An Audit Report on

Texas Children's Health Plan, a Managed Care Organization

June 2020

Report No. 20-032

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Overall Conclusion

Texas Children's Health Plan (Health Plan) accurately reported STAR Kids medical (fee-for-service) and prescription expenses totaling approximately $536.1 million in its fiscal year 2018 financial statistical reports (FSRs). In addition, the Health Plan accurately reported administrative expenses totaling $88.4 million and quality improvement costs totaling $32.5 million in its FSRs for fiscal year 2018.

While the Health Plan made some errors in its reporting, the net effect of those errors did not have a significant impact on the total amounts reported. The Health Plan should improve certain processes and controls to help ensure continued accuracy, completeness, and compliance with the Health and Human Services Commission's (Commission) reporting requirements. Specifically, the Health Plan should:

Background Information

Texas Children's Health Plan (Health Plan) provides the Medicaid STAR, STAR Kids, and Children's Health Insurance Program (CHIP) programs to three service delivery areas in Texas: Harris, Jefferson, and Medicaid Rural Service Area-Northeast (see Appendix 4 for additional information on those service delivery areas). From September 1, 2017, through August 31, 2018, the Health Plan received payments from the Health and Human Services Commission (Commission) for the STAR Kids program that totaled $581.3 million. Approximately $536.1 million (92 percent) of that funding paid for medical claims and prescription drug claims for 31,542 people enrolled in the STAR Kids program. The STAR Kids program serves members age 20 and younger with a disability.

Source: The Commission.

- Strengthen its review process over the provider payment rates in its claims processing system to ensure that the Health Plan pays providers in accordance with their contracts.
- Document its process for periodically evaluating compliance with the Commission's fair market value reporting requirements for affiliate provider claims.
- Strengthen its processes and controls to verify the completeness of the data it uses to prepare the FSRs and the exclusion of unallowable costs.

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.)

This audit was conducted in accordance with Texas Government Code, Section 321.013.

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

Table 1

Summary of Chapters/Subchapters and Related Issue Ratings		
Chapter/ Subchapter	**Title**	**Issue Rating [a]**
1-A	The Health Plan Reported Medical Expenses Accurately; However, It Should Strengthen Controls to Ensure Accurate Processing of Provider Payments and Reporting of Affiliate Provider Claims	Medium
1-B	The Health Plan Accurately Reported Prescription Expenses	Low
2	The Health Plan Accurately Reported Administrative Expenses and Quality Improvement Costs in Its Financial Statistical Reports	Medium

[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 the Health Plan's 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 Health Plan agreed to implement those recommendations.

Audit Objective and Scope

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

The scope of this audit covered the Health Plan's financial processes and related controls for fiscal year 2018 data reported to the Commission. Specifically, it included the Health Plan's STAR Kids, Administrative Expense, and Quality Improvement FSRs; its reported medical and pharmacy claims; and related, significant internal control components.

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Detailed Results

Chapter 1

The Health Plan Reported Its STAR Kids Medical and Prescription Expenses Accurately; However, It Should Improve Controls Over Its Medical Claims Processing and Reporting

Texas Children's Health Plan (Health Plan) accurately reported the medical and prescription expenses totaling $536.1 million on its fiscal year 2018 STAR Kids financial statistical reports (FSRs, see text box for more information). However, the Health Plan should strengthen controls to ensure that it pays provider claims accurately.

Financial Statistical Reports

The Health and Human Services Commission (Commission) receives financial statistical reports (FSRs) from managed care organizations (MCOs) on a quarterly and annual basis. Those reports are the primary statements of financial results that the MCOs submit to the Commission. The reports provide (1) the basis for calculating the amount a MCO may owe the State through the experience rebate profit-sharing requirement (see Appendices 5 and 6 for information on the experience rebate) and (2) a key source of claims and administrative expense information used to set the premiums paid to MCOs.

Source: The Commission.

In addition, the Health Plan did not have a documented process to periodically evaluate its compliance with the Health and Human Services Commission's (Commission) fair market value reporting requirements for affiliate provider claims.

