



An Audit Report on

**Medicaid Managed Care  
Contract Processes at the Health and  
Human Services Commission**

January 2019  
Report No. 19-025



*An Audit Report on*

# ***Medicaid Managed Care Contract Processes at the Health and Human Services Commission***

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## ***Overall Conclusion***

The Health and Human Services Commission (Commission) established new processes and controls related to Medicaid managed care contract management processes and made progress toward implementing the requirements of Senate Bill 894 (85th Legislature, Regular Session) (S.B. 894). For example, the Commission implemented a strategy for managing audit resources and a process to follow up on negative performance audit findings. In addition, it completed a risk assessment for determining which Medicaid managed care organizations (MCOs) to audit, and it billed MCOs for audit-related costs.

However, the Commission should continue to implement its planned improvements related to:

- Conducting planned performance audits, including audits of pharmacy benefit managers.
- Issuing corrective action plans based on agreed-upon procedure (AUP) engagements.
- Monitoring MCOs based on External Quality Review Organization information.

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.)

### **Senate Bill 894**

Senate Bill 894 (85th Legislature, Regular Session) (S.B. 894) addressed existing deficiencies of the Health and Human Services Commission's (Commission) audit coverage of Medicaid managed care organizations (MCOs). The bill established a number of requirements for the Commission related to oversight of MCOs as recommended in *An Audit Report on Medicaid Managed Care Contract Processes at the Health and Human Services Commission* (State Auditor's Office's Report No. 17-007, October 2016). See Appendix 3 for an excerpt of S.B. 894.

### **Background Information**

In federal fiscal year 2017, the Commission spent \$38 billion on the Medicaid program, including managed care.

In state fiscal year 2017, there was an average of 4 million Medicaid clients monthly, and 92 percent of Medicaid clients received services through MCOs. MCOs are paid a fixed amount per member enrolled, per month.

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

Table 1

| Summary of Chapters/Subchapters and Related Issue Ratings   |  |                           |
|---|--|---------------------------|
| Chapter/<br>Subchapter  | Title  | Issue Rating <sup>a</sup> |
| 1-A   | The Commission Implemented a Strategy for Managing Audit Resources and Followed Up On Negative Performance Audit Findings                                    | Low                       |
| 1-B   | The Commission Strengthened Its Processes for Performance Audits and Agreed-upon Procedure Engagements, But It Had Not Yet Fully Implemented Those Processes | Medium                    |
| 2-A   | The Commission Implemented a Process to Seek Reimbursement from MCOs for Audit-related Costs   | Low                       |
| 2-B   | The Commission Implemented a Process to Timely Transfer Experience Rebates, But It Should Resolve Its Experience Rebate Disputes                             | Medium                    |
| 3   | The Commission Developed a Plan to Monitor MCOs Using External Quality Review Organization Information, But It Had Not Yet Implemented That Plan             | Medium                    |
| 4   | The Commission Strengthened Controls Over Its Information Technology Systems and Change Management Process   | Medium                    |
| <p><sup>a</sup> A subchapter is rated <b>Priority</b> 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.</p> <p>A subchapter is rated <b>High</b> 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.</p> <p>A subchapter is rated <b>Medium</b> if the issues identified present risks or effects that if not addressed could moderately affect the audited entity's ability to effectively administer program(s)/function(s) audited. Action is needed to address the noted concern and reduce risks to a more desirable level.</p> <p>A subchapter is rated <b>Low</b> 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.</p> |  |                           |

## ***Summary of Management's Response***

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

## ***Audit Objective and Scope***

The objective of this audit was to determine whether the Commission has implemented selected statutory requirements related to Medicaid managed care contract management processes contained in S.B. 894.

The scope of this audit covered the Commission's implementation of selected S.B. 894 requirements as of December 6, 2018.

# Contents

## ***Detailed Results***

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### Chapter 1

|   |   |
|---|---|
| The Commission Has Improved Its Use of Audit Activities to Monitor MCOs ..... | 1 |
|---|---|

### Chapter 2

|   |   |
|---|---|
| The Commission Improved Its Process for Collecting Reimbursements of Costs Related to Its Contracted Audit Services and Collecting Experience Rebates ..... | 6 |
|---|---|

### Chapter 3

|   |   |
|---|---|
| The Commission Developed a Plan to Monitor MCOs Using External Quality Review Organization Information, But It Had Not Yet Implemented That Plan..... | 9 |
|---|---|

