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State Auditor

An Audit Report on

The Health and Human Services Commission's Medicaid Managed Care Rate-setting Process

- The Commission established effective business processes for setting the fiscal year 2023 Medicaid managed care rates.
- The Commission's rate reports addressed most required information; however, it should enhance communication with oversight entities to comply with all requirements.
- The Commission complied with most applicable requirements in its procurement and monitoring of its actuarial services contract. However, contract team members did not consistently complete required certification and disclosure forms.

This report evaluates the Commission's business processes for setting and implementing the Medicaid managed care rates, communicating the rates to oversight entities, and procuring its contracted actuary. This report also summarizes the rate-setting process and identifies significant drivers of costs in the rates. This is the second of three reports that the State Auditor's Office will release to address Rider 5, page X-7, the General Appropriations Act (87th Legislature) requirements.

- *Background* | p. 4
- *Audit Objectives* | p. 34

This audit was conducted in accordance with Rider 5, page X-7, the General Appropriations Act (87th Legislature).

NOT RATED

MEDICAID MANAGED CARE COST DRIVERS

Significant cost drivers include: (1) expected changes in the cost of providing health care services and (2) changes in enrollment requirements. Health care costs comprise between 88 percent and 92 percent of the rates.

Chapter 1 | p. 7

LOW

RATE-SETTING PROCESS

The Commission established effective business processes for setting the fiscal year 2023 Medicaid managed care rates and established oversight processes for data critical to setting the rates.

Chapter 2 | p. 19

MEDIUM

COMMUNICATION WITH OVERSIGHT ENTITIES

The Commission's rate reports addressed most required information; however, it could enhance communication with oversight entities by explicitly addressing certain General Appropriations Act requirements.

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For more information about this audit, contact Audit Manager Lauren Godfrey or State Auditor Lisa Collier at 512-936-9500.

October 2022 | Report No. **23-005**

LOW

CONTRACT PLANNING, PROCUREMENT, AND FORMATION

The Commission planned, procured, and formed its actuarial services contract in accordance with applicable requirements.

Chapter 4-A | p. 27

HIGH

VENDOR SELECTION

The Commission followed applicable requirements in selecting its actuarial services contractor. However, contract team members did not consistently complete required certification and disclosure forms.

Chapter 4-B | p. 29

LOW

CONTRACT OVERSIGHT

The Commission issued payments to its actuarial services contractor in compliance with applicable rules and monitored that contractor for compliance with the terms of its contract.

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Summary of Management's Response

Auditors made recommendations to address the issues identified during this audit, provided at the end of certain chapters in this report. The Commission agreed with the recommendations.

Ratings Definitions

Auditors used professional judgment and rated the audit findings identified in this report. The issue ratings identified for each chapter were determined based on the degree of risk or effect of the findings in relation to the audit objective(s).

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.

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.

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.

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.

For more on the methodology for issue ratings, see Report Ratings on page 38.

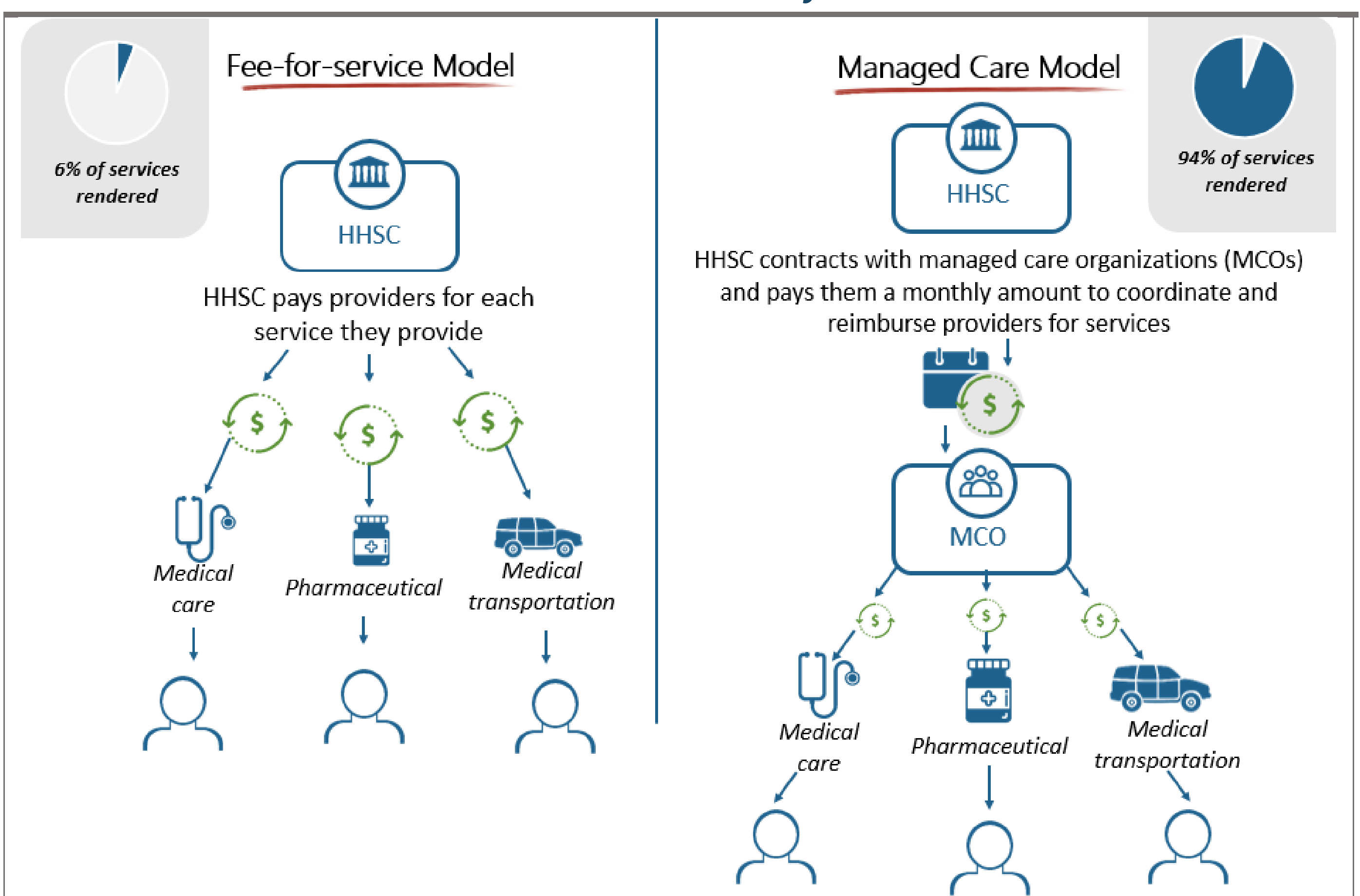
Background Information

Medicaid in Texas

Medicaid is the state and federal cooperative program that provides medical coverage to eligible needy persons. Texas Medicaid provides health care services through two service delivery models: fee-for-service and managed care (see Figure 1).

Figure 1

Medicaid Service Delivery Models



Source: *Texas Medicaid and CHIP Reference Guide,* 13th edition; Health and Human Services Commission (HHSC).

Texas delivers the vast majority (94 percent) of Medicaid services through the managed care model. There are six Medicaid managed care programs that serve different members based on their individual situations (see Figure 2).

