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An Audit Report on

Blue Cross Blue Shield of Texas, a Managed Care Organization

June 2021

Report No. 21-025

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Overall Conclusion

Blue Cross Blue Shield of Texas (Health Plan) accurately reported medical, administrative, and quality improvement expenses in its fiscal year 2018 financial statistical reports (FSRs). However, the Health Plan's processes and controls were not sufficient to ensure that reported pharmacy expenses reflected the final amount retained by pharmacy providers.

The Health Plan reported $26.4 million paid to pharmacy providers in its fiscal year 2018 STAR Kids FSRs. However, that amount did not reflect the final cost of pharmacy services because it did not include funds that the Pharmacy Benefit Manager calculated the pharmacy must return post payment (see text box for more information about the post-payment return of funds). Any inaccuracies may impact the State's long-term Medicaid costs because the Health and Human Services Commission (Commission) uses that reported information to set the monthly amount that Managed Care Organizations (MCOs) are paid per member (known as the premium or capitation rate).

In addition, according to the Commission, the Pharmacy Benefit Manager's year end aggregation process, which may require a pharmacy to return funds post-payment, is an unallowable practice. That process was the result of an "effective rate" contract between the Health Plan's Pharmacy Benefit Manager and a pharmacy provider. This methodology reduces price transparency and makes it more difficult to validate what a pharmacy was ultimately paid for an individual Texas Medicaid claim.

Background Information

Blue Cross Blue Shield of Texas (Health Plan) provides the Medicaid STAR, CHIP, and STAR Kids programs to two service areas: Travis and Medicaid Rural Service Area - Central (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 $149 million. Approximately $143 million (96 percent) of that funding paid for medical and prescription drug services for 9,963 people enrolled in the STAR Kids program. The STAR Kids program serves members age 20 and younger with a disability.

Source: The Commission.

Financial Statistical Reports (FSRs)

The Health and Human Services Commission (Commission) receives FSRs from managed care organizations (MCOs) quarterly and annually. 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 an 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.

Post-payment Return of Funds

One contract tested established a mechanism for determining a "reconciliation amount," which is based on an analysis of aggregated claims. For the time period audited, this methodology resulted in the Pharmacy Benefit Manager calculating that the pharmacy provider must return funds already disbursed.

There may be other circumstances in which the return of funds by a pharmacy may be allowable. However, for purposes of this report, "returned funds" refers to the funds the pharmacy was required to return to the Pharmacy Benefit Manager as a result of the year end aggregation process established in an "effective rate" contract.

Sources: The Commission and the Pharmacy Benefit Manager's contract with a selected pharmacy.

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.

The Health Plan complied with eligibility requirements for pharmacy claims; however, it should strengthen its processes for reporting claims for certain drug types.

The Health Plan accurately reported administrative and quality improvement expenses totaling $49.1 million and medical (fee-for-service) expenses of $109.1 million. In addition, the Health Plan paid medical claims to eligible members.

Table 1 presents a summary of the findings in this report and the related issue rating. (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 Health Plan's $26.4 Million in Reported Pharmacy Expenses Did Not Reflect the Final Amount Paid to Pharmacies	**Priority**
1-B	The Health Plan Paid Pharmacy Claims for Eligible Members Only; However, It Should Strengthen Its Reporting of Claims for Certain Drug Types	Medium
2	The Health Plan Accurately Reported Its STAR Kids Medical Expenses	Low
3	The Health Plan Accurately Reported Administrative and Quality Improvement Expenses	Low

[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 the 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 Health Plan management.

Key Points

The $26.4 million in pharmacy expenses that the Health Plan reported in its fiscal year 2018 FSR did not reflect the final amount paid to the pharmacy providers.

While the $26.4 million represents what was initially paid to pharmacy providers, it did not reflect the final amount retained by pharmacies because it did not include the impact of funds a pharmacy was required to return to the Pharmacy Benefit Manager. That return effectively reduced what the Pharmacy Benefit Manager paid for ingredient and dispensing costs. In addition, the encounter data reported by the Health Plan did not include any returned funds.

According to the Commission, the Pharmacy Benefit Manager's process to require a pharmacy to return funds is an unallowable practice.

For one contract tested, the Pharmacy Benefit Manager calculated the amount of funds to return using an analysis that aggregated Medicaid claims with claims from non-Medicaid programs. In addition, it is the Pharmacy Benefit Manager's practice to require a pharmacy provider to return funds post payment. Both of those practices are unallowable, according to the Commission.

The return of funds resulted from an "effective rate" contract.

The payment methodology established in that contract between the Pharmacy Benefit Manager and the pharmacy provider does not comply with the requirements in the Commission's contract with the Health Plan.

The Health Plan paid medical and pharmacy claims for eligible members.

The Health Plan paid medical and pharmacy claims for members the Commission determined to be eligible for the STAR Kids program. In addition, the Health Plan accurately reported its STAR Kids medical (fee-for-service) expenses, totaling $109.1 million, on its fiscal year 2018 FSRs and in its encounter data submitted to the Commission.

The Health Plan accurately reported administrative expenses.

The Health Plan accurately reported administrative and quality improvement expenses totaling $49.1 million in its fiscal year 2018 FSRs. Information in the Health Plan's accounting system supported the reported expenses, and that system allocated indirect costs as intended.

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 and Commission agreed to implement the recommendations; however, the Health Plan disagreed with the audit findings related to its Pharmacy Benefit Manager's process to require a pharmacy provider to return funds as part of an effective rate contract. Although the Health Plan and its Pharmacy Benefit Manager had multiple opportunities to address these issues during the audit, auditors were repeatedly denied access to the Pharmacy Benefit Manager's complete analysis of pharmacy claims. Instead, the Pharmacy Benefit Manager provided summary documentation, which contained numerous redactions and presented the calculation in two groups.

