LEGISLATIVE BUDGET BOARD

Medicaid Managed Care in Texas

PRESENTED TO HOUSE COMMITTEES ON GENERAL INVESTIGATIONS AND ETHICS AND APPROPRIATIONS SUBCOMMITTEE ON ARTICLE II

LEGISLATIVE BUDGET BOARD STAFF

JUNE 2018

Statement of Interim Charge

Related to House Appropriations Committee Interim Charge 18 / General Investigating and Ethics Interim Charge 10: monitor the agencies and programs under the Committees' jurisdiction and oversee the implementation of relevant legislation passed by the 85th Legislature, including oversight of the Texas Health and Human Services Commission's management of Medicaid managed care contracts.

1. Overview and History of Medicaid Managed Care in Texas
2. Managed Care Costs and Capitation Rates
3. Medicaid Experience Rebates
4. HHSC Managed Care Contract Oversight
5. Managed Care Organization Procurement Process

Medicaid Overview

Medicaid is a jointly-funded State/Federal program providing health insurance primarily to low-income parents, non-disabled children, pregnant women, the elderly, and people with disabilities. As a requirement of participation, states must cover certain groups and have the option to cover additional groups; Texas does not provide significant coverage of optional groups.

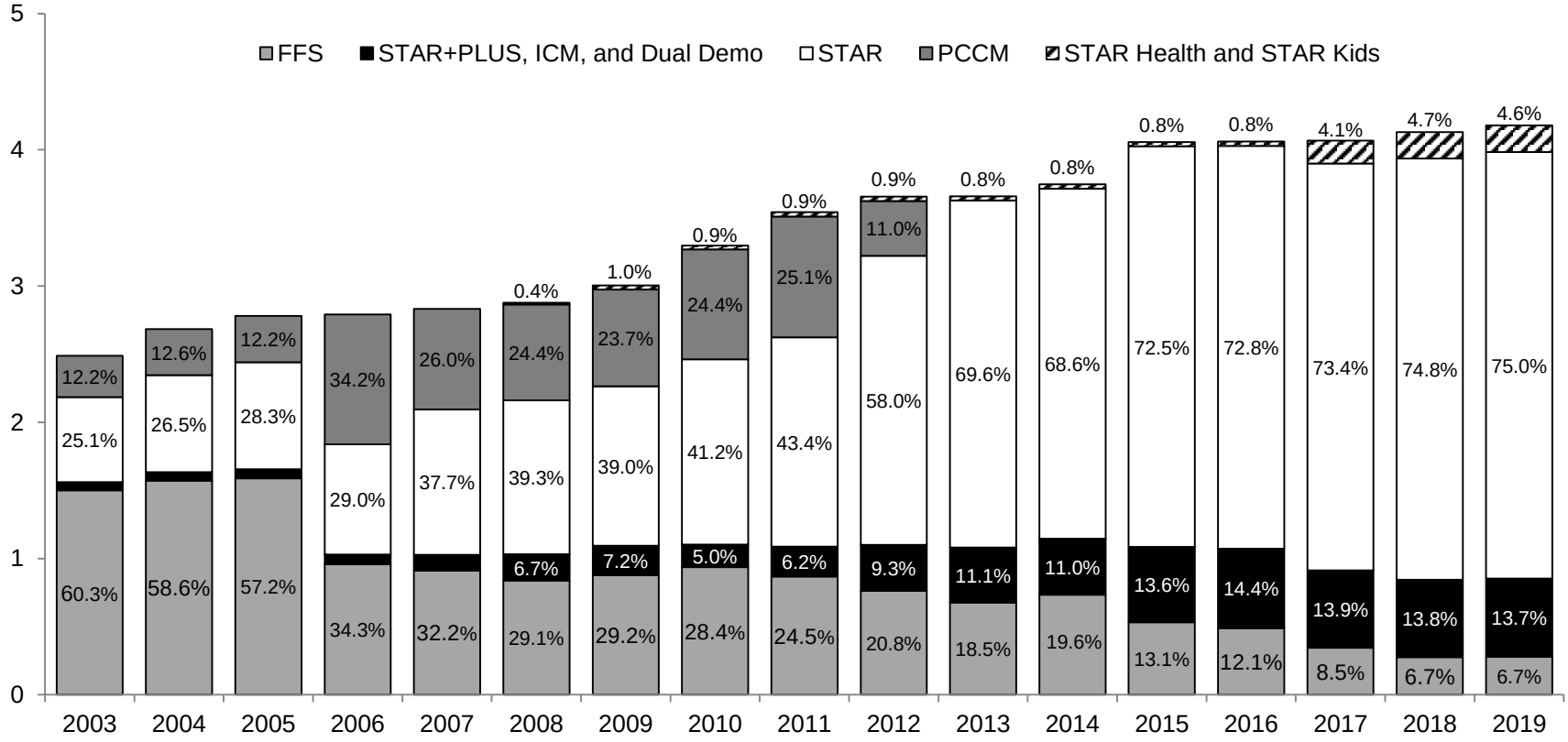
The Health and Human Services Commission (HHSC) is the single state agency responsible for Texas's Medicaid program, but services are administered by a variety of state agencies.

