Managed Care: Contract Oversight and Monitoring

Charles Smith
Executive Commissioner

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State Medicaid Director

March 28, 2018
HHS budget overview
Majority allocated to Medicaid client services

81.2% of the overall budget

HHSC GR/GRD Appropriations 2018-19
($28,680,165,476)

- Medicaid Client Services (Goal A) - 81.2%
- Other Grants/Client Services - 7.6%
- MSS Program Administration - 4.6%
- State Hospitals/SSLCs - 4.4%
- System IT - 0.6%
- Regulatory/Inspector General - 0.6%
- CHIP - 0.5%
- Indirect Administration - 0.4%

Other Grants/Client Services include TANF, Women's Health, MHBG, ECI, etc.
MSS Program Admin includes salary, travel, and contracts (Eligibility staff, TIERS, TMHP, etc.)
State Supported Living Centers appropriations include Medicaid funding.
Indirect Administration includes PCS, FSD, GR/Comms, Legal, Internal Audit, Regional Support, etc.
Medicaid cost growth
Caseload is the primary driver of cost

Even with caseload increases, Texas Medicaid cost per person cost growth is substantially lower than the national trend.

<table>
<thead>
<tr>
<th>2009 to 2016</th>
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<tbody>
<tr>
<td>Texas Medicaid Caseload Growth</td>
</tr>
<tr>
<td>+35%</td>
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</table>

Source: HHSC Financial Services, HHS System Forecasting (Texas Medicaid data), CMS Office of the Actuary (U.S. data)
Positive outcome trends
Reduced potentially preventable events

Improved access to care, ambulatory care coordination, and quality of care may reduce hospital admissions and readmissions.

**Calendar Year 2013 - 2016**

**Preventable Admissions**
- Reduced by 5%
- Reduced by 49%

**Preventable Readmissions**
- Reduced by 6%
- Reduced by 24%

STAR
STAR+PLUS
Positive outcome trends
HEDIS measures for Texas managed care

Measures demonstrate improvement in the effectiveness of or access to care.

HEDIS Performance: Calendar Year 2013 vs. 2016

STAR
Adolescent Well-Care Visits
2013: 65  2016: 71  +9%

STAR
Postpartum Care
2013: 59  2016: 67  +14%

STAR+PLUS
Diabetes Care - HBA1C Testing
2013: 83  2016: 87  +5%

STAR+PLUS
Antidepressant Medication Management (Acute Phase)
2013: 44  2016: 47  +7%

STAR+PLUS
Antidepressant Medication Management (Continuation Phase)
2013: 30  2016: 33  +10%

HEDIS = Healthcare Effectiveness Data and Information Set
Incentivizing value-based care
Based on the Triple Aim

Defined by three factors: experience of care, health of population, and per capita cost.

**Pay for Quality (P4Q)**

*Medical measures:*
  - Prevention
  - Chronic disease management (including behavioral health)
  - Maternal and infant health

*Dental measures:*
  - Annual oral evaluations
  - Primary prevention against dental caries (cavities)

% capitation at risk
Measurement began January 2018

**Alternative Payment Model (APM)**

Contracts require a minimum % of provider payments linked to quality based APMs

Annual % increases over four years

*Year 1 (CY 2018) minimum APM ratios:*
  - Overall: >=25%
  - Risk-Based: >=10%

Measurement began January 2018
An evolving landscape
Rapid growth of managed care model

Source: HHSC Financial Services, HHS System Forecasting
FY 2017 is incomplete/not yet final
An evolving infrastructure
Supporting managed care

## Managed Care Programs

<table>
<thead>
<tr>
<th>Program</th>
<th>MCOs per Program</th>
<th>Product Lines and Supporting Contracts</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHIP</td>
<td>17</td>
<td>CHIP Rural Service Area contracts (2)</td>
</tr>
<tr>
<td>STAR</td>
<td>18</td>
<td>STAR+PLUS expansion contracts (4)</td>
</tr>
<tr>
<td>STAR+PLUS &amp; MMP</td>
<td>5</td>
<td>STAR+PLUS Medicaid Rural Service Area contracts (4)</td>
</tr>
<tr>
<td>STAR Kids</td>
<td>10</td>
<td>MMP contracts (5)</td>
</tr>
<tr>
<td>STAR Health</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Dental</td>
<td>2</td>
<td></td>
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</tbody>
</table>

**Uniform Managed Care contract**

- 21 total contracts, 3 product lines

**Contract numbers** are subject to change. Current as of February 2018.
Contract lifecycle approach
Multiple points being leveraged for oversight

Strength in oversight comes from an integrated horizontal and vertical approach within the organization.