The Health Plan also attempts to diminish the significance of the potential impact of the process to require pharmacies to pay back funds after claims have been finalized. Whether the Pharmacy Benefit Manager aggregates its Medicaid claims with other programs or shares any returned funds with the Health Plan does not alter the Health Plan's obligation to report the final amount retained by pharmacies for ingredient and dispensing costs in its FSRs and encounter data.

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

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 are designed and operating to help ensure (1) the accuracy and completeness of data that 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 (see Appendix 3 for more information about internal control components). In addition, the scope of this audit included the Commission's oversight of effective rate contracts between pharmacy benefit managers and pharmacy providers.

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Detailed Results

Chapter 1

The Health Plan's $26.4 Million in Reported Pharmacy Expenses Did Not Reflect the Final Amount Paid to Pharmacies, and It Should Strengthen Its Reporting of Claims for Certain Drug Types

The $26.4 million in pharmacy expenses that Blue Cross Blue Shield of Texas (Health Plan) reported in its fiscal year 2018 financial statistical report (FSR) did not reflect the final amount paid to pharmacies. Specifically, the amount reported did not include the impact of any funds a pharmacy provider returned to the Pharmacy Benefit Manager as the result of a year-end aggregation process[1]. The amount returned is referred to as the "reconciliation amount" in the contract between the Pharmacy Benefit Manager and the pharmacy. In addition:

- According to the Health and Human Services Commission (Commission), (1) the analysis the Pharmacy Benefit Manager used to calculate the returned funds is an unallowable practice because that analysis aggregated Medicaid claims with claims from non-Medicaid programs and (2) collecting funds post payment from pharmacy providers as a result of that analysis is unallowable.

- The requirement to return funds resulted from the payment methodology established in the contract between the Pharmacy Benefit Manager and the pharmacy provider. However, that contract type established an "effective rate" pricing methodology and does not comply with the Pharmacy Benefit Manager requirements in the Commission's contract with the Health Plan.

The Health Plan complied with eligibility requirements for pharmacy claims; however, it should strengthen its processes for reporting claims for certain drug types.

[1] For purposes of this report, "returned funds" refers to the funds the pharmacy was required to return to the Pharmacy Benefit Manager as a result of the year end aggregation process established in an "effective rate" contract.

Chapter 1-A

The Health Plan's $26.4 Million in Reported Pharmacy Expenses Did Not Reflect the Final Amount Paid to Pharmacies

Chapter 1-A Rating:

Priority [2]

The Health Plan reported $26.4 million in pharmacy expenses in its fiscal year 2018 FSRs; that amount represents what was initially paid to pharmacy providers. However, it did not include the effect of funds it recovered from one pharmacy tested. The Health Plan's encounter data (see text box), which represents individual claims, also did not include the effect of the returned funds. The net effect of any returned funds on the reported amounts and encounter data could not be determined based on the documentation provided.

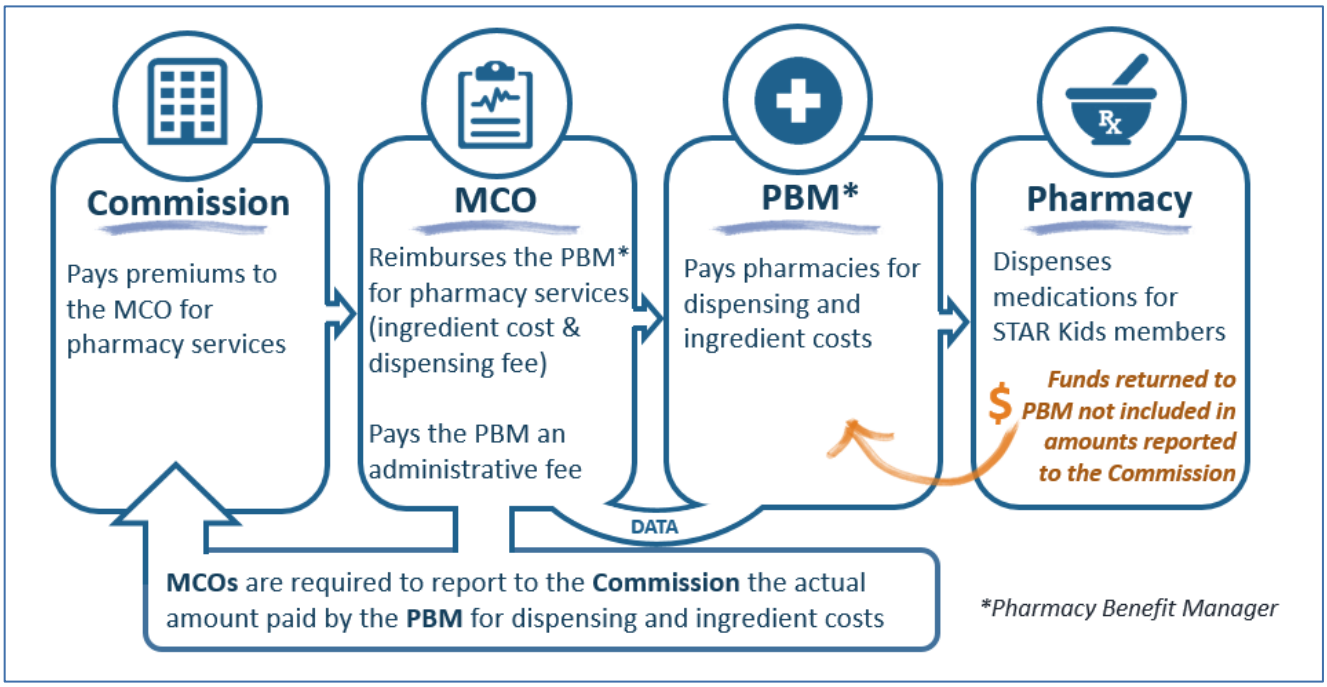
Encounter Data

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.

