



An Audit Report on

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

October 2016
Report No. 17-007



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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"¹ 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.

¹ "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 ^a
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 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.**

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.

Contents

Detailed Results

Chapter 1	
The Commission Should Improve Its Use of Audit Activities to Monitor MCOs	1
Chapter 2	
The Commission Should Improve Its Processes for Collecting Reimbursements of Costs Related to Its Contracted Audit Services and Collecting Experience Rebates	11
Chapter 3	
The Commission Should Use Information That Its External Quality Review Organization Contractor Provides to Strengthen Its Monitoring of MCO Performance	15
Chapter 4	
The Commission Should Strengthen Its Security and Processing Controls Over Certain Information Technology Systems.....	17

Appendices

Appendix 1	
Objective, Scope, and Methodology.....	19
Appendix 2	
Issue Rating Classifications and Descriptions.....	23
Appendix 3	
The Commission’s Payments to MCOs	24
Appendix 4	
Calculating Experience Rebates.....	25
Appendix 5	
Pharmacy Benefit Managers’ Financial Information	26
Appendix 6	
The Commission’s Management’s Response	27

Detailed Results

Chapter 1

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

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:
Priority²

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.

² 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.³ 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

³ 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:
High⁴

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.

⁴ 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:
Priority⁵

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

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.

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 2013⁶ 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

⁵ 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.

⁶ 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:
High⁷

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.

⁷ 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
Cook Children's Health Plan	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

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:
Medium⁸

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).

⁸ 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 ^a					
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 ^b	75%
Performance Audit	1,401,652	711,209	427,901	262,542 ^c	49%
AUP Engagement	2,211,487	1,889,150	303,362	18,975 ^d	15%
Totals	\$4,950,664	\$2,928,639	\$845,597	\$1,176,428	41%

^a 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.

^b 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.

^c 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.

^d 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:
Low⁹

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 accounts¹⁰ 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 \$273,681¹¹, 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 \$3,458,395¹² in experience rebates from 3 MCOs during fiscal years 2011 through 2013.

⁹ 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)/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.

¹⁰ 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.

¹¹ 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.

¹² 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

Chapter 3
Rating:
Low¹³

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

¹³ 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

Chapter 4
Rating:
Medium¹⁴

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

¹⁴ 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

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 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.
Medium	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(s) and reduce risks to a more desirable level.
High	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(s) and reduce risks to the audited entity.
Priority	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(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 ^a	12,025,719,599
Texas Children's Health Plan, Inc.	2,144,891,875
UnitedHealthcare	1,786,576,005
Total	\$ 35,723,212,549
^a 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*.

Pharmacy Benefit Managers' Financial Information

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

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.

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

- 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.

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

- *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.

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

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.

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

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.

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

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.

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

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.

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

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

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

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.

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

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 31st 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 31st 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

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

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

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

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*

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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

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The Honorable Greg Abbott, Governor

Health and Human Services Commission

Mr. Charles Smith, Executive Commissioner



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