



Texas – Health and Human Services Commission (HHSC) Review of Rider 61 Report Findings

Rider 61 Evaluations | October 3, 2018

Today's Agenda

Topic	Slide Number(s)	Timing
Rider 61(b): Evaluation of Medicaid and CHIP Managed Care – Review of Managed Care Contract Review and Oversight Function	3 – 9	20 minutes
Rider 61(c): Evaluation of Medicaid and CHIP Managed Care – Managed Care Rate Setting	10 – 15	10 minutes
Rider 61(d): Evaluation of Medicaid and CHIP Managed Care – Managed Care Administrative Expenditure Audit	16 – 21	10 minutes

The Rider Report 61 is posted at

<https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2018/sb1-rider61-evaluation-medicaid-chip-august-2018.pdf>.

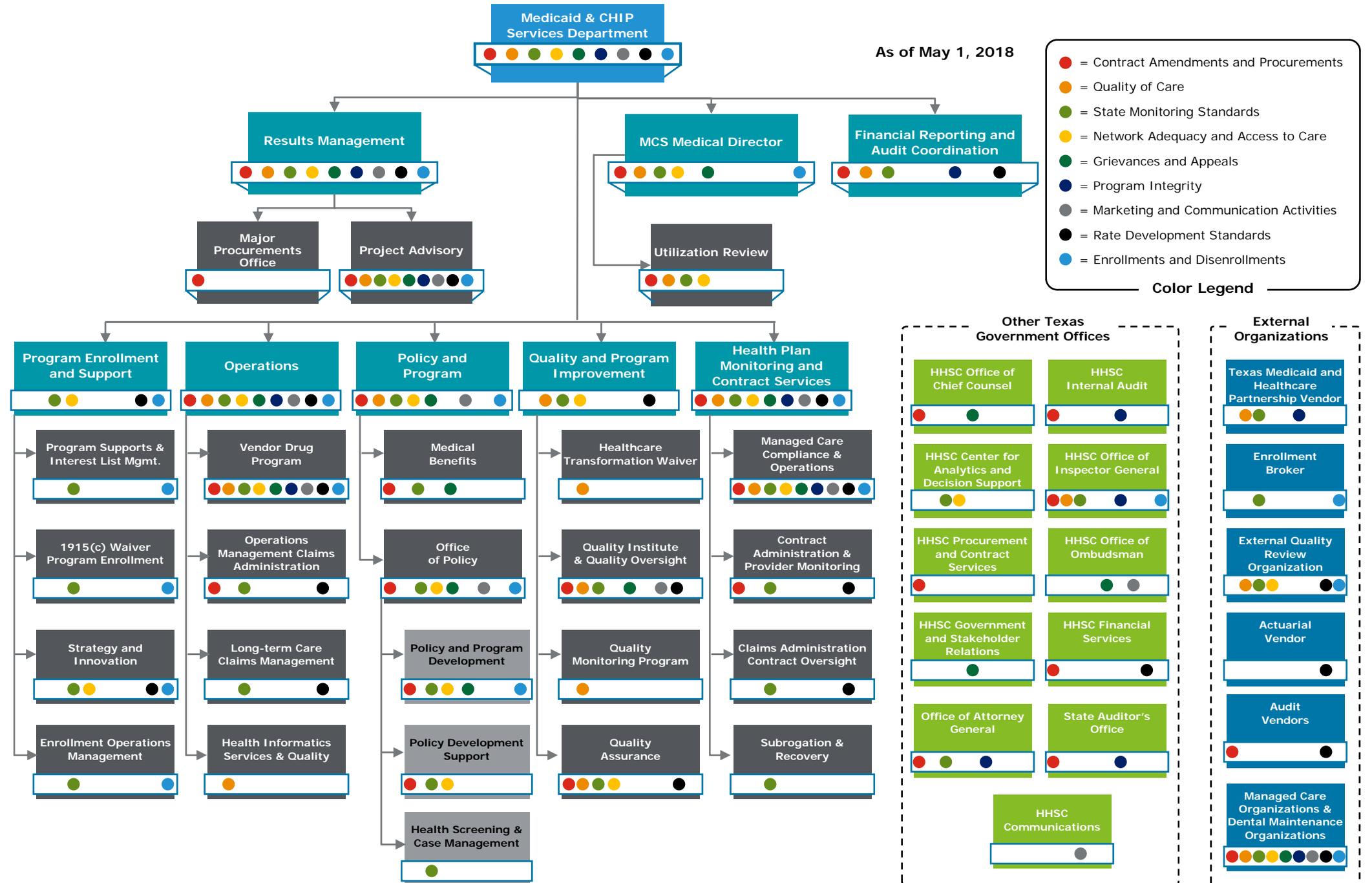
Please send your questions, comments and feedback in writing to

medicaidmanagedcare@hpsc.state.tx.us.

**Rider 61 (b): Evaluation of Medicaid and
CHIP Managed Care –
Review of Managed Care Contract Review
and Oversight Function**

Managed Care Contract Review and Oversight Environment

HHSC's Managed Care Contract Review and Oversight function is a shared effort among sections and offices in HHSC's Medicaid and CHIP Services (MCS) Department with support provided by other HHSC departments, as well as contract vendors.



Managed Care Contract Review and Oversight Frameworks

Two frameworks were applied to assess Texas's Medicaid and CHIP managed care contract review and oversight function.

