliance with uniform criteria that are set in the waiver describing individual eligibility for services

- Compliance with a uniform description and provision of services that is set in the waiver for persons covered by the health care delivery plan

- The assurance that, to the extent possible, payments made to the intergovernmental initiative on a capitated basis consider geographic, risk-adjusted cost of providing care to persons eligible for Medicaid;

- Ensure adequate access to quality health care services consistent with the waiver and the standards prescribed by the Federal Health Care Financing Administration or the Commission, including standards relating to travel time and distance that are designed to ensure access by patients to health care providers in the patient's local community.

- Develop and implement policies regarding financial management, quality assurance, utilization review and patient access in accordance with standards consistent with the waiver.

- Monitor compliance with and take any action as necessary or appropriate, including the use of administrative penalties, to enforce sections 16A, 16B, 16C, 16D, and 16E of the article and related rules, federal waivers, or orders and the decisions of the Commission.

- Ensure grievance and appeal procedures for persons who are denied services or have a complaint regarding the quality of services under the health care plan; grievance and appeal procedures for health care providers who are denied participation in the health care delivery plan or who want to appeal other causes.

- Ensure, to the extent possible, managed care lowers the cost of providing Medicaid services through the use of health care delivery systems such as a primary care case management system, partially capitated system, or full capitated system or a combination of one or more of those systems and use, where possible, multiple, competing managed care organizations within those systems.

In addition, Senate Bill 10 requires that managed care organizations (MCO) which contract to provide services to Medicaid individuals must hold a certificate of authority to operate under the Texas Health Maintenance Organization Act. Also, the MCO must be either regulated by the Texas Department of Insurance or provide proof to the Department that it has obtained insurance to cover the cost of health care benefits in the event of failure and it must meet minimum federal requirements.

Appendix 5:

Related Reports

The State Auditor's Office reviewed the sufficiency of the Texas Department of Health's procurement practices in a separate statewide procurement audit to be released in March of 1998. The procurement of 1998 Medicaid managed care services were evaluated and found to be sufficient to encourage competition and reduce Medicaid costs.

The Kaiser Commission on the Future of Medicaid issued a report in 1995 titled *Medicaid Managed Care: Lessons from Literature.* The report reviewed literature about Medicaid and managed care in an effort to assess what the effect of managed care would be when applied to low-income populations. The report concluded that managed care could change utilization of some health care services, and, in some cases, save money.

The Lewin Group issued a report in 1996 titled *Managed Care Program Objectives.* The report was to provide the Texas Department of Health with concrete, objective measures that could be used to gauge progress of the Medicaid managed care program.

The Lewin Group issued another report in 1996 titled *Medicaid Program Administration and Managed Care Activities: A Look at Other States.* The purpose of the report was to provide the State of Texas with an overview of what other states were doing regarding implementation of Medicaid managed care.