### Chapter 4

|   |    |
|---|----|
| The Commission Strengthened Controls Over Its Information Technology Systems and Change Management Process..... | 12 |
|---|----|

## ***Appendices***

---

### Appendix 1

|   |    |
|---|----|
| Objective, Scope, and Methodology ..... | 14 |
|---|----|

### Appendix 2

|  |    |
|--|----|
| Issue Rating Classifications and Descriptions..... | 17 |
|--|----|

### Appendix 3

|   |    |
|---|----|
| Excerpt from Senate Bill 894 (85th Legislature) ..... | 18 |
|---|----|

### Appendix 4

|   |    |
|---|----|
| Related State Auditor's Office Work ..... | 22 |
|---|----|

# Detailed Results

## Chapter 1

### ***The Commission Has Improved Its Use of Audit Activities to Monitor MCOs***

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The Health and Human Services Commission (Commission) implemented a strategy for managing audit resources and following up on negative performance audit findings as required by Senate Bill 894 (85th Legislature, Regular Session) (S.B. 894).

In addition, the Commission strengthened its performance audit and agreed-upon procedure processes, but it had not fully implemented those processes. For example, the Commission completed a risk assessment for selecting managed care organizations (MCOs) to audit and developed an audit plan. However, it had not started any audits in its plan, including audits of MCOs' pharmacy benefit managers.

#### Chapter 1-A

### **The Commission Implemented a Strategy for Managing Audit Resources and Followed Up On Negative Performance Audit Findings**

**Chapter 1-A  
Rating:**  
Low<sup>1</sup>

**Audit Coordination.** The Commission relies on audit activities to verify the accuracy and reliability of program and financial information reported by MCOs, and it developed and implemented an overall strategy for planning, managing, and coordinating audit resources as required by S.B. 894. Specifically, the Commission established an audit circular that defined the roles and responsibilities of the Medicaid and CHIP Services Department<sup>2</sup>, the Commission's Office of Inspector General, and the Internal Audit Division, all of whom may perform audits of MCOs. All three groups are responsible for coordinating their MCO audit efforts, including assessing risk and developing audit plans and audit scopes, in order to minimize duplicative audit efforts. In addition, the groups met periodically to discuss topics such as audit planning and results.

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<sup>1</sup> The risk related to the issues discussed in Chapter 1-A 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.

<sup>2</sup> The Commission's Medicaid and CHIP (Children's Health Insurance Program) Services Department conducts financial and operational oversight and monitoring activities of all MCOs.

**Performance Audit Corrective Action.** The Commission also established a corrective action plan process (see text box) to (1) document how it follows up on negative performance audit findings and (2) verify that MCOs implement performance audit recommendations. Specifically, the Commission:

**Corrective Action Plan**

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

Source: The Commission.

- Developed written policies specifying when a corrective action plan should be issued based on the results of a performance audit. The Commission's policy established that corrective action plans would be issued for all performance audit findings that identify contractual noncompliance.
- Issued corrective action plans in accordance with those policies.
- Followed up on the implementation of corrective actions with MCOs.
- Offered training to MCOs on common performance audit findings and strategies for implementing corrective action.

## The Commission Strengthened Its Processes for Performance Audits and Agreed-Upon Procedure Engagements, But It Had Not Yet Fully Implemented Those Processes

**Chapter 1-B  
Rating:**  
Medium<sup>3</sup>

**Performance Audit Risk Assessment and Audits of Pharmacy Benefit Managers.** Between November 2017 and January 2018, the Commission's contracted audit firms completed a performance audit of each of the 21 MCO's 2016 reporting activities (see text box for more information about performance audits).

As of February 2018, the Commission had completed a risk assessment to determine which MCOs it would select for upcoming performance audits, as required by S.B. 894. That assessment included consideration of previous audit coverage as required and additional risk factors such as complaints and experience. In addition, when the Commission used professional judgment to increase a MCO's risk rating, it documented its rationale.

Using its risk assessment, the Commission developed an audit plan that prioritized auditing the highest risk MCOs and included conducting performance audits of MCOs' pharmacy benefit managers (see text box for more information about pharmacy benefit managers). However, as of November 2018, the Commission had not started the performance audits in that most recent audit plan, including audits of pharmacy benefit managers. In addition, because it had not completed any audits of pharmacy benefit managers, the Commission had not issued any corrective action plans for pharmacy benefit managers.