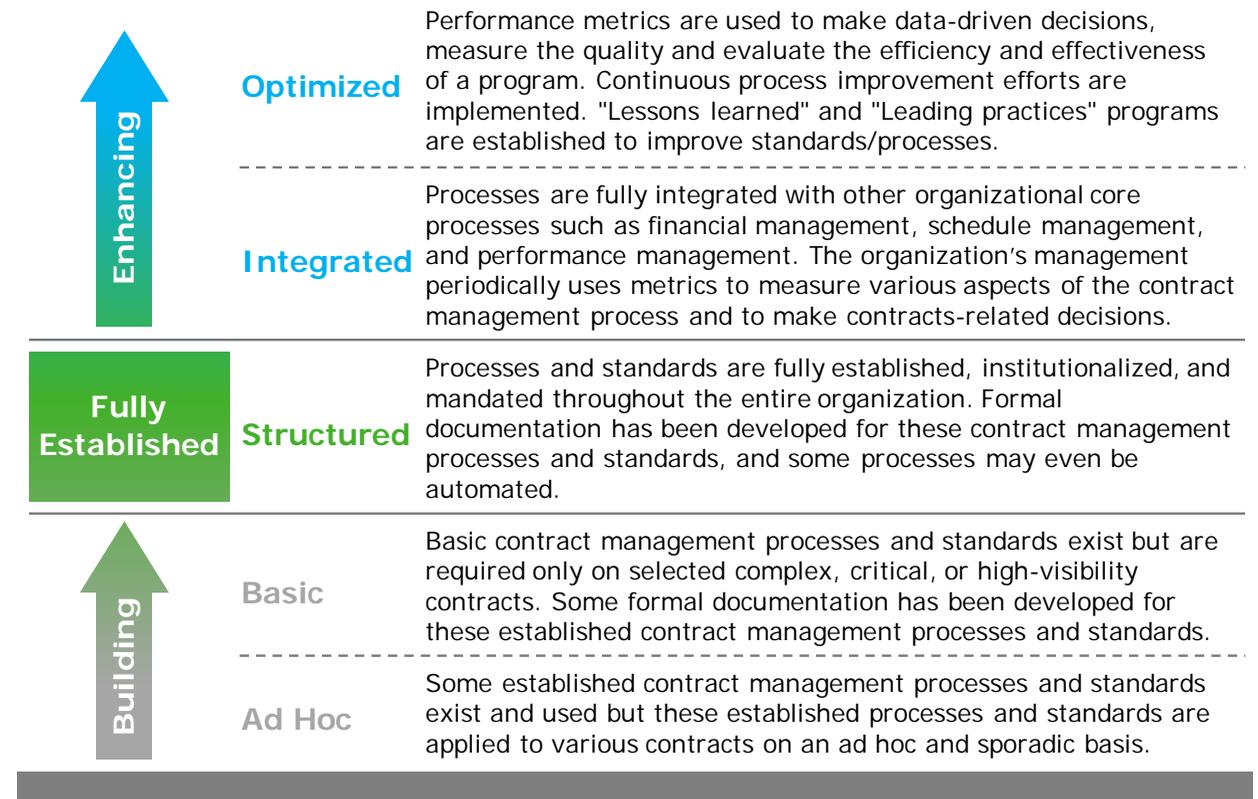
Medicaid and CHIP Managed Care Final Rule

The first is the regulatory framework established by the Centers for Medicare & Medicaid Services (CMS) in April 2016 through the Medicaid and CHIP Managed Care Final Rule, which includes a number of requirements for state oversight of Medicaid and CHIP managed care programs. In addition, a ninth area, Contract Amendments and Procurements, was defined in Rider 61 as a functional area to review.

1. State Monitoring Standards
2. Quality of Care
3. Network Adequacy and Access to Care
4. Program Integrity
5. Grievances and Appeals
6. Marketing and Communication Activities
7. Enrollments and Disenrollments
8. Rate Development Standards
9. Contract Amendments and Procurements

Contract Management Maturity Model (CMMM)

For the purposes of this assessment, the nine functional areas served as a framework for applying the CMMM. The CMMM measures five levels of maturity:

