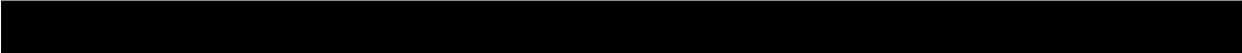




Review of HHSC's Contract Management and Oversight Function for Medicaid and CHIP Managed Care and Fee-for-Service Contracts

As Required by:

**2014-2015 GAA (Article II, HHSC, Rider 65, S.B. 1, 83rd
Legislature, Regular Session, 2013)**



Health and Human Services Commission

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1. EXECUTIVE SUMMARY

The Health and Human Services Commission (HHSC) serves as the single state agency responsible for the state's Medicaid and Children's Health Insurance Program (CHIP). HHSC conducted a review of HHSC's contract management and oversight functions for Medicaid and CHIP's managed care and Medicaid fee-for-service (FFS) areas, as required by Rider 65, S.B. 1, 83rd Legislature, Regular Session, 2013.

In conducting the review, HHSC specifically assessed the management and oversight of the Medicaid Claims Administrator contract. This contract was selected after audits revealed that the previous contractor, Xerox, failed to properly review prior authorization requests for orthodontia services, leading to millions of dollars in fraudulent Medicaid claims.

The review considered: 1) the appropriateness of existing contract requirements, including liquidated damages; 2) the availability of necessary data to identify trends in service anomalies; 3) the need for additional contract management training and resources; 4) the adequacy of the Medicaid FFS prior authorization and utilization functions; and 5) the effectiveness and frequency of audits.

With the termination of the Xerox claims administrator contract, HHSC implemented a number of strategies identified from this review to improve its Claims Administrator contract governance structure and oversight processes. Many of the strategies identified below have been applied in the new Claims Administrator contract, but will be also applicable to and will be implemented for the management of the Medicaid/CHIP managed care contracts.

These strategies include:

- Strengthened contract governance structure, to bring a systematic and coordinated approach to contract oversight and risk management with an emphasis on outcome-based performance monitoring and alignment with the state's priorities.
- Enhanced collaboration with audit entities to improve the effectiveness of the agency's response to internal and external audits and to reduce the likeliness of duplication of efforts.
- Improvements in the utilization of data in identifying service anomalies and other aberrant practices.
- Improvements to prior authorization and service utilization functions, including:
 - Additional contracted clinical staff to process prior authorizations following HHSC policies and guidelines.
 - Strengthened contractual prior authorization requirements and medical policies i.e., orthodontia policy now includes benefit limitations on appliances and brackets and requires more in-depth documentation of medical necessity such as radiographs, photographs, and diagnostic models.

Conclusion

This review, in conjunction with internal and external auditors, has resulted in significant improvements to management and oversight of the Claims Administrator contract monitoring procedures, organizational structure, governing oversight, and processes. Additionally, many of the improvements made to the management of the claims administrator contract highlighted in this report will be applied to the HHSC's Medicaid and CHIP managed care contracts.

2. INTRODUCTION

The Health and Human Services Commission (HHSC) serves as the single state agency responsible for the state's Medicaid and Children's Health Insurance Program (CHIP). This report has been produced to provide the Legislature with the results of HHSC's review of its contract management and oversight functions for CHIP and Medicaid as required by Rider 65, S.B. 1, 83rd Legislature, Regular Session, 2013.

In conducting its review, HHSC focused primarily on the Medicaid/CHIP Division (MCD), which is responsible for administering Medicaid and CHIP. In addition, HHSC reviewed the roles that other HHSC entities play in the Medicaid and CHIP contract management and oversight processes. Contract management and oversight processes reviewed for this report include:

- The roles and responsibilities of the Office of Procurement and Contracting Services (PCS) and Contract Oversight and Support (COS)
- Audit activities related to Medicaid and CHIP (Details regarding PCS, COS and audit activities can be found in Appendix A.)
- The roles, responsibilities and processes of the MCD contract management units. (Details regarding these units can be found in Appendix B.)
- The new contract governance structure and the performance management framework in development. (This information can be found in Section 5 of this report.)
- HHSC claims administrator and managed care organization (MCO) contract requirements and deliverables. This information can be found in Appendix C.

As part of this review, HHSC assessed: 1) the appropriateness of existing contract requirements, including penalties; 2) the availability of necessary data; 3) the need for additional training and resources; 4) the adequacy of current prior authorization and utilization functions; and 5) the effectiveness and frequency of audits.

3. BACKGROUND

Legislation

Rider 65, S.B. 1, 83rd Legislature, Regular Session, 2013 directed HHSC to conduct a review of HHSC's contract management and oversight functions for MCD's managed care and FFS areas and to make recommendations for improving the state's ability to identify anomalies in service utilization and their underlying cause.

Other legislation that provided direction to HHSC regarding contract management and oversight, and utilization management includes:

- **S.B. 8, 83rd Legislature, Regular Session, 2013** – This legislation required HHSC to establish a data analytics unit to improve contract management and identify anomalies, outliers, or red flags in the Medicaid program that could indicate fraud, waste, or abuse.
- **S.B. 348, 83rd Legislature, Regular Session, 2013** – This legislation increases state oversight of participating Medicaid STAR+PLUS managed care organizations by requiring annual reviews by HHSC, in order to ensure accountability and that patients are receiving adequate care.
- **Rider 60, 83rd Legislature, Regular Session, 2013** – This rider directs HHSC to strengthen the capacity of the Office of Inspector General to detect, investigate, and prosecute abuse by dentists and orthodontists who participate in the Texas Medicaid program.

4. MEDICAID AND CHIP PROGRAM OVERVIEW

The Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. CHIP covers children in families who have too much income or too many assets to qualify for Medicaid, but cannot afford to buy private insurance. The federal and state governments jointly fund and administer both programs. At the federal level, the Centers for Medicare & Medicaid Services (CMS) administers the programs. Each state administers its Medicaid and CHIP programs in accordance with CMS-approved state plans. Although the state has flexibility in designing and operating Medicaid and CHIP, it must comply with applicable federal requirements.

Federal Medicaid regulations require that each state designate a single state agency responsible for the state's CHIP and Medicaid programs. In Texas, HHSC is the single state agency responsible for these programs. The Texas Medicaid program provides services to Medicaid clients through two delivery models.

FFS

Under the FFS model, HHSC pays health care providers a fee for each unit of service (i.e., office visit, test, or procedure) they provide. Payments are issued retrospectively, after the services are provided. Over the years, HHSC has significantly reduced the number of Medicaid clients served under the FFS model as there is now widespread agreement that paying for health care on a FFS basis is a key contributor to both cost and quality issues. FFS payments tend to encourage the use of more services, particularly those that are expensive, while failing to reward providers for giving high-quality or coordinated health care.¹

Managed Care

In a managed care model, an MCO is paid a fixed payment per person per month to cover specified health care services. The MCO is then responsible for reimbursing the health care providers in its provider network for the services they provided to the MCO's enrollees. If enrollees cost more than the fixed rates the MCO is paid, the MCO may suffer losses; if enrollees cost less, the MCO profits. This gives the MCO an incentive to control costs. The state's initial managed care program, State of Texas Access Reform (STAR), began in the early 1990s. Since that time, in response to rising health care costs and the need for more cost-effective ways to provide quality health care, Texas has significantly expanded managed care to more services and Medicaid populations, including to those age 65 and older and those with disabilities. In March 2012, HHSC began providing outpatient pharmacy benefits through pharmacy benefits managers (PBMs) that contracted with MCOs, and began providing children's Medicaid dental services through a managed care model.