Separate from the Commission's performance audit process, the Commission's Office of Inspector General (Office) also conducts audits of MCOs. As of November 2018, the Office was conducting a performance audit of a MCO's delivery of pharmacy benefit services through a pharmacy benefit manager.

### Performance Audits

Performance audits provide findings or conclusions based on an evaluation of sufficient, appropriate evidence against criteria.

The Commission contracts with audit firms to conduct performance audits of MCOs. The Commission determines the audit objectives, which vary by MCO based on risk.

The audits completed between November 2017 and January 2018 focused on the accuracy of data that MCOs self-report to the Commission.

Sources: The Commission and generally accepted government auditing standards.

### 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.

Sources: *Texas Medicaid and CHIP in Perspective*, 11th Edition, February 2017, and the Uniform Managed Care Contract.

<sup>3</sup> The risk related to the issues discussed in Chapter 1-B is rated as Medium because they present risks or effects that if not addressed could moderately affect the audited entity's ability to effectively administer the program(s)/function(s) audited. Action is needed to address the noted concern and reduce risks to a more desirable level.

**Agreed-Upon Procedure (AUP) Engagements.** In fiscal year 2017, the Commission contracted with two audit firms to perform AUP engagements (see text box) of all 21 MCOs' fiscal year 2015 financial statistical reports. Those engagements were completed between April 2017 and July 2018. The Commission ensured that its contracted audit firms performed those AUP engagements consistently. Specifically, the procedures were consistent for each engagement, or the Commission approved deviations from agreed-upon procedures.

However, as of November 2018, the Commission had not issued any corrective action plans based on its AUP engagements. During the course of this audit, the Commission developed policies and procedures specifying when a corrective action plan should be issued based on the results of an AUP engagement.

#### **Agreed-upon Procedure (AUP) Engagements**

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

Financial statistical reports are used to calculate whether MCOs owe the Commission money under the State's Medicaid rebate requirements. 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 Commission and the American Institute of Certified Public Accountants.

### **Recommendations**

The Commission should:

- Implement its performance audit plan, including periodically conducting audits of pharmacy benefit managers.
- Implement its policies for issuing corrective action plans based on AUP engagements.
- Ensure that it verifies the implementation of AUP corrective action plans.

### **Management's Response**

*The Health and Human Services Commission (HHSC) agrees with the finding and offers the following response to the recommendations.*

*HHS is currently implementing its performance audit plan, including audits of pharmacy benefit managers. HHSC annually completes a risk assessment based on the requirements of SB 894 to determine which Managed Care Organizations (MCOs) to select for targeted performance audits and develops the audit scope based on the risk assessment results. Audit scope includes pharmacy benefit management oversight unless the HHSC Office of Inspector General or another state or federal auditing entity is auditing the same*



*functions. HHSC will procure auditors and work with the auditors as they complete the audits.*

*Once the audits are complete, HHSC issues corrective action plans to MCOs with audit findings and performs training when appropriate. HHSC monitors the corrective action plans until MCOs provide appropriate reassurance and documentation that corrective actions are complete. HHSC has successfully implemented corrective action plans for previous audits and trained MCOs on HHSC performance expectations. This is an annual process, and completion of the initial round of performance audits based on the requirements of SB 894 is expected in December 2019.*

*HHSC is implementing a process effective with the current AUP engagement in which MCOs will be subject to available contract remedies for:*

- *Lack of responsiveness and cooperation during the AUP cycle;*
- *Lack of compliance with the financial requirements of the contract as demonstrated by the nature and severity of the AUP findings.*

*HHSC is also reviewing the last AUP engagement (SFY 2015) and will issue the appropriate contract remedies associated with the nature and severity of the AUP findings.*

*HHSC has developed an integrated and comprehensive contract compliance and oversight process that includes active monitoring and follow up activities. Corrective Action Plans resulting from AUP compliance issues are part of this oversight process.*

**Implementation Date(s):**

*December 31, 2019, for completion of the initial round of performance audits*

**Responsible Individual/Individuals:**

*Director, Managed Care Compliance and Operations*

*Director of Financial Reporting and Audit Coordination*

## ***The Commission Improved Its Process for Collecting Reimbursements of Costs Related to Its Contracted Audit Services and Collecting Experience Rebates***

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The Commission established a billing process for MCOs to reimburse the Commission for audit-related services and a process to identify experience rebates<sup>4</sup> deposited in its suspense account as required by S.B. 894. In addition, the Commission timely transferred experience rebates out of suspense when appropriate. However, it had not resolved two experience rebates disputed by MCOs.

