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State Auditor

An Audit Report on

Cook Children's Health Plan, A Managed Care Organization

July 2022

Report No. 22-036

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Overall Conclusion

Cook Children's Health Plan (Health Plan) accurately reported STAR Kids medical and pharmacy expenses in its fiscal year 2020 financial statistical report (FSR). In addition, the Health Plan complied with eligibility requirements for medical and pharmacy claims and accurately reported administrative expenses not shared with its parent company.

However, the Health Plan should strengthen its reporting of administrative expenses shared with its parent company. Of the total $60.6 million of administrative and quality improvement expenses the Health Plan reported, $11.4 million (19 percent) were allocated from its parent company. The Health Plan made some errors in its reporting of those shared expenses.

Specifically, the Health Plan reported shared expenses that were not allowed under the Health and Human Services Commission's (Commission's) cost principles, including expenses that exclusively benefited the Health Plan's affiliate providers.

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.)

Background Information

Cook Children's Health Plan (Health Plan) provides the Medicaid STAR and STAR KIDS, and CHIP programs to the Tarrant service delivery area (see Appendix 4 for additional information on service areas). From September 1, 2019, through August 31, 2020, the Health Plan received payments from the Health and Human Services Commission (Commission) for the STAR Kids program that totaled $249.4 million. Approximately $203.2 million (81 percent) of that funding paid for medical and prescription drug services for 11,308 people enrolled in the STAR Kids program. The STAR Kids program serves children and youth with disabilities.

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.

Source: The Commission.

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, State Auditor, at (512) 936-9500.

Table 1

Summary of Chapters and Related Issue Ratings		
Chapter	Title	Issue Rating [a]
1	While the Health Plan Accurately Reported Most Administrative and Quality Improvement Expenses, It Incorrectly Included Unallowable Shared Expenses from Its Parent Company	Medium
2	The Health Plan Accurately Reported STAR Kids Medical Expenses	Low
3	The Health Plan Accurately Reported STAR Kids Prescription Expenses	Low

[a] A chapter 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(s) and reduce risks to the audited entity.

A chapter 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(s) and reduce risks to the audited entity.

A chapter 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(s) and reduce risks to a more desirable level.

A chapter 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.

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 with the recommendations in this report.

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 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 2020 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

While the Health Plan Accurately Reported Most Administrative and Quality Improvement Expenses, It Incorrectly Included Unallowable Shared Expenses from Its Parent Company

Chapter 1 Rating:

Medium [1]

Cook Children's Health Plan (Health Plan) accurately reported $49.2 million of its $60.6 million administrative and quality improvement[2] expenses. The remaining $11.4 million in expenses represented those shared with its parent company. However, those shared expenses were not always allowable (see text box for more information about allowable expenses).

Allowable Expenses

The Health and Human Services Commission's (Commission's) *Uniform Managed Care Manual* defines the cost principles that establish the allowability of expenses related to selected Medicaid programs that a managed care organization (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.

Non-shared Expenses. The Health Plan's underlying accounting data supported the $49.2 million of administrative and quality improvement expenses that were not shared. All 85 individual sampled expenses, totaling $1,265,457, were allowable and appropriately approved. In addition, all employee compensation was within the compensation limits.

Shared Administrative Expenses. Of 60 shared administrative and quality improvement expenses tested, totaling $144,349, 18 (30 percent) were not allowable according to the Health and Human Services Commission's (Commission's) cost principles. As a result, the Health Plan overstated its shared expenses in its financial statistical report (FSR) by $13,322. Specifically, 14 shared expenses tested did not benefit the Health Plan and exclusively benefited affiliate medical providers. Those medical providers are affiliates because they have the same parent company as the Health Plan. These errors occurred because the parent company did not have a process to evaluate whether shared telecommunications expenses benefited the Health Plan.

[1] 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.

[2] Quality improvement costs are administrative-type costs related to activities that improve health care quality.

In addition, the Health Plan could not provide documentation demonstrating that it benefited from two other shared expenses. The remaining two shared expenses tested were never paid, but the Health Plan included them in the FSR because the parent company's process to identify outstanding checks paid to vendors was not performed until after the FSR was submitted.

Shared Payroll Expenses. All 25 shared payroll expenses tested were allowable; however, management did not consistently approve the supporting timesheets before the payroll was processed, as required by the parent company's procedures. Specifically, 10 (40 percent) of 25 timesheets tested were not properly approved. The Commission's cost principles require charges for salaries and wages to be approved by a responsible official(s) of the Health Plan. While no payment errors were identified, not reviewing the timesheets increases the risk that intentional or unintentional timekeeping errors could go undetected.

