An Audit Report on

The Health and Human Services Commission's Management of Its Medicaid Managed Care Contract with Superior HealthPlan, Inc. and Superior HealthPlan Network, and Superior's Compliance with Reporting Requirements

January 2018

Report No. 18-015

State Auditor's Office reports are available on the Internet at http://www.sao.texas.gov/.

An Audit Report on

*The Health and Human Services **Commission's** Management of Its Medicaid Managed Care Contract with Superior HealthPlan, Inc. and Superior HealthPlan Network, and Superior's Compliance with Reporting Requirements*

SAO Report No. 18-015
January 2018

Overall Conclusion

Superior HealthPlan, Inc. and Superior HealthPlan Network (Superior) accurately reported the approximately $1.9 billion in medical (fee-for-service) claims and prescription drug claims it paid for the Medicaid STAR+PLUS managed care program in its financial statistical reports for fiscal year 2016. It should improve its compliance with reporting requirements to ensure that it reports only allowable costs.

However, the Health and Human Services Commission (Commission) did not ensure that its business practices aligned with its managed care contract requirements. For example, the Commission allowed Superior to report bonus and incentive payments paid to affiliate employees in its financial statistical report, which are unallowable costs under its contract with Superior. The disparities between the Commission's actual business practices and the written contract requirements weakens the Commission's ability to consistently oversee all of the contracts the Commission has with its other Medicaid Managed Care Organizations (MCOs).

Background Information

Superior HealthPlan, Inc. and Superior HealthPlan Network (Superior) provides the Medicaid STAR, STAR+PLUS, STAR Health, and STAR Kids programs to seven service delivery areas in Texas: Bexar, Dallas, Lubbock, Nueces, Medicaid Rural Service Area (MRSA) - Central, MRSA - West, and Hidalgo (see Appendix 3 for additional information on those service delivery areas).

From September 1, 2015, through August 31, 2016, Superior received payments from the Health and Human Services Commission (Commission) that totaled $2.4 billion for the STAR+PLUS program. Approximately $2.2 billion of that funding paid for medical claims and prescription drug claims for 1,735,028 people enrolled in the STAR+PLUS program.

Sources: The Commission.

The Commission did not ensure that its business practices aligned with its managed care contract.

The Commission did not ensure that its business practices related to its uniform managed care contract with Superior aligned with the written requirements in the contract and its *Uniform Managed Care Manual*. Specifically, in Superior's financial statistical report for fiscal year 2016, the Commission:

- Allowed Superior to report approximately $29.6 million in bonus and incentive payments paid to affiliates' employees that were unallowable under the contract with Superior.

This audit was conducted in accordance with Texas Government Code, Sections 321.0131, 321.0132, and 321.013(k)(2).

For more information regarding this report, please contact John Young, Audit Manager, or Lisa Collier, First Assistant State Auditor, at (512) 936-9500.

- Approved Superior's request to report affiliate profits as costs without following the approval process outlined in its contract with Superior.

By not following the written requirements in its contract with Superior, the Commission weakens its ability to consistently oversee the contract and creates a lack of transparency in its administration of Medicaid managed care programs.

The Commission also included in its contract with Superior a limitation on reporting the cost of executive compensation that may not be enforceable.

Superior reported medical and prescription claims accurately. However, it should improve its compliance with reporting requirements.

Superior's controls over its financial reporting process provided reasonable assurance that it accurately reported to the Commission the approximately $1.9 billion in medical claims and prescription drug claims that Superior paid in fiscal year 2016 for the Medicaid STAR+PLUS managed care program (STAR+PLUS).

Financial Statistical Reports

The Commission receives financial statistical reports from managed care organizations (MCOs) on a quarterly and annual basis as required by the Commission's contracts with the MCOs. Those reports are the primary statements of financial results the MCOs submit to the Commission. The Commission uses the reports to analyze the MCOs' membership, revenues, expenses, and net income by service area and program. The reports provide a basis for calculating the amount a MCO may owe the State through the experience rebate profit-sharing requirement (see Appendix 6 for information on the experience rebate).

Source: The Commission.

While Superior reported medical and prescription claims accurately, it did not comply with certain reporting requirements outlined in the Commission's Uniform Managed Care Contract and *Uniform Managed Care Manual*, resulting in unallowable and questioned costs in its financial statistical report for fiscal year 2016. Superior included approximately $31.2 million in unallowable costs (including the approximately $29.6 million in bonus and incentive payments that the Commission allowed Superior to report). Superior also included $443,909 in questioned costs. Including unallowable and questioned costs in the financial statistical report affects the calculation of Superior's net profit, which the Commission uses to determine whether Superior owes money to the State under the experience rebate profit-sharing requirement. Table 1 on the next page shows the unallowable and questioned costs that Superior reported on its financial statistical report for fiscal year 2016.

Table 1

Unallowable and Questioned Costs, Per the *Uniform Managed Care Manual,* That Superior Reported on Its Financial Statistical Report (FSR) for Fiscal Year 2016				
Type of Expense/ FSR Line Item	Reported Costs for Fiscal Year 2016	Total Unallowable Costs Identified	Total Questioned Costs Identified	Report Subchapter Discussing the Costs
Costs That Were Unallowable and Questioned per the *Uniform Managed Care Manual*, But That the Commission Allowed Superior to Include in Reported Costs				
Corporate Allocations [a]	$ 119,132,444	$ 28,846,721	$ 0	Chapter 1-A
Bonuses	727,733	727,733	0	Chapter 1-A
Subtotals	$ 119,860,177	$ 29,574,454	$ 0	
Costs That Were Unallowable and Questioned Per the *Uniform Managed Care Manual*				
STAR+PLUS Medical Fee-for-Service [b]	$ 1,578,551,710	$ 1,311,841	$ 0	Chapter 2-A
Salaries	98,343,968	2,309	0	Chapter 2-B
STAR+PLUS Total Other Medical Expenses [b]	58,897,764	44	1,975	Chapters 2-B
Other Administrative Expenses	13,388,215	127,149	35,872	Chapter 2-B
Legal and Professional Services	8,184,061	98,751	139,658	Chapter 2-B
Travel Expenses	2,636,561	71	0	Chapter 2-B
Rent, Lease, or Mortgage Payment for Office Space	4,712,133	0	266,404	Chapter 2-B
Corporate Allocations [c]	(see above)	102,799	0	Chapter 2-B
Subtotals	$1,764,714,412	$ 1,642,964	$443,909	
Totals	$1,884,574,589	$ 31,217,418	$443,909	

[a] Of the $119,132,444 reported in the Corporate Allocations line item, $28,846,721 was bonus and incentive payments to affiliates' employees.

[b] These line items show expenses reported for only the Medicaid STAR+PLUS program. All other line items show expenses reported as administrative costs that Superior had for the STAR, STAR+PLUS, CHIP, STAR Health, STAR Kids, and the Dental Program.

[c] The $102,799 of unallowable costs was due to overreporting administrative expenditures.

Source: Superior's financial statistical report for fiscal year 2016.

In addition, Superior should improve processes related to processing medical and prescription claims. Specifically, Superior did not consistently respond to appeals and notify providers about appeals as required by the Commission's *Uniform Managed Care Manual*.

Auditors communicated other, less significant issues to the Commission and Superior separately in writing.

Table 2 presents a summary of the findings in this report and the related issue ratings. (See Appendix 2 for more information about the issue rating classifications and descriptions.)

Table 2

Summary of Subchapters and Related Issue Ratings		
Chapter/ Subchapter	Title	Issue Rating [a]
1-A	The Commission Allowed Superior to Report Bonus and Incentive Payments to Affiliate Employees in Fiscal Year 2016	Priority
1-B	The Commission Did Not Enforce Its Cost Principles Related to Reporting Affiliate Profits	Priority
1-C	The Commission Cited a Federal Regulation That Was Not Applicable to Its Medicaid Contracts Related to a Limitation for Reporting MCO Executive Compensation, and That Limitation May Not Be Enforceable	Priority
2-A	Superior Accurately Reported Medical and Prescription Claims in Its Financial Statistical Report for Fiscal Year 2016	Low
2-B	Superior Did Not Consistently Report Accurate Expenditures In Its Fiscal Year 2016 Financial Statistical Report	Medium
3-A	Superior Paid Claims for Drugs Covered by the Commission's Vendor Drug Program and Adjudicated Medical and Pharmacy Claims Within the Required Time Frames	Low
3-B	Superior Denied Medical Claims in Accordance with Its Contract; However, It Should Ensure That it Consistently Responds to Appeals and Notifies Providers About Appeals as Required	Medium

[a] A subchapter is rated Priority if the issues identified present risks or effects that if not addressed could critically affect the audited entity's ability to effectively administer the program(s)/function(s) audited. Immediate action is required to address the noted concern and reduce risks to the audited entity.

