Managed Care: Contract Oversight and Monitoring

Charles Smith – Executive Commissioner

Stephanie Stephens – Deputy State Medicaid Director

March 21, 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>
</tr>
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<tbody>
<tr>
<td>Texas Medicaid Caseload Growth</td>
</tr>
<tr>
<td>Texas Medicaid Per Capita Cost Growth</td>
</tr>
<tr>
<td>U.S. Healthcare Per Capita Spending Growth</td>
</tr>
</tbody>
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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.

**CY 2013 - 2016**

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

- **Preventable Readmissions**
  - Reduced by 6%
  - Reduced by 24%
Positive outcome trends
HEDIS measures for Texas managed care

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

HEDIS Performance: CY 2013 vs. 2016

<table>
<thead>
<tr>
<th>Measure</th>
<th>2013</th>
<th>2016</th>
<th>Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>STAR Adolescent Well-Care Visits</td>
<td>65</td>
<td>71</td>
<td>+9%</td>
</tr>
<tr>
<td>STAR Postpartum Care</td>
<td>59</td>
<td>67</td>
<td>+14%</td>
</tr>
<tr>
<td>STAR+PLUS Diabetes Care - HBA1C Testing</td>
<td>44</td>
<td>47</td>
<td>+7%</td>
</tr>
<tr>
<td>STAR+PLUS Antidepressant Medication Management (Acute Phase)</td>
<td>30</td>
<td>33</td>
<td>+10%</td>
</tr>
<tr>
<td>STAR+PLUS Antidepressant Medication Management (Continuation Phase)</td>
<td>83</td>
<td>87</td>
<td>+5%</td>
</tr>
</tbody>
</table>

HEDIS = Healthcare Effectiveness Data and Information Set
Health plan report cards
Quality measures that matter to members

Input by members for members on plan satisfaction

- Four key areas graded:
  1. Getting help from the doctors and plan
  2. Getting check-ups and tests
  3. Getting help with health issues
  4. Overall plan quality

- Ratings by plan based on member surveys and medical bill analysis

- Transparency for members when selecting or changing plans
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>
</tr>
</thead>
<tbody>
<tr>
<td>CHIP</td>
<td>17</td>
</tr>
<tr>
<td>STAR</td>
<td>18</td>
</tr>
<tr>
<td>STAR+PLUS &amp; MMP</td>
<td>5</td>
</tr>
<tr>
<td>STAR Kids</td>
<td>10</td>
</tr>
<tr>
<td>STAR Health</td>
<td>1</td>
</tr>
<tr>
<td>Dental</td>
<td>2</td>
</tr>
</tbody>
</table>

Product lines and supporting contracts

- **Uniform Managed Care contract**
  - 21 total contracts, 3 product lines

- **STAR+PLUS expansion contracts**
  - 4 contracts

- **STAR+PLUS Medicaid Rural Service Area contracts**
  - 4 contracts

- **CHIP Rural Service Area contracts**
  - 2 contracts

- **STAR Kids contracts**
  - 10 contracts

- **STAR Health contract**
  - 1 contract

- **Dental Services contracts**
  - 2 contracts

- **MMP contracts**
  - 5 contracts

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.

HHSC remedies compliance issues for that year.

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.

- **Expenses in excess of admin cap**
  - Counted as
  - Capped by program

- **Net income**
  - MCOs keep profit to <3%

- **Excessive profit**
  - If profit is
    - 3% < 5%: 20%
    - 5% < 7%: 40%
    - 7% < 9%: 60%
    - 9% < 12%: 80%
    - 12% or greater: 100%
  - Experience Rebate
  - HHSC recovers
Operations oversight tools
HHSC and external auditors

Like financial oversight, operations has multiple monitoring perspectives.