Chapter 1-A

The Health Plan Reported Medical Expenses Accurately; However, It Should Strengthen Controls to Ensure Accurate Processing of Provider Payments and Reporting of Affiliate Provider Claims

Chapter 1-A Rating:

Medium [1]

The Health Plan accurately reported its STAR Kids medical (fee-for-service)[2] expenses totaling $435.6 million on its fiscal year 2018 FSRs and in its encounter data submitted to the Commission (see text box). Specifically, the reported claims expenses were supported by the Health Plan's claims processing system. The medical expenses reported on the FSRs also were supported by the total amount of

Encounter Data

MCOs are required to submit encounter data to the Commission on a monthly basis. The data contains detailed member, provider, procedure, and payment information for services provided to Medicaid clients. Encounter data is a key source of claims expense information used to set the premiums paid to MCOs.

Source: The Commission.

[1] The risk related to the issues discussed in Chapter 1-A 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.

[2] Fee-for-service refers to claims received from providers and paid by the MCO for services delivered to Medicaid members and does not refer to the population of members receiving services through the Medicaid Fee-for-Service program. The fee-for-service amount excludes payments to providers on a fixed, per-member basis and is recorded on a separate line on the FSRs.

encounters reported to the Commission, and for a sample of 60 claims tested, key fields in the encounter data were accurately reported to the Commission. In addition, the Health Plan paid medical claims for eligible members only and to providers who had not been excluded by either the U.S. Department of Health and Human Services' Office of Inspector General or the Commission's Office of Inspector General as required.

Controls over the accuracy of provider payment rates in the Health Plan's claims processing system were not always operating effectively. The Health Plan paid 996,788 medical claims during fiscal year 2018. For 54 (90 percent) of 60 claims tested, the Health Plan paid its providers accurately; however, for the remaining 6 (10 percent) tested, the Health Plan did not pay its providers in accordance with the providers' contract terms.

Those errors occurred because the Health Plan did not set up the providers' payment rates accurately in its claims processing system, and the Health Plan's review of that set-up did not prevent or detect those errors. As a result, the Health Plan did not pay six providers at their contracted rates. Based on the errors observed in the sample tested, auditors performed further analysis on the claims population and identified a net overpayment of $183,634. In addition, the Health Plan did not consistently document its review of its set-up of provider rates for an additional 22 provider contracts tested; but for the claims tested, the payments were accurate.

The Health Plan did not have a documented process to periodically evaluate its compliance with the Commission's fair market value reporting requirements for affiliate medical claims. The cost principles in the Commission's *Uniform Managed Care Manual* require managed care organizations (MCOs) to report medical claims from affiliate medical providers at fair market value in their FSRs. If fair market value cannot be established or sufficient evidence of fair market value cannot be provided, the cost principles state that the MCOs should report medical claims at the affiliate's actual cost incurred.

The Health Plan paid its four affiliate providers $138.4 million during fiscal year 2018 for the STAR Kids program. Those providers are considered affiliates because they share a parent entity with the Health Plan. The Health Plan's process is to report affiliate provider medical claims in its FSRs using the contracted amounts paid, and the Health Plan relies on its contract terms to be at fair market value to comply with the Commission's reporting requirements.

Upon auditors' request, the Health Plan or its affiliate provided evidence that the Health Plan's contracted payment rates for its affiliates did not exceed fair market value for the STAR Kids program for fiscal year 2018. However, because there may be changes in the market, the Health Plan's process does not necessarily ensure continued reporting at fair market value. Therefore, it

is important that the Health Plan document its process to evaluate compliance periodically.

Recommendations

The Health Plan should:

- Strengthen its review process over the set-up of provider payment rates in its claims processing system to ensure the Health Plan pays providers in accordance with their contracts.
- Document its process for periodically evaluating compliance with the Commission's fair market value reporting requirements.

Management's Response

SAO Report Chapter	SAO Finding	TCHP Management Response	Person Responsible and Implementation Timeline
1-A	*Errors occurred because the Health Plan did not set up the providers' payment rates accurately in its claims processing system, and the Health Plan's review of that set-up did not prevent or detect those errors. As a result, the Health Plan did not pay six providers at their contracted rates. Based on the errors observed in the sample tested, auditors performed further analysis on the claims population and identified a net overpayment of $183,634. In addition, the Health Plan did not consistently document its review of its set-up of provider rates for an additional 22 provider contracts tested, but for the claims tested the payments were accurate.*	*Texas Children's Health Plan agrees with this finding. In SFY 2018, Texas Children's Health Plan processed over 1.2 million STAR Kids claims resulting in over $435 million in payments to over 1,100 medical providers. Of the six discrepancies identified, one contract was revised to better indicate that the claims paid in alignment with the intent of the contract. The claims related to the remaining five provider contracts will be reprocessed to recuperate approximately $175 thousand in overpayments. TCHP is committed to strengthening and improving its processes and controls over the claims process.*	*Assistant VP, Claims Administration and Business Operations* *<u>Timeline</u>: November 27, 2020*