Recommendations

The Health Plan should work with its parent company to strengthen the Health Plan's processes and controls so that:

- Shared expenses reported (1) reflect valid expenses and (2) benefit the Health Plan.
- Timesheets are reviewed in accordance with the Commission's and the parent company's requirements.

Management's Response

CCHP agrees with both recommendations.

CCHP performs an exhaustive review process of corporate allocation costs to ensure those are reported per HHSC's Cost Principles. Transactions without enough support are excluded from the FSR, but as this is a manual process, not all transactions can be verified. Shared services allocation at parent company will be improved after the implementation of a new ERP application, which is schedule to go live in late 2023.

In the meantime, CCHP will create a process to validate some of the shared services transactions and report any variances to management.

Parent company will also work on creating a new report to show timecards not being approved and follow up with supervisors to ensure timecards are approved per policy.

***Responsible person**: AVP, Corporate Controller CCHCS; CFO CCHP; and Director of Accounting CCHP*

***Timelines**:*

CCHP validating shared services transactions: December 2022

Parent company shared services allocation improvement: 2024

New report for timecard approval: September 2022

Chapter 2

The Health Plan Accurately Reported STAR Kids Medical Expenses

Chapter 2 Rating:

Low [3]

The Health Plan accurately reported its STAR Kids medical (fee-for service) expenses, totaling $168.5 million, on its fiscal year 2020 FSR and in its encounter data submitted to the Commission (see text box for more information about encounter data). Specifically, the reported claims expenses were supported by the Health Plan's claims processing system. The medical claims expenses reported on the FSR were also supported by the total amount of expenses associated with the encounters reported to the Commission. In addition, for a sample of 65 claims tested totaling approximately $2.0 million, the Health Plan:

Encounter Data

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

Source: The Commission.

- Accurately reported key fields in the encounter data.
- Accurately paid its providers for 64 (98 percent) of the claims tested.

Five of the 65 claims tested were high dollar claims[4] and, according to the Health Plan's policy, were required to undergo manual review to verify that they were processed correctly. However, the Health Plan did not document its review to verify the payment was accurate for 2 (40 percent) of those 5 high dollar claims tested. While the Health Plan accurately paid those 2 claims, inconsistently conducting the review increases the risk that a high dollar claim could be paid at an incorrect amount.

The Health Plan 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, the Health Plan's 2020 STAR Kids contracted payment rates for its affiliate providers did not exceed fair market value. The Commission's cost principles require MCOs to report medical claims from affiliate medical providers at fair market value in its FSRs.

[3] 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)/functions(s) audited or the issues identified do not present significant risks or effects that would negatively affect the audited entity's ability to effectively administer the program(s)/function(s) audited.

[4] The Health Plan's policy defines high dollar claims as claims with a paid amount of either $50,000 or $20,000 depending on the type of claim.

Recommendation

The Health Plan should consistently perform and document its review of high-dollar claims in accordance with its policy.

Management's Response

CCHP agrees with this recommendation. The high dollar claim review process has improved with the implementation of a new claim system on September 2020. On the new system, high dollar claims are automatically routed to a workqueue, where the claim pended until the claim auditor review it. Audit results are added to all claims audited under the Notes section on the system. If for any reason, a high dollar claim is paid without going through the audit claim process, Claims departments run a report on a weekly basis to verify all high dollar claims were audited. If an exception is found, the claim is send to the claims auditor for a post payment audit.

Responsible person*: Director of Claims and Manager of Reimbursement Analysis.*

Timeline*: Implemented on September 2020*

Chapter 3

The Health Plan Accurately Reported STAR Kids Prescription Expenses

Chapter 3 Rating:

Low[5]

The Health Plan accurately reported STAR Kids prescription expenses on its fiscal year 2020 FSR and in its encounter data submitted to the Commission. Specifically, data from its pharmacy benefit manager's claims processing system supported the STAR Kids prescription expenses, which totaled $34.7 million (see text box for information about pharmacy benefit managers).

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.

In addition, for a sample of 63 claims tested, totaling $239,322, the Health Plan's pharmacy benefit manager:

- Accurately paid its providers.
- Accurately reported key fields in the encounter data.

The Health Plan's pharmacy benefit manager also paid pharmacy claims for only 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.