Figure 1 shows the process for STAR Kids pharmacy expenses.

Figure 1



Sources: Information from the Commission, the Health Plan, and PBM.

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

Pharmacy Benefit Manager

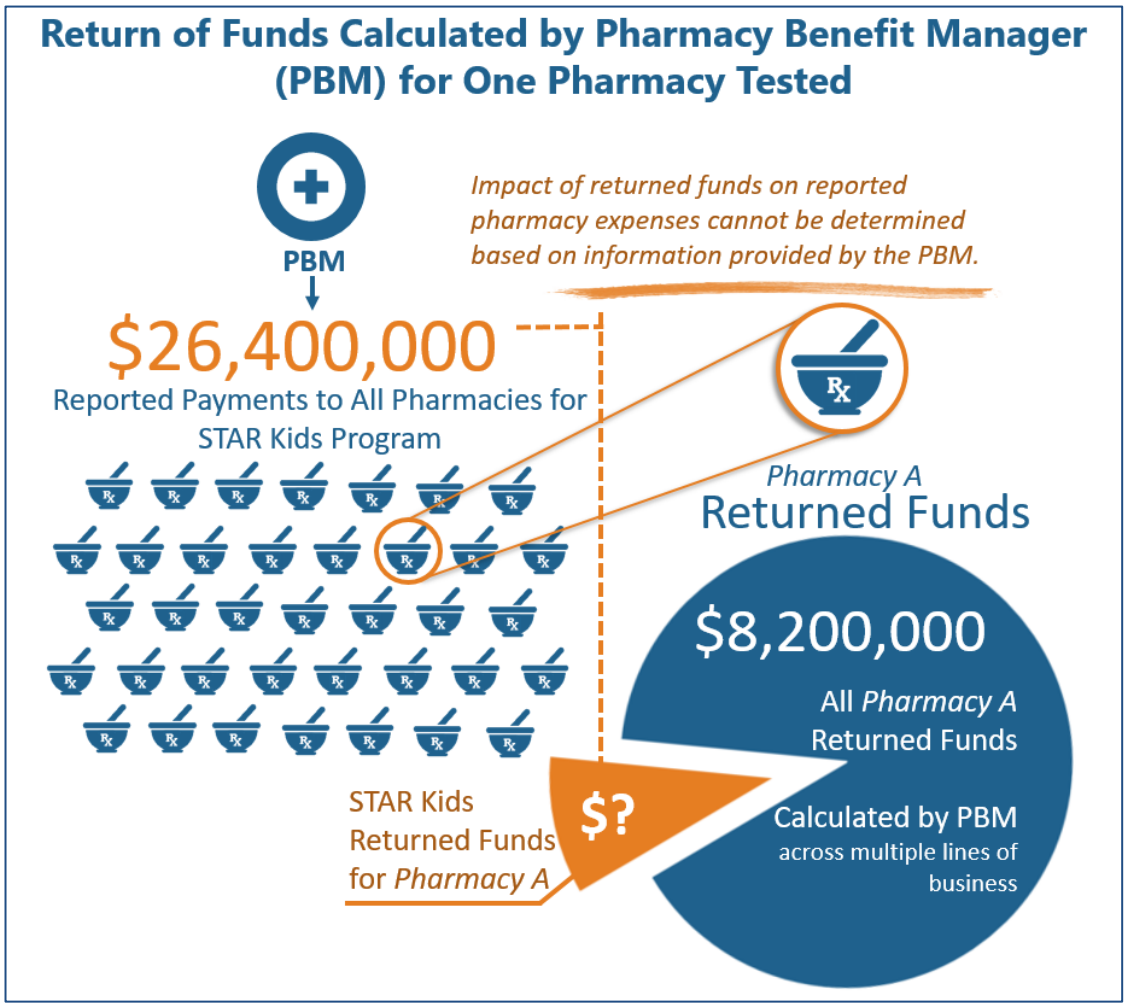
MCOs are required to contract with pharmacy benefit managers to process prescription claims. Pharmacy benefit managers contract with pharmacies that dispense medications to Medicaid managed care members.

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

Specifically, for one contract tested, the Health Plan's affiliate Pharmacy Benefit Manager (see text box), which is partially owned by the Health Plan[3], conducted a year-end analysis of payments to the pharmacy provider. Based on that analysis, the Pharmacy Benefit Manager calculated a return of funds (referred to as "reconciliation amount" in the contract tested) by the pharmacy provider totaling $8.2 million for both Medicaid and non-Medicaid programs.

In its analysis, the Pharmacy Benefit Manager combined multiple lines of business and did not identify what portion of the calculated return of funds were related to STAR Kids or its other Medicaid programs (see Figure 2). As a result, auditors could not determine the validity of the analysis or the impact on what the Health Plan reported in its FSRs and encounter data.

Figure 2



Sources: Information from the Commission, the Health Plan, and the Pharmacy Benefit Manager.

[3] According to information submitted to the Commission for fiscal year 2018, Blue Cross Blue Shield of Texas' parent company, Health Care Services Corporation, owns 42% of the Health Plan's Pharmacy Benefit Manager. In addition, 78% of the Pharmacy Benefit Manager's revenue is generated from affiliated sources.

According to the Commission, aggregating Medicaid claims with claims from non-Medicaid programs and requiring pharmacy providers to return funds based on that aggregation are unallowable practices. While the $26.4 million represents what was initially paid to pharmacy providers, it does not reflect the final amount retained by pharmacies because any return of funds effectively reduces what the Pharmacy Benefit Manager paid for ingredient and dispensing costs.

