An Audit Report on

The Health and Human Services Commission's Use of Remedies in Managed Care Contracts

November 2019

Report No. 20-008

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Overall Conclusion

The Health and Human Services Commission (Commission) has made significant improvements in its process for applying contract remedies, including liquidated damages, and it should continue to address its backlog of liquidated damage assessments.

Specifically, the Commission developed:

- An agency-wide process to coordinate identified noncompliance for the assessment of contract remedies.
- A documented methodology for calculating liquidated damages.
- A process to require MCOs to complete corrective action plans.

Liquidated Damages. Liquidated damages entitle the Commission to demand a set monetary amount for a MCO's failure to meet contract requirements (see text box for examples of MCO contractual noncompliance that may result in a liquidated damage). As of June 2019, the Commission had assessed and collected liquidated damages totaling $28 million for 1,455 instances of noncompliance identified from September 2016 through August 2017. Commission staff individually calculated each of those 1,455 liquidated damages, and, in some cases, made calculation errors. However, those errors did not significantly affect the total amount of liquidated damages calculated.

In addition, the Commission had a backlog of unassessed liquidated damages. As of July 2019, it had not assessed damages for noncompliance identified since September 2017. Delays in assessing liquidated damages diminish their effectiveness in compelling MCO contract compliance.

Background Information

The Health and Human Services Commission (Commission) uses the managed care model to deliver Medicaid services to certain populations though the STAR, STAR+PLUS, STAR Kids, and STAR Health programs. In addition, the Commission administers the Children's Health Insurance Program (CHIP) through its managed care model. (See Appendix 3 for a description of each program and the populations served).

Under the managed care model, the Commission contracts with managed care organizations (MCOs) to coordinate services for Medicaid and CHIP recipients, and MCOs are paid a monthly premium per member.

The Commission's Uniform Managed Care contract establishes the baseline requirements for all MCOs, including a contract remedy process to address MCO noncompliance with contract requirements.

Source: *Texas Medicaid and CHIP Reference Guide*, 12th Edition (2018).

Examples of MCO Noncompliance

Through its contract monitoring, the Commission may identify MCO contractual noncompliance, such as a MCO's failure to:

- Provide a covered service to a member.
- Process claims within required time frames.
- Submit required reports timely and accurately.
- Meet privacy and security standards.

Source: The Commission.

This audit was conducted in accordance with Texas Government Code, Section 321.0132.

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

Corrective Action Plans. The Commission uses corrective action plans to help address MCO noncompliance. The Commission promptly requested that MCOs complete those plans and it consistently verified each MCO's implementation of corrective action.

Identifying MCO Noncompliance. The Commission was unable to apply contract remedies for certain contract requirements because it did not have a process to identify MCO noncompliance for those requirements (see text box for information on the monitoring reviewed for this report). For example, the Commission did not have a process to identify MCO noncompliance with three performance standards exclusively related to pharmacy services.

In addition, for other areas, the Commission did not incorporate the results of its monitoring into its contract remedies process. For example, the Commission had not established a process to apply contract remedies, such as liquidated damages, when MCOs reported unallowable administrative expenses in the financial information they were required to submit.

Monitoring Reviewed

For the purposes of this report, auditors reviewed the Commission's contract remedy processes for noncompliance that its divisions identified. In some cases, auditors also determined whether the Commission performed monitoring for key contractual requirements in order to apply contract remedies.

In cases for which the Commission had established a monitoring process that it used to identify potential non-compliance, the scope of this audit did not include evaluating the adequacy of that monitoring. Instead, auditors determined whether the Commission applied contract remedies based on the results of that monitoring.

Information Technology. Auditors identified areas in which the Commission should improve its access controls. Auditors communicated details about the identified weaknesses related to access controls and other sensitive information technology issues separately to the Commission in writing.

Pursuant to Standard 7.41 of the U.S. Government Accountability Office's Generally Accepted Government Auditing Standards, certain information was omitted from this report because that information was deemed to present potential risks related to public safety, security, or the disclosure of private or confidential data. Under the provisions of Texas Government Code, Section 552.139, the omitted information is also exempt from the requirements of the Texas Public Information Act.

Table 1 on the next page 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 1

Summary of Chapters/Subchapters and Related Issue Ratings		
Chapter/ Subchapter	**Title**	**Issue Rating [a]**
1-A	The Commission Established Processes to Apply Contract Remedies for Noncompliance Identified	Low
1-B	The Commission Had a Backlog of Unassessed Liquidated Damages	Medium
1-C	The Commission Should Strengthen Controls Over Its Liquidated Damages Calculations	Medium
2	The Commission Did Not Have Processes to Identify Certain Noncompliance, and It Did Not Apply Remedies for All Noncompliance Identified	High
3	The Commission Established a Process for Requiring Corrective Action Plans	Low
4	The Commission Should Strengthen Access Controls Over Liquidated Damages and Corrective Action Plan Information	Priority

[a] A chapter/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 chapter/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 chapter/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 chapter/subchapter is rated **Low** if the audit identified strengths that support the audited entity's ability to administer the program(s)/function(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.

Auditors communicated other, less significant issues separately in writing to Commission management.

Summary of Management's Response

At the end of certain chapters in this report, auditors made recommendations to address the issues identified during this audit. The Commission agreed with the findings and recommendations in this report.

Audit Objective and Scope

The objective of this audit was to determine if the Commission has processes and related controls to help ensure that managed care contractor deficiencies are addressed through the assessment and collection of liquidated damages and other sanctions according to applicable requirements.

The scope of this audit covered MCO noncompliance with contract requirements identified for which the Commission applied contract remedies, including issuing corrective action plans and liquidated damages. This audit focused on contract remedies initiated from fiscal years 2017 through 2019, as of May 2019.

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Detailed Results

Chapter 1

The Commission Established Processes to Apply Contract Remedies for Noncompliance Identified; But the Commission Had a Backlog of Unassessed Liquidated Damages

The Health and Human Services Commission (Commission) administers the Medicaid program for Texas primarily through contracts with managed care organizations (MCOs). The Commission has implemented processes and controls to address identified MCO noncompliance with contract requirements primarily through:

- The assessment and collection of liquidated damages, and
- The development and implementation of corrective action plans (see text box for more information).

Liquidated Damages and Corrective Action Plans

Liquidated damages entitle the Commission to demand a set monetary amount for the loss of service due to a MCO's failure to meet any aspect of the responsibilities of the contract and/or the specific performance standards identified in the contract's deliverables/liquidated damages matrix.

A **corrective action plan** is a detailed written plan to remedy contractual noncompliance. Corrective action plans are completed by MCOs and approved by the Commission. The Commission monitors the implementation of corrective action and determines when a MCO has adequately addressed all issues of noncompliance.

Sources: *State of Texas Procurement and Contract Management Guide*, Version 1.2; the Commission's Uniform Managed Care Contract, Version 2.27; and the Commission.