CHIP services, including pharmacy benefits and dental services, are also delivered by MCOs selected by the state.

As of September 1, 2014, about 84 percent of Medicaid clients' healthcare services were coordinated by MCOs. By fiscal year 2017, more than 90 percent of all Medicaid clients are expected to receive services through MCOs.

¹ United Health Center for Health Reform & Modernization, "FAREWELL TO FEE-FOR-SERVICE? A "Real World Strategy For Health Care Payment Reform," *Working Paper 8*, (December 2012).

The state imposes a number of contractual requirements on the MCO, including specifying members' benefit packages, setting service accessibility standards, mandating a sufficient provider network and establishing quality measures. The risk-based, capped (capitated) payment model is intended to incentivize the MCO to deliver care that keeps its members as healthy as possible, while delivering services efficiently.

5. RESULTS OF THE REVIEW

In response to this review and findings from previous state audits, HHSC has made numerous improvements to its contract management and oversight processes. These improvements are described in the following sections.

5.1 Contract Governance Structure

In this review, HHSC assessed the effectiveness of the Claims Administrator contract governance process, including HHSC staff's contract monitoring responsibilities. In addition, a new MMIS Contract Compliance and Performance Section is focusing on performance management of the claims administrator contract. These units work closely together to direct and manage the operational performance of the claims administrator contract. These units and their responsibilities are described in detail in Appendix B of this document. In order to bring a more systematic and coordinated approach to contract oversight and emphasizes outcome-based performance monitoring and change management in alignment with the state's priorities. As a result, the agency created a new MMIS Contract Operations Management Unit to focus on daily contract operations. Additionally, the State Medicaid director chairs a newly created **steering committee** that meets at least monthly to monitor key contract performance measures, evaluate the root cause of any key measure failures, and approve any incentives and remedies. The steering committee is comprised of executives from HHSC and the Claims Administrator contract representing program policy, information systems, risk management, budget, and operations.

The new governance structure includes a focus on risk and issue management as defined in the newly developed Claims Processing & Administration Contract Risk and Issue Management Plan. The plan provides state and the Claims Administrator contract staff with a process for escalating risks and issues to leadership and for development of risk mitigation plans and issue resolution plans. The goal is to identify and resolve risks prior to risks becoming issues, and to be able to act quickly on them.

Along with an enhanced governance structure, new performance monitoring processes to further improve contract monitoring and oversight. This framework should include the following components:

- Documentation of the desired outcomes for the contract
- Validation of key measures
- Introduction of a standardized risk-based monitoring approach intended to concentrate monitoring efforts on areas where non-compliance poses the greatest risk
- Utilization of on-site monitoring to verify actual performance against scheduled or reported performance
- Adoption of routine performance review meetings, a collaborative effort among stakeholders intended to address any perceived or potential issues discovered during the monitoring process for training and continuous performance improvement purposes

- Development of content, format, and recommended frequency of contract management performance reviews
- Identification of key participants in the contract management performance reviews
- Use of a clear escalation path for risks and issues identified in the contract management performance reviews
- Utilization of report cards and dashboards to ensure that the contractor's performance is visible

Once the framework is developed, training on performance-based contracting is recommended to facilitate organizational change management.

5.2 Improved Audit Coordination

The review identified a significant amount of audit coverage of Medicaid and CHIP managed care and Medicaid FFS activities managed by HHSC agencies. Some audit coverage includes all providers who perform a similar activity, such as audits of all Financial Statistical Reports submitted by MCOs. Most audits are performed after risk assessments have identified higher risk contractors, medical providers, pharmacies, MCOs, or processes. Other audits are performed after data analysis identifies potentially aberrant payment patterns or other unusual payment outliers.

Audit coverage includes audits of medical providers, the claims administrator contractor, pharmacy administrator contractor, MCOs, hospitals, and internal processes performed by HHSC staff to manage and monitor Medicaid and CHIP contractors. HHSC audits are performed by HHSC Office of Inspector General (HHSC OIG), HHSC Internal Audit Division (HHSC Internal Audit), and independent audit firms contracted by HHSC. External audits of CHIP and Medicaid are performed by the federal Government Accountability Office (GAO), U.S. Department of Health and Human Services Office of Inspector General (federal HHS OIG), CMS, and State Auditor's Office (SAO). More details regarding these auditing entities and the audits they conduct can be found in Appendix A.

Given the amount and frequency of audits of the Medicaid, the review identified the need for enhanced audit coordination. The Audit Coordinator serves as a point of contact within the agency, and analyzes audit issues and develops strategies for MCD program and executive management to resolve outstanding audit issues; provides guidance in the development, preparation, review, and evaluation of MCD management responses and corrective action plans; provides consultative services and technical assistance to program management and staff of all MCD divisions being audited; and reviews, tracks, evaluates, and prepares reports for MCD management and HHS Risk and Compliance Management on the current status of corrective action plan implementation in response to external audits.

Given the number of entities within HHSC working on audits, contract compliance and risk management, the review identified the need for improved collaboration and communication to ensure that issues are identified and resolved before they become major issues, reduce the likelihood of duplication of efforts, and improve responsiveness to audit findings. Efforts are currently underway within the agency to ensure that all appropriate entities within the agency to provide input on enterprise risk assessment to more accurately identify and mitigate areas of higher risk and offer suggestions for meaningful audit projects.

5.3 Improved Data Analytics

HHSC utilizes managed care data within HHSC's encounter data warehouse in conducting audits and reviews of Medicaid and CHIP MCOs and providers within the MCOs' network. As a

result of the passage of Senate Bill 8, 83rd Legislature, Regular Session, HHSC established a new data analytics unit to support the management of the Medicaid and CHIP managed care contracts and identify anomalies, outliers, or red flags in the Medicaid program that could indicate fraud, waste, or abuse. The data analytics unit works with contract management and operations staff to identify early trends and validate accuracy of performance metrics. This information is utilized by contract management staff to identify areas of potential risk and the need for targeted and/or on-site contractor reviews.

The data analytics unit analyzes FFS claims data and MCO encounter data utilizing queries, contractor reports, and other data sources to identify trends and anomalies in service utilization and their underlying cause. Data analysts within the unit assess practice billing patterns, compare patterns to appropriate peer groups to validated benchmarks if possible, and identify outliers. The work of the unit assists in improving the consistency of data used and enhances decision-making. As the unit becomes more firmly established, it will assist in assessing the impact of new policies and programs and validate quality indicators.

5.4 Prior Authorization and Utilization Functions

On March 1, 2012, HHSC moved Medicaid dental care to a risk-based managed care model. As a result, comprehensive orthodontia requests and claims for most Medicaid FFS and Medicaid managed care clients are reviewed and processed by dental maintenance organizations (DMOs) that are paid a capped monthly rate. Medicaid coverage of dental services and medical necessity reviews for orthodontic services by the claims administrator under the FFS model is now limited to a small population.