**Pre-contract stage**
- Ongoing leadership engagement in the Request for Proposal (RFP) process
- Comprehensive contract development and structuring
- Robust readiness reviews and transition process

**Management and oversight of the contract**
- Policy and Program Requirements
- Encounter Data
- Performance on Quality Metrics and Initiatives
- Operational Compliance
- Financial Compliance
- Utilization Reviews
Contract oversight tools
Span a multitude of areas

Administered by various expertise across the organization.

1. Validation of contractual requirements
2. Biennial operational review process
3. Utilization Reviews
4. HHSC targeted reviews

Financial oversight
Strength in oversight
Starts with contract formation

Example: Financial Oversight

Contract formation with clear terms
- Set standards for reported financial data
  - Principles
  - Timing
  - Templates
- Cap administrative expenses
- Limit profits

Management by specialized expertise
- Reconcile and validate financial data
- Define scope of annual financial audit based on compliance
- Manage other additional financial audits & reviews

Audits annually & as needed
- Conduct annual audit by two independent contractors for additional data validation
- Conduct supplemental audits or reviews based on other identified issues

Non-compliance discoveries enforced as established in the contract, including liquidated damages or recovery of the Experience Rebate (i.e. recovery of “excess profit”).
Financial oversight
Timeline for managing compliance

An 18-20 month audit process post-year end.

FSR = Financial Statistical Report
Contract financial structure
Safeguards to ensure FISCAL responsibility

Major components are caps on administrative expenses, conversions to income, and rebates on excessive profit.

<table>
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<th>Profit Range</th>
<th>HHSC Recovery</th>
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<tr>
<td>3% &lt; 5%</td>
<td>20%</td>
</tr>
<tr>
<td>5% &lt; 7%</td>
<td>40%</td>
</tr>
<tr>
<td>7% &lt; 9%</td>
<td>60%</td>
</tr>
<tr>
<td>9% &lt; 12%</td>
<td>80%</td>
</tr>
<tr>
<td>12% or greater</td>
<td>100%</td>
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</tbody>
</table>

MCOs keep profit to <3%

Net income

Experience Rebate

Expenses in excess of admin cap

Capped by program

Administrative Expenses

Excessive profit

Profit
Operations oversight tools
HHSC and external auditors

Like financial oversight, operations has multiple monitoring perspectives.

HHSC onsite biennial operational reviews

- Claims Processing
- Encounter Data
- Prior Authorization Process
- Utilization Management
- Website Critical Elements
- Call Center Functioning
- Provider Relations

+ Additional modules under development

3rd party biennial performance audits (or more frequently as determined by risk)

Critical indicator focus

MCO self-reported data

- MCO Hotlines
- Complaints and Appeals

Operational processes

Two areas of focus

Targeted area(s) may vary. Examples include:

- Claims processing
- Subcontractor monitoring (including PBMs)

Can inform the focus of the 3rd party audit or the need for an incremental one.
Utilization Reviews (UR) are conducted by nurses and overseen by the Office of the Medical Director.

**Overall purpose**
1. To ensure MCOs are correctly enrolling members in HCBS through assessment and justification of service need
2. To ensure MCOs are providing services according to their assessment of service needs

**UR components**
- MCO on-site visit
- Records request
- Desk reviews
- Client home visits
- Complaint referrals
- Reporting of results

**Findings inform**
- Needed policy and contract clarifications
- MCO consultation or training topics
- Internal process improvements
- Necessary MCO remedies

Ongoing training, consultation, and technical assistance to MCOs

HCBS = Home and Community Based Services
MCO member complaints
Two areas of focus

#1 is resolution

- No wrong point of entry
- HHSC resolution specialist assigned until case is closed
- Resolution timelines in contract requirements

Note: FFS complaint process varies

#2 is oversight

- Analysis of MCO member complaints to pinpoint trends that indicate:
  - Operational issues
  - Needed policy clarifications
- Adding additional resources to strengthen analytics and focus on real time data
Addressing non-compliance
Graduated remedy process

Multiple stages to address non-compliance discovered via oversight and monitoring.

Increased levels of impact for MCOs.