### Chapter 2-A

#### **The Commission Implemented a Process to Seek Reimbursement from MCOs for Audit-related Costs**

**Chapter 2-A  
Rating:  
Low<sup>5</sup>**

The Commission developed, documented, and implemented a billing process for MCOs to reimburse the Commission for audit-related services as required by S.B. 894. The Commission's contracts with the MCOs also specify that each MCO will reimburse the Commission for reasonable costs incurred by the Commission to perform examinations, investigations, audits, or other types of attestations that the Commission determines are necessary to ensure MCO compliance with its contracts.

Since July 2015<sup>6</sup>, the Commission contracted for 63 performance audits and AUP engagements, and it paid its contractors \$6,411,977 for that work. Specifically, the Commission:

- Received \$4,659,638 (73 percent) in reimbursement from MCOs for 42 of the 63 engagements.
- Requested reimbursement from MCOs for the remaining 21 engagements with costs totaling \$1,752,339 (27 percent) in December 2018. Those engagements were completed between April 2017 and July 2018.

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<sup>4</sup> "Experience rebates" are a portion of a MCO's net income before taxes that is returned to the State in accordance with statute and the Uniform Managed Care Contract terms.

<sup>5</sup> The risk related to the issues discussed in Chapter 2-A 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.

<sup>6</sup> The Commission contracted for those audit services between July 2015 and July 2017, and as of November 2018, it had not contracted for any additional audit services at MCOs.

## The Commission Implemented a Process to Timely Transfer Experience Rebates, But It Should Resolve Its Experience Rebate Disputes

**Chapter 2-B  
Rating:**  
Medium <sup>7</sup>

**Transfer of Experience Rebates.** The Commission developed, documented, and implemented a process to identify experience rebates deposited in its suspense account, and it timely transferred those rebates when appropriate, as required by S.B. 894. For example, the Commission created an agency fund to strengthen its tracking of experience rebates.

### Suspense Fund

A suspense fund is a clearing account established to separately account for certain receipts pending their distribution.

Source: The Office of the Comptroller of Public Accounts.

As of September 2018, the Commission appropriately held \$206,971,397 of experience rebates in suspense. Specifically:

- \$185,511,963 (89.6 percent) was related to the Medicare-Medicaid Plan. The Commission must share those rebates with the federal government and holds those funds in suspense until it finalizes a settlement agreement with the Centers for Medicare and Medicaid Services.
- \$5,284,256 (2.6 percent) was related to (1) overpayments made by one MCO and (2) the finalization of a financial statistical report for a MCO that was no longer participating in the Medicaid program.

The remaining \$16,175,178 (7.8 percent) had been in suspense for fewer than 45 days. The Commission holds experience rebates in suspense upon receipt until it validates MCOs' experience rebate calculations.

**Experience Rebate Disputes.** The Commission had not established a process for resolving disputes over experience rebates claimed by MCOs. As a result, as of November 2018, the Commission had only resolved one of three open experience rebate disputes. The two other disputes remained outstanding. Those two disputes related to \$3,226,667 in uncollected experience rebates from fiscal years 2011 and 2013.

### Recommendation

The Commission should develop, document, and implement a process to timely follow up on and resolve disputes over experience rebates claimed by MCOs.

<sup>7</sup> The risk related to the issues discussed in Chapter 2-B is rated as Medium because they present risks or effects that if not addressed could moderately affect the audited entity's ability to effectively administer the program(s)/function(s) audited. Action is needed to address the noted concern and reduce risks to a more desirable level.

## **Management's Response**

*HHSC agrees with the finding and offers the following response to the recommendations.*

*MCOs are required to pay all Experience Rebates in accordance with the UMCC. HHSC disallows any deductions from Experience Rebates. MCOs that are non-compliant are subject to contractual remedies and potential offsets from monthly capitation payments equal to the disallowed amount.*

*Audit findings have the potential to affect the amount of Experience Rebate that may be due from an MCO. The current audit process allows MCOs to provide a management response within the audit report. In that response the MCOs can express their disagreement with specific findings. If those findings are material, HHSC allows an appeal process. The HHSC process for assessing and handling MCO-disputed audit findings was put into effect on January 1, 2019 and is currently initiated with two MCO appeals to help identify any necessary process refinements. The refined process will be documented for FRAC staff by March 1, 2019 to ensure consistent and timely handling of future MCO appeals.*