**HHSC onsite biennial operational reviews**

- Claims Processing
- Provider Relations
- Complaints/Appeals
- Call Center Functioning

**Critical indicator focus**

- Encounter Data
- Prior Authorization Process
- Utilization Management
- Website Critical Elements

+ Additional modules under development

**3rd party biennial performance audits**

(or more frequently as determined by risk)

**Two areas of focus**

- MCO self-reported data
- Operational processes

Targeted area(s) may vary. Examples include:

- MCO Hotlines
- 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
Addressing non-compliance
Graduated remedy process

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

Increased levels of impact for MCOs.

Remedy issued is contingent on type of non-compliance and not necessarily sequential.
Liquidated damages (LDs) increasing with ongoing strengthening of oversight practices.
Quarterly monitoring process using provider reconciliation files and member eligibility files. No longer using MCO self-reported data.

The travel time and distance standards are outlined in current managed care contracts.

HHSC will include both LTSS and Pharmacy standards in September 2018 managed care contracts.

Management and oversight of the contract

Quarterly monitoring process using provider reconciliation files and member eligibility files. No longer using MCO self-reported data.

MCOs who do not meet 75% compliance with standards will be issued a corrective action plan (CAP).

January 2019, this requirement will increase to 90% compliance and issuance of both CAPs and liquidated damages (LDs).

Implemented Provider Directory requirements.
## Network Adequacy

### High level federal vs. state comparison

<table>
<thead>
<tr>
<th>CMS required</th>
<th>Texas HHSC implemented</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Services</strong></td>
<td><strong>Services</strong>*</td>
</tr>
<tr>
<td>24</td>
<td>31</td>
</tr>
<tr>
<td><strong>CHIP Providers</strong></td>
<td><strong>CHIP Providers</strong></td>
</tr>
<tr>
<td>Not required</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Time/Distance Standards</strong></td>
<td><strong>Time/Distance Standards</strong></td>
</tr>
<tr>
<td>States to develop</td>
<td>Analysis based on county level vs. high level service area</td>
</tr>
</tbody>
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* LTSS and Pharmacy standards proposed to be implemented in the September 2018 managed care contracts
Active: Competitive bidding on administrative services

• Included competitive pricing component for administrative services in STAR/CHIP draft RFP released on January 29.

Information gathering: Experiences and utility in using price as a component of a competitive bid for Medicaid products

• Publishing a questionnaire for states, MCOs, and other respondents to obtain information.
• On target to obtain information to compile a summary of findings by mid-summer 2018.
Next steps and recommendations
Primary areas of focus

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.
SAO Audit Update

Report 17-007
An Audit Report on Medicaid Managed Care Contract Processes at the Health and Human Services Commission
SAO audit actions taken
HHSC implementation summary

15 out of 18 (83%) recommendations for the below findings have been implemented.

- MCO PBM internal controls and compliance
- Improve coordination of audit activities
- Collect cost of audit-related activities
- Experience rebate collection activities
- Strength securities and controls over certain IT systems
- Improve process for MCO performance audits
- Enhance use of Agreed-Upon-Procedures (AUPs)
- Use of EQRO information

Completion is dependent on when measurement and data is available.
SAO audit actions taken
HHSC implementation details

**Completed actions**
- Developed a cross-functional standard operational tool to monitor multiple areas of contractual compliance.
- Implemented a unified CAP process for monitoring audit findings, other areas of non-compliance, CAP issuance and determination.
- Standardized process for MCOs to submit CAPs for non-compliance to improve monitoring of required changes/actions.

**To be completed**
- Use results of FY2017 enhanced risk assessment that completed in Feb. 2018 to select MCOs for performance audits. Estimated to select MCOs by late **March 2018**.

**Completed actions**
- Required audit firms to align AUPs beginning with FY 2014 audit plan.
- Ongoing consultation with audit firms during and at end of audit to discuss planned actions to address errors on medical claims or admin spending.
- AUPs contain a step for auditors to review implementation of prior recommendations. If performance lacks improvement or has deteriorated, tailored remedies are applied (CAPs or LDs).