Figure 2

Medicaid Programs and Coverage

Program	Description	Average Estimated FY 2023 Beneficiaries	Projected FY 2023 Program Costs[a]
TEXAS STAR	*STAR* is a program for low-income families, children, and pregnant women.	4,026,259	$12,279,000,000
TEXAS STAR PLUS	*STAR+PLUS* is a program for adults with a disability or who are age 65 and older.	550,644	$10,436,000,000
TEXAS STAR Health	*STAR Health* is a program for children and youths who are in the State's foster care system.	35,428	$465,000,000
TEXAS STAR Kids	*STAR Kids* is a program for children and adults age 20 and younger with a disability.	168,597	$4,188,000,000
TEXAS Medicaid Dental PLAN	*Medicaid Dental* is a program that provides dental services for Medicaid children through age 20.	3,709,854	$1,380,000,000
TEXAS Medicare Medicaid PLAN	*Dual Demonstration* is for certain clients dually enrolled in Medicare and Medicaid.	36,472	$513,000,000

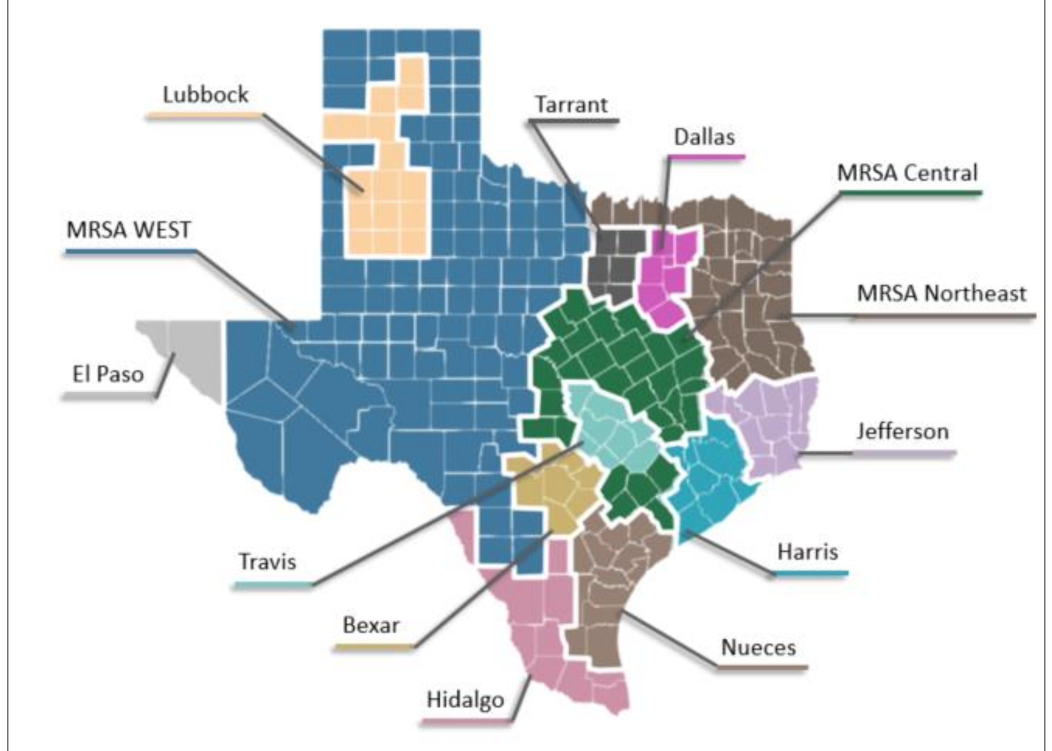
[a] Excludes directed payments.

Source: *Actuarial Analysis of the Health and Human Services Commission's Fiscal Year 2023 Medicaid Managed Care Rates* (State Auditor's Office Report No. 22-042, August 2022).

For 2023, the Commission contracted with a total of 18 managed care organizations (MCOs) to provide services to members throughout the state's 13 service delivery areas shown in Figure 3 on the next page.

Figure 3

Service Delivery Areas



Source: Health and Human Services Commission.

Medicaid Managed Care Rates

Similar to health insurance, the Commission pays a monthly premium, known as a capitation rate, to an MCO for each member enrolled in Medicaid managed care in a given month. In return, the MCO covers the eligible health care costs of the member. The Commission, in collaboration with its contracted actuarial firm, determines the rates at which MCOs are paid.

Managed care rates must be actuarially sound, meaning that they must be appropriate to cover the projected costs and developed in accordance with generally accepted actuarial principles and practices. The rates are intended to cover an MCO's costs to serve an individual member. MCOs negotiate contracts with health care providers (doctors, dentists, hospitals, etc.) and pay them for services provided to their members. Unlike in the fee-for-service model, in the managed care model, an MCO bears the risk that a member's costs will exceed the capitation rate.

Chapter 1
Medicaid Managed Care Cost Drivers

Rider 5, page X-7, the General Appropriations Act (87th Legislature) directed the State Auditor's Office (SAO) to audit the Health and Human Services Commission's (Commission) Medicaid managed care rate-setting process, including identifying significant cost drivers, which are described in this chapter.

As discussed in the background section, Texas pays MCOs a monthly premium in return for the MCO covering the eligible health care costs of members. These premiums are at the rates set by the Commission and are designed to cover an MCO's expected costs to coordinate and pay for health care services for its members.

The most significant rate component is the cost of providing health care services to Medicaid members. Significant factors that caused rates to change from fiscal year 2022 to fiscal year 2023 include (1) expected changes in the cost of providing health care services to members and (2) changes in federal and state requirements for enrollment.

The SAO's contracted actuary evaluated the Commission's handling of rate components and cost drivers in its report released in August 2022 (see text box for more information).

Actuarial Analysis

The State Auditor's Office contracted with the actuarial firm Milliman, Inc. (Milliman) to evaluate the actuarial soundness of the fiscal year 2023 rates and analyze key factors that affect the rates, including rate structure, historical cost and enrollment, data validation, adjustments, trend assumptions, program changes, non-benefit cost assumptions, and COVID-19 impacts.

Milliman concluded that, overall, the Commission followed methods to produce actuarially sound fiscal year 2023 capitation rates. Additionally, Milliman did not identify a program-wide pattern of over- or under-funding or material issues that indicate the rates are not actuarially sound.

However, Milliman made several recommendations to improve the actuarial process and mitigate the risk of future unsoundness.

Source: *Actuarial Analysis of the Health and Human Services Commission's Fiscal Year 2023 Medicaid Managed Care Rates* (State Auditor's Office Report No. 22-042, August 2022).

What are the components of Medicaid managed care rates?

The Medicaid managed care rates are made up primarily of two types of projected costs: health benefit costs and non-health benefit costs.

Health Benefit Costs

Health benefit costs are the direct costs of health care provided to Medicaid members. These are also referred to as "benefit expenses" and comprise between 88 percent and 92 percent of the rates, on average. The costs are for providing members with the following:

- Medical care.
- Pharmacy services.
- Non-emergency medical transportation (NEMT).

Non-health Benefit Costs

Non-health benefit costs are the other operating costs involved in administering Medicaid managed care services, and they comprise between 8 percent and 12 percent of the rates, on average. Federal regulations[1] require rates to include the following non-health benefits costs:

- **Administrative** costs involved in processing claims, such as personnel, information technology, care management, licensing and regulatory fees, and other operational costs.
- **Taxes**, which are a state tax on insurance premiums and a state tax for the maintenance and support of the Texas Department of Insurance.[2]
- A **risk margin** (also called a "risk premium"), which provides compensation for the financial and other risks assumed by the MCOs. These risks include mispricing, investment, inflation, and regulatory risks, as well as risks associated with social, economic, and legal environments.

[1] Title 42, Code of Federal Regulations, Section 438.5(e).
[2] Texas Insurance Code, Chapters 221, 252, and 253.