Effective Rate Contracts

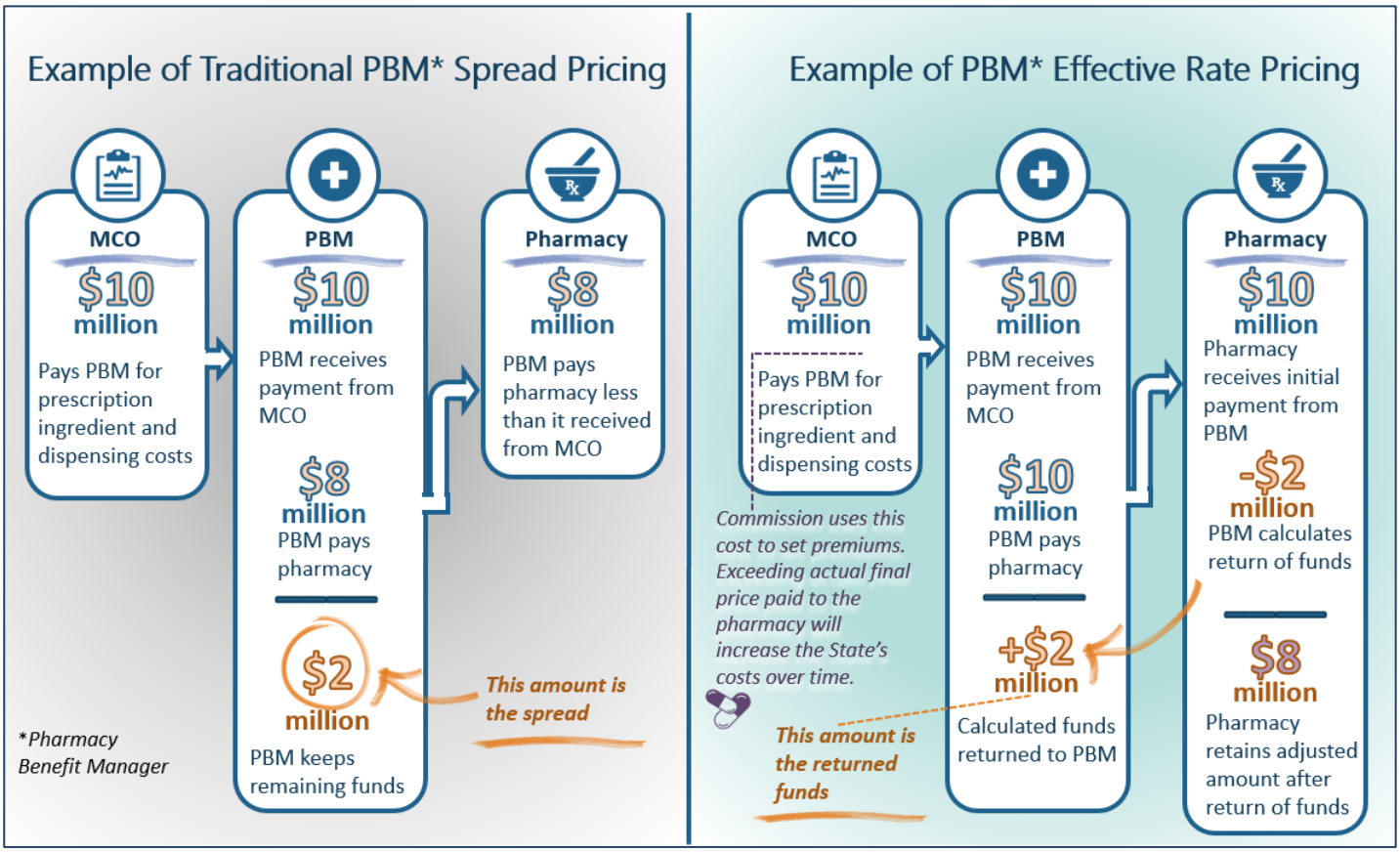
The contract between the Pharmacy Benefit Manager and pharmacy provider discussed above established an "effective rate" pricing methodology. This type of contract does not base payments on rates set for each individual claim/encounter. Instead, final payment is based on aggregated claims and allows the Pharmacy Benefit Manager to require the pharmacy provider to return funds at year end. While the Commission's contract with Managed Care Organizations (MCOs) allows a pharmacy benefit manager to charge MCOs an administrative fee for providing services, the contract prohibits "spread pricing."

Spread pricing is when a pharmacy benefit manager charges an MCO more for ingredient and dispensing costs than the amount a pharmacy benefit manager pays a pharmacy (see Figure 3 on the next page). Since spread pricing is prohibited, reporting those returned funds is not explicitly required by the Commission's contract with the Health Plan. However, effective rate contracts may have the same impact to the State as spread pricing because they may result in the reporting of pharmacy costs at an amount other than the final amount retained by pharmacies for ingredient and dispensing costs.

The effective rate methodology reduces price transparency and makes it more difficult to validate what a pharmacy was ultimately paid for an individual Texas Medicaid claim/encounter.

Figure 3 on the next page illustrates the effect of spread pricing and the return of funds discussed above; it does not represent any actual amounts for the Health Plan.

Figure 3



Sources: Based on information from the U.S. Department of Health and Human Services, Office of Inspector General; the Health Plan; and the Pharmacy Benefit Manager.

According to the Health Plan's Pharmacy Benefit Manager, it has effective rate contracts with other pharmacy providers in addition to the one tested. If MCOs increase the use of this type of contract, the potential effect on the accuracy of the reported pharmacy expenses in the FSRs and encounter data would be significantly increased. Any inaccuracies may impact the State's long-term Medicaid costs because the Commission uses that reported information to set the monthly amount that MCOs are paid per member (known as the premium or capitation rate). In addition, the Commission uses those expenses to calculate whether the Health Plan must pay an experience rebate[4] under the profit sharing requirements (see Appendix 5 for more information about experience rebates).