SAO Report Chapter	SAO Finding	TCHP Management Response	Person Responsible and Implementation Timeline
1-A	*Upon auditors' request, the Health Plan or its affiliate provided evidence that the Health Plan's contracted payment rates for its affiliates did not exceed fair market value for the STAR Kids program for fiscal year 2018. However, because there may be changes in the market, the Health Plan's process does not necessarily ensure continued reporting at fair market value. Therefore, it is important that the Health Plan document its process to evaluate compliance periodically.*	*Texas Children's Health Plan agrees with this finding. TCHP is committed to strengthening and improving its processes and controls. As of April 1, 2020, TCHP implemented a policy and procedure to clearly define and document the process for assessing fair market value for reimbursement to affiliate medical providers.*	*Vice President, Government Programs* *Timeline:* *April 1, 2020*

Chapter 1-B

The Health Plan Accurately Reported Prescription Expenses

Chapter 1-B Rating:
Low [3]

The Health Plan accurately reported STAR Kids prescription expenses in its fiscal year 2018 FSRs and in its encounter data submitted to the Commission. Specifically, data from its pharmacy benefit manager's claims processing system supported the 431,626 STAR Kids prescription claims totaling $100.5 million reported by the Health Plan in its fiscal year 2018 FSRs (see text box for information about pharmacy benefit managers). The prescription expenses reported on the FSRs also were supported by the total amount of encounters reported to the Commission, and key fields in the encounter data were accurately reported to the Commission.

Pharmacy Benefit Managers

MCOs are required to contract with pharmacy benefit managers to process prescription claims. Pharmacy benefit managers contract with pharmacies that dispense medications to Medicaid managed care members.

Source: The Commission's *STAR Kids Managed Care Contract*.

[3] The risk related to the issues discussed in Chapter 1-B 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.

In addition, the Health Plan's pharmacy benefits manager (1) paid pharmacy claims for eligible members only and to providers who had not been excluded by either the U.S. Department of Health and Human Services' Office of Inspector General or the Commission's Office of Inspector General as required and (2) paid its providers in accordance with contract terms for all 60 prescription claims tested.

Chapter 2

The Health Plan Accurately Reported Administrative Expenses and Quality Improvement Costs in Its Financial Statistical Reports

Chapter 2 Rating:

Medium [4]

The Health Plan accurately reported administrative expenses totaling $88.4 million and quality improvement costs totaling $32.5 million in its fiscal year 2018 FSRs. However, the Health Plan should strengthen certain processes and controls to ensure that the data it uses to prepare its reports is complete and expenses reported are allowable. (See text box for more information on allowable costs.)

Allowable Costs

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, allocable, and reported as they are incurred.

Source: The Commission.

Administrative Expenses and Quality Improvement Costs. The administrative expenses and quality improvement costs the Health Plan reported in its FSRs were supported by its underlying accounting data (see text box for more information on quality improvement costs). In addition, the Health Plan's reporting of administrative expenses complied with the Commission's requirements. Specifically, for 65 (97 percent) of 67 administrative expenses tested totaling $4,824,790, the expenses were allowable and supported.

Quality Improvement Costs

Quality improvement costs are administrative-type costs related to activities that improve health care quality. Quality improvement costs were previously accounted for as administrative expenses but are currently treated as medical expenses. Those costs support the following activities:

- Improve health quality and health outcomes.
- Increase the likelihood of good health outcomes.

Additionally, these costs are grounded in evidence-based medicine and widely accepted best clinical practices.

Sources: The Commission and the Code of Federal Regulations, Title 45, Section 158.150.

However, for the 2 remaining expenses tested (3 percent), the Health Plan incurred the expense outside of fiscal year 2018, resulting in unallowable costs totaling $405,013. Those expenses should have been reported in the fiscal year 2017 administrative FSR, as required by the Commission's *Uniform Managed Care Manual*. In addition, the data the Health Plan used to prepare its fiscal year 2018 FSRs was incomplete because the Health Plan compiled the data before all transactions had posted to its accounting system. As a result, the Health Plan inappropriately excluded $658,385 in administrative expenses from its

[4] The risk related to the issues discussed in Chapter 2 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.

fiscal year 2018 FSRs. While the net effect of the errors described above did not have a significant impact on the total amounts the Health Plan reported for fiscal year 2018, it is important that the Health Plan strengthen its controls to ensure accuracy and completeness of its future FSRs.