In addition, HHSC strengthened its policy on orthodontia and prior authorization requirements. Orthodontia policy now includes benefit limitations on appliances and brackets and requires more in-depth documentation of medical necessity such as radiographs, photographs, and diagnostic models. The new claims administrator contractor has hired additional clinical staff to process prior authorizations following HHSC policies and guidelines.

As a result of these changes, Medicaid expenditures for orthodontia services dropped by over 48 percent in state fiscal year 2012 and by 62.8 percent in fiscal year 2013.

6. CONCLUSION

This review of HHSC contract management and oversight processes emphasized the need for a strong contract governance structure, effective data analytics, and a formal feedback loop for audit findings.

6.1 Improvements to Claims Administrator Contract

- Key measures are streamlined, measurable, focus on timeliness and accuracy, and carry remedies. They enable the state to:
 - Focus contract compliance efforts on what is most important and has the greatest impact to the state, clients, and providers.
 - Have a robust performance management program to independently validate contractor's performance and identify trends in service anomalies.
- Contract staff ratios were increased with requirements for providing significant clinical oversight, including medical directors. As a result, the Claims Administrator hired 40 additional clinical staff, supervisors, and medical directors.
- The Claims Administrator is required to develop and implement a training curriculum for its clinical and non-clinical staff regarding MCD Medicaid and CHIP policies and procedures.

- Additional operations support staff has been added to reduce the time it takes to process Medicaid provider applications.
- The Claims Administrator implemented a state approved reliable tracking system for supporting documents received from providers, as reviews of the previous claims administrator contractor found deficiencies in document controls.
- HHSC continues to improve and refine the Claims Administrator contract's key performance measures.

6.2 Impact to Managed Care Contract Management

Many of the improvements made to the management of the claims administrator contract highlighted in this report are recommended to be applied to HHSC's Medicaid and CHIP managed care contracts.

- The new contract governance structure developed for the claims administrator contract is being leveraged in the management of the MCO contracts. The newly established executive steering committee will set strategic focus and provide executive level oversight of managed care contracts.
- The use of dashboards that identify contractors' key performance data enables HHSC executive leadership to quickly identify trends, issues, and performance indicators at all levels.
- Enhanced data analytics capabilities will better inform policy decisions, identify trends, monitor and independently validate the MCOs performance, and compare performance across managed care plans.
- HHSC claims administrator and managed care contract oversight units are collaborating in the development of standard uniform tools and processes to measure and monitor contract performance.

As described in this report, this assessment identified opportunities for the agency to make significant improvements to contract monitoring procedures, organizational structure, governing oversight, and processes.

Appendix A - System-Wide Contract Management and Oversight

The Office of Procurement and Contracting Services

The Office of Procurement and Contracting Services (PCS) oversees and directs the purchasing and contracting processes for the Health and Human Services (HHS) enterprise. Administrative and client goods and services are purchased directly through PCS. Types of PCS support provided to the agencies include: planning and coordination of procurements, centralized receipt of vendor proposals, proposal evaluation assistance, vendor communications, and contract award administration. PCS is also responsible for developing system-wide policies, procedures, and best practices related to procurement and contracting. To ensure uniformity of process throughout the enterprise, PCS created the Contracting Processes and Procedures Manual. PCS is also developing a contract management handbook.

Contract Oversight and Support (COS)

Contract Oversight and Support (COS) serves as the central contracts administration team for HHSC. COS manages and maintains the HHSC Contract Administration and Tracking System (HCATS), a web-based tracking system that offers one centralized storehouse of contract information. HCATS offers automated collection and maintenance of contract and performance data such as contract status information (active, expired, etc.) and key deliverables. HCATS also has the ability to generate predefined reports. In addition to management of HCATS, COS assists HHSC in forecasting, reporting, planning, procuring, and awarding contracts in a timely manner.

HHSC Internal Audit Division

HHSC Internal Audit provides independent, objective assurance and consulting services designed to add value and improve operations. HHSC Internal Audit division's responsibilities include coverage of both HHSC and the HHS enterprise. Audit coverage consists of assessments of programs, processes, and systems under the operational responsibility of HHSC and those programs, processes, and systems (a) under the oversight of HHSC Deputy Executive Commissioners, or (b) that involve two or more HHS agencies.

HHSC Internal Audit Division Audits Related to Medicaid and CHIP

Recent internal audits related to the managed care program include:

- *Medicaid/CHIP Division Managed Care Contract Monitoring*
- *Medicaid/CHIP Division Contract Management Unit*
- *Security and integrity of data transferred to and from Premiums Payable System (PPS)*

These audits were performed to (a) determine whether processes effectively and efficiently ensure that contractors were held accountable for delivery of quality services and whether information technology (IT) systems adequately support monitoring efforts, (b) evaluate whether roles and responsibilities were defined, communicated, understood, and effectively coordinated between the MCD Contract Compliance and Support (CCS) unit staff and Medicaid/CHIP managed care staff, and (c) determine whether controls are effective in ensuring that eligibility and payment related data transmitted between relevant HHS and contractor systems is secure, accurate, and complete.

Positive audit results noted that: (a) the overall approach and organizational structure for monitoring managed care contracts was adequately designed to promote effective contract

monitoring and (b) MCOs' liquidated damages were received timely and agreed with the amount assessed by managed care staff.

Audit results related to managed care contract management and oversight also identified risks and included recommendations for improving contract monitoring, defining and communicating roles and responsibilities, and developing and implementing more comprehensive policies and procedures. For example, recommendations stated that MCD should:

- More efficiently detect contractor financial and performance deficiencies by implementing a more collaborative and interactive contract monitoring approach between the Medicaid/CHIP financial and performance monitoring sections to ensure that issues related to contractor noncompliance are adequately addressed.
- Better evaluate contractor performance by implementing more detailed and comprehensive monitoring techniques of performance data and utilization of compliant information.
- More effectively track contracts and contract deliverables by reviewing records to ensure all required deliverables are recorded and related contract information is current, accurate, and eliminating redundant deliverables tracking tools.

Recent internal audits related to the FFS program include:

- *Claims Administrator Contract Monitoring*
- *Medicaid Management Information System (MMIS) Edits and Audits*
- *Enterprise Audit of HHS Agency Collections of HHSC OIG Identified Overpayments*
- *American Recovery and Reinvestment Act (ARRA) Accountability Processes*
- *MMIS Change Management*
- *Proxy Server and Batch File Processing Security and Compliance*
- *Confidential Data Transfers*
- *Follow Up of Confidential Data Transfers*
- *HHS Enterprise Information Security*
- *Medicaid Eligibility and Health Information System (MEHIS)*

These audits were performed, in part, to (a) evaluate whether governance and oversight processes adequately support contract monitoring and promote the achievement of contracting objectives, (b) determine whether monitoring processes were adequate to effectively assess contractor performance and ensure corrective actions, when needed, achieve intended results and (c) determine whether the governance and oversight activities of MMIS change management effectively managed risks and promoted the achievement of change management goals.

Positive audit results noted that MMIS system edits and audits were functioning as intended, claims were adjudicated in accordance with established guidelines, and processes for identifying, implementing, and maintaining edits and audits were followed. In addition, project management and oversight procedures were in place to identify project issues related to the MEHIS project.