[4] "Experience rebates" are a portion of a managed care organization's net income before taxes that is returned to the State in accordance with statute and the uniform managed care contract terms.

Recommendations

The Health Plan should:

- Work with the Commission to ensure that its Pharmacy Benefit Manager's practices are in compliance with the STAR Kids contract.
- Report pharmacy expenses based on the final amount paid to pharmacy providers.

The Commission should monitor MCOs to verify:

- Compliance with its prohibition of spread pricing.
- Reported pharmacy expenses represent the final amount retained by pharmacies for dispensing and ingredient costs.

Management's Response from the Health Plan

The Health Plan agrees with the Recommendations, with the following comments:

Moving forward, BCBSTX will report annual Reconciliation Amounts received or paid by the PBM attributable to Texas Medicaid, regardless of whether BCBSTX receives payment. Please note that the PBM's contract with the pharmacy in question no longer includes a provision for payment by the pharmacy to the PBM of any Reconciliation Amount.

The Health Plan respectfully disagrees with the finding, for the following reasons:

As an initial matter, BCBSTX notes that the $8,200,000 Reconciliation Amount reported on page 2 and in Figures 2 and 3 of the Draft Report is incorrect, and respectfully requests that the references be amended to reflect the actual Reconciliation Amount paid by the pharmacy to the PBM of $4,147,419. A payment remittance was provided to the auditors on April 15, 2021 that reflects the year end Reconciliation Amount. The auditors lifted the $8,200,000 figure from a data point in the Reconciliation Amount calculation from a certain point in time during the Reconciliation Process, but it does not represent the final Reconciliation Amount that was ultimately remitted to the PBM. The report's use of the $8,200,000 figure is incorrect, as it is nearly double the actual Reconciliation Amount paid by the pharmacy to the PBM.

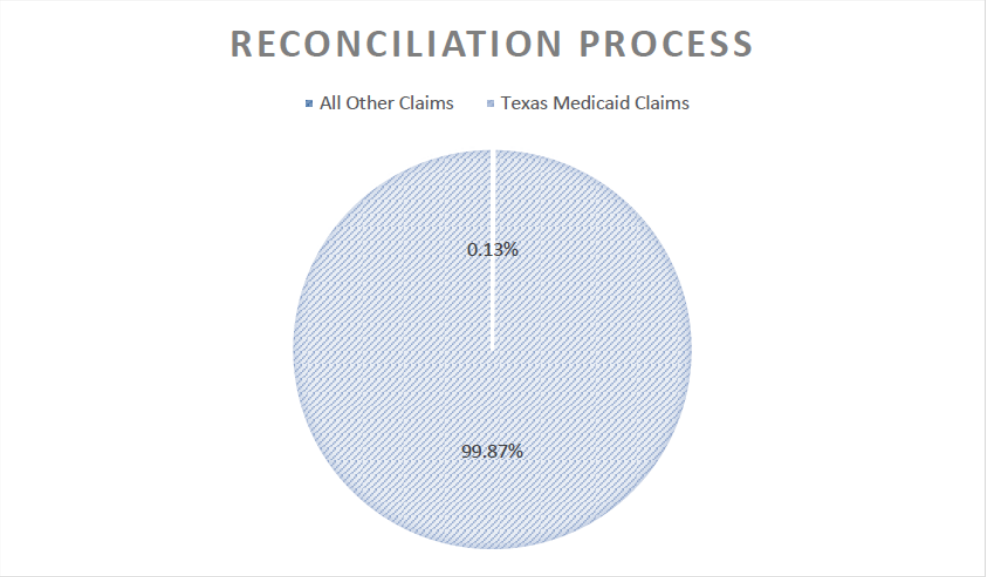
Effective Rate Contract and the Accuracy of the FSR

The finding attempts to equate the effective rate contract in place between the PBM and pharmacy during the audit period with spread pricing; however, these are not the same and the contract's Reconciliation Process does not violate the terms of the Uniform Managed Care Contract (UMCC). As demonstrated by this audit and required by the UMCC, BCBSTX was invoiced by its PBM at that same rate (ingredient cost plus dispensing fee) the pharmacy was paid. This is true regardless of whether the PBM's contract with the pharmacy utilized an effective rate pricing model.

As illustrated by the State Auditor's Office in Figure 3, under a prohibited spread pricing arrangement each claim would generate a mark-up (spread) that would be paid by the MCO. The mark-up is a PBM's margin on the claim.

Effective rate contracts, however, are distinct from spread pricing arrangements and not prohibited by the UMCC. Effective rate contracts allow the PBM to leverage its scale while managing to the needs of various plans (of various sizes and parameters) while also providing a pricing safeguard for the pharmacy. The goal is to ensure the pharmacy is paid, in aggregate across all of a PBM's clients, at the contracted effective rate for the applicable network. It does not contemplate built-in margin and is not intended to set the rate for specific plan performance or specific claims. This is why the PBM's receipt of a Reconciliation Amount does not result in an adjustment to the claim. In the same way, an over performance (amount owed to the pharmacy based on the annual Reconciliation Process) would not result in an invoice to the MCO or HHSC.

Additionally, the State Auditor's Office illustration in Figure 3 implies that the spread retained by the PBM in a spread pricing arrangement and the Reconciliation Amount received by the PBM has the same impact on the State Medicaid program. That is not accurate. Using the illustration provided as an example, the $2,000,000 generated in a spread pricing arrangement is directly attributable to the excess amount paid by the MCO on the prescription drug claims for Texas Medicaid claims. Conversely, if the $2,000,000 were returned to the PBM under an effective rate contract, it would not be directly tied to Texas Medicaid claims. In fact, Texas Medicaid represents only 0.13% of the business subject to the Reconciliation Process. For the illustration in Figure 3 to be accurate, the $2M Reconciliation Amount needs to be reduced to $2,600 (0.13% of $2M). The below illustrates the percentage of Texas Medicaid claims compared to all other claims included in the Reconciliation Process.