Compensation Expenses. The Health Plan's direct compensation expenses reported on its administrative and quality improvement FSRs complied with the Commission's requirements (see text box for more information on direct and indirect costs). Specifically, the compensation expenses reported were supported by the Health Plan's payroll system. In addition, for all 50 payroll-related expenses tested, which totaled $146,056, the expenses were allowable, supported, and appropriately approved. The Commission establishes a limit for the amount of compensation that can be reported, and the Health Plan's direct compensation expenses reported were within that limit.

Direct and Indirect Costs

The Commission's *Uniform Managed Care Manual* defines direct costs as those that can be identified specifically with and are readily assignable to the objectives of the Commission's contract with the MCO.

Indirect costs are those incurred for a common or joint purpose benefiting the contract and one or more other activities of the MCO and are not readily assignable to the activities specifically benefited. Indirect costs may be assessed or allocated by a parent or affiliate of the MCO and are allowable only to the extent that: (1) the costs clearly represent specifically identified operating services provided for the operating subsidiary; and (2) the services directly benefit the Commission or its Medicaid or CHIP Members.

Source: The Commission.

However, the Health Plan did not have a process in place to ensure that it complied with the applicable compensation reporting limit for indirect compensation expenses allocated from its parent affiliate, Texas Children's Hospital. As a result, the Health Plan included $91,098 in unallowable compensation because the compensation reported in the corporate allocations line item exceeded the limit on compensation that an MCO can report. Not having a process to apply the compensation limit to indirect costs increases the risk of continued over-reporting of compensation expenses.

Recommendations

The Health Plan should strengthen its processes and controls to:

- Verify the completeness of the data it uses to prepare its administrative and quality improvement FSRs.
- Exclude unallowable costs in its FSRs, including costs incurred outside of the fiscal year and compensation above the Commission's reporting limit.

Management's Response

SAO Report Chapter	SAO Finding	TCHP Management Response	Person Responsible and Implementation Timeline
2	*The data the Health Plan used to prepare its FSRs was incomplete because the Health Plan compiled the data before all transactions had posted to its accounting system. As a results, the Health Plan inappropriately excluded $658,385 in administrative expenses from its FSRs.*	*Texas Children's Health Plan agrees with this finding. This amount comprises 0.5% of total administrative expenses ($120,940,530) and represents allowable expenses not charged to the Medicaid contract. There was no impact to the SFY18 experience rebate. TCHP is committed to strengthening and improving its processes and has implemented the following:* *(1) G/L reports will be regenerated to identify any changes to the original reports, and any variances identified will be documented and identified in our workpapers and FSR submissions, as appropriate;* *(2) A review worksheet control is being utilized, which includes a procedure to agree corporate allocation expense to the latest version of the calculation.* *Additionally, (3) TCHP will implement a period-to-date (23-month) Statement of Operations will be reconciled to administrative expenses reported in the 334-day FSR workpapers by August 31, 2020.*	*Director, Finance* *Timeline:* *(1) March 31, 2020* *(2) March 31, 2020* *(3) August 31, 2020*
2	*The Health Plan incurred the expense outside of fiscal year 2018, resulting in unallowable costs totaling $405,013. Those expenses should have been reported in fiscal year 2017 administrative FSR.*	*Texas Children's Health Plan agrees with this finding. This amount represents 0.3% of total administrative expenses ($120,940,530). There is no financial impact to the SFY18 nor SFY17 Experience Rebates. As this timing difference related to an allowable expense, there is no overall cost impact to the Medicaid contract. TCHP is committed to strengthening and improving it's processes and controls and, beginning in June 2020, TCHP will apply additional scrutiny to line items that do not contain the necessary data*	*Director, Finance* *Timeline: June 1, 2020*

SAO Report Chapter	SAO Finding	TCHP Management Response	Person Responsible and Implementation Timeline
		elements in the General Ledger to determine appropriate service period and exceed a certain dollar threshold.	
2	*The Health Plan included $91,098 in unallowable compensation because the compensation reported in the corporate allocations line item exceeded the limit on compensation that an MCO can report.*	*Texas Children's Health Plan agrees with this finding. This amount represents 0.1% of total administrative expenses ($120,940,530). TCHP is committed to strengthening and improving its processes and controls. TCHP will implement the auditor's recommendation to include the compensation limit pre-allocation of expenses from its affiliates reported in the 334-day FSR workpapers by August 31, 2020.*	*Director, Finance* *Timeline: August 31, 2020*