Specifically, the Commission had:

- Assessed and collected 1,455 liquidated damages totaling $28 million for noncompliance identified in fiscal year 2017.
- Tracked the status of 321 corrective action plans for noncompliance identified from September 2016 through May 2019. In addition, as of May 2019, the Commission was tracking 3 other corrective action plans for noncompliance it had identified prior to September 2016.

However, the Commission had a backlog of unassessed liquidated damages and had not assessed liquidated damages for noncompliance identified since September 2017. Continued backlogs (1) prevent the Commission from providing adequate notice to MCOs and (2) limit its ability to compel MCOs to meet contractual requirements and prevent continued or worsening noncompliance.

In addition, the Commission's process for calculating liquidated damages relies on Commission staff calculating damage amounts by evaluating several inputs and recording the results of those calculations in a spreadsheet. As a result, it made errors in calculating damages and did not always correctly apply its methodology.

Chapter 1-A

The Commission Established Processes to Apply Contract Remedies for Noncompliance Identified

Chapter 1-A Rating:

Low [1]

The Commission developed an agency-wide process to manage identified MCO noncompliance. Under that process, the Commission addressed MCO noncompliance primarily through (1) the assessment and collection of liquidated damages and (2) the development and implementation of corrective action plans.

Assessment of Liquidated Damages

Throughout fiscal years 2018 and 2019, the Commission developed and implemented an improved process for assessing liquidated damages. Specifically, as of March 2019, the Commission had:

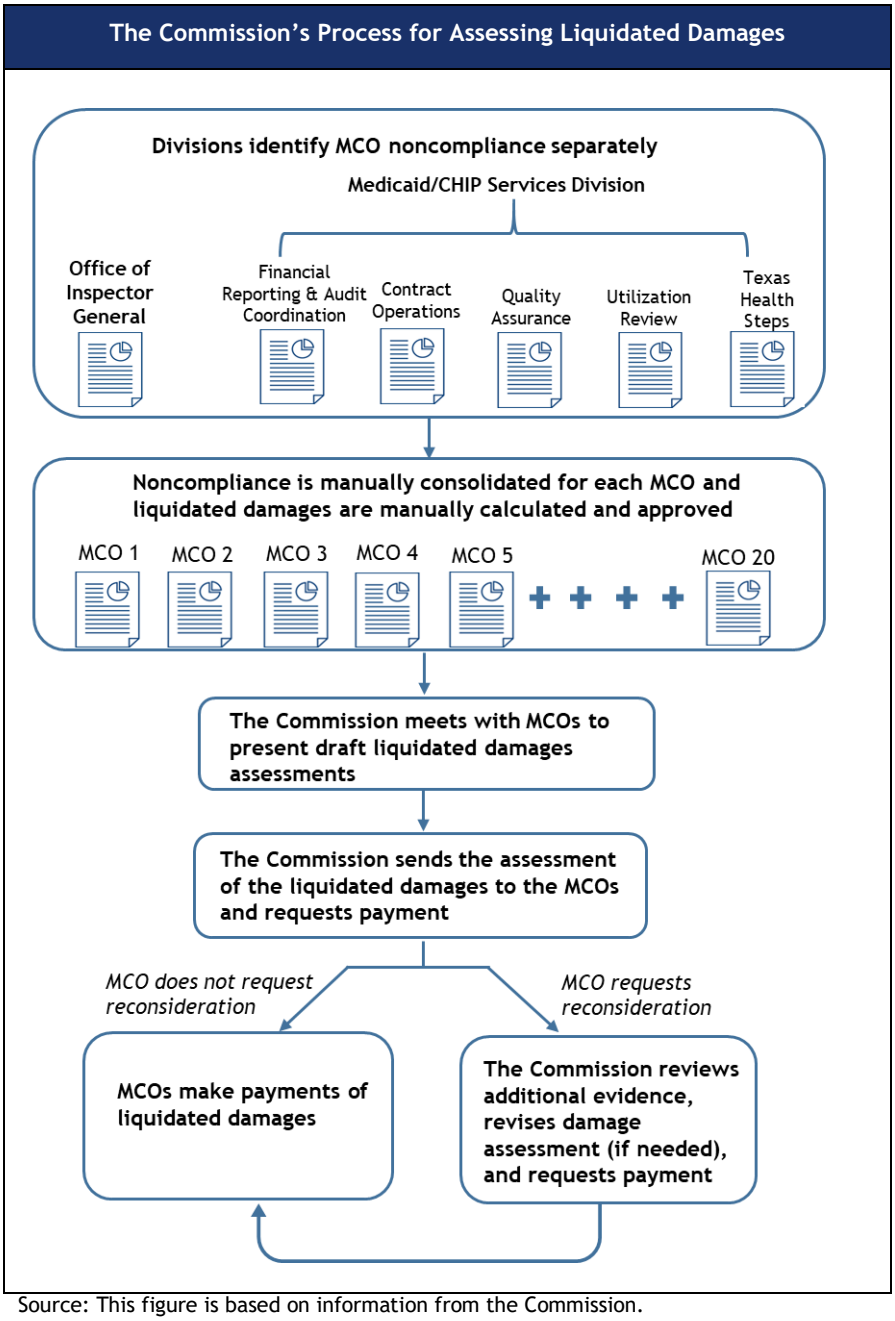
- Designed a template spreadsheet that multiple divisions used to help ensure that details of identified noncompliance were recorded consistently.
- Centralized the liquidated damage calculations and implemented a decision matrix that streamlined the calculation methodology.
- Implemented a documented approval process for liquidated damage assessments.

The Commission's improved liquidated damage process begins when divisions identify and record MCO noncompliance in multiple spreadsheets. Commission staff then compiles the noncompliance by MCO and calculates the liquidated damage amounts. For 497 (99 percent) of the 502 instances of noncompliance tested, the Commission carried forward all of the identified noncompliance for assessment. Those liquidated damage assessments are then approved, communicated to the MCOs, and finalized before the Commission requests payment.

Figure 1 on the next page shows the liquidated damage process that the Commission began using for noncompliance identified in the fourth quarter of fiscal year 2017.

[1] The risk related to the issues discussed in Chapter 1 is rated as Low because the audit identified strengths that support the audited entity's ability to administer the program(s)/function(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.

Figure 1



Source: This figure is based on information from the Commission.

Corrective Action Plans

The Commission's corrective action plan process also begins when divisions identify MCO noncompliance. The Commission requests that MCOs develop corrective action plans to remedy the noncompliance identified, and it works with the MCOs to approve the planned corrective action. The Commission then monitors the MCO's implementation of corrective action and reviews supporting documentation to close out the plan.

From September 2016 through May 2019, the Commission tracked the status of 324 corrective action plans (see Chapter 3 for further discussion of the Commission's use of corrective action plans).

Other Contract Remedies

While the Commission established processes for applying corrective action plans and liquidated damages, it did not have a process to determine under what circumstances it would consider initiating other remedies available in its contract (see text box for examples of those remedies). For example, in cases of recurring or severe noncompliance, the Commission had not established a framework for when it should evaluate the need for more serious remedies, such as suspending the MCO from enrolling new members.