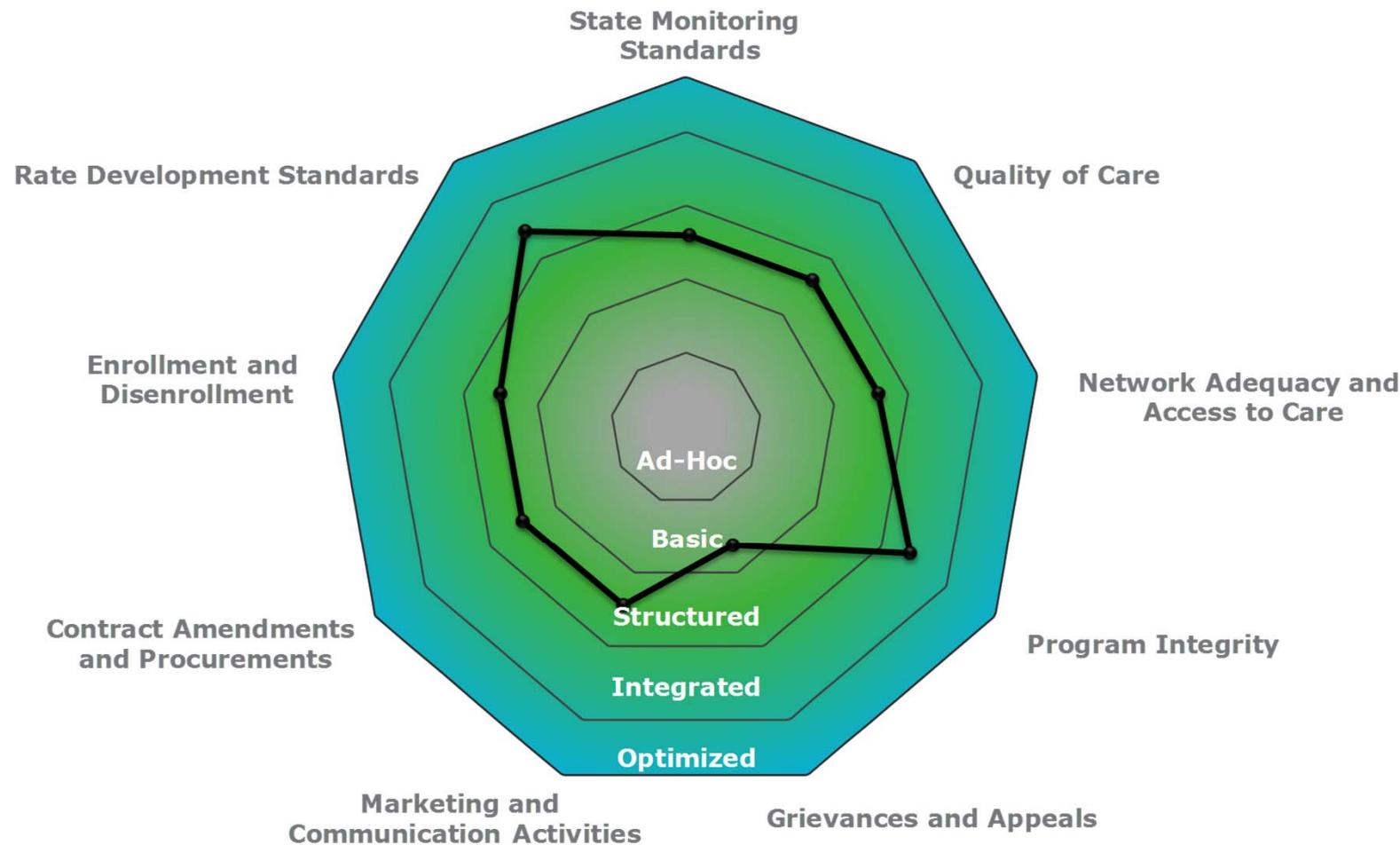


The assessment was based on nine interviews, 16 sessions with leaders and staff from HHSC sections and offices, the review of over 300 documents, and the use of relevant benchmarks from other states. The assessment was conducted between February 21, 2018, and June 1, 2018.

Functional Areas by CMMM Stage

The review of HHSC's Medicaid and CHIP Managed Care contract review and oversight function indicates that the CMMM level for each of the functional areas assessed includes Basic, Structured, and Integrated.

Functional Areas by Contract Management Maturity Model (CMMM) Stage



Functional Area	CMMM Stage
State Monitoring Standards	Structured
Quality of Care	Structured
Network Adequacy and Access to Care	Structured
Program Integrity	Integrated
Grievances and Appeals	Basic
Marketing and Communication Activities	Structured
Contract Amendments and Procurements	Structured
Enrollments and Disenrollments	Structured
Rate Development Standards	Integrated

Summary of Findings

Findings for each functional area were developed for HHSC to further evolve its managed care contract review and oversight capabilities. Each finding was broadly characterized as either 1) “Continue,” which means that the activity is well aligned to the oversight function and should be maintained and/or enhanced, or 2) “Opportunity,” which means that HHSC could introduce new activities to improve the oversight function.

Findings: Activities for HHSC to Continue

They fall into four broad categories that emphasize some of the key accomplishments of HHSC’s Medicaid and CHIP Managed Care oversight efforts:

- **Adherence to standard processes:** HHSC has developed and documented processes for its core managed care oversight functions. Staff are aware of these processes and follow them.
- **Collaboration within and outside of HHSC:** HHSC works across divisions and with other entities in executing a wide range of oversight functions.
- **Validation of information utilized for oversight:** HHSC has established processes to validate and audit much of the data provided to them for oversight purposes.
- **Provision of Guidance:** HHSC has developed written guidance for MCOs for many of the elements of the various Medicaid programs.

Findings: Opportunities for HHSC to Consider

These opportunities fall into five broad categories:

- **Increase efficiency and automation of processes:** There are number of opportunities to take existing processes and make them less time and/or labor-consuming.
- **Share information across organizational units:** HHSC has opportunities to enhance sharing of information gathered for one oversight function to another oversight function to strengthen oversight efforts using information that already exists.
- **Improve data integration:** Merging existing data sources or pulling in additional data sources could offer HHSC more insights on addressing certain oversight functions.
- **Improve the effectiveness of priority functions:** HHSC has opportunities to strengthen some key oversight efforts.
- **Increase transparency of relevant information:** While HHSC makes a significant amount of information available to the public, there are additional opportunities to provide more information to policy makers and consumers.

Summary of Findings: Activities for HHSC to Continue

The findings, relative to the activities that HHSC should continue to execute, indicate that HHSC has built a strong foundation for its oversight of Medicaid and CHIP managed care programs.

Adherence to standardized processes

Continue: Activities are well-aligned to the managed care oversight function	Functional Area Reference
Continue Accountability through the Strengthened Graduated Remediation Process and Liquidated Damages (LDs)	5.1. State Monitoring Standards
Continue to Improve Grievances and Appeals Data Aggregation and Identification of Trends	5.5. Grievances and Appeals
Continue Recovery Activities	5.4. Program Integrity

Collaboration within and outside of HHSC

Continue: Activities are well-aligned to the managed care oversight function	Functional Area Reference
Continue Ongoing Effort to Streamline Managed Care Organization (MCO) Deliverables	5.1. State Monitoring Standards
Continue the Newly Redesigned Pay-for-Quality (P4Q) Program	5.2. Quality of Care
Continue to Improve Guidance on Utilization Management and Medical Necessity Determinations	5.2. Quality of Care
Continue the Consumer (Member) Information Toolkit	5.6. Marketing and Communication Activities
Continue to Provide Financial Reporting Transparency	5.9. Rate Development Standards

Validation of information utilized for oversight

Continue: Activities are well-aligned to the managed care oversight function	Functional Area Reference
Continue to Enhance Coordination of Audits and Reviews	5.1. State Monitoring Standards
Continue with Integrated Managed Care Compliance and Operations (MCCO) Teams	5.1. State Monitoring Standards
Continue to Strengthen Integration of managed care oversight Across Divisions	5.1. State Monitoring Standards
Continue Elevation of the Medicaid and CHIP Services (MCS) Major Procurement Office	5.7. Contract Amendments and Procurements
Continue the Texas Fraud Prevention Partnership	5.4. Program Integrity

Provision of guidance

Continue: Activities are well-aligned to the managed care oversight function	Functional Area Reference
Continue the MCO Risk Assessment Instrument	5.1. State Monitoring Standards
Continue to Enhance Validation of Encounter Data	5.2. Quality of Care
Continue Use of the External Quality Review Organization (EQRO)	5.2. Quality of Care
Continue to Enhance the Texas Healthcare Learning Collaborative (THLC) Portal	5.2. Quality of Care
Continue Efforts to Automate Deliverable Submissions	5.1. State Monitoring Standards

Summary of Findings: Opportunities for HHSC to Consider

Opportunities include new activities that HHSC may wish to implement in order to improve the oversight function.