Managed care is a system of delivering health care in which the state contracts with managed care organizations (MCOs) to provide services to Medicaid members and pays the MCOs a per member per month amount (premium or capitation payment).

HHSC is responsible for monitoring MCO contract compliance, service utilization, and quality of care, as well as developing and maintaining Uniform Managed Care Contracts (UMCC) and the Uniform Managed Care Manual (UMCM).

Medicaid Average Monthly Full-Benefit Caseload by Delivery Model
Fiscal Year 2003 to 2019

IN MILLIONS



NOTES:
(1) Represents average monthly number of clients receiving full-benefit Medicaid health insurance services. Managed Care delivery models include all but Fee-for-Service. The percent of clients receiving STAR+PLUS and ICM from 2003 to 2007 was between 2.4 and 4.1 percent.
(2) Fiscal years 2018 through 2019 are based on Legislative Budget Board projections prepared for the 2018-19 General Appropriations Act.
(3) Integrated Care Management (ICM) was an alternative to STAR+PLUS operating in Dallas from February 2008 through May 2009.
(4) Primary Care Case Management (PCCM) was a non-capitated model implemented in September 2005 and discontinued in March 2012.
SOURCES: Legislative Budget Board; Health and Human Services Commission.

Current Managed Care Programs

STAR

Serves eligible non-disabled children, pregnant women, and certain other adults.

Provides acute care, behavioral health care, and pharmacy services.

- August/December 1993: LoneSTAR managed care pilot programs implemented in Travis county and Chambers, Jefferson, and Galveston counties.
- December 1995: Expanded to three additional counties, renamed STAR (State of Texas Access Reform).
- September 1996: Expanded to Bexar, Lubbock, and Tarrant service areas and Travis area was expanded to include additional counties.
- December 1997: Expanded to Harris service area.
- 1999: Expanded to Dallas and El Paso service areas.
- 2006: Expanded to Nueces service area.
- September 2011: Expanded to counties contiguous to existing service areas and to Jefferson service area.
- March 2012: Expanded to Medicaid Rural Service Areas (MRSA) and Hidalgo service area.
- March 2012: Pharmacy benefits carved in. Children's dental services provided through a managed care model.
- September 2017: Expanded to include children for whom an adoption subsidy or permanency care assistance payment is made.

Current Managed Care Programs (cont.)

STAR+PLUS

Serves eligible adults with disabilities, adults over the age of 65, and women enrolled in Medicaid for Breast and Cervical Cancer.

Provides the same services as STAR but incorporates long-term-care services.

Includes waiver-like services for certain qualifying persons similar to the former Community-based Alternatives (CBA) waiver.

- December 1997: Implemented in Harris service area.
- February 2007: Expanded to Bexar, Travis, Nueces, and Harris contiguous service areas.
- February 2011: Expanded to Dallas and Tarrant service areas.
- March 2012: Expanded to El Paso, Lubbock, and Hidalgo service areas.
- March 2012: Pharmacy and inpatient hospital benefits carved in.
- September 2014: Expanded statewide.
- September 2014: Non-dual-eligible clients in waivers for individuals with intellectual and developmental disabilities and nursing-facility benefits carved in.
- September 2017: Expanded to include women enrolled in Medicaid for Breast and Cervical Cancer.