[5] 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)/functions(s) audited or the issues identified do not present significant risks or effects that would negatively affect the audited entity's ability to effectively administer the program(s)/function(s) audited.

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 Cook Children's Health Plan's (Health Plan) financial processes and related controls for fiscal year 2020 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. In addition, during the audit, matters not required to be reported in accordance with *Government Auditing Standards* were communicated to Health Plan management for consideration.

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, payroll data, and expense data from the Health Plan and its parent company, as well as the related encounter data and capitation data. Auditors reconciled the FSRs to those data sets as appropriate 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 that the sample included a cross section of expenses and the highest-dollar transactions.

In addition, auditors selected a nonstatistical random sample of information technology and telecommunications expenses (from related cost centers), including payroll expenses, that the parent company shared with the Health Plan. Many of those expenses were allocated across multiple affiliate companies, and only a portion of each expense was attributable to the Health Plan. This sampling design was chosen because information technology and telecommunications expenses represented 84 percent of the shared costs reported by the Health Plan.

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 fiscal year 2020 FSRs for (1) 334-day STAR Kids, (2) administrative expense, and (3) quality improvement.
- The Health Plan's accounting and payroll data and supporting documentation.
- The Health Plan's supporting documentation for calculating reported shared corporate costs for fiscal year 2020.

- The Health Plan’s pharmacy benefits 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 to the Health Plan’s claims system and general ledger.
- Reconciled prescription expenses in the Health Plan’s FSRs 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 benefits manager paid providers for expenses reported in its FSRs, in accordance with its contracts.
- Reconciled the FSRs’ supporting worksheets to the underlying source data.
- Tested controls over the Health Plan’s preparation of the FSRs and expense and claim approval processes.
- 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.
- The Health Plan's contracts with medical providers.
- The pharmacy benefit manager's contracts with pharmacy providers.

Project Information

Audit fieldwork was conducted from September 2021 through May 2022. 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)
- Bianca F. Pineda, CFE, CGAP (Assistant Project Manager)
- Cody Bogan, CFE
- Erica Chapa
- Alex Lukose
- Emmanuel Melendez, CPA, MBA
- Kate Reagor, MSIS
- Jerel Deacon
- Dana Musgrave, MBA, CFE (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 five integrated components of internal control, which are listed in Table 3.

Table 3

Internal Control Components	
Component	**Component Description**
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.
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.
Control Activities	Control activities are the policies and procedures that help ensure that management's directives are carried out.
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.
Monitoring Activities	Monitoring is a process that assesses the quality of internal control performance over time.