Increase efficiency and automation of processes

Opportunity: Findings to enhance managed care oversight function	Functional Area Reference
Opportunity to Introduce a Summary Compliance Framework	5.1. State Monitoring Standards
Opportunity for Process Automation	5.3. Network Adequacy and Access to Care
Opportunity to Align Entry Points for Grievances	5.5. Grievances and Appeals
Opportunity to Streamline Planning and Development Procurement Phase	5.7. Contract Amendments and Procurements
Opportunity to Improve the Manual Contracting Process	5.7. Contract Amendments and Procurements
Opportunity to Improve Contract Amendment Guidance	5.7. Contract Amendments and Procurements

Share information across organizational units

Opportunity: Findings to enhance managed care oversight function	Functional Area Reference
Opportunity to Align Network Adequacy and Access to Care Efforts	5.3. Network Adequacy and Access to Care
Opportunity to Introduce Additional Factors into the Default Enrollment Methodology	5.8. Enrollments and Disenrollments

Improve data integration

Opportunity: Findings to enhance managed care oversight function	Functional Area Reference
Opportunity for Network Adequacy Standards for Long-Term Services and Supports (LTSS) provider types	5.3. Network Adequacy and Access to Care
Opportunity to Introduce Additional Factors in Network Adequacy Analysis	5.3. Network Adequacy and Access to Care
Opportunity to Leverage Performance Metrics to Make Data-Driven Decisions	5.9. Rate Development Standards

Improve the effectiveness of priority functions

Opportunity: Findings to enhance managed care oversight function	Functional Area Reference
Opportunity to Increase Utilization Review Resources	5.2. Quality of Care
Opportunity to Update the Methodology for Measuring Program Integrity	5.4. Program Integrity
Opportunity to Enhance Education on the Issue Resolution Process	5.5. Grievances and Appeals
Opportunity to Validate New Member Onboarding	5.6. Marketing and Communication Activities
Opportunity to Enhance Data Validation with Financial Subject Matter Expertise	5.9. Rate Development Standards

Increase transparency of relevant information

Opportunity: Findings to enhance managed care oversight function	Functional Area Reference
Opportunity to Enhance the HHSC Website	5.6. Marketing and Communication Activities
Opportunity to Enhance Managed Care Report Cards	5.8. Enrollments and Disenrollments

Rider 61 (c): Evaluation of Medicaid and CHIP Managed Care – Managed Care Rate Setting

Managed Care Rate Setting: Approach

Rider 61(c) requires HHSC to provide an overview of the Medicaid managed care rate setting methodology for Texas and compare Texas's rate setting methodology to other states. In addition to rate setting, HHSC will provide an overview and comparison of states' funding and MCO procurement methods, including competitive bidding procedures.

1

Managed Care Rate Setting Methodology

- **Gather Information:** Collect publicly available rate development documentation for states selected for comparison
- **Compare Rate Setting Methodologies:** Leverage rate setting experience across the country, knowledge of the current Texas MCO environment, and prior experience in program evaluation support, to summarize and document procedures for developing, adjusting, and applying the various components of capitation rates, highlighting potential areas of opportunity for Texas



2

MCO Selection

- **Gather Information:** Collect publicly available MCO procurement information for states identified as comparable to Texas. Analyze responses from "Managed Care Pricing Models" RFI released by HHSC to the Texas MCOs
- **Summarize MCO Selection Processes:** Consolidate data and document state MCO selection processes including, competitive bid arrangements, variation in selection process by Medicaid population, contracting requirements, and competition requirements

3

Funding Methods

- **Gather Information:** Collect data for funding methods used in comparable states through interviews, subscription services (e.g. HealthLeaders Interstudy), and publicly available information
- **Document Other States' Funding Methods:** Document inventory of funding methods used in other states, accounting for insured, self-insured, and hybrid funding models

Managed Care Rate Setting: Managed Care Rate Setting Methodology

The review of the rate development process compared six rate setting elements across Texas and other states. The figure below provides a high-level summary of the rate development comparison across Texas and other states.

Rate Setting Element	Texas Methodology	Comparison to Other States
Base Data: <i>Historical data set serving as a starting point for the development of capitation rates.</i>	<ul style="list-style-type: none"> One year of encounter claims as their base data Adjusted with incurred but not reported (IBNR) 	<ul style="list-style-type: none"> One to three years of encounter claims data Service carve-outs have the most variation across states
Claim Trends: <i>Claim cost trends are a series of assumptions used to project base data from the historical base period to the current rating period.</i>	<ul style="list-style-type: none"> Medical and prescription trend rates based on historical data Medical trends applied by service delivery area and risk group Prescription drug trends applied by risk group and drug type 	<ul style="list-style-type: none"> Historical data is the preferred method by CMS Historical data is a common source, but some states supplement historical experience with other data sources
Adjustments: <i>States may make additional adjustments to base data in order to develop rates that best fit their programs, populations, and covered services.</i>	<ul style="list-style-type: none"> Applies efficiency reimbursement reduction adjustment Implemented additional incentive programs to improve quality and effectiveness of care 	<ul style="list-style-type: none"> Incorporate efficiency adjustments in a similar manner Some states make adjustments for incentive programs and withholds
Nonmedical Expenses: <i>Nonmedical expenses must include expenses related to MCO administration, taxes, licensing and regulatory fees, contribution to reserves, risk margin, and cost of capital.</i>	<ul style="list-style-type: none"> Administrative load development utilizes hybrid of percentage of projected benefit costs and fixed per member per month (PMPM) amount, with varying values across each program Risk margin of 1.5% of premium for all programs except STAR+PLUS and STAR Kids where it is 1.75% 	<ul style="list-style-type: none"> Other states utilize a percentage of projected benefit costs, fixed PMPM amount, or hybrid method Other states typically have risk margins between 1% and 2%, but some include the risk margins in the administrative load.
Risk Mitigation: <i>Various techniques are used to appropriately mitigate the acuity differences across various populations.</i>	<ul style="list-style-type: none"> Prospectively applies risk adjustment to recognize cost differences between MCOs based on the health of their members Does not include any other risk-sharing mechanisms 	<ul style="list-style-type: none"> The risk adjustment methodology used in Texas's rate development process is a similar approach utilized by many other states.
Rate Detail: <i>States have the flexibility to develop capitation rates at the community level, such as on a statewide or regional basis, or at a more granular level specific to each MCO.</i>	<ul style="list-style-type: none"> Certifies specific point estimates by rate cohort and service delivery area for all programs Develops capitation rates for 13 managed care service delivery areas or regions and broken down by one to eight risk groups 	<ul style="list-style-type: none"> Many states are now adjusting their approaches to comply with the new managed care regulations requiring certifying specific point estimates Other states have similar numbers of rate cells as Texas

Managed Care Rate Setting: Managed Care Rate Setting Considerations

The review of the rate development process compared six rate setting elements across Texas and other states. The figure below provides a high-level summary of the rate setting considerations across the six rate setting elements.