Audit results related to FFS contract management and oversight also identified risks and related recommendations for improving processes and management controls. For example, recommendations stated that MCD should:

- Expand the risk-based framework used to determine the frequency and extent of contract monitoring
- More efficiently and effectively utilize existing resources by increasing oversight of contract monitors activities and providing tools and training to monitors for verifying contractor performance
- More effectively measure and validate contractor performance results and financial activity by obtaining supporting data from the contractor to verify the accuracy of reported costs and establishing an effective remedies process to help ensure corrective actions result in improved contractor performance
- Inform management about the level of performance and degree of contractor compliance by developing reports of key contractor performance measures, trends, and the status of performance remediation activity
- Strengthen processes for oversight of contract monitors by obtaining performance indicators and results from monitors to determine the level of contractor compliance with a monitored requirement and status of any corrective actions that were underway to address performance issues

HHSC Office of Inspector General

The 78th Legislature created the Office of Inspector General in 2003 to strengthen HHSC's ability to combat fraud, waste, and abuse in HHS programs. To fulfill its mandate, HHSC OIG maintains clear objectives, priorities, and performance standards that emphasize coordinating investigative efforts, ensuring allocation of resources to cases with the strongest supporting evidence and greatest potential for monetary recovery, and maximizing opportunities to refer cases to the Office of the Attorney General.

The HHSC OIG is divided into five divisions: Compliance, Enforcement, Operations, Internal Affairs and Chief Counsel. These divisions help HHSC OIG to fulfill its responsibilities by:

- Issuing sanctions and performing corrective actions against providers and clients
- Auditing the use of state and federal funds
- Researching, detecting, and identifying fraud and abuse to ensure accountability and responsible use of resources
- Conducting investigations and reviews and making referrals to the appropriate outside agencies for further action
- Recommending policies to enhance the prevention of fraud, waste, and abuse
- Providing education, technical assistance, and training to promote cost-avoidance activities and to sustain improved relationships with providers

The following areas within HHSC OIG are most involved with Medicaid-related audit and service utilization activities:

- The **Compliance Division** audits and reviews providers, contractors, and recipients to ensure compliance with all state and federal laws, rules, regulations, and guidelines related to payment for reimbursable services. This division facilitates, through HHS system agencies or HHSC OIG sanctions, the collection of identified overpayments and educates providers and contractors on how to submit accurate information for reimbursable services. The compliance division also refers cases of suspected fraud, waste, and abuse by

providers and contractors for investigation to the Office of Attorney General or HHSC OIG's Enforcement Division.

- The **Contract Audit Unit** conducts audits of intermediate care facilities to ensure the proper management of residents' trust funds, audits prescription drug claims made through the Medicaid Vendor Drug program, and audits high-risk contractors within the HHS system.
- The **Managed Care Organization Audit Unit (MCOAU)** conducts performance audits to ensure the MCOs comply with contract terms, obligations, deliverables, and applicable regulations. The unit reviews MCOs' claims administration, contract administration, quality of care, credentialing, member services, case management, and utilization. It examines each aspect of MCO operations, including medical compliance and finances. These audits help the state prevent and detect fraud, waste, and abuse among state-contracted MCOs. Contractors are selected for audit based on a risk assessment. Examples of risk factors include total amounts paid under the contract, type and number of programs, prior audit findings, and recommendations from contract monitoring actions conducted by the HHSC enterprise agencies. These activities use paid claims and MCO encounter data in performing their functions.
- The **Hospital Audit Unit** conducts performance audits of outpatient hospitals to ensure costs are accurately recorded in the cost reports that are submitted through the Medicaid program. The auditors review the general ledger transactions and supporting documentation as well as the cost reports to determine if only allowable costs are reported.
- The **Sub-recipient Financial Review Unit (SFRU)** conducts audits of high risk programs to ensure providers are observing the rules and regulations set forth for the programs. Currently SFRU is looking at home health care providers, specifically the Medically Dependent Children Program. SFRU is reviewing the billing practices, documentation procedures and medical records of providers to determine compliance with the program rules and the children's medical needs are being met as indicated by the treating physician.
- The **Cost Report Review Unit (CRRU)** concentrates on the cost reports of providers within the community-based care programs. The cost reports are audited to determine if expenses are properly reported to the state. The audit reports are provided to the HHSC Rate Analysis Division to use in the rate setting process.
- The **Utilization Review Unit** conducts hospital FFS utilization reviews that verify the correct reimbursement of services provided. Utilization review uses a case selection process which includes criteria that identifies error prone diagnostic related groups, short stays, readmissions, day and cost outliers. In addition, utilization review conducts reviews of nursing facility minimum data set assessments for accuracy of coding. These reviews validate whether the facility has correctly assessed and documented the resident's needs to receive the proper reimbursement. This unit also reviews the medical necessity of the patient to reside in the nursing facility. The unit makes referrals for potential fraud, waste, and abuse to Medicaid Provider Integrity (MPI). The unit refers its findings to the Department of Aging and Disability Services (DADS) to recoup overpayments and adjust underpayments.
- The **Medicaid Provider Integrity** section within HHSC OIG's Enforcement Division investigates allegations of fraud, waste, and abuse involving Medicaid providers. If MPI determines that criminal conduct may have occurred, HHSC OIG refers the case to the Office of the Attorney General's Medicaid Fraud Control Unit for further criminal investigation, but retains authority to continue with the administrative investigation and enforcement action. MPI may refer any allegation to the provider's licensing board for

administrative action, to CMS, or to other regulatory or law enforcement entities. MPI also has the authority to conduct its own investigations and refer its findings to the HHSC OIG sanctions section or other appropriate enforcement or prosecution authorities. In addition, MPI monitors the investigative activities of special investigative units (SIUs) used by managed care entities. MPI receives regular reports from these SIUs regarding alleged fraud waste or abuse in managed care settings and has the authority to assume any investigation from the SIUs in order to conduct an expanded state investigation.

- The Enforcement Division's **Data Analytics and Fraud Detection Unit (DAFD)** is responsible for conducting policy research and analysis to confirm any patterns that are identified; completing ad hoc queries and conducting data analysis; and for the development of Investigative Analysis reports that are provided to MPI for full-scale investigations.
- The **Research, Analysis and Detection Unit (RAD)** conducts a variety of utilization review activities designed to identify potential fraud, waste, and abuse. The unit is composed of both registered nurses (RNs) and research specialists. RAD RNs utilize the SURProfiler +, a CMS-approved Surveillance and Utilization Review Subsystem (SURS) solution used to perform utilization review, detection, and normative benchmarking using clinical, analytical provider grouping, and profiling methodologies. This solution provides predefined reports along with the unlimited flexibility of ad hoc reporting. SURProfiler+ creates a specialized, report-ready, SURS analytical data mart that provides HHSC OIG with rapid access to a myriad of views of data. It supports drill-to-detail reports and is integrated with the Medicaid Fraud and Abuse Detection System (MFADS) data warehouse where detailed claims and encounter data, as well as summarized data, are stored and available to the users through a user-friendly reporting interface. The ad hoc reporting flexibility allows detailed analysis and research to support case development, maximize automation, and avoid duplication of effort. Providers are notified regarding the review outcome, their appeal rights, and encouraged to share the educational information with their staff and billing agents.