Appendices

Appendix 1

Objective, Scope, and Methodology

Objective

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

Scope

The scope of this audit covered Texas Children Health Plan's (Health Plan) financial processes and related controls for fiscal year 2018 data reported to the Commission. Specifically, it included the Health Plan's STAR Kids, Administrative Expense, and Quality Improvement financial statistical reports (FSRs); its reported medical and pharmacy claims; and related, significant internal control components. (See Appendix 3 for more information about internal control components.)

Methodology

The audit methodology included conducting interviews with Health Plan management and staff; reviewing the Health Plan's managed care contract and policies and procedures; collecting, reviewing, and analyzing the Health Plan's FSRs and supporting claims and financial data; and performing selected tests and other procedures.

Data Reliability and Completeness

Auditors reviewed multiple data sets to assess the reliability of the Health Plan's FSRs, including medical claims data, pharmacy claims data, encounter data, premium payment data, general ledger data, and payroll data. Auditors reconciled the FSRs to those data sets and performed procedures to assess the reliability of those data sets including (1) observing data extracts, (2) reviewing query parameters used to extract the data, and (3) comparing the data to system report totals.

Auditors determined that the data was sufficiently reliable for the purposes of this audit.

Sampling Methodology

Auditors selected nonstatistical samples of medical claims, prescription claims, and employee payroll transactions primarily through random selection. This sample design was chosen to ensure that the sample could be evaluated in the context of the population. The test results may be projected to the population, but the accuracy of the projection cannot be measured.

In addition, auditors selected a nonstatistical sample of administrative expense transactions primarily through random selection. In some cases, auditors selected additional transactions for testing based on risk. This sampling design was chosen to ensure the sample included the highest dollar transactions. The test results as reported do not identify which items were randomly selected or selected using professional judgment; 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 Kids contract with the Health Plan.
- The Commission's STAR Kids member eligibility records for the Health Plan.
- The Health Plan's medical claims and prescription claims data.
- The Health Plan's contracts with selected medical providers.
- The Health Plan's policies and procedures.
- The Health Plan's 334-day STAR Kids, administrative expense, and quality improvement FSRs for fiscal year 2018.
- The Health Plan's general ledger and payroll data and supporting documentation.
- The Health Plan's supporting documentation for calculating reported allocated corporate costs for fiscal year 2018.
- The Health Plan's pharmacy benefits manager's contracts with selected pharmacy providers.

Procedures and tests conducted included the following:

- Reconciled medical expenses, administrative expense, and quality improvement costs in the Health Plan's FSRs for fiscal year 2018 to the Health Plan's claims system and general ledger.

- Reconciled prescription expenses in the Health Plan's FSRs for fiscal year 2018 to the Health Plan's pharmacy benefit manager's claims system.
- Performed data analysis to determine whether the Health Plan and its pharmacy benefits manager paid medical and prescription claims only for eligible STAR Kids members.
- Performed data analysis to determine whether the Health Plan and its pharmacy benefits manager did not pay medical and prescription claims to providers excluded from the Medicaid program.
- Tested medical and pharmacy claims to determine whether the Health Plan and its pharmacy benefits manager accurately paid providers for expenses reported in its FSRs.
- Tested controls over the Health Plan's set-up of provider payment rates.
- Reconciled the FSRs' supporting worksheets to the underlying source data.
- Tested controls over the Health Plan's preparation of the FSRs.
- Tested administrative expenses, including payroll costs, to determine whether amounts reported were allowable, appropriate, and adequately supported.
- Performed data analysis on general ledger data, payroll data, and other underlying source data for accuracy and allowability.
- Reviewed the Health Plan's corporate allocation methodology to determine whether it was accurate, reasonable, and supported.

Criteria used included the following:

- Title 41, United States Code, Sections 1127 and 4304.
- Title 2, Code of Federal Regulations, Part 200.
- Title 48, Code of Federal Regulations, Part 31.
- Title 1, Texas Administrative Code, Chapter 353.
- The Commission's STAR Kids Contract.
- The Commission's *Uniform Managed Care Manual*.
- The Health Plan's policies and procedures.