Opportunity Area	Opportunities for HHSC to Consider
Base Data	<ul style="list-style-type: none"> • Key similarities between Texas’s approach and those utilized by other states include referencing different data sources to verify the most complete and accurate data is used to set the managed care capitation rates and utilizing a one-year period for base data. • The base data component with the most variation in methodology across the states was the service carve-outs, which are often driven by state-specific program policy rather than an actuarial rate setting determination.
Claim trends	<ul style="list-style-type: none"> • The use of state-specific historical data is a method preferred by CMS and an approach which Texas has been using for many years for the more mature managed care programs. • Additionally, the application of medical trends by risk group and service delivery area is a useful method in capturing the difference in claims experience across populations and geographic regions.
Adjustments	<ul style="list-style-type: none"> • Texas currently incorporates incentive arrangements, efficiency adjustments, and quality programs in a similar manner as the other states reviewed. • Analysis should continue to be performed to review the impact of these adjustments, arrangements, and programs on reducing the rate of growth for total Medicaid health care expenditures and increasing the quality of the provided services.
Nonmedical Expenses	<ul style="list-style-type: none"> • Texas could consider performing a deeper analysis on which costs from the Financial Status Report (FSR) should be considered fixed versus variable costs and modify their current fixed and variable assumptions accordingly.
Risk Mitigation	<ul style="list-style-type: none"> • One consideration is to determine if additional risk adjustment approaches could be incorporated into the rate development process for more specific conditions. For example, some states are beginning to consider social determinants of health within the development of capitation rates.
Rate Detail	<ul style="list-style-type: none"> • Since Texas has been certifying specific rates for each rate cell rather than rate ranges, it is ahead of many states which are now adjusting their approaches to comply with the new managed care regulations. • The Texas-selected number of rate cells is similar to the selections seen across other states, but should continue to be monitored for credibility or deviations in actual versus expected claims experience.

Managed Care Rate Setting: MCO Selection Challenges / Considerations

Competitive bidding allows states to have more discretion in which MCOs are awarded contracts. However, there are still many things to consider when reviewing potential competitive bidding models.

Number of MCOs	<ul style="list-style-type: none">• Some states use competitive bidding as a means to reduce the number of MCOs in the state. When states use competitive bidding to achieve this goal, they need to determine if they will publish the number of MCO slots available for award.• An additional way to incentivize competition through competitive bidding is to guarantee a certain number of MCOs within zones of a state, such as requiring at least two MCOs among each particular region.
Published Rate Change	<ul style="list-style-type: none">• Another consideration for competitive bidding is whether to publish a rate range or to publish no rate range and provide the MCOs with enough data and information to develop the rates on their own.• On the state's end, if a rate range is published, a majority of the actuarial analysis needs to be completed before procurement. This can be challenging with incorporating emerging experience and the gap between procurement, MCO selection, and rating period effective dates.
Adjustments to Submitted Bids	<ul style="list-style-type: none">• Often in procurements utilizing competitive bidding with a cost component, the submitted MCO bids may require an adjustment after submission due to program changes or other emerging experience that occurred prior to the effective date of the contract, but after the bids were accepted.• Most states calculate these adjustments internally and then apply the adjustments to the MCO submitted bids. In other instances, certain factors may be published with the RFP, so that the MCOs can incorporate them into their bid development.
Procurement and Ongoing Administrative Costs	<ul style="list-style-type: none">• When exploring competitive bidding, states should also consider the procurement costs involved with releasing and scoring an RFP, as well as the ongoing implications of maintaining more rates than they have in the past.
Cost Savings	<ul style="list-style-type: none">• While cost savings are likely to have some impact in the reasoning for states to shift to a competitive bidding model, there are no known studies to support cost savings.• However, one method states can utilize to achieve cost savings is through auto-enrollment. Through the RFP process, states may choose to offer MCOs with the lowest bid a greater portion of the auto-assigned lives. This strategy can motivate MCOs to both achieve larger membership, as well as enrolling the auto-assigned lives as they have historically had lower morbidity than members who choose their own MCO.

Managed Care Rate Setting: Reimbursement Arrangement Findings

There are three primary reimbursement arrangements with varying levels of risk that states typically utilize for their Medicaid programs. The three reimbursement models are as follows: self-funded models, full risk capitation models, hybrid models. Given the variety of services and populations covered under Medicaid programs, states may use one or more of the reimbursement models for their programs.

General Findings

Texas' reimbursement arrangements are similar to other states that have carved the majority of their Medicaid members into managed care. They should consider analyzing whether they should continue to roll in additional populations, while balancing considerations on cost effectiveness, quality of care, and access to care.

Reimbursement Models

- **Self-funded Models:** Most commonly performed using FFS payments. Under an FFS arrangement, the provider receives payments from the state for each service they provide, so there is no risk in the arrangement.
- **Full Risk Capitation Models:** Provides MCOs with a fixed PMPM payment for the services they deliver. This is the reimbursement method for many of the Medicaid managed care programs across the nation. As of September 2017, 39 states, had Medicaid contracts that provided coverage for comprehensive services with MCOs.
- **Hybrid Models:** Combination of a self-funded model and a full-risk capitation model.

HHSC's Pay-for-Quality Program

- HHSC has recently revised its MCO pay-for-quality program that creates both incentives and penalties based on MCO performance on certain quality measures.
- Up to 3% of the managed care premium is at risk in this program, and the program was designed so that all recouped dollars are redistributed to the high performing MCOs. Thus, there is a net zero impact at the program level.
- HHSC should continue to monitor the results as the program continues to mature and emerging experience becomes available.

