Managed Care: Contract Oversight and Monitoring

Enrique Marquez
Chief Program & Services Officer

Stephanie Muth
State Medicaid Director

June 20, 2018
Provider Access Landscape

Network adequacy is influenced by many factors:

- Provider density,
- Provider capacity,
- Program administrative complexity, and
- Payment rates.

These same issues are common to commercial insurance plans and Medicaid programs nationally.
Network Adequacy
Oversight Approach

Cross-functional approach to monitoring and improving network adequacy.

Program Operations
- Streamline provider credentialing
- Simplify and expedite provider enrollment

Contract Monitoring and Oversight
- Monitor time, distance, and appointment availability standards
- Review provider directories quarterly
- Enforce contract remedies

Quality and Program Improvement
- Conduct EQRO studies: Appointment Availability and PCP Referral
- Implement Pay-4-Quality, Performance Improvement Projects, and quality measure standards
- Survey members

Routine and targeted data analytics support activities.

Care coordination helps members access the services they need.

PCP: Primary Care Physician
EQRO: External Quality Review Organization
Network Adequacy Standards

Distance and Travel Time Standards

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Distance in Miles</th>
<th>Travel Time in Minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Metro</td>
<td>Micro</td>
</tr>
<tr>
<td>Behavioral Health-outpatient</td>
<td>30</td>
<td>30</td>
</tr>
<tr>
<td>Cardiovascular Disease</td>
<td>20</td>
<td>35</td>
</tr>
<tr>
<td>ENT (otolaryngology)</td>
<td>30</td>
<td>60</td>
</tr>
<tr>
<td>General Surgeon</td>
<td>20</td>
<td>35</td>
</tr>
<tr>
<td>Hospital - Acute Care</td>
<td>30</td>
<td>60</td>
</tr>
<tr>
<td>Nursing Facility</td>
<td>75</td>
<td>75</td>
</tr>
<tr>
<td>OB/GYN</td>
<td>30</td>
<td>60</td>
</tr>
<tr>
<td>Occupational, Physical, or Speech Therapy</td>
<td>30</td>
<td>60</td>
</tr>
<tr>
<td>Ophthalmologist</td>
<td>20</td>
<td>35</td>
</tr>
<tr>
<td>Orthopedist</td>
<td>20</td>
<td>35</td>
</tr>
<tr>
<td>Prenatal</td>
<td>10</td>
<td>20</td>
</tr>
<tr>
<td>Primary Care Provider</td>
<td>10</td>
<td>20</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>30</td>
<td>45</td>
</tr>
<tr>
<td>Urologist</td>
<td>30</td>
<td>45</td>
</tr>
</tbody>
</table>

Long Term Services and Supports (LTSS) and Pharmacy standards proposed to be implemented in the September 2018 managed care contracts. Metro = county with a pop. of 200,000 or greater, Micro = county with a pop. between 50,000-199,999, Rural = county with a pop. of 49,999 or less.
Network Adequacy
Appointment Availability Study

“Secret shoppers” call enrolled providers to see how long it takes to get an appointment.

<table>
<thead>
<tr>
<th>Level/Type of Care</th>
<th>Time to Treatment Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent Care (child and adult)</td>
<td>Within 24 hours</td>
</tr>
<tr>
<td>Routine Primary Care (child and adult)</td>
<td>Within 14 calendar days</td>
</tr>
<tr>
<td>Preventive Health Services for New Child Members</td>
<td>No later than 90 calendar days of enrollment</td>
</tr>
<tr>
<td>Initial Outpatient Behavioral Health Visits (child and adult)</td>
<td>Within 14 calendar days</td>
</tr>
<tr>
<td>Preventive Health Services for Adults</td>
<td>Within 90 calendar days</td>
</tr>
<tr>
<td>Prenatal Care (not high-risk)</td>
<td>Within 14 calendar days</td>
</tr>
<tr>
<td>Prenatal Care (high-risk)</td>
<td>Within 5 calendar days</td>
</tr>
<tr>
<td>Prenatal Care (new member in 3rd trimester)</td>
<td>Within 5 calendar days</td>
</tr>
</tbody>
</table>

Actions
• Corrective Action Plans (CAPs) have been imposed on all the managed care organizations (MCOs) in at least one service area for not meeting appointment availability standards.
• EQRO will repeat the studies over 2018 and 2019.
Network Adequacy Oversight

Oversight Requirements

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

• MCOs who do not meet 75 percent compliance with standards are issued a CAP.

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

• Implemented Provider Directory requirements in the Spring of 2016.
Network Adequacy
Next Steps

• Ramp up standards and remedies for time, distance, and appointment availability requirements.

• Perform targeted analysis of access to specialty services, including STAR Health psychiatry services and PCP referral study.

• Strengthen linkages between data analytics and program oversight and operations.

• Identify opportunities, in collaboration with stakeholders, to expand alternative service delivery models, such as telemedicine, telehealth, and remote monitoring.

• Promote quality and access through the Pay-for-Quality program, Performance Improvement Projects, and quality measure standards.

• Examine provider directory data issues.

• Analyze claims data to identify and address inactive providers that are not delivering services.