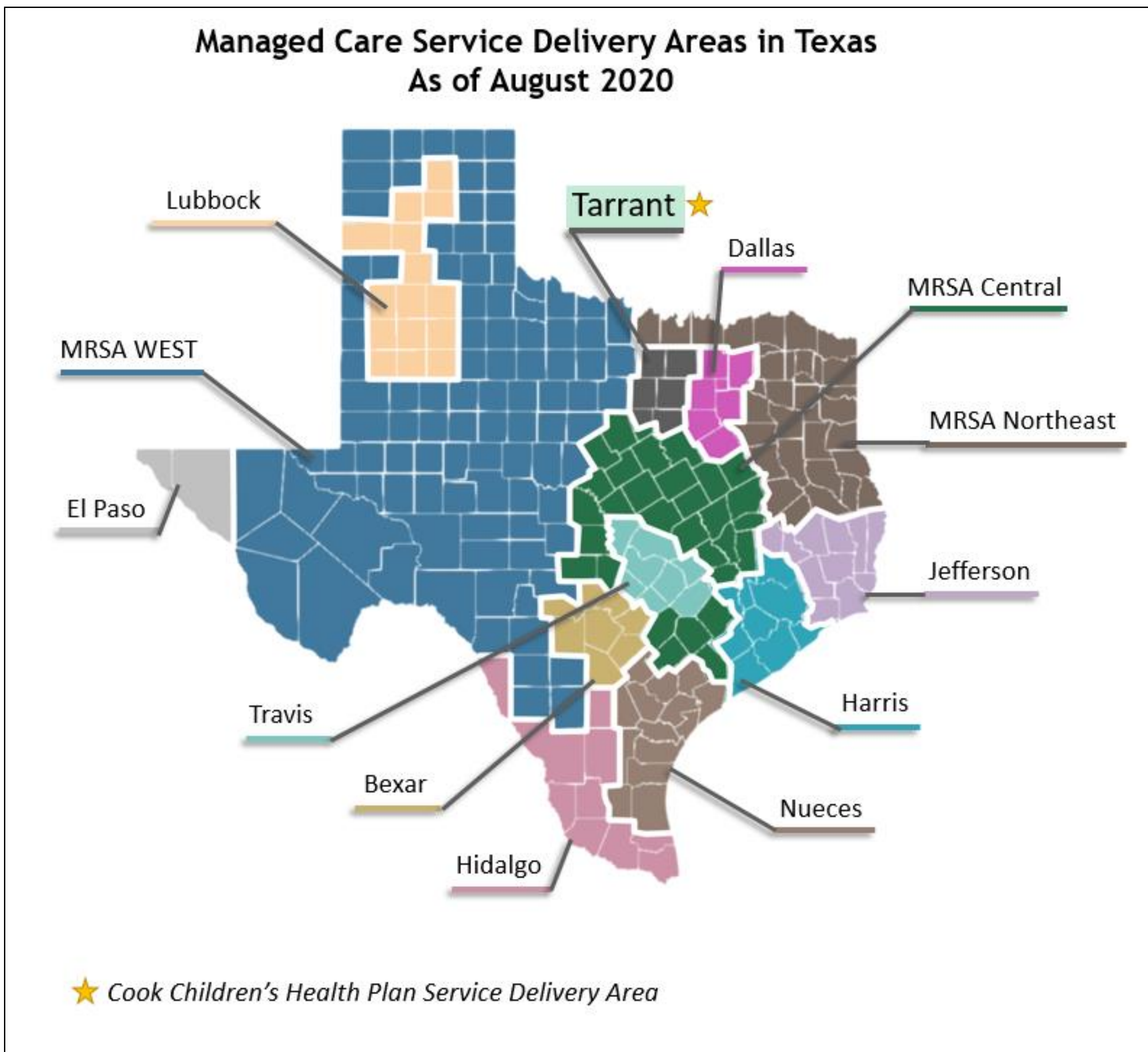
Source: Internal Control – Integrated Framework, Committee of Sponsoring Organizations of the Treadway Commission, May 2013.

Appendix 4

Cook Children's Health Plan Service Delivery Area for STAR Kids

Cook Children's Health Plan provides the Medicaid STAR Kids program to the Tarrant service delivery area. Figure 1 shows the managed care service delivery areas in Texas as of August 2020.

Figure 1



Source: Map was obtained from the Health and Human Services 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 (86th Legislature), Rider 124, page II-84, requires that experience rebates the Commission receives from MCOs be used to fund services for Medicaid members.

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 2020 Experience Rebate for Cook Children's Health Plan

Based on Cook Children's Health Plan's (Health Plan) financial statistical report for fiscal year 2020, Table 5 shows the adjusted income subject to the experience rebate calculated by the Health Plan. As of June 2022, the Health and Human Services Commission had not yet completed its review of that calculation, and the calculation does not reflect the results of any audits. Table 6 shows the Health Plan's calculation of the income that is subject to the tiered rebate methodology described in Appendix 5.

Table 5

Cook Children's Health Plan Calculation of Income Subject to Experience Rebate For Fiscal Year 2020	
Income Subject to Experience Rebate	$23,690,718

Sources: The Commission and the Health Plan.

Table 6

Cook Children's Health Plan Experience Rebate Calculation for Fiscal Year 2020					
Tiers - Percent of Revenue	Upper Revenue Limit	Net Income	Health Plan's Share	State's Share	State's Share Percentage
0 percent to 3 percent	$18,508,079	$18,508,079	$18,508,079	$0	0 percent
3 percent to 5 percent	$30,846,798	$5,182,639	$4,146,111	$1,036,528	20 percent
5 percent to 7 percent	$43,185,518	$0	$0	$0	40 percent
7 percent to 9 percent	$55,524,237	$0	$0	$0	60 percent
9 percent to 12 percent	$74,032,316	$0	$0	$0	80 percent
Over 12 percent	Not Applicable	$0	$0	$0	100 percent
Totals		**$23,690,718**	**$22,654,190**	**$1,036,528**	

Sources: The Commission and the Health Plan.

Appendix 7

Related State Auditor's Office Reports

Table 7

Related State Auditor's Office Reports		
Number	**Report Name**	**Release Date**
21-025	*An Audit Report on Blue Cross Blue Shield of Texas, a Managed Care Organization*	June 2021
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 Joan Huffman, 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 Erwin Young, Executive Commissioner

Cook Children's Health Plan

Ms. Karen Love, President

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