Data mining activities within the unit both augment the current utilization review activities and identify additional areas of concern. RAD Research Specialists conduct claim data analysis and identify inappropriate payments for recoupment. Through the use of targeted queries they identify policy based violations and provider educational opportunities. All RAD case activity is tracked in the Insurance Fraud Management (IFM) case management system, a component of the MFADS. IFM allows coordination of case development and effective communication across HHSC OIG to ensure efficient resource utilization. The IFM with its' robust reporting capabilities affords users the opportunity to monitor case activities, perform workload evaluation, address case specific issues, and report outcomes. RAD has conducted MCO training regarding the RAD utilization review activities and works with the HHSC OIG Managed Care Unit to identify educational opportunities.

- The **Managed Care Unit (MCU)** performs a variety of activities to support all HHSC OIG areas in matters relating to managed care. Staffed with subject matter experts in investigation, audit, policy, clinical review, and data research and analysis, the MCU works with other HHSC OIG staff, MCD, Medicaid MCO SIUs, and federal program integrity partners. The MCU serves as the HHSC OIG liaison with MCO SIUs; works with other HHSC OIG areas to evaluate and identify risks to HHSC OIG's overall operational success, providing advice and making recommendations as appropriate; provides education and support to HHSC OIG staff regarding managed care; works with MCD concerning Medicaid managed care contract requirements and encounter data integrity; and provides specialized assistance to other HHSC OIG units in matters of data and workflow analysis, research, reviews, audits, investigations, and special projects relating to Medicaid managed care program integrity.

HHSC OIG Audits Related to Medicaid and CHIP

HHSC OIG performs audits of the following areas related to Medicaid and CHIP:

- Managed care
- Enrollment broker, CHIP, and eligibility support services contracts
- MCO pharmacy benefit managers
- MCO performance audits
- FFS
- Pharmacies that dispense Medicaid prescriptions
- Outpatient hospital costs charged to Medicaid
- Electronic health records

Independent Audit Firms Contracted by HHSC

MCD contracts with independent accounting firms to conduct audits and reviews of MCOs and the claims administrator. These audits include:

- Audits of financial statistical reports to determine whether the reports submitted by MCOs are presented in conformity and compliance with the contract provisions
- Examinations of claims summary reports to determine whether the MCOs comply with contract provisions related to completion of and submittal of claims summary reports
- Risk assessments to identify risk areas to aid in determining which MCOs should receive a performance audit
- Performance audits of MCOs
- Claims administrator statement on standards for attestation engagements (SSAE) 16
- Health Insurance Portability and Accountability Act (HIPAA) compliance report

State Auditor's Office

The State Auditor's Office (SAO) is the independent auditor for Texas state government. SAO performs audits, reviews, and investigations of any entity receiving state funds, including state agencies and higher education institutions. The types of audits SAO performs include financial statement opinion audits, financial audits, compliance audits, economy and efficiency audits, effectiveness audits, and other special audits.

SAO has included managed care recommendations in recent statewide single audit reports related to:

- Processes for charging expenses to federal programs
- Eligibility determination policies, processes, and procedures
- IT security controls over Medicaid and CHIP eligibility systems
- Reporting of program expenditures and activities to federal government
- Segregation of duties and internal controls over managed care payments

Recent SAO audits involving the FFS program include "An Audit Report on HHSC's Management of Home Health Services within the Texas Health Steps Program." SAO

recommended that HHSC significantly strengthen its oversight of personal care services to ensure processes are in place in the areas of case management, delivery of services, and claims administration.

SAO has also included FFS program recommendations in recent statewide single audit reports related to:

- Processes for charging expenses to federal programs
- Eligibility determination policies, processes, and procedures
- IT security controls over Medicaid claims processing and eligibility systems
- Reporting of program expenditures and activities to federal government
- Provider enrollment and eligibility
- Invoicing and collection of drug rebates

Government Accountability Office

The GAO, the audit, evaluation, and investigative arm of Congress, supports Congress in meeting its constitutional responsibilities and to help improve the performance and accountability of federal government programs, like Medicaid and CHIP. GAO examines the use of public funds; evaluates federal programs and policies; and provides analyses, recommendations, and other assistance to help Congress make informed oversight, policy, and funding decisions.

Recent GAO reviews involving Medicaid and CHIP managed care programs include:

- *CMS Payment Error Rate Measurement Process*
- *States' Use of Managed Care*
- *Medicaid Providers that Received ARRA Funding who owe Federal Taxes*

Recent GAO reviews involving the Medicaid FFS program include:

- *CMS Payment Error Rate Measurement Process*
- *Medicaid Electronic Health Records Implementation*
- *National Medicaid Audit Program*
- *Medicaid Providers that Received ARRA Funding who owe Federal Taxes*

GAO reviews contain policy recommendations for Congress and federal agencies to consider and implement. Ultimately, Congress, working through CMS, will provide guidance to state Medicaid and CHIP programs regarding any changes in rules, regulations, or best practices to be implemented as a result of GAO's reviews.

U.S. Department of Health and Human Services Office of Inspector General

The U.S. Department of Health and Human Services Office of Inspector General conducts federal audits of HHS programs (such as Medicaid and CHIP), and of HHS grantees and contractors. The audits provide independent assessments of programs and the operations, and help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Recent federal HHS OIG audits involving the Medicaid FFS program include:

- *Audit of Medicaid Payments Made for Nonemergency Services*

- *Texas Accounts Receivable System for Medicaid Provider Overpayments*
- *Nonemergency Medical Transportation Costs – Capital Area Rapid Transit System*
- *Nonemergency Medical Transportation Costs – League of United Latin American Citizens*
- *Medicaid Payments for Services to Deceased Recipients in Texas*
- *IT Controls at Texas Medicaid Healthcare Partnership*
- *Texas Did Not Refund Excess Contractor Profits in Accordance With Federal Regulations*
- *Medicaid Payments for Medicare Buy-In Parts A and B*
- *States Inappropriately Retained Federal Funds for Medicaid Collections for the First Recovery Act Quarter*
- *Medical Claims Beneficiaries Under the Age of 21 Who Reside in Institutions for Mental Diseases*
- *Texas Did Not Ensure that Prior-Authorization Process Was Used to Determine the Medical Necessity of Orthodontic Services*

Federal HHS OIG audits typically contain policy and process recommendations for HHSC to implement. In addition, these audits will question costs for services paid by HHSC that are determined, as a result of the audit, not to be in accordance with applicable federal and state rules and regulations or the Medicaid state plan that is approved by CMS, the federal agency that has oversight of Texas' Medicaid and CHIP programs. HHSC refunds the federal share of questioned costs identified by the federal HHS OIG Office of Audit Services to CMS.

As a result of actions taken to address issues identified in these audits, HHSC has made changes and improvements in the following areas:

- FFS claims processing system edits and audits
- Reporting of Medicaid overpayments and refunds to CMS
- Monitoring of nonemergency Medicaid transportation providers
- Identifying deceased Medicaid beneficiaries
- IT security controls over Medicaid claims processing

CMS Payment Error Rate Management Reviews

The CMS PERM program measures improper payments in Medicaid and CHIP and produces error rates for each program. CMS uses PERM review results to measure payment accuracy in Medicaid and CHIP.