• Lead cross-functional workgroup to identify network adequacy issues and solutions.
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

#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

Note: FFS complaint process varies
Future Improvements

• Cross-divisional workgroup to standardize and improve on data collection.

• Contract oversight escalation team.
  ➢ Analyze complaints to determine root cause of issues presented and identify needed actions

• Flexible data portal.
  ➢ Support data visualization
  ➢ Faster extraction of complaints analysis
  ➢ Facilitate strategic oversight of health plans

• Improvements will allow HHSC to use complaints data to identify risks, increase program transparency, and inform areas for improvement.
Operational Reviews
Current Activities / Next Steps

• HHSC strengthened contract oversight by adding onsite operational reviews of MCOs in September 2017.
  ➢ Team of 20-25 subject matter experts conduct onsite monitoring of one MCO per month.

• Onsite comprehensive review of MCO performance across a series of critical indicators, including:
  ➢ Claims processing,
  ➢ Prior authorization,
  ➢ Utilization management, and
  ➢ Encounter submissions.

• Continue to refine the process and add modules
  ➢ Additional staffing resources will support this effort

• Results of operational reviews inform contractual enforcement and training and technical assistance needs.
Long-term Services and Supports Utilization Reviews
Current Activities / Next Steps

• Created by S.B. 348, 83rd Legislature, Regular Session, 2015.

• Provides oversight of STAR+PLUS Home and Community Based Services (HCBS) program in order to ensure:
  ➢ MCOs are correctly enrolling members in HCBS through assessment and justification of service need; and
  ➢ MCOs are providing services according to their assessment of service needs.

• Additional resources allocated to provide oversight of STAR Kids and STAR Health Medically Dependent Children’s Program (MDCP).
MCO Oversight

Next Steps

Rider 61(b) Recommendations
In July 2018, Deloitte will complete their independent assessment of contract review and oversight for Medicaid and CHIP managed care contracts, including:

- Effectiveness and frequency of audits;
- Data necessary to evaluate existing contract requirements and enforcement including penalties; and
- Need for additional training and resources for effective contract management.
Appendix
An Evolving Landscape
Rapid Growth of Managed Care Model

Source: HHSC Financial Services, HHS System Forecasting
FY 2017 is incomplete/not yet final
## 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>Uniform Managed Care contract</td>
</tr>
<tr>
<td>STAR</td>
<td>18</td>
<td>21 total contracts, 3 product lines</td>
</tr>
<tr>
<td>STAR+PLUS &amp; MMP</td>
<td>5</td>
<td>STAR+PLUS expansion contracts (4)</td>
</tr>
<tr>
<td>STAR Kids</td>
<td>10</td>
<td>STAR Kids contracts (10)</td>
</tr>
<tr>
<td>STAR Health</td>
<td>1</td>
<td>STAR Health contract (1)</td>
</tr>
<tr>
<td>Dental</td>
<td>2</td>
<td>Dental Services contracts (2)</td>
</tr>
<tr>
<td>CHIP Rural Service Area contracts (2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>STAR+PLUS Medicaid Rural Service Area contracts (4)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MMP contracts (5)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Contract numbers are subject to change. Current as of February 2018.
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 validates data

12 months for claims to run out

6 – 8 months to conduct

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.
Operations Oversight Tools
HHSC and External Auditors

Like financial oversight, operations has multiple monitoring perspectives.

HHSC onsite biennial operational reviews

**Critical indicator focus**
- Claims Processing
- Provider Relations
- Complaints/Appeals
- Call Center Functioning

**Two areas of focus**
- MCO self-reported data
- Operational processes

- Targeted area(s) may vary. Examples include:
  - MCO Hotlines
  - Complaints and Appeals
  - Claims processing
  - Subcontractor monitoring (including PBMs)

Can inform the focus of the 3rd party audit or the need for an incremental one.
Services Oversight Tool
Utilization Reviews

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.
Financial Impact Stage
Liquidated Damages Issued

Liquidated damages (LDs) increasing with ongoing strengthening of oversight practices.

*Q3 2017 LD dollar amount of $17.7MM is not final. All dollars are based on state fiscal year. All numbers are rounded.
Utilization Review Liquidated Damages Matrix

<table>
<thead>
<tr>
<th>Risk of Harm Impact Tiers</th>
<th>Covered Service</th>
<th>Administrative Service</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Isolated</td>
<td>Systemic</td>
</tr>
<tr>
<td>4 - significant harm</td>
<td>$ 5,000</td>
<td>$ 7,500</td>
</tr>
<tr>
<td>3 - actual harm</td>
<td>$ 3,500</td>
<td>$ 5,000</td>
</tr>
<tr>
<td>2 - no actual harm,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>imminent risk for more</td>
<td>$ 1,500</td>
<td>$ 2,500</td>
</tr>
<tr>
<td>than minimal harm to</td>
<td></td>
<td></td>
</tr>
<tr>
<td>member</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 - no actual harm,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>imminent risk for minimal</td>
<td>$ 500</td>
<td>$ 1,000</td>
</tr>
<tr>
<td>harm to member</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>