### **Implementation Date(s):**

*The new appeal process was implemented on January 1, 2019 and is currently in effect regarding two open issues. The appeal process was documented as an internal procedure in FRAC on January 17, 2019.*

### **Responsible Individual/Individuals:**

*Director of Financial Reporting and Audit Coordination*

## ***The Commission Developed a Plan to Monitor MCOs Using External Quality Review Organization Information, But It Had Not Yet Implemented That Plan***

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**Chapter 3  
Rating:**  
Medium <sup>8</sup>

The Commission developed a plan to enhance its monitoring of MCOs using external quality review organization (EQRO) information (see text box) as required by S.B. 894. That information includes:

- Medicaid survey results<sup>9</sup>.
- The results of matching paid claims data to medical records (“encounter data validation”).

**Survey Results.** The Commission established minimum performance standards for MCOs based on its EQRO’s Medicaid survey results for three Medicaid programs. For example, the Commission established as a standard that a minimum of 65 percent of STAR program members rate their personal doctor a “9” or “10”. However, as of October 2018, the Commission had not yet set standards for an additional program, the STAR Kids program.

According to the Commission’s Uniform Managed Care Manual, it will begin holding MCOs accountable for meeting minimum performance standards related to Medicaid survey results (1) reported in 2019 for three Medicaid programs and (2) reported in 2020 for its STAR Kids program. MCOs that do not meet at least two-thirds of the minimum performance standards will be placed on a corrective action plan. In addition, prior to implementing its minimum performance standards, the Commission held a forum with MCOs to communicate the changes.

**Encounter Data Validation.** As of October 2018, the Commission had not established minimum performance standards for MCOs based on the EQRO’s encounter data validation. According to the Commission, it will begin holding MCOs accountable for meeting minimum performance standards related to encounter data validation results based on when it will receive the results. Specifically, it plans to begin enforcing its minimum performance standards

### **External Quality Review Organization (EQRO)**

Federal regulations require an external quality review of Medicaid managed care programs to ensure state programs and their contracted MCOs are compliant with established standards.

The EQRO follows the Centers for Medicare and Medicaid Services’ protocols to assess access, utilization, and quality of care for members in Texas’ Medicaid programs. The EQRO produces reports to support the Commission’s efforts to ensure managed care clients have access to timely and quality care in each of the managed care programs. The results allow comparisons of findings across MCOs in each program and are used to develop overarching goals and quality improvement activities for Medicaid managed care programs.

Source: *Texas Medicaid and CHIP in Perspective*, 11th Edition, February 2017.

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<sup>8</sup> The risk related to the issues discussed in Chapter 3 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 the program(s)/function(s) audited. Action is needed to address the noted concern and reduce risks to a more desirable level.

<sup>9</sup> Medicaid survey results include detailed data from results of surveys of Medicaid recipients and, if applicable, child health plan program enrollees, caregivers of those recipients and enrollees, and program providers.

for (1) Dental Maintenance Organization results reported in 2020 and (2) MCO results reported in 2021.

## Recommendations

The Commission should:

- Implement its plan to use the information provided by the EQRO to enhance its monitoring of MCOs.
- Develop and implement minimum performance standards for the results of Medicaid surveys for the STAR Kids program.
- Develop and implement minimum performance standards for the EQRO's encounter data validation results.

## Management's Response

*HHSC agrees with the finding and offers the following response to the recommendation.*

*HHSC set performance indicator dashboard standards, including member surveys, for STAR, STAR+PLUS, STAR Health and CHIP for calendar year 2018 in November 2017. MCOs are allowed six months after the end of the measurement year to correct any errors in their data; calendar year 2018 data will be finalized in summer 2019 and exported to the EQRO for processing. Due to the timeline required for data collection, finalization and review, the earliest the calendar year 2018 performance can be assessed and appropriate actions taken is in fall 2019.*

*HHSC staff set performance indicator dashboard standards, including member surveys, for STAR Kids on January 2, 2019. These standards apply to all STAR Kids MCOs for calendar year 2019. Due to the data collection and review timelines, member survey performance by STAR Kids MCOs in calendar year 2019 will be assessed and appropriate actions will be taken in fall 2020.*

*HHSC will begin holding MCOs accountable to the electronic data validation (EDV) standards as the data becomes available. The EQRO performs dental and medical record reviews on an alternating biennial basis; dental records are reviewed for even calendar years and medical records are reviewed for odd calendar years. The EDV record review is also subject to the data collection and assessment timelines in addition to the two year review cycle. Dental maintenance organizations (DMOs) will be required to meet minimum performance standards for EDV beginning with calendar year 2018 data.*