For some instances of noncompliance, the Commission required additional, more detailed and frequent reporting by MCOs. However, establishing a documented process for determining when escalated remedies should be considered would help the Commission ensure consistency in addressing identified issues and may help deter prolonged and/or worsening noncompliance.

Contract Remedies

The Commission may impose one or more of the following contract remedies for MCO noncompliance:

- Require the MCO to submit a corrective action plan.
- Assess liquidated damages.
- Conduct accelerated monitoring of the MCO.
- Require additional, more detailed, financial and/or programmatic reports.
- Require additional and/or more detailed financial and/or programmatic audits.
- Decline to renew or extend the contract.
- Appoint temporary management.
- Initiate disenrollment of member(s).
- Suspend enrollment of members.
- Withhold or recoup payment to MCO.
- Require forfeiture of all or part of MCO's bond.
- Terminate contract.

Source: The Commission's Uniform Managed Care Contract, Version 2.27.

Recommendation

The Commission should develop and implement a process to evaluate when the escalation of contract remedies is necessary.

Management's Response

Statement of Agreement/Disagreement

HHSC agrees with the finding and will continue the development and implementation of the contract remedies process.

Action Plan

As noted in this audit, HHSC established documented processes for the most common contract remedies; with corrective action plans documented and

implemented in February 2017, followed by standardization of liquidated damages by August 2018.

Currently, HHSC has an informal process to escalate issues beyond what can be captured through the corrective action process and liquidated damages. For example, to address issues with an MCO's non-compliance with encounters, HHSC implemented an escalated corrective action plan that included a targeted onsite review, weekly meetings and increased liquidated damages assessments to address the harm incurred by the agency.

As a next step to further strengthen the remedy process, the agency will formalize, document, and implement a process for other escalated remedies. Often, further escalation of remedies is not required because the MCO corrects the issue under the correction action plan. However, HHSC recognizes the need to formalize the escalation process for areas of continued contract non-compliance. Guidance on how to identify and escalate issues of ongoing non-compliance will be incorporated into the existing quality compliance training for HHSC staff.

Responsible Manager

Director, Managed Care Compliance & Operations

Target Implementation Date

March 2020: Develop and implement process to evaluate the escalation of contract remedies.

June 2020: Incorporate procedures to identify and evaluate issue escalation into quarterly compliance training.

Chapter 1-B

The Commission Had a Backlog of Unassessed Liquidated Damages

Chapter 1-B Rating:

Medium [2]

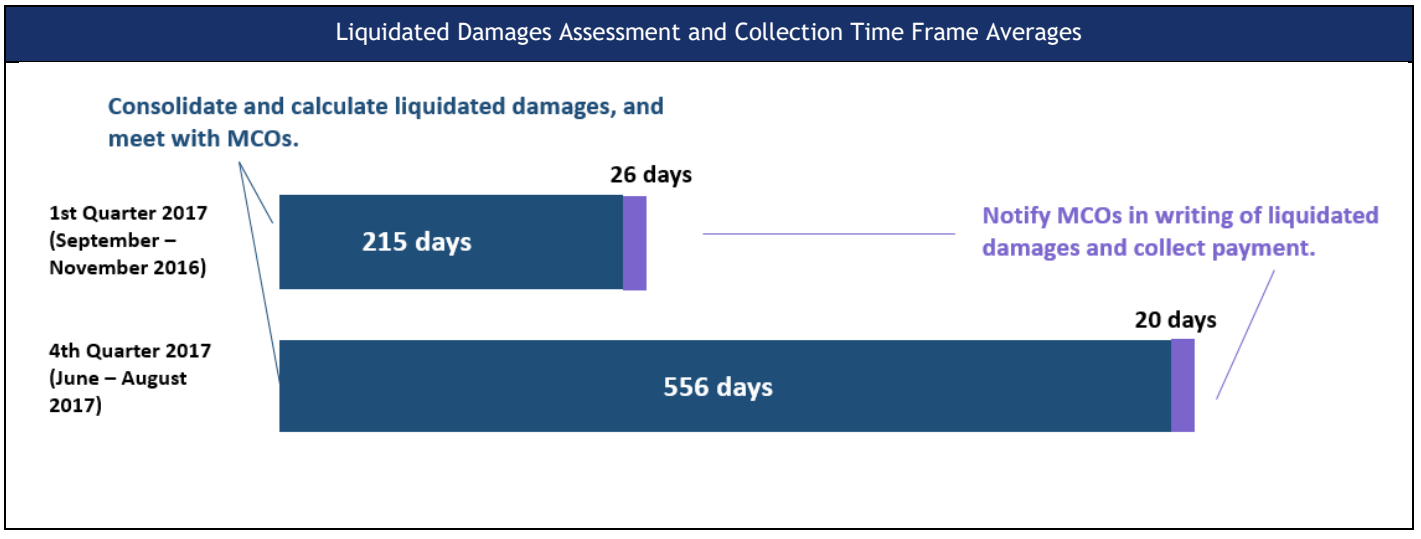
The Commission had a significant backlog of unassessed liquidated damages. Liquidated damages are important to address and resolve MCOs' contractual noncompliance. Continued backlogs (1) prevent the Commission from providing adequate notice to MCOs and (2) limit its ability to compel MCOs to meet contractual requirements and prevent continued or worsening noncompliance.

For noncompliance it had identified since September 2017, the Commission had not finalized its calculations of liquidated damages as of July 2019. For example, at that time, the Commission had not finalized liquidated damages for noncompliance it identified 20 months previously during the first quarter of fiscal year 2018.

Overall, the Commission's time frame for assessing liquidated damages has increased (see Figure 2). Specifically:

- For the first quarter of fiscal year 2017, the Commission took an average of approximately 7.2 months (215 days) from when the noncompliance was identified to when MCOs were formally notified of the liquidated damage assessment.
- For the fourth quarter of fiscal year 2017, that time frame had increased to an average of approximately 18.5 months (556 days).

Figure 2



Source: Based on information from the Commission.

[2] The risk related to the issues discussed in Chapter 1-B is rated as Medium because they 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.

In addition, some MCO noncompliance may have occurred in a time period prior to when it was identified, lengthening the time between when it occurred and when liquidated damages would be assessed.

The Commission indicated that its process improvements, which started with the fourth quarter of fiscal year 2017 liquidated damages, contributed to delays in assessing liquidated damages.

As Figure 2 also shows, once the Commission formally notified MCOs of liquidated damage assessments, the Commission collected payments from the MCOs in a timely manner. For example, it took the Commission an average of 20 days to collect the liquidated damages for the fourth quarter of fiscal year 2017 (which ended August 31).

Updating Web Site

In addition, Texas Government Code, Chapter 533, requires the Commission to update its internet posting of sanctions for contract violations at least quarterly, and the Commission had a process for posting liquidated damages to its Web site. Under that process, the Commission updates its Web site with all liquidated damages for a quarter after it has collected all of the assessments for that quarter. As of August 2019, the Commission had updated its Web site to reflect the liquidated damages tested through the third quarter of fiscal year 2017.[3]

Recommendations

The Commission should:

- Implement a process to eliminate its current backlog of liquidated damages.
- Design and implement methods to increase efficiencies for assessing liquidated damages.