How much of each rate is related to the risk margin?

Nationally, based on research by the SAO's contracted actuary, risk margin assumptions range from 1.0 percent to 2.0 percent for most comprehensive Medicaid managed care programs.

The 2018–2019 General Appropriations Act (85th Legislature) reduced the Commission's appropriations as a result of a reduction in the risk margins. Those reductions were:

- From 2.0 percent to 1.5 percent for the STAR and STAR Health programs; and
- From 2.0 percent to 1.75 percent for the STAR Kids and STAR+PLUS programs.

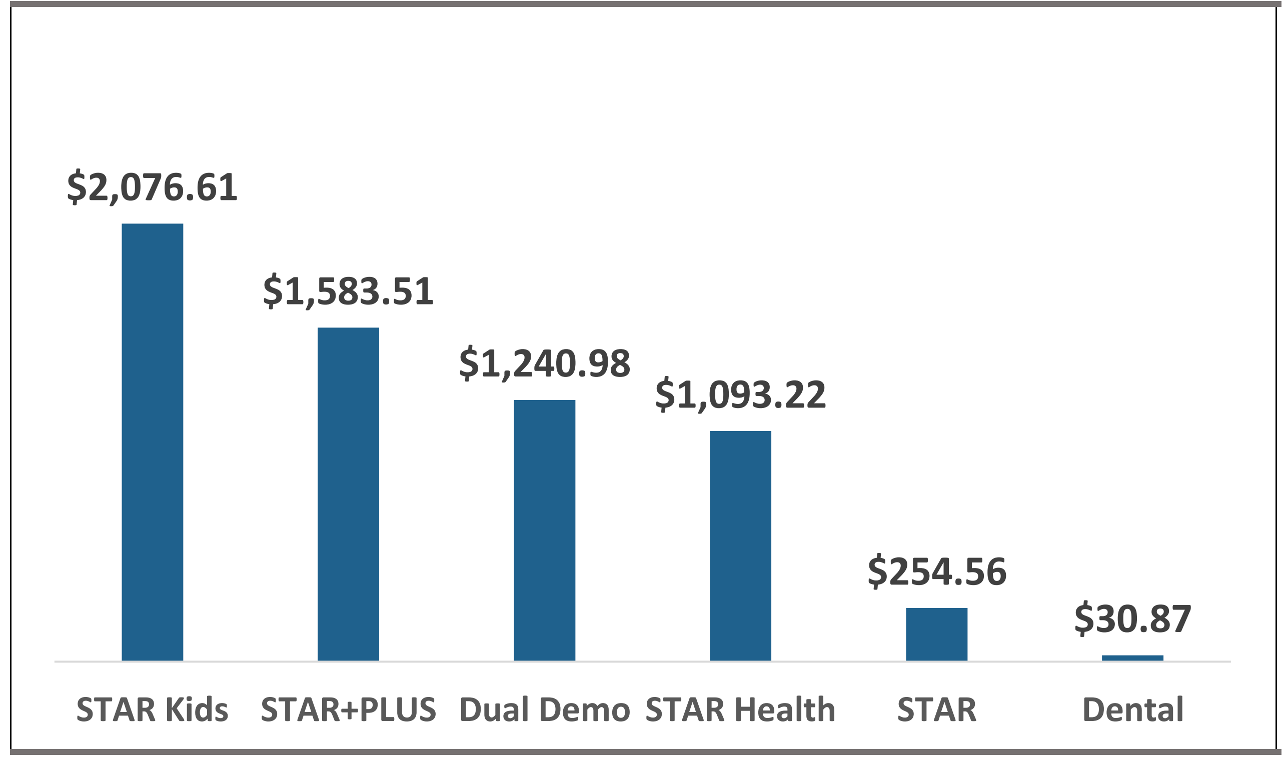
The Commission continued to apply those same risk margins of 1.5 percent and 1.75 percent in setting the fiscal year 2023 rates. The Commission also applied a risk margin of 1.5 percent to the Dental program.

What is the average rate for each program and how does each component contribute?

The average rates for fiscal year 2023 vary significantly by program. As Figure 4 on the next page shows, for fiscal year 2023, STAR Kids has the highest rate per member per month and the dental program has the lowest rate per member per month.

Figure 4

Fiscal Year 2023 Average Per Member Per Month Rates by Program

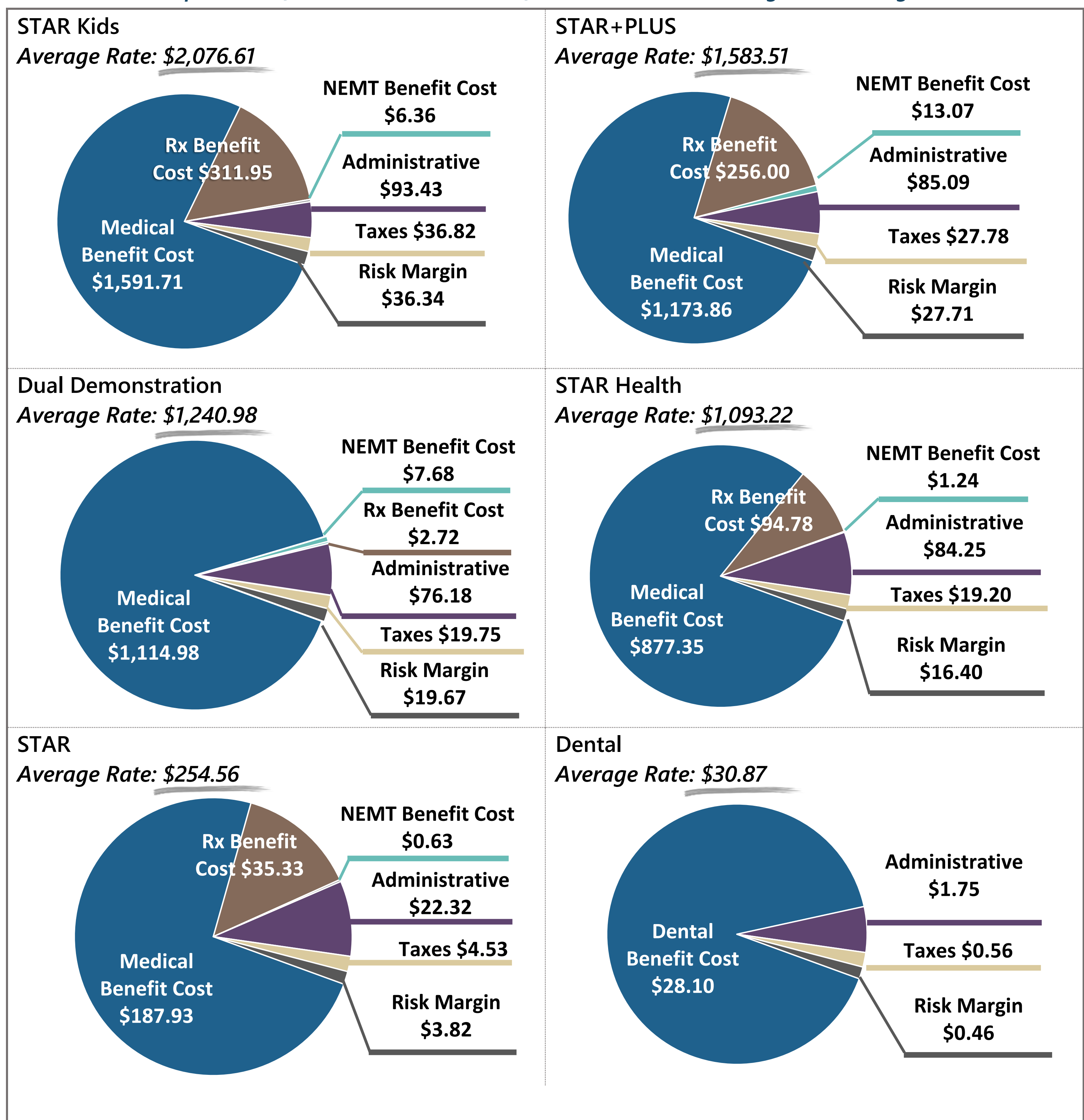


Source: The SAO's contracted actuary using the Commission's fiscal year 2023 rates, as certified on July 8, 2022.