*MCOs will be required to meet minimum performance standards for EDV beginning with calendar year 2019 data.*

**Implementation Date(s):**

- *Communicate performance indicator dashboard standards, including member surveys, to STAR Kids MCOs by January 17, 2019.*
- *Implement plan to use the information provided by the EQRO to enhance HHSC monitoring of MCOs.*
  - ♦ *MCOs will receive corrective action plans (CAPs) for STAR, STAR+PLUS, STAR Health and CHIP 2018 performance indicator dashboard results in fall 2019.*
- *Develop and implement minimum performance standards for the results of Medicaid surveys for the STAR Kids program.*
  - ♦ *Minimum standards were posted to the Texas Healthcare Learning Collaborative Portal on January 16, 2019. Standards for 2020 will be posted in December 2019.*
  - ♦ *MCOs will receive CAPs for STAR Kids 2019 performance indicator dashboard results in fall 2020.*
- *Develop and implement minimum performance standards for the EQRO's EDV results.*
  - ♦ *DMOs will be required to meet minimum EDV standards for their 2018 data as part of their operational reviews beginning in 2020.*
  - ♦ *MCOs will be required to meet minimum EDV standards for their 2019 data as part of their operational reviews beginning in 2021.*

**Responsible Individual/Individuals:**

*Quality Assurance Manager*

## ***The Commission Strengthened Controls Over Its Information Technology Systems and Change Management Process***

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**Chapter 4  
Rating:**  
Medium<sup>10</sup>

The Commission strengthened user access controls over its Accounts Receivable Tracking System (ARTS) as required by S.B. 894 and implemented a semiannual user access review. In addition, access to the network folder that the Commission uses to manage the collection of experience rebates was properly restricted. Properly restricting access to ARTS and network folders helps the Commission protect its data from unauthorized changes.

The Commission documented its daily reconciliations of deposits recorded in ARTS to transactions processed in the Commission's accounting system and the Uniform Statewide Accounting System as required by S.B. 894. Performing reconciliations helps the Commission ensure that deposits are correctly recorded in its financial systems.

The Commission also developed, documented, and implemented a process to track programming changes to ARTS as required by S.B. 894. However, it should ensure it consistently documents that those changes were properly authorized and tested. Specifically, for 2 (33 percent) of 6 completed changes tested, the Commission did not document that the changes were properly authorized or tested. Not following its change management process increases the risk of unauthorized changes that could adversely affect the Commission's operations.

### **Recommendation**

The Commission should consistently follow its process to document the authorization and testing of programming changes to ARTS.

### **Management's Response**

*HHSC agrees with the finding and offers the following response to the recommendations.*

*The Administrative Applications team is in the process of strengthening the change management process that applies to the Accounts Receivable Tracking System (ARTS). The improved process includes the documentation*

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<sup>10</sup> The risk related to the issues discussed in Chapter 4 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 the program(s)/function(s) audited. Action is needed to address the noted concern and reduce risks to a more desirable level.



*of system change authorization approvals and the approval of test results.  
The updated process will be implemented prior to August 31st 2019.*

**Implementation Date(s):**

*August 31, 2019*

**Responsible Individual/Individuals:**

*Manager, HHSC IT - Administrative Applications*

# Appendices

## Appendix 1

### **Objective, Scope, and Methodology**

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#### **Objective**

The objective of this audit was to determine whether the Health and Human Services Commission (Commission) has implemented selected statutory requirements related to Medicaid managed care contract management processes contained in Senate Bill 894 (85th Legislature, Regular Session) (S.B. 894).

#### **Scope**

The scope of this audit covered the Commission's implementation of selected S.B. 894 requirements as of December 6, 2018.

#### **Methodology**

The audit methodology included conducting interviews with Commission staff; reviewing S.B. 894 and Commission policies and procedures; collecting, reviewing, and analyzing the Commission's implementation documentation; and performing selected tests and other procedures.

#### **Data Reliability and Completeness**

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

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

#### **Sampling Methodology**

To test daily deposit reconciliations and corrective action plans, auditors selected nonstatistical samples primarily through random selection. The sample items were not necessarily representative of the population; therefore, it would not be appropriate to project the test results to the population.

Auditors selected a risk-based sample to test user access reviews and programming changes for ARTS. The sample items were generally not

representative of the population; therefore, it would not be appropriate to project those test results to the population.