Two types of reviews are normally conducted to validate the accuracy of claims payments. One type assesses the accuracy of eligibility determinations and the other assesses the accuracy of FFS claims and managed care payments. CMS combines the results of the reviews in Texas with results from other states to produce national Medicaid and CHIP program error rates.

HHSC has processes in place to recoup from providers confirmed overpayments associated with payment errors and return the federal share to CMS. Near the end of each PERM cycle, HHSC develops corrective action plans to improve systems and processes that contribute to errors identified during PERM reviews. HHS Risk and Compliance Management serves as Texas' single point of contact with CMS for PERM.

CMS Medicaid Integrity Program Audits

MIP audits are performed on individual providers, with efforts focused on providers with potential aberrant billing practices. The audits are designed to identify instances of waste, abuse, or fraud. At the discretion of CMS, audits may incorporate statistical extrapolation to estimate total inappropriate Medicaid claim payments for a provider. CMS requires states to refund the federal share of provider overpayments identified, either at the claim level or using extrapolation. HHS Risk and Compliance Management also serve as Texas' single point of contact with CMS for MIP audits. Recent MIP audit activities include:

- Reviews of Medicaid provider actions
- Audits of individual provider's claims
- Identification of overpayments
- Education of providers and others about Medicaid integrity issues

Appendix B – MCD Contract Management Units and Functions

Three areas within MCD have primary responsibility for contract compliance. The MMIS Contract Compliance and Performance Management (CCPM) section has primary responsibility for the claims administrator contract. The CCS unit within the MCO and Administrative Contracts Section and the Health Plan Management (HPM) unit, have primary responsibility for the MCO contracts. These units work collaboratively with one another and with other HHSC staff (and when necessary staff at other agencies) to provide management and oversight.

1. Contract Compliance and Performance Management

A new CCPM section has been established within MCD. This section replaces the Claims Administrator Contract Compliance (CACC) unit and is responsible for contract compliance and performance management for MMIS contracts, including the claims administrator contract. CCPM implements and provides oversight of contract monitoring processes and activities for the claims administrator contract. The Department of State Health Services (DSHS), DADS, and HHSC OIG continue to share oversight of some contract requirements. CCPM has a liaison for these entities. CCPM is integrating the use of risk and issue management tools and methodologies in the management and oversight of the claims administrator contract.

CCPM is comprised of three units:

- 1) A **Contract Compliance Unit** is staffed by experts on the requirements and remedies under the claims administrator contract. The responsibilities of this unit include:
 - Managing the contract remedy process, which includes:
 - Working with appropriate MCD units to develop recommendations for corrective action plans and remedies
 - Presenting recommendations for remedies to the steering committee. All recommendations regarding remedies are reviewed with HHSC legal before going to the steering committee for a final decision regarding the type of remedy
 - Communicating remedies to the MCD Financial Management unit and to the contractor
 - Maintaining and using a contract management automated tool, the Medicaid Contract Administration Tracking System (MCATS). MCATS is an automated, web-based tool that supports CCPM and other program areas in monitoring the claims administrator contract. MCATS is a sub product of the state's HHS Contract Administration and Tracking System (HCATS). HCATS is the official repository for all HHS contracts.
 - The contract compliance unit documents findings and recommended contract actions within MCATS and updates MCATS with any new contractual requirements, remedies, and enhancements. The contract compliance team also conducts trainings to other areas on the use of the MCATS tool.
 - Developing recommendations for new contract requirements when change order requests (CORs) expand the scope of work.
 - Participating as a member of contract management team (described on the following page)
 - Managing formal correspondence with the contractor
 - Coordinate contract closeout activities

2) A **Performance Management Unit** is staffed by programmatic and operational experts. This unit focuses solely on performance management for the claims administrator contract and works closely with appropriate representatives within the DSHS and DADS regarding specific contract requirements as well as HHSC OIG. This unit's responsibilities include:

- Serving as business owners for contract requirements
- Monitoring key requirements
- Ongoing deliverable expectations document (DED) development, updates, and revisions for claims administrator documents
- Reviewing quality reports and data related to assigned key requirements
- Coordinating with program and policy stakeholders across HHSC and the claims administrator contractor
- Making recommendations regarding changes to the key requirements
- Representing HHSC in root cause analyses to determine the cause when the contractor performance does not meet expectations
- Providing support for:
 - Contract compliance in developing and presenting remedies
 - Investigating early trends identified by operations analysts or others
- Participating as a member of the contract management team

3) A **Financial Management Unit** is staffed by financial experts who manage and report on the financial aspects of the claims administrator contract. This unit is responsible for the following functions:

- Reviewing, reconciling, and paying contractor invoices
- Actively monitoring costs to ensure they fall within established cost ceilings
- Assessing and documenting approved remedies
- Reviewing and providing input on pricing for CORs
- Serving as point of contact for internal and external audits involving the claims administrator contract
- Developing financial analyses related to the claims administrator contract
- Participating as a member of the contract management team

CCPM continues work on refining the above roles, responsibilities, and processes to continually strengthen the team's ability to efficiently oversee and monitor MCD contracts. In addition, the CCPM section manages the new MMIS contract governance processes and the following committees:

- A new **Steering Committee** has been established to govern the claims administrator contract. The committee is chaired by the Associate Commissioner for Medicaid and CHIP and meets monthly, or more frequently as needed. The steering committee is responsible for providing oversight and direction related to performance management, remedies, and change management. The committee approves deliverable, dashboard, and contractor report content to assure accurate indicators of actual performance are used in the contract management process.

- The **Contract Management Team** includes representatives from the section's three units, along with staff from MCD's Program Operations Management section, legal, and data analytics unit, as appropriate. The contract management team meets regularly to discuss contractor performance and contract compliance. Team recommendations regarding performance and remedies are presented to the steering committee. Team members also participate in the Claims Processing and Administration Contract Operating Committee meetings with the contractor(s).

2. The Contract Compliance and Support Unit

CCS provides oversight for a variety of Medicaid and CHIP contracts. Currently, CCS is responsible for managing approximately 6,550 contracts. Approximately 150 of these contracts are competitively procured. Examples of competitively-procured contracts overseen by the CCS unit include managed care, external quality review organization, enrollment broker, consulting, and professional services contracts. Other contracts include contractor drug provider enrollment, drug rebate, data access, interagency, memorandums of understanding, and interlocal agreements. When carrying out its roles, CCS works with other MCD organizational units to varying degrees, assisting with contract procurement and development, management, tracking, and invoicing.

CCS serves as the primary point of contact in the MCO contract amendment process. It assumes responsibility for establishing timelines and processes to amend these contracts. To comply with new federal and state legislative mandates and support developing program goals, contract amendments are frequently necessary.

While CCS coordinates and facilitates contract amendments, many other MCD areas participate in the process. Program experts who work with and monitor the MCOs on a regular basis have the expertise to determine when it is necessary to initiate a contract change to reflect current law or policy. Once the need for a change is identified, CCS works with the relevant unit's staff to amend the language, schedules and oversees internal workgroups to discuss proposed amendments, and works with HHSC's legal counsel to ensure legal sufficiency. Further, CCS communicates the proposed changes to the MCOs in a face-to-face meeting and by sending a change log where the MCOs can comment or ask questions. Once finalized, CCS works with MCD policy development to send the amended contracts to the federal CMS for review and approval.