While health benefit costs make up the majority of each program's average rate, the relative significance of each component varies by program. The specific breakdown of the rate components for each program are presented in Figure 5 on the next page.

Figure 5

Components of Fiscal Year 2023 Rates for Each Medicaid Managed Care Program



Source: The SAO's contracted actuary using the Commission's fiscal year 2023 rates, as certified on July 8, 2022.

How does the Commission set the rates?

The Commission and its contracted actuary determine the **rate structure**, which is the number of rates that will be developed. Then, they analyze **historical costs** (“base data”) and **enrollment data** and project how they expect costs and enrollment to change (“**trend**”). In addition, they **make adjustments** for changes to the program or other factors not reflected in the historical data or trend. Lastly, they estimate and add the **non-health benefit costs** to the rate.

Determine the rate structure

Number of Rates for FY 2023

1,181

The rate structure is based on a combination of risk group (see text box), service delivery area, program, and MCO. The rate structure is important because it determines how many rates the Commission will set. For fiscal year 2023, there are 1,181 Medicaid managed care rates.

Risk Groups

Risk groups are produced by classifying members based on factors or characteristics that actuaries determine are useful in predicting the expected costs to provide Medicaid services to the member. For Medicaid managed care in Texas, these groups are identified by age range, gender, program, eligibility category, or other characteristics established by the Commission.

Sources: The Actuarial Standards Board’s *Actuarial Standard of Practice No. 12* and the Commission’s *Uniform Managed Care Contract Terms and Conditions*, version 2.36.

Each rate differs based on several factors, including:

- Covered services (which vary by program).
- Costs of care (which vary by service delivery area).
- Differences in the covered populations’ expected medical needs (which may vary based on age, demographics, and/or known health conditions).

Analyze historical costs

Historical costs are the past costs that MCOs incurred to provide medical care to members in the Medicaid managed care program. The main historical cost data sources that the Commission and its contracted actuary use to set the rates include:

- Claims for medical care paid by MCOs, also referred to as “encounter data”;
- Unaudited MCO quarterly and annual financial statistical reports (FSRs); and
- Other MCO data requested by the Commission.

Analyze enrollment data

Enrollment data reflects the individuals enrolled in Medicaid managed care and includes demographic information, including geographical data, age, and the MCO in which the member is enrolled. Enrollment data is used to project future enrollment and health care service needs by risk group.

Apply trends and project costs

The actuarial model the Commission and its contracted actuary use to set the rates relies primarily on historical MCO costs. To establish trends, they review year-over-year changes in historical costs. The trends identified assist in projecting anticipated costs for the fiscal year for which the rates are being set.

Separate trends are developed for the costs of providing medical care, prescription drugs, and non-emergency transportation (NEMT). Those trends consider expected changes in the utilization of those health care services and the unit costs of providing each service.

Make adjustments

The Commission and its contracted actuary make adjustments to the base data to account for factors such as:

- Changes in laws or rules at the federal or state level governing the Medicaid program. Examples may include changes with regard to health services covered or eligibility requirements.
- Other information or events that, in the Commission's judgment, warrant adjustments to the historical data. An example of this is the impact from the COVID-19 Public Health Emergency, which started in 2020.

Include non-health benefit costs

The Commission and its contracted actuary evaluate historical program administrative expenses to estimate non-health benefit costs for inclusion in the rates. Additionally, MCOs provide input about future administrative expenses. The administrative expenses are split between a fixed and variable component so that a larger percentage of the administrative dollars are allocated to the higher cost risk groups.

Set the rates

The Commission and its contracted actuary finalize the rates and certify the actuarial soundness of those rates.

For a detailed explanation of how the Commission sets the rates and an evaluation by the SAO's contracted actuary, see *Actuarial Analysis of the Health and Human Services Commission's Fiscal Year 2023 Medicaid Managed Care Rates* (SAO Report No. 22-042, August 2022).

What happens if the rates are set too high?

The Commission has incorporated provisions into its contracts with MCOs that require MCOs to share certain percentages of their net income before taxes with the Commission.

As required by Texas Government Code, Chapter 533, the Commission adopted rules that require each MCO to pay an experience rebate to the State under certain conditions. Prior to the COVID-19 Public Health Emergency, MCOs were required to share profits in excess of 3 percent with the State on a sliding scale and any profits 12 percent or greater were required to be returned to the State in full.

Starting in fiscal year 2022, due to the impact of the COVID-19 Public Health Emergency, the Commission revised the experience rebate schedule so that MCOs were required to return profits in excess of 5 percent to the State in full. Figure 6 shows the Commission's profit-sharing requirements for MCOs for fiscal year 2023.

Figure 6

Experience Rebate Schedule for Fiscal Year 2023

Pre-tax Income as a Percent of Revenues	MCO Share	Commission Share
Less than or equal to 3 percent	100 percent	None
Greater than 3 percent but less than or equal to 5 percent	80 percent	20 percent
Greater than 5 percent	None	100 percent

Source: The Commission.