A subchapter is rated High if the issues identified present risks or effects that if not addressed could substantially affect the audited entity's ability to effectively administer the program(s)/function(s) audited. Prompt action is essential to address the noted concern and reduce risks to the audited entity.

A subchapter is rated Medium if the issues identified present risks or effects that if not addressed could moderately affect the audited entity's ability to effectively administer program(s)/function(s) audited. Action is needed to address the noted concern and reduce risks to a more desirable level.

A subchapter is rated Low if the audit identified strengths that support the audited entity's ability to administer the program(s)/functions(s) audited or the issues identified do not present significant risks or effects that would negatively affect the audited entity's ability to effectively administer the program(s)/function(s) audited.

Summary of Management's Response

At the end of each chapter in this report, auditors made recommendations to address the issues identified during this audit. The Commission agreed with the findings and recommendations in Chapter 1 that address its oversight of the Superior contract. The Commission's detailed management responses are presented immediately following the recommendations in Chapter 1.

Superior provided management responses to the findings and recommendations in Chapter 1 that were addressed to the Commission. Superior disagreed with the

findings related to employee bonuses and incentive payments and affiliate profits. Superior provided a summary of its management's response. That summary and Superior's responses to the issues discussed in Chapter 1 are presented in Appendix 8.

Superior agreed with the recommendations addressed to it in Chapter 2 and 3. However, it disagreed with certain findings in those chapters related to Superior's reported expenditures and auditors' data analysis of paid medical and prescription claims. Superior's detailed management responses are presented immediately following the recommendations in Chapters 2 and 3.

After review and consideration of Superior's management's responses, the State Auditor's Office stands by its conclusions based on evidence presented and compiled during this audit.

Audit Objective and Scope

The objective of this audit was to determine whether selected financial processes and related controls at a Medicaid managed care organization are designed and operating to help ensure (1) the accuracy and completeness of data that the Medicaid managed care organization reports to the Commission and (2) compliance with applicable requirements.

The scope of this audit covered Superior's contracts with the Commission to deliver the Texas Medicaid program. It covered Superior's financial statistical reports and its reported medical claims and pharmacy claims for fiscal year 2016. It also included the Commission's management of its contract with Superior, including the two most recent agreed-upon procedures engagements for which it contracted with an external audit firm.

Contents

Detailed Results

Appendices

Detailed Results

Chapter 1

The Commission's Business Practices Did Not Align with Its Contract with Superior to Deliver the Texas Medicaid Program, and Its Limit on Reporting MCO Executive Compensation May Not Be Enforceable

Cost Principles

The Commission's cost principles are part of its *Uniform Managed Care Manual*, which contains policies and procedures that all Managed Care Organizations (MCOs) participating in Medicaid programs are required to follow. The *Uniform Managed Care Manual* is incorporated by reference into the contract between the Commission and MCOs.

Source: The Commission.

The Health and Human Services Commission's (Commission) business practices did not align with its contract with Superior HealthPlan, Inc. and Superior HealthPlan Network (Superior). Specifically, the Commission did not adhere to certain provisions within the cost principles, which is part of its contract with Superior, related to reporting affiliate employee bonus and incentive payments and affiliate profits as costs in Superior's financial statistical report for fiscal year 2016 (see text box for information about the contract and the cost principles).

In addition, the Commission's limitation on reporting the cost of executive compensation in financial statistical reports may not be enforceable because the Commission cited a federal regulation that is not applicable to its contracts with Medicaid managed care organizations (MCOs).

Chapter 1-A

The Commission Allowed Superior to Report Bonus and Incentive Payments to Affiliate Employees in Fiscal Year 2016

Chapter 1-A Rating:

Priority [1]

The cost principles in the Commission's contract with Superior state that "bonuses paid or payable to affiliates are unallowable." However, the Commission allowed Superior to report bonus and incentive payments paid to its affiliates' employees as costs to deliver Texas Medicaid programs (see Appendix 4 for contract language related to bonus and incentive payments).

In its financial statistical report for fiscal year 2016, Superior reported $29,574,454 of bonus and incentive payments[2] paid to employees of affiliate companies. It reported $28,846,721 (98 percent) of those bonus and incentive payments within the single corporate allocation line item (that line

[1] The risk related to the issues discussed in Chapter 1-A is rated as Priority because the issues identified present risks or effects that if not addressed could critically affect the audited entity's ability to effectively administer the program(s)/function(s) audited. Immediate action is required to address the noted concern and reduce risks to the audited entity.

[2] The reported bonus and incentive payments included cash bonuses and incentive plan payments, such as stock options.

item totaled $119,132,444[3]). Reporting bonus and incentive payments paid to employees of affiliate companies within the corporate allocation line item decreases transparency over the expenditure of Medicaid managed care funds. For example, auditors identified the bonus and incentive payments to affiliate employees while reviewing the supporting documentation for the expenses reported in the corporate allocation line item. Superior reported the remaining $727,733 of bonus and incentive payments in the financial statistical report's bonus line item.

Reporting affiliate bonus and incentive payments as costs in the financial statistical report is a business practice known to the Commission. Superior does not have employees; all staff working for Superior are employees of affiliate companies (Centene Company of Texas, LP or Centene Management, LLC). (See Appendix 5 for an organizational chart with bonus and incentive payments for Superior's affiliates.)

Allowing Superior to report bonus and incentive payments, which are unallowable costs under the Commission's cost principles, results in Superior understating its net profit in its financial statistical report. That affects the calculation that determines whether Superior owes money to the Commission under the experience rebate profit-sharing requirements (see text box and Appendix 6 for more information on experience rebates).

By not requiring MCOs to follow the written requirements in its contract related to reporting bonus and incentive payments to affiliates, the Commission weakens its ability to oversee its contracts consistently and creates a lack of transparency in its administration of Texas Medicaid managed care programs.

Experience Rebates

Texas Government Code, Section 533.014, requires the Commission to adopt rules that ensure MCOs share profits they earn through the Medicaid managed care program. The Commission has incorporated profit-sharing provisions into its contracts with MCOs that require MCOs to share certain percentages of their net income before taxes with the Commission (see Appendix 6 for more information on how experience rebates are calculated).

The General Appropriations Act (84th Legislature), Rider 13, page II-88, requires that experience rebates the Commission receives from MCOs be spent on funding services for Medicaid.

Recommendations

The Commission should:

- Adhere to its cost principle that states bonus and incentive payments are unallowable costs for financial statistical reports, or amend the cost principles to allow bonus and incentive payments to reflect current business practices.

[3] The corporate allocation line item consisted of compensation expenses ($42,331,022), non-compensation expenses ($47,954,701), incentive plan expenses such as stock options ($16,621,142), and annual bonus expenses ($12,225,579) that Superior made to its parent company or affiliates.

- If it amends its cost principle to allow MCOs to report bonus and incentive payments to affiliates, require MCOs to report bonus and incentive payments paid to affiliates separately from the corporate allocation line item in financial statistical reports to increase transparency.

The Commission's Management's Response

The Health and Human Services Commission (HHSC) is in agreement with the findings and associated recommendations and offer the following responses.

HHSC will amend the contracts with the MCOs to clarify the definition of affiliates to be consistent with business practices which have evolved over the last several years. FSR reporting will also be amended to show affiliate bonuses as a separate line item.

Implementation Date:

HHSC will issue a contract amendment effective September 1, 2018 which will clarify the definition of affiliates and the treatment of affiliate bonuses.

Responsible Person:

Director of Financial Reporting and Audit Coordination

Chapter 1-B

The Commission Did Not Enforce Its Cost Principles Related to Reporting Affiliate Profits

Chapter 1-B Rating: Priority [4]

The Commission did not require Superior to follow the approval process outlined in its cost principles for reporting affiliate profits even though it was aware that Superior included affiliate profits in its financial statistical reports. Specifically, for a MCO to report an affiliate's profit as a cost, it must obtain the Commission's prior written approval, which is called a "comparable unaffiliated sales exception." To obtain the exception, the cost principles require a MCO to submit documentation prior to receiving an exception that demonstrates that the prices charged to the MCO are comparable to the prices that the affiliate charges to unrelated third parties. However, the Commission approved an exception for Superior without obtaining or reviewing documentation on affiliate pricing.

[4] The risk related to the issues discussed in Chapter 1-B is rated as Priority because the issues identified present risks or effects that if not addressed could critically affect the audited entity's ability to effectively administer the program(s)/function(s) audited. Immediate action is required to address the noted concern and reduce risks to the audited entity.