Management's Response

Statement of Agreement/Disagreement

HHSC agrees with the finding and has dedicated significant resources to eliminating the backlog of liquidated damages.

[3] As of August 2019, the third quarter of fiscal year 2017 was the most recent quarter for which the Commission had assessed and collected liquidated damages for all MCOs.

Action Plan

HHSC identified concerns with the liquidated damages assessment process in October 2017 and implemented appropriate managed care contract amendments. Following that, HHSC began overhauling the processes to identify and assess liquidated damages based on the contract. During this improvement effort, HHSC paused its processing of liquidated damages to focus on reviewing, revising, and documenting the new processes.

When the new processes were documented, HHSC dedicated eight staff members to address the backlog utilizing the new standards starting in July 2019. The team initiated simultaneous work on multiple quarters. The backlog is expected to be addressed by December 2020 with a goal of being two quarters behind at any given time. This time lag is due to the timing of deliverables and other data submission. For example, MCOs are generally required to submit data thirty days following the end of the quarter, although some deliverables such as complaints and appeals are due 45 days following the end of the quarter.

Currently, liquidated damages for state fiscal year (FY) 2017 are completed, approved and payment has been received from the MCOs. For FY 2018, the first two quarters are nearly complete with only a few corrections remaining. HHSC has initiated discussions with MCOs on the third quarter liquidated damages. Fourth quarter management approvals are in process.

In addition to dedicating staff to resolve the backlog, HHSC is also automating liquidated damages in its new managed care contract oversight tool, TexConnect. Implementation in TexConnect will increase efficiencies by automating a large portion of the liquidated damages process and centralizing the logging of program area reports of non-compliance. Additionally, TexConnect will strengthen internal controls by tracking staff responsible for making changes. The system will automate the MCO's ability to request reconsideration of liquidated damages.

Responsible Manager

Director, Managed Care Compliance & Operations

Target Implementation Date

August 2020: Complete all of state fiscal year 2019 liquidated damages.

December 2020: Complete catch up of all liquidated damages.

December 2020: Liquidated damages components implemented in TexConnect.

Chapter 1-C

The Commission Should Strengthen Controls Over Its Liquidated Damages Calculations

Chapter 1-C Rating:

Medium [4]

The Commission assessed liquidated damages based on noncompliance identified primarily through its (1) monitoring of contract deliverables and (2) utilization reviews. Commission staff individually calculated each of the 1,455 liquidated damages it had collected as of June 2019. In addition, the Commission staff calculated liquidated damages for 736 other instances of MCO noncompliance and, as of July 2019, was in the process of finalizing those assessments.

The Commission followed its process for calculating liquidated damages. While the Commission made several errors in its individual calculations, those errors did not significantly affect the total amount of liquidated damages calculated.

Liquidated Damage Calculations. The Commission did not correctly apply its methodology when it calculated certain liquidated damages for noncompliance identified primarily through its monitoring of contract deliverables. Specifically, while the 66 liquidated damages totaling $2.0 million tested were within contractual limits, the Commission:

- Made errors in its calculations for 11 (17 percent) liquidated damages tested that totaled $47,188.
- Did not document all factors that supported its calculations of liquidated damage amounts for 6 (9 percent) liquidated damages tested.

In addition, through data analysis, auditors identified four other instances of noncompliance that the Commission incorrectly excluded from its liquidated damage calculations.

Waived Liquidated Damages. The Commission's methodology allows the Commission to waive liquidated damages for isolated noncompliance that did not result in actual harm to a member or the Commission. The Commission's methodology does not allow it to waive liquidated damages for MCO noncompliance related to the behavioral health hotline, the nurse hotline, claims, and encounter data[5] standards. All 28 waived liquidated damages tested were waived according to the Commission's methodology and were associated with isolated noncompliance.

[4] The risk related to the issues discussed in Chapter 1-C is rated as Medium because they 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.

[5] Encounter data is a claim received and adjudicated by an MCO.

Utilization Reviews

The Commission performs utilization reviews to determine whether MCOs are authorizing, justifying, and providing appropriate, medically necessary services to Medicaid members, without over-utilization or under-utilization. The Commission's Office of the Medical Director oversees the utilization reviews, which a team of nurses conduct.

As of fiscal year 2019, the scope of the Commission's utilization reviews was limited to only the STAR+PLUS program.

Sources: *Texas Medicaid and CHIP Reference Guide*, 12th Edition (2018); and the Commission.

Individual Service Plan

An Individual Service Plan is an individualized plan in which a STAR+PLUS member identifies and documents his or her preferences, strengths, and health and wellness needs. The plan documents the services to be provided to the members and the effective dates of those services.

Source: The Commission.

Utilization Review Liquidated Damages. The Commission also assessed liquidated damages based on the results of utilization reviews (see text box for more information about utilization reviews). Unlike the liquidated damages discussed above, those based on utilization reviews relate to a MCO's failure to provide covered or administrative services for individual members.

The Commission assessed liquidated damages based on the results of utilization reviews for the first time in May 2018.[6] For those assessments, the Commission began an initial effort to assess liquidated damages for the STAR+PLUS program. In that initial effort, the Commission calculated preliminary liquidated damages of $102.2 million; however, those calculations did not include evaluating the significance of harm. Instead, it based those calculations only on (1) the maximum damage allowed under the contract and (2) the date the member's need was identified.

The Commission subsequently developed a methodology to address the weaknesses in its original calculations. Under that newly developed methodology, the Commission considered (1) the harm or risk of harm to the member and (2) the number of days the member waited for services authorized by the member's individual service plan (see text box for information about those plans). As a result, it adjusted its preliminary calculations and assessed 61 liquidated damages totaling $11.7 million.

The Commission's calculations for 17 (85 percent) of the 20 liquidated damages tested were consistent with its newly developed methodology. The Commission made minor errors totaling $2,500 for the other 3 liquidated damages tested.

Recommendations

The Commission should:

- Verify that it calculates liquidated damages for each instance of noncompliance, as appropriate.
- Strengthen controls over its liquidated damage calculations, including implementing automated controls or additional reviews where appropriate.

[6] Those utilization reviews were conducted in 2017. As of July 2019, the Commission had not finalized its calculation of liquidated damages based on the results of its 2018 utilization reviews.

- Strengthen its review of liquidated damage calculations to verify calculations are consistent with its methodology.

Management's Response

Statement of Agreement/Disagreement

HHSC agrees that calculation errors were made as a result of manual processes, and that these errors did not significantly affect the calculation of liquidated damages.