Consistent with the above, the pharmacy expenses reported in the 2018 FSR reflect the actual amount billed by the PBM to BCBSTX, as required by the UMCC, which states that "the MCO's reimbursement methodology for the PBM must be based on the actual paid amount by the PBM to a pharmacy for dispensing and ingredient costs." The PBM bills BCBSTX the payment amount that is due to the pharmacy for dispensing and ingredient costs. The claims detail provided during the audit demonstrates that BCBSTX paid the PBM the ingredient cost and dispensing fee that the PBM had paid to the pharmacy for the prescription drug claims.

Receipt of a Reconciliation Amount by the PBM from the pharmacy does not support a conclusion that the FSR is inaccurate or "overstated," particularly because the PBM did not pay to BCBSTX any amount of the Reconciliation Amount received. As explained above, had a Reconciliation Payment gone the other way and resulted in a payment by the PBM to the pharmacy, the PBM would not have invoiced BCBSTX for the remitted amount and an adjustment to the FSR would not have occurred. Had a payment been made to BCBSTX by the PBM, current processes would ensure that the amount would be recorded in the general ledger, with a portion allocated to Texas Medicaid, and the amount would be reported on the FSR. As such, the 2018 FSR accurately reflects the pharmacy expenses incurred by BCBSTX for the year under review.

While the Reconciliation Amount resulted in a payment from the pharmacy to the PBM, it does not support the conclusion that Texas Medicaid claims over-performed for the year. As noted in the Draft Report, the Reconciliation

Amount is an aggregate calculation of claims across all lines of business. As noted above, Texas Medicaid represents only 0.13% of the business subject to the Reconciliation Process. If it is determined that the Reconciliation Amount is reportable, then the pro rata portion of the Reconciliation Amount received by the PBM that would have been allocated to Texas Medicaid is $5,391.65 (0.13% of $4,147,419).

Please note, as mentioned above, the PBM's contract with the pharmacy in question no longer includes a provision for payment by the pharmacy to the PBM of any Reconciliation Amount.

Auditor Follow-up Comment

The information presented in Chapter 1-A is based on the documentation provided by the Health Plan and its Pharmacy Benefit Manager. Despite numerous requests, auditors were repeatedly denied access to the Pharmacy Benefit Manager's complete analysis of pharmacy claims. Instead, the Pharmacy Benefit Manager provided summary documentation, which contained numerous redactions and presented the calculation in two groups. For the group that included Texas Medicaid, that analysis showed the pharmacy owed the Pharmacy Benefit Manager $8.2 million. Neither the Health Plan nor the Pharmacy Benefit Manager provided documentation to support the final amount the pharmacy paid back for Medicaid claims or to support the Health Plan's assertion that Medicaid accounted for 0.13% of the final amount of returned funds.

Whether the Pharmacy Benefit Manager aggregates its Medicaid claims with other programs or shares its funds returned with the Health Plan does not alter the Health Plan's obligation to report the final amount retained by pharmacies for ingredient and dispensing costs in its FSRs and encounter data. If the final amount retained by pharmacies is less than the amount MCOs reimburse the Pharmacy Benefit Manager for claims, pharmacy expenses will be overstated and it will have the same effect as spread pricing as Figure 3 demonstrates.

Management's Response from the Commission

Statement of Agreement/Disagreement

MCS currently monitors MCOs to verify compliance with the prohibition of spread pricing. MCS agrees to enhance monitoring to verify that reported pharmacy expenses represent the final amount retained by pharmacies for dispensing and ingredient costs.

Action Plan

Currently, to address the prohibited practice of spread pricing, MCS reconciles reported pharmacy expenses and expenses reported through encounters. Additionally, through the annual agreed-upon procedures (AUP) engagements, HHSC's contract auditors validate that the amounts pharmacy benefit managers (PBMs) pay the pharmacies match the amounts MCOs record on financial statements submitted to HHSC. HHSC also reviews encounters during the capitation rate setting process to identify whether spread pricing has occurred.

In May 2021, MCS began a targeted review of each MCO/PBM's Network Agreements with pharmacy providers to ensure any prohibited language is removed from all agreements and new approved agreements are executed timely. The submission, review, and network agreement re-execution process will be completed by August 31, 2022.

If MCS identifies non-compliance on the part of any MCO, MCS will consider conducting a targeted financial audit of the MCO. MCS will determine appropriate remedies and work with the MCO on any necessary corrective action.

MCS will create a new deliverable in the Uniform Managed Care Manual to require submission of pharmacy network agreements to HHSC in the future.

Responsible Manager(s)

Deputy Associate Commissioner, MCS Operations

Target Implementation Date

August 31, 2022

Chapter 1-B

The Health Plan Paid Pharmacy Claims for Eligible Members Only; However, It Should Strengthen Its Reporting of Claims for Certain Drug Types

Chapter 1-B Rating:

Medium [5]

The Health Plan complied with eligibility requirements for pharmacy claims; however, it should strengthen its processes for reporting claims for certain drug types.

Claims tested. The Health Plan accurately reported 26 (93 percent) of 28 claims tested, and those claims were paid in accordance with the contracts. The Health Plan could not demonstrate whether the 2 (7 percent) remaining claims tested were paid in accordance with the contract due to the issues discussed in Chapter 1-A.