In addition, although the Commission's cost principles require MCOs to report and separately identify affiliate profits, the Commission did not include a section in the template for the financial statistical report for MCOs to separately identify and report affiliate profits.

By not enforcing the written requirements related to reporting affiliate profits, the Commission weakens its ability to effectively oversee its managed care contracts. In addition, not including a section in the financial statistical report template for MCOs to separately identify and report affiliate profits creates a lack of transparency in the Commission's administration of the Texas Medicaid programs.

Recommendations

The Commission should:

- Obtain and review MCO documentation on affiliate pricing before providing written approval for a comparable unaffiliated sales exception.
- Include a section in its template for financial statistical reports to separately identify and report affiliate profits.

The Commission's Management's Response

The Health and Human Services Commission (HHSC) is in agreement with the findings and associated recommendations and offer the following responses.

The Medicaid and CHIP Services Department within HHSC currently collaborates with Actuarial Analysis and contract auditors in analyzing affiliate pricing arrangements. That process uses data that is collected from MCOs through various channels. HHSC will clarify the MCOs' responsibilities in conforming to the requirements of that process in an amendment to the MCO contracts.

HHSC will evaluate reporting methodologies that would give the appropriate level of transparency to affiliate transactions without exposing MCO proprietary data.

Implementation Date:

HHSC will issue a contract amendment effective September 1, 2018. The amendment will define the process that MCOs will follow to justify pricing in affiliate arrangements.

Affiliate data reporting will commence with 1st quarter FY 2019.

Responsible Person:

Director of Financial Reporting and Audit Coordination

Chapter 1-C

The Commission Cited a Federal Regulation That Was Not Applicable to Its Medicaid Contracts Related to a Limitation for Reporting MCO Executive Compensation, and That Limitation May Not Be Enforceable

Chapter 1-C Rating:

Priority [5]

The Commission's *Uniform Managed Care Manual* incorporates a federal acquisition regulation that includes a limitation on executive compensation. However, that federal acquisition regulation (Title 48, Code of Federal Regulations, Part 31) related to the executive compensation limitation is applicable only to cost-based contracts. In its cost principles, which are part of its contract with Superior, the Commission explicitly defined its contract with Superior as a fixed-price contract. As a result, the Commission's limitation for reporting the cost of executive compensation may not be enforceable.

The Commission contracts with external audit firms to perform limited reviews related to the executive compensation limitation as part of agreed-upon procedures (AUP) engagements. However, those AUPs, for which the Commission approves the procedures, may not be sufficient to identify all instances in which the contractor exceeds the limitation on executive compensation. For example, an AUP report for fiscal year 2014 evaluated whether Superior's bonus and incentive payments for the top five highest compensated individuals exceeded the Commission's limitation on executive compensation. That report concluded that Superior had exceeded the limitation on executive compensation by $6.9 million for those five individuals. However, pursuant to the approved procedures, testing was not expanded to determine whether the reported compensation costs for other employees exceeded the limitation. In its management response to the AUP report, Superior disagreed that the executive compensation limitation was applicable to its contract with the Commission.

[5] The risk related to the issues discussed in Chapter 1-C is rated as Priority because the issues identified present risks or effects that if not addressed could critically affect the audited entity's ability to effectively administer the program(s)/function(s) audited. Immediate action is required to address the noted concern and reduce risks to the audited entity.

Recommendation

The Commission should:

- Review and adjust, if necessary, its cost principle regarding the executive compensation limitation to ensure that it is enforceable.
- Ensure that AUPs include sufficient procedures to identify all employees whose compensation exceeds the limitation on executive compensation.

The Commission's Management's Response

The Health and Human Services Commission (HHSC) is in agreement with the findings and associated recommendations and offer the following responses.

HHSC will develop language related to allowable executive compensation which specifically defines a cap.

HHSC will ensure that Agreed-Upon-Procedures include a procedure which identifies instances where MCO compensation exceeds the contract limit.

HHSC will also review and modify, if necessary, specific contract language that invokes the Federal Acquisition Regulations (FAR). The objective is to ensure that the FAR does not diminish HHSC's ability to establish firm contract requirements.

Implementation Date:

HHSC will issue a contract amendment effective September 1, 2018.

AUPs for the next cycle will have sufficient procedures to identify MCO employees who exceed the compensation cap.

Responsible Person:

Director of Financial Reporting and Audit Coordination

Chapter 2

Superior Reported Medical and Prescription Claims Accurately in Its Financial Statistical Report for Fiscal Year 2016; However, It Did Not Comply With Certain Reporting Requirements

Superior's financial reporting process provided reasonable assurance that it accurately reported certain costs in its financial statistical report for fiscal year 2016. Specifically, Superior accurately reported STAR+PLUS medical (fee-for-service) and prescription expenses totaling approximately $1.9 billion. However, Superior did not report some of its expenses accurately in its 2016 financial statistical report. The issues discussed in Chapter 2 address the accuracy of Superior's financial statistical report for fiscal year 2016.

Chapter 2-A

Superior Accurately Reported Medical and Prescription Claims in Its Financial Statistical Report for Fiscal Year 2016

Chapter 2-A Rating:

Low [6]

Auditors reconciled the reported $1.6 billion in paid medical expenses to Superior's claims processing system and matched the amount to within less than 1 percent. Auditors also reconciled the $362.7 million in paid prescription expenses to Superior's pharmacy claims data and matched the amount to within less than 1 percent.

In addition, auditors compared medical and prescription claims for the STAR+PLUS program that Superior paid in fiscal year 2016 to eligibility data from the Commission and determined that Superior paid medical and prescription claims to eligible members.

The Commission's *Uniform Managed Care Manual* requires a MCO to process and pay Medicaid provider claims in accordance with the benefits limits and exclusions as listed in the *Texas Medicaid Provider Procedures Manual*. Auditors reviewed 11.4 million paid medical claims that Superior paid during fiscal year 2016 (reported at $1.6 billion) and determined that Superior paid claims for medical procedures covered by Texas Medicaid as part of its STAR+PLUS program. However, auditors identified 1,635 paid claims for procedure codes that were not covered by Texas Medicaid. The total cost of those uncovered claims was $1.3 million in Superior's financial statistical report for fiscal year 2016, which was less than 1 percent of Superior's total paid medical claims for that time period.

[6] Chapter 2-A is rated Low because the audit identified strengths that support the audited entity's ability to administer the program(s)/functions(s) audited or the issues identified do not present significant risks or effects that would negatively affect the audited entity's ability to effectively administer the program(s)/function(s) audited.

Recommendations

Superior should improve its processes to ensure that it:

- Pays only for covered medical claims.
- Reports only covered medical claims in its financial statistical reports.

Superior's Management's Response

The errors identified were a very low percentage of the 11.4 million claims processed by Superior during fiscal year 2016. Superior will review and improve its processes.

Chapter 2-B

Superior Did Not Consistently Report Accurate Expenditures in Its Fiscal Year 2016 Financial Statistical Report

Chapter 2-B Rating:

Medium [7]

Auditors tested random samples of expenditures[8] that Superior reported in its fiscal year 2016 financial statistical report. That expenditure testing identified $331,123 in unallowable costs and $433,909 in questioned costs (see text box for information about those types of costs). The inaccuracies identified may affect the calculation of Superior's net income, which the Commission uses to determine whether Superior owes money to the Commission under the experience rebate profit-sharing requirement. (See Table 3 on the next page for detailed results of the expenditure testing.)

Costs were identified as unallowable because:

- Superior reported $226,015 in expenditures in its fiscal year 2016 financial statistical report that it did not incur during that time period. The Commission's *Uniform Managed Care Manual* states that a MCO should report expenditures in its financial statistical report based on the dates it incurred a service. Superior's policies and procedures did not address the requirement that it report only expenditures incurred within the reporting period of its financial statistical report.

- Superior overreported $2,309 in salary expenditures. Auditors identified eight expenditures for employees that Superior either incorrectly included in or excluded from its financial statistical report for fiscal year 2016. Superior's review process did not identify the inaccuracies.

- Superior overstated administrative expenditures by $102,799. Superior reported expenditures related to outsourced services in both the outsourced

Unallowable Cost

The Commission's *Uniform Managed Care Manual* defines the cost principles that establish allowability of expenses related to selected Medicaid programs that a MCO can report on its financial statistical report (FSR). A designation of "allowable" or "unallowable" does not generally govern whether the MCO can incur a cost or make a payment; allowability reflects only what is reportable on the FSR. To be allowable, expenses must conform to the requirements of the Commission's cost principles, which include being reasonable and allocable.