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
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<tbody>
<tr>
<td>Stage 1</td>
<td>Plans of Action</td>
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<tr>
<td>Stage 2</td>
<td>Corrective Action Plan (CAP)</td>
</tr>
<tr>
<td>Stage 3</td>
<td>Liquidated Damages (LDs)</td>
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<tr>
<td>Stage 4</td>
<td>Suspension of Default Enrollment</td>
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<tr>
<td>Stage 5</td>
<td>Contract Termination</td>
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Financial Impacts
Liquidated damages (LDs) increasing with ongoing strengthening of oversight practices.

All dollars are based on state FISCAL year. All numbers are rounded.
MCO Oversight
Next steps and recommendations

Maximize current contract resources
Implement an Annual Review of MCO deliverables to identify deliverables that no longer contribute to evaluation of outcomes and performance.

Consider service delivery area reconfiguration for future procurements
Engage stakeholders in development of potential new configurations.

Utilization review expansion
Seek resources to expand STAR+PLUS utilization reviews and include reviews for STAR Health and STAR Kids programs.
Update on Internal Audit and Contract Oversight Implementation

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State Medicaid Director

Sonja Gaines
Associate Commissioner, IDD-BH

Ron Pigott
Deputy Executive Commissioner, PCS

March 28, 2018
Enrollment Broker Functions

- Provides state-wide enrollment assistance for Medicaid and CHIP managed care programs
- Produces and distributes materials related to Medicaid managed care and Texas Health Steps
- Provides call center operations
- Provides outreach and informing services for Texas Health Steps
- Processes premium payments for CHIP and Medicaid Buy-In programs
Internal Audit of Enrollment Broker Contract Monitoring

• HHSC Internal Audit conducted an Audit of Enrollment Broker Contract Monitoring and published their report August 2016.

• Internal Audit made four recommendations:
  1. Improve Critical Contract Monitoring Processes
  2. Clearly Define and Communicate the Contract Monitoring Roles and Responsibilities
  3. Validate the Accuracy and Ensure Completeness of Required Reports
  4. Verify Whether Self-Reported Expenses are Unallowable Based on a Review of Expense Detail
<table>
<thead>
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<th>HHSC Actions</th>
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<tbody>
<tr>
<td>Conduct quarterly random onsite reviews of mail house operations and monthly sampling of call center operations</td>
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<tr>
<td>Perform enhanced monthly financial desk reviews and use of external audit firm for financial contract audits</td>
</tr>
<tr>
<td>Track and review contractual deliverables for outcomes and risks</td>
</tr>
<tr>
<td>Convene internal work group to identify items for future solicitations and contracts</td>
</tr>
<tr>
<td>Strengthening documentation for contract oversight and future procurement</td>
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HHSC Internal Audit completed the Audit of Contract Monitoring of Local Mental Health Authorities (LMHAs) in October 2017.

• Purpose: To determine if contract monitoring effectively ensures funds are utilized appropriately and LMHAs are meeting performance expectations.

• Findings and Recommendations: Focused on improving the administration and monitoring of the LMHA contracts.

• Management Action Steps: Currently underway with full implementation expected August 2018.
Senate Bill 20 implementation

HHSC is in full compliance with the provisions of SB 20, 84th Legislature, Regular Session.

- Records Retention
- Revolving Door Prohibition
- Using CAPPS
- Best Value Certification
- Vendor Performance Tracking System
- DIR Purchases
- Conflicts of Interest
- Prohibited Contracts
- Contracts on the Web
- Enhanced Monitoring
- Contracts over $1 million
- Contracts over $5 million
- Risk Analysis
- Contract Management Handbook
Update on major contracting legislation

**HHSC has fully implemented legislation enacted by the 85th Legislature that continued to improve procurement and contracting processes in Texas.**

Senate Bill 533, 85th Regular Session, improved upon SB 20 provisions:

- Increased DIR’s purchasing thresholds from $1 million to $5 million; and
- Lowered the Contract Advisory Team review threshold from $10 million to $5 million.

Senate Bill 255, 85th Legislature, Regular Session, requires agencies to:

- Identify all employees that must receive purchasing and contract management training;
- Report the number needing training to the Comptroller; and
- Send purchasers who are directly negotiating IT contracts to the required DIR training.
Other key contracting provisions

- Section 7.04 and Section 7.12, Article IX, Senate Bill 1, Regular Session, requires agencies to report all contracts of $50,000 or more within 30 days.

- These riders also require specific notification of contracts with an amendment changing the value by 10 percent or more.