Eligibility. The Health Plan paid pharmacy claims for members whom the Commission determined to be eligible for the STAR Kids program. In addition, the Health Plan paid 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.

Compound Drug Claims. The Health Plan did not report 1,297 pharmacy encounters for drugs that included more than one ingredient (known as compound drugs). Those encounters totaled $132,511 and were not reported because coding errors caused the encounter reporting system to reject those encounters. The Health Plan did not work with the Commission to correct the errors and resubmit the claims.

Recommendation

The Health Plan should develop, document, and implement a process to review rejected encounters, correct coding errors, and resubmit rejected encounters to the Commission.

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

Management's Response from the Health Plan

BCBSTX agrees with the Recommendation, with the following comments:

A correction was implemented to facilitate reporting of and remediate coding errors that caused the rejection of compound claims. After implementation, no further rejections resulted for this reason for the remainder of the year. The overall encounter acceptance rate in 2018 was approximately 99%. The rejected encounters will be resubmitted to the Commission promptly.

Chapter 2

The Health Plan Accurately Reported Its STAR Kids Medical Expenses

Chapter 2 Rating:

Low [6]

The Health Plan accurately reported its STAR Kids medical (fee-for-service) expenses, totaling $109.1 million, on its fiscal year 2018 FSRs and in its encounter data submitted to the Commission. Specifically, information in the claims processing system that the Health Plan used supported the reported medical expenses. The medical expenses reported on the FSRs were also supported by the encounter data submitted to the Commission. For a sample of 65 claims tested, totaling $1.1 million, the Health Plan accurately reported key fields in the encounter data.

The Health Plan also paid medical claims for eligible members 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. In addition, for 61 (94 percent) of 65 claims tested, the Health Plan accurately paid its providers.

[6] The risk related to the issues discussed in Chapter 2 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 3

The Health Plan Accurately Reported Administrative and Quality Improvement Expenses

Chapter 3 Rating:

Low [7]

The Health Plan accurately reported administrative and quality improvement[8] expenses totaling $49.1 million in its fiscal year 2018 FSRs. Information in the Health Plan's accounting system supported the reported expenses, and that system allocated indirect costs as intended (see text box for more information on direct and indirect costs).

Administrative and Quality Improvement Expenses. Of 65 expenses tested, 59 (91 percent) were allowable and supported (see text box for more information on allowable costs).

Affiliate Contract. The Health Plan's contracted payment rates for its affiliate contract for outsourced administrative services did not exceed fair market value for the STAR Kids program for fiscal year 2018. The cost principles in the Commission's *Uniform Managed Care Manual* require health plans to report outsourced administrative services at either (1) the cost to the affiliate providing the service or (2) fair market value of the services provided.

Compensation Expenses. The Health Plan's compensation expenses reported on its administrative and quality improvement FSRs complied with the Commission's requirements. Specifically, the compensation expenses reported on the Health Plan's fiscal year 2018 FSR were supported by the Health Plan's accounting system. In addition, all 25 payroll expenses tested were allowable and supported.

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 Children's Health Insurance Program (CHIP) Members.

Source: The Commission.

Allowable Costs

The Commission's *Uniform Managed Care Manual* defines the cost principles that establish the allowability of expenses related to selected Medicaid programs that an MCO can report on its 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.

[7] The risk 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.

[8] Quality improvement expenses are administrative-type costs related to activities that improve health quality and health outcomes.

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 Blue Cross Blue Shield of Texas (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). In addition, the scope of this audit included the Commission's oversight of effective rate contracts between pharmacy benefit managers and pharmacy providers.

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, capitation data, accounting 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, employee payroll transactions, and administrative and quality improvement 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 a cross section of expenses and the highest-dollar transactions.

For administrative and quality improvement expenses, the population obtained from the Health Plan included indirect expenses. Those expenses were allocated across multiple programs, and only a portion of each expense was attributable to Texas Medicaid[9]. The pre-allocated payroll expenses totaled $239.6 million; auditors sampled $65,142. For the largest five non-payroll accounts, the pre-allocated administrative and quality improvement expenses totaled $655.8 million; auditors sampled $11.9 million.

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 adjustments to its administrative expense and quality improvement FSRs for fiscal year 2018.
- The Health Plan's accounting and payroll data and supporting documentation.

[9] Of the total pre-allocated administrative and quality improvement expenses, the Health Plan allocated $49.1 million to Texas Medicaid in its 2018 FSR (see Chapter 3).

- The Health Plan's supporting documentation for calculating reported allocated costs for fiscal year 2018.
- The Health Plan's Pharmacy Benefit Manager's contracts with selected pharmacy providers.

Procedures and tests conducted included the following:

- Reconciled medical expenses, administrative expenses, and quality improvement costs in the Health Plan's FSRs for fiscal year 2018 to the 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 Benefit Manager paid medical and prescription claims only for eligible STAR Kids members.
- Performed data analysis to determine whether the Health Plan and its Pharmacy Benefit 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 Benefit Manager accurately paid providers for expenses reported in its FSRs.
- Reconciled the FSRs' supporting worksheets to the underlying source data.
- 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 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 July 2020 through May 2021. 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:

- Scott Labbe, CPA (Project Manager)
- Stacey Williams, CGAP (Assistant Project Manager)
- Arnton W. Gray, CPA, CIA
- Derek Lopez, MBA
- Sarah Jane M. Puerto, CIA, CFE, CGAP
- Adam Ryan
- Kiara White, MPP, CFE
- 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. The U.S. Government Accountability Office's *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 5 integrated components and 17 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.

Internal Control Components and Principles		
Component	**Component Description**	**Principles**
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 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.