Questioned Cost

According to the Code of Federal Regulations, a "questioned cost," is a cost charged that MCO management, federal oversight entities, an independent auditor, or other audit organization authorized to conduct an audit of a MCO has questioned because of an audit or other finding. A cost may be questioned because:

- There may have been a violation of a provision of a law, regulation, contract, grant, or other agreement or document governing the use of MCO funds.
- The cost is not supported by adequate documentation.
- The cost incurred appears unnecessary or unreasonable and does not reflect the actions that a prudent person would take in the circumstances.

Sources: The Commission's *Uniform Managed Care Manual*, and Title 45, Code of Federal Regulations, Section 1630.2(g).

[7] The risk related to the issues discussed in Chapter 2-B is rated as Medium because the issues identified present risks or effects that if not addressed could moderately affect the audited entity's ability to effectively administer program(s)/function(s) audited. Action is needed to address the noted concern and reduce risks to a more desirable level.

[8] Except for third-party recovery expenditures, which auditors selected a risk-based sample of expenditures due to the quantity of line items for each payment related to that expense.

services and corporate allocation line items. Superior's review process did not identify the overstatement.

Table 3 shows the detailed results for the unallowable costs that auditors identified through expenditure testing of Superior's financial statistical report for fiscal year 2016.

Table 3

Testing Results for Unallowable Costs					
Line Item	Number of Expenditures Tested	Number of Unallowable Expenditures	Percent of Tested Expenditures in Error	Dollar Amount Tested	Dollar Amount of Unallowable Costs
Other Medical Expenses [a]	50	2	4%	$ 36,812	$ 44
Legal and Professional Services	30	8	27%	488,251	98,751
Other Administrative Expenses	49	17	35%	281,471	127,149
Travel	50	5	10%	3,588	71
Salaries	75	8	11%	110,084	2,309
Totals	254	40	16%	$920,206	$228,324 [b]

[a] Line item reported for the STAR+PLUS program only.

[b] The total amount does not include the $102,799 in overstated administrative expenditures described in the previous page.

Source: Auditor testing of expenditures reported in Superior's financial statistical report for fiscal year 2016.

In addition to the unallowable costs discussed above, auditors identified questioned costs. Specifically:

- Superior did not consistently ensure that it had sufficient supporting documentation for $443,909 of reported expenses. The Commission's uniform managed care contract requires a MCO to maintain records for administrative services or functions and provide to auditors detailed records and supporting documentation for all costs it reported. Superior's policies and procedures did not specify the documentation that it was required to maintain to support expenditures included in its financial statistical report.

Table 4 on the next page shows the detailed results for the questioned costs that auditors identified during the testing of expenditures that Superior reported in its financial statistical report for fiscal year 2016.

Table 4

Testing Results for Questioned Costs					
Line Item	Number of Expenditures Tested	Number of Questioned Expenditures	Percent of Tested Expenditures in Error	Dollar Amount Tested	Dollar Amount of Questioned Costs
Other Medical Expenses [a]	50	1	2%	$ 36,812	$ 1,975
Legal and Professional Services	30	5	17%	488,251	139,658
Other Administrative Expenses	52	5	10%	430,955	35,872
Rent, Lease, or Mortgage	30	30	100%	266,404	266,404
Totals	162	41	25%	$1,222,422	$443,909

[a] Line item reported for the STAR+PLUS program only.

Source: Auditor testing of expenditures reported in Superior's financial statistical report for fiscal year 2016.

Recommendations

Superior should:

- Update its policies and procedures to ensure that it reports only items incurred within the reporting period for financial statistical reports.
- Improve its reporting and review process for calculating and reporting expenditures in its financial statistical reports so that it (1) can identify any overstatements and (2) ensure that staff salaries are correctly reported.
- Update its policies and procedures to ensure that it retains adequate detailed documentation to support all expenses included in its financial statistical reports.

Superior's Management's Response

The majority of the $443,909 of questioned costs relates to the auditor's questioning of Superior's rent expenses. It is disappointing that the technical accounting procedure for three (3) months of rent expenses that were offered as "rent-free" months has been labeled as a medium risk to the Texas Medicaid program. The disagreement here is nothing more than whether Superior should be allowed to use GAAP (Generally Accepted Accounting Principles) in considering the cost of the entire life of the lease and then finding a monthly expense by dividing the entire cost by the number of leased months. The first bullet in Chapter 2-B does not provide this context. Considering the context, the auditor appears to assert that, for those months

in which no rent payment was required, Superior should not be allowed to state a rent expense per understood GAAP requirements that reflect an overall monthly cost of the entirety of the lease.

Superior incurs, records and reports rent expenses on a straight line basis, as prescribed by GAAP. As the auditor has referenced within this report, MCOs are instructed to report expenditures in the period incurred rather than on a cash basis. Superior has provided its lease contracts and ledger activity that agree with and support the amounts reported as expenses (Note: Superior's lessors do not provide invoices for monthly payments). Superior considers this adequate documentation.

Additionally, the auditor's statement regarding "adequate…documentation," does not mean documentation did not exist for the financial statistical reports. Superior will review it systems to ensure the level of detail the auditors require will be available. This has no financial impact on the cost the program.

Auditor Follow-up Comment

The *Uniform Managed Care Manual*, which is incorporated into Superior's contract with the Commission, states that the financial statistical report should include only paid expenses that support the Texas Medicaid program. Superior provided documentation regarding the Rent, Lease, or Mortgage line item. However, the documentation provided did not support the actual amounts paid, resulting in questioned costs.

Chapter 3

Superior Should Improve Certain Processes Related to Processing Medical and Prescription Claims

Overall, Superior paid only for drugs covered by the Commission's vendor drug program and adjudicated and paid or denied the medical and pharmacy claims it received within the time frames required by its contract with the Commission. However, Superior did not consistently respond to appeals and notify providers as required by its contract. The issues discussed in Chapter 3 address Superior's processes and compliance with requirements related to delivering the Medicaid STAR+PLUS program.

Chapter 3-A

Superior Paid Claims for Drugs Covered by the Commission's Vendor Drug Program and Adjudicated Medical and Pharmacy Claims Within the Required Time Frames

Chapter 3-A Rating:

Low [9]

Superior paid prescription claims for the STAR+PLUS program for drugs covered by the Commission's Vendor Drug Program's drug formulary. Of the approximately 3.3 million prescription claims for $362.7 million paid during fiscal year 2016 that auditors reviewed, more than 99 percent were for drugs covered by the drug formulary.[10]

In addition, Superior ensured that medical claims for the STAR+PLUS program were adjudicated within the required time frames. The Commission's *Uniform Managed Care Manual* requires that once a MCO receives a "clean claim" (see text box for explanation of a clean claim), it is required within the 30-day claim payment period to: (1) pay the total amount of the claim, or part of the claim, in accordance with the contract or (2) deny the entire claim, or part of the claim, and notify the provider why the claim will not be paid.

Clean Claims

Title 28, Texas Administrative Code, Section 21.802(6), defines a clean claim as follows:

- For nonelectronic claims, a claim submitted by a physician or a provider for medical care or health care services rendered to an enrollee under a health care plan or to an insured person under a health insurance policy that includes required data elements and the amount paid by a health plan.
- For electronic claims, a claim submitted by a physician or a provider for medical care or health care services rendered to an enrollee under a health care plan or to an insured person under a health insurance policy using the ASC X12N 837 format and in compliance with all applicable federal laws related to electronic health care claims, including applicable implementation guides, companion guides, and trading partner agreements.

The Commission's *Uniform Managed Care Manual* also states that a MCO is subject to remedies, including liquidated damages, if it does not pay providers interest

[9] Chapter 3-A is rated Low because the audit identified strengths that support the audited entity's ability to administer the program(s)/functions(s) audited or the issues identified do not present significant risks or effects that would negatively affect the audited entity's ability to effectively administer the program(s)/function(s) audited.

[10] Superior did not include the paid claims for drugs not covered by the drug formulary in its financial statistical report for fiscal year 2016 or as part of the encounter data reported to the Commission.

for the full period in which the clean claim or a portion of the clean claim remains unadjudicated beyond the 30-day claims processing time period.

Of the approximately 11.4 million paid medical claims (reported at $1.6 billion) that auditors reviewed, approximately 11.3 million (99 percent) were adjudicated within the required time frames. Auditors identified 132,140 claims that were adjudicated from 1 day to 623 days after the required time frame. Superior did not pay the required interest for 10,285 (8 percent) of those late claims.

In addition, Superior ensured that it adjudicated all 3.5 million paid prescription claims that auditors reviewed within 18 days as required during fiscal year 2016.

Recommendations

Superior should improve its processes to ensure that it:

- Adjudicates all claims within required time frames.
- Pays interest on the claims that were not adjudicated within the required time frames.