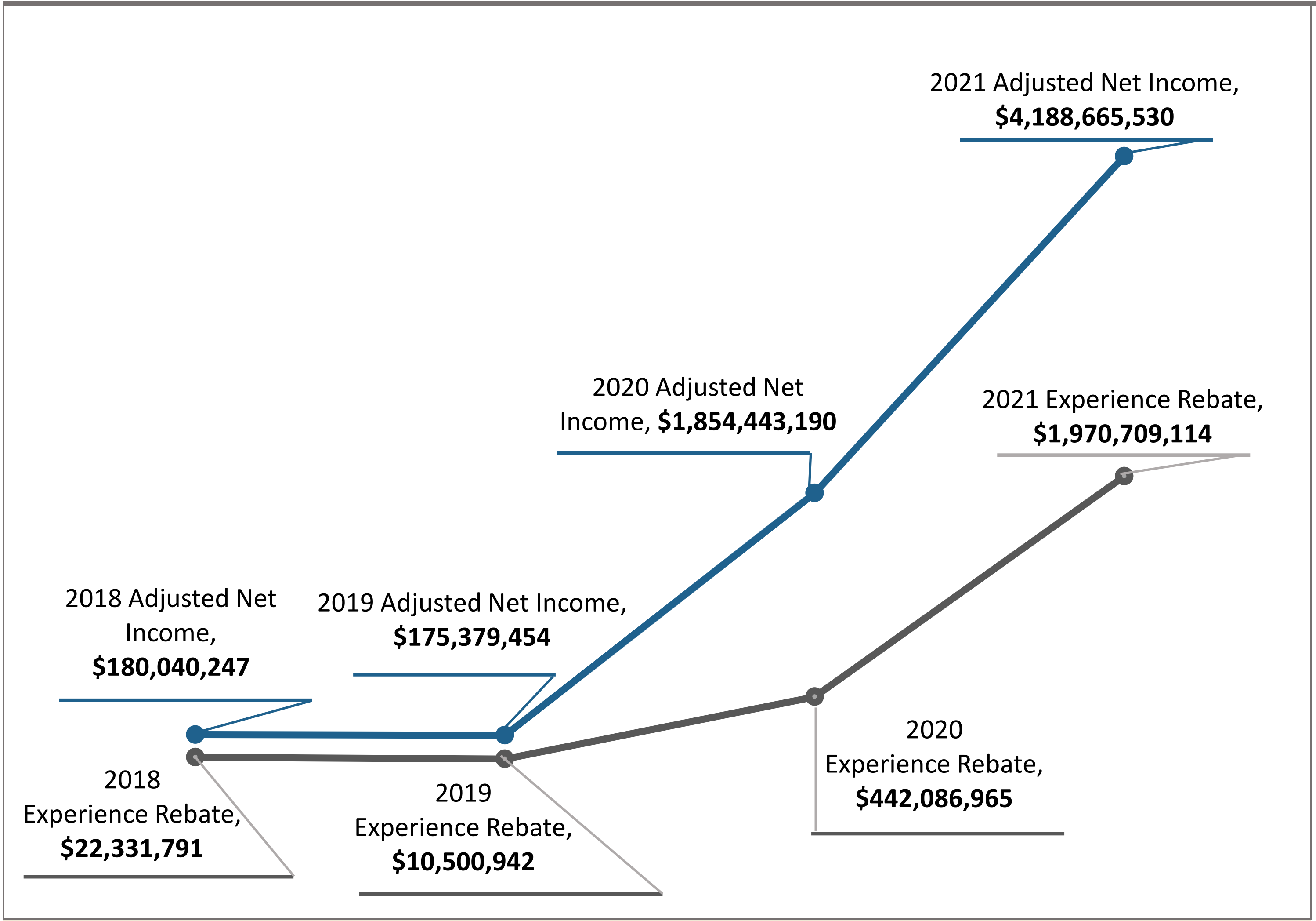
How much has the State recovered from MCOs in experience rebates?

As MCOs' profits increased in recent years, so did the amount paid back to the State. Figure 7 on the next page compares the aggregate net income for all MCOs and the experience rebates that the Commission calculated for fiscal years 2018 through 2021.

According to the Commission, the continuous eligibility requirement due to the COVID-19 Public Health Emergency has resulted in significant increases in the number of members enrolled in Medicaid, reducing the average costs per member. As a result, adjusted net income and associated experience rebates increased significantly since the COVID-19 Public Health Emergency.

Figure 7

Statewide (All MCO) Income and Experience Rebates for Fiscal Years 2018–2021 [a]



[a] The adjusted net income shown is the income subject to the experience rebate calculation. It will not always match the income reported in MCO FSRs due to adjustments, such as carrying forward of prior-year losses.

Source: Unaudited information from the Commission's experience rebate calculations.

Why do the rates change from year to year?

Rates are adjusted from year to year due to many factors, including anticipated changes in:

- Costs of providing health care.
- The health care needs of members.
- Medicaid program requirements.

As shown in Figure 8, between fiscal year 2022 and fiscal year 2023 the changes in the average rates for each program ranged from a decrease of 12.6 percent to an increase of 2.9 percent.

Figure 8

Changes in Texas Medicaid Managed Care Rates From Fiscal Years 2022 to 2023 [a]

Program	Average Rate Per Member Per Month Fiscal year 2022 [b]	Average Rate Per Member Per Month Fiscal year 2023 [c]	Percent Change
STAR	$247.31	$254.56	2.9%
STAR Health	$1,093.78	$1,093.22	-0.1%
Dental	$31.18	$30.87	-1.0%
STAR+PLUS	$1,724.28	$1,583.51	-8.2%
STAR Kids	$2,067.32	$2,076.61	0.4%
Dual Demonstration [d]	$1,420.28	$1,240.98	-12.6%

[a] Excludes directed payments.

[b] The rates listed for fiscal year 2022 are not the original rates the Commission set for fiscal year 2022, but are the adjusted rates the Commission recertified midway through the year.

[c] The rates listed for fiscal year 2023 are the rates as certified on July 8, 2022.

[d] Excludes the application of a 5.5% contractual savings assumption.

Source: Analysis by the SAO's contracted actuaries based on the Commission's rate reports for fiscal years 2022 and 2023.

Why did the rates change between fiscal years 2022 and 2023?

The SAO's contracted actuary identified the following changes in the Commission's estimates as significant drivers of changes in the rates between fiscal years 2022 and 2023:

- Cost of providing healthcare services, which is expected to increase. Depending on the program, medical service costs are expected to increase between 3.0 percent and 6.9 percent per year, dental service costs are expected to increase 0.5 percent per year, and pharmacy service costs are expected to increase between 1.2 percent and 5.1 percent per year.
- Utilization per member, which is expected to decrease because of the (1) changes in federal and state requirements for enrollment and (2) expected health care needs of the enrolled members.
- Reimbursement amounts to nursing homes, which increased during the COVID-19 Public Health Emergency but are expected to decrease for fiscal year 2023. This change specifically decreased the STAR+PLUS rates.

The SAO's contracted actuary determined that the Commission's changes to expected non-health benefit costs (such as administrative costs, taxes, and risk margin) were not a material driver of the rate changes from fiscal years 2022 to 2023.

How do the changes in the rates affect overall program costs?

Because the overall cost to the State is a combination of the capitation rates and the number of members, changes in rates will not always result in a proportional change in costs. For example, when rates go down, overall costs may go up due to increases in enrollment. Enrollment is expected to continue to increase during the COVID-19 Public Health Emergency.

LOW

Chapter 2
Rate-setting Process

The Commission, which manages the rate-setting process, works with its contracted actuaries to develop the Medicaid managed care capitation rates using data the Commission collects from MCOs.

The Commission established effective business processes for setting the fiscal year 2023 Medicaid managed care rates.

Actuary Credentials. All actuaries performing significant actuarial work on the rates were properly credentialed and up-to-date on their continuing professional development compliance certifications.

Rate-Setting Process. The Commission established and implemented a process to track and monitor the development of the fiscal year 2023 rates. That process required the completion of 91 tasks to set the rates. Of those, auditors identified 18 key tasks and verified that the Commission completed each task in accordance with its documented procedures.

In addition, for each task, the Commission documented and tracked (1) who was responsible, (2) an expected completion date, and (3) when it was completed. In tracking its process, the Commission also:

- Identified and documented key tasks necessary to set the rates in compliance with applicable requirements and deadlines.
- Re-evaluated and made updates to reflect new requirements and other changes.
- Regularly assessed its progress towards its expected completion dates.

Approvals. The Commission's chief actuary, chief financial officer, and executive commissioner reviewed and approved the fiscal year 2023 rates as required by the Commission's procedures.

The Commission established oversight processes for data critical to setting the rates.

Encounter Data Certification. The Commission obtained and reviewed an independent certification of the encounter data (see text box for information about that data) for fiscal years 2019, 2020, and 2021 from an external quality review organization as required by the Code of Federal Regulations, Title 42, Section 438.350, and Texas Government Code, Section 533.0131. Those certifications stated that the encounter data for those years was complete, accurate, and reliable.

Financial Statistical Report (FSR) Submission. The Commission accurately tracked and recorded the MCOs' submission of FSRs (see textbox for information about those reports) for fiscal years 2019 and 2020 to verify that MCOs were submitting them as required.