Action Plan

In addition to dedicating staff to resolve the backlog, HHSC also modified the review process by automating several steps in the calculations to reduce the opportunity for manual errors. This is an interim step to improve the process until a more automated approach to support liquidated damages can be established within HHSC's new managed care contract oversight tool, TexConnect. Implementation in TexConnect will increase efficiencies and accuracy by automating a large portion of the liquidated damages process and centralizing the logging of program area reports of non-compliance. Additionally, TexConnect will strengthen internal controls by tracking staff responsible for making edits. The system will enable the MCOs to request reconsideration of liquidated damages.

Manual processes that are currently relied upon for calculation of liquidated damages carry an increased risk for errors. Ultimately, as noted in the previous response, HHSC will implement TexConnect which will automatically calculate a large portion of liquidate damages. Until then, HHSC continues to strengthen manual controls. These controls contributed to the low error rate. For example, HHSC strengthened controls beginning in May 2019 by applying a multi-part quality check for all calculations. Staff ensures that each liquidated damage submitted by HHSC program areas is included on the final log and provides a second-level review of all calculations. The previously mentioned automation of the liquidated damages logs also addresses the risk for calculation errors as an intermediate mitigation until the liquidated damages process and its associated calculations are automated in TexConnect.

Responsible Manager

Director, Managed Care Compliance & Operations

Target Implementation Date

December 2020: Liquidated damages components implemented in TexConnect.

Chapter 2

The Commission Did Not Have Processes to Identify Certain Noncompliance, and It Did Not Apply Remedies for All Noncompliance Identified

Chapter 2 Rating:

High [7]

The Commission performed monitoring for several types of significant contract deliverables, and it applied contract remedies based on the results of that monitoring. However, the Commission was unable to apply contract remedies for certain contract requirements because it did not have processes to identify MCO noncompliance for those requirements. That included not performing utilization reviews for most Medicaid programs and not monitoring to identify MCO noncompliance related to specific pharmacy performance standards.

In addition, for some other areas, the Commission did not incorporate the results of its monitoring into its contract remedies process, and it did not consistently ensure that it applied contract remedies for MCO noncompliance related to certain access-to-care requirements.

The Commission had not assessed liquidated damages based on the results of utilization reviews for most of its Medicaid programs.

The passage of Senate Bill 348 (83rd Legislature, Regular Session), effective May 2013, required the Commission to perform utilization reviews at MCOs participating in the STAR+PLUS program, which provides services for adults with a disability, individuals age 65 or older, and women with breast or cervical cancer. As required, the Commission has implemented a process for conducting those utilization reviews.

In addition, managed care contracts for all Medicaid programs establish a performance standard related to MCOs providing covered services to members. Utilization reviews are the primary method for evaluating MCOs' compliance with that standard. However, as of fiscal year 2019, the Commission had not performed utilization reviews of MCOs to enforce that performance standard for the STAR, STAR Kids, STAR Health, and CHIP programs (see Appendix 3 for a description of each program). Without those reviews, the Commission's ability to apply contract remedies, including liquidated damages, for a MCO's failure to provide covered services to members is limited. According to the Commission, it plans to expand its utilization reviews to STAR Kids and STAR Health in fiscal year 2020.

[7] The risk related to the issues discussed in Chapter 2 is rated as High because they 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.

The Commission did not have adequate processes to identify MCO noncompliance related to pharmacy services.

The Commission's managed care contract established five performance standards exclusively related to pharmacy services; however, the Commission did not have a process to identify MCO noncompliance with three of those standards. For example, it did not have a process to identify noncompliance for a performance standard that it established for requiring MCOs to reimburse pharmacies for providing emergency prescription drug supplies when authorizations are not processed within required time frames. The Commission had a process to identify noncompliance for the remaining two pharmacy performance standards, but it had not applied any contract remedies for the noncompliance it identified for those two standards.

Not having processes to identify MCO noncompliance related to pharmacy services and not applying contract remedies for the noncompliance identified increases the risk that MCO noncompliance may escalate or be prolonged. The Commission asserted that it was evaluating whether the pharmacy standards were appropriate or needed to be modified.

The Commission did not apply contract remedies for certain noncompliance related to MCO financial statistical reports.

The Commission uses agreed-upon procedures (AUP) engagements[8] to identify unallowable costs that MCOs report on their financial statistical reports (see text box for information about those reports). However, as of August 2019, it had not applied any corrective action plans or liquidated damages to address the noncompliance the AUP engagements identified, which primarily related to the MCOs reporting unallowable administrative costs. The unallowable administrative costs that MCOs reported on financial statistical reports identified by the Commission's AUP engagements increased by 601 percent between 2013 and 2016 (see Figure 3 on the next page).

Financial Statistical Reports

The Commission receives financial statistical reports from MCOs on a quarterly and annual basis. Those reports include key financial results and are submitted by the MCOs to the Commission.

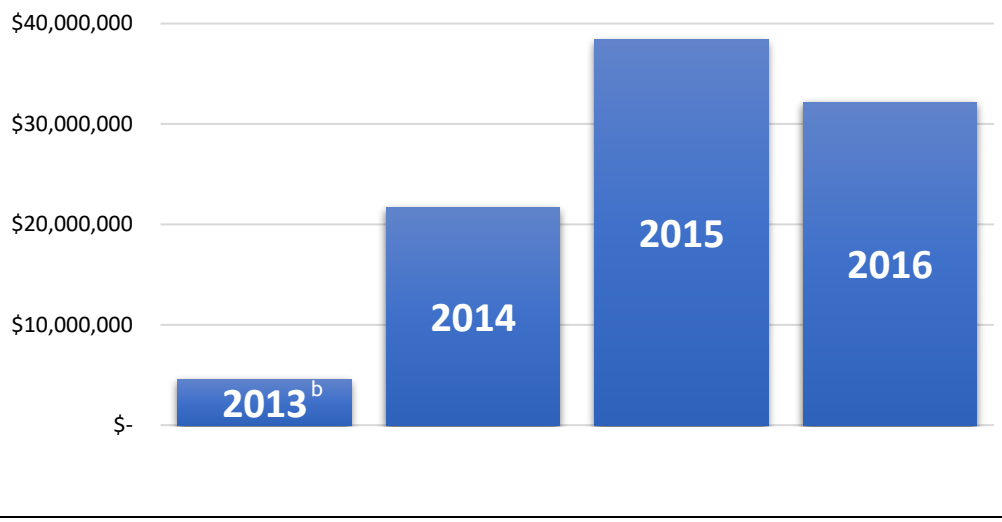
The Commission uses AUP engagements to determine whether the financial statistical reports that MCOs submit were completed in accordance with Commission requirements.

Source: The Commission.

[8] In an AUP engagement, which is limited in scope, the auditor does not provide an opinion or conclusion and reports only on the findings related to the procedures that the Commission approved.

Figure 3

Unallowable Costs Reported by MCOs on Administrative Financial Statistical Reports [a] By Fiscal Year



[a] This figure shows the net unallowable administrative costs identified by the AUP engagements.

[b] The fiscal year 2013 AUP engagements covered an 18-month time period; the fiscal year 2014 through 2016 AUP engagements each covered 12-month time periods.