Superior's Management's Response

Auditors selected "non-statistical, random samples" which should be considered in reviewing the results regarding the percent of error. However, Superior will review its adjudicated claims processes and implement any necessary improvements. Superior will pay interest when required.

Auditor Follow-up Comment

Auditors did not conduct sampling of paid medical claims. Data analysis was conducted on the entire population to test the timeliness of the adjudication of the approximately 11.4 million paid medical claims, and whether the required interest was paid for claims that were not processed within required timeframes.

Chapter 3-B

Superior Denied Medical Claims in Accordance with Its Contract; However, It Should Ensure That it Consistently Responds to Appeals and Notifies Providers About Appeals as Required

Chapter 3-B Rating:

Medium [11]

Of the approximately 11.4 million paid medical claims that auditors reviewed, 958,347 were denied claims. Auditors reviewed a random sample of 25 of those denied medical claims and determined that Superior included an explanation for the denial and adjudicated the denial within 30 days, as required by the Commission's *Uniform Managed Care Manual*.

Auditors received a separate file of 1,243 appealed claims for fiscal year 2016. Auditors reviewed a random sample of 25 of those appealed medical claims and determined that:

- For 1 (4 percent) claim, Superior did not respond to the appeal within 30 days as required.
- For 2 (8 percent) claims, Superior did not retain any evidence that it notified the provider regarding the disposition of the appeal as required.

Recommendations

Superior should improve its processes to ensure that it:

- Responds to all appealed medical claims within required time frames.
- Communicates the disposition of all appealed medical claims to its providers as required.

Superior's Management's Response

The auditors selected "non-statistical, random samples" which invalidates the accuracy of these results regarding the percent of error. Also, and by way of example, in many cases, errors in filing the claims prevented Superior from responding within the 30 days. Nevertheless, Superior will give the results consideration and review its appeals and notification process, implement any necessary improvements, and communicate the disposition of all appeals to its providers.

[11] The risk related to the issues discussed in Chapter 3-C is rated as Medium because the issues identified present risks or effects that if not addressed could moderately affect the audited entity's ability to effectively administer program(s)/function(s) audited. Action is needed to address the noted concern and reduce risks to a more desirable level.

Auditor Follow-Up Comment

The samples were designed to be representative of the population. The error rates may be projected to the population. However, the accuracy of the projection cannot be measured. Please see Appendix 1 for more information about auditors' sampling methodology.

Appendices

Appendix 1

Objective, Scope, and Methodology

Objective

The objective of this audit was to determine whether selected financial processes and related controls at a Medicaid managed care organization (MCO) are designed and operating to help ensure (1) the accuracy and completeness of data that the Medicaid managed care organization reports to the Health and Human Services Commission (Commission) and (2) compliance with applicable requirements.

Scope

The scope of this audit covered Superior HealthPlan, Inc. and Superior HealthPlan Network's (Superior) contracts with the Commission to deliver the Texas Medicaid program. It covered Superior's financial statistical reports and its reported medical claims and pharmacy claims for fiscal year 2016. It also included the Commission's management of its contract with Superior, including the two most recent agreed-upon procedures (AUP) engagements for which it contracted with an external audit firm.

Methodology

The audit methodology included selecting a MCO based on risk by obtaining and reviewing information from the Commission. Additionally, the audit methodology included collecting information and documentation, performing selected tests and other procedures, analyzing and evaluating results of the tests, and interviewing management and staff at Superior and the Commission.

Data Reliability and Completeness

Auditors assessed the reliability of data used in the audit and determined the following:

- For medical claims data managed by Superior's claims processing system and pharmacy claims data from Superior's subcontractor's pharmacy benefits system, auditors reconciled claims data to claim payment totals reported on Superior's financial statistical reports and to medical claims and pharmacy claims reported to the Commission. In addition, auditors reconciled payroll data to Superior's general ledger. Auditors determined that the medical claims data and pharmacy claims data, payroll data, and

Superior's general ledger was sufficiently reliable for the purposes of this audit.

- Auditors relied on Superior's external auditors' prior work on general and application controls for Superior's (1) claims processing system, (2) financial accounting system, and (3) third-party vendor systems and determined that data from those three information systems was sufficiently reliable for the purposes of this audit.

Sampling Methodology

For the samples discussed below, auditors applied a nonstatistical sampling methodology primarily through random selection. Auditors selected the following samples:

- To test for allowability, appropriateness, and adequate support, auditors selected nonstatistical, random samples through random selection designed to be representative of the population. Specifically, auditors selected :
  - Twenty-five service coordinator salary, wages, and overtime expenditures from Superior's payroll system.
  - Twenty-five service coordinator travel expenditures from Superior's accounting system.
  - Twenty-five related party transactions from Superior's accounting system.
  - Thirty rent, lease, and mortgage payments related to the rent, lease, and mortgage line item from Superior's accounting system.
  - Thirty legal and professional services expenditures from Superior's accounting system.
  - Fifty travel expenses from Superior's accounting system.
  - Twenty-five expenditures related to the other administrative expenses line item from Superior's accounting system.
  - Twenty-five denied claims and 25 appealed claims from Superior's claims system.

Test results for the samples listed above may be projected to the population, but the accuracy of the projection cannot be measured.

To test for proper classification, appropriateness, and adequate support, auditors selected nonstatistical, random samples designed to be

representative of the population from Superior's payroll system of salary, wages, and overtime expenditures for 75 employees. Test results may be projected to the population, but the accuracy of the projection cannot be measured.

To test for allowability, appropriateness, and adequate support, auditors selected a nonstatistical, risk-based sample of 27 third-party recovery transactions from Superior's accounting system. The sample items were not generally representative of the population; therefore, it would not be appropriate to project the test results to the population.

Information collected and reviewed included the following:

- The Commission's STAR+PLUS contracts with Superior.
- The Commission's STAR+PLUS member eligibility records for Superior.
- Superior's medical claims and pharmacy claims data.
- Superior's policies and procedures.
- Superior's 90-day and 210-day financial statistical report for fiscal year 2016.
- Superior's payroll and human resources records for fiscal year 2016.
- Superior's supporting documentation for calculating reported allocated corporate costs for fiscal year 2016.
- External audit reports and consultant reports on Superior's claims processing system, financial accounting system, and select third-party vendor systems.
- The Commission's required MCO reports, manuals, and AUP reports.
- Superior's subcontractor agreements with its pharmacy benefit manager and affiliate companies.

Procedures and tests conducted included the following:

- Reviewed required reports, bonus and incentive payment plans, and encounter data that Superior submitted to the Commission.
- Reviewed the fiscal years 2013 and 2014 AUPs prepared by the Commission's external auditors to determine whether the AUP identified or addressed significant weaknesses or areas of concern related to selected line items in Superior's financial statistical reports for fiscal years 2013 and 2014.

- Recalculated and reconciled selected medical expenses and administrative expenses line items in Superior's financial statistical report for fiscal year 2016 to the Superior's general ledger.
- Tested to determine whether service coordinator salaries, wages, overtime, and travel expenditures reported in the other medical line item of Superior's financial statistical report for fiscal year 2016 were allowable, appropriate, and adequately supported.
- Tested to determine whether Superior's reported payroll expenditures were appropriately classified and allocated, incurred in fiscal year 2016, and adequately supported.
- Tested to determine whether transactions reported in the related party expenses line item of Superior's fiscal year 2016 financial statistical report were allowable, appropriate, and adequately supported.
- Tested to determine whether payments reported in the rent, lease, and mortgage line item of Superior's fiscal year 2016 financial statistical report were allowable, appropriate, and adequately supported.
- Tested to determine whether expenditures reported in the legal and professional services line item of Superior's fiscal year 2016 financial statistical report were allowable, appropriate, and adequately supported.
- Tested to determine whether expenditures reported in the travel expenses line item of Superior's fiscal year 2016 financial statistical report were allowable, appropriate, and adequately supported.
- Tested to determine whether administrative expenditures and third-party recovery transactions reported in the other administrative expenses line item of Superior's fiscal year 2016 financial statistical report were allowable, appropriate, and adequately supported.
- Tested to determine whether denied and appealed claims were adjudicated according to the Commission's contract requirements and whether interest was paid if needed.
- Reviewed Superior's corporate allocation methodology to determine reasonableness and allowability.
- Analyzed and tested all STAR+PLUS medical and pharmacy claims for fiscal year 2016 to determine whether they were paid in accordance with the Commission's contract requirements, and submitted for STAR+PLUS eligible members.