Actuarial Data Validation. The Commission and its contracted actuaries have additional processes for validating encounter data, financial data, and supplemental MCO data for use in the rate-setting process. The SAO's contracted actuaries reviewed those processes and issued observations and recommendations (see *Actuarial Analysis of the Health and Human Services Commission's Fiscal Year 2023 Medicaid Managed Care Rates*, SAO Report No. 22-042, August 2022).

Encounter Data

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

Financial Statistical Reports (FSRs)

The Commission receives FSRs from 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 Chapter 1 for information on the experience rebate) and (2) a key source of claims and administrative expense information used to set the rates.

Source: The Commission.

The Commission exercises oversight of MCO financial reporting, which it could better leverage to inform the rate-setting process.

FSR Reconciliations. The Commission has monitoring processes for reconciling the FSRs to encounter and other data, and it works with the MCOs to resolve discrepancies. In some cases, these reconciliations take place more than one year after the end of the fiscal year to allow for claim settlement. According to the Commission, as of June 2022, it was working to complete year-end reconciliations for the fiscal year 2020 FSRs.

Agreed-Upon Procedures (AUP) Engagements

Work contracted out to external accounting firms to assess whether the revenues, costs, and resulting net income that MCOs reported were materially accurate.

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

Sources: The fiscal year 2018 AUP engagement reports and the American Institute of Certified Public Accountants.

Agreed-Upon Procedures. The Commission also contracts with accounting firms to validate the FSRs through agreed-upon procedures (AUPs) engagements (see text box). These engagements take place more than two years after the end of a given fiscal year. The Commission and its contracted actuary relied on fiscal years 2018–2021 FSRs in setting the 2023 rates. Although they reported in their 2023 rate packets to oversight entities[3] that the FSRs are audited, the AUP engagements for fiscal year 2018 FSRs were not completed until June 2022 and AUPs for subsequent fiscal years had not been completed. Therefore, the FSRs had not been audited at the time that information was used in setting the rates.

Communicating Results. According to the Commission, the primary objective of the year-end FSR reconciliations and the AUPs is to help the Commission to calculate or adjust each MCO's experience rebate (see Chapter 1 for an explanation of experience rebates). Because of the difference between when the data needs to be used in setting the rates and when the year-end reconciliations and AUPs occur, the Commission does not consider them to be significant to the rate-setting process. As a result, the Commission does not have a process for consistently communicating issues identified in the year-end reconciliations and AUP engagements to its Actuarial Analysis Department for consideration in setting future rates.

[3] Rate packets were submitted to the federal Centers for Medicare and Medicaid Services (CMS), the Governor, the Legislative Budget Board, and the SAO.

Although the results of AUPs and year-end reconciliations are generally not available until after the FSR information has already been used to set rates, they may be informative in evaluating FSRs used in setting future rates. Specifically, the Commission's year-end reconciliations and AUPs identify errors and inconsistencies in the data that MCOs submit. For example, according to the Commission, its fiscal year 2018 AUP engagements (the most recent year for which AUPs have been completed as of August 2022) identified $78.2 million[4] in net proposed adjustments to MCO FSRs.

The Commission accurately implemented the fiscal year 2023 rates.

After the rates are certified, the Commission loads the rates into its Premiums Payable System (PPS). That system is then used to make monthly payments to each MCO. For fiscal year 2023, the Commission accurately and completely loaded the certified rates into PPS.

The Commission also accurately incorporated the fiscal year 2023 certified rates into its contracts with the MCOs. For fiscal year 2023, there were 1,139 rates (excluding rates for members dually enrolled in Medicaid and Medicare) and the Commission accurately incorporated all 25 rates tested.

Recommendation

The Commission should develop and implement a process to consistently communicate to its Actuarial Analysis Department the results of the agreed-upon procedures engagements and year-end reconciliations of MCO financial statistical reports.

[4] For fiscal year 2018, MCOs reported expenses totaling $23.2 billion and net income of $271 million in the FSRs they submitted to the Commission.

Management's Response

Statement of Agreement/Disagreement

HHSC agrees with this finding and recommendation.

Action Plan

HHSC will incorporate a formal process to consistently communicate to the Actuarial Analysis Department the results of the agreed-upon procedures (AUP) engagements and the year-end reconciliations of the MCO financial statistical reports. HHSC has set bi-annual meetings to discuss final AUP results and identified findings with the Actuarial Analysis Department. HHSC will develop a process to communicate the results of the year-end reconciliations to Actuarial Analysis Department.

Responsible Manager

Director of Financial Reporting and Audit Coordination, Medicaid & CHIP Services

Target Implementation Date

May 31, 2023

MEDIUM

Chapter 3
Communication with Oversight Entities

The Commission's communications with state oversight entities regarding the preliminary and final fiscal year 2023 Medicaid managed care rates complied with most requirements. The General Appropriations Act (87th Legislature) requires the Commission to submit preliminary and final reports on new Medicaid managed care rates and certain related information within specified timelines to the Legislative Budget Board, the Governor, and the State Auditor each fiscal year.

In addition, the Commission also sent its rate certifications to the federal Centers for Medicare and Medicaid Services (CMS) as required by the Code of Federal Regulations, Title 42. The SAO's contracted actuaries evaluated the Commission's rate certifications for compliance with CMS requirements and made observations and recommendations (see *Actuarial Analysis of the Health and Human Services Commission's Fiscal Year 2023 Medicaid Managed Care Rates* [SAO Report No. 22-042, August 2022]).

The Commission submitted preliminary and final rate reports to state oversight entities within required timeframes.

The Commission submitted preliminary and final rate reports to state oversight entities within the timeframes required by the General Appropriations Act. For example, the Commission submitted the final rates at least 45 days prior to their effective date.

In addition to the rate reports, the Commission is also required to submit separate schedules showing the amount by which anticipated expenditures may exceed appropriated funding. While the Commission did not submit the preliminary schedule, it did submit the final schedule within the required timeframe.

The Commission's rate reports addressed most required information; however, it could enhance communication by explicitly addressing certain General Appropriations Act requirements.

The Commission covered most of the information required by the General Appropriations Act in its preliminary and final rate communications to state oversight entities. For example, the Commission included the previous rates and the new proposed rates, the reasoning and basis for all trends used in the rate-setting process, and an estimate of the fiscal impact of the rate change.

The General Appropriations Act also requires the Commission to include a thorough explanation of its rounding methodologies used in rate-setting, as well as all analyses conducted by the Data Analysis Unit that were pertinent to the rate-setting process. However, the Commission did not explicitly address those requirements in its preliminary or final rate communications.

Recommendations

To enhance communication with state oversight entities in its preliminary and final rate reports, the Commission should:

- Include a thorough explanation of all rounding methodologies used in the rate-setting process.
- Explicitly address whether analyses pertinent to the rate-setting process were conducted by the Data Analysis Unit.

Management's Response

Statement of Agreement/Disagreement

HHSC agrees with this finding and recommendation.

Action Plan

HHSC will include a thorough explanation of all rounding methodologies used in the rate setting process and explicitly address if any analysis conducted by the Data Analysis Unit is pertinent to the rate setting process in future communication with state oversight entities.

Responsible Manager

Chief Actuary, HHSC Actuarial Analysis

Target Implementation Date

May 19, 2023, or earlier if mid-year rate adjustments are needed.

LOW

Chapter 4-A
Contract Planning, Procurement, and Formation

The Commission planned, procured, and formed its contract with Rudd and Wisdom, Inc. in accordance with applicable requirements (see text box for more information about the contract phases). That contract is for actuarial services (actuarial services contract) and is primarily related to establishing rates for Medicaid managed care services. According to the Commission's fiscal year 2023 rate reports, Rudd and Wisdom has provided actuarial services to the Texas Medicaid program for more than 35 years and has participated in the State's managed care rating process since the inception of that process in 1993.