In addition to ensuring that contracts accurately reflect MCO requirements, HHSC also engages in regular monitoring of contractor performance under these contracts. CCS oversees the process. However, since there are multiple components to managed care contracts each requiring subject matter expertise, CCS works in conjunction with other MCD areas to perform contract management and monitoring functions, including operations coordination (OC), HPM, financial management (FM), program management (PM), and vendor drug program (VDP). These other units often identify areas of noncompliance requiring HHSC action and apprise CCS so it can take appropriate action, which may include requiring a corrective action plan, assessing damages, or suspending or terminating a contract.

Recently, CCS developed and instituted standardized forms and processes to assist the HPM unit in determining MCO compliance with contractual requirements and recommending appropriate remedies. This has enhanced the consistency and objectivity of MCD's MCO contract management and oversight process.

3. Health Plan Management Unit

HPM is the MCD unit responsible for the day-to-day interactions with contracted health plans. HPM monitors MCOs' compliance with the managed care contracts, the Uniform Managed Care Manual, and the Texas Government Code Section 533 and Texas Administrative Code §353 on a daily basis. HPM's major activities include monitoring MCO service delivery, provider networks, claims processing, deliverables, marketing, and other administrative requirements. When the HPM unit determines that an MCO may be out of compliance with its contractual requirements, it makes a referral to the CCS unit and works closely with CCS in determining the appropriate remedy.

One tool by which HHSC monitors MCO compliance is through the receipt and review of various required reports. HPM compiles MCO quarterly reports and works with the MCOs to address any inaccuracies found in the data. Through these reports, HHSC is able to track and trend a large number of MCO deliverables that are then evaluated by agency staff with appropriate subject matter expertise. For example, MCOs are required to submit quarterly financial statements using accounting principles developed by the FM unit. Statements are reconciled and validated by FM using comparisons to known data (encounters and subcontracts). To cite another example, VDP assists HPM by monitoring pharmacy-related provider and member materials and other contract deliverables for compliance. Additionally, PM reviews MCO reports to monitor MCO performance on health care indicators and performance improvement projects and to report performance outcomes to CMS.

HPM also compiles information collected through MCO deliverables into a master report. For tracking purposes, HPM records deliverables that focus on ongoing activities used to monitor MCO performance, comply with federal reporting requirements in HCATS, and in its internal deliverable tracking system (DTS).

Performance deficiencies are addressed through a continuous feedback loop of mentoring, educating, and training, or through more severe actions, such as monetary damages or corrective action plans.

External Quality Review Organization (EQRO)

Federal law requires state Medicaid agencies to provide for an annual external independent review of the quality outcomes, timeliness of, and access to services provided by Medicaid MCOs. HHSC contracts with an EQRO to develop studies, surveys, and other analytical approaches to assess the quality of care the MCOs provide to clients, care outcomes, and identify opportunities for MCO improvement. The assessment results allow comparison of findings across MCOs in each Medicaid program. Results are used in the identification and development of overarching program goals and performance improvement projects (PIPs) for Medicaid and CHIP managed care programs.

The EQRO assesses access to care, satisfaction with care, and quality of care for Medicaid enrollees in all managed care programs. The EQRO also assesses the MCO's quality improvement program – both internal to the MCO organization and external in the MCO's delivery of services - and uses a variety of nationally recognized evaluation tools and member satisfaction surveys to assess MCO quality, including:

- National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®)
- Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey Tool
- Children with Special Health Care Needs (CSHCN) screener
- The RAND® Health Survey

- Agency for Healthcare Research and Quality (AHRQ) prevention indicators for adult and pediatric patients
- 3M Health Information System (HIS) software to calculate potentially preventable events including potentially preventable admissions, readmissions, emergency department visits, ancillary service use, and complications

Major EQRO deliverables that assist in monitoring the quality of the MCO service delivery include the following:

- Member, caregiver, and provider surveys
- Annual MCO report cards
- Annual quality of care reports
- MCO encounter data validation report
- Data certification reports
- Quality assurance and performance improvement reports
- Administrative interview questionnaire and on-site interviews with MCOs selected by HHSC
- Assessment and evaluation of MCO performance improvement projects
- EQRO summary of activities report
- Evaluation and update of HHSC Performance Indicator Dashboards

Appendix C – MCD Client Services Contracts

Medicaid has become increasingly complex. Texas Medicaid now covers more than 3.6 million individuals with annual expenditures reaching \$20.9 billion in fiscal year 2013. Medicaid serves the state's most socially and medically-disadvantaged, providing a broader range of services than that covered by a typical health insurer. To meet the growing demand, MCD administers these programs through a number of contracts. The largest MCD contracts involving client services are the claims administrator contract and MCO contracts, which now include dental maintenance organizations.

1. Claims Administrator Contract

The claims administrator contractor delivers a wide range of Medicaid and non-Medicaid services for HHSC, DSHS, and DADS. The claims administrator processes paper and electronic claims for clients enrolled in Texas' Medicaid FFS healthcare delivery model. The claims administrator is responsible for the receipt, adjudication, and payment or denial of all acute care FFS claims. Long term care functions include the determination of medical necessity for long term care services, operation of an online portal to process service authorization forms submitted by providers as well as the adjudications of long term care claims for payment by DADS. Contracted services include long term care operations to support form and claim review and processing, CSHCN program services, the Texas Women's Health Program, staffing a call center for clients and providers and provider enrollment functions. The claims administrator also collects and validates encounter data from the MCOs to use in the evaluation of quality and utilization of services.

Xerox State Healthcare Service, LLC (Xerox) was the claims administrator until May 9, 2014, when the state terminated Xerox's contract for cause. Accenture State Healthcare Services, LLC (Accenture) now serves as the Claims Administrator until the contract can be competitively rebid. In fiscal year 2013, expenditures under the claims administrator contract totaled \$168 million (state and federal funds).

Contract Requirements and Deliverables

The current claims administrator contract contains approximately 1,900 requirements covering contractual mandates that include, but are not limited to, the MMIS system, reports, claims processing, client and provider call centers, surveillance and utilization reviews, and prior authorization and referral management requirements. This represents a significant reduction from the 7,000 requirements found in the previous claims administrator contract. Previously, the high volume of requirements made it difficult to properly monitor and evaluate them as they were duplicative, confusing, vague and process oriented. HHSC has revised the contract requirements and key measures to focus its contract compliance efforts on what is most important and has the greatest impact to the state, clients, and providers. This assures that MCD staff is able to timely and accurately evaluate compliance with contractual requirements. All requirements are recorded in the MCATS. MCATS is the automated contract management tool that contains standard reporting templates to capture findings and recommended contract actions.

In addition, the Claims Administrator contract contains **key measures**. Each measure has corresponding remedies that may be assessed if the measure is not met.

In addition to meeting all contractual requirements, the Claims Administrator contractor must produce **deliverables** such as:

- **Quality Management (QM) Plan** – The QM Plan must include: (a) Defined performance measures with methods for calculating measures, benchmarks or goals for each operational area; (b) Defined statistical sampling methodologies; (c) Defined report formats to report quality monitoring outcomes for each operational area and individual program; and (d) Defined report schedules and report templates to report quality-monitoring outcomes.
- **Monthly Key Measures Report** – This provides actual reports against the key measures that are measured monthly or measured in the applicable month, including a dashboard.