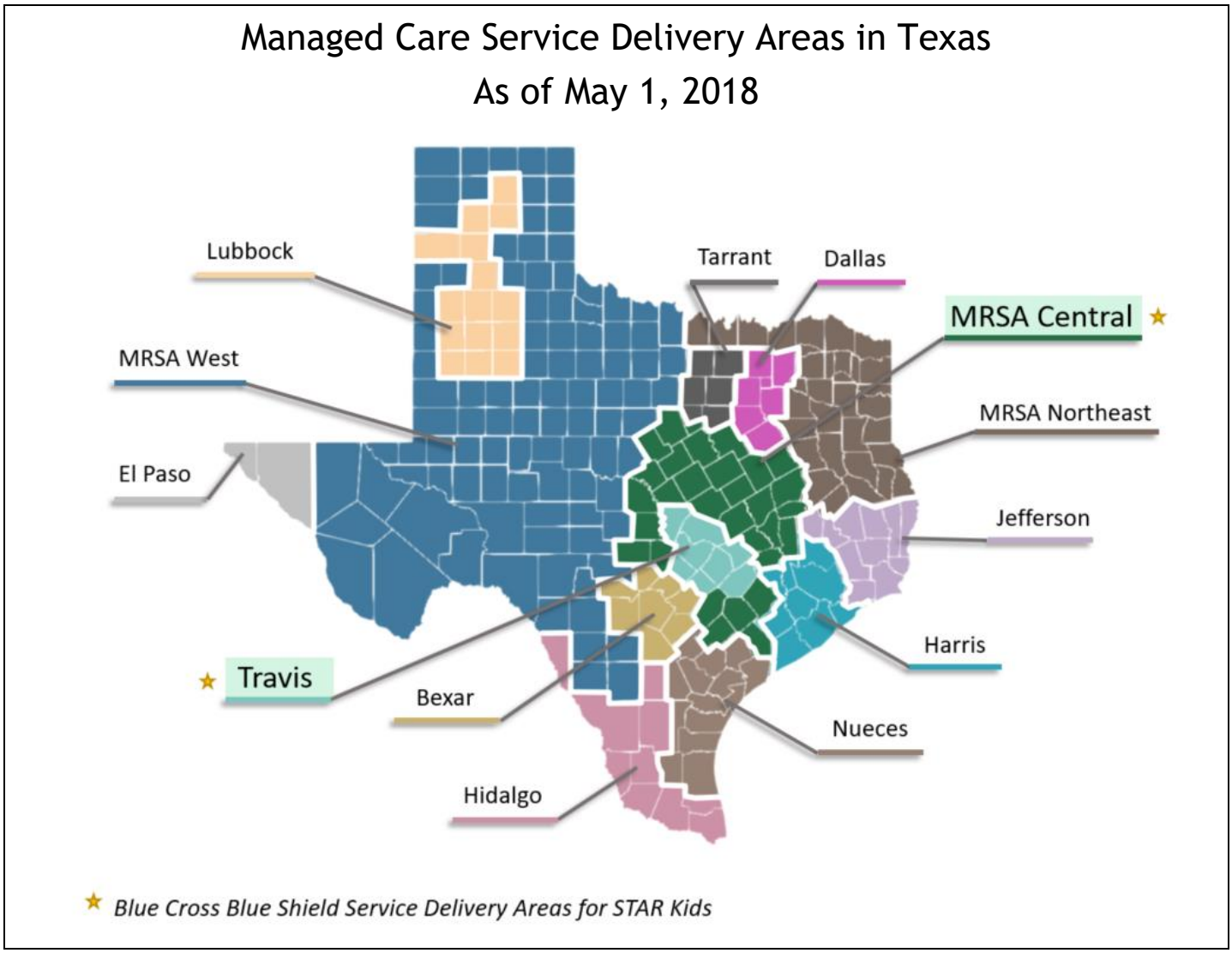
Appendix 4

Blue Cross Blue Shield Service Delivery Areas for STAR Kids

Blue Cross Blue Shield of Texas (Health Plan) provides the Medicaid STAR Kids program to two service delivery areas: Travis County and Medicaid Rural Service Area (MRSA) – Central.

Figure 4 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 4



Source: Map was obtained from the Health and Human Services Commission.

Appendix 5

Calculation of 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, 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 Blue Cross Blue Shield of Texas

Based on Blue Cross Blue Shield of Texas' (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 2021, the Health and Human Services Commission had not 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 that it did not owe the Commission an experience rebate for fiscal year 2018.

Table 5

Blue Cross Blue Shield's Calculation of Income Subject to Experience Rebate For Fiscal Year 2018	
Unaudited Pre-tax Net Income	($38,828,666)
Admin Cap (Reduction of Administrative Expenses) [a]	$24,916,621
Prior Year Loss Carry Forward	($6,175,897)
Adjusted Income Subject to Experience Rebate	($20,087,942)

[a] The Commission's contract with MCOs establishes an Admin Cap that limits administrative expenses that MCOs can deduct from revenues for purposes of calculating the experience rebate. Any amount over the Admin Cap become disallowed expenses.

Source: The Health Plan.

Appendix 7

Related State Auditor's Office Reports

Table 6

Related State Auditor's Office Reports		
Number	**Report Name**	**Release Date**
20-032	*An Audit Report on Texas Children's Health Plan, a Managed Care Organization*	June 2020
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 Dade Phelan, Speaker of the House, Joint Chair
The Honorable Jane Nelson, Senate Finance Committee
The Honorable Robert Nichols, Member, Texas Senate
The Honorable Greg Bonnen, House Appropriations Committee
The Honorable Morgan Meyer, House Ways and Means Committee

Office of the Governor

The Honorable Greg Abbott, Governor

Health and Human Services Commission

Ms. Cecile Young, Executive Commissioner

Blue Cross Blue Shield of Texas

Ms. Sara Daugherty, Texas Medicaid Executive Director