Information collected and reviewed included the following:

- Commission policies and procedures.
- *Coordination of Managed Care Organization Audit Circular C-054*, March 2017, and other supporting documentation.
- Commission performance audit risk assessment and related documentation.
- Commission corrective action plans and related documentation.
- Performance audit and agreed-upon procedures (AUP) reports.
- Commission revenue and vendor payment information from the Uniform Statewide Accounting System and supporting documentation.
- Commission receivable documentation, including receivable data from ARTS.
- Experience rebate dispute documentation.
- The Commission's *Uniform Managed Care Manual*.
- ARTS user access reviews and access listings for the network folders the Commission uses to manage the collection of experience rebates.
- Daily deposit reconciliation documentation.
- ARTS change management documentation.

Procedures and tests conducted included the following:

- Interviewed Commission staff.
- Reviewed Commission policies and procedures.
- Reviewed Commission performance audit risk assessment and related documentation.
- Tested Commission corrective action plans issued based on performance audit findings.
- Reviewed AUPs for consistency.

- Verified billing and receipt of funds for performance audits and AUP engagements.
- Reviewed experience rebate suspense account activity.
- Reviewed experience rebate dispute documentation.
- Reviewed user access reviews and tested access for the network folders the Commission uses to manage the collection of experience rebates.
- Tested the Commission's daily deposit reconciliations.
- Tested programming changes to ARTS.

Criteria used included the following:

- Texas Government Code, Chapter 533 (as amended by S.B. 894).

### **Project Information**

Audit fieldwork was conducted from September 2018 through December 2018. 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 objective.

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

- Lauren Godfrey, CIA, CGAP (Project Manager)
- Scott Labbe, CPA (Assistant Project Manager)
- Valerie W. Bogan, CFE
- Ashlie Garcia, MS
- Oliver R. Guerra
- Kristyn Scoggins, CGAP
- Sherry Sewell, CGAP
- Ann E. Karnes, CPA (Quality Control Reviewer)
- Audrey O'Neill, CIA, CFE, CGAP (Audit Manager)

## Issue Rating Classifications and Descriptions

Auditors used professional judgement 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 <u>or</u> 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 <u>moderately affect</u> the audited entity's ability to effectively administer program(s)/function(s) audited. Action is needed to address the noted concern(s) and reduce risks to a more desirable level.   |
| High                     | Issues identified present risks or effects that if not addressed could <u>substantially affect</u> 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 <u>critically affect</u> 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.                               |

## ***Excerpt from Senate Bill 894 (85th Legislature)***

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Below is an excerpt from Senate Bill 894 (85th Legislature, Regular Session) (S.B. 894) with the requirements that were audited. S.B. 894 amended Texas Government Code, Chapter 533, by adding Subchapter B as follows:

### **SUBCHAPTER B. STRATEGY FOR MANAGING AUDIT RESOURCES**

**Sec. 533.051. DEFINITIONS.** In this subchapter:

- (1) “Accounts receivable tracking system” means the system the commission uses to track experience rebates and other payments collected from managed care organizations.
- (2) “Agreed-upon procedures engagement” means an evaluation of a managed care organization’s financial statistical reports or other data conducted by an independent auditing firm engaged by the commission as agreed in the managed care organization’s contract with the commission.
- (3) “Experience rebate” means the amount a managed care organization is required to pay the state according to the graduated rebate method described in the managed care organization’s contract with the commission.
- (4) “External quality review organization” means an organization that performs an external quality review of a managed care organization in accordance with 42 [Code of Federal Regulations] Section 438.350.

**Sec. 533.052. APPLICABILITY AND CONSTRUCTION OF SUBCHAPTER.** This subchapter does not apply to and may not be construed as affecting the conduct of audits by the commission’s office of inspector general under the authority provided by Subchapter C, Chapter 531, including an audit of a managed care organization conducted by the office after coordinating the office’s audit and oversight activities with the commission as required by Section 531.102(q), as added by Chapter 837 (S.B. 200), Acts of the 84th Legislature, Regular Session, 2015.

**Sec. 533.053. OVERALL STRATEGY FOR MANAGING AUDIT RESOURCES.** The commission shall develop and implement an overall strategy for planning, managing, and coordinating audit resources that the commission uses to verify the accuracy and reliability of program and financial information reported by managed care organizations.