2. MCO Service Contracts

Texas Medicaid and CHIP now provide health care services to most clients through managed care systems. HHSC currently manages 34 managed care contracts with 21 MCOs across the programs described below:

- **STAR** – A managed care program in which HHSC contracts with 18 MCOs to provide, arrange for, and coordinate preventative, primary, and acute care covered services, including pharmacy. As of June 2014, 2.6 million Medicaid recipients were enrolled in the STAR program.
- **STAR+PLUS** – The agency’s program for integrating the delivery of acute and long-term services and supports through a managed care system. Medicaid recipients who are eligible include Supplemental Security Income (SSI) and SSI-related clients with a disability and those who are age 65 and older and have a disability. Acute, pharmacy, and long-term services and supports are coordinated and provided through a provider network under contract with the recipient’s MCO. The Star+PLUS program has contracts with six (6) MCOs. As of June 2014, 411,943 Medicaid recipients were enrolled in the STAR+PLUS program.
- **NorthSTAR** – An integrated behavioral health delivery system in the Dallas service area, serving people who are eligible for Medicaid or who meet other eligibility criteria. Services are provided via a fully capitated contract with a licensed behavioral health organization. As of June 2014, approximately 400,000 Medicaid recipients were enrolled in the NorthSTAR program.
- **STAR Health** – A comprehensive managed care program for children in Department of Family and Protective Services (DFPS) conservatorship and young adults recently leaving conservatorship. STAR Health clients receive medical, dental, and behavioral health benefits through a medical home. Star Health services are provided by the Superior HealthPlan Network (Superior). As of June 2014, 31,087 Medicaid recipients were enrolled in the STAR Health program.
- **Medicaid Dental Managed Care** – Effective March 1, 2012, children’s Medicaid dental services are provided through a managed care model to children under age 21, those eligible for Medicaid Texas Health Steps Comprehensive Care services, including SSI recipients. Clients who receive their dental services through a Medicaid managed care dental plan are required to select a dental plan and a primary dentist. This dentist serves as the client’s dental home and is responsible for providing routine care, maintaining the continuity of patient care, and initiating referrals for specialty care. The Medicaid dental program holds contracts with two (2) dental maintenance organizations.
- **CHIP** – A program for children in families with too much income or too many assets to qualify for Medicaid, but who cannot afford private insurance. CHIP provides acute care services to eligible children as well as prenatal care to unborn children. The CHIP program contracts with 17 MCOs.

- CHIP Dental Services – A program that provides CHIP recipients primary and preventative dental care through dental maintenance organizations, subject to annual benefit limits. The CHIP dental program holds contracts with two (2) dental maintenance organizations.

In fiscal year 2013, agency expenditures for all managed care contracts totaled more than \$10.2 billion (state and federal funds)

Contract Requirements and Deliverables

There are approximately 100 deliverables within the **uniform managed care contract**. Below are just a few examples of MCO contract deliverables:

- Fraudulent Practices Report - Utilizing the HHSC OIG fraud referral form, the MCO's assigned officer or director must report and refer all possible acts of waste, abuse, or fraud to the HHSC OIG within 30 business days of receiving the reports of possible acts of waste, abuse or fraud from the MCO's SIU. The report and referral must include: an investigative report identifying the allegation, statutes/regulations violated or considered, and the results of the investigation. Copies of program rules and regulations violated for the time period in question must be provided along with the estimated overpayment identified. The MCO must submit a summary of the interviews conducted; the encounter data submitted by the provider for the time period in question; and all supporting documentation obtained as the result of the investigation. This requirement applies to all reports of possible acts of waste, abuse and fraud.
- Geo-Mapping Provider Interface – The MCO must provide to HHSC on the last business day of the state fiscal quarter a complete picture of the primary care provider, CHIP, and specialist/facilities networks.
- Member Complaints & Appeals Summary Report – The MCO must submit quarterly member complaints and appeals reports. The MCO must include in its reports complaints and appeals submitted to its subcontracted risk groups (e.g., IPAs) and any other subcontractor that provides member services.
- Provider Training – The MCO must provide training to all providers and their staff regarding the requirements of the contract and special needs of members. The MCO's Medicaid, CHIP and/or CHIP perinatal program training must be completed within 30 days of placing a newly contracted provider on active status. The MCO must provide ongoing training to new and existing providers as required by the MCO or HHSC to comply with the contract.

The **Medicaid/CHIP Dental Services contracts** contain 37 deliverables with corresponding remedies that may be assessed if the deliverable is not provided.

Appendix D – Definitions

The following table has been arranged in alphabetical order by Acronym with corresponding definition in the right hand column.

Acronym	Definition
AHRQ	Agency for Healthcare Research and Quality
ARRA	American Recovery and Reinvestment Act Accountability Process
CACC	Claims Administrator Contract Compliance
CAHPS®	Consumer Assessment of Healthcare Providers and Systems Survey Tool
CCPM	Contract Compliance and Performance Management
CCS	Compliance and Support
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare and Medicaid Services
COR	Change Order Requests
COS	Contract Oversight and Support
COTS	Commercial off-the-shelf
CRRU	Cost Report Review Unit
CSHCN	Children with Special Health Care Needs
DADS	Department of Aging and Disability Services
DAFD	Data Analytics and Fraud Detection Unit
DED	Deliverable Expectation Document
DFPS	Department of Family and Protective Services
DSHS	Department of State Health Services
DTS	Deliverable Tracking System
EQRO	External Quality Review Organization
FFS	Fee-for-service
FM	Financial Management
GAO	Government Accountability Office
HCATS	Health and Human Services Commission Contract Administration and Tracking System
HEDIS®	Healthcare Effectiveness Data and Information Set

Acronym	Definition
HHSC	Health and Human Services Commission
HIS	Health Information System
HPM	Health Plan Management
IFM	Insurance Fraud Management
IT	Information Technology
MCAC	Medical Care Advisory Committee
MCATS	Medicaid Contract Administration Tracking System
MCD	Medicaid/CHIP Division
MCO	Managed care organization
MCOAU	Managed Care Organization Audit Unit
MCU	Managed Care Unit
MEHIS	Medicaid Eligibility and Health Information System
MFADS	Medicaid Fraud and Abuse Detection System
MIP	Medicaid Integrity Program
MMIS	Medicaid Management Information System
MPI	Medicaid Provider Integrity
NCQA	National Committee for Quality Assurance
OC	Operations Coordination
OIG	Office of Inspector General
PBM	Pharmacy benefits managers
PCS	Office of Procurement and Contracting Services
PERM	Payment Error Rate Measurement
PIP	Performance improvement projects
PM	Program Management
RAD	Research, Analysis and Detection Unit
RFP	Request for Proposal
RN	Registered Nurse
SAO	State Auditor's Office

Acronym	Definition
SFRU	Sub-recipient Financial Review Unit
SIU	Special Investigative Units
SSI	Supplemental Security Income
STAR	State of Texas Access Reform
SURS	Surveillance and Utilization Review Subsystem
UR	Utilization Review
VDP	Vendor Drug Program