Contract Planning, Procurement, and Formation

Planning – Defining the business need and establishing the procurement objectives.

Procurement – Identifying the appropriate procurement method and, if applicable, issuing a solicitation.

Formation – Ensuring that the awarded contract complies with applicable procurement law and contains provisions that achieve the procurement objectives.

Source: *State of Texas Procurement and Contract Management Guide*, version 1.1.

Planning and procurement of the audited contract took place in fiscal year 2019. The contract was effective in September 2019. As of August 2022, it was extended through August 2023. In addition, the Commission has the option to extend the contract through August 2024. The maximum total contract amount, including all optional renewals and extensions, is $7.5 million and, as of August 2022, the Commission had paid $3.8 million to the contractor.

The Commission performed required planning activities necessary for identifying the contract objective and procurement strategy.

The Commission complied with applicable planning requirements in the *State of Texas Procurement and Contract Management Guide,* agency policies, and other applicable statutory requirements for its actuarial services contract. Specifically, the Commission:

- Assessed its needs for actuarial services and estimated costs based on reasonable information.

- Selected the appropriate procurement method.
- Incorporated all applicable Contract Advisory Team recommendations into the solicitation.
- Ensured that purchasers and contract managers met training and certification requirements.

The Commission procured the actuarial services contract in accordance with applicable state and agency requirements.

The Commission included required elements in its solicitation, such as minimum qualifications, best value considerations, and requirements to disclose conflicts. The Commission also clearly defined its business needs in the scope of work by outlining the (1) services needed, (2) methods for monitoring contractor performance, and (3) criteria for determining satisfactory contract completion. In addition, the Commission reviewed its solicitation and advertised it as required.

The Commission included all contract terms required by the *State of Texas Procurement and Contract Management Guide*.

In addition to including all required contract terms and clauses, the Commission completed the appropriate reviews and approvals for the actuarial services contract and amendment prior to execution in accordance with Texas Government Code, Section 2261.254, and the Commission's *Contract Management Handbook*. Additionally, the Commission posted the contract on its website and reported it to the Legislative Budget Board, as required.

Chapter 4-B
Vendor Selection

While the Commission complied with requirements in selecting the contractor, it did not consistently obtain required certification and disclosure forms (see text box for more information about those forms) from contract staff prior to participating in contract activities.

Contract team members[5] did not consistently complete required certification and disclosure forms.

Nondisclosure and Conflict of Interest Certifications. The Commission did not obtain 3 (25 percent) of 12 required nondisclosure and conflict of interest certification forms from contract team members prior to receiving vendor proposals or participating in evaluation activities.

Specifically:

- Two team members did not complete the form.
- One team member completed the form 176 days after scoring the proposals.

The Commission used two different nondisclosure and conflicts of interest certification forms to ensure compliance with Texas Government Code, Section 2261.252, and the *State of Texas Procurement and Contract Management Guide*. Evaluation team members complete a new form for each procurement; other procurement staff complete a form within 30 days of hire and a new form annually.

Required Certifications and Disclosures

The Commission uses the following forms to comply with conflicts of interest disclosure requirements.

Nondisclosure and Conflict of Interest Certification Form: Applicable employees involved in procuring and managing contracts complete these forms in which they agree to (1) protect confidentiality of procurement-related information and (2) disclose any actual or potential conflict of interest.

Nepotism Disclosure Form: Used to disclose certain family relationships and financial interest by employees of a state agency who make decisions or provide recommendations regarding:

- The preparation of solicitations for a major contract or evaluation of bid proposals.
- The development of contract terms or conditions on major contracts.
- Who is to be awarded a major contract.

Sources: Texas Government Code, Sections 2261.252 and 2262.004, the *State of Texas Procurement and Contract Management Guide,* version 1.1, and the Commission.

[5] Contract team members include purchasers, evaluation team members, contract managers, and compliance and quality control staff.

Nepotism Disclosures. Additionally, the Commission did not obtain 5 (38 percent) of 13 required nepotism forms from contract team members prior to awarding the contract. Texas Government Code, Section 2262.004, requires employees who work on contracts valued at $1 million or greater to complete that form.

The Commission used a review checklist to verify completion of planning and procurement steps. While the Commission completed its review checklist, it did not identify the missing certification and disclosure forms. Not ensuring compliance with certification and disclosure requirements increases the risk that the Commission might not identify, and if necessary mitigate, potential conflicts of interest. Auditors performed additional procedures related to conflicts of interest and did not identify any potential conflicts of interest for the contract team members.

The Commission followed applicable requirements in selecting the vendor.

The Commission scored the proposals in a manner consistent with the criteria established in its solicitation and accurately tabulated the scores to select the winning bidder. It also reviewed vendor proposals for responsiveness and performed vendor compliance verifications as required by Texas Government Code, Section 2252.152, and the *State of Texas Procurement and Contract Management Guide*. In addition, the Commission verified the contractor completed the Texas Ethics Commission's form for disclosure of interested parties as required by Texas Government Code, Section 2252.908.

Recommendation

The Commission should verify that it obtained all contract team members' required certifications and disclosures when completing its solicitation review checklist.

Management's Response

Statement of Agreement/Disagreement

HHSC agrees with this finding and recommendation.

Action Plan

Effective September 1, 2019, the HHSC adopted Policy 403, Non-Disclosure, Conflict of Interest, and Nepotism Certification, establishing requirements for how HHSC's Procurement and Contracting Services (PCS) division ensures compliance with statutory requirements related to procurement and contracting-related non- disclosure, conflict of interest, and nepotism certification. HHSC completes all non- disclosure and nepotism forms using DocuSign which sends the form to the intended recipient and all completed forms are saved in a central location, thus mitigating the risk of lost certifications.

In addition to Policy 403, PCS has updated all solicitation procedures which requires these forms to be completed, specifically for Request for Proposal, Request for Qualifications, Request for Applications and Request for Offers, and Form PCS 160 - HHSC Solicitation Checklist - to ensure compliance with statutory requirements related to procurement and contracting-related non-disclosure, conflict of interest, and nepotism certification. One requirement of the PCS 160 is form PCS 131, SAO Nepotism Disclosure Purchasing Personnel Tracking Form, which identifies, and tracks received non-disclosure forms and the mandatory State Auditor's Disclosure Statement for Purchasing Personnel form to disclose nepotistic relationships with business entities, from individuals who assisted with solicitation development, evaluation, and contract award.

Responsible Manager

Associate Commissioner of Procurement

Target Implementation Date

Already implemented - January 1, 2020.

Reference PCS Policy 403 effective September 1, 2019, updates to various solicitation specific procedures to identify the requirements, and Form PCS 160 HHSC Solicitation Checklist to ensure compliance

with statutory requirements related to procurement and contracting-related non-disclosure, conflict of interest, and nepotism certification.

LOW

Chapter 4-C
Contract Oversight

The Commission effectively administered the management and oversight of its actuarial services contract (see text box for more information about this contract phase).

Contract Management and Oversight

The objective of contract management is to ensure that the contract is performed satisfactorily and the responsibilities of both parties—the agency and the contractor—are properly discharged.

Source: *State of Texas Procurement and Contract Management Guide,* version 1.1.

The Commission issued payments in compliance with applicable requirements.

The Commission made payments to its actuarial services contractor in accordance with applicable requirements and guidelines. As of February 2022, the Commission made 75 payments totaling $2.96 million for actuarial services. All 21 payments tested, totaling $1.92 million, were appropriately supported, reviewed, and approved.