**Rider 61 (d): Evaluation of Medicaid and
CHIP Managed Care –
Managed Care Administrative Expenditure
Audit**

Managed Care Administrative Expenditure Audit: Approach

Rider 61(d) required HHSC to review Texas's Medicaid MCO's administrative cost including developing a survey for each MCO to determine the nature and scale of administrative resources devoted to the Texas Medicaid and CHIP Programs and the identification of cost reduction opportunities.

1. Gather and review existing data

- This task included examining national administrative expense trends, including new federal Medicaid managed care regulations, and analyzing Texas Medicaid and CHIP MCO Financial Statistical Reports (FSRs) from state fiscal year (SFY) 2016 and SFY 2017, with considerations to membership size, programs serviced, as well as the detailed FSR cost categories and relevant changes from SFY 2016 to SFY 2017.

2. Develop and release MCO survey

- Pursuant to Rider 61d requirements, a survey was developed and provided to the State's 20 MCOs to collect information on staff supporting the Medicaid and CHIP programs, gather additional details on certain FSR functional categories to better understand cost drivers, changes in costs year over year, allocation of cost assumptions, and solicit feedback from MCOs on current administrative challenges and potential opportunities for new efficiencies or cost savings.

3. Analyze and document findings

- Following receipt of completed surveys from each of Texas' MCOs, the survey results were analyzed for trends and information to help broaden the understanding of administrative expenditures, and recommendations were developed on potential opportunities for new administrative cost savings or program efficiencies.

MCO Administrative Expenditure Survey Topics

- Number of FTE Resources by Functional Component
- Corporate Allocations
- Outsourced Services
- FSR Reporting Requirement Expenditures
- Clarification on Reported FSR Expenditures
- Cost Allocation Methodology
- FY 2016 to FY 2017 Administrative Expenditure Changes
- Areas of Opportunity

Summary of Current Data

On a PMPM basis, Texas has lower administrative expenses than the national average. Additionally, when reviewing Medical Loss Ratios (MLRs), Texas's MLR in SFY2016 and SFY2017 was 89.9% and 90.9%, above the 85% minimum managed care MLR threshold and better than the national averages.⁽²⁾

Administrative Expenses by Program

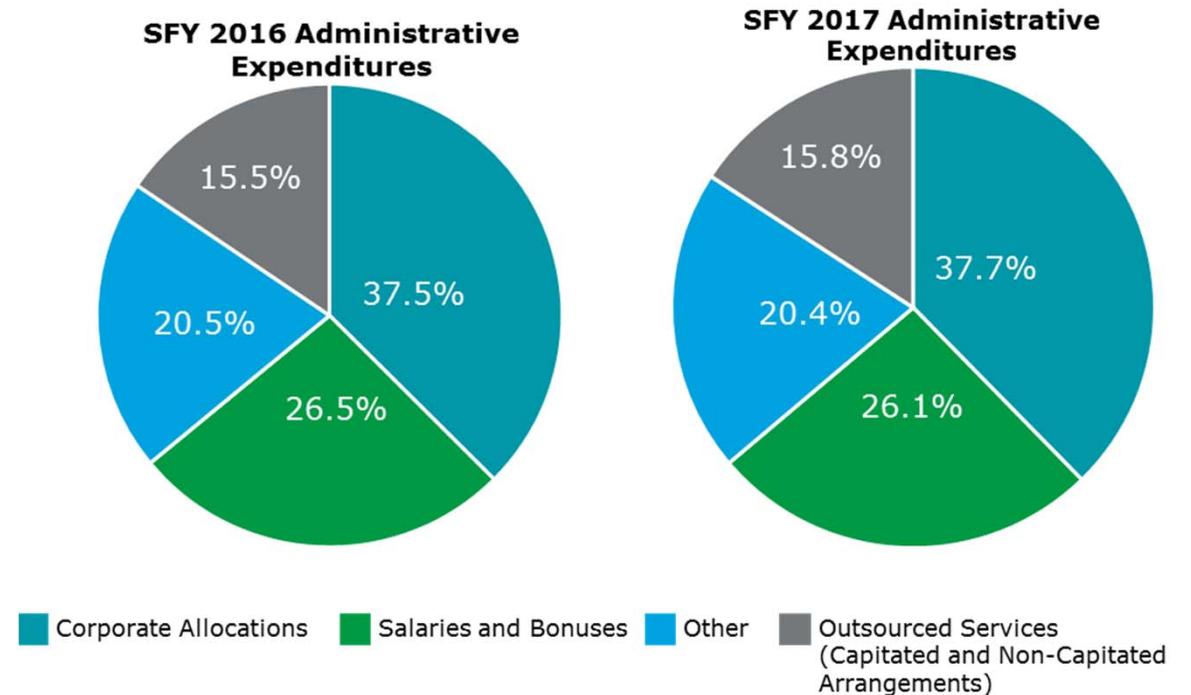
Despite the increase in total spending, overall MCO administrative costs declined in SFY 2017. This decline is primarily driven by over \$535 million in quality improvement costs being reclassified as medical expenses in SFY 2017. The reduction of quality improvement costs from administrative expenses is partially offset by the introduction of the STAR Kids program, which added almost \$167 million in MCO administrative expenditures in SFY 2017.

Program	Total Administrative Expenses		Administrative Expense PMPM ¹	
	SFY2016	SFY2017	SFY2016	SFY2017
STAR	\$654,366,000	\$536,871,000	\$18.45	\$14.98
STAR+PLUS	\$606,333,000	\$504,037,000	\$94.15	\$79.65
STAR Kids	N/A	\$166,956,000	N/A	\$102.28
STAR Health	\$23,922,000	\$20,348,000	\$64.52	\$52.83
Sub Total	\$1,284,621,000	\$1,228,212,000	\$30.38	\$27.80
CHIP	\$60,085,000	\$53,586,000	\$12.65	\$10.51
Dental	\$90,364,000	\$90,014,000	\$2.57	\$2.54
Grand Total	\$1,435,070,000	\$1,371,812,000	\$30.50	\$27.83

⁽¹⁾ Expenditures and PMPMs include quality improvement (QI) costs for SFY2016, but are excluded for SFY2017. The values are not adjusted to account for QI reallocation.