Current Managed Care Programs (cont.)

STAR Health

Serves foster children and certain former foster children.
Provides a service array similar to STAR+PLUS but includes dental services.

- April 2008: Implemented statewide.
- March 2012: Pharmacy benefits carved in.

Dual Demonstration

Serves persons dually eligible for Medicare and Medicaid who were previously enrolled in separate coverage for each program.
Provides the full array of Medicaid and Medicare services.

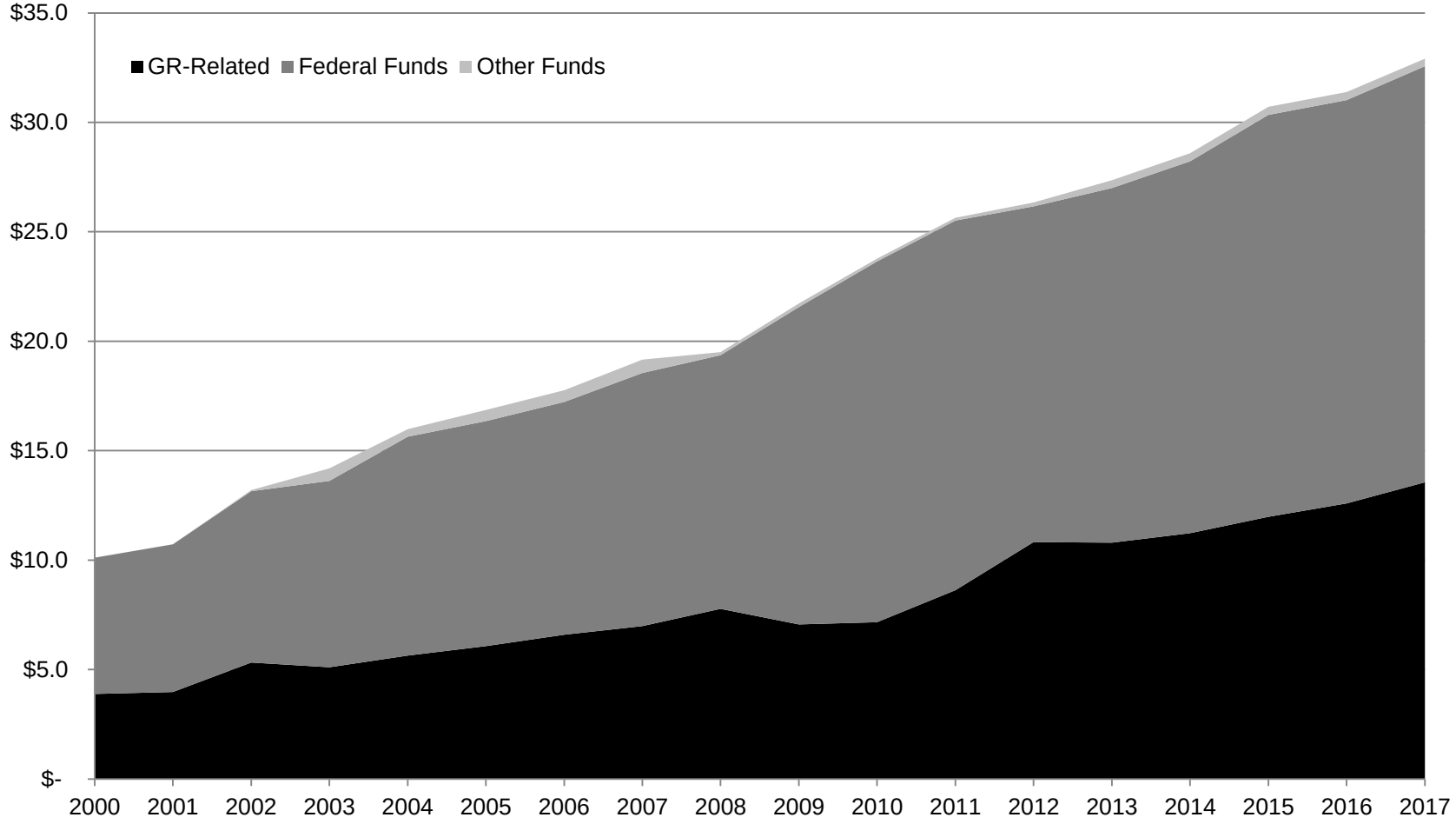
- September 2014: Implemented in Bexar, Dallas, El Paso, Harris, Hidalgo, and Tarrant counties.