Source: The Commission's AUP Engagement Reports.

Financial statistical reports are important because they are the primary source of information that the Commission uses to set the administrative portion of the monthly amount that MCOs are paid per member (called the premium or capitation rate). Using the contract remedy process is essential in compelling MCOs to comply with financial reporting requirements because the administrative expenses reported in those reports are not verified until after the information is used to set premiums. For example, the Commission's actuary used the MCOs financial statistical reports for 2016 through 2018 to set its 2019 premiums for the STAR+PLUS program; at the time those premiums were set, the financial statistical reports had not yet been verified through the Commission's AUP process.

The Commission should ensure that it applies contract remedies for noncompliance related to certain access-to-care requirements (see text box for information about those requirements).

Out-of-Network Utilization. The Commission had a process to identify noncompliance and assess liquidated damages for MCOs that exceeded out-of-network utilization limits. MCOs are required to report to the Commission member out-of-network utilization for emergency room visits, hospital admissions, and other outpatient services.

Network Adequacy. The Commission also had a process to identify MCO noncompliance with network adequacy distance standards and it issued corrective action plans for MCOs that it determined did not have adequate networks. However, as of May 2019, the Commission was not applying liquidated damages related to network adequacy distance standards due to errors in provider address information.

Access to Care

MCOs are required to provide all members timely access to quality care through a network of providers designed to meet the needs of the population served. Auditors reviewed the following access-to-care measures that the Commission used to monitor access to care:

- **Out-of-Network Utilization.** The Commission evaluates the percentage of claims that MCOs paid to providers outside of each MCO's network. Exceeding out-of-network standards may indicate that the MCO has an inadequate network of providers.
- **Network Adequacy.** The Commission evaluates the adequacy of MCOs' provider networks by analyzing how far members must travel to reach a network provider.
- **Texas Health Steps.** The Commission evaluates whether 50 percent of MCO members receive check-ups for early and periodic screenings, diagnosis, and treatment.

Source: The Commission.

Texas Health Steps. The Commission had a process to identify noncompliance and apply contract remedies for the timeliness and accuracy of Texas Health Steps reporting. However, it did not apply liquidated damages for MCOs with 50 percent or fewer of their members receiving timely Texas Health Steps check-ups. In addition, the Commission's contract for STAR Health (for children in the foster care program) did not authorize liquidated damages should the MCO fail to meet Texas Health Steps performance standards. Texas Government Code, Chapter 533, requires the Commission to include that provision in its STAR Health contract.

Recommendations

The Commission should:

- Implement its plan to expand utilization reviews to additional Medicaid programs and apply contract remedies as needed based on the results of those reviews.
- Determine the appropriate performance standards for pharmacy services.

- Develop, document, and implement processes to verify MCO compliance with pharmacy services performance standards and issue contract remedies for noncompliance identified.

- Apply contract remedies for noncompliance identified as a result of AUP engagements, including corrective action plans and liquidated damages.

- Implement requirements for how MCOs should submit provider address information and assess liquidated damages for MCO noncompliance with network adequacy requirements.

- Revise its STAR Health contract to authorize liquidated damages should the MCO fail to meet Texas Health Steps performance standards.

Management's Response

The Commission should:

- ***Implement its plan to expand utilization reviews to additional Medicaid programs and apply contract remedies as needed based on the results of those reviews.***

Statement of Agreement/Disagreement

HHSC agrees with the finding and was appropriated increased resources to expand utilization reviews in Medicaid.

Action Plan

As noted in the audit, utilization review is a vital resource for ensuring that MCOs are providing covered services to members. Utilization review encompasses long-term services and supports, as well as acute care services. Utilization reviews are conducted using a variety of methods from desk reviews to home visits. HHSC conducts both acute and long-term services and supports utilization reviews in the STAR+PLUS, STAR Kids, STAR Health and STAR program.

In 2018, HHSC recognized the need to expand utilization reviews to include more programs and services, and requested approval from the Legislative Budget Board to transfer full-time equivalents (FTEs) within the agency to significantly expand resources supporting utilization review activities. From that approval, an additional 48 FTEs were provided to support utilization reviews. As continued recognition of the need to further support the expansion and scope of reviews, HHSC put forward an exceptional item to the 86th Legislature, which resulted in an additional 24 FTEs.

Long-term Care Services and Supports Utilization Review

In 2013, Senate Bill 348 (83rd Legislature, regular session) directed HHSC to perform utilization reviews of MCOs participating in STAR+PLUS. These reviews began in 2014. Initially, reviews focused on STAR+PLUS home and community-based services reviewing MCO assessments and determination of membership enrollment in the program. HHSC continues to conduct annual LTSS utilization reviews in STAR+PLUS to ensure the MCOs meet contractual obligations and provide members with the required standard of medically necessary services, including accurately determining whether MCOs are providing services according to their assessment of service needs.

In addition to long-term services and supports reviews in STAR+PLUS, HHSC conducted a pilot review of the STAR Kids Medically Dependent Children Program (MDCP) in FY 2019. In FY 2020, as a result of additional staffing approved by the Legislature, HHSC will conduct reviews in both STAR Kids and STAR Health for MDCP, and will apply contract remedies as appropriate.

Acute Care Utilization Review

HHSC has significantly expanded the scope of acute care utilization reviews in the last two years. Acute care utilization reviews are performed across programs including STAR, STAR+PLUS, STAR Kids, and STAR Health. Acute care utilization desk reviews are part of the managed care operational review process and are conducted on a targeted sample set of records. The review includes, but is not limited to, the authorization process and medical necessity determination.

Since 2018, 15 corrective action plans have been issued to 11 health plans. Examples of findings include coordination of covered benefits and limits in prior authorizations. Currently, HHSC is reviewing operational review findings for nine MCOs and will identify utilization review-related remedies in December 2019.

HHSC will continue to apply remedies, when necessary, to ensure MCOs are meeting all performance standards and requirements for providing covered services to program members.

<u>Responsible Manager</u>

Chief Medical Director, Medicaid & CHIP Services

Target Implementation Dates

December 2019: Identify remaining remedies for 2019 utilization reviews.

August 2020: Complete STAR Kids and STAR Health utilization reviews and begin identifying remedies for FY 2020, as necessary.

The Commission should:

- ***Determine the appropriate performance standards for pharmacy services.***
- ***Develop, document, and implement processes to verify MCO compliance with pharmacy services performance standards and issue contract remedies for noncompliance identified.***

Statement of Agreement/Disagreement

HHSC agrees with the finding and has taken steps to improve oversight of pharmacy services.

Action Plan

Pharmacy services are an essential part of service delivery in managed care. HHSC is currently integrating monitoring of pharmacy services contractual requirements into the reoccurring MCO/PBM operational reviews and third-party audits, as well as future MCO/PBM readiness reviews through the creation of standardized modules and tools used by HHSC to monitor MCO compliance. In the event non-compliance is identified, HHSC will issue contract remedies, including CAPs and/or liquidated damages, as appropriate.