Administrative Expense by FSR Expense Category

The review of MCO FSRs identified the most prevalent categories of administrative data, including corporate allocations, salaries, bonuses, and outsourced services.



A review was conducted of MCO FSRs, independent MCO audit reports, and results of the 2012 managed care staffing and spending survey previously conducted by HHSC, to identify gaps in the available data and determine where further information may be needed for full comprehension of administrative expenditures.

⁽²⁾ Based on external studies as further defined in the Rider 61(d) report

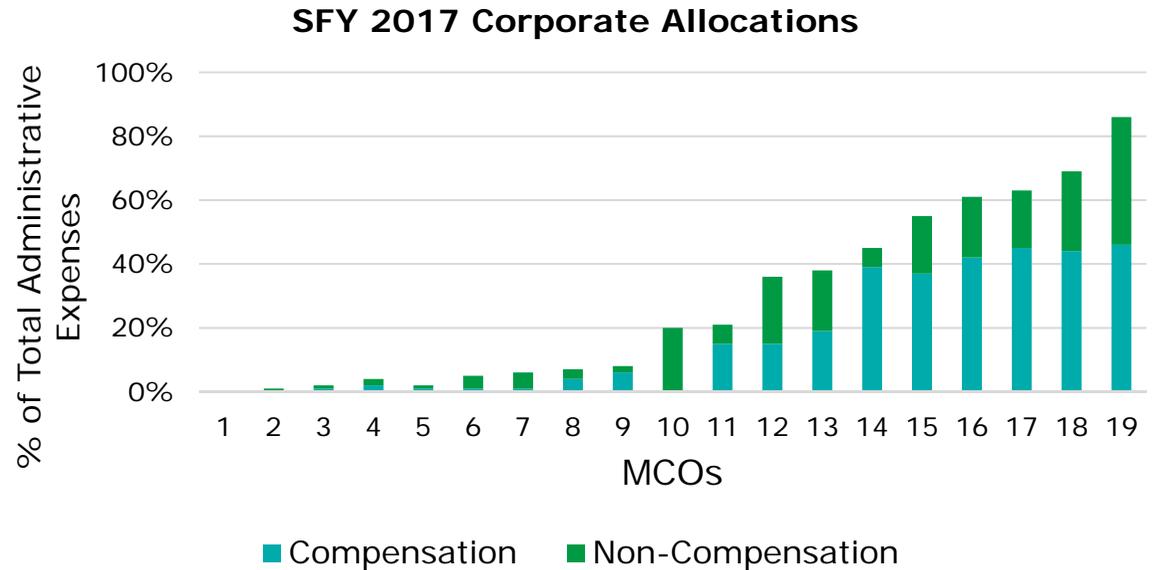
Survey Results: Notable Findings

There is a wide variation in the amount of corporate allocations, as well as in-state vs. out-of-state workforce spending across the MCOs. However, the results do not indicate that variances in these spending patterns lead to outliers when comparing total administrative expenditures across the MCOs.

Corporate Allocations

Overall, there is a wide range of corporate allocation expenditures by MCO. In SFY 2017, corporate allocation spending as a percentage of overall administrative expenditures ranged from 0% to over 80%.

Over 20% of the non-compensation costs in each year went toward information technology costs across the corporate business, as the MCOs allocated a portion of the overall costs to the Texas Medicaid and CHIP programs



Percent of In-State FTEs		SFY 2016 Administrative Expenses per FTE		SFY 2017 Administrative Expenses per FTE	
		# MCOs	Total	# MCOs	Total
0%	39%	1	\$127,620	1	\$127,504
40%	69%	5	\$116,171	5	\$86,013
70%	99%	4	\$117,345	5	\$115,559
100%		9	\$174,795	9	\$159,866
Total		19	\$127,754	20	\$112,421

Administrative Expense per FTE

Administrative expenses per FTE averaged approximately \$127,000 in SFY 2016 and \$112,000 in SFY 2017.

When reviewing the expenses by FTE against the percentage of staffing located within the State of Texas versus out of state, the results were mixed. There was not a clear indication that the relation of an MCO's administrative expenditures relative to all other MCOs was driven by the location of its staff.

Survey Results: Notable Findings

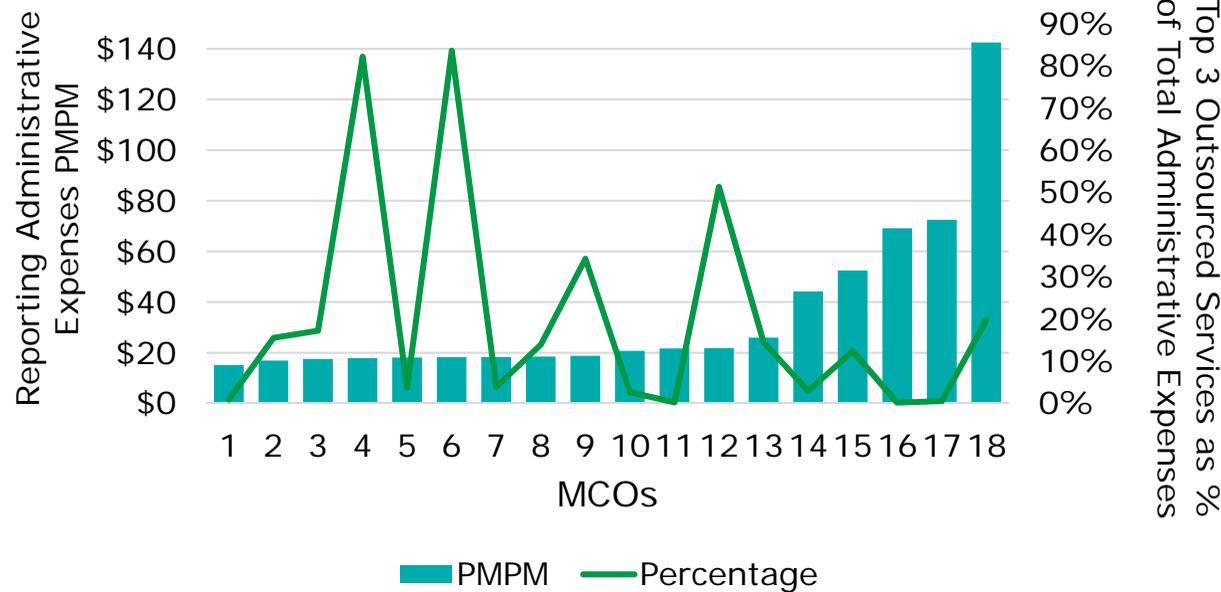
There is a wide variation across MCOs on the amount of services which are outsourced to a third party. However, there is no indication that outsourcing services necessarily results in higher/lower total administrative spending.