STAR Kids

Serves eligible children with disabilities.
Provides a service array similar to STAR+PLUS.
Includes children enrolled in the Medically Dependent Children Program (MDCP waiver).

- November 2016: Implemented statewide.

Medicaid Funding by Method of Finance
Fiscal Years 2000 to 2017



NOTES:
(1) Fiscal year 2017 is estimated.
SOURCE: Legislative Budget Board.

Managed Care Capitation Rates

The state pays MCOs a set amount for each enrolled person, whether or not that person seeks care (capitation rate).

Capitation rates are set primarily on the basis of base year experience data, adjusted for cost, inflation, and utilization trends (trend factors). Capitation rates include the following components:

(1) An amount for health care services performed (including adjustments for service-specific rate changes or the addition of new benefits);

(2) An amount for administration (including both fixed and variable administrative components); and

(3) An amount for the risk margin (reflecting the level of uncertainty regarding the costs of providing coverage).

- Risk margin percentages were reduced beginning in fiscal year 2018 pursuant to Health and Human Services Commission Rider 37 in the 2018-19 General Appropriations Act.
  - From 2.0 to 1.5 percent for STAR and STAR Health
  - From 2.0 to 1.75 percent for STAR+PLUS and STAR Kids

(4) An amount for premium tax.

Experience Rebates

Texas Government Code, §533.104, requires HHSC to adopt rules to ensure MCOs share profits earned through the Medicaid managed care program. 1 TAC §353.3 states that each MCO must pay an experience rebate according to a tiered rebate method described in the MCOs contract with HHSC.

By contract, MCOs must submit a Financial Statistical Report (FSR) including revenue and cost data to HHSC every 12 months. At the end of each FSR Reporting Period, the MCO must pay an Experience Rebate to the state if the percentage of the MCO's Net Income Before Taxes is more than three percent of the total Revenue for the period. The amount of the rebate varies based on the percentages in the table below.

Revenue from experience rebates is appropriated to HHSC to fund Medicaid client services.

Pre-tax Income as a % of Revenues	MCO Share	State Share
> 3% and ≤ 5%	80%	20%
> 5% and ≤ 7%	60%	40%
> 7% and ≤ 9%	40%	60%
> 9% and ≤ 12%	20%	80%
> 12%	0%	100%

Source: Uniform Managed Care Contract

Administrative Cap

Under contract with HHSC, MCOs are required to assemble and pay a network of providers to provide covered services to members enrolled with the MCO. MCOs have flexibility to organize business practices and discretion over how to spend capitation payments, provided that the MCO meets all the requirements of the contract.

The Uniform Managed Care Contract provides for a cap on administrative expenses that an MCO may deduct from Revenue for the purposes of determining income subject to an Experience Rebate. The administrative cap:

1) Does not affect FSR reporting;

2) Does not prohibit the MCO from incurring administrative expenses above the cap; but

3) Requires that administrative expenses above the limit must be counted as Net Income for the purposes of calculating an Experience Rebate.

Managed Care Contract Oversight

	Planning	Solicitation	Contract Award & Formation	Post Award
Internal Oversight	• Medicaid/CHIP Staff • HHSC Management	• Medicaid/CHIP Staff • HHSC Management	• Medicaid/CHIP Staff • HHSC Management	• Medicaid/CHIP Staff • HHSC Management • Inspector General • Internal Audit
External Oversight	• Centers for Medicare & Medicaid Services (CMS)	• Contract Advisory Team	• Attorney General (over $250M)	• LBB • State Auditor • Federal HHS OIG • CMS

HHSC Managed Care Contract Oversight

Components of HHSC's contractual requirements on MCOs include:

- Specifying member's benefit packages;
- Setting service accessibility standards;
- Mandating provider network adequacy;
- Mandating a process for resolving member and provider complaints and appeals; and
- Establishing measures of quality.