By November 2019, HHSC will assess the appropriate MCO/PBM contractual performance requirements for monitoring efforts. This effort will inform contract changes that will become effective September 2020.

Responsible Manager

Director, Managed Care Compliance & Operations

Director, Medicaid & CHIP Operations

Target Implementation Dates

November 2019: Identify contract requirements changes and determine current MCO/PBM performance level for contractual requirements to establish a starting point for monitoring.

September 2020: Implement contract changes related to pharmacy benefit standards.

The Commission should:

- ***Apply contract remedies for noncompliance identified as a result of AUP engagements, including corrective action plans and liquidated damages.***

Statement of Agreement/Disagreement

HHSC agrees with the finding and has issued the initial corrective action plans to the MCOs for FY 2015 and 2016 AUP engagements.

Action Plan

HHSC relies on agreed upon procedures (AUP) engagements to identify unallowable costs on the MCO financial statistical reports.

While AUPs were being conducted and actions were being taken on their findings, HHSC acknowledges that non-compliance identified through prior AUP engagements had not resulted in the application of corrective action plans or liquidated damages. As the complexity and scale of the Texas Medicaid programs in managed care evolved over time, the financial oversight resources remained flat. In recognition of the need to address this gap, in early 2018 Medicaid & CHIP Services requested staff transfers to add members to the financial oversight team. With these additional resources, HHSC was able to create standards and processes for applying appropriate contract remedies related to AUP engagements.

As of October 7, 2019, HHSC has issued 8 corrective action plans to 8 of the 21 MCOs to address non-compliance identified in the FY 2015 and 2016 AUPs. The types of non-compliance identified include unallowable costs per the UMCM cost principles, required supporting documentation, and out of period costs included on the FSRs. HHSC anticipates issuing the remaining corrective action plans to the remaining MCOs by December 31, 2019.

Responsible Manager

Director, Financial Reporting and Audit Coordination

Target Implementation Dates

December 2019: Issue all AUP engagement corrective action plans for FYs 2015 and 2016.

March 2021: Determine the appropriate contractual remedies for SFY 2017 AUP findings.

The Commission should:

- ***Implement requirements for how MCOs should submit provider address information and assess liquidated damages for MCO noncompliance with network adequacy requirements.***

Statement of Agreement/Disagreement

HHSC agrees with the finding and considers this recommendation complete as a result of an amendment to the managed care contracts requiring MCOs to use United States Postal Service (USPS) standards.

Action Plan

An amendment to the managed care contracts requiring MCOs to use United States Postal Service (USPS) standards has been made. This change will reduce the number of mismatched files generated in the reconciliation process and ensure accurate provider address information by applying the standard to MCOs and all other entities that use provider data (including the Texas Medicaid Healthcare Partnership and MAXIMUS).

HHSC recognizes the importance of accurate provider address information and its impact to member access to care.

HHSC ensures MCOs are working with their members to ensure access to care by monitoring areas of MCO performance that impacts network adequacy, including out-of-network utilization, complaints and provider terminations that result in contractual non-compliance.

HHSC also monitors contractual compliance with appointment availability standards through appointment availability studies. The studies are conducted through secret shopper calls, which focus on determining how many days it takes for a member to get an appointment.

Additionally, the managed care contracts require plans to provide members with direct access to staff who can assist them in obtaining access to care. This includes a member services email mailbox and the requirement that MCOs maintain the ability to perform a three-way telephone call between the MCO, member, and provider to schedule member appointments.

HHSC will continue to assess areas of non-compliance and recommend liquidated damages, as appropriate.

Responsible Manager

Director, Managed Care Compliance & Operations

Target Implementation Dates

Implemented

The Commission should:

- ***Revise its STAR Health contract to authorize liquidated damages should the MCO fail to meet Texas Health Steps performance standards.***

Statement of Agreement/Disagreement

HHSC agrees and considers this recommendation to be complete as a result of a recent amendment to the STAR Health contract, effective September 1, 2019.

Action Plan

HHSC amended the STAR Health Contract, Section 8.1.28.3, Texas Health Steps (EPSDT) Medical and Dental, to include language that allows for the assessment of liquidated damages if the MCO fails to develop effective methods to ensure that members receive Texas Health Steps medical checkup services. HHSC will evaluate and assess contract remedies as appropriate.

Responsible Manager

Director, Managed Care Compliance & Operations

Target Implementation Dates

Implemented

Chapter 3

The Commission Established a Process for Requiring Corrective Action Plans

Chapter 3 Rating:
Low [9]

The Commission established a process to require MCOs to complete corrective action plans to address identified noncompliance and it promptly requested MCOs to complete those plans (see Figure 4 for more information about the Commission's process for corrective action plans).

Figure 4

The Commission's Process for Requiring Corrective Action Plans

Source: This figure is based on information from the Commission.

Specifically, the Commission opened corrective action plans within four months for noncompliance tested. Opening corrective action plans in a timely manner increases the effectiveness of the Commission's monitoring of an MCO's progress toward implementing corrective action, increasing the likelihood that the MCO will quickly remedy identified noncompliance.

In addition, the Commission consistently verified MCOs' implementation of corrective action prior to closing each of the 18 closed corrective action plans tested. Specifically, the Commission reviewed documentation that MCOs provided to determine whether the MCOs had taken adequate steps to remedy the noncompliance.

The Commission should ensure that it consistently complies with its policy to "routinely" follow-up on the implementation of corrective action. The Commission routinely monitored the status of the MCOs' implementation of corrective action for 25 (89 percent) of 28 corrective action plans tested.

[9] The risks related to the issues discussed in Chapter 3 is rated as Low because the audit identified strengths that support the audited entity's ability to administer the program(s)/function(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.

Chapter 4

The Commission Should Strengthen Access Controls Over Liquidated Damages and Corrective Action Plan Information

Chapter 4 Rating:

Priority [10]

Auditors identified significant weaknesses in the Commission's controls over access to its information systems used to manage liquidated damages and corrective action plans. Auditors communicated details about the identified weaknesses separately to the Commission in writing.

Pursuant to Standard 7.41 of the U.S. Government Accountability Office's generally accepted government auditing standards,[11] certain information was omitted from this report because that information was deemed to present potential risks related to public safety, security, or the disclosure of private or confidential data. Under the provisions of Texas Government Code, Section 552.139, the omitted information is also exempt from the requirements of the Texas Public Information Act.

[10] The risk related to the issues discussed in Chapter 4 is rated as Priority because they 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.

[11] United States Government Accountability Office's *Government Auditing Standards*, 2011 Revision.

Appendices

Appendix 1

Objective, Scope, and Methodology

Objective

The objective of this audit was to determine if the Health and Human Services Commission (Commission) has processes and related controls to help ensure that managed care contractor deficiencies are addressed through the assessment and collection of liquidated damages and other sanctions according to applicable requirements.

Scope

The scope of this audit covered managed care organization (MCO) noncompliance with contract requirements identified for which the Commission applied contract remedies, including issuing corrective action plans and liquidated damages. This audit focused on contract remedies initiated between fiscal years 2017 through 2019, as of May 2019.