The Commission monitored its actuarial services contractor for compliance with the terms of its contract.

The Commission adequately performed monitoring activities. Specifically, the Commission documented all deliverables and performance monitoring reports in its System of Contract Operation and Reporting (SCOR). In addition, the Commission's chief actuary reviewed all contract deliverables and monitored the contractor's progress throughout the rate-setting process.

Appendix 1

Objectives, Scope, and Methodology

Objectives

The objectives of this audit were to:

- Determine if the Health and Human Services Commission (Commission) complied with applicable requirements related to the procurement of managed care actuarial services.
- Evaluate the Commission's Medicaid managed care rate making process, including:
  - Identifying cost drivers in the rate-setting process; and
  - The process of communicating rates with oversight entities.

This audit was conducted in accordance with Rider 5, page X-7, of the General Appropriations Act (87th Legislature) and is the second of three reports that the State Auditor's Office will release to address Rider 5 requirements.

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

- Matthew M. Owens, MBA, CGAP, CIA, CFE, CISA (Project Manager)
- Jeffrey D. Criminger, CFE (Assistant Project Manager)
- Aaron Daigle, CPA
- Joe Kozak, CPA, CISA
- Matthew J. Montgomery, CFE
- Matthew Page
- Robert G. Kiker, CFE, CGAP (Quality Control Reviewer)
- Lauren Godfrey, CIA, CGAP (Audit Manager)

Scope

The scope of this audit covered the Commission's Medicaid managed care rate-setting process for the fiscal year 2023 rates. Additionally, the audit covered the Commission's contracting activities for its actuarial services contract with Rudd and Wisdom, Inc., through February 2022.

The scope also included a review of significant internal control components related to the Commission's (1) 2023 Medicaid managed care rate-setting development process, (2) communication with federal and state oversight entities regarding the rate-setting process, and (3) contracting activities for its actuarial services contract.

Methodology

We conducted this performance audit from September 2021 through September 2022 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. In addition, during the audit, matters not required to be reported in accordance with Government Auditing Standards were communicated to Commission management for consideration.

Addressing the Audit Objectives

To determine the key components of the fiscal year 2023 Medicaid managed care rates, the State Auditor's Office consulted with and reviewed data provided by a specialist, the actuarial firm Milliman, Inc. (Milliman). The State Auditor's Office relied on Milliman's work to summarize significant cost drivers. As required by *Government Auditing Standards* as issued by the U.S. Government Accountability Office, auditors determined that Milliman was qualified and competent to perform the contracted work by verifying that the actuaries were appropriately credentialed, independent to perform the work, and experienced specifically with Medicaid managed care.

We evaluated whether the Commission established effective business processes for setting the 2023 Medicaid managed care rates by performing the following:

- Verified the credentials of the Commission's actuaries and the contracted actuaries who performed significant work on the rates.
- Interviewed Commission management and staff to gain an understanding of its process for setting the rates, including identifying key tasks that must be completed to set the rates in accordance with applicable federal and state requirements.
- Tested a nonstatistical sample of key tasks to determine if the Commission completed those tasks in accordance with its documented procedures. The sample was selected using professional judgement and the sample design was chosen to ensure that the sample included the most significant tasks in the Commission's rate-setting process.
- Verified the Commission obtained approvals of the rates as required by its procedures.

We evaluated the Commission's processes for collecting and validating key data used in setting the rates by performing the following:

- Verified the Commission obtained an independent certification of the encounter data as required by the Code of Federal Regulations, Title 42, Section 438.350, and Texas Government Code, Section 533.0131.
- Verified that the Commission tracked the submission of financial statistical reports (FSRs) by managed care organizations (MCOs).
- Tested a nonstatistical sample of 26 of 250 FSRs to determine if the Commission performed reconciliations and followed up on issues identified. The sample was selected using professional judgement and the sample design was chosen to ensure that the sample would include a cross section of MCOs, programs, and service delivery areas.
- Determined whether the Commission was consistently communicating the results of its monitoring activities over MCO financial reporting to its actuaries.

In addition, we determined the following:

- Whether the Commission's communication of the rates with oversight entities complied with the General Appropriations Act (87th Legislature).
- Whether the Commission accurately implemented the fiscal year 2023 capitation rates by:
  - Verifying it accurately and completely loaded the certified rates into its Premiums Payable System (PPS).
  - Verifying it accurately incorporated the rates into its contracts with MCOs for a stratified random sample of rates. That sampling design was chosen to ensure that the sample included a cross section of MCOs.
- Whether the Commission's actuarial services contract complied with state contracting requirements, as applicable (see text box) by:
  - Interviewing Commission management and staff to gain an understanding of the contract and the Commission's contracting processes.
  - Reviewing the Commission's documentation related to contract planning, procurement, vendor selection, reporting, and monitoring.
  - Reviewing information to identify potential conflicts of interest among key Commission staff and contractors.
  - Testing a nonstatistical sample of contractor payments that were selected both randomly and based on payment amount. That sampling design was chosen to ensure significant coverage of the total payments.

State Contracting Requirements

Criteria used to determine the Commission's compliance with contracting requirement included the following:

- Texas Government Code, Chapters 572, 2155-2156, 2251, 2252, 2261, 2262, and 2270.
- Title 34, Texas Administrative Code, Chapter 20.
- The *Texas Procurement and Contract Management Guide*, version 1.1.
- The Commission's policies and procedures.

All of the samples discussed in this report were not necessarily representative of the populations and therefore it would not be appropriate to project the results, as reported, to the population.

Data Reliability and Completeness

Auditors determined that all data sets were sufficiently reliable for the purposes of the audit. Specifically, to determine the reliability:

- Of actuarial services contract payments from the Centralized Accounting and Payroll/Personnel System (CAPPS), auditors reviewed the query parameters used to extract the payment data and reconciled it to data from the Uniform Statewide Accounting System (USAS). Auditors relied on prior State Auditor's Office work to determine that the vendor payment data from USAS was reliable.
- Of the PPS data, auditors observed the incorporation of the final published rates as provided by the Commission's actuary into PPS and verified the Commission's completion of its validation procedures, including control total checks.
- Of the Commission's FSR tracking spreadsheets, auditors verified each plan code from PPS was included to ensure completeness. In addition, to assess the reliability of its FSR reconciliation spreadsheets auditors verified the Commission's completion of each sampled reconciliation.

Report Ratings

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.

Appendix 2

Related State Auditor's Office Reports

Report Number	Report Name	Release Date
22-042	*Actuarial Analysis of the Health and Human Services Commission's Fiscal Year 2023 Medicaid Managed Care Rates*	August 2022
22-036	*An Audit Report on Cook Children's Health Plan, a Managed Care Organization*	July 2022
22-021	*An Audit Report on the Health and Human Services Commission's Oversight of the Medical Transportation Program*	March 2022
21-025	*An Audit Report on Blue Cross Blue Shield of Texas, a Managed Care Organization*	June 2021
21-021	*A Report on Health and Human Services Commission Contracts*	May 2021
21-007	*An Audit Report on Selected Contracting Functions at the Health and Human Services Commission*	January 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
19-028	*An Audit Report on the Health and Human Services Commission's System of Contract Operation and Reporting*	February 2019
19-025	*An Audit Report on Medicaid Managed Care Contract Processes at the Health and Human Services Commission*	January 2019
19-011	*An Audit Report on Amerigroup Texas, Inc. and Amerigroup Insurance Company, a Managed Care Organization*	November 2018

Report Number	Report Name	Release Date
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

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

House Appropriations Committee

Members of the House Appropriations Committee

Senate Finance Committee

Members of the Senate Finance Committee

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