HHSC is responsible for monitoring contract compliance and determining contractual remedies (including corrective action plans, assessment of liquidated damages, or contract termination) for non-compliance. Monitoring activities include:

- Agreed Upon Procedures engagements conducted by an audit contractor to verify accuracy of the FSR.
- Utilization Review of utilization management practices in managed care programs.
- Contracting with an external quality review organization to ensure state programs and contracted MCOs are compliant with established standards.

HHSC MCO Contract Oversight
2018-19 General Appropriations Act

Medicaid and CHIP Contracts and Administration
(dollar amounts in millions)

Strategy	General Revenue	All Funds	FTEs
B.1.1, Medicaid Contracts and Administration	$387.6	$1,258.5	806.1
B.1.2, CHIP Contracts and Administration	$2.1	$30.3	60.0
Total	$389.7	$1,288.8	866.1

These strategies include costs for administering the Texas Medicaid and CHIP programs. Expenditures include staffing costs as well as contracted costs for the claims administrator, managed care quality monitoring support, enrollment broker services, informal dispute resolution, and MCO contract oversight.

HHSC MCO Contract Oversight
2018-19 General Appropriations Act (cont.)

HHSC has broad authority to allocate funding and FTEs that are not otherwise restricted by a rider in the 2018-19 GAA between functions and activities within the Medicaid and CHIP Contracts and Administration strategies.

- **Transfer Authority**
  - Provided by Rider 195, Limitations on Transfer Authority – Medicaid & CHIP Contracts and Administration
    - Requires HHSC to obtain written approval from the LBB and the Governor before making any transfers of funding, FTEs, or capital budget authority into or out of Strategy B.1.1, Medicaid Contracts and Administration or B.1.2, CHIP Contracts and Administration.
    - HHSC requested and received approval from the LBB on June 1, 2018 to transfer an additional $4.5 million and 98.0 FTEs for the biennium from Strategy I.1.1, Integrated Eligibility and Enrollment, to Strategy B.1.1, to increase contract oversight and utilization review of the Medicaid program.

Agency Requested Funding

Eighty-fifth Legislature, Regular Session, 2017

- HHSC's LAR for the 2018-19 biennium included a request for $13.7 million in All Funds ($6.8 million in General Revenue Funds) and 79.0 FTEs for contract management, oversight, system improvements, and to extend the Quality Monitoring Program for Intermediate Care Facilities for Individuals with Intellectual Disabilities.

- Agency exceptional item requests are typically not funded in the Introduced General Appropriations Bills. Agencies were asked to revise their exceptional item requests after the General Appropriations Bills (Senate Bill 1 and House Bill 1) were Introduced.

- HHSC did not include the request in their revised exceptional item list after the General Appropriations Bills (Senate Bill 1 and House Bill 1) were Introduced.

MCO Procurement Process

Planning Phase

- Solicitation development and determination of evaluation criteria
- Solicitation review by the Contract Advisory Team

Solicitation Phase

- Solicitation posted to Electronic State Business Daily website
- Pre-proposal conference and vendor questions

Evaluation and Negotiation Phase

- Respondents evaluated against best value criteria
- Preliminary negotiation with vendors in competitive range
- Vendor selection and HHSC internal approval

MCO Procurement Process (cont.)

Contract Award

- Final negotiations with selected vendors
- Contract review by OAG and CMS
- Final review and approval by HHSC Executive management

Contract Management and Oversight

- Internal
- External

MCO Procurement Concerns

- Staffing shortages
  - Procurement and Contracting Services (PCS) had 109 vacancies out of 256 total FTEs as of May 2018
- Evaluation Tools and Process
  - Lack of quality control in vendor scoring and evaluation
- Corrective Actions
  - Audits and management review of procurement processes
  - Procurement consultant RFP released in May 2018
  - In June, HHSC received approval to transfer $0.6 million in All Funds ($0.5 million in General Revenue) and 4.0 FTEs for the biennium into Strategy L.1.1, HHS System Supports, to increase salaries and provide for a quality control team in PCS

Contact the LBB

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