Criteria used included the following:

- The General Appropriations Act (84th Legislature).
- Title 48, Code of Federal Regulations, Part 31.
- Title 41, United States Code, Sections 1127 and 4304.
- Texas Government Code, Chapters 531, 533, and 536.
- Title 1, Texas Administrative Code, Chapters 353 and 370.
- The Commission's uniform managed care contract for STAR+PLUS with Superior.
- The Commission's *Uniform Managed Care Manual*.
- The Commission's *Uniform Managed Care Pharmacy Claims Manual*.
- The Commission's Vendor Drug Program drug formulary.
- The Commission's *Texas Medicaid Provider Procedures Manual*.
- The Commission's *Texas Medicaid Pharmacy Provider Procedures Manual*.
- The Commission's Texas Medicaid fee schedule.

Project Information

Audit fieldwork was conducted from March 2017 through December 2017 year. We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

The following members of the State Auditor's staff performed the audit:

- Arby James Gonzales, CPA, CFE (Project Manager)
- Serra Tamur, MPAff, CISA, CIA (Assistant Project Manager)
- Katherine Curtsinger
- Scott Labbe, CPA

- Anca Pinchas, CPA, CISA, CIDA
- Sarah Rajiah
- Adam K. Ryan
- Cameron Scanlon, CFE
- Felicia Villela
- Dennis Bushnell, CPA (Quality Control Reviewer)
- Brianna C. Pierce, CPA (Quality Control Reviewer)
- John Young, MPAff (Audit Manager)

Appendix 2

Issue Rating Classifications and Descriptions

Auditors used professional judgement and rated the audit findings identified in this report. Those issue ratings are summarized in the report chapters/sub-chapters. The issue ratings were determined based on the degree of risk or effect of the findings in relation to the audit objective(s).

In determining the ratings of audit findings, auditors considered factors such as financial impact; potential failure to meet program/function objectives; noncompliance with state statute(s), rules, regulations, and other requirements or criteria; and the inadequacy of the design and/or operating effectiveness of internal controls. In addition, evidence of potential fraud, waste, or abuse; significant control environment issues; and little to no corrective action for issues previously identified could increase the ratings for audit findings. Auditors also identified and considered other factors when appropriate.

Table 5 provides a description of the issue ratings presented in this report.

Table 5

Summary of Issue Ratings	
Issue Rating	**Description of Rating**
Low	The audit identified strengths that support the audited entity's ability to administer the program(s)/functions(s) audited or the issues identified do not present significant risks or effects that would negatively affect the audited entity's ability to effectively administer the program(s)/function(s) audited.
Medium	Issues identified present risks or effects that if not addressed could moderately affect the audited entity's ability to effectively administer program(s)/function(s) audited. Action is needed to address the noted concern(s) and reduce risks to a more desirable level.
High	Issues identified present risks or effects that if not addressed could substantially affect the audited entity's ability to effectively administer the program(s)/function(s) audited. Prompt action is essential to address the noted concern(s) and reduce risks to the audited entity.
Priority	Issues identified present risks or effects that if not addressed could critically affect the audited entity's ability to effectively administer the program(s)/function(s) audited. Immediate action is required to address the noted concern(s) and reduce risks to the audited entity.

Appendix 3

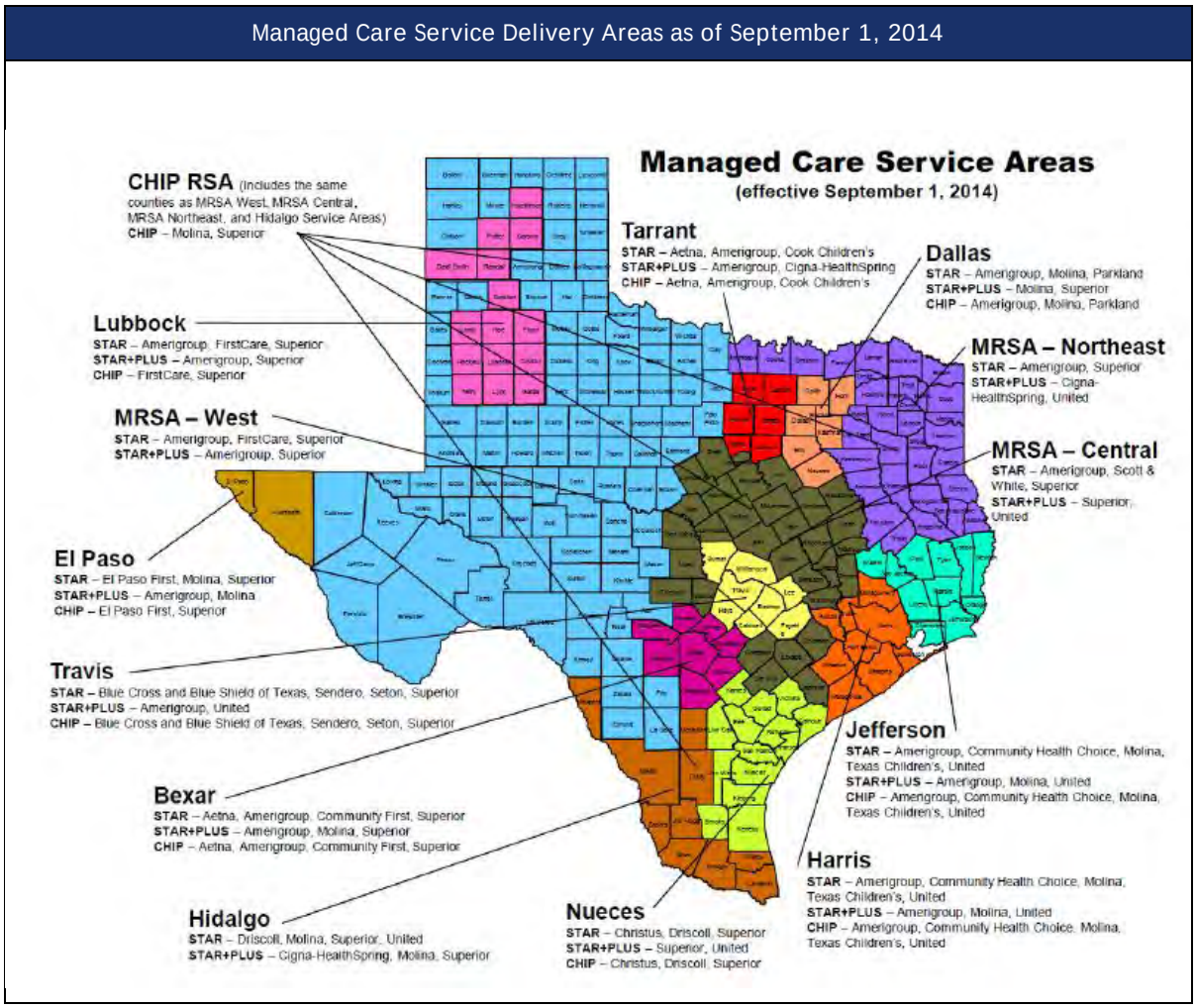
Superior's Service Delivery Areas for STAR+PLUS

Superior HealthPlan, Inc. and Superior HealthPlan Network (Superior) provides Medicaid STAR+PLUS services to seven service delivery areas in Texas through its contracts with the Health and Human Services Commission. Those seven service delivery areas are: Bexar, Dallas, Lubbock, Nueces, Medicaid Rural Service Area (MRSA) - Central, MRSA - West, and Hidalgo (for Superior HealthPlan Network).

Figure 1 is a regional map that shows the location of all the managed care service delivery areas, including Superior's service delivery areas as of September 1, 2014.

Figure 1

Managed Care Service Delivery Areas as of September 1, 2014



Source: The Commission.

Appendix 4

Excerpts from Superior's Uniform Managed Care Contract and the Commission's Uniform Managed Care Manual *Related to Bonus and Incentive Payment Plans*

Below is an excerpt from Section 7.2.4.1 of uniform managed care contract between Superior HealthPlan, Inc. and Superior HealthPlan Network and the Health and Human Services Commission (Commission).

> Employee Bonus and/or Incentive Payment Plan
>
> If the MCO intends to include Employee Bonus or Incentive Payments as allowable administrative expenses, the MCO must furnish a written Employee Bonus and/or Incentive Payments Plan to HHSC. The written plan must include a description of the MCO's criteria for establishing bonus and/or incentive payments, the methodology to calculate bonus and/or incentive payments, and the timing of bonus and/or incentive payments. The Bonus and/or Incentive Payment Plan and description must be submitted during the Transition Phase, no later than 30 days after the Effective Date of the Contract. If the MCO substantively revises the Employee Bonus and/or Incentive Payment Plan during the Operations Phase, the MCO must submit the revised plan to HHSC at least 30 days in advance of its effective date.
>
> HHSC reserves the right to disallow all or part of a plan that it deems inappropriate. Any such payments are subject to audit, **and must conform within the Uniform Managed Care Manual, Chapter 6.1, "Cost Principles for Expenses"** [emphasis added].