Methodology

The audit methodology included conducting interviews with Commission staff; reviewing the Commission's managed care contracts and Commission policies and procedures; collecting, reviewing, and analyzing Commission MCO sanctioning documentation; and performing selected tests and other procedures.

Data Reliability and Completeness

Auditors relied on previous State Auditor's Office work to determine that the Commission's revenue data in the Uniform Statewide Accounting System (USAS) was sufficiently reliable for the purposes of this audit.

To determine the reliability of accounts receivable data from the Commission's Accounts Receivable Tracking System (ARTS), auditors compared that data to (1) hard copies of checks received from MCOs and (2) data in USAS. Auditors determined that the receivable data was sufficiently reliable for the purposes of this audit.

To determine the reliability of the Commission's corrective action plan tracking logs and liquidated damages logs, auditors (1) compared the logs to source documents on a sample basis and (2) tested access controls over the logs. Due to the control weaknesses discussed in Chapters 1-C and 4, there is a risk that the logs were not complete. Despite this limitation, auditors

verified the accuracy of the data for the corrective action plan and liquidated damage samples and concluded the logs were sufficiently reliable for the purposes of this audit.

Sampling Methodology

Auditors selected nonstatistical samples of liquidated damages related to (1) utilization reviews, (2) monitoring of contract deliverables, and (3) liquidated damages that the Commission waived, primarily through random selection. This sample design was chosen to ensure that the samples included liquidated damages representing (1) a range of dollar amounts or (2) each group of contractual performance standards. In some cases, auditors selected additional liquidated damages for testing based on risk. Those sample items were not necessarily representative of the population; therefore, it would not be appropriate to project the test results to the population.

Auditors selected a nonstatistical sample of corrective action plans primarily through random selection. This sample design was chosen to ensure that a cross section of corrective action plans were selected. In addition, auditors selected additional corrective action plans for testing based on risk. The test results as reported do not identify which items were randomly selected or selected based on risk. Therefore, it would not be appropriate to project those test results to the population.

In addition, to test the completeness of the liquidated damage logs and corrective action plan tracking logs, auditors selected a risk-based sample of division logs and other reports related to MCO noncompliance for testing. This sample design was chosen so high-risk divisions that identify noncompliance were represented in the sample. The sample items were generally not representative of the population and, therefore, it would not be appropriate to project those test results to the population.

Information collected and reviewed included the following:

- Commission policies and procedures, including decision matrices for calculating liquidated damages.
- Commission corrective action plans and related documentation.
- Commission revenue information from USAS and supporting documentation.
- Commission receivable documentation, including receivable data from ARTS.

- Agreed-upon procedures (AUP) reports for MCOs' financial statistical reports.
- The Commission's MCO noncompliance tracking spreadsheets.
- The Commission's liquidated damage calculations, approvals, Web postings, and other supporting documentation.
- Access information for the Commission's information systems.
- The Commission's Uniform Managed Care Contract and other related contracts.
- Documentation related to MCO noncompliance identified by the Commission.

Procedures and tests conducted included the following:

- Interviewed Commission staff.
- Tested the Commission's calculation of liquidated damages.
- Tested the Commission's tracking and close out of MCOs' corrective action plans.
- Tested user access for the information systems that the Commission used to manage liquidated damages and corrective action plans.
- Verified receipt of liquidated damages from MCOs.
- Tested if the Commission had processes to identify MCO noncompliance and if that noncompliance was carried forward to the Commission's remedy process.

Criteria used included the following:

- Texas Government Code, Chapter 533.
- The Commission's Uniform Managed Care Contract.
- Department of Information Resources' *Security Control Standards Catalog*, Version 1.3.
- Commission policies and procedures.

Project Information

Audit fieldwork was conducted from March 2019 through September 2019. We conducted this performance audit in accordance with generally accepted government auditing standards.[12] 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:

- Lauren Godfrey, CIA, CGAP (Project Manager)
- Scott Labbe, CPA (Assistant Project Manager)
- Michael Bennett
- Emmanuel Melendez, CPA, MBA
- Christina Nguyen
- Anne O'Riordan
- Fabienne Robin, MBA
- George D. Eure, CPA (Quality Control Reviewer)
- Audrey O'Neill, CIA, CFE, CGAP (Audit Manager)

[12] United States Government Accountability Office's *Government Auditing Standards*, 2011 Revision.

Appendix 2

Issue Rating Classifications and Descriptions

Auditors used professional judgment 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 2 provides a description of the issue ratings presented in this report.

Table 2

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)/function(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 the 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

Medicaid and CHIP Managed Care Programs

The Health and Human Services Commission (Commission) delivers Medicaid Managed Care services though the STAR, STAR+PLUS, STAR Kids, and STAR Health programs, each of which are designed to serve specific populations. In addition, the Commission administers the Children's Health Insurance Program (CHIP). For each program, Table 3 lists the populations served and the percentage of the Commission's Medicaid and CHIP caseloads.

Table 3

The Commission's Medicaid and CHIP Managed Care Programs		
Program	**Population Served**	**Percentage of Caseload [a]**
STAR+PLUS	Adults with a disability, individuals age 65 or older (including those dually eligible for Medicare and Medicaid), and women with breast or cervical cancer.	12.6%
STAR	Children, newborns, pregnant women, and some families.	66.5%
STAR Kids	Children and adults age 20 and younger with a disability.	3.0%
CHIP	Children and unborn children (CHIP Perinatal) in families that earn too much money to qualify for Medicaid but cannot afford to buy private health insurance.	9.5%
STAR Health	Children who get Medicaid through the Department of Family and Protective Services and young adults previously in foster care.	0.7%

[a] The remaining 7.7 percent of the Commission's caseloads is related to Medicaid members who do not receive services through the managed care model.

Sources: The Commission and *Texas Medicaid and CHIP Reference Guide*, 12th Edition (2018).

Appendix 4

Related State Auditor's Office Work

Related State Auditor's Office Work		
Number	**Product Name**	**Release Date**
19-028	An Audit Report on the Health and Human Services Commission's System of Contract Operation and Reporting	February 2019
19-025	An Audit Report on Medicaid Managed Care Contract Processes at the Health and Human Services Commission	January 2019
19-011	An Audit Report on Amerigroup Texas, Inc. and Amerigroup Insurance Company, a Managed Care Organization	November 2018
18-038	An Audit Report on Scoring and Evaluation of Selected Procurements at the Health and Human Services Commission	July 2018
18-015	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
18-006	A Report on Health and Human Services Commission 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 Dennis Bonnen, Speaker of the House, Joint Chair
The Honorable Jane Nelson, Senate Finance Committee
The Honorable Robert Nichols, Member, Texas Senate
The Honorable Dustin Burrows, House Ways and Means Committee

Office of the Governor

The Honorable Greg Abbott, Governor

Health and Human Services Commission

Dr. Courtney N. Phillips, Executive Commissioner