**To be completed**
- Upon completion of the audit cycle, HHSC and external auditors will determine if any corrective action plans are appropriate. Audit cycle estimated to complete by **March 31, 2018**.*

*Contingent on responsiveness of MCOs
SAO audit actions taken

HHSC implementation details

**Completed actions**

- Meyers & Stauffer conducted an audit of an MCO to determine if the PBM function was being monitored appropriately.
  - Determined the MCO was meeting contractual requirements but recommended improvements to the MCO’s monitoring practices. HHSC is working with the MCO to track the implementation of the recommendations.
- Finalized monitoring policies, procedures, and tools in August 2017 related to MCOs and PBMs to ensure:
  1. MCOs will receive periodic onsite and/or desk reviews in accordance with agency risk assessments.
  2. MCOs are performing audits on PBMs and correcting/resolving any identified findings.
  3. MCOs are satisfactorily correcting and resolving findings that are identified as a result of a performance audit.
- Transferred HHSC Vendor Drug contract performance staff into the Managed Care Compliance and Operations unit as part of the monitoring team. These staff participate in onsite reviews of MCOs and ongoing oversight of the PBM management/monitoring performed by MCOs.
- Included PBM monitoring in the selection of topics for upcoming third party audits and IG is engaged in an audit of a PBM. Field work began in September 2017.
SAO audit actions taken
HHSC implementation details

**Chp. 2-A**

Collect cost of audit-related activities

- Completed actions
  - Initiated billing MCOs for risk assessments, reviews, and audits conducted by external auditors including activities utilized for broader compliance and performance testing.
  - Amended the Uniform Managed Care Manual to clarify language related to the collection of audit-related costs.

**Chp. 2-B**

Experience rebate collection activities

- Completed actions
  - MCO checks are received by the Accounts Receivable Tracking System (ARTS) and deposited into suspense. Communication is sent to MCS to request coding for allocation.
  - When experience rebate submissions from the MCOs are validated by MCS, an internal form is sent to Accounts Receivable with coding instructions to process the funds.
  - Implemented a MCS Claims Report that is sent to MCS Financial Reporting and Audit Coordination on a monthly basis.

**Chp. 1-D**

Improve coordination of audit activities

- Completed actions
  - Coordinate with IG in the development and periodic revision of proposed MCO audits in the IG Audit Plan – including timing, applicable risks, proposed scope and objectives.
  - Quarterly briefings with IG and MCS leadership on the active MCO audits.
  - Issued a circular titled ‘Coordination of Managed Care Organization Audits’.
  - Participate in key IG MCO audit meetings, including entrance conferences, status updates, and exit conferences.
  - Review proposed IG audit findings and recommendations, and draft audit reports.
SAO audit actions taken
HHSC implementation details

To be completed – Member Survey Data
➤ The measure results for these data will be available in Fall 2019.
  ✓ Setting new minimum standards for a list of quality measures, including member survey results.
  ✓ New standards apply starting with calendar year 2018 data. MCOs below minimum standards on many measures will be targeted to improve quality.
  ✓ Risk assessment has been updated to include finalized measures.

To be completed – Validation Results of Paid Claims Data
➤ Results from this encounter data validation will be available for DMOs by Spring 2020 and for MCOs by Spring 2021.
  ✓ Texas’s EQRO has analyzed the validity of paid claims data for many years following federal protocol. The results have been made public.
  ✓ Starting with data from calendar year 2018, the results of this encounter data validation by medical/dental record review will be included in the Operational Review documents used to score MCOs/DMOs on a number of topics.

Completed
✓ Put in place an automated change management system.
✓ Accounts Receivable implemented a daily reconciliations log and incorporated adding staff initials and dates to all vouchers accounting for deposits processed in HHSAS and USAS.
✓ Modified the existing user security module to tighten the access to system.
✓ Implemented password standards to further strengthen the security and access to the ARTS system.
✓ Migrated the ARTS system to a single platform with full functionality available.