Below is an excerpt from the Commission's *Uniform Managed Care Manual,* Chapter 6.1, "Cost Principles for Expenses" Section VI(14)(i) related to bonus and incentive payment plans.

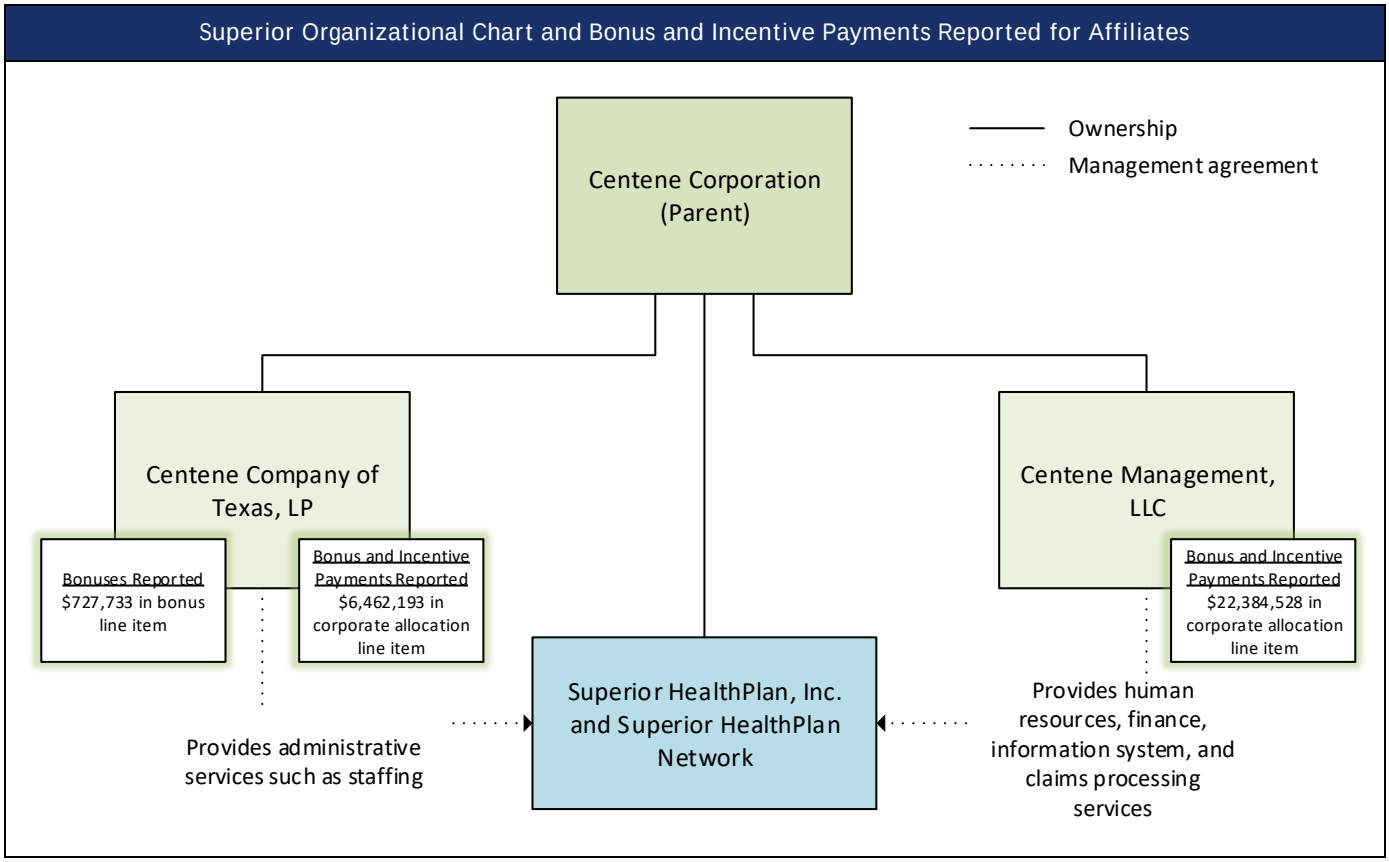
> Employee Bonuses or Incentive Payments.
>
> 1. Employee bonuses are allowable if they are:
>
> (a) Part of and in conformance with an existing plan that has been submitted at least nine months in advance to HHSC, and which is in compliance with any relevant specific terms of the Contract, such as those describing the criteria required for an employee bonus or incentive payment plan;
>
> (b) Based on individual or group performance with respect to clearly-stated goals within a defined period (generally either the MCO's fiscal year, the MCO Parent's fiscal year, the calendar year, or the FSR reporting period); and
>
> (c) Paid after the end of and within 90 days of the defined period, and is not contingent upon future services any recipient would provide.
>
> 2. **Bonuses paid or payable to an Affiliate are unallowable.** [emphasis added].

Appendix 5

Superior's Organizational Chart with Bonus and Incentive Payments for Affiliates

Figure 2 shows an organizational chart for Superior HealthPlan, Inc. and Superior HealthPlan Network (Superior) with bonus and incentive payments for affiliates.

Figure 2



Source: Auditors created the figure based on information Superior reported to the Commission.

Appendix 6

Calculating Experience Rebates

Texas Government Code, Section 533.014, requires the Health and Human Services Commission (Commission) to adopt rules that ensure that managed care organizations (MCOs) share profits they earn through the Medicaid managed care program. Title 1, Texas Administrative Code, Section 353.3, states that each MCO participating in Medicaid managed care must pay to the State an experience rebate calculated according to the graduated rebate method described in the MCO's contract with the Commission. The Commission has incorporated profit-sharing provisions into its contracts with MCOs that require MCOs to share certain percentages of their net income before taxes with the Commission. The General Appropriations Act (84th Legislature), Rider 13, page II-88, requires that experience rebates the Commission receives from MCOs be spent on funding services for Medicaid.

According to the Commission's contracts with MCOs, a MCO must pay an experience rebate to the Commission if the MCO's net income before taxes exceeds a certain percentage, as defined by the Commission, of the total revenue the MCO receives each fiscal period. The experience rebate is calculated in accordance with a tiered rebate method that the Commission defines (see Table 6). The tiers are based on the consolidated net income before taxes for all of the MCO's Medicaid program and Children's Health Insurance Program service areas that are included in the scope of the contract, as reported on the MCO's financial statistical reports (which the Commission reviews and confirms through annual agreed-upon procedures engagements performed by its contracted audit firms).

Table 6

Tiers for Experience Rebates		
Pre-tax Income as a Percent of Revenues	MCO Share	**The Commission's Share**
Less than or Equal to 3 percent	100 percent	0 percent
Greater than 3 percent and Less than or Equal to 5 percent	80 percent	20 percent
Greater than 5 percent and Less than or Equal to 7 percent	60 percent	40 percent
Greater than 7 percent and Less than or Equal to 9 percent	40 percent	60 percent
Greater than 9 percent and Less than or Equal to 12 percent	20 percent	80 percent
Greater than 12 percent	0 percent	100 percent

Source: The Commission's *Uniform Managed Care Terms and Conditions*.

Appendix 7

Calculation of the Experience Rebate Superior Owed for Fiscal Year 2016

Based on Superior HealthPlan, Inc. and Superior HealthPlan Network's (Superior) unaudited financial statistical report for fiscal year 2016, the Health and Human Services Commission (Commission) calculated the experience rebate amount that Superior owed the Commission for that fiscal period. Table 7 shows the Commission's calculation of the income that is subject to the tiered rebate methodology described in Appendix 6.

Table 7

The **Commission's Calculation of** Superior**'s Income Subject to Experience Rebate** for Fiscal Year 2016	
Unaudited Pre-tax Net Income	$94,651,680
Admin Cap impact: Expenses reduced [a]	$10,805,292
Cap-adjusted Pre-tax Net Income	$105,456,972
Pre-implementation Costs	$0
Adjusted Income Subject to Experience Rebate	$105,456,972

[a] The Admin Cap is a calculated maximum amount of administrative expenses that can be deducted from revenues for purposes of determining income subject to the experience rebate. While administrative expenses may be limited by the Admin Cap to determine experience rebates, all valid allowable expenses will continue to be reported on the financial statistical reports. The Admin Cap does not affect financial statistical reporting, but it may affect any associated experience rebate calculation. For fiscal year 2016, the $10,805,292 amount is the difference between Superior's Admin Cap of $337,743,981 and its reported administrative expenses of $348,549,273.

Source: The Commission.

Table 8 shows the Commission's calculation of the experience rebate that Superior owed the State for fiscal year 2016.