**Sec. 533.054. PERFORMANCE AUDIT SELECTION PROCESS AND FOLLOW-UP.**

(a) To improve the commission's processes for performance audits of managed care organizations, the commission shall:

- (1) document the process by which the commission selects managed care organizations to audit;
- (2) include previous audit coverage as a risk factor in selecting managed care organizations to audit; and
- (3) prioritize the highest risk managed care organizations to audit.

(b) To verify that managed care organizations correct negative performance audit findings, the commission shall:

- (1) establish a process to:
  - (A) document how the commission follows up on negative performance audit findings; and
  - (B) verify that managed care organizations implement performance audit recommendations; and
- (2) establish and implement policies and procedures to:
  - (A) determine under what circumstances the commission must issue a corrective action plan to a managed care organization based on a performance audit; and
  - (B) follow up on the managed care organization's implementation of the corrective action plan.

**Sec. 533.055. AGREED-UPON PROCEDURES ENGAGEMENTS AND CORRECTIVE ACTION PLANS.** To enhance the commission's use of agreed-upon procedures engagements to identify managed care organizations' performance and compliance issues, the commission shall:

- (1) ensure that financial risks identified in agreed-upon procedures engagements are adequately and consistently addressed; and
- (2) establish policies and procedures to determine under what circumstances the commission must issue a corrective action plan based on an agreed-upon procedures engagement.

**Sec. 533.056. AUDITS OF PHARMACY BENEFIT MANAGERS.** To obtain greater assurance about the effectiveness of pharmacy benefit managers' internal controls and compliance with state requirements, the commission shall:

(1) periodically audit each pharmacy benefit manager that contracts with a managed care organization; and

(2) develop, document, and implement a monitoring process to ensure that managed care organizations correct and resolve negative findings reported in performance audits or agreed-upon procedures engagements of pharmacy benefit managers.

**Sec. 533.057. COLLECTION OF COSTS FOR AUDIT-RELATED SERVICES.** The commission shall develop, document, and implement billing processes in the Medicaid and CHIP services department of the commission to ensure that managed care organizations reimburse the commission for audit-related services as required by contract.

**Sec. 533.058. COLLECTION ACTIVITIES RELATED TO PROFIT SHARING.** To strengthen the commission's process for collecting shared profits from managed care organizations, the commission shall develop, document, and implement monitoring processes in the Medicaid and CHIP services department of the commission to ensure that the commission:

(1) identifies experience rebates deposited in the commission's suspense account and timely transfers those rebates to the appropriate accounts; and

(2) timely follows up on and resolves disputes over experience rebates claimed by managed care organizations.

**Sec. 533.059. USE OF INFORMATION FROM EXTERNAL QUALITY REVIEWS.**

(a) To enhance the commission's monitoring of managed care organizations, the commission shall use the information provided by the external quality review organization, including:

(1) detailed data from results of surveys of Medicaid recipients and, if applicable, child health plan program enrollees, caregivers of those recipients and enrollees, and Medicaid and, as applicable, child health plan program providers; and

(2) the validation results of matching paid claims data with medical records.



(b) The commission shall document how the commission uses the information described by Subsection (a) to monitor managed care organizations.

**Sec. 533.060. SECURITY AND PROCESSING CONTROLS OVER INFORMATION TECHNOLOGY SYSTEMS.** The commission shall:

(1) strengthen user access controls for the commission's accounts receivable tracking system and network folders that the commission uses to manage the collection of experience rebates;

(2) document daily reconciliations of deposits recorded in the accounts receivable tracking system to the transactions processed in:

(A) the commission's cost accounting system for all health and human services agencies; and

(B) the uniform statewide accounting system; and

(3) develop, document, and implement a process to ensure that the commission formally documents:

(A) all programming changes made to the accounts receivable tracking system; and

(B) the authorization and testing of the changes described by Paragraph (A).

## ***Related State Auditor's Office Work***

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| Related State Auditor's Office Work |  |               |
|-------------------------------------|--|---------------|
| Number                              | Product Name   | Release Date  |
| 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  |
| 18-006                              | A Report on Health and Human Services Commission Contracts   | December 2017 |
| 17-025                              | An Audit Report on HealthSpring Life and Health Insurance Company, Inc., a Medicaid STAR+PLUS Managed Care Organization  | February 2017 |
| 17-007                              | An Audit Report on Medicaid Managed Care Contract Processes at the Health and Human Services Commission  | October 2016  |

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The Honorable Dennis Bonnen, Speaker of the House, Joint Chair

The Honorable Jane Nelson, Senate Finance Committee

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