Project Information

Audit fieldwork was conducted from September 2019 through April 2020. 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:

- Sonya Tao, CFE (Project Manager)
- Scott Labbe, CPA (Assistant Project Manager)
- Ashlie Garcia, MS, CFE
- Elijah Marchlewski
- Emmanuel Melendez, CPA, MBA
- Christina Nguyen
- Dana Musgrave, MBA (Quality Control Reviewer)
- Lauren Godfrey, CIA, CGAP (Audit Manager)

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

Internal Control Components

Internal control is a process used by management to help an entity achieve its objectives. Government Auditing Standards require auditors to assess internal control when internal control is significant to the audit objectives. The Committee of Sponsoring Organizations of the Treadway Commission (COSO) established a framework for five integrated components and seventeen principles of internal control, which are listed in Table 3.

Table 3

Internal Control Components and Principles		
Component	**Component Description**	**Principles**
Control Environment	The control environment sets the tone of an organization, influencing the control consciousness of its people. It is the foundation for all other components of internal control, providing discipline and structure.	▪ The organization demonstrates a commitment to integrity and ethical values. ▪ The board of directors demonstrates independence from management and exercises oversight of the development and performance of internal control. ▪ Management establishes, with board oversight, structures, reporting lines, and appropriate authorities and responsibilities in the pursuit of objectives. ▪ The organization demonstrates a commitment to attract, develop, and retain competent individuals in alignment with objectives. ▪ The organization holds individuals accountable for their internal control responsibilities in the pursuit of objectives.
Risk Assessment	Risk assessment is the entity's identification and analysis of risks relevant to achievement of its objectives, forming a basis for determining how the risks should be managed.	▪ The organization specifies objectives with sufficient clarity to enable the identification and assessment of risks relating to objectives. ▪ The organization identifies risks to the achievement of its objectives across the entity and analyzes risks as a basis for determining how the risks should be managed. ▪ The organization considers the potential for fraud in assessing risks to the achievement of objectives. ▪ The organization identifies and assesses changes that could significantly impact the system of internal control.
Control Activities	Control activities are the policies and procedures that help ensure that management's directives are carried out.	▪ The organization selects and develops control activities that contribute to the mitigation of risks to the achievement of objectives to acceptable levels. ▪ The organization selects and develops general control activities over technology to support the achievement of objectives. ▪ The organization deploys control activities through policies that establish what is expected and procedures that put policies into action.
Information and Communication	Information and communication are the identification, capture, and exchange of information in a form and time frame that enable people to carry out their responsibilities.	▪ The organization obtains or generates and uses relevant, quality information to support the functioning of internal control. ▪ The organization internally communicates information, including objectives and responsibilities

Internal Control Components and Principles		
Component	**Component Description**	**Principles**
		for internal control, necessary to support the functioning of internal control. ▪ The organization communicates with external parties regarding matters affecting the functioning of internal control.
Monitoring Activities	Monitoring is a process that assesses the quality of internal control performance over time.	▪ The organization selects, develops, and performs ongoing and/or separate evaluations to ascertain whether the components of internal control are present and functioning. ▪ The organization evaluates and communicates internal control deficiencies in a timely manner to those parties responsible for taking corrective action, including senior management and the board of directors, as appropriate.

Source: Internal Control – Integrated Framework, Committee of Sponsoring Organizations of the Treadway Commission, May 2013.