Outsourced Services

MCO decision-making on outsourced services, as the survey confirms, is varied. MCOs appear to make decisions regarding completing functions internally vs. outsourcing that work best for their business model.

Based on survey responses and FSR data, it appears that there is little relationship between higher than average outsourced services and overall administrative expenditures.

SFY 2017 Top 3 Outsourced Service Expenditures

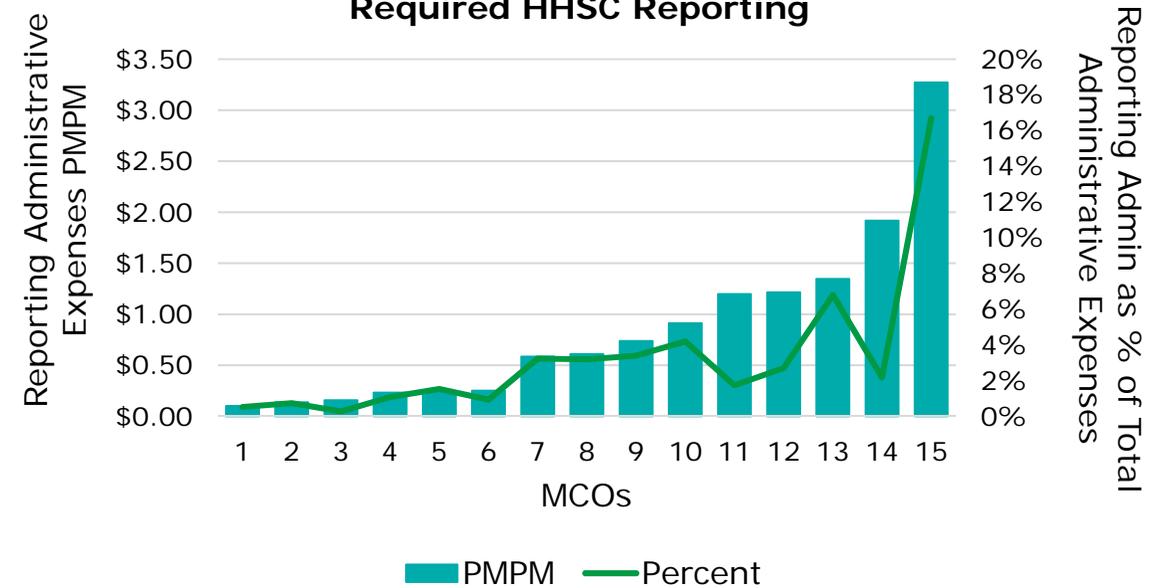


Reporting Requirements

Responses to the Administrative Expenses survey indicates that reporting requirements account for approximately 3% of overall administrative costs based on survey responses

Many MCOs believe that the true cost of reporting requirements is higher than reported in their survey response but difficult for them to fully quantify.

SFY 2017 Administrative Expenses Related to Required HHSC Reporting



Summary of Opportunities

Texas MCOs administrative expenditures in total appear to be in line with national managed care trends. However, there are opportunities Texas could implement to increase transparency, embrace cost containment opportunities, and continue to hold MCOs accountable in managing state and federal funds.

Opportunity Area	Opportunities for HHSC to Consider
Transparency	<p>Greater transparency on reporting of administrative expenses, especially corporate allocations</p> <ul style="list-style-type: none"> – While MCOs are required to report on top-level expenditure data, there remain many unknowns on the reports <p>Greater transparency on reporting components of outsourced services and related expenditures</p> <ul style="list-style-type: none"> – Additional information may allow for a more comprehensive and consistent analysis of expenditures by cost category within the FSR for each MCO, encompassing both services performed in-house and those outsourced <p>There is minimal correlation between total MCO administrative spending, corporate allocations, and outsourced services spending</p>
Workforce	<p>Annual reporting on FTEs supporting the Texas Medicaid and CHIP managed care programs</p> <ul style="list-style-type: none"> – This level of reporting can help the State analyze staffing outliers to determine if efficiencies can be gained
Cost Containment	<p>Increased evaluation of MCO cost allocation approaches to better understand the various methodologies and potential ways to standardize the process</p> <p>Potential strengthening of the experience rebates for those MCOs deemed to have excessive administrative expenses or profits</p> <ul style="list-style-type: none"> – If the State seeks to provide an increased incentive to moderate expense growth over time, consider revisiting the profit sharing thresholds – Adjustments should consider the impact the experience rebates have on incentivizing medical efficiencies <p>Further analysis of high-cost outliers by FSR reporting category</p> <ul style="list-style-type: none"> – Specific categories may identify opportunities for cost efficiencies that could be gained if incentives or reimbursement mechanisms were utilized to move such costs closer to the statewide averages <p>Coordination with the MCOs to refine the reporting requirements as defined by Section 5.0 Consolidated Deliverable Matrix of Uniform Managed Care Manual (UMCM)</p> <ul style="list-style-type: none"> – Revisit the MCO ideas, particularly around the ideas related to reporting, including simplifying or streamlining requirements and deliverables (effort underway noted in Rider 61b report), increasing transparency, and improving efficiencies through standardization and automation

Thank You for Attending the Webinar

The Rider Report 61 is posted at

<https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2018/sb1-rider61-evaluation-medicaid-chip-august-2018.pdf>.

Please send your questions, comments and feedback in writing to
medicaidmanagedcare@hpsc.state.tx.us.