Table 8

The Commission's Calculation of **Superior's** Experience Rebate for Fiscal Year 2016					
Tiers - Percent of Revenue	Upper Rev Limit	Net Income	**Superior's** Share	**State's** Share	**State's** Share Percentage
0 percent to 3 percent	$148,799,961	$105,456,972	$105,456,972	$ 0	0 percent
3 percent to 5 percent	$247,999,935	0	0	0	20 percent
5 percent to 7 percent	$347,199,908	0	0	0	40 percent
7 percent to 9 percent	$446,399,882	0	0	0	60 percent
9 percent to 12 percent	$595,199,843	0	0	0	80 percent
Over 12 percent	No Limit	0	0	0	100 percent
Totals		$105,456,972	$105,456,972	$0	

Source: The Commission.

Appendix 8

Additional Management's Responses from Superior

In addition to its management's responses to the recommendations directed to it in Chapters 2 and 3 of this report, Superior HealthPlan, Inc. and Superior HealthPlan Network (Superior) submitted (1) a summary of its management's response and (2) detailed responses to the recommendations in Chapter 1 directed to the Health and Human Services Commission. That summary and those additional responses are presented below.

Summary

Superior disagrees with the auditors on two key issues, performance based incentive payments to employees and the reporting of affiliate cost. Superior disagrees with the auditor's interpretations of the cost principles and contract requirements. Further, Superior is concerned that the auditor chose to ignore: (1) the documentation of the long-standing course of performance by the parties; and (2) the manner in which both the Texas Health and Human Services Commission (HHSC) and Superior interpreted their own agreement in applying the Uniform Managed Care Manual's cost principles to the specific structure of Superior's participation in the Texas Medicaid program. Superior has consistently worked with HHSC to transparently disclose the employee incentive payments and the technicalities associated with a holding company staffing structure. HHSC has permitted the employee incentives (after receiving the required filings and request from Superior) consistent with allowances that would be available for a company not using Superior's structure. Superior believes this approach to be well within the letter, spirit, and intent of the cost principles. Similarly, Superior has made HHSC aware of its affiliate cost structure and both Superior and HHSC have arrived at an approach for the application of the cost principles to Superior's specific structure. The inconsistency between the auditor's findings and the well-established history of the course of performance between the parties to the agreement is further evidenced by more recent proposed changes to the referenced provisions by HHSC that would allow the parties to maintain the current approach.

Unfortunately, the auditor gave neither the history nor the proposed language changes any weight or context in the report and instead relied upon its own interpretation of a contractual and regulatory structure in which it does not have day-to-day experience. Incentive payments and affiliate cost could be considered by the auditor to be questionable costs,

rather than unallowable, due to the technical language issues raised by the auditor. However, the auditor should not ignore the documented decisions, planning, reporting and auditing of the costs for multiple years by the actual parties to the contract when communicating these issues in this report.

Chapter I-A

Superior does not agree with the auditor's interpretation of the cost principles regarding performance based compensation and incentive payments and is disappointed that the auditor chose to omit the fundamental contextual issues related to this issue, which include a technical inter-company staffing arrangement the auditor is not properly considering or explaining in presenting the interpretation, and a filing by Superior to HHSC seeking the approval of this compensation and incentive payment structure. The auditors have misinterpreted the cost principles relating to payments to employees in contrast to payment to an affiliate. The performance incentive payments identified are paid directly to employees providing contract services directly to Superior and not paid to an entity such as an affiliate for discretional distribution to actual employees. Many of the employees in question are the only employees that can properly be attributed to Superior and they function as the day-to-day employees of Superior through a staffing agreement. The staffing agreement between Superior and Centene of Texas, Inc. (CTX), an affiliate of Superior, provides a level of simplicity for the holding company system in which Superior is a wholly owned subsidiary. CTX provides employees to Superior and does so for only Superior.

The cost principles are complex and the provision related to employee bonus and incentive payments unfortunately includes language regarding bonus payments to affiliates that does not make any reference to employees. This results in some ambiguity. Superior has long understood this language to prohibit bonus payments directly to affiliated entities for reaching certain performance targets and to not apply to employees who are technically employed through an affiliate but providing services specifically to Superior. HHSC's approval of Superior's filed employee bonus and incentive plans is consistent with that understanding and with the allowable employee bonus and incentive expenses for MCOs not utilizing this staffing structure. However, the auditor determined that this language should be interpreted to completely disallow the employee bonus and incentive payments. The ambiguity in the cost principle language should be resolved consistent with usual contract construction principles, which would properly consider the course of performance of

the parties to the agreement. This well understood contractual interpretation principle is expressed in numerous sources, including judicial decisions, the Restatement (Second) of Contracts, and in state statute at TEX. BUS. & COM. CODE sec. 1.303.

The HHSC cost principles allow MCOs to structure compensation arrangements to employees such that those employees are paid bonus or incentive payments. This is consistent with general practices in employment arrangements. The cost principles indicate that an MCO is not allowed to take the employee incentive payment allowance and use it to pay a bonus to an affiliate. To ensure that an MCO's planned employee incentive structure is consistent with the intent of the allowance, MCOs are required to file the details of the employee bonus and incentive structure with HHSC.

Incentive payments to Superior employees have been authorized by the Health and Human Services during the years that Superior has been a contractor. The payments are based on meeting established employee goals during the year. This issue is well known and understood by HHSC due to the filing process. Superior has been reviewed by HHSC's contracted third party auditors on multiple occasions through annual AUP reviews and the issue has not been raised as a finding in those reviews. The application of the cost principles in this audit report without a transparent effort to provide context, history, or reference to the pattern and practice of the parties subject to the cost principles agreement has provided an opportunity to issue a notable finding by the SAO, but the finding does not reflect the situation accurately.

Finally, Superior understands that the placement of the cost principle language regarding bonuses and incentives can be confusing in the context of an audit and can raise questions like those identified in the report. HHSC has recently proposed changes to the cost principles that Superior believes further clarify the intent of the language and eliminate opportunities for confusion in future reviews or audits.

Chapter I-B

Superior has worked cooperatively and transparently with HHSC for many years regarding the methodology for reporting the appropriate pricing of the services Superior receives from its affiliated entities. The annual Agreed Upon Procedures (AUP) reviews by a third party auditor contracted through HHSC also test this specific issue. Superior understands that the State Auditor's Office would raise the issue as being potentially inconsistent with a technical reading of the cost principles and

associated requirements. However, the issue is easily identified by an auditor's review because it is being handled by both HHSC and Superior in a transparent manner that includes Superior's requests to HHSC and HHSC's instructions regarding testing in the AUP reviews. The State Auditor's Office appears to have identified an opportunity to enforce the contract in a more stringent manner. Superior's position is that HHSC was aware of that opportunity and made a more fact-specific determination that is backed up by post-reporting third-party review. This context was also known to the State Auditor's Office but was not effectively communicated or referenced in the audit report.

Chapter 1-C

Superior's contract with HHSC is a risk-based contract. The Executive Compensation limitation (cited above) per federal requirements applies to cost reimbursement or solely cost-based contracts and thus does not affect this agreement. The recommendations in the report are not, in Superior's view, well-considered. The application of the Federal Acquisition Regulation (FAR) to the HHSC-MCO contracts is a much larger issue than the identified executive compensation matter. The complexity related to hundreds of pages of FAR regulatory requirements and decisions is not expertise routinely maintained by either the MCOs or HHSC. Recommending any changes to the method for referencing FAR is far more complicated than an effort at addressing a singular issue identified in this report.

Appendix 9

Related State Auditor's Office Work

Related State Auditor's Office Work		
Number	Product Name	Release Date
18-006	A Report on Health and Human Services Contracts	December 2017
17-025	An Audit Report on HealthSpring Life and Health Insurance Company, Inc., a Medicaid STAR+PLUS Managed Care Organization	February 2017
17-007	An Audit Report on Medicaid Managed Care Contract Processes at the Health and Human Services Commission	October 2016

Copies of this report have been distributed to the following:

Legislative Audit Committee

The Honorable Dan Patrick, Lieutenant Governor, Joint Chair
The Honorable Joe Straus III, Speaker of the House, Joint Chair
The Honorable Jane Nelson, Senate Finance Committee
The Honorable Robert Nichols, Member, Texas Senate
The Honorable John Zerwas, House Appropriations Committee
The Honorable Dennis Bonnen, House Ways and Means Committee

Office of the Governor

The Honorable Greg Abbott, Governor

Health and Human Services Commission

Mr. Charles Smith, Executive Commissioner

Superior HealthPlan, Inc. and Superior HealthPlan Network

Mr. Mark Sanders, Plan President and Chief Executive Officer