Appendix 4

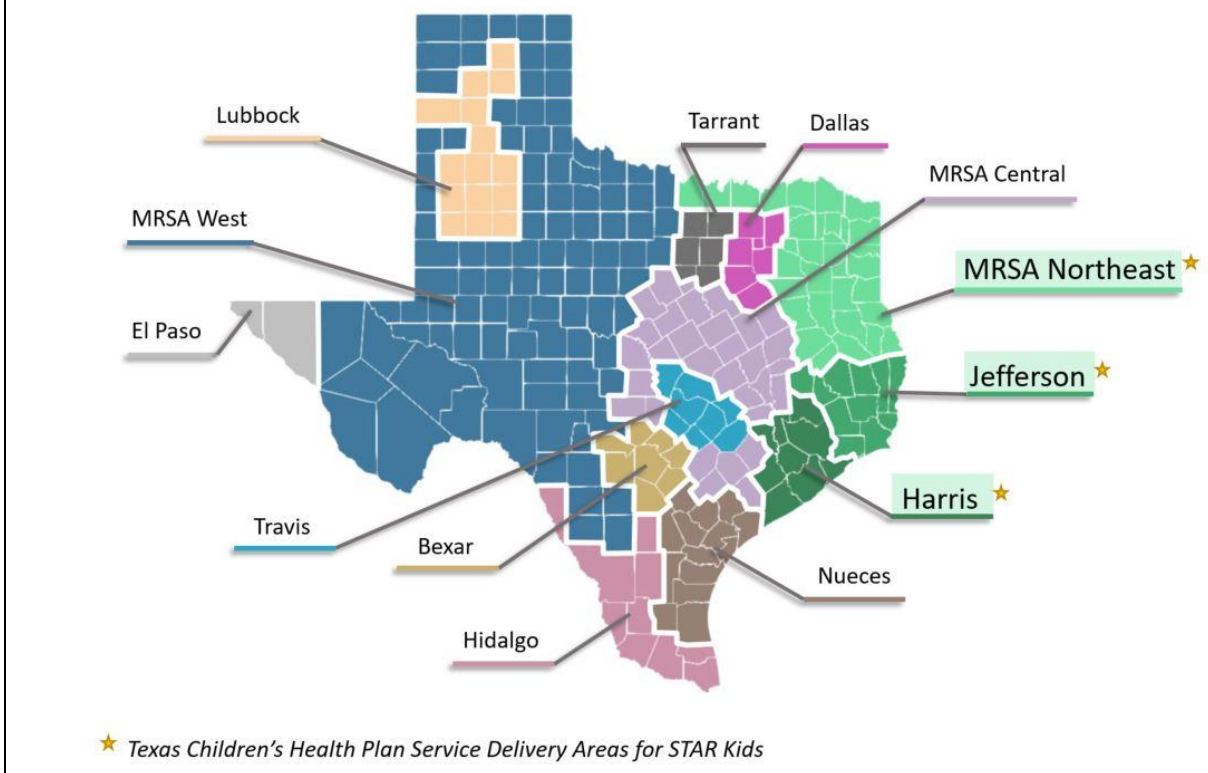
Texas Children's Health Plan Service Delivery Areas for STAR Kids

Texas Children's Health Plan's (Health Plan) provides the Medicaid STAR Kids program to three service delivery areas: Harris, Jefferson, and Medicaid Rural Service Area (MRSA) – Northeast.

Figure 1 is a regional map that shows the location of all the managed care service delivery areas, including the Health Plan's service delivery areas, as of May 1, 2018.

Figure 1

Managed Care Service Delivery Areas as of May 1, 2018



Source: Based on information from the Commission.

Appendix 5

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 (85th Legislature), Rider 164, page II-91, 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 4). 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 4

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 *STAR Kids Contract Terms and Conditions*.

Appendix 6

Calculation of the Fiscal Year 2018 Experience Rebate for Texas Children's Health Plan

Based on Texas Children's Health Plan's (Health Plan) financial statistical reports for fiscal year 2018, Table 5 shows the adjusted income subject to the experience rebate calculated by the Health Plan. As of April 2020, the Commission had not yet completed its review of that calculation, and the calculation does not reflect the results of any audits. The Health Plan's calculation of adjusted income indicates the Health Plan did not owe an experience rebate for fiscal year 2018.

Table 5

Texas Children's Health Plan's Calculation of Income Subject to Experience Rebate for Fiscal Year 2018	
Unaudited Pre-tax Net Income	$(11,311,196)
Prior Year Loss Carry Forward	$(28,259,308)
Adjusted Income Subject to Experience Rebate	$(39,570,504)

Source: The Health Plan.

Appendix 7

Related State Auditor's Office Work

Related State Auditor's Office Work		
Number	**Product Name**	**Release Date**
20-008	An Audit Report on the Health and Human Services Commission's Use of Remedies in Managed Care Contracts	November 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
18-015	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
17-025	An Audit Report on HealthSpring Life and Health Insurance Company, Inc., a Medicaid STAR+PLUS Managed Care Organization	February 2017

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 Giovanni Capriglione, House Appropriations Committee
The Honorable Dustin Burrows, House Ways and Means Committee

Office of the Governor

The Honorable Greg Abbott, Governor

Health and Human Services Commission

Mr. Phil Wilson, Acting Executive Commissioner

Texas Children's Health Plan

Mr. Mark Mullarkey, President